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# MEDICARE SECONDARY PAYER LAW COMPLIANCE FOR LITIGATORS AFTER THE MEDICARE, MEDICAID AND S-CHIP EXTENSION ACT OF 2007

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I. Background- Medicare Secondary Law before MMSEA

In effect since 1980, Medicare Secondary Payer (‘‘MSP’’) rule provides that Medicare is the secondary payer. 42 USC 1395y. Medicare won’t pay if there is a primary payer.

CMS, the Centers for Medicare and Medicaid services, administers the MSP. MEDICARE is part of the Department of Health & Human Services (‘‘HHS’’). References to ‘‘Secretary’’ mean the Secretary of the Department of Health & Human Services. CMS has consolidated all of the functions and workloads related to MSP post-payment recoveries into one MSP recovery contract. The Medicare Secondary Payer Recovery Contractor (‘‘MSPRC’’) is the recovery contractor. Each of these entities has its own website for further information.

“Primary Payers” include
- Liability, Workers Compensation, and no-fault insurers
- Self-insureds
- Health insurers

Under MSP, Medicare may make a “conditional payment” to a medical provider, but it has a “right of recovery” (aka “lien”) to get it back.

26 Code of Federal Regulations § 411.24 provides:
- CMS has a direct right of action to recover from any primary payer.
- CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.
- The primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.
- If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount of the amount of the Medicare primary payment.

Penalties for failure to reimburse Medicare for a conditional payment include:
For claimant: loss of Medicare benefits
For primary payer: 100% penalty for shortfall up to total amount of settlement

Duty to repay a conditional payment is known as “Medicare reimbursement liability.” Enforcement was not pervasive.

Plaintiff attorneys should notify Medicare early in the case so a Conditional Payment Letter will issue

II. Workers Compensation Medicare Set-Asides 2001
On 7/23/2001, by publication of an internal memo, CMS mandated Medicare Set-Asides in workers compensation claims to protect Medicare’s interest.

Parties are required to set aside that portion of a workers compensation settlement which represents payment for future claim-related Medicare-eligible expenses. The set-aside account can be administered by a third party administrator or self-administered.

CMS established two categories of claims where a Set-Aside would be required to protect Medicare’s interest:

- “Class 1”: The claimant is already receiving Medicare benefits due to disability or age regardless of the amount of the settlement.
  
  OR

- “Class 2”: The settlement will pay out $250,000 or more and the claimant is likely to be eligible for Medicare within 30 months

CMS refined its position through a series of memoranda. These are synthesized into a single document at: http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp

CMS offices will review and issue an approval letter for Class 1 workers compensation claims exceeding $25,000 and Class 2 workers compensation claims. Approval is not required, though most insurance carriers have insisted on it.

III. Medicare, Medicaid and S-CHIP Extension Act of 2007 (“MMSEA”)

On December 29, 2007, President Bush signed into law the Medicare, Medicaid and S-CHIP Extension Act of 2007 (“MMSEA”). By its terms, the law was to go into effect on 7/1/2009, but technological difficulties have delayed implementation. MMSEA is an amendment to the MSP.

This is a big, sprawling, omnibus law; only §111(g) applies to claims seen in litigation which might close out a claim for medical benefits.

MMSEA creates reporting requirements to facilitate enforcement of the Medicare Secondary Payer law. Primary payers are required to file quarterly reports detailing information about the parties and the claim.

This new potential for Medicare reporting liability allows better enforcement of Medicare reimbursement liability. The goal is to stop double-dipping and thereby strengthen Medicare so it will be around for the rest of us.

The reporting law applies to:

- Settlements
- Judgments
Payments to be reported fall into two categories:

- “TPOC”, pronounced “tea-pock”, stands for Total Payment Obligation to Claimant. This is a lump sum payment, such as typically concludes a liability case or a total closure of a workers compensation claim.
- “ORM”, Ongoing Responsibility for Medical applies to workers compensation claims and no-fault claims. A report is required upon the assumption and closing of ORM.

The penalty for failure to report is $1,000 per day per claimant.

Primary Payers must electronically report through their Responsible Reporting Entity (“RRE”) 132 information fields in the basic report, more if there is more than 1 Claimant and 1 Defendant.

A Primary Payer’s “Responsible Reporting Entity” must register to electronically report.

Reports will be quarterly. Primary Payers must start transmitting real data in 1st Quarter 2011. Each RRE is assigned a one-week window in which to report.

“Trigger dates” for reporting:

- TPOC after 10/01/2010
- ORM for claims open as of 01/01/2010

Small claim TPOC exemptions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 and 2011</td>
<td>$5,000</td>
</tr>
<tr>
<td>2012</td>
<td>$2,000</td>
</tr>
<tr>
<td>2013</td>
<td>$ 600</td>
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</tbody>
</table>

How To Determine If A Claimant Is A Medicare Beneficiary

1) Use the status request form.

2) Query software

The RRE can obtain free query software from CMS. A query system is available to determine Medicare status, but submitter must have claimant’s Health Insurance Claim Number or Social Security Number. Queries may be submitted once a month for an unlimited number of claimants.

3 of 4 fields must match the submitted #:

- First initial of first name
- First 6 characters of last name
- Gender
MEDICARE SECONDARY PAYER LAW COMPLIANCE FOR LITIGATORS AFTER THE MEDICARE, MEDICAID AND S-CHIP EXTENSION ACT OF 2007

• DOB
  01=Yes  51=No match

Report Data Elements

Identifying information about:
• The Primary Plan (Insurance Carrier or Self-Insured plan)
• Injured Medicare beneficiary or claimant, if different
• Policy-Holder
• Claimant’s Attorney (or other representative)
• Incident and Resolution Information:
  ▪ Nature of Claim- Unique fields for Product Liability claims
  ▪ Venue
  ▪ International Classification of Diseases Code(s)
  ▪ Date of Occurrence
  ▪ Description of injury field-- in place through 2010
  ▪ TPOC

How To Handle Settlements, Judgments, Awards, Payments After MMSEA

Determine claimant’s Medicare status
Guidelines:
• 65 years old
• Disabled Receiving SSDI (Social Security Disability Income)
• End-Stage Renal Disease

REPORT!
There is no “safe harbor”

Medicare Set-Asides For Claim-Related Medicare-Eligible Expenses—
New Deal Point In Negotiations
All parties will benefit from a lower Medicare Set-Aside

Four distinct Medicare Set-Aside concepts
  MSA ALLOCATION
  The amount of future claim-related Medicare-eligible expenses necessary to protect Medicare’s interest
  When is an allocation unnecessary?
  1) The facts demonstrate that claimant is only being compensated for PAST medical expenses
2) No evidence of attempt to maximize other aspects of the settlement, *e.g.*, lost wages, to Medicare’s detriment
3) *Treating* physicians conclude in writing that to a reasonable degree of medical certainty that individual will no longer require any Medicare-covered treatments related to the claim

CMS memo 4/22/2003

MSAs can be set up as a lump sum with no discount for present value

- **OR-**

as a structured settlement with a discount for present value and taking into account the claimant’s individual life expectancy

Allocation must be in good faith

Sample language:

- The parties have taken Medicare’s interests into account and set aside $2,000 for claim-related Medicare-eligible expenses”
- “The parties have taken Medicare’s interests into account and set aside $26,447.06 as an initial deposit and annual lifetime payments of $3,676.47 commencing within one year of settlement for claim-related Medicare-eligible expenses”

Lump sum MSA

No discount for present value, *e.g.*, an MSA allocation of $118,358.81 to be paid upon settlement will cost $118,358.81.

Structured MSA

Almost always costs less due to the discount for present value

<table>
<thead>
<tr>
<th>MSA Initial Deposit</th>
<th>Cost</th>
<th>Payout</th>
</tr>
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<td>$26,447.06</td>
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<table>
<thead>
<tr>
<th>Annual MSA payment</th>
<th>Cost</th>
<th>Payout</th>
</tr>
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<tbody>
<tr>
<td>$3,676.47 per year for life starting on 7/10/2011 (Expected Lifetime 25.4 yrs)*</td>
<td>$54,783.00</td>
<td>$91,911.75</td>
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</table>

$81,230.06 $118,358.81

In liability cases, resolution is a compromise of many elements not present in health insurance or workers compensation, *e.g.*, comparative negligence, policy limits, nuisance value settlements

CMS’ position is that they are entitled to the entire TPOC amount necessary to satisfy their right of recovery:

“… The agency’s perspective is that we have priority right of recovery as well as a subrogation right. We do not do a pro rata reduction based on comparative negligence. Nor do we do a reduction based on allocation of fault or any allocation of the parties. … If you settle for a nuisance value of $10,000 then we have recovery rights up to that amount. … [But] beneficiaries have certain rights including the right to request a waiver of recovery
in certain situations which takes into account both determinations of what’s called without fault as well as whether it’s against equity and good conscience would defeat the purpose of the Medicare program in order to recover. And they have full administrative appeal rights and potentially judicial review rights on that issue. . . .”
CMS teleconference 12-15-2009, transcript pp.50-52

Will this work?
- “The parties have taken Medicare’s interests into account and set aside $0 for claim-related Medicare-eligible expenses. Notwithstanding the release by Plaintiff of all claims for future medical care, the parties do not have reason to believe such claim-related care will be incurred.”
- “The parties have taken Medicare’s interests into account and set aside $20,000 as an initial deposit and annual lifetime payments of $4,325 commencing within one year of settlement for 50% of future anticipated claim-related Medicare-eligible expenses. Due to 50% comparative negligence, the settlement does not compensate the balance.”

MSA REPORT
If parties cannot agree, or need assistance, an MSA allocation company, such as Ringler Medicare Solutions, can prepare a report of projections of future claim-related Medicare-eligible expenses

Report is an analysis of medical reports and paid medical benefits resulting in a recommendation for an MSA allocation; typically provides both lump sum and annuitized funding options

MSA APPROVAL
MSA approval is optional and may not be available for your case

Whether approval is available depends on the CMS Regional Office’s workload. Approval is not currently available for California liability claims. Regional offices are in Atlanta, Boston, Chicago, Dallas, Philadelphia, San Francisco, Seattle.

“Liability set-asides; both of them, worker’s comp and liability, neither one of them has ever been required to participate in a CMS review process”
CMS teleconference transcript 3/24/09. page 61

MSA ACCOUNT
An interest-bearing bank account administered by the claimant or a professional custodian for payment of claim-related Medicare-eligible expenses
An MSA Account is not a trust, though it may be wrapped in a Special Needs Trust where appropriate.

### Medicare Set-Aside Account Administration

| YEAR ONE | Initial Dep. $30k | Medicare-Eligible Expenses $5k | Bal. $25k | Medicare pays $0 |
| YEAR TWO | Ann. Pymt. $5k | Medicare-Eligible Expenses $5k | Bal. $25k | Medicare pays $0 |
| YEAR THREE | Ann. Pymt. $5k | Medicare-Eligible Expenses $35k | Bal. $0 | Medicare pays $5k |
| YEAR FOUR | Ann. Pymt. $5k | Medicare-Eligible Expenses $4k | Bal. $1k | Medicare pays $0 |
| YEAR FIVE | Ann. Pymt. $5k | Medicare-Eligible Expenses $2k | Bal. $4k | Medicare pays $0 |
| YEAR SIX | Ann. Pymt. $5k | Medicare-Eligible Expenses: $2k | Bal. $7k | Medicare pays $0 |
| YEAR SEVEN | (Plaintiff dies after receiving his annual payment) | Ann. Pymt. $5k | Medicare-Eligible Expenses $1k | Bal. $11k | Medicare pays $0 |

Medicare has a right of recovery for $5,000. $6,000 goes to Plaintiff’s heirs.

### Take-Away Points
- For claims brought by a Medicare beneficiary, create a good-faith allocation
- Your structured settlement broker can compute the present value of a future stream of expenses (no fee)

### What happens if the case is tried or arbitrated?
Plaintiff should create and administer own set-aside account—no input from the primary payer

Amount should reflect a good-faith allocation based on the verdict and admitted evidence

### Scenarios:
Medicare patient obtains treatment post-settlement  
Medicare makes “conditional payment” to provider  
Medicare checks Health Insurance Claim Number against reported tort payments, sends Explanation of Benefits letter to patient to determine what sums from settlement were attributable to future claim-related Medicare-eligible expenses

1) No set-aside in agreement  
100% of settlement deemed available to pay for care  
2) Set-aside in agreement
Inquiry as to how money was spent and how much is left; if anything left, must be used to reimburse Medicare, if nothing left, how was it spent?

If spent on expenses other than claim-related Medicare-eligible expenses, patient must reimburse Medicare. Set-aside is not binding on Medicare

**Both scenarios:** Medicare can seek $$ from primary payer
BEWARE THE “DANGER ZONE”

Example:

- Case closes on 30th day of quarter
- Primary Payer reports on 46th day of quarter, this case not included
- Primary Payer reports on 46th day of next quarter
- Plaintiff presents for claim-related medical care on 60th day of first quarter and continues treatment through 40th day of next quarter; Medicare pays because it has no notice of the primary payment
- Medicare can seek reimbursement of its payment from the beneficiary, the health care provider, or the Primary Payer

What if Medicare was not notified of the claim prior to the report submission?

At its April 14 2010 electronic town hall meeting, MSPRC unveiled its new document, the Conditional Payment Notice (CPN). Upon receipt of an electronic MMSEA report where there was no prior notice to Medicare, MSPRC will issue a CPN in lieu of the Conditional Payment Letter (CPL) it normally issues upon notice of a claim on a primary payer. The CPN can be disputed. The MSPRC will issue a Demand for payment. The CPN amount can increase if there are additional claim-related Medicare-eligible payments.

The CPN procedure should not be common, as the Primary Payer will not report claims where there is no notice or query response that the claimant is on Medicare. If the Primary Payer does have notice that the claimant is on Medicare, it will likely take steps to make sure the Right of Recovery is resolved.

Look for continuing information from CMS
https://www.cms.hhs.gov/MandatoryInsRep/
§ 1395y. Exclusions from coverage and Medicare as secondary payer

***

(b) Medicare as secondary payer

***

(2) Medicare secondary payer

(A) In general

Payment under this subchapter 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.

(B) Conditional payment

(i) Authority to make conditional payment The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility for such 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. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer
that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires
The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

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(3) Enforcement
(A) Private cause of action
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 paragraphs (1) and (2)(A).

***

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers’ compensation laws and plans
(A) Requirement
On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information
The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and
(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) **Timing**
Information shall be submitted under subparagraph (A) (ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) **Claimant**
For purposes of subparagraph (A), the term “claimant” includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) **Enforcement**

(i) In general An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a (a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) **Applicable plan**
In this paragraph, the term “applicable plan” means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers’ compensation laws or plans.

(G) **Sharing of information**
The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) **Implementation**
Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

***
42 CODE OF FEDERAL REGULATIONS- RELEVANT SECTIONS

§ 411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

*Conditional payment* means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

*Coverage or covered services*, when used in connection with primary payments, means services for which a primary payer would pay if a proper claim were filed.

*Monthly capitation payment* means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

*Plan* means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

*Primary payer* means, when used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

*Primary payment* means, when used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

*Primary plan* means, when used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.
Prompt or promptly, when used in connection with primary payments, except as provided in §411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

§ 411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.

(a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had a responsibility to make payment.

(b) A primary payer's responsibility for payment may be demonstrated by—

(1) A judgment;

(2) 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 payer or the primary payer's insured; or

(3) By other means, including but not limited to a settlement, award, or contractual obligation.
§ 411.23  Beneficiary's cooperation.

(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.

§ 411.24  Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) Release of information. The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses 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.

(b) Right to initiate recovery. CMS 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.

(c) Amount of recovery. (1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment recipient, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.
(d) *Methods of recovery.* CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) *Recovery from primary payers.* CMS has a direct right of action to recover from any primary payer.

(f) *Claims filing requirements.*

(1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is a primary plan to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) *Recovery from parties that receive primary payments.* CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

(h) *Reimbursement to Medicare.* If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) *Special rules.* (1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.
(3) In situations that involve procurement costs, the rule of §411.37(b) applies.

(j) Recovery against Medicaid agency. If a primary payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the primary payment, whichever is less.

(k) Recovery against Medicare contractor. If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, CMS may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) Recovery when there is failure to file a proper claim—(1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions: (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) CMS will not recover from providers or suppliers that are in compliance with the requirements of §489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) Interest charges. (1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision—
(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by CMS, is charged until reimbursement is made, and is applied for full 30-day periods; and

(iii) The rate of interest is that provided at §405.378(d) of this chapter.


§ 411.25 Primary payer's notice of mistaken Medicare primary payment.

(a) If a primary payer learns that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in §411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to CMS. Otherwise, the insurer, underwriter, or third party administrator must give the notice.


§ 411.26 Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a primary payer.

(b) Right to intervene. CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.
§ 411.28 Waiver of recovery and compromise of claims.

(a) CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in subpart F of part 401 and §405.376 of this chapter.

(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.
July 23, 2001

To: All Associate Regional Administrators
Attention: Division of Medicare

From: Deputy Director
Purchasing Policy Group
Center for Medicare Management

SUBJECT: Workers’ Compensation: Commutation of Future Benefits

Medicare’s regulations (42 CFR 411.46) and manuals (MIM 3407.7 & 3407.8 and MCM 2370.7 & 2370.8) make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the Workers’ Compensation (WC) carrier and the injured individual. This Regional Office letter clarifies the Centers for Medicare & Medicaid Services (CMS) policy regarding a number of questions raised recently by several Regional Offices (RO) concerning how the RO should evaluate and approve WC lump sum settlements to help ensure that Medicare’s interests are properly considered.

Regional Office staff may choose to consult with the Regional Office’s Office of the General Counsel (OGC) on WC cases because these cases may entail many legal questions. OGC should become involved in WC cases if there are legal issues which need to be evaluated or if there is a request to compromise Medicare’s recovery claim or if the Federal Claims Collection Act (FCCA) delegations require such consultation. Because most WC carriers typically dispute liability in WC compromise cases, it is very common that Medicare later finds that it has already made conditional payments. (A conditional payment means a Medicare payment for which another payer is responsible.) If Medicare’s conditional payments are more than $100,000 and the
beneficiary also wishes Medicare to compromise its recovery under FCCA (31 U.S.C. 3711), the case must be referred to Central Office and then forwarded to the Department of Justice. It is important to note in all WC compromise cases that all pre-settlement and post-settlement requests to compromise any Medicare recovery claim amounts must be submitted to the RO for appropriate action. Regional Offices must comply with general CMS rules regarding collection of debts (please reference the Administrator’s March 27, 2000 memo re: New instructions detailing your responsibilities for monies owed to the government).

Medicare is secondary payer to WC, therefore, it is in Medicare’s best interests to learn the existence of WC situations as soon as possible in order to avoid making mistaken payments. The use of administrative mechanisms sometimes referred to by attorneys as Medicare Set-Aside Trusts (hereafter referred to as "set-aside arrangements") in WC commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. Medicare learns of the existence of a primary payer (WC) as soon as possible when Medicare reviews a proposed set-aside arrangement at or about the time of WC settlement. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement’s funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual’s disability related expenses. It is important to note that set-aside arrangements are only used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.
Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.

One of the distinctions that Medicare’s regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump-sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare’s manuals and regulations make between compromise and commutation cases. Thus, lump-sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump-sum settlements should not automatically be considered as commutation cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.
WC commutation cases are settlement awards intended to compensate individuals for future medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual’s current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured individual’s future medical expenses and simultaneously designate another part of the settlement for all of the injured individual’s medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case.

Generally, parties to WC commutation cases agree on a lump sum amount in exchange for giving up the usual continuing payments by WC for lost wages and for lifetime medical care related to the injuries. Such lump sum amounts are usually requested because the beneficiary wishes to use the funds for some specific purpose. For example, the individual’s home may need to be remodeled to accommodate a wheelchair or, more typically, he or she is so disabled that lifetime attendant care is needed. In these latter cases, the injured individual
seeks a lump sum payment so that such care can be arranged with certainty in the future. The amount of the lump sum is typically established by using a life care plan and actuarial methods to determine the individual’s life expectancy. When WC has accepted full liability in a case prior to the creation of a set-aside arrangement, the likelihood of any Medicare conditional payments being made is reduced.

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. These set-aside arrangements are typically not created until the individual’s condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.

Medicare regulations at 42 CFR 411.46 state that:

“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 the Medicare manuals (3407.8 of the MIM, 2370.8 of the MCM) state:

“When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of
the lump-sum settlement allocated to medical treatment."

Questions that have been raised are paraphrased below.

**Question 1:**

(a) Does the Medicare program have a claim against a lump sum WC payment before an individual’s Medicare entitlement?

(b) If not, can the Medicare program give a written opinion on the sufficiency of a set-aside arrangement even if the individual is not as yet entitled to Medicare?

(c) In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare’s interests be considered before the parties can settle the case?

**Answer:**

These questions have been raised by attorneys who wish to devise set-aside arrangements, which represent amounts for medical items, and services that would ordinarily be covered by Medicare and are specified for future medical treatment for work-related illness or injuries. The attorneys are concerned that Medicare will not pay once the individual becomes entitled to Medicare, because the lump-sum included payment for future medical treatment.

The answer to Question 1(a) is no, Medicare cannot make a formal determination until the individual actually becomes entitled to Medicare. However, the attorneys are correct that once the individual becomes entitled, Medicare payment may not be made to the extent of Medicare’s interests in the lump sum payment per 42 CFR 411.46 or a set-aside arrangement that adequately considers Medicare’s interests in the lump sum payment.
The answer to Question 1(b) is that the RO (with consultation from the Regional OGC, if necessary) can review a proposed settlement including a set-aside arrangement and can give a written opinion on which the potential beneficiary and the attorney can rely, regarding whether the WC settlement has adequately considered Medicare's interests per 42 CFR 411.46. These settlements should all be handled on a case-by-case basis, as each situation is different. If there are several years prior to Medicare entitlement, the RO should use its best judgment regarding what Medicare utilization might be once there is Medicare entitlement. This decision should be based on the documentation obtained as stated in the answer to Question 10. Once the RO has given written assurance that the set-aside arrangement is sufficient to satisfy the requirements at 42 CFR 411.46, when the set-aside arrangement is established and the settlement is approved, the RO, should then set up a procedure to follow the case.

The answer to question 1(c) is, it is not in Medicare's best interests to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests when the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

For example, if the injured individual is designated by WC as a Permanent Total disabled individual, has filed for Social Security disability, and the settlement apportions $25,000 per year (combined for both future medical expenses and disability/lost wages) for the next 20 years, then the RO should review that WC settlement because the total settlement amount over the life of the settlement agreement is greater than $250,000 ($25,000 x 20 years = $500,000) and the injured individual has a "reasonable expectation" of Medicare
enrollment within 30 months of the settlement date. If the injured individual in this example fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 CFR 411.46 once the injured individual actually becomes entitled to Medicare.

NOTE:
Injured individuals who are already Medicare beneficiaries must always consider Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, ALL WC PAYMENTS regardless of amount must be considered for current Medicare beneficiaries.

Question 2:

Should a "system of records" be established for the documentation that the RO and contractors receive/collect concerning these set-aside arrangements?

Answer:

Yes. CMS' Division of Benefit Coordination is in the process of establishing a "system of records" via the Federal Register process, which will provide legal authority to maintain records on individuals that are not enrolled in Medicare. The RO will be responsible for maintaining or "housing" the records for every arrangement on which the RO provides a written opinion. Please note that these records are not subject to Freedom of Information Act requests and may not be disseminated to the public.

Question 3:

Once the set-aside arrangement has been approved by the RO (with consultation from the Regional OGC, if necessary), what is the subsequent role of the ROs and contractors?
Answer:

When the RO approves a set-aside arrangement (with consultation from the regional OGC, if necessary), the RO will check on a monthly basis the National Medicare Enrollment database in order to determine when an injured individual actually becomes enrolled in Medicare. Once the RO verifies that the injured individual has actually been enrolled in Medicare, the RO will assign a contractor responsible for monitoring the individual’s case. The RO will assign the contractor based on the injured individual’s State of residence.

When the injured individual has actually been enrolled in Medicare, the RO must provide the Coordination of Benefits Contractor (COBC) with identifying information to add a WC record to Common Working File. The RO must exercise one of the following options: 1) Fax the information to the COBC; or 2) Submit through an Electronic Correspondence Referral System (ECRS) inquiry. At a minimum, the RO must indicate that this is a WC set-aside arrangement case, and include the following information:

Beneficiary Name
Beneficiary HIC
Date of Incident
DX code(s): If you do not have dx codes readily available, you must include a description of the illness/injury. Note: Do not forward to COB without a dx or description.
Administrator of Trust
Claimant Attorney Information

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for insuring/verifying that the funds allocated to the set-
aside arrangement were expended on medical services for Medicare covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

Question 4:

What types of measures should the RO and the contractors take to ensure that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been depleted?

Answer:

Generally, set-aside arrangements that are designed as lump sums (i.e., the arrangement is funded by the WC settlement all at once) present less of a problem to monitor than structured arrangements. Medicare would not make any payments for individuals that possess lump sum arrangements until all of the funds within the arrangement have been depleted. For example, if a set-aside arrangement were established for $90,000, Medicare would not make any payments until the entire $90,000 (plus interest, if applicable) were exhausted on the individual's medical care (for Medicare covered services only).

Structured set-aside arrangements generally apportion settlement monies over fixed or defined periods of time. For example, a structured arrangement may be designed to disburse $20,000 per year
over the next ten years for an individual's medical care (for Medicare-covered services only). If the $20,000 allocated on January 1 for Year One were fully exhausted on August 31, Medicare may make payments for the services performed after August 31 once the contractor responsible for monitoring the individual's case can verify that the entire $20,000 (plus interest, if applicable) is exhausted. However, when the structured arrangement allocates money for the start of Year Two (i.e., on January 1) Medicare would not make any payments for services performed until Year Two's allocation was completely exhausted.

In every set-aside arrangement case the contractor responsible for monitoring the individual's case (with assistance from the RO, if necessary) should ensure that Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the arrangement have truly been exhausted.

NOTE:
Until the individual actually becomes entitled to Medicare, the set-aside arrangement fund must not be used to pay the individual's expenses. That is, an individual's medical expenses must be paid from some other source besides the set-aside arrangement when the individual is not a Medicare beneficiary. Once the individual actually becomes entitled to Medicare, then the administrator of the arrangement is permitted to make payments for the individual's medical care (for Medicare-covered services only) from the arrangement.

If the contractor monitoring the individual's case discovers that payments from the set-aside arrangement have been used to pay for services that are not covered by Medicare or for administrative expenses that exceed those approved by the RO (see Question 11), then the contractor will not pay the Medicare claims. The contractor
must provide the evidence of the unauthorized expenditures to the RO for investigation. If the RO determines that the expenditures were contrary to the RO's written opinion on the sufficiency of the arrangement, then the RO will notify the administrator of the arrangement that the RO's informal approval of the arrangement is withdrawn until such time as the funds used for non-Medicare expenses and/or unapproved administrative expenses are restored to the set-aside arrangement.

**Question 5:**

What are the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken its interests into account?

**Answer:**

The following criteria should be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the cost of a work-related injury or illness to Medicare. Specifically, is the amount allocated for future medical expenses reasonable? If Medicare has already made conditional payments their repayment also has to be taken into account.

1. Date of entitlement to Medicare.

2. Basis for Medicare entitlement (disability, ESRD or age)-- If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.

3. Type and severity of injury or illness-- Obtain diagnosis codes so
injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?

4. Age of beneficiary-- Acquire an evaluation of whether his/her condition would shorten the life span.

5. WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).

6. Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized-- If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.

7. Amount of lump sum or amount of structured settlement-- Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.

8. Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis?-- Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services related to the accident or illness?
9. Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.?—If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.

10. Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary’s condition?—Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost $20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare’s interests into account.

The attorney for the individual for whom the arrangement is set-up should be advised that Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of WC.

NOTE:
Before evaluating whether an arrangement reasonably covers/considers Medicare’s interests, the RO must know whether
the arrangement is based upon WC fee schedule amounts or full actual charge amounts.

**Question 6:**

Some attorneys have indicated that a set-aside arrangement should only contemplate three to five years of estimated Medicare covered items or services. Would this be reasonable?

**Answer:**

No. To protect the Medicare Trust Fund, a set-aside arrangement should be funded based on the expected life expectancy of the individual unless the State law specifically limits the length of time that WC covers work related conditions. If an estimate of the beneficiary’s estimated longevity was not submitted, one must be obtained.

**Question 7:**

What other issues should be considered?

**Answer:**

The lump sum amount should be interest bearing and indexed to account for inflation consistent with how Medicare calculates its growth in spending. Provision should also be made in the settlement agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the set-aside arrangement. (For example if outpatient prescription drugs become more widely covered.) If the beneficiary belongs to a Health Maintenance Organization that may not be coordinating benefits based on WC entitlement, the settlement
should still set-aside funds for Medicare covered services in case the beneficiary converts to a fee for service plan.

**Question 8:**

Is it permissible for Medicare to accept an up-front cash settlement instead of a set-aside arrangement?

**Answer:**

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when WC did not pay promptly. Thus, when future benefits are included in a WC settlement agreement, Medicare cannot pay until the medical expenses related to the injury or disease equal the amount of the settlement allocated to future medical expenses or the amount included for medical expenses in the set-aside arrangement has been exhausted.

**Question 9:**

How do providers and suppliers obtain payment for the services covered by the set-aside arrangement?

**Answer:**

There are two distinct methods for providers, physicians and other suppliers to obtain payment for WC covered services when funds are held in a set-aside arrangement. Determining which distinct payment method applies depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charges or WC fee schedule amounts (i.e., were the injured individual’s medical expenses determined based on full actual charge estimates or WC fee schedule
estimates).

When a set-aside arrangement’s settlement agreement contains specific provisions establishing that the WC carrier will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan, and when the RO reviews and approves the sufficiency of the arrangement based on the WC plan’s WC fee schedules, then, providers, physicians and other suppliers will be paid based on what would normally be payable under the WC plan (i.e., under the WC fee schedule). Therefore, providers, physicians and other suppliers would not be permitted to bill the arrangement more than the WC fee schedule rate. For example, if a provider’s full charge for a particular service is $100 and the WC carrier normally pays $65 for that particular service, then the arrangement should only pay $65. However, when an arrangement’s settlement agreement does not contain specific provisions ensuring that the arrangement cannot be charged more than what would normally be payable under the WC plan, then providers, physicians and other suppliers are permitted to bill the arrangement their full charges. It is important to note that when an arrangement’s settlement agreement does not contain specific provisions ensuring that providers, physicians and other suppliers cannot bill the arrangement more than the WC fee schedule amounts, then the RO must review the sufficiency of that particular arrangement based upon full actual charge estimates.

Before evaluating whether an arrangement reasonably covers/considers Medicare’s interests, the RO must know whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts. If the arrangement is based upon WC fee schedule amounts, then, the RO cannot provide a written opinion on the sufficiency of an arrangement until the arrangement’s settlement agreement contains specific provisions that establish that the WC carrier can and will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan. The
WC carrier must require all entities and individuals that accept WC payments to agree not to charge the arrangement more than what the WC plan would normally pay.

If a WC carrier is unable to enforce the requirement that the arrangement can only be charged the WC fee schedule rates, then the RO will evaluate whether an arrangement reasonably covers/considers Medicare's interest based on whether the future medical expenses billed to the arrangement are enough to cover the actual expenses for the services at issue. If State WC laws do not provide a particular WC carrier with the legal authority to enforce that requirement, then the RO can still provide a written opinion on the sufficiency of the arrangement so long as future medical expenses are evaluated by the RO using full actual charge estimates, not WC fee schedule amounts.

If the arrangement is constructed based upon full actual charge estimates, then the RO must determine whether the proposed amount to be placed in the arrangement for future medical expenses and administrative costs (see Question 11) is sufficient to cover the actual charges for the services at issue (rather than an amount equal to what would have been the Medicare approved amount for a particular service).

Once the arrangement has been depleted because of payments for otherwise Medicare covered services, a complete accounting must be provided to the contractor responsible for monitoring the individual's case and if the payments have been properly made Medicare can then be billed.

**Question 10:**

Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a set-aside arrangement?
Answer:

Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:

A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual’s estimated life span, then a “rated age” may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. Also, documentation which gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

The RO may require additional documentation, if necessary and approved by CO.

Question 11:

How does the RO determine whether or not the administrative fees and expenses charged to the arrangement are reasonable?

Answer:

Before a proposed arrangement can be approved, the RO must determine whether the administrative fees and expenses to be charged to the arrangement are reasonable. The RO must be notified (in writing) of all proposed administrative fees prior to the RO providing its written assurance that the set-aside arrangement is sufficient to satisfy the requirements of 42 CFR 411.46. If the administrative fees are determined to be unreasonable, the RO must withhold its approval of the set-aside arrangement. The amount of the approved arrangement
must include both the estimated medical expenses plus the amount of administrative fees found to be reasonable.

**Question 12:**

What impact will arrangements have on Medicare payment systems and procedures?

**Answer:**

Because an arrangement’s purpose is to pay for all services related to the individual’s work-related injury or disease, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the set-aside arrangement. Arrangements are established in order to pay for all medical expenses resulting from work-related injuries or diseases; arrangements are not designed to simply pay portions of medical expenses for work-related injuries or diseases.

When arrangements are designed as lump sum commutations (i.e., the arrangement is designed in a manner that the WC settlement is paid into the arrangement all at once, see Question #4 above), Medicare would not make any payments for that individual’s medical expenses (for work-related injuries or diseases) until all the funds (including interest) within the arrangement have been completely exhausted. These same basic principles also apply to structured commutations (see Question #4 above).

When providers, physicians and other suppliers submit claims to Medicare related to the individual’s work-related injury or disease, claims processing contractors should deny those claims and instruct the entity or individual to seek payment from the administrator of the arrangement. Since the injured individual will be a Medicare beneficiary at the time when the provider, physician, or other supplier
submits the claim to Medicare, the contractor responsible for monitoring the individual's case will have already updated the Common Working File to indicate that the injured individual's claims should be denied. However, when a provider, physician or other supplier submits any claims that are for injuries or diseases that are not work-related, then contractors should process those claims like they would any other claim for Medicare payment.

When the administrator of an arrangement refuses to make payment on a provider's, physician's or other supplier's claim because the administrator of the arrangement asserts the services are for injuries or diseases that are not work-related (or when the administrator of the arrangement denies the claim for any other reason), and the provider, physician or other supplier, subsequent to the administrator's denial, submits the claim to Medicare, then the contractor should consult the RO in order to determine whether Medicare should pay the claim. If a determination to deny the claim is made, then Medicare's regular administrative appeals process for claim denials would apply to the claim.

Please note that Central Office is planning to have a contractor assist ROs in monitoring and processing (however, not evaluating) these set-aside arrangement cases as early as possible in Fiscal Year 2002. Further instructions will be issued at that time.
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

Claimant Name (Please Print) ____________________________  Claim Number ____________________________

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:**

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Signature of Person Completing This Form   Date
ADDITIONAL CITATIONS

*Cox v. Shalala*, 112 F. 3d 151 (4th Cir. 1997)
MSP trumps state law

*Gory v. U.S. Food Service, Inc.*  WCAB ADJ1180690 (OAK 0281569)
10/23/2009
Employer didn’t pay Medicare as anticipated in Compromise & Release; injured worker’s Social Security Disability Income benefits garnished to reimburse Medicare

*In re Dow Corning*
Settlement of U.S. government’s claim in bankruptcy court for failure of Debtor to create Medicare Set-Aside fund in settling the breast implant class action:

Plaintiff Attorney liable for Medicare Secondary Payer reimbursement

*U.S. v. Rhode Island Insurers’ Insolvency Fund*, 80 F. 3d 616 (1st Cir. 1996)
A state insolvency fund can be a primary payer

Government suit to collect Medicare Secondary Payer reimbursement from defendants and their insurers in underlying class action arising from settlement where claims for past and future medical expenses were released.