No matter how well the Center for Medicare and Medicaid Services ("CMS") provides insight on Medicare compliance with respect to the Medicare Secondary Payer Act, there continues to be consistent, pervasive and substantial confusion about the issue within the legal community. This confusion is only magnified by the fact that the Federal Legislature often enacts new laws in an effort to help reduce the ever increasing costs associated with Medicare entitlements. By placing a growing burden on the legal community to register and report various pieces of information to Medicare when a Medicare beneficiary is involved in litigation and then verify and resolve Medicare's interest in that lawsuit, the litigation process is prolonged. For example, recent legislation, highlighted by the enactment of §111 of the Medicare Medicaid SCHIP Extension Act ("MMSEA"), is causing defendants to be hyper sensitive to any and all issues surrounding Medicare. This is due in large part to two major factors: (1) the dissemination of bad advice by those that are in a position to take financial advantage of those in fear; and (2) CMS' continued extension of the enforcement deadline for compliance. The second factor became an issue again on November 9, 2010 when CMS delayed the submission deadline for liability insurance claim reports from the first calendar quarter of 2011 to the first quarter of 2012. When considered in a vacuum, the delay in the MMSEA reporting timeline may seem like a good thing, but when CMS' various memoranda, alerts and notices regarding the MMSEA and the Medicare Secondary Payer Act (MSP) are taken as a whole, it highlights a certain level of inconsistency and uncertainty that the legal community abhors.

It is the intent of this author that the information provided in the sections below provide you with some semblance of understanding as to your obligations to Medicare and how best to address the concerns of those with whom you litigate.

Medicare's Conditional Payment Interest:

When a Medicare beneficiary is injured and subsequent medical services are required, Medicare is prohibited from making payment for such medical care or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan). This prohibition is suspended if the liability insurance plan has not made or cannot reasonably be expected to make payment promptly. If liability payment has not been made or cannot reasonably be expected to be made promptly, Medicare may make payment but it is made conditioned upon reimbursement.
ment once a final payment is made from the liability carrier. This Medicare payment is called the conditional payment and represents Medicare’s claim for recovery against the liability settlement proceeds. The total conditional payment value for litigation purposes is the amount paid by Medicare for injury related medical care received between the time of injury and the time of settlement.

Upon the final resolution of the litigated matter, Medicare’s claim must be resolved or several parties run the risk being found liable for failing to properly protect Medicare’s interest. This potential liability can be found at 42 CFR §411.24 and §411.26. Together these two regulations provide Medicare with the requisite authority to seek reimbursement of their conditional payment interest from either the party making a settlement payment or any party who receives said payment.

Practice Tip:

Relief may be on the way with House Bill 4796. This bill contains the following provisions: (1) it establishes a 3 year statute of limitations from date of settlement, award or judgment for Medicare to recover their lien; (2) it establishes a primary payer right of appeal - plaintiff can appeal the enforcement of a lien prior to paying the lien in full as one is required to do under the law is it is now; (3) it eliminates the use of private information such as SSN or HICN for MMSEA §111 Compliance; (4) it establishes threshold for all MSP claims to start at $5K; (5) it softens the penalty provision found in §111 of the MMSEA by providing the government with discretion to impose monetary penalties rather than requiring them; and (6) it simplifies the conditional payment process by allowing a plaintiff to either request a demand from MSPRC and, if not available in 60 days, then no lien is enforceable or to make a good faith estimate as to the conditional payment amount and then send said estimate to the MSPRC – the good faith estimate becomes final after 75 days if CMS fails to contest the amount.15

Medicare Claim Resolution Procedure:11

In order to ensure that the plaintiff’s attorney properly protects Medicare’s conditional payment interest and avoids any liability under either 42 CFR §411.24 or 411.26, it is important that he or she notify the Medicare Coordinator of Benefits Contractor ("COBC") of the cause of action. Making this notification to Medicare early in the personal injury case will help reduce the chance Medicare’s recovery process will delay resolution of the litigation. The following pieces of information should be provided to the COBC: (1) client’s name and address; (2) client’s date of birth; (3) client’s SSN social security number ; (4) client’s Medicare number ; (4) the date of incident; (5) the type of incident; (6) an injury description; (7) attorney’s full name; and (8) attorneys address and telephone number. This information should be sent to:

Medicare (COBC)
MSP Claims Investigation Project
PO Box 33847
Detroit, MI 48232
(800) 999-111813

Once the COBC receives this information they will assign the case to the Medicare Secondary Payer Recovery Contractor ("MSPRC"). At this point, all future written correspondence should be made to the MSPRC:

MSPRC – Non-Group Health Plan (NGHP)
PO Box 138832
Oklahoma City, OK 73113
(PH): 866-677-7220
(FX): 405-869-3309

After the attorney provides the required information along with a signed retainer agreement or proof of representation form, the MSPRC will send the attorney a conditional payment summary within 60-90 days. It is important that an attorney reviews this summary for any unrelated expenses as it can often contain charges that are unrelated to the accident that gave rise to the litigation. Once the MSPRC is notified of the final settlement and provided the final settlement detail, Medicare will send a final demand that must be paid within 60 days in order to avoid incurring interest and penalties.14

Note - 42 CFR 411.37 permits Medicare to reduce its recovery to take into account the cost of procuring (attorneys’ fees/expenses) the judgment or settlement.15

Practice Tip:

Should a defense insurer ever suggest or require that they place Medicare’s name on the check then cite to the Pennsylvania Superior Court’s recent ruling in Zaleppa v. Seiwell (2019 MDA 2019) in which the Court held that where there is verdict in a case, the defense is unable to withhold the payment of its judgment by either demanding that they place Medicare as payee on the settlement draft or insist that funds be escrowed until notification that any Medicare lien doesn’t exist.16

Medicare’s Interest in Future Cost of Care Liability:

Unfortunately there is nothing definitive from CMS on whether a Medicare Set Aside (“MSA”)17 is needed to account for future medical expenses in the case of a liability settlement. While there is clear guidance from the CMS on the issue of whether or not to establish an MSA in a worker’s compensation case, there is no such guidance on the liability side of the law. Currently, there are twelve (12) memoranda from CMS about the use of MSAs in worker’s compensation cases and zero (0) memoranda about the use of MSAs in liability cases. When looking at this discrepancy, it is hard not to come across the feeling that if Medicare wants to provide guidance on the use of MSAs in liability cases, then...
such guidance would already exist. CMS is, after all, the federal Health and Human Services agency responsible for administering Medicare, Medicaid, SCHIP (State Children’s Health Insurance), and several other health-related programs. CMS is not a law making body, but their guidance, when provided, is done so with the intent of helping individuals better understand and comply with the laws that relate to the programs CMS is responsible for administering. Consequently, if CMS was in a position to provide further insight on liability MSAs, as they did with workers’ compensation MSAs, it is reasonable to conclude that this information would already exist.

Practice Tip:

When the defense states that MSAs are required by §111 of the MMSEA or some other law, then inform them of the following: (1) Congressional Research Service (CRS) provided Congress with analysis of the MMSEA and reiterated that §111 is simply a reporting requirement, and that it makes no mention of the need for set-asides in liability cases; and (2) that House Bill 2641 is current legislation in the house that would set forth the requirements for an MSA and would outline the process for approval of a qualified MSA, including appeals, and provides for the administration of MSAs. Why would this law be up for consideration in the House or Representatives if a law requiring MSAs already existed?

Due to the lack of guidance on the issue of MSAs in liability cases, the legal community is left to chart its own course of action, and so far, the results are not pretty. Assuming the plaintiff is a Medicare beneficiary, and knowing that Medicare is prohibited from paying for medical care or services to the extent that payment has been made, or can reasonably be expected to be made promptly, the question that must be answered is whether the terms of settlement contemplate or specifically allocate monies to the plaintiff’s future cost of injury related care.

The answer is simple, an MSA is appropriate when a verdict sheet possesses a line item for future medical expense or, albeit rare, a settlement release contains a definitive allocation for future medical treatment, such as a surgery, in an effort to ensure that the defendant avoids any future liability for that specific line item expense or future medical care. But, such is not the case in the majority of settlements where the parties settle liability cases using a broad, general release of all damages and do not specify or otherwise allocate monies to specific injury categories due to policy limitations or other confounding factors. In such situations, the only guidance that the legal community can rely on comes from an October 2009 teleconference on the

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MMSEA in which CMS stated that one way to adequately consider Medicare’s future interest in a settlement is by obtaining an advisory opinion from an objective third party about the need for an MSA to be established. This third party will then bear responsibility for making a good faith evaluation of the facts and terms of settlement in order to determine what, if any, allocation of settlement monies should be made for the future cost of injury related care. With a general release, many factors must be considered in order to properly evaluate whether an MSA is necessary and this is best left to legal professionals or companies that specialize in this area. This analysis will help ensure that the attorney and plaintiff adhered to the limited guidance from CMS and that an effort was made to properly protect Medicare’s interest in the plaintiff’s future cost of care.

Note – many times defendants insist they will determine if an MSA is needed or not. But this is simply not what the law requires. Most defense entities do not realize that the obligation to consider and protect Medicare’s future interests falls squarely on the plaintiff and his or her counsel as opposed to the defendants. To reiterate, the obligation to satisfy Medicare’s future interests via an MSA or any other vehicle, as opposed to conditional payment reimbursement, is the responsibility of the plaintiff and plaintiff’s attorney, not that of the defendant or their insurer.

One need only review the 42 CFR §411.46 in order to find evidence that the liability for protecting Medicare’s interest in a plaintiff’s future cost of care is placed squarely on the plaintiff. There is simply no language in the regulation that places liability on the defense in a future cost of care situation. That the defense bears no liability to Medicare for future costs of care is further supported on the CMS website under the “Intro to WC” tab of the WCMSA site. Please see http://www.cms.gov/WorkersCompAgencyServices/02_workerscompensationoverview.asp#TopOfPage.

In the future, the medical services portion in the final paragraph of the above referenced website asserts that the liability to consider and protect Medicare’s future interests extends to those entities that receive a primary payment as opposed to liability for conditional payments under 42 CFR §411.24 and §411.26 whereby Medicare may recover its conditional payment interest from any entity that makes/receives a primary payment.

While the above is intended to help attorneys come away with a better understanding of the MSA evaluation and determination process, this certainly will not ensure that the defendant or its insurer will agree with this position/opinion. Defendants may continue to push for an MSA as a condition of settlement. When faced with this situation and the injured party wants to settle, this author recommends the following (in this order):

1. Be armed with the law and information regarding the MSP and MMSEA.
2. Have a third party (i.e., a law firm, business or physician who is familiar with Medicare compliance) provide an opinion letter that analyzes the facts of the
case, makes a future allocation for medicals and evaluates past v. future medicals reasonably associated with the allocation.

3 If the first two steps fail to win over all parties, put indemnification language in the Settlement Agreement and Release such as: “plaintiffs will indemnify defendants from any and all injury-related obligations/Medicare rights (past, present or future) arising out of 42 U.S.C. §1395y(b)(2).”

4 Finally, if an MSA is still being demanded as a condition of settlement, proceed with obtaining an MSA evaluation from a qualified MSA allocation provider. The attorney may even consider submitting this to the local Medicare Regional Office, but please know that the regional office is under no obligation to respond to a request for approval, so this approval may take some time.

In conclusion, due to the lack of guidance from CMS on liability cases, the legal community is left to decide how best to remain compliant with 42 USC §1395y(b)(2), while not over-reacting and establishing an MSA unnecessarily. MSAs are simply CMS’ preferred methodology for protecting Medicare’s future interest and are not required by law.

Thus, in every case in which a Medicare beneficiary is involved, some attention must be paid to determining what, if any, interest Medicare possesses in that case. The author’s rule of thumb is as follows: if there is going to be a permanent shift of the burden for paying for the Medicare beneficiary’s future injury related medical expenses from the liability insurance policy or plan to Medicare; and the settlement contemplates a definitive allocation of settlement money to the plaintiff’s future injury related medical care, then this author would recommend establishing an MSA or at a minimum obtaining an objective third party opinion about the need to protect Medicare’s interest in the plaintiff’s future cost of injury related care via an MSA. If either answer to the above is no, then a claimant cannot be reasonably expected to set aside any money to protect Medicare’s interest in the injured plaintiff’s future cost of care, because no settlement money is actually being paid or received in consideration of that care. Finally, if the answer to either question is difficult to determine, then the default action should always be to obtain a third party opinion on the matter in order to fully protect the attorney and his or her client’s current and future eligibility for Medicare. It is inevitable that an attorney will come across a case in the near future with some issues concerning how to properly protect Medicare’s interest. That said, this author is hopeful that the information contained above provides a little light at the end of that dark Medicare compliance tunnel.

Endnotes
1 42 USC §1395y(b)(2)
3 See 42 CFR §411.24 and 411.26
4 The MMSEA enforces a Medicare reporting requirement on all primary payers, including liability insurance providers, self-insurers, no-fault insurers and workers’ compensation. Failure to comply with this reporting requirement and provide Medicare with timely notice of a settlement could result in a civil penalty of $1,0000 for each day of noncompliance with respect to each claimant. See 42 USC 1395y(b)(8).
5 https://www.cms.gov/MandatoryInsRep/Downloads/RevTimelineTPOC110910.pdf. Note – this revision only applies to liability insurers, thus the reporting date requirements for October 1, 2010 and subsequent associated with no-fault insurance and workers’ compensation claims remain unchanged.
6 42 USC §§1395y(b)(2)(A) and (B)
7 U.S. vs. Stricker: The government filed a lawsuit against various law firms representing claimants, underlying corporate defendants, and insurers. The government alleged that at the time of settlement its interests were not adequately protected as proper attention was not given to whether the settling claimants were Medicare beneficiaries [907 of the claimants were]; (1) government sought reimbursement for conditional payments, double damages; (2) Court ruled on September 30, 2010 and (3) found that the claims against the corporate defendants were barred due to the expiration of the 3 year statute of limitations passing and against the attorneys due to the expiration of the 6 year statute of limitations.
8 42 C.F.R. §411.24(e): Recovery from third parties. HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan or program, and a third party administrator.
9 42 C.F.R. §411.24(g): Recovery from parties that receive third party payments. HCFA 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 third party payment.
10 http://www.marccoalition.com/MSP_Reform.html
12 US. vs. Paul Harris: (West Virginia Civil Action 5-08CV102) Harris’s client was injured by an allegedly defective ladder. Harris sued the retailer of the ladder and settled for $25,000. Medical expenses for the injury had been paid by Medicare to the tune of $22,000 and change. Medicare was never reimbursed by Harris or his client. CMS started enforcement proceedings, namely a federal court suit against attorney Harris to get reimburse. The case is pending in the United States District Court for the Northern District of West Virginia. Mr. Harris filed a motion to dismiss, arguing that as an attorney for the Medicare beneficiary, he had no duty to protect Medicare’s interest and is not liable for failing to reimburse Medicare. The judge assigned to the case disagreed. U.S. District Court Judge Frederick Stamp, Jr. denied Harris’ motion on November 13, 2008. In his written opinion Judge Stamp ruled that a lawyer can be held individually liable under 42 USC §1395y(b)(2) when he or she distributes settlement funds without satisfying an existing Medicare reimbursement right. Cited 42 CFR §411.24(g) specifically!
13 For the fastest response it is often best to call and provide this information to the COBC over the phone.
14 Haro v. Sebelius: (2009 US Dis. LEXIS 111053) Collection practices established by the secretary of the Health and Human Services are being challenged in litigation pending in the State of Arizona. On November 30, 2009, the court concluded two Medicare Beneficiaries have standing to bring a lawsuit alleging violations of the due process clause of the US Constitution in the following respects: (1) by demanding repayment in advance of the resolution of an appeal or request for waiver; and (2) by making the plaintiff’s attorney financially responsible if they do not hold or immediately turn over to the federal government their clients’ litigation proceeds; (3) in a follow up Order on April 12, 2010 the Court denied the US’s request that discovery be limited to the administrative record.
15 ABA Formal Ethics Opinion 08-451 permits an attorney to outsource the resolution of Medicare’s lien interest in a judgment, settlement or verdict. This is true for all forms of subrogated interests that possess a lien against the judgment, settlement or verdict.
16 See Also Tomlinson v. Landers, 2009 WL 1117399 (M.D.Fla.)
17 A Medicare Set Aside is money that is allocated from the settlement to protect Medicare’s interest in an injured plaintiff’s future cost of injury related care. The intent is to prevent the burden shift of responsibility for this care from the liability insurance plan or policy to Medicare. If the insurance plan or policy pays money for future injury related care then Medicare wants for that money to be exhausted on that injury related before bearing

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injured workers can expect to be charged on very flimsy proof. One of my clients was charged with a felony after he was told by the company doctor to do what he felt he could do. And when he went fishing to supplement his groceries, there was the video snoop recording and charges were filed for fraud. He plead no-contest to avoid the possibility of the penitentiary on advise from his appointed attorney.

Also, the employer need not worry about safety. There are no longer penalties for even gross and flagrant safety violations. See Vittitow v. Central Maloney, Inc., 69 Ark. App. 176 (2000) We know of nothing done by the Safety Division of the WC Commission to punish unsafe conditions. Many times in the claim letter sent to the WC Commission establishing a claim, we have referred to gross safety violations and never has we been contacted by the safety division or advised that they were interested in the allegations of safety violations over the years. Again, it would only be fair to everyone to give back penalties to the employee rather than leave it to a Safety Division of the WC Commission.

Another problem that is bad for our State is the fact that our Worker’s Compensation Commission is a financial disaster. Arkansas is truly unique in that it has in reality a one-person Commissioner. Supposedly a three member Commission, in reality the Labor Commissioner will always vote for the injured employee and the Management Commissioner will always vote for the employer. So ultimately, the Chairman of the Commission decides the cases alone. Yet taxpayers pay for three times the price for the same decision.

Therefore, the Act on its face should be held unconstitutional as it introduces and highlights the Executive Branch of government over and above the Judicial Branch of government. Our approach to injured citizens in this State is bad because it speaks volumes about us. Senator Hubert H. Humphrey once said “(t)he moral test of government is how it treats those who are in the dawn of life . . . the children; those who are in the twilight of life . . . the elderly; and those who are in the shadow of life . . . the sick . . . the needy . . . and the disabled.” We have truly lost our way in the quest to save money at any costs. And the essential definition of our moral base is our Constitutional guarantees of due process and equal protection and sanctity giving equal power and separation from influence of the three branches of government.

The Good

The WC Act is unconstitutional, violating our basic understanding of equal protection, due process and the promise that each of the three branches of Government are separate but equal in power. So the good is that our Supreme Court will do its duty and act against this travesty of justice. Arkansas cases advance the concept that statutes are presumed constitutional. But precisely how far does that concept reach? The usual rules of constitutional scrutiny have no place in a separation-of-powers analysis. It is commonly known that statutes infringing on fundamental rights cannot survive unless a “compelling state interest is advanced by the statute and the statute is the least restrictive method available to carry out the state interest” Legley v. Picado, 349 Ark. 600, 80 S.W.3d 332 (2002). The proponent of the statute carries this burden. Once the constitutional infringement is demonstrated, the statute will fail unless the proponent carries this weighty burden.

Conclusion

The undersigned has written the above with the intent of appealing to the humanitarian interests of persons who at the time of this writing are celebrating Christmas with family and friends. Hopefully instead of seeing this author as the enemy to be attacked as before by the previous administrations and their agents, you will agree with me that “there’s some good, in this world,* * * and it’s worth fighting for!!!” The WC Act is unfair. Either we need to throw it out or give the compensation bargain back to the injured Arkansas citizen. Surely the small difference in an insurance premium is not worth the pain inflicted by the present WC Act.

I implore you: get in the fight. Send ATLA what you can. Send it even if you shouldn’t. This is not a drill. We can use a history lesson, or we can be a history lesson. The train that David Williams warned us about 17 years ago will return with reinforcements, and history will do what it is alleged to always do – unless we are all there with our time or our money, or both, to stop it.

Responsibility for those injury related medical expenses.

18 http://www.marccoalition.com/MSP_Reform.html
20 The basis for this opinion comes from CMS Town Hall Teleconference held on October 22, 2009, in which Barbara Wright, Technical Advisor, Division of Medicare Debt Management, opined that obtaining the opinion of an objective 3rd party as to the need for and financial value of a MSA is one way to adequately consider Medicare’s interest in a client’s future cost of injury related care. Such an opinion will help ensure that the attorney and his or her client complies with the Medicare Secondary Payer Act.
21 These opinions generally range in cost from $750 - $3,000 depending on the level of work involved in the opinion.
23 Id.