Medicare Secondary Payer Compliance: The Plaintiff’s Perspective

By Tim Nay, M.S.W., Attorney at Law,
Law Offices of Nay & Friedenberg, Portland, Oregon
(503) 245-0894    www.naylaw.com


A. 42 U.S.C. 1395y(b) et seq.(1980)


(A) In general. Payment under this title [42 USCS §§ 1395 et seq.] may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –
   (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
   (ii) payment has been made or can reasonably be expected to be made under a workmen’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. In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan. An automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.1

B. Why is Medicare and MSP compliance suddenly such a big deal? MMSEA

Section 111 of the Medicare/Medicaid State Children’s Health Insurance Program SCHIP Extension Act of 2007 (MMSEA) has ignited a large reaction from liability insurers, including self insurance, settlements, judgments and Workers’ Compensation (W.C.). The pressure is on!

1. Section 111 of the MMSEA: CMS Fantasy or 2012 Reality? Section 111 of MMSEA implemented serious reporting requirements and penalties on insurers with potential $1,000 per day penalties for failure to report injury related medical services or charges to Medicare when the injured party is Medicare eligible.

§ 3.04 [1] Reporting Requirements

When a group health carrier determines that one of its insured’s employees, or employee’s spouse, is eligible for Medicare, the carrier must contact the insured to determine at which times, if at all, these parties were also covered by the group health plan provided by the employer [42 U.S.C.S. § 1395y(b)(5)(C) (2008)]. In addition, before an individual may enroll in Medicare, he or she must first provide CMS with information about whether and to what extent the individual is also covered by a group health plan that would be primary to Medicare [42 U.S.C.S. § 1395y(b)(5)(D) (2008)].

In addition to these standard reporting requirements by Medicare beneficiaries, their employers, and the carriers that provide their coverage, the MSP places duties on providers to determine whether a presenting Medicare beneficiary has access to other insurance [42 U.S.C.S. § 1395y(b)(6)(A) (2008)]. Specifically, providers that submit claims for reimbursement to Medicare must determine, to the best of their abilities, and on the basis of the information that the patient provides, whether the patient is covered by a non-Medicare plan [42 U.S.C.S. § 1395y(b)(6)(A) (2008)]. At the time of hospital admission or the commencement of care, providers are also required to ask Medicare patients if the services are for treatment of an injury or illness resulting from an accident or incident for which the patient holds another party responsible [Medicare Intermediary Manual § 3418.4]. These requirements assist Medicare in determining whether some other entity should be a primary payer.

Willful and repeated failure to comply in reporting (or falsely reporting) the requisite information carries monetary penalties ranging from $1,000 to $2,000 per individual or incident in which the employer or provider fails to provide the information required to notify CMS that Medicare is a secondary payer [see 42 U.S.C.S. § 1395y(b)(5)(C)(ii), (b)(6)(B) (2008)].

Included among the sections governing Medicare as a secondary payer are those authorizing the Social Security Administration to coordinate with the Secretary of the Treasury and CMS to exchange information concerning Medicare-eligible individuals [see 42 U.S.C.S. § 1395y(b)(5)(A) (2008)]. This subsection authorizes CMS to disclose this information to insurers and other intermediaries to assist these entities in determining whether a secondary payer situation may exist [42 U.S.C.S. § 1395y(b)(5)(B) (2008)].

2 Exposure to paying Medicare after paying settlement amounts to plaintiffs if Medicare’s interests are not adequately considered and possible double damages if CMS has to file suit to collect.

---

3. Implementation of some of the Section 111 reporting requirements have been postponed three times and now will not be implemented before January 1, 2012\(^3\). (See Attachment 1)

II. **Gain Better Control of MSP Compliance In Your Case**

A. **Is your client Medicare eligible?**\(^4\)

1. Individuals 65 or older and eligible for retirement benefits including railroad retirement.

2. Individuals under age 65 who have received SSDI benefits for 24 months.

3. Individuals medically determined to have end stage renal disease (ESRD).

B. **Get Started Quickly.**

You can optimize your control over the lumbering MSP machinery by taking the following steps:

(A) Obtain your client’s signature and submit Social Security Form SSA- 3288 (See Attachment 2), to the nearest Social Security Office, even if your client can tell you if s/he is or isn’t Medicare eligible. This form is available at [http://www.ssa.gov/online/ssa-3288.pdf](http://www.ssa.gov/online/ssa-3288.pdf). You will then receive Social Security’s form indicating your client’s eligibility for Social Security benefits, including SSDI and SSI, Medicare and Medicaid benefits. If your client is a minor or incapacitated adult, conservatorship will be required for the submissions above. If your client is not Medicare eligible, this form should satisfy the defense counsel as proof of ineligibility.

(B) If your client is or will be Medicare eligible before settlement, once eligibility is established:

1. **Immediate actions:**
   b. Obtain client’s signature and submit to MSPRC the Proof of Representation Model Form (see [www.MSPRC.info/](http://www.mSPRC.info/))

---

\(^3\) Nov 9, 2010 CMS alert  
\(^4\) 42 U.S.C 1395c
When your client’s Medicare eligibility is established, enable your client to establish a personal “mymedicare.gov” account at www.mymedicare.gov. With your client’s consent, be sure to establish your unrestricted access to the account.

After completion of actions in (2), above, go through the CMS tutorial at http://www.msprc.info/includes/MyMSP/myMSP.htm and access your client’s “My MSP” custom tab on your client’s “mymedicare.gov” account (See Attachment 3). According to the tutorial, once you have notified COBC of your client’s case, all Medicare reimbursed injury medical claims and Medicare payments will be updated on a weekly basis in order to provide you accurate conditional payment information as your case moves forward. This means you are not in the dark about Medicare payments prior to receiving either the CPL, CDN or the final demand letter from CMS.

C. Become familiar with and use CMS’s extremely helpful website, HTTP://www.msprc.info/. Review home page tabs “Letters”, “FAQ’s” and “Tool Kits”


E. Always use the CMS Correspondence Cover Sheet on the “Attorney Tool Kit” page at www.msprc.info/ when sending or faxing to CMS.

III. MSP Compliance Overview: Three Legs of the Stool.

A. § 1.04 Three Separate and Distinct Obligations Under MSP

[1] MMSEA Reporting

MMSEA enforces a reporting requirement on all primary payers, including liability insurance providers, self-insurers, no-fault insurers, and workers’ compensation laws and plans [see 42 U.S.C.S. § 1385y(b)(7), (8); 42 C.F.R. § 411.20], which, generally speaking, comprises all bodily injury claims, including but not limited to malpractice, general casualty, auto liability, product liability, toxic tort, Federal Employers’ Liability Act claims, Longshore and Harbor Workers’ Compensation Act claims, Federal Employees’ Compensation Act, and uninsured/underinsured motorist. Although federal regulations have long required the reporting of such settlements under certain circumstances, they failed to specify any adverse consequences for failing to do so.

---

Now, under MMSEA, failure to give timely notice of a settlement to Medicare results in “a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant” [see 42 U.S.C.S. § 1385y(b)(8)(E)(i)]. For a full discussion of MMSEA reporting, see Ch. 2.


Medicare is entitled by statute to reimbursement for any payments made when it is demonstrated that another party is responsible for those payments. Once a secondary payer situation is identified, parties to a settlement must look to see if Medicare has provided any benefits related to the claimed injury and make reimbursement. Failure to repay Medicare may result in statutory interest accruing and double damages if the government must file suit to recover. Upon initiation of MMSEA reporting in first quarter 20ll, it is anticipated that there will be a flurry of conditional payment demands from the MSPRC. Conditional payment practices are discussed fully in Ch. 3.


By statute, Medicare is prohibited from making payment for treatment that is the responsibility of another party. Absent provisions for future medical treatment made at the time of settlement, and given the fact that Medicare is prohibited from providing treatment, injured parties may be left without medical care if MSP issues are not dealt with properly at the time of settlement. Full discussion of these topics is found in Chs. 4-6.

B. MSP Compliance Statute of Limitations: Six Years

1. U.S. v. Stricker


C. MSP Compliance In W.C. Cases.

1. Conditional Payments (pre-settlement Medicare reimbursement). MSP conditional payment recovery is uncommon in W.C. cases because W.C. carrier usually pays pre-settlement injury related medicals. Industry estimates indicate only 5-10% of conditional


recovery actions are W.C. cases. But if Medicare makes a payment for which a primary “insurer” is liable, Medicare’s right to recover extends to the entire amount of the settlement.8

2. Medicare Set Aside (MSA) arrangements (future injury-related treatment after settlement). An MSA is an amount of the settlement carved out of the total settlement to cover only future injury medical payments. In W.C. cases the amount of the MSA must be approved by CMS, then funded and spent only on post settlement injury medicals and finally accounted for also in accordance with CMS policy until the MSA funds are “exhausted.” Upon proper “exhaustion” of the MSA, Medicare will pay future injury medicals if needed. Medicare will pay non injury medicals regardless of MSA status before and after settlement. However, if the final W.C. settlement provides for all future injury related medical payments required by the client, an MSA is not “required.”9

W.C. cases represent the “birthplace” of MSA arrangements, starting in July 2001. The only authority supporting MSA arrangements in any case is 42 C.F.R. 411.46. Virtually all other authority concerning MSA arrangements has been released as agency memos, alerts, the CMS MSP Manual, Do’s and Don’ts, downloads, Town Hall Teleconferences, etc., none of which are subject to APA rulemaking, notice, due process or appeal.

On July 23, 2001, CMS issued the now famous “Patel Memo” – Workers’ Compensation: Commutation of Future Benefits to “All Associate Regional Administrators.”10 In a series of questions and answers which have been the hallmark of most of the CMS MSP memos, the Patel Memo established the parameters for MSAs in W.C. cases. Subsequent CMS memos have superseded many provisions of the initial Patel memo. Changes in CMS policy over time have been very common. The November 9, 2010, postponement of some Section 111 reporting for the third time is an example.

The Patel Memo, named after CMS employee Parashar B. Patel, was the first of many policy memos, currently numbering 15, setting out MSP compliance procedures and methods in W.C. cases.

---

8 Zinman et al. v. Shalala, 67 F.3rd 841 (9th Cir. 1995)
D. MSP Compliance In Liability Cases, FELA and Jones Act Cases

1. Conditional payments are frequently seen when your client is age 65 or greater at the time of injury or turns 65 prior to settlement. If your client becomes eligible for Social Security Disability Insurance, (SSDI), 30 months or more before settlement, Medicare may make conditional payments before settlement. Even if your client is not Medicare eligible at the time of settlement, or if Medicare has made no conditional payments, defense carriers and insurers are increasingly demanding proof that Medicare has made no payments.

2. MSA Arrangements.

The Medicare Secondary Payer Act makes no distinction between W.C., liability, FELA or Jones Act cases in regards to protecting Medicare’s interests. However, CMS currently has no policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of the future medical aspect of a liability settlement or recover of future medical expenses incurred in liability cases. Big R Towing v. Benoit et.al.11, Finke v. Hunter’s View12

CMS periodically conducts “Town Hall Teleconferences” to discuss MSP compliance issues with members of the MSP compliance community and transcribes the dialogue. In dialogue from teleconferences dated January 28, 2010, March 16, 2010, and September 22, 2010 (See Attachment 5), Barbara Wright, Director of the Medicare Debt Management Division at CMS has stated that “…with respect to set-asides or liability situations that set-asides are not required in terms of CMS being involved in any type of determination of how much the set aside should be.”13 “As we’ve said on many calls, CMS has formalized the process to review proposals for workers’ compensation, Medicare set aside amounts. It does not have the same formalized process for liability Medicare set aside arrangements.”14

Although Town Hall Teleconferences don’t have the effect of a statute, regulation or case law, these comments clearly indicate that MSA arrangements are not “required” by CMS. But the same is also true of W.C. MSAs. On the March 16, 2010, Town Hall transcript at page 41, Ms. Wright stated that “The process for worker’s compensation is voluntary.”15

---

11 Big R Towing, Inc. v. David Wayne Benoit et al., 2011 U.S. Dist. LEXIS 1392
12 Finke v. Hunter’s View, 2009 WL 6326944 (D.Minn.)
13 CMS Town Hall Teleconference 1-28-2010, Page 17
14 CMS Town Hall Teleconference 3-16-2010, Page 41
15 CMS Town Hall Teleconference 3-16-2010, Page 41
3. So why worry about MSA arrangements in either liability cases, FELA or Jones Act cases? Because conditional payment recovery puts CMS on notice of your client’s injury and that CMS is secondary to the primary source for both pre-settlement and post-settlement payments. After settlement, if your client furnishes a Medicare card to a medical provider for injury related treatment, CMS could easily deny payment to the provider. The provider would then initiate action against your client for payment. Your client calls you. How do you advise your client? If CMS mistakenly paid the provider, then CMS could initiate action against your client. Your client would then look to you for a remedy. Without a record showing that Medicare’s interests were protected during the settlement, a malpractice claim could be the only remedy, assuming the client couldn’t pay for the service.

Consider advising your client to “set aside” an amount of the settlement to be used for future injury related medical services. The most conservative approach would be to hire an MSP compliance contractor to prepare an MSA allocation proposal, submit it to CMS even though it might not even be reviewed, then put the recommended amount into a separate account to be spent on medical services. You must decide what level of risk exposure you want yourself and your client to assume.

4. Courts have occasionally set MSA amounts when parties have brought the issue into the litigation. See Footnotes 11 and 12 above.

E. Federal Employers’ Liability Act (FELA) and Jones Act Cases:

1. FELA (and similar state employers’ liability acts) cases are treated the same as liability cases by CMS, CMS MSP Manual, Chapter 1, Section 10.4.

2. Jones Act Cases are currently treated by CMS in the same manner as liability cases and FELA cases. The author is unaware of specific authority from CMS authorizing such treatment.

IV. Pre-Settlement Conditional Payments.

court order on the merits of the case.”\textsuperscript{19} A recent 11\textsuperscript{th} Circuit Court of Appeals case limited Medicare’s priority recovery right, Bradley, et al. v. Sebelius\textsuperscript{20}. The Bradley court determined that the MSP Manual was not entitled to Chevron\textsuperscript{21} deference and upheld the adjudication of the rights of the children of the decedent and those of the estate by the Florida probate Court. The probate court of Alachua County, Florida adopted the plaintiffs’ proposed allocation of $787.50 to Medicare and the remaining $51,712.50 to the children of the decedent.

**B. The only certain reduction of Medicare’s conditional payment recovery is for procurement costs (attorney’s fees and costs) 42 C.F.R. 411.37.**

See “Final Settlement Detail Document” on “Attorney Tool Kit” tab at www.msprc.info/.

---

**V. Post-Settlement “Future” Payments and (MSA) Arrangements**

**A. Since 2001, CMS MSP Enforcement Policy includes MSA submission in certain WC cases. (See Attachment 6)**

**B. Two States, Maryland and Kentucky Have Proposed Legislation That Would Require MSA Approval By CMS Prior To Approving A W.C. Settlement Involving Future Medicals.**

**C. CMS has not mirrored MSA submission in liability cases.\textsuperscript{22}**

But if your client’s case involved conditional payment recovery, CMS already has the ICD-9 codes related to your client’s injury. After settlement, if your client had future injury medicals paid by Medicare, it would be very easy for CMS to inquire into whether Medicare’s interests were considered. Suggestions to preempt a Medicare denial or collection action if Medicare pays for the injury related medicals are found in “Liability Cases & Medicare Compliance” by Mark Popolizio. (See Attachment 7)

---

**VI. Problems Encountered in MSP Compliance Practice**

**A. Plaintiff’s counsel, defense counsel and insurers frequently confuse elements of pre settlement and post settlement MSP compliance standards.**

---

\textsuperscript{19} MSP Manual Chapter 7, Section 50.4.4; The Complete Guide To Medicare Secondary Payer Compliance, 2010 Edition

\textsuperscript{20} Bradley, et. al., v. Sebelius, 2010 WL 3769132 (C.A.11 (Fla.)


\textsuperscript{22} See Footnotes 11, 12 above.
B. All parties involved in MSP compliance, plaintiff's counsel, their clients, defense counsel, insurers and MSP Compliance Contractors express frustration with the process, except CMS.

C. Major complaints:

CMS delays, complexity, liability exposure, differing CMS regional policies and procedures, communication problems, frequent CMS policy and procedure changes and autocratic, arrogant “customer service.”

VII. Legislative, Grassroots and Judicial MSP Compliance Reform Efforts

A. Legislative:


B. Grassroots:

1. Medicare Advocacy Recovery Coalition (MARC),
   www.marccoalition.com, was formed in September of 2008 to advocate for the improvement of the MSP program for beneficiaries and all players in the MSP process. MARC was a major force behind the introduction of H.B. 4796, H.B. 2641 and has participated in several direct meetings with CMS regarding MSP policies and practices. Their website has a useful list of MSP cases, most of which are also in this outline.

2. National Alliance of Medicare Set Aside Arrangements (NAMSAP)
   www.namsap.org, was formed in 2004 to provide information, education and certification of entities working in the MSP compliance industry, primarily in the preparation and submission of MSA allocation proposals. NAMSAP has engaged CMS on a number of issues relating to the MSP compliance process.
VIII. Thorny MSP Compliance Issues Facing Plaintiff’s Attorney

A. Many issues driven by fear of Section 111 insurer reporting requirements.

B. “Number please, Number please”: The battle for social security numbers in liability cases.

This issue is rarely seen in W.C. cases because the W.C. carrier obtains the covered party’s SSAN when the worker enrolls in the plan.

1. Starting point: CFR 411.23 “(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action” and “(b) if CMS’s recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.”

2. CFR 411.24(a) The filing of a Medicare claim by or on behalf of the beneficiary constitutes an express authorization (emphasis added by author) for any entity, including State Medicaid and worker’s compensation agencies, and data depositories, that possess information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

It is unclear if the “express authorization” extends to defense counsel or the carrier/insurer.

3. CMS first raised the issue following the enactment of Section 111 in a June 23, 2008, “ALERT.” (See Attachment 8) Nowhere in the ALERT does CMS mandate an injured party to provide her/his SSAN or Medicare Health Insurance Claim Number (HICN). In fact, this first ALERT begins with the following sentence:

“This ALERT is to advise that collection of SSNs, HICNs or EINs for purposes of compliance with the reporting requirements under Section 111 of Public Law 100-173 is appropriate.” (emphasis added by author)
The same ALERT did, however, mandate SSAN/HICN reporting by “group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits.”

4. On August 24, 2009 (See Attachment 9), CMS released its second ALERT regarding HICN and/or SSAN compliance and also provided model language to assist reporting entities in obtaining this information and being compliant with Section 111. Submission of SSAN or HICN by individuals was not mandated.

5. On April 6, 2010 (See Attachment 10), CMS issued its third ALERT on the subject and again did not mandate submission by claimants.

6. Recent case law.
   (A) Hackley v. Garofano. Settlement was unenforceable because the parties did not “unambiguously agree” on SSAN/HICN issue.
   
   (B) Seger v. Tank Connection, LLC. The court granted defendant’s motion to compel plaintiff to provide SSAN or HICN.

7. Based upon the authority above, you have to decide if withholding your client’s SSAN or HICN when demanded from defense counsel is worth the potential delay in settlement.

C. Weeding out unrelated Medicare charges from the initial conditional payment letter (CPL) and the final conditional payment amount on the CMS demand letter.

1. Reviewing service entries on the CPL CDN and final demand letter, it is a complicated, highly specific process requiring fluency in ICD-9 codes (soon to be ICD-10) as well as the ability to distinguish non-injury entries from injury-related injuries. Some OTLA members are doing it in house.

2. Consider using an MSP compliance contractor if the information on your client’s “mymsp.gov” custom tab on your client’s “mymedicare.gov” account has many entries for both injury and non-injury Medicare services. MSP compliance contractors have the skill sets to do this quickly and accurately. Using the “MYMSP” tab on your client’s “MyMedicare.gov” account gives you a healthy head start on reviewing the data.

3. Many OTLA members have expressed frustration because after alerting CMS of non-injury related services on the CPL, such entries are not removed from the final demand. An experienced MSP compliance contractor will ensure removal of unrelated items. When using an MSP compliance contractor, always order “expedited” or “rush” service. An amended CPL or final demand is the goal.

D. Allocation/apportionment of gross proceeds. CFR 401.601 – 401.625

1. CMS will not recognize allocation of policy limit settlement between multiple injured parties by:
   - Agreement of the parties
   - Mediation or arbitration
   - Probate court determination

2. CMS will not recognize apportionment of proceeds among damage categories unless a court makes such a determination “on the merits.”

The most notable exception to this CMS position has been the 11th Circuit Case of Bradley, et al v. Sebelius, discussed above.

E. Administrative Remedies to Alter CMS 100% Conditional Payment Recovery.

2. Request for Reconsideration, 42 C.F.R. 405.960.
4. Medicare Appeals Counsel Review, 42 C.F.R. 401.613(c)(2)
5. U.S. Court of Appeals

26 Roland v. Sebelius, 2010 U.S. Dist. LEXIS 1502
27 Bradley et al. v. Sebelius, see Footnote 11
28 See Footnote 19, above
29 Bradley, et al v. Sebelius, see Footnote 11
6. MSP Appeals, Explained:

7. Hardship Waiver
   (A) Exhaustion of administrative remedies above required US v. Harris
   Roland v. Sebelius
   (B) Lusker v. HHS
   (C) Gray v. Doe, et. al.
   (D) Go to www.msprc.info/ Attorney Tool Kit, “SSA 632 Request for Waiver”
   (E) Hadden v. USA. In Hadden, plaintiff Vernon Hadden requested a waiver of his conditional payment based on theories of equitable allocation citing Arkansas v. Ahlborn, equity and good conscience citing Quinlivan v. Sullivan, and Make Whole Doctrine with no citation to authority. All were rejected by the court. This is also the established position of the Ninth Circuit when CMS exercises its direct right of action as opposed to subrogation.

8. Pre Settlement Compromise
   The author recently presented at a Portland MSP compliance training for insurance industry employees. One of the co-presenters was Jonella Windell, CMS Region X MSP Compliance Coordinator from Seattle. Ms. Windell stated that she would directly review requests for Pre Settlement Compromise submitted by any party to reduce the conditional payment amount sought by CMS. If the conditional payment amount is over $100,000, the request is forwarded to CMS Central Office and then forwarded to the U.S. Department of Justice. Apparently a compromise of 60% or more is higher than CMS will likely recommend, regardless of the facts.

---

31 Roland v. Sebelius, see Footnote 16
32 Lusker v. HHS, 2010 U.S. Dist. LEXIS 1076
33 Gray v. Doe, et. al., 2010 U.S. Dist. LEXIS 83067
34 Hadden v. USA, 2009 U.S. Dist. LEXIS 69383
36 Quinlivan v. Sullivan, 916 F. 2d 524 (9th Cir. 1990)
37 Farmers v. Forkey, See Footnote 17 above
F. Medicare As Payee On Proceeds Check. OTLA members have regularly reported that following settlement negotiations, in which naming Medicare on the proceeds was never discussed. The check arrives, nonetheless, with Medicare as a payee. Needless to say, getting Medicare’s endorsement on the check is impossible, thus requiring the other payees to endorse the check and then the check must be submitted to CMS for deposit in the Medicare Trust Fund. Upon deposit of the check, Medicare then issues a check payable to the other parties in the original check for the net proceeds after the conditional payment amount, minus procurement costs have been deducted. This process takes anywhere from one to three months for the turn around and is strongly discouraged by CMS. If the defense insists on making CMS a payee on a check, print the complete “MYMSP” tab screen on your client’s “MYMEDICARE.gov” account and ask the defense to cut two checks: one to CMS for the amount on the screen and the second check to you and the client or to your client trust account.

In Tomlinson v. Landers, the United States District Court of Florida dismissed the defense’s motion to enforce a settlement that was silent on Medicare’s inclusion on the check based upon a “lack of meeting of the minds.” In Wall, et al v. Leavitt, the Federal District Court for Eastern District of California upheld the defense’s motion to dismiss a plaintiff’s class action suit regarding Medicare as a payee on the check. In Zaleppa v. Seiwell, the Superior Court of Pennsylvania concluded that there is no legal basis under either federal or Pennsylvania law to assert the interests of the United States government as to the reimbursement of Medicare liens.

G. Medicare Advantage (Medicare M+C Plan) MSP recovery. Although C.F.R. 422.108 and 42 U.S.C. 1395y(b)(2)(B) grant certain elements of MSP conditional payment recovery to Medicare Advantage Plans and plan agents, the recent United States District Court for the Southern District of Florida decision in Humana v. Reale, et al held that a Medicare advantage provider cannot claim the same right to recovery under C.F.R. 422.108(f) that is granted only to the United States. This means that the numerous Medicare advantage plan providers in Oregon, often represented by Simpson Subrogation Services, might not have the

39 Tomlinson v. Landers, 2009 WL 1117399 (M.D. Fla.)
authority to pursue recovery on behalf of Medicare even though the plan provider was authorized to make the conditional payment.

**H. Private right of action.** Statutory basis: 42 U.S.C 1395y(b)(3)(A) provides that “there is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with” the Medicare Secondary Payer Act.

1. Although this provision of Medicare Secondary Payer Compliance has been the subject of numerous cases\(^43\), the majority of the case law has dismissed such claims for lack of standing which is narrowly defined as only the injured Medicare recipient.

2. Things that the MSP private right of action will not do:
   (A) Recover without an actual injury for which Medicare has paid for treatment
   (B) Recover on behalf of Medicare because suspect/know that Medicare is paying when it shouldn’t
   (C) Recover for lack of an MSA provided at settlement (Medicare only has a claim to expenses already made – no claim for future unknown meds under MSP)
   (D) Recover as a tax payer (injury too generalized and too attenuated to constitute an actual injury warranting any merit)
   (E) Recover against a GHP who refused to make payment for Medicare entitled individual (Medicare had not made any payments for the treatment in question, therefore no MSP recover rights triggered)

3. The only fact situation this author has seen that would fit into the current statute above was posted on the OTLA list serve several months ago. A Medicare eligible client fell at a neighbor’s house while helping the neighbor move a freezer. Medicare made several thousand dollars of conditional payments. The liability carrier refused to acknowledge the accident, even thought the premises were covered by a no fault policy. This appears to be a perfect facts situation to bring the MSP private right of action claim and such claim would be

entitled to double damages under 42 U.S.C. 1395y(b)(3)(A) Liggette. 44 See also O’Connor v. Mayor and City Counsel of Baltimore.45

I. Medicare provider bills Medicare then seeks recovery of actual charges from a beneficiary. This fact situation arose recently on the OTLA listserv and is addressed specifically by Chapter 2, Section 40.2 C. of the Medicare Secondary Payer Manual.46

Provider Charges to Beneficiaries for Services Covered by Medicare

The following applies to providers who participate in Medicare, emergency hospitals who do not participate in Medicare, and foreign hospitals with an election to bill Medicare:

- If the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.
- If the provider pursues liability insurance, the provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

Physician and Other Supplier Charges to Beneficiaries for Services Covered by Medicare

The following applies to physicians and other suppliers who participate in Medicare:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.
- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

J. Settlement document release/waiver/indemnification language. Every plaintiff’s attorney whose client has been Medicare eligible prior to settlement has seen a plethora of release/waiver/indemnification provisions in settlement documents. (See Attachment 11)47. In addition, many plaintiff’s attorneys have seen egregious settlement document language

44 Glover, et. al, v. Liggette Group, Inc., see Footnote 36 above
45 O’Connor v. Mayor and City Counsel of Baltimore, 494 F. Supp. 2d 372 (D.Md. 2007)
47 “Samples of Release Language” Mary Re Knack Esq, Williams Kastner, Seattle, Wash.
requiring the plaintiff to guarantee that s(he) will never seek Medicare reimbursement for future injury-related medicals. Even in the worst case of Medicare set aside amounts, once the set aside amount approved by CMS has been properly exhausted, future injury-related claims by plaintiff will be reimbursed by Medicare. None of this language will prevent CMS from recovering from a provider or insurer after settlement if CMS determines that Medicare’s interests have not been adequately considered. The only effect of agreeing to such language is that the insurer/provider will have a cause of action against the plaintiff if Medicare recovers after settlement.
November 09, 2010

Medicare Secondary Payer Mandatory Reporting Provisions in
Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

ALERT

I. Revised Implementation Timeline for TPOC Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards or Other Payments

II. Extension of Current Dollar Thresholds for Liability Insurance (Including Self-Insurance) and Workers’ Compensation

I. Revised Implementation Timeline for TPOC Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards or Other Payments

The required submission of liability insurance (including self-insurance) initial claim reports has been changed from the first calendar quarter of 2011 to the first calendar quarter of 2012 for all liability insurance (including self-insurance) TPOC amounts with no ORM involvement. Liability insurance (including self-insurance) ORM reporting is not subject to this delay.

Liability insurance (including self-insurance) TPOCs must be reported if the TPOC Date is on or after 10/1/2011.

- The current rule requiring reporting of NGHP TPOC Dates of 10/1/2010 has been changed to 10/1/2011 but only for liability insurance (including self-insurance) TPOCs.
- The reporting date requirements for TPOC Dates of 10/1/2010 and subsequent associated with no-fault insurance or workers’ compensation claims remain unchanged.
- The reporting date requirements as documented in the User Guide for all NGHP ORM remain unchanged.
- Initial Claim Input Files for reportable claims are still due during the RRE’s assigned file submission timeframe for the first calendar quarter of 2011. RREs that have reportable claims must commence production reporting in first calendar quarter 2011 and then include liability insurance (including self-insurance) TPOC reporting in the first calendar quarter of 2012 for TPOC Dates of 10/1/2011 and subsequent.

Regardless of this delay, an RRE who wishes to report liability insurance (including self-insurance) TPOC information may do so during their assigned file submission timeframe for any quarter prior to the first required submission in the first calendar quarter of 2012.
Social Security Administration
Consent for Release of Information

Instructions for Using this Form
Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor’s non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:
• Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY 1-800-325-0778), or
• Request information about your earnings or employment history. Instead, complete form SSA-7060-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7060.pdf.

How to Complete this Form
We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

• Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
• Fill in the name and address of the individual (or organization) to whom you want us to release your information.
• Indicate the reason you are requesting us to disclose the information.
• Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
• You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
• If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT
Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person’s eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT
This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA’s website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21236-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-3288  (07-2010) EF (07-2010) Destroy Prior Editions

Attachment 2, Page 1 of 2
Social Security Administration
Consent for Release of Information

SSA will not honor this form unless all required fields have been completed (* signifies required field).

TO: Social Security Administration

*Name

*Date of Birth

*Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME

*ADDRESS

*I want this information released because:

There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

☐ Social Security Number
☐ Current monthly Social Security benefit amount
☐ Current monthly Supplemental Security Income payment amount
☐ My benefit/payment amounts from ___________ to ___________
☐ My Medicare entitlement from ___________ to ___________
☐ Medical records from my claims folder(s) from ___________ to ___________
   If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
☐ Complete medical records from my claims folder(s)
☐ Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.)

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: ___________________________  *Date: ___________________

Relationship (if not the individual): ___________________________  *Daytime Phone: __________________

Form SSA-3288 (07-2010) EF (07-2010)
What will you see on your My Medicare Menu

The My Medicare site is structured into several areas. These areas are available by using the navigation menu located under the My Medicare banner. Additional buttons may appear dependent on the beneficiary.

The My MSP tab is only visible if/when the beneficiary has claims subject to recovery efforts. This area contains the conditional payment information about the specific case.
On September 30, 2010, the United States District Court for the Northern District of Alabama (The Honorable Karon Owen Bowdre) issued an Order dismissing the U.S. v. Stricker lawsuit (CV-09-PT-2423-F) against certain named defendants on statute of limitations grounds. The Court basically ruled that the Federal Government (hereinafter “Government”) failed to file its lawsuit in a timely manner.


By way of background, in December, 2009, the Government sued numerous party defendants (including certain named plaintiff lawyers, plaintiff law firms, corporations and insurance carriers) for their alleged failure to reimburse Medicare for conditional payments in connection with a large toxic tort liability settlement reached in 2003.

Several (but not all) of the defendants filed separate Motions to Dismiss the Government’s actions on various grounds, including that the Government had failed to file its action within the required legal time period under the law. The Government filed a Motion for Partial Summary Judgment on Liability arguing that, as a matter of law, the Court should rule in its favor.

On September 13, 2010, these motions were heard before the Court at which time the parties presented oral arguments in support of their respective positions. Upon hearing the parties’ arguments, the Court dismissed the Government’s action against those particular defendants that had filed motions to dismiss. At the time this article was drafted, the Government had not filed an appeal, and the author is unaware at this time as to whether or not the Government plans to appeal this decision.

The Court’s decision in U.S. v. Stricker is obviously an important legal victory, especially for the party defendants in whose favor the Court ruled. Notwithstanding, the significance of the U.S. v. Stricker action itself, and the technical grounds upon which the action was dismissed, must be assessed in the larger context of Medicare compliance and kept in proper perspective.

By deciding the issue on statute of limitations grounds, the court in Stricker indeed addressed an important and underdeveloped aspect of the Medicare Secondary Payer Statute (MSP). In this respect, the Court’s decision certainly provides some welcomed substance to an otherwise peculiar legal and analytical terrain.
However, while the Government’s action was dismissed, it is important to understand that the major substantive issues regarding primary payer and practitioner obligations to protect Medicare’s interests for conditional payments under the MSP (which was at the core of the Government’s action) remain.

Thus, notwithstanding the Government’s defeat in this case, primary payers and practitioners must still ensure that they are properly addressing the issue of Medicare conditional payments as part of their claims handling and settlement practices to meet their MSP obligations, and to avoid a possible similar Stricker action from being filed against them.

Through this article, the author aims to place the U.S. v. Stricker lawsuit and the Court’s ruling into proper perspective to assist the reader in his/her larger assessment of this case in the bigger picture of MSP compliance.

This analysis is broken down as follows:

Part I: How It All Began (The Abernathy Settlement - Factual Background) (p. 2-3)

Part II: The Federal Government Files Suit (U.S. v. Stricker) (p. 3-5)

Part III: The Court’s Ruling Why Did the Court Dismiss the Government’s Action? (p. 5-10)

PART I
How It All Began
(The Abernathy Settlement – Factual Background)

The U.S. v. Stricker lawsuit arises from the settlement of a large toxic-tort case in Alabama in which thousands of parties (referred to as “plaintiffs” under the law) filed lawsuits against certain chemical companies for injuries and other damages allegedly caused by PCB chemical contamination.5

These lawsuits began to be filed in 1996 in various state and federal courts. These suits were eventually consolidated given the scale of the filed actions. The consolidated action in the federal court was styled as Tolbert v. Monsanto Co. (CV-01-C-1407S (N.D. Ala.). The consolidated action in the state court was styled as Abernathy v. Monsanto (No. CV-01-832 (Circuit Court of Etowah County, Ala.).

In 2003, the parties reached a “global settlement” for $300 million. This settlement became known as the Abernathy Settlement.

Understanding the terms of the Abernathy Settlement Agreement and its corresponding payout structure is important as the Court’s ultimate determinations and ruling hinged on certain transaction dates related thereto.

The pertinent factual components of the Abernathy Settlement are as follows:

• August 20, 2003 — The global settlement was announced as part of a joint session of the applicable federal district and state circuit courts.

• August 26, 2003 — Defendants Monsanto, Pharmacia and Solutia wire transferred the initial $75 million payment into a special settlement account set up in the Circuit Court.

• September 9, 2003 — Parties executed a formal written Settlement Agreement.

• September 10, 2003 — The Calhoun County Circuit Court entered an Order approving the Settlement Agreement.

• September 17, 2003 — An additional $200 million was transferred to a court-established settlement account.

• As will be noted, by the middle of September, 2003, the sum of $275 million had been deposited into the court registry. The Settlement Agreement contained specific terms governing the subsequent distribution of the funds to the individual plaintiffs.

In accordance therewith, on October 28, 2003 plaintiff counsel filed the required certification representing that 75% of the adult plaintiffs had signed the required releases and at that time requested transfer of the $275 million to the court approved trust account held by one of the plaintiff law firms.

• December 2, 2003 — Plaintiff’s counsel filed a certification that the last remaining condition for distribution had been met; specifically, that court approval had been obtained of the claims involving minors and that at least 97% of the total plaintiffs had signed releases.

• The remainder of the settlement proceeds was to be paid in annual $2.5 million installments from 2004 to 2013.5
PART II
The Government Files Suit -
(U.S. v. Stricker)

A little over six years after the parties executed the Abernathy Settlement Agreement, the Government filed a lawsuit against certain parties to the Abernathy settlement seeking reimbursement of Medicare conditional payments. This lawsuit became known as U.S. v. Stricker (Stricker being the surname of the first named defendant in the action).


Who Did the Government File Suit Against?

The Government filed suit against numerous parties in connection with the Abernathy Settlement, which can be categorized as follows:

- The chemical companies sued in Abernathy and their liability insurance carriers (and their subsidiaries) [Referred to by the Stricker Court as “Corporate Defendants”].
- Certain named plaintiff attorneys and plaintiff attorney firms that represented the Abernathy plaintiffs [Referred to by the Stricker Court as “Attorney Defendants”].

It is interesting to note that the Government did not sue any of the alleged Medicare beneficiaries to the settlement, although under the MSP it would appear that it could have also filed suit against these individuals. See e.g., 42 C.F.R. § 411.24(g)

What Was the Basis of the Government’s Action?

The Government alleged that the Abernathy Settlement contained 907 Medicare beneficiaries and that the defendants failed to properly reimburse Medicare for conditional payments made by the Medicare program for medical treatment related to the claimed injuries and illnesses as required under the MSP.

Against the Attorney Defendants, the Government alleged that they had “received” primary payments entitling Medicare to recover conditional payments under the MSP.

In this respect, the Government alleged that the Attorney Defendants failed to properly comply with the MSP as follows:

- Attorney Defendants knew or should have known that one or more of the claimants were Medicare-eligible individuals on whose behalf Medicare was entitled to recover any conditional payments.
- Failed to reimburse Medicare for conditional payments as required under the MSP.

Against the Corporate Defendants, the Government asserted that payment of the settlement represented “primary payment” under the MSP entitling Medicare to recover conditional payments.

In this regard, the Government alleged that the Corporate Defendants failed to properly comply with the MSP as follows:

- Failed to determine if any of the settling plaintiffs were Medicare beneficiaries, and that they knew or should have known that one or more of the claimants were Medicare-eligible individuals on whose behalf Medicare was entitled recover any conditional payments.
- Failed to identify any amount(s) owed to Medicare for reimbursement of conditional payments.
- Failed to reimburse Medicare for conditional payments as required under the MSP.
In its Complaint, the Government listed several MSP statutes and regulations outlining the statutory bases for Medicare’s right to pursue an action to recover conditional payments and the parties against which this right can be pursued, including the following:

- **42 U.S.C. § 1395y(b)(2)(A)(ii) –**

  **Basis for Medicare’s Secondary Payer Status & Conditional Payments**

  In pertinent part, this section provides that Medicare will not make payment for medical services if “payment has been made or can reasonably be expected to be made under a worker’s compensation law or plan of the United States or a State or under an automobile or liability policy or plan (including self-insurance) or under no-fault insurance.”

  However, Medicare may make “conditional payment” for medical treatment if a primary plan “has not made or cannot reasonably be expected to make payment” with any such payment “conditioned on reimbursement to the appropriate Trust Fund…” 42 U.S.C. §1395y(b)(2)(B)(i), 42 C.F.R. §§ 411.21 and 411.52.

- **42 U.S.C. § 1395y(b)(2)(B)(ii) –**

  **Establishes Medicare’s Right to Bring an Action to Recover Conditional Payments**

  In pertinent part, this statute states:

  A primary plan, and an entity that receives payment from a primary plan, shall reimburse [Medicare] with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.

  A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.

  In addition to above factors, “responsibility” may also be demonstrated by a “settlement,” “award,” or “contractual obligation.” 42 C.F.R. § 411.22(b).

- **42 U.S.C. § 1395y(b)(2)(B)(iii) –**

  **Medicare Has The Right to Pursue Parties Who “Make” or “Receive” Primary Payment**

  This section states that the government may bring an action to recover conditional payments against “any and all entities that are or were required or responsible … to make payments with respect to the same item or service (or any portion thereof) under a primary plan.”

  This section allows Medicare to seek *double damages* from any entity responsible to make payment under a primary plan which fails to reimburse Medicare conditional payments. *See also*, 42 C.F.R. § 411.24(c)(2)

  In addition, this section also provides the government with a right of action against “any entity that has *received* payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.”  *See also*, 42 C.F.R. § 411.24(g)

- **42 C.F.R. § 411.25(a) –**

  **Notice to Medicare (Primary Payers)**

  This section provides that if a third party learns that CMS has made a Medicare primary payment for services for which the third party has made or should have made primary payment, it must give notice to that effect to Medicare.

- **42 C.F.R. § 411.24(b) –**

  **Medicare’s Initiation of Recovery for Conditional Payments**

  This regulation provides that CMS may initiate recovery for payment of Medicare conditional payments as soon as it learns that payment “has been or could be made” under workers’ compensation, any liability or no-fault insurance, or an employer group health plan.
• **42 C.F.R. § 411.24 (h) & 42 C.F.R. §§ 411.24(i)(1) and (2)** -

**Reimbursement Medicare**

Under 42 C.F.R. § 411.24 (h), the beneficiary or other party who receives a third party payment must reimburse Medicare within 60 days.

Per 42 C.F.R. § 411.24 (i)(1), if the claimant does not reimburse CMS within 60 days, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

From the author’s perspective, an understanding of these statutes and regulations is helpful in terms of not only understanding the bases of the Government’s action, but also in relation to the reader assessing their own potential obligations as part of claims handling and settlement practices.

**What Legal Relief Did the Government Seek?**

The Government claimed the following in terms of legal relief:

1. Reimbursement of the alleged Medicare conditional payments (the exact figure was not referenced in the Complaint) against all of the defendants, plus interest.

2. **Double damages** against the Corporate Defendants.

3. Declaratory relief against the Corporate Defendants requiring them to give notice to CMS of all future payments to Medicare beneficiaries per 42 C.F.R. § 411.25, and to ensure that they make appropriate payment to Medicare before any future settlement payments were made from the settlement.

**PART III**

**The Court’s Ruling**

**Why Did the Court Dismiss the Government’s Action?**

By Order dated September 30, 2010, the Court dismissed the Government’s action on grounds of the statute of limitations as to those defendants that had filed motions to dismiss. 56

As part of its analysis, the Court first briefly summarized the basic statutory tenets and conceptual underpinnings of the MSP noting that other courts had referred to the statute as “convoluted and complex” and a “model of unclarity.” 57

However, at its core, the Court noted that the objective of the MSP was relatively straightforward observing that the MSP is essentially “a statutory reimbursement mechanism for the Government to recover expenses conditionally paid by Medicare.” 58 (Many of the provisions referenced by the Court were contained in the Government’s Complaint as outlined by the author above in Part II of this article).

On this point, the Court referenced the following summary of the MSP from the Eleventh Circuit opinion in United States v. Baxter Int’l, Inc., 345 F.3d 866 (11th Cir. 2003): 59

In a nutshell, the MSP declares that, under certain conditions, Medicare will be the secondary rather than primary payer for its insureds. Consequently, Medicare is empowered to recoup from the rightful primary payer (or from the recipient of such payment) if Medicare pays for a service that was, or should have been, covered by the primary insurer. Although the statute is structurally complex—a complexity that has produced considerable confusion among courts attempting to construe it—the MSP’s function is straightforward. 60

After establishing this framework, the Court then turned its attention to addressing the specific issues before it. Before dissecting the Court’s Order, a few preliminary points are in order.

**First,** the statute of limitations issue regarding the MSP is an unsettled area of the law. A full examination of the statute of limitations issue is beyond the scope of this article. Accordingly, the discussion herein will be limited to the Court’s analysis of the issue within the specific confines of the U.S. v. Stricker action.

**Second,** in reaching its ruling the Court expressly stated that its decision was premised upon the assumptions that the Corporate Defendants were “primary payers” (as that term is defined under the MSP) and that there was no issue concerning the applicability of certain retroactive amendments made to the MSP back in 2004. 61 The Court also assumed that the Attorney Defendants were entities that “received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity” under the MSP. 62
It is important to understand that the Court did not render factual or legal determinations on these assumptive points. Rather, these points served to establish applicability of the MSP thereby allowing the Court to proceed with analyzing (and ultimately deciding) the issue from the standpoint of the statute of limitations.

With these preliminary matters established, the focus can now shift to examining the Court's ruling.

The Court framed the two issues to be determined as follows:

**Issue #1**

**What is the applicable statute of limitations?**

**Court's Ruling on Issue #1**

1. The Court ruled that a **three year** statute of limitations applied to the Corporate Defendants.

2. The Court ruled that a **six year** statute of limitations applied to the Attorney Defendants.

**Court's Analysis**

The Court started its analysis by noting that it found the MSP to be "silent" in regard to a deadline for filing a claim for recovery in relation to this action. [By way of note, it is interesting that neither the parties nor the Court discussed, or even referenced, the possible relatedness (or non-relatedness) of the "Claims-Filing Period" section as specifically contained in the MSP. See, 28 U.S.C. § 1395y(b)(2)(B)(vi).]

As such, the Court referenced that the parties agreed that the "relevant statute of limitation for the Government's claims, if any, is governed by the Federal Claims Collection Act (FCAA) [codified at] 28 U.S.C. § 2415 (2008)."

The FCCA establishes either a six or **three year** statute of limitations.

**Subsection (a) of the FCCA sets forth a six year statute of limitations based on contract as follows:**

[H]e defendant's reimbursement duties to the Government are based solely on the MSP statute because no express contract exists between the Defendants and the Government. The defendant's relationship with the Government prompting liability for reimbursement under the MSPA arises only, if at all, from the defendant's tortious activity with any potential Medicare beneficiaries arising from the allegations of reckless and negligent behavior, which prompted the $300 million settlement agreement. [H]e Court finds in this scenario that logic and reason compel the application of the three year statute of limitations founded upon tort, because the Government's MSPA claims are founded upon allegations of the Corporate Defendant's tortious activity and the resulting tort settlement. (Emphasis by the Court).

The Government argued that the six year statute should apply based upon the "implied at law" contract theory (the Government conceded the point that no express contract existed). However, the Court rejected this argument unless the Complaint is filed within six years after the right first accrues." 28 USC § 2415 (a). (Emphasis Added)

**Subsection (b) of the FCCA sets forth a three year statute of limitations based on tort as follows:**

[For] every action for money damages brought by the United States ... which is founded upon a tort shall be barred unless the Complaint is filed within three years after the right of action first accrues. 28 USC 2415 (a). (Emphasis Added).

In applying the FCCA, the Court noted that "because the nature and origin of the purported relationship between the Government and the two [defendant] categories differ" it was necessary to perform a separate analysis for each defendant.

Accordingly, the Court broke down its analysis in the following manner:

**Corporate Defendants (Three Year Statute Applies)**

The Court ruled that the FCCA's **three year statute of limitations applied to the Corporate Defendants** finding that the Government's claims arise from an underlying tort action between the plaintiffs and the Corporate Defendants.

On this point, the Court stated:

[T]he defendant's reimbursement duties to the Government are based solely on the MSP statute because no express contract exists between the Defendants and the Government. The defendant's relationship with the Government prompting liability for reimbursement under the MSPA arises only, if at all, from the defendant's tortious activity with any potential Medicare beneficiaries arising from the allegations of reckless and negligent behavior, which prompted the $300 million settlement agreement. (Emphasis by the Court).

The Court finds in this scenario that logic and reason compel the application of the three year statute of limitations founded upon tort, because the Government's MSPA claims are founded upon allegations of the Corporate Defendant's tortious activity and the resulting tort settlement. (Emphasis by the Court).

The Government argued that the six year statute should apply based upon the "implied at law" contract theory (the Government conceded the point that no express contract existed). However, the Court rejected this argument
stating that "while creative, [that argument] stretches too far beyond the bounds of logic and reason to adopt as precedent." The Court also rejected the Government’s arguments for application of a six year statute based on the theory of restitution and actions invoking cost-recovery statutes.

**Attorney Defendants (Six Year Statute Applies)**

The Attorney Defendants took the position that the six year statute of limitations controlled in regard to them, which was accepted by the Court.

The Court’s rationale on this point was as follows:

Logic suggests that the Attorney Defendants who represented the tort plaintiffs in the Abernathy case, the alleged Medicare beneficiaries in the instant case, essentially acted as agents pursuant to the contractual relationship between the Government and the Medicare beneficiaries. More specifically, the Attorney Defendants’ obligation to pay their clients any monies allegedly owed to the Government for Medicare reimbursement, unlike that of the Corporate Defendants, arose not from any tortious conduct on behalf of the Attorney Defendants themselves but from an express contractual relationship with the Medicare beneficiaries—namely, any fee agreement or attorney-client agreement between them. From that perspective, the Attorney Defendants’ MSPA obligation is essentially founded upon a contractual obligation.

For these reasons, the grounds for statute of limitations determination as applied to the Attorney Defendants is more reasonably founded upon contract rather than tort. The contractual nexus is clearer in this instance than as alleged against the Corporate Defendants, whose MSPA obligations ultimately arose from, and cannot be divorced from, allegations of tortious conduct.

The court, therefore, concurs that the six-year statute of limitations applies as to the Attorney Defendants.

**Issue #2**

What is the appropriate time of accrual concerning the Government’s cause of action?

**Court’s Rulings On Issue #2**

1. **Corporate Defendants**

The Court ruled that the three-year statute of limitations began running against the Corporate Defendants no later than September 10, 2003, which was the date the executed Abernathy Settlement Agreement was approved by the state court.

Therefore, the Court found that the statute of limitations expired no later than September 10, 2006, thereby making the Government’s claim filed against the Corporate Defendants on December 1, 2009 untimely.

Alternatively, the Court ruled that even under the six-year statute of limitations, the Government’s claims against the Corporate Defendants expired no later than September 10, 2009, thereby barring the Government’s claim as untimely.

2. **Attorney Defendants**

The Court ruled that the six-year statute of limitations began running against the Attorney Defendants no later than October 29, 2003, the date they received the $275 million payment from the Abernathy settlement.

Therefore, the Court found that statute of limitations expired no later than October 17, 2009 thereby barring the Government’s claims against the Attorney Defendants which was filed on December 1, 2009.

3. **Federal “Tolling” Statute Held Inapplicable**

The Court ruled that the Federal tolling statute, which would extend the Government’s accrual period for determining the statute of limitations, was inapplicable.

**Court’s Analysis**

Once the Court established the applicable statute of limitations (three years for the Corporate Defendants, and six years for the Attorney Defendants), it had to decide whether or not the Government had filed its action timely.
Regarding this issue, the Court proceeded from the following analytical perspective:

"[I]mportant to accrual analysis of the statute of limitations ... the regulations define the Government’s right to initiate recovery beginning ‘as soon as it learns that payments has been made or could be made under workers’ compensation, any liability or no-fault insurance, or an employer group health plan (citing 42 C.F.R. § 411.24(b)).49

To determine when the Government’s MSPA cause of action first accrued for purposes of the statute of limitations, the court considers the point of time when the Government could have brought an independent action for Medicare reimbursement related to the Abernathy settlement. See 42 C.F.R. § 411.24(b) ("[The Government] may initiate recovery as soon as it learns that payment has been made or could be made under [workers’ compensation], any liability or no-fault insurance, or an employer group health plan.").49

As the Government asserted a different basis of liability pertaining to each defendant category, the Court again rendered separate analyses for the Corporate and Attorney Defendants.

As to the Corporate Defendants

The Court stated that the key question involved at what point the Corporate Defendants could be viewed to have demonstrated a “responsibility to pay” under the MSP in relation to the Abernathy Settlement.

In making this very specific determination, the Court’s analysis centered on 42 U.S.C. § 1395y(b)(2)(B)(ii) which provides:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse [Medicare] with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.

A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means. (Emphasis Added).

In addition, “responsibility” may also be demonstrated by a “settlement,” “award,” or “contractual obligation.” 42 C.F.R. § 411.22(b)(3).

According to the Court, once “responsibility to pay” is demonstrated, the statute “unambiguously establishes the earliest point at which the Government could have asserted it claims for reimbursement [against the Corporate Defendants], as third party payers; as soon as it learned that ‘payment has been or could be made under ... any liability or no-fault insurance.’” 42 C.F.R. § 411.24(b).

From this standpoint, the Court found as follows:

- The Corporate Defendants’ “responsibility to pay” arose “no later than the point of execution and court approval of the Abernathy Settlement Agreement [which was September 9, 2003].” 47

- The Court noted that the August 26, 2003 initial settlement payment, and the additional payment made on September 17, 2003, “demonstrated responsibility to pay” under the MSP. 48

In this regard, the Court stated that “[d]espite these dates reflecting accrual of its cause of action, the Government did not bring its MSPA claims until December 1, 2009,” which was well beyond the three year statute of limitations found to be applicable to the Corporate Defendants. 49

The Government argued that the accrual date in the context of the “responsibility to pay” requirement under the MSP did not actually arise until payment was distributed to the Abernathy plaintiffs in exchange for the signed releases which occurred on December 2, 2003.

However, the Court rejected the Government’s “distribution-accural” interpretation of the statute stating this argument “directly contradicted the plain reading of the language of §42 U.S.C. § 1395y(b)(2)(B)(ii)” and, accordingly, that it would “not so expand the clear intent of Congress by adding language to the MSPA statute.” 50

The Court explained:

Despite the Government’s attempt to twist the reading of this statute, its terms squarely contemplate that a payment conditioned upon release triggers a responsibility to reimburse Medicare under the MSPA, which is exactly the situation presented here.
Consequently, as to the Corporate Defendants, the court finds that the Government’s cause of action accrued, at the latest, on September 10, 2003, when the state court approved the executed Abernathy Settlement Agreement and at which point Defendants’ responsibility to pay was clearly established.

The Government reasonably could have intervened in the Abernathy litigation to initiate its MSP-related claims against the Corporate Defendants at least by September 10, 2003, if not earlier. Applying either the three-or-six-year statute of limitations, the Government’s right of action expired long before it filed suit on December 1, 2009. (Emphasis by the Court). 43

With regard to the issue of when the Government knew or otherwise “learned” of the Abernathy Settlement Agreement, the Order indicates that the Government did not argue that it had not learned of this settlement until December 2, 2003. 44 Rather, the Government argued that the accrual limitations period could not have accrued prior to December 2, 2003 under the MSP. However, as noted, the Court rejected the Government’s interpretation of the MSP on this point.

Regarding the issue of the Government’s knowledge of the underlying Abernathy action, the Court found it questionable how the Government could have not been aware of the underlying litigation given its magnitude and publicity. In a footnote, the Court stated:

Considering the widely publicized nature of the Abernathy Settlement Agreement — a comprehensive 20 page document detailing the logistics of the settlement payments, including dates, times and specific accounts — the court finds it hard to conceive a reasonable argument as to the Government’s lack of knowledge about its MSP claim at the time the settlement was executed. 45

On this point, the Court highlighted the wide national attention the underlying actions had generated — noting that articles about the cases were published in several major national news publications and journals, along with multiple reports aired on National Public Radio. In addition, the Court noted that the Alabama Supreme Court recognized the “media frenzy” in its 2001 ruling related to a request for a venue change in the state actions. 46

As to the Attorney Defendants

In deciding the issue of when the Government’s action accrued as to the Attorney Defendants, the Court utilized a different standard under the theory that these defendants were alleged “recipients” of payments under the MSP.

The Court’s focus concentrated on that aspect of the MSP providing that any “recipient” of a payment that qualifies as reimbursable to Medicare must reimburse Medicare within 60 days per 42 C.F.R. §§ 411.22(a) and 411.24(h).

The Court also referenced 42 C.F.R. § 411.24(g) which provides that Medicare has a direct “right of action against to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney. State agency or private insurer that has received a third party payment.” (Emphasis Added).

The Court found that the Government’s cause of action accrued against the Attorney Defendants on October 29, 2003, at the latest, which was the date the court in the Abernathy litigation ordered the transfer of $275 million from the court registry to the plaintiff attorney’s escrow account. 47

The Government argued that the actual date the funds were released for distribution to the plaintiffs (which was December 2, 2003) was the more appropriate date to be utilized.

However, the Court rejected the Government’s argument stating:

To the contrary, the most logical and appropriate time for the Government’s right of reimbursement under the MSP to be honored would have been at the time of initial transfer of the settlement funds into the attorneys’ escrow account, if not earlier. At that time, a court could have determined proper distribution of those funds as allocated to the plaintiffs, to vendors, to attorneys for legal fees, and to any parties with subrogation claims, including the Government’s claim here for Medicare reimbursement.

The Government most certainly could, and should, have intervened before the Abernathy settlement monies were actually distributed to the thousands of plaintiffs. The Government’s MSP claims were, therefore, ripe for accrual no later than October 29, 2003, the date the Attorney Defendants received payment of the $275 million settlement monies in escrow.

The court notes that in practical terms, the Government likely could have intervened at any time during the pendency of the Abernathy litigation, and certainly at the time the Settlement Agreement was executed and judicially approved in September 2003.
To afford every possible benefit to the Government, however, the court reaches its generous conclusion that accrual of its MSPA claim occurred no later than October 29, 2003. (Emphasis by the Court).

**Court Rejects Government’s “Tolling” Argument**

The Government also argued applicability of the Federal tolling statute (28 U.S.C. § 2146(c)), asserting that under this theory its action did not actually accrue until much later than December 2, 2003 and, therefore, was timely.

This statute basically stops the FICA statute of limitations during periods where “facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances.” (Emphasis by the Court).

In analyzing this argument, the Court referenced the Eleventh Circuit case, United States v. Kass, 740 F.2d 1493 (11th Cir. 1984), noting that the court held that “once the facts making up the ‘very essence of the right of action’ are reasonably knowable, the 2146 bar is dropped.” Kass at p. 1497.

As part of its analysis, the court in Kass examined the history of this tolling statute noting that it was designed to promote “diligence by the government in bringing claims to trial.” Id. at p. 1497 (Citations Omitted). Furthermore, the court noted that a major underpinning of the statute was the thought that the government should not be penalized if the fraud of an adverse party restricted its ability to discover a valid cause of action until long after its accrual.” Id. at 1497 (Emphasis in Original).

However, the Court rejected the Government’s tolling argument finding that there was no evidence of fraud and on a technical pleading point stating:

> The facts of this case do not implicate any fraudulent concealment of any related MSPA claim. Moreover, the Government has not alleged that it did not or reasonably could not have known the facts giving rise to its MSPA causes of action prior to December 2, 2003. While the Eleventh Circuit has not designated which party bears the burden of proving the elements of this particular federal tolling statute, “federal courts have repeatedly held that plaintiffs seeking to toll the statute of limitations on various grounds must have included the allegation in their pleadings.” Wasco Prods. v. Southwall Techs., Inc., 435 F.3d 989, 991 (9th Cir. 2006) (citing cases from the Ninth, Tenth, Eighth, and D.C. Circuit Courts of Appeals).

Indeed, the Government would be hard pressed to show that it reasonably could not have known of the widely reported Abernathy litigation, initiated in 1996, and the ensuing settlement reached in August 2003. Rather, the Government argues the “obvious fact” that it “could not have had knowledge of its claim before that claim arose, which . . . was on December 2, 2003.” (Citation Omitted). Because the court ultimately disagrees with the Government as to the accrual date of its claim, it finds no merit in this particular argument.

**Conclusion**

As the dust settles from the Court’s ruling, the interesting and more sobering question of “so, exactly what does Stricker mean in the bigger picture of MSP compliance?” emerges.

The author recognizes that this question will surely open the gates (and, in fact, should open the gates) to many different and divergent viewpoints and angles, observations and questions, conclusions, and even perhaps some predictions — all of which are certainly part of a healthy post-game analysis of the Stricker decision.

In the spirit of this larger discourse, keeping the Stricker decision in proper perspective should be an integral part of any assessment from the author’s standpoint. The court in Stricker certainly provided welcomed and keen analysis in interpreting important aspects of the MSP with respect to determining when and how, from its viewpoint, an action for recovery of conditional payments accrues, and the applicable statute of limitations controlling the government’s rights related thereto.

However, it must be remembered that the Government’s action was essentially dismissed on the sole ground that the Government simply failed to file its lawsuit timely. The Court did not reach the underlying substantive allegations — namely, that the parties failed to properly protect Medicare’s interests under the MSP. In this respect, caution is in order to avoid overstating whatever victory the Stricker decision may represent. The industry must not be drawn into a false sense of complacency by the narrow technical ruling of Stricker as the MSP arms Medicare with some pretty strong legal rights and broad enforcement powers regarding conditional payment recovery.

Accordingly, notwithstanding the dismissal of the Stricker case, the author believes it is vitally important for primary payers and practitioners to understand their
obligations under the MSP regarding conditional payments, the potential risk and exposure it could face for failing to protect Medicare’s interests (including a possible Stricker lawsuit and the prospect of “double damages”), and to build the necessary practical compliance protocols to address the issue as part of claims handling and settlement.

With the implementation of MMSEA Section 111 reporting around the corner, the need to tackle this issue takes on even greater significance as more cases will now be squarely on Medicare’s radar. A review of the MSP statutes and regulations outlined by the author in Part II of this article, and the Court’s general discussion of same in Part III, would seem to be a good starting point toward this end.

In the interim, it will be interesting to learn if the Government decides to appeal the Stricker decision, and, if so, how the issues will be addressed at the appellate level. It will also be interesting to see how the Stricker ruling may, or may not, be followed by other courts in the future as part of their examination and determination of MSP issues.

About the Author

Mark Popolizio, Esquire is the Vice President of Customer Relations for NuQuest/Bridge Pointe. Prior to joining NuQuest, Mark practiced workers’ compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included Medicare Set-Aside and Medicare Compliance. Mark also served as Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) from 2006-2008 and remains active with NAMSAP concentrating on educational and legislative matters.

Mark is very active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations. Mark has also published several articles on MSA/Medicare issues. Mark can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.

Endnotes

1 The Court’s Order indicates that the following defendants filed Motions to Dismiss: Monsanto Company; Solutia, Inc.; Pharmacia Corporation; James J. Stricker; Daniel R. Benson; Donald W. Stewart and Kasowitz, Benson, Torres and Friedman, LLP; Don Barrett, The Barrett Law Firm, P.A.; Charles E. Fell, Jr., Charles Cunningham, Jr., and Cunningham & Fell, PLLC; American International Group, Inc; and Travelers Companies, Inc. Stricker Memorandum Opinion at p. 1.

The Court noted that not all of the defendants the Government sued filed motions to dismiss. As to those defendants who did not file motions, the Court noted that it did not have the necessary information related to the claims against these defendants to determine whether or not the government’s action could be similarly dismissed against them. As such, the Court stated that “the decision set forth in this Memorandum Opinion and accompanying Order does not apply to these Defendants [meaning those Defendants that had not filed motions to dismiss].” Stricker Memorandum Opinion at p. 2, fn. 1.

2 See Endnote 1.

3 Stricker Memorandum Opinion at p. 2.

4 Stricker Memorandum Opinion at p. 3.

5 The settlement terms as outlined in the bullet points can be found in the Stricker Memorandum Opinion at p. 3-4.
The named Corporate Defendants included, Monsanto Company, Pharmacia Corporation, Solutia, Inc., Travelers Companies, American International Group, Inc., and certain named subsidiaries. Government's First Amended Complaint (May 26, 2010) at p.3-4 (paragraphs 1-5).

7 Stricker Memorandum Opinion at p. 8; Government's First Amended Complaint (May 26, 2010) at 7 (paragraph 21)


9 Government's First Amended Complaint (May 26, 2010) at 12 (paragraph 38).

10 Government's First Amended Complaint (May 26, 2010) at 12 (paragraph 39).

11 Government's First Amended Complaint (May 26, 2010) at 12 (paragraph 40).


13 Government's First Amended Complaint (May 26, 2010) at 14 (paragraph 43).

14 Government's First Amended Complaint (May 26, 2010) at 14 (paragraph 44).

15 Government's First Amended Complaint (May 26, 2010) at 14 (paragraph 43).

16 Government's First Amended Complaint (May 26, 2010) at 15 (paragraph 45).

17 See Endnote 1.


19 Stricker Memorandum Opinion at p. 8, citing 42 U.S.C. §1395y.

20 Stricker Memorandum Opinion at p. 8, citing, Baxter, at 345 F.3d at p. 888.

21 Stricker Memorandum Opinion at p. 10.

22 Stricker Memorandum Opinion at p. 10.

23 Stricker Memorandum Opinion at p. 11.


25 Stricker Memorandum Opinion at p. 12.

26 Stricker Memorandum Opinion at p. 12.

27 Stricker Memorandum Opinion at p. 15.

28 Stricker Memorandum Opinion at p. 15.

29 Stricker Memorandum Opinion at p. 13.


31 Stricker Memorandum Opinion at p. 16.

Stricker Memorandum Opinion at p. 24-25. The author is unclear if the Court's reference to the “October 17, 2009” date is a scrivener's error. Specifically, the Court ruled that the applicable six year statute of limitations against the Attorney Defendants began running “no later than October 29, 2003.” It then stated that, accordingly, the statute of limitations “expired October 17, 2009.” However, from the author's understanding, basing the six year statute of limitations from October 29, 2003 would have barred the Government’s action as of October 29, 2009, not October 17, 2009. Notwithstanding this technical point, any issue in this regard is really moot as the Government’s action would be deemed as being filed untimely from either date per the Court's analysis and ruling.

Stricker Memorandum Opinion at p. 10.

Stricker Memorandum Opinion at p. 17.

Stricker Memorandum Opinion at p. 19-20.

Stricker Memorandum Opinion at p. 17-18.

Stricker Memorandum Opinion at p. 18.

Stricker Memorandum Opinion at p. 18.

Stricker Memorandum Opinion at p. 19.

Stricker Memorandum Opinion at p. 20-21.

Stricker Memorandum Opinion at p. 20.

Stricker Memorandum Opinion at p. 20, fn.14.

Stricker Memorandum Opinion at 4-5.

Regarding the Government's “knowledge” of the Abernathy action, as noted the Court indicates that the Government did not argue that it “[had] not learn[ed]” of the Abernathy Settlement until December 2, 2003. Stricker Memorandum Opinion at p. 20. Furthermore, the Court noted that the Government did “not [allege] that it did not or reasonably could not have known the facts giving rise to its MSPA causes of action prior to December 2, 2003.” Stricker Memorandum Opinion at p. 23.

The fact that the Government was not alleging “lack of notice” or “knowledge” appeared to eliminate the potential application of 42 C.F.R. § 411.25(a) which can be interpreted to place an obligation on third party payers to put Medicare on “notice” of an action involving a Medicare beneficiary. This regulation states that if a third party learns that CMS has made a Medicare primary payment for services for which the third party has made or should have made primary payment, it must give notice to that effect to Medicare.

While the Government in its First Amended Complaint (paragraph 36) references 42 C.F.R. § 411.25(a) as part of its general review of the MSP, the Government did not apparently assert this section against the defendants as part of its more specific allegations against them. Thus, for these reasons, it appears that the Court's analysis is essentially devoid of any discussion of this “notice” regulation in relation to its ultimate determination of the issues. In fact, as noted above, the Court actually focused on the Government's “knowledge” of the Abernathy action, and strongly suggested that the Government had ample opportunity to reasonably “learn” of the Abernathy action given its national publicity.

From the author's view, it is interesting to contemplate how, if at all, the Court's analysis in Stricker may have been altered if a “notice” issue per 42 C.F.R. § 411.25(a) was raised. That is, what would have been the effect on the Court's analysis and ultimate determinations if it was alleged that the Government did not in fact have knowledge of the action, or was not provided notice of the action by the third party payer? Again, in Stricker this was not at issue - the Government did not allege lack of notice or knowledge, and the Court essentially indicated that the Government had reasonable opportunity to have learned about the Abernathy action given its national notoriety.

However, the author does not believe it is unreasonable to suggest that there could very well be other cases in the litigation settlement stream in which this type of issue could arise. It would indeed be interesting to see how a court in that situation would analyze the limitations period if the issue of “notice” to Medicare, or lack of agency knowledge, was thrown into the equation. With the passage of time, this potentially concerning issue should recede with full implementation of the mandatory reporting requirements per the Medicare, Medicaid & SCHIP Extension Act (42 U.S.C. § 1395y(b)(7) and (8)).
Stricker Memorandum Opinion at p. 21.

Stricker Memorandum Opinion at p. 21-22. The Court also noted that at the close of the hearing on the motions to dismiss the Government for the first time raised a theory “of continuing accrual, vaguely proposing that a new MSPA cause of action accrues every year when the Corporate Defendants make additional payments to the Attorney Defendants.” However, as this was not raised in any of the briefs before the Court and not pled in the Amended Complaint, the Court determined that it was not properly before it for determination. See, Stricker Memorandum Opinion at p. 20, fn. 15.


Stricker Memorandum Opinion at p. 23.

Stricker Memorandum Opinion at p. 23.

TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
ACT OF 2007
42 U.S.C. 1395y(b) (8)

DATE OF CALL: January 28, 2010

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities- Question and Answer Session.

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS' DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.
agreement. We’ve had it phrased just in terms of we’re paying the money, et cetera.

Keep in mind that we’ve said from the beginning, when you have excess insurance, reinsurance, stop-loss, et cetera and that insurance, the excess insurance is reimbursing the first insurer, in that case that second insurer, the excess is not the RRE. And I think we’ve said that pretty consistently, but we had I think at least five or six questions in the last month or so.

On foreign insurance, which is one I neglected to mention in the beginning, where language is still pending; we believe we’re fairly close to issuing an alert with the policy when we’re talking purely about entities that have liability insurance or that have workers compensation, et cetera. What will be a little bit longer forthcoming is CMS’s position when the individual or entity is foreign and is self-insured, since that’s not quite the same scenario in terms of, for example, whether or not they’re doing business within the United States. So know that that is forthcoming as well.

(Bill Decker): A purely – a purely foreign employer, for example, that self-insures for liability.

(Barbara Wright): Well it could be a foreign manufacturer, for instance, who’s self-insured and who is clearly selling products within the United States. We still are awaiting information from internal discussions and our counsel on how we’re going to proceed in that situation.

We have had a couple of questions that have to do with attorney responsibility if someone’s an attorney for an RRE. We cannot give you legal advice on what your obligations are with respect to your client. We were also asked whether such attorneys could ever by RREs.

Whether or not they’re an RRE when they’re acting purely in a – in an attorney responsibility to an entity that’s an RRE would not eliminate the fact that they might be RREs in their own right, either because their law firm was self-insured or their law firm was involved purely from a status of being an RRE on their own. So attorney firms or individual attorneys are going to have to evaluate or not they are an RRE in a particular situation.
We have continued to say with respect to set-asides or liability situations that set-asides are not required in terms of CMS being involved in any type of determination of how much the set-aside should be. We have also said that our regional offices have the ability to evaluate proposed set-aside amounts for liability if their workload permits them to do so.

This is not the same thing as a blanket statement that liability set asides are simply not required or not appropriate. Regardless of the mechanism, Medicare’s interests need to be protected. The statute says that we don’t make payment where payment has already been made. Whether or not this is protected through setting up a formal set-aside, setting up a formal trust, simply keeping the money and ensuring that it’s being – that it’s paying prior – in a priority manner to Medicare until the appropriate funds are exhausted; those are all choices, but we need to make it clear that’s not the same thing as saying – and that we are not in fact saying that liability set-asides aren’t appropriate. So that’s our general response on that.

In terms of reporting requirements, again, with respect to recovery, various entities seem to be confusing the Section 111 process with the preexisting and ongoing recovery process for conditional payments once there’s been a settlement judgment payment award or other payment.

If a case is self-identified, either by the plaintiff’s attorney or the plaintiff himself or the insurance company or workers compensation to the COBC on an individual basis, where it – while it’s still pending, we have a multistep process that establishes a potential recovery case allows us to start collecting conditional payment information.

This process is not the same as the Section 111 process and does not eliminate any Section 111 requirements. We received two or three questions that said if the plaintiff’s attorney has reported this as a pending case or if the plaintiff’s attorney promises me or certifies that they will report this, do I still have to report it as an RRE and the answer is yes. If you have an obligation of an – as an RRE that is separate and apart from any other reporting responsibilities and repayment responsibilities.
We had a general record retention requirement. As we've said before, there are no specific record retention requirements tied to Section 111; however, there are a number of different other statutes out there that tie into MSP in general. So we have no specific advice for you in terms of record retention, to the extent that you are potentially subject to penalties or subject to issues in terms of other recoveries. Laws and regulations that govern those recoveries have to be taken into account.

We asked – we were asked whether or not there’s any reason why an RRE could not purchase insurance for Section 111 penalties and fines if it becomes available in the marketplace. Several surplus line carriers appear to be interested in that. Again, we can’t give you any legal advice on this. Know that if there’s a situation where CMPs are ultimately ever imposed, we would be imposing that penalty against the RRE. It would not be our obligation to pursue directly from the insurer.

In terms of who is an RRE, where there’s both a deductible and an amount paid above the deductible, there’s at least one situation where an entity has asked for further clarification on situations that throw one or more TPAs into this mix and has a question about what happens if the TPA belongs to – the only contract with the TPA is the actual – is the contract with the insurer, but the bank account is funded by the insured. And that’s one of the issues that we will be more specific on in our – in our final language.

I can’t remember if I’ve hit this on one of the other questions before, but again, the issue of entities coming in and repeating that well, when we pay medicals and we continue to pay medicals, how do we report all these TPPOCs, all these additional payments? And as I said, all the descriptions we’ve seen so far of the people sending the questions in are reporting situations that to us appear to be ongoing responsibility for medical situations, in which place – case, you would be reporting that ongoing responsibility and wouldn’t be reporting the underlying separate payment.

Where we’re leaning in terms of the periodic payments for workers comp and no-fault is to – and this – I will say leaning. I will repeat again, this is not a final position. We’re trying to determine whether there are any loopholes or
TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b) (8)

DATE OF CALL: March 16, 2010

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation Responsible Reporting Entities- Question and Answer Session.

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS’ DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.
I know – I’ve talked to at least one individual recently who said that he had some thoughts of potentially how to write that up. I said send it into the mailbox so that it could be considered. So, if you have an approach, or anything that you think would help us get around that problem, please send to the mailbox.

(Victoria Vance): And thank you for that.

One quick follow-up. We sometimes hear discussion in the course of settling cases and claims about whether on the liability side, not worker’s comp, but on the liability side, there is now, or is expected to be in the future, any vehicle such a what they refer to as a Medicare set aside, or starting to get into that sort of practice. Do you have any thoughts or any expectation that doing Medicare set aside is ever going to be something that enters the world of the liability and casualty payers?

Barbara Wright: It has already entered. As we’ve said on many calls, CMS has formalized process to review proposals for workers’ compensation, Medicare set aside amounts. It does not have the same formalized process for liability Medicare set aside arrangements. The process for worker’s compensation is voluntary.

We have a process for an informal process on the liability side that if a plaintiff’s attorney or insurer, et cetera, wishes to approach the appropriate CMS regional office and the regional office has the ability to do so workload or otherwise, that they can choose to review a proposed set aside amount if they believe there is significant dollars at issue.

Again, it’s not the same extensive process that we have for worker’s compensation. But regardless of whether CMS has a formalized process, or regardless of whether or not you’re participating in the formalized process for worker’s compensation Medicare set aside, the statute has the same language in either situation. It’s not parallel language. It’s not similar language. It’s literally the same physical sentence that we’re not to make payment where payment has already been made.
So where future medicals are a consideration in arriving at the settlement, et cetera, then appropriate arrangements should be made for appropriate exhaustion of the settlement before Medicare is billed for related services.

(Victoria Vance): Thank you.

You’ve indicated that there may be times at some point in the future, some education may be put on by CMS that specifically addresses these MSP ...

Barbara Wright: (inaudible) ...

(Victoria Vance): ... practices.

Barbara Wright: ... more recovery issues, yes.

(Victoria Vance): Right. Is that expected to happen?

Barbara Wright: It’s on the list of things that are being looked at and worked on.

(Victoria Vance): OK.

Barbara Wright: In the meantime I guess what I should say, if we haven’t referenced it before, there isn’t anything – there wouldn’t be anything on – the MSPRC, the Medicare Secondary Payer Recovery Contractor is our contractor for recoveries related to liability insurance, no fault insurance, worker’s compensation insurance, or even group health plan insurance.

They are not the ones responsible for reviewing the establishment, or proposed amounts, for set asides. So you aren’t going to find information on their site about set asides. What you will find on their Web site is information about their recovery process and general steps, everything like that.

So if you’re not familiar with that, you can go to their Web site, which is www.msprc.info, I-N-F-O, and they do have some PowerPoint presentations about the recovery process for GHP, the recovery process for non-GHP, they have information about proof of representative, consent to release, and other documents available on that site. So if you’re not familiar with the process
and you want to start familiarizing yourself, I would recommend you check out their Web site.

(Victoria Vance): Yes, I've looked at it. I think it's very, very good.

Barbara Wright: They have also recently, I understand, I haven't had a chance to go look, but they are doing some reorganizing and beefing up the Web site in terms of trying to more categorize some of the information. I think they have a page for attorney tools. And they have some pages for other things. So if you haven't been there recently, you may want to recheck it.

(Victoria Vance): Thank you very much, Barbara. I appreciate it.

Operator: Your next question comes from the line of (Nancy Birch) from Chevron. Your line is open.

(Nancy Birch): Thank you, very much. This is a quick question.

In regards to the conversation that was earlier in for the DCN and the system problem that occurred, we're still in test mode and we did get error messages and we were trying to figure out on our end, should we resubmit our test now that it is been corrected in your system?

Female: Are you talking about query files?

(Nancy Birch): Yes. It was the query file. It was all the blanks embedded fields.

Female: Yes. I would resubmit it so that you have — you get a response file that has DCN said we're exactly matching what you submitted, and it will make your process a little bit simpler.

(Nancy Birch): OK, fine. Because you're not going to reprocess those files, so we just need to resubmit it?

Female: Correct.

TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
ACT OF 2007
42 U.S.C. 1395y(b) (8)

DATE OF CALL: September 22, 2010

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation Responsible Reporting Entities- Question and Answer Session.

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS’ DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.
(Mark Tipettal): Hi, good afternoon. I have a question regarding the applicability and the correlation of M.A. plans to NGHP in light of NGHP, the guide says M.A. is out of scope. What is the situation with M.A. and NGHP?

Barbara Wright: It's out of scope but it's not out of scope. You cannot assume simply because a beneficiary is in the Medicare Advantage plan that Medicare fee for service has not paid for any medical items or services.

People can go in and out of the M.A. plans; there are rare instances where they have claims paid under fee for service even when they are in a Medicare Advantage plan. There are situations where Medicare Advantage enrollment is actually retroactive and so claims have been – being paid for under fee for service so if they are a beneficiary, your reporting obligation exists. It's not – your reporting obligation is not determined or affected by whether or not they also happen to be in a Medicare Advantage plan.

(Mark Tipettal): OK. Thank you. So to be safe, we should definitely report all of them then?

Barbara Wright: Yes. You absolutely need to. What happens in terms of recovery, if everything was in fact paid only by a Medicare Advantage plan, then the – any obligation or any repayment would occur directly with the Medicare Advantage plan who the beneficiary has an obligation to deal with directly.

(Mark Tipettal): OK, thank you very much, I appreciate it.

Operator: Your next question comes from the line of (Anne Armstrong) from (Inner Mountain). Your line is open.

(Anne Armstrong): Thank you. (Anne Armstrong) again from (Inner Mountain Healthcare) and I have a couple of questions concerning reporting – I think they may – both related to ORM but in the first case, this corporation is self insured for liability including premises liability in a malpractice.

And so this is not a workers' compensation claim, no fault or other statute supplied. But for example, a patient who is suffers a complication let's say, related to surgery and our risk manager agrees without determining whether or not we are liable from a legal standpoint, agrees to reimburse the subsequent
medical treatment, visits to a doctor or medications or something along those lines.

And then at some point, there is a settlement made to resolve that claim, can we use that TPOC settlement date as the termination date for ORM without a formal Medicare (set aside) agreement and without a written physician statement to the effect that no further medical treatment will be needed for this injury?

Barbara Wright: You have several things going on in your question.

To the extent in the beginning, there – any services that your particular – I guess I didn’t hear in the beginning whether or not you also happen to be like a hospital or a doctor?

(Anne Armstrong): Yes, we are a provider.

Barbara Wright: OK, so if you’re a provider and you decide that any services you provided, you are not charging for, you are reducing the cost for, then with respect to those, those would be taking care of through the billing process where you make sure that anything that you are writing off is shown as a liability payment in your billing process.

And that is covered under the normal billing procedures.

The second thing is since you said that you are assuming responsibility for other associated care, you would need to report the ORM. Your last one was about termination of the ORM in a liability insurance situation, if by the terms of the settlement, it terminates any ongoing responsibility for medicals, then yes, you would terminate ORM with that date.

Last but not least, you asked about (set asides) and that doesn’t have anything to do with whether or not you can terminate the ORM date for reporting purposes.

John Albert: You also need to report the TPOC.
Barbara Wright: Someone reminded me that I didn’t note – in that litany that I just gave you that you are of course, also reporting the TPOC but as far as the (set aside) arrangements, we will repeat what little we talked about these in prior calls, is that Medicare beneficiaries and insurers have an obligation to protect Medicare's interests but Medicare does not mandate the specific mechanism they use to do that.

So can we say a set aside is required? No. But Medicare's interests do need to be protected and any TPOC or settlement should be exhausted appropriately before Medicare is billed for related services.

(Anne Armstrong): OK so I'm hearing you say that the settlement documents, it would be a good idea for the settlement documents to include language clarifying that the ongoing responsibility for medicals is terminated with the agreement and that – is it necessary to include language regarding a portion or anticipated portion of the settlement amount that would go toward future medical expenses.

Does that kind of detail...

Barbara Wright: We're straying over into a little bit of territory that we can't take responsibility for. We cannot give you legal advice. The terms of your settlement are the terms of your settlement. If for liability insurance, if those terms terminate any ongoing responsibility for medicals, then that is what they do and you would report the termination of the ORM.

In terms of future medicals, whether or not you wish to specify in the settlement how much is for future medicals is an issue for you and your council and for the beneficiary and their council. All I can tell you is that the parties do have an obligation to protect Medicare's interest and as I said...

Pat Ambrose: Separation of the medical from what isn’t, right? (Inaudible).

Barbara Wright: Yes, again, as I said, that we can't mandate the set aside, the settlement should be exhausted appropriately and as we said on other calls, we are not bound by the allocations of the parties to any settlement judgment or award.

(Anne Armstrong): OK, thank you.
What Do I Do If My Case Does NOT Meet CMS’ WC-MSA Review Thresholds?

Understanding CMS’ WC-MSA Review Thresholds & Addressing Non-Threshold Cases

By: Mark Popolizio, Esquire

It has been almost ten years since the Centers for Medicare and Medicaid Services (CMS) released its seminal policy memorandum in July, 2001 (known as the "Patel Memo") formally introducing the Medicare Set-Aside (MSA) arrangement regarding workers’ compensation (WC) settlements. The WC-MSA is CMS’ recommended compliance mechanism to protect Medicare’s “future interests” under the Medicare Secondary Payer Statute (MSP).

The Patel Memo, in part, established two “review thresholds” outlining when review and approval of a WC-MSA by CMS is deemed appropriate. While not every component of CMS’ WC-MSA review thresholds may necessarily be clear, they have at least provided some practical guidance for the industry in determining WC-MSA applicability.

However, the issue quickly plunges into murky waters when the focus shifts to determining WC-MSA applicability in “non-threshold” cases — that is, those WC settlements which do not meet CMS’ formal WC-MSA review thresholds.

On this front, several perplexing questions remain regarding what obligations the parties may have to consider Medicare’s interests in non-threshold cases, and exactly how this should (or could) be accomplished. This unusual and troubling state of affairs is largely the result of incomplete and unclear guidance from CMS.

When the dust settles, the question that continues to haunt the claims industry almost a decade into the WC-MSA process is: “What should I do if my case does not meet CMS’ WC-MSA review thresholds?”

This question is currently receiving a fresh new look as primary payers and practitioners re-examine their MSP best practices and compliance protocols. At least one jurisdiction, Maryland, has even recently proposed formal regulations that would require parties to take affirmative measures to ensure that Medicare’s interests are considered in non-threshold WC settlements.

Through this article, the author aims to place the convoluted issue of MSP compliance in non-threshold WC cases into proper and practical perspective. In analyzing this issue, it is important to understand up front that we cannot simply and blindly dive straight into the topic. Rather, the issue first requires an understanding of the WC-MSA review thresholds, as determining whether your case first meets the review thresholds dictates whether or not you will find yourself in the unusual world of non-threshold cases.

Accordingly, the author lays the ground work by first examining CMS’ WC-MSA review thresholds and highlighting potential review threshold “pitfalls,” such as the popular $24,999 settlement. From this pivot point, the spotlight then turns to the thorny issue of MSP compliance in non-threshold WC cases.
This analysis is broken down as follows:

**Part I:** Does My Case Meet CMS’ WC-MSA Review Thresholds?  
*Understanding the Review Thresholds & Avoiding the Pitfalls* (p. 2-4)

**Part II:** My Case Does NOT Meet CMS’ WC-MSA Review Thresholds—What Should I Do?  
*Practical Options & Considerations* (p. 4-7)

**Part III:** How NuQuest/Bridge Pointe Can Help  
*NuQuest’s MSA and Non-Threshold WC-MSA Services* (p. 12)

**PART I**

**Does My Case Meet CMS’ WC-MSA Review Thresholds?**

*Understanding the Review Thresholds & Avoiding the Pitfalls*

Under CMS’ WC-MSA framework, the initial screening test in determining WC-MSA applicability requires an assessment of the type of settlement at issue. CMS classifies WC settlements as *commutation* or *compromise settlements.*

A detailed examination of CMS’ commutation/compromise distinction is beyond the scope of this article. However, in general, CMS views a *commutation settlement* as a settlement that compensates claimants for *future* medical expenses related to the work injury; while a *compromise settlement* is viewed as a settlement that compensates only *current or past* medical expenses. CMS also notes that it is possible for a single settlement to possess both a commutation and compromise component. Per CMS, a MSA is appropriate only in relation to settlements that possess a *commutation* aspect.

Along these lines, CMS indicates that admission of liability is *not* the sole determining factor of whether or not a settlement is considered a commutation or compromise. Furthermore, and importantly, CMS states that a settlement which does not provide for future medical care could still be viewed as possessing a commutation aspect if the facts indicate a need for future medical care in relation to the WC injury.

Once it is determined that a particular settlement is a *commutation,* contains a *commutation* component, or could possibly be viewed by CMS as possessing a *commutation* aspect, the focus shifts to determining whether or not the case meets CMS’ WC-MSA review thresholds.

**CMS’ Current WC-MSA Review Thresholds**

**CMS’ current WC-MSA review thresholds are as follows:**

**Threshold #1 ➔ Medicare Beneficiaries**

The claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is greater than $25,000.

**Threshold #2 ➔ Non-Medicare Beneficiaries**

The claimant is *not* a Medicare beneficiary at the time of the settlement but has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the total settlement amount is greater than $250,000.

If a WC settlement meets either one of the above thresholds, CMS deems submission of a WC-MSA proposal for its review and approval appropriate.

In determining whether a WC settlement meets the review thresholds, it is important to understand how CMS defines the terms *total settlement amount* (Thresholds #1 and #2), and *reasonable expectation of Medicare enrollment* (Threshold #2).

**How Does CMS’ Define Total Settlement Amount?**

CMS defines the term *total settlement amount* as follows:

Total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement.

To determine if the monetary component of the review thresholds is met (that is, whether the total settlement amount is greater than $25,000 or $250,000) every settle-
ment should be filtered through each of the above definitional criterion as a matter of standard practice. In doing so, the author highlights the following three definitional components warranting specific consideration:

**Payout Totals For All Annuities -**

Structure annuity MSA funding is commonly used as part of claim settlement. When using these arrangements, it is important to remember that, per CMS policy, it is the total payout to the claimant — not the cost or present day value of the annuity — which should be used to calculate the total settlement amount.10

**Any Previously Settled Portion of the WC Claim -**

Unfortunately, CMS has not provided any further guidance as to exactly what may be considered to fall within this concept. This could create uncertainty in particular situations given the host of payment arrangements (formal, informal and administrative) that are typically used in WC practice.11

While it is unclear how CMS could interpret this factor in light of the various payment arrangements commonly used in typical WC claims administration, this definitional component would at least appear to have direct applicability to those situations where there is a settlement closing out indemnity benefits (but leaving medicals open) at one point, followed by a settlement of medicals (including future medicals) at some subsequent point in time. In this situation, the amount of the prior indemnity settlement would seemingly need to be added to the amount of the subsequent medical settlement to determine if the combined sum exceeds the applicable monetary threshold amount.12

**Repayment of Any Medicare Conditional Payments**

Perhaps the most overlooked (and troubling) component of CMS' total settlement amount definition is repayment of any Medicare conditional payments.13 This definitional factor comes into play in settlements involving claimants who are Medicare beneficiaries at the time of settlement (Threshold #1).

Unfortunately, CMS has not provided any guidance regarding exactly how conditional payments should actually be factored for total settlement amount calculation purposes. From the author's view, a key and unknown interpretational point is how CMS intends the concept of "repayment" to be applied. In particular, a strict technical interpretation of this concept could result in significant practical complications, as pursuant to current CMS policy, the parties generally cannot obtain the "final" conditional payment amount that would technically need to be "repaid" until after the case is actually settled, and the executed settlement agreement is sent to the appropriate CMS contractor.

Along these lines, this factor could cause considerable problems (or even doom) for the popular $24,999 settlement or a settlement for some other amount that is close to, but does not exceed, CMS' $25,000 monetary threshold. From the author's observations, these settlements are considered sometimes by the parties to keep the claim below the review thresholds. However, by factoring conditional payments (in some manner or form) into the total settlement amount calculation, it is possible that the case could end up tipping over and into the review thresholds — despite the parties' intentions to keep the settlement under the $25,000 threshold.16

Accordingly, absent clarification from CMS, primary payers and practitioners are left to wrestle with how best to address the repayment of any Medicare conditional payments component of CMS' total settlement amount definition.

In doing so, it is important to recognize the larger issues: (1) Per CMS policy, repayment of any Medicare conditional payments is an ineluctable factor in calculating the total settlement amount for WC-MSA review threshold purposes; and (2) Accordingly, a settlement seemingly below the $25,000 monetary threshold could actually end up meeting the WC-MSA review thresholds when the repayment of any Medicare conditional payments factor is considered.

**How Does CMS Define Reasonable Expectation of Medicare Enrollment?**

The next definitional component needing dissection relates to how CMS defines the term "reasonable expectation of Medicare enrollment." This concept deals with those claimants who are not Medicare beneficiaries at the time of settlement (Threshold #2).

CMS defines reasonable expectation of Medicare enrollment in its April 22, 2003 memo as follows:

**Question:** When dealing with a WC case, what is "a reasonable expectation" of Medicare enrollment within 30 months?

**Answer:** Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are not limited to:
a) The individual has applied for Social Security Disability Benefits;

b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;

c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;

d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or

e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

As will be noted, three of the factors (a-c) revolve around the claimant’s social security disability (SSD) status. To determine whether (a-c) could be applicable, direct measures need to be taken to determine the claimant’s SSD status. From the author’s viewpoint, best practices dictate that this determination be made via direct inquiry to the social security administration (SSA) for a variety of reasons.

Importantly, it should be noted that CMS’ Query Function process, which has been established to determine a claimant’s Medicare status in relation to Medicare’s new notice and reporting law (Section III of the Medicare, Medicaid and SCHIP Extension Act of 2007), will not provide any information related to the claimant’s social security status.

Special attention to factors (b) and (c) is in order. As will be noted, applicability of these factors could, in some situations, ultimately hinge on the claimant’s intentions and representations. For example, assume the SSA provides confirmation that the claimant’s application for SSD was denied, and that he/she has not appealed or re-filed for SSD. This information is indeed important, but it is only part of the analysis.

In this situation, per CMS’ definition, if the claimant “anticipates appealing that decision” or is “in the process of appealing and/or re-filing” for SSD, CMS considers him/her to have a reasonable expectation of Medicare enrollment. Thus, primary payers and practitioners should develop the necessary practice protocols to properly address this aspect of CMS’ definition in terms of documenting (as best as possible) a claimant’s intentions and representations. Defense practitioners should consult with their clients to determine if they have any specific protocols to be followed in this particular situation, and in relation to the larger issue of determining whether a claimant has a reasonable expectation of Medicare enrollment as defined by CMS.

PART II

My Case Does NOT Meet CMS’ WC-MSA Review Thresholds – What Should I Do?

Practical Options & Considerations

If it is determined that the settlement does not meet CMS’ WC-MSA review thresholds, the focus shifts to what obligations the parties may have under the MSP to consider and protect Medicare’s interests in “non-threshold” cases.

To tackle this topic in an orderly fashion, it may be helpful to analyze the issue using the following three “Step” approach:

Step One:

Assess CMS’ Policy Statements

The starting point in this analysis is CMS’ July 11, 2005 policy memo (Q&A #1) which states as follows:

Q1. Clarification of WCMSA Review Thresholds – Should I establish a Workers’ Compensation Medicare Set-aside Arrangement (WCMSA) even if I am not yet a Medicare beneficiary and/or even if I do not meet the CMS thresholds for review of a WCMSA proposal?

A1. The thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or “safe harbor” thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers’ compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare’s interest when settling any workers’ compensation case; even if review thresholds are not met, Medicare’s interest must always be considered. (Emphasis Added)

CMS revisited the issue in its April 25, 2006 policy memo stating, in pertinent part, as follows:

The CMS wishes to stress [that the $25,000 monetary threshold related to Medicare beneficiaries] is a CMS workload review threshold and not a substantive dollar or “safe harbor” threshold. Medicare beneficiaries must still consider Medicare’s interests in all WC cases and ensure that Medicare is secondary to WC in such cases. (Emphasis by CMS).

From CMS’ policy statements, important pieces of the puzzle fall into place:

• First, CMS does not consider its WC-MSA review thresholds to be safe havens.
Second, CMS indicates that its interests must be considered in all WC settlements, regardless of whether or not the settlement meets the WC-MSA review thresholds.

But what does this all mean exactly?

Unfortunately, CMS has not really provided much by way of guidance and, thus, has basically placed the industry in the very peculiar position of having to develop its own practice protocols to determine when, and how, to consider and protect Medicare’s interests in relation to non-threshold WC settlements.

**Step Two:**

**Develop Practice Protocols to Address Non-Threshold WC-Cases**

In addressing the issue of non-threshold WC cases, primary payers and practitioners should consider establishing specific non-threshold protocols to ensure that Medicare’s interests are properly addressed.

In this regard, it must be recognized that there may not necessarily be a universal or “one size fits all” approach. Rather, each primary payer and practitioner will likely approach the issue differently based on a variety of factors such as, different interpretations of the MSP and CMS’ policy statements, and different views and approaches relating to general compliance philosophies and objectives, risk tolerance, and other specific considerations.

While approaches may differ in terms of degree and scope, core elements in developing non-threshold protocols generally involve:

(a) Identifying *when* and in which cases specific measures should be taken to protect Medicare’s interests; and

(b) Determining exactly *how* that will actually be done, such as perhaps including a non-threshold MSA or some other form of future medical projection. (Step Three of this analysis below will address possible options and mechanisms to be utilized).

Regarding concept (a), primary payers and practitioners essentially need to determine in which non-threshold situations *they* believe specific action should be taken in *all* non-threshold cases. On this point, many take the position that employing specific measures in every non-threshold settlement is unrealistic and unnecessary. This is based upon the premise that Medicare’s future interests are not necessarily implicated (or potentially implicated) in every non-threshold situation. Examples often cited from this perspective include claimants with minor injuries that have resolved, or settlements involving younger claimants with minor or non-significant injuries.

More typically, non-threshold protocols generally revolve around such considerations as the claimant’s proximity to Medicare entitlement, the claimant’s social security status, the severity of the claimant’s injuries, and the settlement amount. To a certain degree, these approaches either take into account specific criteria from the WC-MSA review thresholds, or are based on some direct variation of the review thresholds.

From the author’s observations, the following often serve as key factors dictating when parties are more likely to take direct measures to protect Medicare’s interests in non-threshold settlements:

1. A settlement involving a Medicare beneficiary where the total settlement amount (per CMS’ definition) is $25,000, or less. In this instance, Medicare’s interests are already implicated as the claimant is a Medicare beneficiary. (CMS’ April 25, 2006 memo could be viewed as supporting this rationale).

2. A settlement involving a non-Medicare beneficiary where only one prong (but not both prongs) of review Threshold #2 is met. (Review Threshold #2 is outlined on p. 2 above).

**Example A:** A case involving a non-Medicare beneficiary is settled for $250,000 or less, but the facts indicate that the claimant has a reasonable expectation of Medicare enrollment as defined by CMS in its April 22, 2003 policy memo (See p. 3-4 above).

**Example B:** A case involving a non-Medicare beneficiary is settled for $250,000 or less, and it has been determined that the claimant will in fact become a Medicare beneficiary at some point after the settlement (e.g. the claimant is a SSD beneficiary at the time of the settlement, and his/her Medicare benefits in connection with the SSD award are scheduled to commence at some point after the settlement).

In both of these examples, review Threshold #2 is *not* met. This is so because while the claimant has a reasonable expectation of Medicare enrollment, the total settlement amount in these examples is below the
$250,000 monetary component of Threshold #2. However, in terms of non-threshold consideration, the key factor is that Medicare’s interests could be implicated (Example A), or will in fact be implicated (Example B) at some point after the settlement.

3. A settlement involving a non-Medicare beneficiary that exceeds the $250,000 monetary threshold, but where the claimant does not have a reasonable expectation of Medicare enrollment as defined by CMS. This is the reverse of point #2 immediately above in that this time the monetary component of Threshold #2 is met (i.e. the total settlement amount is greater than $250,000), but not the reasonable expectation prong. In these situations, there could be several different rationales or concerns at play in relation to the size of the settlement prompting the primary payer or practitioner to include cases such as these as part of their non-threshold protocol.

The above considerations are by no means inclusive, and each non-threshold case should be closely analyzed to determine if taking affirmative steps to protect Medicare’s interests is appropriate.

In addition, primary payers and practitioners should determine if there are any applicable administrative regulations, guidelines, or other authority in their jurisdiction addressing non-threshold cases. On this point, the Maryland Workers’ Compensation Commission recently proposed formal regulations that would require the parties to take specific measures to ensure that Medicare’s interests are properly considered in non-threshold WC settlements.  

Importantly, primary payers and their defense counsel need to be on the same page when it comes to how non-threshold cases will be handled and settled. Primary payers should communicate any specific non-threshold protocols to their claims adjusters and defense counsel. Defense counsel should also contact their clients to determine if they have in fact established specific non-threshold protocols. Knowing this information up front and prior to commencing settlement negotiations is crucial in terms of ensuring that the claim is handled and settled in accordance with protocol. If the primary payer has not established non-threshold criteria, the defense practitioner should consult with the client to confirm that they have a complete and proper understanding of the issue.

As for claimant practitioners, it would be prudent to inquire as to whether or not the primary payer involved in your case has non-threshold settlement guidelines. Additionally, claimant practitioners should independently address this issue and consider developing their own non-threshold practice parameters.

**Step Three:**

**Determine the Specific Non-Threshold Settlement Mechanism to Be Used**

Once it has been determined that specific measures will in fact be employed to protect Medicare’s interests in a non-threshold settlement, the question becomes: *What are some practical options and mechanisms that could be used to accomplish this?*

With respect to this question, there are conceivably a number of possible options that the parties may wish to consider or deem appropriate under the circumstances.

In regard thereto, the author outlines the following two options as examples of mechanisms which are commonly used to protect Medicare’s interests in relation to non-threshold settlements:

**Option A:** Non-CMS Approved MSA (Non-Threshold MSA) 

This option involves obtaining a non-CMS approved MSA, or non-threshold MSA, from a Medicare set-aside vendor or other MSA allocation specialist. Remember, in this instance since the settlement does not meet the WC-MSA review thresholds, the non-threshold MSA would not be submitted to CMS for review and approval.

Aside from obtaining the actual MSA projection, there are several practical considerations that should be addressed. For example, the claimant and his/her lawyer should be placed on notice regarding the specific intent and purpose of non-threshold MSA; namely, that said amount is limited and restricted to compensating the claimant’s future accident related medical expenses post-settlement that would otherwise be covered by Medicare. Consideration should also be given to whether or not the claimant has the competency and skills to properly administer the non-threshold MSA account; or whether some form of administration assistance would be appropriate.

In addition, primary payers should consult with their legal counsel to ensure that appropriate settlement language and provisions regarding the non-threshold MSA (as well as any other applicable MSP compliance issues) are properly addressed as part of the settlement agreement. Some general considerations in this regard include, but are not necessarily limited to, documenting exactly how the parties are considering and protecting Medicare’s interests; clearly
identifying the non-threshold MSA amount and its intended purpose; documenting that the claimant understands and agrees that he/she may only use the non-threshold MSA funds for their intended purpose; addressing pertinent account administration issues and responsibilities, and, in cases where the claimant is self-administering the account, confirming that the claimant understands and agrees that he/she must properly exhaust the non-threshold MSA funds before submitting bills to Medicare for accident related medical treatment.

**Option B: Projection & Apportionment of All Injury Related Future Medical Costs**

This option involves obtaining a projection and apportionment of both Medicare allowable and non-allowable accident related expenses. Again, since the case in this instance does not meet the review thresholds, the mechanism used under this option would not need to be submitted to CMS for review and approval.

This information can be obtained through a medical cost projection, or some other method, such as the projection of future medicals from the claimant's treating physician, or a cost projection prepared by an internal case manager, nurse, or other medical professional. Obviously, whatever approach is ultimately selected it should be defensible in the event that CMS ever questions same at some point down the line.

Importantly, similar practical considerations as discussed immediately above in relation to the non-threshold MSA need to be also addressed in regard to whatever mechanism is used under this option. Likewise, counsel should incorporate the necessary and proper settlement language and provisions into the settlement agreement documenting the specific measures being taken to consider and protect Medicare's interests, the intent and purpose of the account funds, the claimant's responsibilities in relation thereto, and matters pertaining to the claimant's proper utilization and administration of account funds.

**Conclusion**

As the foregoing demonstrates, the issue of MSP compliance in non-threshold WC cases involves a host of complex issues and considerations that ultimately need to be addressed and determined by WC primary payers and practitioners as part of their MSP compliance programs.

The absence of clear guidance on this issue has in many respects created a practical and logistical compliance nightmare on many levels, with concerns regarding potential liability swirling in the balance. The complexity of the issue may defy black and white answers, and the wide array of factual situations that can dot this troubled landscape can present several practical challenges in devising compliance approaches. Nevertheless, as part of any inclusive MSP compliance program, primary payers and practitioners need to address the issue of non-threshold cases and develop the necessary practices and protocols to ensure that Medicare's interests are being properly considered.

---

**About the Author**

Mark Popolizio, Esquire is the Vice President of Customer Relations for NuQuest/Bridge Pointe. Prior to joining NuQuest, Mark practiced workers' compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included Medicare Set-Aside and Medicare Compliance. Mark also served as Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) from 2006-2008 and remains active with NAMSAP concentrating on educational and legislative matters.

Mark is active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations. Mark has also published several articles on MSA/Medicare issues. Mark can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.
Endnotes


2. The Medicare Secondary Payer Statute (MSP) is codified at 42 U.S.C. § 1395y, et. seq. In addition, pertinent provisions related to MSP compliance are contained in Subparts C and D of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 411.20 through 411.50, et. seq.)

3. The author understands the larger arguments raised in some quarters questioning the underlying validity of the WC-MSA process in general, the agency’s WC-MSA review process in particular, and the legal “authority” of CMS’ policy memoranda. While the author acknowledges these issues and arguments, that larger debate is not the focus of this article.


CMS further addresses its *commutation* vs. *compromise* distinction in its April 22, 2003 policy memorandum stating as follows:

**What’s the difference between commutation and compromise cases? And can a single WC case possess both?**

**Answer:** When a settlement includes compensation for future medical expenses, it is referred to as a “WC commutation case.” When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a “WC compromise case.” A WC settlement can have both a compromise aspect as well as a commutation aspect.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

**Example:** The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.


11. CMS sets forth and discusses its WC-MSA review thresholds in the following agency policy memoranda:

Parasher B. Patel, CMS Memorandum to All Regional Administrators, *Workers’ Compensation Commutation of Future Benefits*, July 23, 2001, p. 4-6;

Gerald Walters, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer (MSP) – Workers’ Compensation (WC) Additional Frequently Asked Questions, July 11, 2005, p. 2 (FAQ Nos. 1 and 2); and

Gerald Walters, CMS Memorandum to All Regional Administrators, Workers’ Compensation Medicare Set-Aside Arrangement (WC-MSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries, April 25, 2006.

It should be noted that CMS reserves the right to adjust or modify the review thresholds at any time.

As stated, the WC-MSA and CMS’ review process regarding same is the agency’s recommended method to protect its future interests under the MSP. In this regard, CMS has stated that its review procedure is a voluntary compliance process.

While CMS’ WC-MSA process is technically a voluntary process, from the author’s experience a significant segment (if not the majority) of the claims industry has been, and is, complying with the agency’s WC-MSA review process. Industry compliance with CMS’ review process is based primarily upon the belief that obtaining CMS approval provides a degree of security from future liability. The thought being that the parties would be in a far better position to defend any future claim by CMS if the agency was afforded the opportunity to review and approve the proposed WC-MSA.

By way of note, in certain quarters some are currently questioning continued participation in the WC-MSA review process in light of the difficulties the industry is experiencing in relation to CMS’ prescription drug calculation methods (which have been widely criticized as being unreasonable and unrealistic) that are, in many cases, resulting in significant increases in the WC-MSA amount ultimately being required by CMS.

12 Gerald Walters, CMS Memorandum to All Regional Administrators, Workers’ Compensation Medicare Set-Aside Arrangement (WC-MSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries, April 25, 2006.

13 See also, Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers’ Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 6 (FAQ No. 17).

14 One example (of many) that could arise in the WC context involves whether CMS would consider an administrative lump sum payment to the claimant to “resolve” a dispute concerning past due indemnity (versus payment made via a formal settlement agreement) a “previously settlement portion of the WC claim?”

15 In the stated example, per CMS’ October 15, 2004 policy memo, at the time of the indemnity settlement, a WC-MSA would not have been applicable as medicals were to remain open. In addressing this scenario, CMS provides as follows:

**WC Claim Resolution Where Medicals Remain Open** – Is a WC Medicare Set-Aside Arrangement appropriate when resolution of the WC claim leaves the medical aspects of the claim open?

No. However, a WC Medicare Set-Aside Arrangement is appropriate where the resolution of the WC claim permanently closes the medical aspects of the claim, and the claimant will require future medical services related to the WC claim that Medicare would otherwise reimburse.


16 A Medicare conditional payment can be defined as a Medicare payment for services for which another payer is responsible and regarding which Medicare is entitled to be reimbursed per the terms and directives of Medicare Secondary Payer Statute. See, 42 U.S.C. § 1395y, et. seq.

17 As referenced, there remain several unknown and troubling questions in terms of the practical application of this factor.

For example, CMS’ use of the word **repayment** is interesting in that taken literally this could be interpreted to mean the “final” conditional payment amount that CMS ultimately determines is reimbursable. However, under CMS’ current policy, the parties generally cannot obtain CMS’ “final” conditional payment amount until after the claim is settled and the executed settlement agreement is sent to the agency’s contractor. At that point, CMS issues its final conditional payment figure and demand for payment. Accordingly, if it is CMS’ intent to apply this factor in said manner, this would seemingly create an impractical and, perhaps, unworkable scenario on many levels, and would likely inject additional delay, complication and risk to the process.

As mentioned, absent clarification from CMS, primary payers and practitioners are left to deal with how best to address and apply this definitional component. Along these lines, addressing this issue would at least seem to entail considering CMS’ claimed conditional payment amount, or at the very least the conditional payment amount of which the parties are aware of, at the time of settlement. In doing so, this figure when added to the actual settlement amount to be paid to the claimant could end up yielding a total settlement amount that exceeds the $25,000 threshold amount.
However, this approach (assuming that CMS would even endorse same as an acceptable interpretation of this factor) raises certain practical questions and issues in its own right. For instance, how should the concept of using the conditional payment amount at the time of settlement be measured? The fact that it could take a few months to obtain a conditional payment figure under CMS’ current process would seemingly complicate this determination. As it is unlikely that the exact conditional payment amount could be obtained at the exact time of the settlement, would CMS allow the parties to use an interim conditional payment estimate that they may have received from during the course of the claim? If so, how recent would the figure have to be?

[Note: Another possible consideration in this regard is how and to what extent (if at all) conditional payment information that may be obtained from MyMedicare.gov could possibly be used. Through this site, it may be possible to obtain conditional payment information. However, from a few accounts received by the author, this site may not always contain the most current information. Furthermore, there may be issues regarding informational accuracy and system access in particular situations.]

Another issue would involve the conditional payment amount that should be used for calculation purposes. Should the gross conditional payment figure be used? Utilizing this figure would likely increase the prospects that the monetary threshold amount would be exceeded. Or, would CMS allow the parties to use a reduced figure taking into account removal of inappropriate claims; or perhaps a reduction via application (in some form) of the permitted conditional payment reduction factors contained in 42 C.F.R. § 411.24 and 42 C.F.R. § 411.37?

The following examples may help illustrate the approach and ideas presented:

**Example 1:**

**Note:** The following examples assume that the conditional payment (CP) amount could in fact be obtained at the time of settlement or, alternatively, that a CP figure is at least “known” based on an interim conditional payment estimate received by the parties during the course of the claim.

The parties reach a WC settlement agreement (SA) involving a Medicare beneficiary for $20,000. At the time of the settlement, it is determined that Medicare is claiming conditional payments as of that time in the amount $5,000.01.

In this example, if CMS took the position that it is the gross conditional payment amount being claimed at the time of the settlement which must be included in calculating the total settlement amount for WC-MSA purposes, then the settlement in this instance would exceed CMS’ $25,000 monetary threshold as the combined sum of these figures equals $25,000.01 [$20,000 SA + 5,000.01 CP = $25,000.01]. Thus, using this approach, this settlement would meet CMS’ WC-MSA review thresholds.

**Example 2:**

The parties reach a WC settlement agreement (SA) involving a Medicare beneficiary for $12,000. At the time of the settlement, it is determined that Medicare is claiming conditional payments in the amount of $14,000.

If, as in Example #1, CMS took the position that it is the gross CP amount which needs to be included in calculating the total settlement amount, then the settlement would exceed CMS’ $25,000 monetary threshold as the combined sum of these figures equals $26,000 [$12,000 SA + 14,000 CP = $26,000]. Thus, using this approach, the settlement would meet CMS’ WC-MSA review thresholds.

However, a different result could seemingly be reached if CMS in this instance permitted an application of 42 C.F.R. § 411.24(c). Under this section, the amount of recoverable conditional payments is the lesser of either (a) the Medicare primary payment, or (b) the amount of the full primary payment that the primary payer is obligated to pay.

Assuming that CMS would permit an application of this formula at this juncture of the claim, then Medicare’s conditional payment recovery would be limited to $12,000 [this amount represents the lesser of factors (a) and (b) above]. Thus, in this instance, the settlement would not meet the WC-MSA review thresholds as the combined figures would only total $24,000 [$12,000 SA + $12,000 CP = $24,000] which is below the $25,000 threshold.

An additional and interesting question that could arise using these approaches involves how, if at all, CMS would allow the includable conditional payment amounts to be reduced by specific claims that the parties dispute or question. Also, to what extent (if at all) would CMS permit the includable conditional payment amount to be reduced by procurement costs per 42 C.F.R. § 411.37?

By way of caveat, the above are presented solely for illustrative discussion purposes only to highlight the significant conceptual and practical difficulties posed by this underdeveloped definitional component. In presenting same, the author is not stating or otherwise suggesting that the above approaches represent, or could represent, a proper interpretation of CMS’ policy.
Section 111 of the MMSEA is codified at 42 U.S.C. § 1395y(b)(7) and (8).

The outlined factual situations are presented for illustrative purposes only and are not intended to represent legal advice, nor should same be construed as providing legal advice, by the author and/or NuQuest/Bridge Pointe. Primary payers and practitioners need to independently determine what they believe their compliance obligations are, or may be, under the Medicare Secondary Payer Statute and to formulate the necessary practices and approaches in regard thereto.

In January, 2011, the Maryland Workers’ Compensation Commission released proposed regulations to ensure that Medicare’s interests are considered in relation to Maryland WC settlements.

These proposed regulations are published in the Maryland Register (Issue Date: January 3, 2011, Volume 38, Issue 1, p. 57-59). These proposals set forth specific directives to be followed by the parties regarding (a) settlements which meet CMS’ WC-MSA review thresholds and (b) non-threshold settlements.

In regard to settlements that meet CMS’ WC-MSA review thresholds, the proposed regulations state as follows:

B. Future Medical Expenses.

(1) In determining whether a settlement must be reviewed and approved by [CMS], the Commission shall apply the Medicare thresholds set forth in the most current memorandum or regulation available at the CMS website.

(2) A settlement that falls within the Medicare thresholds must be approved by CMS before it will be approved by the Commission. (Md. R. p. 58). (Emphasis Added).

In regard to non-threshold settlements, the proposed regulations would require that the parties take certain affirmative measures to ensure that Medicare’s interests are considered as follows:

(3) A settlement that falls outside the Medicare thresholds may be approved by the Commission provided that the settlement agreement:

(a) Contains a statement confirming that the interests of Medicare have been considered in reaching the settlement; and

(b) Identifies the amount of the proposed settlement:

(i) Apportioned to future medical expenses; or


The proposed regulations also set forth specific evidentiary and documentary requirements as follows:

(4) The apportionment of the amount the settlement associated with future medical expenses shall be supported by medical evidence such as a medical opinion or evaluation.

(5) A formal set-aside allocation shall comply with the guidelines established by Medicare for set-aside allocations. (Md. R. p. 58).

The proposed regulations were open for public comment through February 2, 2011. The contact individual to which comments were to be submitted is referenced as: Amy S. Lackington, Administrator, Workers’ Compensation Commission, 10 East Baltimore Street, Baltimore, MD 21202, Phone: (410) 864-5300, Fax: (410) 864-5301; E-mail: allackington@wcc.state.md.us. The proposals also noted that a public hearing had not been scheduled in relation to these proposed regulations.

Important Note: At the time this article was prepared, the above outlined provisions were proposed (non-final) regulations. As noted, the public was afforded a period of time to “comment” on the proposals. Accordingly, the reader will need to follow up with the Maryland authorities to determine whether or not the above proposed regulations were ultimately enacted (either as proposed, or in some modified version).

21 The author wishes to acknowledge that the “options” outlined in this section are essentially an adoption in large part (with some modifications) of those as presented by Patty Melfert in her very excellent 2007 article entitled MSP Compliance in Settlements NOT Meeting the CMS Review Thresholds: Options for Primary Payers. This article can be obtained by logging onto www.NQSE.com; select News & Resources, and then choose Articles.

22 The information discussed under these options is not intended to provide (nor should it be interpreted as providing) legal advice from the author and/or NuQuest/Bridge Pointe. Rather, the information presented is intended for illustrative discussion purposes only to provide an example of methods currently being used by primary payers and practitioners in regard to considering and protecting Medicare’s interests in non-threshold WC cases. Primary payers and practitioners need to independently determine what they believe their compliance obligations are, or may be, under the Medicare Secondary Payer Statute and to formulate the necessary practices and approaches in regard thereto.
Allocation Services

WC MSA I
Includes MSA allocation, Social Security and Medicare status determination. Reporting to COBC to initiate Medicare conditional payment claim investigation process, determination of rated age life expectancy, and recommendations for frequency and amounts of periodic payments when a structured settlement is being utilized.

WC MSA II
Includes all aspects of MSA I above plus a detailed projection of non-Medicare allowable costs to provide a total cost projection.

Non-Threshold WC MSA
MSA Allocation for claims that do not meet the CMS review thresholds. Includes the determination of Rated Age Life Expectancy and recommendations for frequency and amount of periodic payments if a structured settlement is utilized.

Liability MSA
MSA Allocation for incident related, Medicare allowable treatment for Liability cases. This service does not include Social Security/Medicare entitlement determination, COBC reporting or conditional payment inquiry.

MCP with Free MSA
Apportions both Medicare allowable and non-Medicare allowable future injury related medical costs. Costs are calculated at WC reimbursement rates or rates actually paid, when available, over the rated age life expectancy. Utilize to set reserves, obtain settlement authority or as a settlement tool now, and receive a free MSA allocation within one year of the MCP report completion date, if needed.

Low Dollar Settlement MSA
MSA allocation for total settlements of $25,000 or less. Does not include Social Security and Medicare status determination, COBC reporting or conditional payment investigation.

Submission of MSA to CMS for Approval
Includes submission of MSA allocation and supporting documents to CMS and ongoing communication with CMS throughout the review process.

Submission of S0 Allocation to CMS for Approval
Includes preparation of submission document and supporting attachments requesting approval of a S0 MSA allocation in disputed/denied cases. Social Security and Medicare Status determination, Medicare conditional payment claim investigation and ongoing communication with CMS throughout the review process.

Administration Services

MSA Self Administration Support Services
Services are provided for 1, 3 or 5 years and provide instructions, forms, contacts, unlimited medical bill review, discount pharmacy services and other resources necessary for self administration of an MSA account. Includes professional support via our toll-free Help Line for the duration of the service selected. Available in English or Spanish.

MSA Custodial Account Administration
Professional administration complies with CMS administration requirements for the life of an MSA account. Includes preparation of individualized Custodial Agreement.

Medical Custodial Account Administration
Professional administrator provides services to protect, conserve or extend settlement dollars post settlement through network access, discount pharmacy program, care coordination, bill review and payment. May be used in conjunction with an MSA account or stand alone.

Ancillary Services

Social Security & Medicare Status Determination only

Rush Referral (MSA allocation in 1 - 5 business days)

Updating an MSA or MCP

Medicare Conditional Payment Investigation
Provides Social Security and Medicare status determination, reporting to Medicare and an estimate of Medicare conditional payments

Medicare Conditional Payment Claim Negotiation
Includes a review of Medicare's claim and requests removal of inappropriate claims.
It appears that the recent passage of Senate Bill 2499 (entitled the “Medicare, Medicaid, and SCHIP Extension Act of 2007”) has rung the “alarm bell” for the liability industry as carriers and other parties suddenly scramble to address the issue of Medicare compliance. While Senate Bill 2499 has certainly sent shock waves through the entire claims industry, the new legislation appears to have struck a particular chord in the liability setting.

This amendment to the Medicare Secondary Payer Statute (MSP) is the latest salvo in Medicare’s campaign to strengthen its rights against all primary payers. In 2001, the Centers for Medicare and Medicaid Services (CMS) released the “Patel Memo” setting the stage for Medicare to take a more involved role in the workers’ compensation (WC) arena. Through the Patel Memo, CMS introduced the Medicare Set-Aside (MSA) arrangement as the recommended vehicle for WC primary payers to protect Medicare’s “future interests” in WC settlements. CMS has since released eight additional memos further solidifying and expanding the MSA concept in WC cases. In addition, CMS has increased enforcement activities regarding conditional payment reimbursement in WC cases.

With the passage of Senate Bill 2499, Medicare is now poised to play a greater role in liability cases. This has given rise for concern (and rightfully so) in most quarters of the liability arena. As may be expected, there are still some pockets of resistance toward what is viewed as Medicare’s unwarranted “interference” into liability claims. However, this later view is not only inaccurate, but a potential recipe for disaster.

The reality of the situation is that Congress invited Medicare to the party over 25 years ago through the MSP. It has taken that long for the insurance industry to realize that Medicare was indeed on the guest list, and, ironically, that long for Medicare to figure out how to find the front door. While Medicare may have not made a “perfect ten” entrance, make no mistake —
Medicare has arrived. Thus, consideration of Medicare’s interests should certainly be on the radar of all primary payers – including liability primary payers.

This article focuses on (a) the current obligations of liability primary payers under the MSP, (b) the impact of the forthcoming requirements under Senate Bill 2499, and (c) the issue of Medicare’s “future interests” and liability cases – that vexing question of whether MSA arrangements are applicable in liability settlements.

1. Liability Primary Payors Are Required to Reimburse Medicare For Conditional Payments

To start, it is necessary to dispel any notion that the MSP does not apply in the liability context.

Under the MSP, a “primary plan” includes “an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance... An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”

Several forms of insurance fall under the umbrella of “liability insurance” including, but not limited to, automobile, self-insurance, uninsured motorist, underinsured motorist, homeowners, malpractice, product liability, general casualty, medical payments coverage, medical expense coverage and no-fault.

The next issue for consideration involves Medicare “conditional payments.” The general rule is that Medicare will not make payment for medical services if “payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a state or under an automobile or liability policy or plan (including self-insurance) or under no fault insurance.” However, Medicare may make “conditional payment” if a primary plan “has not made or cannot reasonably be expected to make payment... promptly.” Any such payment made by Medicare “shall be conditioned on reimbursement to the appropriate Trust Fund.”

Thus, a “conditional payment” can be defined as a payment made by Medicare for services for which another payer is responsible. Conditional payments can arise in a variety of ways. In the liability setting, they typically arise from the fact that most liability claims are denied and, thus, the primary payer does not provide medical services for an injured party’s accident related injuries. Accordingly, if the injured party is a Medicare beneficiary then Medicare often times ends up providing and paying for the treatment.

Under the MSP, liability primary payers are obligated to reimburse Medicare for conditional payments – and this obligation currently exists.

Pursuant to 42 U.S.C. § 1395y(b)(2)(B)(iii), primary payers, and an entity that receives payment from a primary plan, are obligated to reimburse Medicare for conditional payments when it is demonstrated that a primary plan “has or had a responsibility” to make payment. A primary plan’s “responsibility” may be “demonstrated” by a “judgment” or “a payment conditioned upon a recipient’s compromise, waiver and release.” A “settlement” or “contractual obligation” is further evidence of “responsibility” under the MSP. It is important to note that this obligation applies “whether or not there is a determination or admission of liability.” Thus, even denied claims are included under the statute.

With respect to repayment, if CMS does not need to take legal action, the amount of recoverable conditional payments is the lesser of either the Medicare primary payment, or the amount of the full primary payment that the primary payer is obligated to pay. If it is necessary for CMS to take legal action, Medicare may recover twice the amount of the Medicare primary payment. Medicare’s claim may be reduced by procurement costs.

Medicare has broad enforcement rights under the MSP. For example, Medicare has a direct right against all primary payers responsible for making payment and any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer. Medicare also has a subrogation right, as well as rights of joinder and intervention.
Primary payers are also currently required to place Medicare on “notice” of claims implicating its interests. According to 42 C.F.R. 411.25(a), primary payers are obligated to place Medicare on notice “if it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer had made or should have made primary payment…” 17

Senate Bill 2499 will significantly impact the current obligations of all primary payers to protect Medicare’s interests for conditional payments.

This amendment to the MSP becomes effective July 1, 2009 for all primary payers except for group health plans for which the effective date is January 1, 2009.18

Senate Bill 2499 places an affirmative obligation on all primary payers to (a) determine if a claimant is entitled to Medicare and (b) notify Medicare of said entitlement as specifically required.19

Under Senate Bill 2499, primary payers must “determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis.” 20 If it is determined that the claimant is entitled to Medicare, then the primary payer must put Medicare on notice “within a time specified by the Secretary after the claim is resolved through settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).” 21 The penalty for non-compliance is $1,000.00 per day, per claim which is in addition to any other penalties available at law.22

It is important to note that key aspects of Senate Bill 2499 remain unknown or unclear at this time. For instance, further direction is needed as to exactly what information must be provided to Medicare. The only information known to be required at this time is the “identity of the claimant.” 23 Furthermore, it is unclear if CMS will require that “notice” be provided only with respect to “resolved” cases (as would seem to be indicated by the legislative text), or whether it will also require notice in relation to “unresolved” claims. Likewise, the exact time period within which the required “notice” is to be given is unknown. It is believed that CMS will be issuing a memo in July of this year addressing these aspects of Senate Bill 2499, as well other matters regarding applicability and enforcement.24

Given the current obligations under the MSP (and the forthcoming requirements of Senate Bill 2499), what practical measures can liability primary payers take to assure that they adequately protect Medicare’s interests for conditional payments?

To meet these obligations, it is incumbent upon all primary payers to develop workflows and protocols to (a) identify claimants entitled to Medicare, (b) report said cases to Medicare and (c) resolve conditional payment claims.

Since 2001, NuQuest/Bridge Pointe has been at the forefront nationally in assisting primary payers to develop the necessary workflows and protocols to meet their obligations under the MSP. NuQuest/Bridge Pointe has developed a recommended workflow and process to address the issue of conditional payments which is attached at the end of this article.

II. Liability Cases & Medicare “Future Interests”

At the other end of the consideration pole is the concept of protecting Medicare’s “future interests.” That is, assuring that the parties to a settlement are not improperly shifting the burden of an injured party’s medical care to Medicare.

Per CMS policy directives, primary payers in the WC arena are obligated to protect Medicare’s “future interests” in certain settlements through a MSA. In general, a MSA can be defined as CMS’ recommended method to protect Medicare’s future interests in a WC case through which the parties to a WC settlement allocate or “set aside” a sum of money from that settlement to cover future anticipated medical expenses for a claimant’s accident related injuries that would otherwise be covered under Medicare.25

A question that has been raised over the years (and one which seems to be resurfacing in light of Senate Bill 2499) is whether MSA arrangements are applicable in liability cases? To address this question it is first necessary to understand how this issue plays out in the WC arena.
A. The MSA in WC Cases – How It Works

In WC, primary payers must protect Medicare’s future interests when a settlement relieves the WC primary payer of liability to provide medical treatment and services. Under the WC system, a primary payer is generally liable (or potentially liable) for providing medical care for compensable injuries or other accident related medical conditions for a claimant’s lifetime. Medicare is interested in settlements that close out a primary payer’s obligation for future medicals (CMS views these agreements as “commutation settlements”) to assure that the parties are not improperly shifting the burden of the claimant’s future care to the Medicare system.

The MSA concept in the WC context is derived principally from 42 C.F.R. § 411.46. Subsection (a) of this regulation states as follows:

Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment.

In addition, subsection (d) (2) states “if the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump sum settlement allocated to future medical.”

This regulation was basically on the books from the 1980’s but CMS did not start to enforce these provisions until the release of the “Patel Memo” in July, 2001. CMS cited this regulation in establishing the MSA arrangement.26

CMS has established specific MSA “review thresholds” in WC cases defining when it is appropriate to submit a formal MSA proposal to CMS for review and approval.

CMS’ current review thresholds for WC cases are as follows:

1. The claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is greater than $25,000; or
2. The claimant is not a Medicare beneficiary at the time of settlement but has a “reasonable expectation” of Medicare enrollment within 30 months of the settlement and the total settlement amount is greater than $250,000.27

CMS defines the term “total settlement amount” as follows: total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement.28

CMS defines the term “reasonable expectation” as including, but not limited to, situations where the claimant has applied for social security disability (SSD); has been denied SSD but anticipates appealing the decision or re-filing for SSD; is 62 years and 6 months old (in this case the claimant would be eligible for Medicare within 30 months based on age) or has End State Renal Disease.29

Significantly, CMS is on record as stating that the established WC review thresholds are simply agency “workload review” thresholds and are not “safe harbors.” It is CMS’ position that Medicare’s interests must “always” be “considered and protected” even if the review thresholds are not met.30 Unfortunately, CMS has not given any further guidance on this point.

As a result, WC primary payers have been left to develop their own approaches and protocols regarding cases falling outside of CMS’ official review thresholds (these are commonly referred to as “non-threshold” cases). Most in the industry are of the opinion that inclusion of a MSA is not necessary in every non-threshold case. Nonetheless, it is widely recognized that inclusion of a “non-threshold” MSA may be applicable in certain instances.
Determining exactly when to include a non-threshold MSA involves consideration of many different factors. For example, it has become common to include a non-threshold MSA in cases where Medicare’s interests are already implicated at the time of the settlement, or will be in close proximity of the settlement. An example of the former scenario would be a settlement involving a Medicare beneficiary where the total settlement is $25,000 or less. Examples of the later situation would include cases settling for $250,000 or less involving a 64 year old claimant who is not yet a Medicare beneficiary, or a claimant who is a SSD beneficiary at the time of the settlement but whose Medicare benefits have not yet commenced.

In the above examples the claimant is either already on Medicare or will become Medicare entitled at a known time in close proximity to the settlement. However, Medicare entitlement is not the only factor for consideration. There may very well be other facts and circumstances supporting the inclusion of a non-threshold MSA. The issue should be considered on a case by case basis. Formal approval of a non-threshold MSA by CMS is not required.

On a practical level, the MSA arrangement is comprised of three components: (1) the MSA allocation amount (2) MSA funding and (3) MSA administration.

The MSA amount is the actual projection of the claimant’s anticipated future medical treatment and services related to the claim that would otherwise be covered by Medicare. This is usually performed by a MSA vendor or other MSA allocation professional. The projection is typically calculated at the WC reimbursement rate for the applicable state of jurisdiction. Aside from the MSA amount, the parties need to decide how the MSA will be funded. The two options are “lump sum” funding or funding via a “structured annuity arrangement.” MSA administration options include claimant directed administration (known as “self administration”) or third party administration (known as “professional administration”).

The claimant can only use the MSA account to pay for post settlement medical services and items related to the claim that would otherwise be covered by Medicare. CMS requires annual reporting regarding expenditures issued from the MSA account. A complete examination of the MSA allocation, funding and administration options, as well as CMS’ various requirements related thereto, are beyond the scope of this article.

B. Considering Medicare “Future Interests” in Liability Cases – Medicare’s New Frontier?

With an appreciation of how the MSA works in the WC context under our belts, we can now approach the question of whether the MSA is applicable to liability cases. Splitting this atom requires a two level approach.

On the first level, the issue must be measured in relation with the MSP’s current statutory and regulatory framework. In this regard, it is important to note that 42 C.F.R. § 411.46 which gave rise to the MSA in WC falls under the WC section of the C.F.R. Furthermore, the actual text of the regulation references “work related injury or disease” and “workers’ compensation benefits.” In addition, the Patel Memo itself speaks in terms of WC cases and actually references 42 C.F.R. § 411.46.

From the author’s review, the MSP does not contain any specific provisions directly addressing future medicals in liability cases. Specifically, the liability equivalent of 42 C.F.R. § 411.46 does not seem to exist under the liability provisions of the MSP. The author is unaware of any judicial decisions or other administrative proclamation requiring the establishment of a MSA in the liability context. Furthermore, CMS has not released any memoranda or other written policy proclamation directly on point.

As part of the national discussion on Senate Bill 2499, the author has become aware of a perception in some quarters that the new legislation now “requires” liability MSAs. However, in the author’s opinion Senate Bill 2499 standing alone, from a pure textual standpoint, does not “require” MSAs in liability cases. The legislative text does not speak to the issue of future medicals at all. Rather, Senate Bill 2499 addresses the obligations of primary payers to determine a claimant’s Medicare entitlement status and to place Medicare on notice of such entitlement. As such, from a textual standpoint Senate Bill 2499 is not the liability equivalent of 42 C.F.R. § 411.46 – the later of which clearly speaks to the issue of future medicals in WC cases.
Notwithstanding, the author fully recognizes that there is always the possibility that CMS may somehow use Senate Bill 2499 as a "springboard" to issue subsequent directives formally requiring MSAs in liability cases. Although from the author’s perspective the actual text of Senate Bill 2499 would not appear to really provide much "spring" for any such directive given the absence of any specific provisions addressing the issue of future medicals. By way of contrast, 42 C.F.R. § 411.46 placed the issue of future medicals in WC cases on a silver platter for CMS back in 2001.

In addition, there is always the possibility that Congress could use Senate Bill 2499 as a footstep for further legislation. Subsequent Congressional amending of the MSP to include a specific provision addressing future medicals in liability cases could go a long way to provide the industry with much needed clarity on the issue – one way or the other.

While the MSP and current CMS policy memoranda would not appear to support the premise that liability MSAs are "required," there are still ample reasons why liability primary payers should keep the lights on and stay tuned. Medicare’s overall efforts to increase compliance with the MSP, ambiguities regarding enforcement of the MSP, and the overall intent of the MSP are all legitimate concerns that need to be considered. Further, how the issue is actually playing out in the industry and CMS’ actions over the past few years need to be understood.

Thus, the second level of the analysis requires an understanding of what is actually going on “in the trenches” and its potential significance. On this point, CMS has given some indications over the past few years that it is in fact interested in having Medicare’s future interests protected in certain liability cases. For example, in 2005 the author was a panelist at an educational seminar in which a CMS panelist indicated that CMS would in fact be interested in MSA arrangements (and in possibly reviewing same) in “larger” liability settlements. 37

Along these lines, it is noted that other commentators have obtained similar indications.38 Specifically, in 2005 the cited commentators verified the following with CMS per actual conversations with agency representatives:

CMS has advised that it is not asking for Medicare Set-Aside arrangements, nor does it have any current plans for a formal process for reviewing and approving Medicare Set-Aside arrangements, in liability cases.

However, even though no formal process exists, there is an obligation to inform CMS when past or future medical expenses were a consideration in reaching the liability settlement, judgment, or award whether or not specifically provided for in the settlement, judgment, or award in cases involving a Medicare beneficiary.

In addition, CMS expects that any settlement funds that were intended to compensate for future medicals be spent for that purpose before any claims related to the settlement, judgment or award are submitted to Medicare for payment.39

Since these indications were given in 2005 there have been significant developments in this area. Specifically, some parties have actually begun to include liability MSAs in their settlements and submit same to CMS for review. Perhaps more significantly, CMS has actually been agreeing to review liability MSA submissions in certain instances. While CMS does not currently have a formal review process in the liability context, it appears that it may (at least at some level) expect that Medicare’s future interests in fact be protected. Thus, a situation may be brewing in which CMS’ actions may start to speak louder than its words – notwithstanding any questions of statutory right or other issues concerning possible bureaucratic overreach.

Thus, against this backdrop how can liability primary payers address the issue of Medicare’s future interests from a practical level? The following may help chart the blueprint.

The first step requires liability primary payers to arrive at their own interpretational understanding and comfort level with the MSP, balanced against an appreciation of Medicare’s increasing role in the claims context, CMS’ oral indications regarding liability cases, and CMS’ current practices in the area. Given the sig-
significant legal component to this fundamental inquiry. Consultation with counsel should figure prominently.

If the decision is made to consider Medicare’s future interests as part of the settlement process, the second step involves determining exactly which settlements will be implicated. That is, in the absence of CMS guidelines or “thresholds” where and how should liability primary payers draw the lines? On this point, liability primary payers essentially end up in the same boat as their WC brethren in their dealing with non-threshold cases. Accordingly, it is incumbent upon liability primary payers to develop their own protocols regarding when direct measures will be employed to protect Medicare’s future interests as part of a liability settlement – either through a liability MSA or some other arrangement. In this regard, CMS’ WC review thresholds may serve as a helpful starting point.

Once internal protocols are set, the third step involves addressing certain necessary issues from a practical standpoint. These considerations include: (a) deciding on the exact method to be used to designate future medicals, (b) assuring that the designated funds are used properly by the plaintiff, and (c) addressing issues of responsibility and liability in the event that the plaintiff fails to utilize the funds as designated. In the absence of specific directives and prior precedent, the ultimate approach to be utilized is really a call to be made by each liability primary payer.

In exploring the options, the following may be helpful in developing an actual approach to the issue:

**OPTION 1: Obtain an estimate of the plaintiff’s future anticipated medical needs**

This option involves obtaining an estimate of the plaintiff’s future anticipated medical needs related to the claim. It would not technically be a MSA, but rather a cost projection that would include all anticipated medical services without differentiation between Medicare and non-Medicare covered services. This estimate could be obtained from a number of sources including, a medical cost projection, information from the treating physicians, a medical review and projection, or a Life Care Plan. This would not need to be submitted to CMS nor require CMS approval. Since the estimate would not be submitted to CMS, this approach would not delay finalization of the settlement.

**OPTION 2: Obtain a Liability Medicare Set-Aside (MSA)**

An alternate option would be to obtain a MSA from a MSA vendor or other MSA professional. In contrast to the future medical estimate under Option 1, the MSA would be limited to a projection of the plaintiff’s future anticipated medical needs related to the claim that would otherwise be covered by Medicare.

If the MSA route is chosen, it must be decided whether to request formal approval of the MSA from CMS. As noted above, CMS does not have a formal review/approval process for liability claims. Nonetheless, certain CMS Regional Offices (ROs) are electing to review liability MSAs. However, there is no guarantee that the RO will agree to review each submitted proposal – this decision lies solely in the discretion of the RO. It should be noted that submitting the MSA to CMS for review will likely cause a delay in finalizing the settlement.

Regardless of which option is pursued, specific provisions should be included in the settlement agreement as follows:

**Make sure that the funds designated for future medical care are clearly identified in the settlement agreement and that the plaintiff is placed on notice of the intended purpose of said funds.**

The projected amount of the plaintiff’s future medical care (whether the future medical estimate under Option 1 or the MSA under Option 2) should be clearly identified in the settlement agreement.

The plaintiff and his/her attorney should also be placed on notice of the intended purpose of the designated funds and that the plaintiff may only use said funds for their intended purpose. Under Option 1 this would relate to all future medical treatment related to the claim. Under Option 2, the plaintiff’s use of the funds would be limited to cover only future claim related medical treatment that would otherwise be payable under Medicare.

The plaintiff should also be instructed to maintain receipts and other documentation...
related to his/her treatment in the event CMS requests same at a later date.

Include settlement language addressing all Medicare related matters

It is important to assure that the settlement agreement contains provisions reflecting that the parties have taken Medicare's interests into account. The settlement agreement should be drafted by legal counsel experienced in Medicare compliance. In the general sense, the agreement should include language showing that the parties reached the underlying settlement in compliance with the MSP. More specifically, provisions addressing the issues of future medicals, conditional payments and indemnification should be included.

There is no guarantee that CMS will accept either option outlined above or other possible approaches to the issue. Nonetheless, given the lack of guidance in the area the outlined approaches would appear to be reasonable under the circumstances. Of course, the industry will need to stay vigilant for any subsequent amendments to the MSP or CMS policy statements on the issue.

About the Author

Mark Popolizio, J.D. is a Vice President of Customer Relations for NuQuest/Bridge Pointe and the Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP).

Prior to joining NuQuest, Mark practiced workers’ compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included Medicare Set-Asides and Medicare Compliance. Mark is very active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations.

Mark has also published several articles on MSA/Medicare issues. Mark can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.

Conclusion

The issue of Medicare compliance for liability primary payers (as is the case with all other primary payers) is really a two pronged concept. In the first right, liability primary payers have a well established obligation to reimburse conditional payments. This obligation exists today and has for the better part of the past two decades.

The new and significant area that must be addressed involves consideration of Medicare’s future interests. Liability primary payers must recognize the realities and challenges on both fronts and should develop the practical workflows and related procedures to assure proper compliance with the MSP. Hovering above the industry as it wrestles with these considerations is Senate Bill 2499 — which squarely places all primary payers in Medicare’s bull’s eye. Granted, not every aspect of the MSP or Medicare compliance is necessarily clear. However, what is clear is that failure to consider Medicare’s interests as part of the claims handling and settlement process could have significant negative ramifications.

Endnotes

3 See, 42 C.F.R. § 411.50.
6 Id.
7 See, 42 C.F.R § 411.21
9 42 C.F.R. § 411.22 (b)(3).
13 42 C.F.R. § 411.37.
15 42 C.F.R. § 411.24(g).
17 The author recently provided a detailed overview of the “notice” issue in relation to recent amendments made to the C.F.R. earlier this year. Please see the author’s article Protecting Medicare’s Interests for Conditional Payments: The Time Is Now, NuQuest/Bridge Pointe “Settlement News,” March 2008. This article can be obtained by logging onto www.NOBP.com (select “Resource Library” and then choose “Newsletters”).
It should be noted that the requirements regarding group health plans are treated separately under Senate Bill 2499. This article does not address the requirements of Senate Bill 2499 in relation to the group health context.

These requirements apply to workers’ compensation, liability insurance (including self-insurance), and no-fault insurance and includes “the fiduciary or administrator for such law, plan, or arrangement.” See, Senate Bill 2499, Medicare, Medicaid, and SCHIP Extension Act of 2007, Section 111(a)(8)(F).


Id., Section 111(a)(8)(C).

Id., Section 111(a)(8)(E)(i).

Id., Section 111(a)(8)(B)(i).

For a detailed analysis of Senate Bill 2499, please see the author’s article Just in Time for the New Year ... New Amendments to the Medicare Secondary Payor Statute, NuQuest/Bridge Pointe “Ssettlement News,” January 2008. This article can be obtained by logging onto www.NOBP.com (select “Resource Library” and then choose “Newsletters”).

Author’s definition.


See, Parasher B. Patel, CMS Memorandum to All Regional Administrators, “Workers’ Compensation Commutation of Future Benefits,” July 23, 2001, p. 4-6; Thomas L. Grissom, CMS Memorandum to All Regional Administrators, “Medicare Secondary Payor — Workers’ Compensation (WC) Frequently Asked Questions,” April 22, 2003, FAQ Nos. 2 and 17; Gerald Walters, CMS Memorandum to All Regional Administrators, “Medicare Secondary Payor (MSP) — Workers’ Compensation (WC) Additional Frequently Asked Questions,” July 11, 2005, FAQ Nos. 1 and 2; and Gerald Walters, CMS Memorandum to All Regional Administrators, “Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) and Revision of the Low Dollar Threshold for Medicare Beneficiaries,” April 25, 2006. Please note that CMS has reserved the right to adjust, modify or even eliminate the review thresholds.

Gerald Walters, CMS Memorandum to All Regional Administrators, “Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) and Revision of the Low Dollar Threshold for Medicare Beneficiaries,” April 25, 2006.


An excellent overview of the whole non-threshold area is addressed by Patty Meifert in her article entitled MSP Compliance in Settlements NOT Meeting the CMS Review Thresholds: Options for Primary Payers. This article can be obtained by logging onto www.NOBP.com (select “Resource Library” and then choose “Articles”).


This section is entitled: Supp. C: Limitations on Medicare Payment for Services Covered Under Workers’ Compensation.

42 C.F.R. § 411.46(a).

42 C.F.R. § 411.46(d)(2).


This FAQ deals with the specific issue of MSA applicability in a situation involving both a WC and third party liability claim. In this regard, CMS stated that “To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the third party liability settlement is exhausted.” The significant aspect of CMS’ proclamation in this regard is the reference to the WC carrier being “relieved” of its obligation to provide future medical benefits which is in keeping with CMS’ overall concern with possible burden shifting from the WC side. Accordingly, affording a broader interpretation beyond the specific and limited context presented by CMS would not appear to be warranted. Furthermore, to the author’s knowledge CMS has never cited this particular FAQ as establishing a requirement for MSAs in the liability context.

Medi-Pro Seminars, LLC, October, 2005, Orlando, Florida. By way of note, a definition of what may constitute a “larger” settlement was never really enunciated to any appreciable degree.

See the article entitled Considering Medicare’s Interests in Liability Cases: Will the Real Expert Please Stand Up, Patty Meifert & Robert T. Lewis. This article can be obtained by logging onto www.NOBP.com (select “Resource Library” and then choose “Articles”).

Id.

Id. The author wishes to acknowledge that the proposed approach he outlines under “step three” is essentially an adoption in large part of the proposed approach proffered by the credited authors in their prior article, with certain modifications made by the author to take into account his own perspective on the issue and events that have subsequently occurred. The author wishes to note that permission was obtained from the credited authors in this regard.

The author’s comments and acknowledgment in footnote 40 are hereby restated.

NuQuest/Bridge Pointe

One Source for Medicare Secondary Payor Compliance

P.O. Box 915619, Longwood, FL 32791-5619
866-858-7161 Toll Free  Fax 407-389-0299
www.NOBP.com

© 2008 NuQuestBridgePointe

June 2008

Attachment 7, Page 9 of 9
Office of Financial Management/Financial Services Group

DATE: June 23, 2008

SUBJECT: Collection of Social Security Numbers (SSNs), Medicare Health Insurance Claim Numbers (HICNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT

This ALERT is to advise that collection of SSNs, HICNs, or EINs for purposes of compliance with the reporting requirements under Section 111 of Public Law 100-173 is appropriate.

SSNs and EINs:

- The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that The Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.

- The EIN is the standard unique employer identifier. It appears on the employee’s federal Internal Revenue Service Form W-2, Wage and Tax Statement received from their employer. The Medicare program uses the EIN to identify businesses. The establishment of a standard for a unique employer identifier was published in the May 31, 2002 Federal register, with a compliance date of July 30, 2004.

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers’ compensation laws or plans. Two key elements that will be required to be reported are SSNs (or HICNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers’ compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a group health plan arrangement, your SSN and/or HICN will likely be requested in order to meet the requirements of P.L. 110-173 if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers’ compensation or who receive a settlement, judgment or award from liability insurance (including self-insurance), no-fault insurance, or workers’ compensation will be asked to furnish information concerning their SSN and/or HICN and whether or not they (or the injured party, if the settlement, judgment or award is based upon an injury to someone else) are Medicare beneficiaries. Employers, insurers, third party administrators, etc. will be asked for EINs.

To confirm that this ALERT is an official Government document and for further information on the mandatory reporting requirements under this law, please visit the CMS website at www.cms.hhs.gov/MandatoryInsRep.

MMSEA111AlertSSNandHICNandEINcollection062308final
August 24, 2009

The Medicare Secondary Payer Mandatory Reporting Provisions in
Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (the MMSEA)
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

ALERT: Compliance Guidance Regarding Obtaining
Individual HICNs and/or SSNs for Non-Group Health Plan (NGHP) Reporting
Under 42 U.S.C. 1395y(b)(8)

Persons with Medicare need to be aware that workers’ compensation plans, no-fault insurance and
liability insurance (including self-insurance) (Non-Group Health Plan (NGHP) Insurance
Arrangements) are now required to report data necessary to identify Medicare beneficiaries for whom
the NGHP is responsible for paying primary to Medicare. Reporting entities have access to a query
function which can assist them in: 1) verifying a Medicare Health Insurance Claim Number (or
HICN) for a given Medicare beneficiary; or 2) determining whether or not an individual is a
Medicare beneficiary if the individual furnishes his/her Social Security Number (SSN).

Some NGHP reporting entities have advised the Centers for Medicare & Medicaid Services (CMS)
that they are having difficulties in obtaining either the HICN or SSN from some claimants. The CMS
is providing the attached model language (with a picture of a Medicare card), to assist reporting
entities in obtaining this information and being compliant with Section 111.

Claimants should routinely cooperate in furnishing either their HICN (or SSN if they do not have a
HICN available) as requested. If an individual refuses to furnish either a HICN or SSN, and the
NGHP reporting entity chooses to use the attached model language, CMS will consider the reporting
entity compliant for purposes of its next Section 111 file submission if:

- A signed copy of the model language in the format provided is obtained (even if the
  individual is later discovered to be a Medicare beneficiary).

- With respect to that same individual, the reporting entity has the model language (with the
  picture of the Medicare ID card) re-signed and dated at least once every 12 months in cases
  where ongoing responsibility for medicals (ORM) applies.

- The reporting entity should retain this documentation.

NOTE:
This process does not provide a “safe harbor” to any reporting entity attempting to use it to avoid
reporting MSP data about an individual known to the reporting entity to be a Medicare beneficiary.
Also note that reporting entities are not required to use the specific model language provided by
CMS.
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? □ Yes □ No

If yes, please complete the following. If no, proceed to Section II.

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)

Medicare Claim Number: _______________ Date of Birth (Mo/Day/Year) ____________

Social Security Number: (If Medicare Claim Number is Unavailable) ____________ Sex □ Female □ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) __________________________ Claim Number __________________________

Name of Person Completing This Form If Claimant is Unable (Please Print) __________________________

Signature of Person Completing This Form __________________________ Date __________________________

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.
Section III

<table>
<thead>
<tr>
<th>Claimant Name (Please Print)</th>
<th>Claim Number</th>
</tr>
</thead>
</table>

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

**Reason(s) for Refusal to Provide Requested Information:**

| | |
| | |
| | |
| | |

<table>
<thead>
<tr>
<th>Signature of Person Completing This Form</th>
<th>Date</th>
</tr>
</thead>
</table>
Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT


This ALERT is to advise that collection of HICNs, SSNs, or EINs for purposes of compliance with the reporting requirements under Section 111 of Public Law 100-173 is appropriate.

HICNs, SSNs and EINs:

• The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. The SSN is used as the basis for the Medicare HICN. While the HICN is required to identify a Medicare beneficiary, if the HICN is not available some beneficiaries may also be identified by the SSN. Please note that The Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting HICNs or SSNs for coordination of benefit purposes.

• The EIN is the standard unique employer identifier. It appears on the employee’s federal Internal Revenue Service Form W-2, Wage and Tax Statement received from their employer. The Medicare program uses the EIN to identify businesses. The establishment of a standard for a unique employer identifier was published in the May 31, 2002 Federal register, with a compliance date of July 30, 2004.

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan
administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers’ compensation laws or plans. Two key elements that are required to be reported are HICNs (or SSNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers’ compensation benefits, Medicare relies on the collection of both the HICN (or SSN) and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a group health plan arrangement, it is likely that your employer or insurer will ask for proof of your Medicare program coverage, by asking for your Medicare HICN (or your SSN) in order to meet the requirements of P.L. 110-173, if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers’ compensation or who receive a settlement, judgment or award from liability insurance (including self-insurance), no-fault insurance, or workers’ compensation will be asked to furnish information concerning whether or not they (or the injured party, if the settlement, judgment or award is based upon an injury to someone else) are Medicare beneficiaries, and if so, to provide their HICNs or SSNs. Employers, insurers, third party administrators, etc. will be asked for EINs. To confirm that this ALERT is an official Government document and for further information on the mandatory reporting requirements under this law, please visit the CMS website at www.cms.hhs.gov/MandatoryInsRcp.
Samples of Release Language

WILLIAMS KASTNER

Mary Re Knack
601 Union Street, Suite 4100
Seattle, WA 98101
(206) 628-6600
Settlement Considerations and Draft Release Language for the Case Involving a Medicare Beneficiary

Mary Re Knack
Williams Kastner
mknack@williamskastner.com

I. Issues to consider in Release Involving Medicare Claimant

- Only Satisfaction of Medicare’s Interest Will Protect
- Include Medicare conditional payment amount and any amounts allocated for future costs
- Release MSP Private Cause of Action
  - 42 USC 1395y(b)(3)(A)
- Consider including ICD-9 codes associated with claimed injuries
- Agreement by plaintiff and plaintiff’s counsel to cooperate if any future action by CMS
- Agreement by plaintiff and plaintiff’s counsel on how payment to plaintiff and to Medicare is to be made, make an express condition of settlement
- Agreement claimant provide copies of any settlement agreements with CMS/Medicare
- Agreement claimant obtain and provide copy of General Release from CMS
- Statement that claimant understands that settlement may impact claimant’s future benefits, and that claimant has the right to seek waiver, compromise or otherwise reduce the amount sought by CMS based on cost of procurement and / or hardship
- Indemnification/Hold Harmless language (if not already specifically addressed elsewhere in settlement agreement)
- Multiple defendants will require modification of language, and additional agreements to make sure Medicare’s interest is satisfied

The Government can sue directly “any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly” if those third-party funds should have covered injury-related medical expenses, instead of Medicare. The Government can also bring an action against anyone responsible to make payment under a primary plan, if Medicare is not reimbursed for payments that should have been made by the primary plan. The right of reimbursement exists regardless of whether a settlement acknowledges liability and irrespective of how the settlement agreement stipulates disbursement should be made.
II. Possible Settlement Language to Include in Cases Involving Medicare

The Language set forth below does not represent a complete settlement agreement. Rather, these are examples of language you might consider using in your settlement agreement.

A. Payment

The “Payment” language set forth below follows payment option “A” above. If different options are used, different language would need to be used. Additional examples of sample language may be added to the Extranet in the future. If you have examples that you have successfully used, please advise the Health Care Practice Group.

Payment Language:

As express consideration for the settlement of this matter, CLAIMANT/PLAINTIFF agrees that a check in the amount of _____________ (fill in the total settlement amount, less the Medicare Conditional Payment Letter amount or that amount plus some to allow for additional items or services to be included) will be issued to the trust account of the attorney for CLAIMANT/PLAINTIFF. The amount of _____________ (fill in the amount in the Medicare Conditional Payment Letter or that amount plus some to allow for additional items or services to be included) (the Conditional Payment Letter amount [plus ______]), will initially be withheld by DEFENDANT/INSURER. Once the Medicare Final Demand Letter is provided to the DEFENDANT/INSURER, DEFENDANT/INSURER will issue a check directly to Medicare. The amount of the check to Medicare will either be the Conditional Payment Letter amount (___________) (fill in the amount in the Medicare Conditional Payment Letter) or, if the Final Demand Letter is less than the Conditional Payment Letter amount, the amount in the Final Demand Letter. If the amount in the Final Demand Letter is less than the Conditional Payment Letter amount, DEFENDANT/INSURER will issue an additional check to the trust account of the attorney for CLAIMANT/PLAINTIFF for difference between the Conditional Payment Letter amount and the Final Demand Letter amount. If the Final Demand Letter amount is greater than the Conditional Payment Letter amount, then [specify the arrangement to which the parties agree]. Under no circumstances will the total amount paid by DEFENDANT/INSURER exceed the total settlement amount of _____________ (fill in the total settlement amount).

B. Waiver of Private Cause of Action

The Medicare eligible claimant has a private cause of action under 42 U.S.C. 1395y(b)(3)(A) “in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement)” under the MSP Act. This potential claim should be waived as part of settlement.

Waiver of Private Cause of Action Language:

In consideration of the payments set forth in the Settlement Agreement, CLAIMANT/PLAINTIFF waives, releases, and forever discharges DEFENDANT/INSURER
from any obligations for any claim, known or unknown, arising out of the failure of DEFENDANT/INSURER to provide for a primary payment or appropriate reimbursement pursuant to 42 U.S.C. 1395y(b)(3)(A).

C. Impact on Future Benefits

Potential Impact on Future Medicare Benefits Language:

The CLAIMANT/PLAINTIFF understands that this settlement may impact, limit or preclude ________’s right or ability to receive future Medicare benefits arising out of the injuries alleged in this lawsuit.

D. Right to Seek Waiver, Compromise or reduction for Procurement Costs

Request for waiver, compromise and procurement cost language:

The CLAIMANT/PLAINTIFF understands that [he/she] has the right to seek a waiver, compromise or otherwise reduce the amount of conditional payments sought by the Centers for Medicare and Medicaid Services (“CMS”) based upon the cost of procurement and/or hardship.

E. Cooperation

Insureds/Insurers should require that the Injured Party or the Injured Party’s representative agree to cooperate and assist the insured/insurer if the insured/insurer is pursued or sued by the United States for failure to reimburse Medicare arising out of the Injured Party’s claim.

Part of this cooperation should include an exchange of any and all agreements between the Injured Party/the Injured Party’s representative and Medicare regarding the reduction of the amount reflected in the Conditional Payment Letter or Final Demand Letter. After CMS is placed on notice of the settlement, the MSPRC will issue a Final Demand Letter. The Injured Party/Injured Party’s representative can negotiate with the MSPRC over the amount and seek reductions for financial hardship, for “equity and good conscience,” and / or for procurement costs (i.e., attorneys fees). This negotiation is expected to take place after settlement, so defendants most likely will have no access to these documents or agreements.

Cooperation/Assistance Language:

CLAIMANT/PLAINTIFF further agrees that he/she will execute and deliver to DEFENDANT/INSURER copies of all documents or agreements and do such further acts and things as DEFENDANT/INSURER may reasonably request when necessary to effectuate the purposes of the Settlement Agreement, including but not limited to providing copies of all documents between CLAIMANT/PLAINTIFF and Medicare regarding the reduction in the amount owed Medicare for Conditional Payments, either for financial hardship, equity and good conscience, or due to procurement costs, or any other reason.
Should any person or entity not a party hereto challenge the validity of this Agreement, or any term thereof, pursue recovery of monies from DEFENDANT/INSURER or bring a claim or claims against DEFENDANT/INSURER arising out of 42 U.S.C. § 1395y(b) related to payment for items or services related to the injuries claimed in this action, the CLAIMANT/PLAINTIFF shall provide to DEFENDANT/INSURER such cooperation and assistance as DEFENDANT/INSURER may reasonably request in order to resist such a challenge or defend such a claim.

F. Hold Harmless

Hold Harmless Language:

CLAIMANT/PLAINTIFF acknowledges that all subrogation and lien claims arising out of contract or under state or federal law, including, but not limited to, any subrogation or lien claims of CLAIMANT/PLAINTIFF’s health care providers, insurance carriers, state worker’s compensation, and any federal agency or programs such as Medicare, Medicaid, or Social Security, are the sole and separate obligation of CLAIMANT/PLAINTIFF which CLAIMANT/PLAINTIFF agrees to pay or otherwise resolve. CLAIMANT/PLAINTIFF further hereby covenants to defend, indemnify and hold harmless the DEFENDANT/INSURER from and against all such lien and subrogation claims brought against DEFENDANT/INSURER.

G. Declaration of Non-Eligibility for Medicare

If the injured party claims not to be currently eligible for Medicare Benefits, then the injured party should sign a declaration in the Settlement Agreement to that effect. Remember, this will not provide protection from being required to reimburse Medicare for payment for items and services related to the claimant/plaintiff’s injuries, should it later be determined that the claimant/plaintiff was a Medicare patient.

Non-Eligibility Language:

I further declare under penalty of perjury under the laws of the State of Washington, that: 1) I am not currently eligible for Medicare Benefits; and 2) none of the treatments that I received for the injury or injuries claimed in this lawsuit (or related to the incident giving rise to this lawsuit) or released in this agreement were paid for by Medicare.

Signed this ______ day of 20__, at __________ (city), __________ (state).

[CLAIMANT/PLAINTIFF signature]
Acknowledgment: (to be placed in the recitals section of agreements)

[Plaintiff and Defendant, (collectively, the “Settling Parties”) hereby acknowledges the following: (1) Under the Medicare Secondary Payor (“MSP”) statute, 42 U.S.C. §1395y(b), and its accompanying regulations (“the MSP Provisions”), the Centers for Medicare and Medicaid Services (the “CMS”) in certain circumstances may have an obligation to seek reimbursement of conditional payments made by the Medicare program (Title XVIII of the Social Security Act) (the “Medicare Program”) on claims for items and services relating to injuries allegedly sustained by [Plaintiff]; (2) [Plaintiff] and [Plaintiff’s counsel] are in the best position to determine if any reimbursement obligation exists, based on [Plaintiff’s] entitlement (or lack thereof) to Medicare Program benefits, [Plaintiff]’s actual receipt of such benefits, and, if there is a reimbursement obligation, to ensure that the Medicare Program’s interests are properly considered and discharged; (3) If there is a reimbursement obligation to the Medicare Program, [Plaintiff] and [Plaintiff’s counsel] are responsible under the MSP Provisions to verify, resolve and satisfy such obligation; and (4) If [Plaintiff] is now or in the past has been enrolled in the Medicare Program, [Defendant] will report the [Settlement] to the CMS pursuant to the MSP Provisions (even if [Defendant] does not agree that the evidence actually establishes liability for injuries allegedly sustained by [Plaintiff]).

Plaintiff Statements:

[Plaintiff] represents and warrants that [Plaintiff] and [Plaintiff’s counsel] have reviewed the underlying facts and evidence of this case. [Plaintiff] understands and acknowledges that if [Plaintiff] is Medicare-enrolled at the time of settlement, [Defendant] is required to report this [Settlement] to the CMS but further acknowledges that by doing so, [Defendant] does not concede or admit that it necessarily agrees that [Defendant] is liable for [Plaintiff’s] alleged injuries.

[Plaintiff] also represents and warrants that, if [Plaintiff] has not already reimbursed or otherwise satisfied the Medicare Program for conditional payments made on claims for items and services relating to the injuries that are the subject of this action being resolved by this [Settlement], [Plaintiff] will do so in a timely manner as set forth in the MSP Provisions.

[Plaintiff] further represents and warrants that, to the extent any other government payer (including but not limited to Medicaid, Veteran’s Administration, Tricare/CHAMPUS) has a right to be reimbursed for any payments made on claims for items and services relating to the alleged injuries that are the subject of this action being resolved by this [Settlement], [Plaintiff] has, or will, fully reimburse, resolve, otherwise satisfy, or properly consider, the rights of such payers.

[Plaintiff] acknowledges that in making payment to [Plaintiff] pursuant to this [Settlement], [Defendant] is reasonably relying on the representations and warranties made by [Plaintiff] herein and these representations and warranties are a material inducement to [Defendant] to make payment as part of this Agreement.

Plaintiff’s Counsel Statements:

In addition to [Plaintiff]’s representations and warranties set forth above, [Plaintiff’s counsel] represents and warrants that it has applied a formalized screening process to determine if [Plaintiff] is enrolled to Medicare Program benefits, and, if [Plaintiff] is so enrolled, when [Plaintiff] became so enrolled to Medicare Program benefits. [Plaintiff’s counsel] has reviewed the relevant MSP Provisions regarding reporting of claims by [Defendants] to the CMS and reimbursement to the Medicare Program for conditional payments made, and has reviewed all relevant case-specific evidence, including but not limited to medical records, interrogatories, depositions, expert witness reports, affidavits, brochures and other reports, where available. [Plaintiff’s counsel]
understands and acknowledges that where Plaintiff is identified as Medicare-enrolled at the time of execution of this Agreement, [Defendant] is required to report this [Settlement] to the CMS but further acknowledges that by doing so [Defendant] does not concede or admit that it necessarily agrees that [Defendant] is liable for [Plaintiff's] alleged injuries.

[Plaintiff's counsel] also represents and warrants that it will hold or arrange to hold sufficient net settlement funds in trust, escrow, or other similar account, until such time as any obligation to reimburse the Medicare Program for conditional payments on claims for items and services relating to the injuries that are the subject of this action being resolved by this [Settlement] have been fully resolved or satisfied. [Plaintiff's counsel] further represents and warrants that it will take all reasonable and necessary actions to ensure that any such reimbursement obligation is in fact resolved or satisfied. Finally, [Plaintiff's counsel] represents and warrants that, as a material inducement to [Defendant] making payment under this [Settlement] before such reimbursement obligation is resolved or satisfied, and as a condition subsequent to this [Settlement], [Plaintiff's counsel] will provide [Defendant] with proof of the Medicare Program's determination that such reimbursement obligation has been fully resolved or satisfied once such determination is received by [Plaintiff's counsel].

[Plaintiff's counsel] further represents and warrants that, to the extent any other government payer (including but not limited to Medicaid, Veteran's Administration, Tricare/CHAMPUS) has a right to be reimbursed for any payments made on claims for items and services relating to the alleged injuries that are the subject of this action being resolved by this [Settlement], [Plaintiff's counsel] will take all necessary and reasonable actions to ensure that [Plaintiff] has, or will, fully reimburse, resolve, otherwise satisfy, or properly consider, the rights of such payers.

[Plaintiff's counsel] acknowledges that in making payment to [Plaintiff] pursuant to this [Settlement], [Defendant] is reasonably relying on the representation and warranties made by [Plaintiff's counsel] herein and these representations and warranties are a material inducement to [Defendant] to make payment under this Agreement.

Tort Recovery or Similar Record
Based on the warranties and representations made above, a tort recovery or similar record may need to be established by [Plaintiff's counsel] and a reporting event may be triggered, which would be the responsibility of the [Defendant], by and through its insurance carrier. In the case of a reportable event, [Defendant] will comply with the MSP Provisions. [Defendant] will determine whether the [Settlement] is reportable under the Act. If there is an obligation to establish a tort recovery or similar record with the CMS, [Plaintiff's counsel] shall provide [Defendant] appropriate information validating that such a record has been established with the CMS and/or its recovery contractor. The [Settling Parties] expressly agree that payment of settlement proceeds is not conditioned upon Plaintiff providing proof that all Medicare reimbursement claims and obligations have been satisfied. Rather, [Defendant] agrees to forward the settlement proceeds within the time frame agreed between the [Settling Parties] at the time of settlement once [Plaintiff] has tendered an executed release, and [Plaintiff's counsel] has provided [Defendant] with appropriate information validating that a tort recovery or similar record has been established with the CMS and/or its recovery contractor.

Following [Plaintiff's] opening of a tort recovery or similar record, [Plaintiff's counsel] agrees to: (1) hold all net settlement proceeds in a client trust account (or similar account should needs-based government benefits require preserving) until [Plaintiff] obtains claims satisfaction documents from the CMS and/or its recovery contractor; and (2) provide [Defendant] with written proof of the resolution or satisfaction of any claim asserted by Medicare pursuant to the MSP prior to disbursing to [Plaintiff] any proceeds received in connection with this [Settlement].
Medicare's Potential Future Interests
The [Settling Parties] do not intend to shift responsibility of future medical benefits to the Federal Government. [Plaintiff] and [Plaintiff's counsel] have been informed and acknowledge that Medicare cannot accept the terms of the [Settlement] as to an allocation of funds of any type if the [Settlement] does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered and protected, Medicare will refuse to pay for services related to the alleged injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire settlement. Medicare may also assert a recovery claim, if appropriate, based on conditional payments made by Medicare within the meaning of 42 U.S.C. §1395y(b)(2). The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insuror, that has received any portion of a third party payment directly or indirectly. The CMS also has a subrogation right with respect to any such third party payment. See, for example, 42 C.F.R. §§411.24(b), (e), and (g) and 42 C.F.R. §411.26. Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a liability carrier from any future medical expenses, based on an allocation of future medical expenses as part of a settlement or judgment, and creates a permanent shift of the burden of paying and managing that future injury-related care over to Medicare, a Medicare Set-aside Arrangement ("MSA") may be appropriate. This MSA, if required, would need sufficient funds from the [Settlement] to cover future medical expenses incurred once the total third party liability settlement is exhausted.

Federal regulations provide that the liability for work-related injuries resulting in lifetime medical expenses should not be shifted to Medicare from the responsible party after settlement. Accordingly, a portion of a Medicare beneficiary's workers' compensation settlement in certain cases must be set aside to pay for the beneficiary's future work-related injury or illness resulting in medical expenses per 42 C.F.R. §411.46. However, because this [Settlement] does not involve a workers' compensation claim, and no Federal laws or regulations exist in mandating an MSA in a liability settlement, the [Settling Parties] agree that Medicare's interests may be properly considered absent an MSA being established. Nevertheless, [Plaintiff] agrees to take such actions as are considered legally necessary to ensure Medicare's interests are properly considered.

[Plaintiff] and [Plaintiff's counsel] represent and warrant that they have reviewed any applicable statutes and regulations, including, but not limited to, 42 U.S.C. §1395y(b)(2), 42 C.F.R. §§411.24(e) and (g-i), §411.26, §411.46 and §411.47.

Consequently, to comply with the applicable Federal regulations and to reasonably recognize Medicare's interests, [Plaintiff] and [Plaintiff's counsel] represent that they agree to satisfy any and all Medicare subrogation interests, claims and/or liens, as may be finally determined and/or compromised, from the proceeds of the settlement funds as distributed to [Plaintiff's counsel].

[Plaintiff] understands that it is [his] responsibility to properly consider Medicare's future interest. If Medicare's future interest is not properly considered, [Plaintiff] understands that the CMS may be entitled to recover its future interest from [Plaintiff], and that [Defendant] is not liable to the CMS for [Plaintiff's] failure to properly consider Medicare's future interest. Recovery of this future interest may include but may not be limited to the following: payment directly to the CMS out of the settlement proceeds and/or revoking/denying the [Plaintiff's] Medicare benefits for injury-related or non-injury related medical expenses for a certain amount of time to be determined by the CMS in its sole discretion.