

MEDICARE and MEDICAID CLAIMS

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TABLE OF CONTENTS

INTRODUCTION	3
TEXAS MEDICAID: RIGHT OF RECOVERY OR CLAIM	4
Acute care claims	4
Long Term Care Claims	6
Applicant's Duties	7
Attorney Duty to Inform Medicaid	7
Limit on Attorney Fees	7
Waiver of Attorney Fees	8
Balance Billing	8
MEDICARE'S SUBROGATION CLAIM	9
Medicare Secondary Payer Statute	9
Attorney Responsibility For Payment Of Medicare Claim	9
PROCEDURE FOR PAYING A CLAIM	12
Providing Notice of Potential MSP Case	12
Step One	13
Step Two	14
Step Three	14
Step Four	15
Procurement Costs	15
Waiver or Compromise of the Claim	16
MEDICARE SET-ASIDE ARRANGEMENTS OR TRUSTS	16
Procedure	17
Funding	18
MEDICARE, MEDICAID SCHIP EXTENSION ACT OF 2007 (MMSEA)	18
CONCLUSION	19

I. INTRODUCTION

Successful prosecution of cases based on tort liability require plaintiffs' attorneys to be experts in many areas of the law. You must be specialists in tort law, gathering evidence, presenting the case and assessing the value of the claim for settlement. Likewise, defendants' counsel and insurance claims adjusters involved in settling tort claims must have extensive knowledge of these areas. It would be a great luxury if your job were considered done when the check is issued. Although post settlement issues may have been a small part of wrapping-up a case in the past, the entire landscape of what happens after the case settles has changed dramatically in recent years. Plaintiffs' attorneys may not have, nor want to develop, expertise in probate, trust and public benefits law. Additionally, a variety of medical, rehabilitation and social issues must be considered for the long-range benefit of the individual with a life-long disability. However, failing to consider these issues can result in a disservice to the individual client and a potential liability to all involved.

In Texas, plaintiffs' counsel for many years has taken on the responsibility for paying claims from medical providers and subrogation interests as a part of their service to the client. With financial pressures on state and federal budgets, come increased efforts by government entities to seek reimbursement for medical expenses that the government may have paid on behalf of plaintiffs. These efforts have likewise resulted in increased regulations and laws dealing with such issues. The time and expertise that it takes to handle such matters has increased tremendously in the last several years. The phenomenon has spawned a whole new industry with many companies taking on the task of "lien resolution" and providing an alternative to the personal injury bar. Personal injury attorneys may now hire experts in these complex areas. It may be cost effective and result in a better outcome for the client if these issues are contracted out to firms or companies with knowledge and expertise in these issues. Additionally, the increased recovery actions by governmental agencies has had another impact on this area. It has and will continue to delay the ability to settle the claims that exist as the government agencies become flooded with more and more of these claims. It can tie up the resources of plaintiffs' attorneys and result in funds languishing in non-interest bearing or IOLTA accounts for extended periods of time.

The solution to these problems has, as previously stated, created a new area of law that focuses on "lien resolution." In addition, the use of Qualified Settlement Funds, also commonly referred to as 468B funds, has provided an avenue to allow for the proceeds of a settlement to be invested in interest-bearing accounts. The use of these funds also allows for expenses and fees—including attorney fees—to be disbursed while the complex issues surrounding liens and claims are eventually addressed—even if such work takes years. The result is that plaintiffs are free to receive monies that are not subject to claims or to purchase qualified annuities and benefit from the proceeds of the lawsuit while the necessary work continues to satisfy the claims of the government or other subrogation interest. For more information regarding the uses and advantages of Qualified Settlement Funds, please visit the author's website at www.pi-yimayo.com.

Even with the ability to outsource lien resolution matters, personal injury attorneys must have working knowledge of the issues involved because many times the amount of money received in the case may be such that outsourcing is not practical. This paper is intended to give the personal injury attorney practical advice on those issues and how to effectively handle them.

II. TEXAS MEDICAID: RIGHT OF RECOVERY OR CLAIM

Medicaid is a needs-based program that is available only to persons of limited means who are aged, blind, or disabled. Upon signing up for Medicaid benefits, the applicant actually **assigns to Medicaid any rights of recovery the applicant may have against third parties for payments of medical expenses**. The law governing the entire area of Medicaid's subrogation right can be found at TEX. HUM. RES. CODE ANN. §32.033 (2009). Unlike some states that claim or impose a lien upon the recovery of any monies for medical expenses that are recovered in liability cases, the State of Texas' position is that they own the cause of action for any damages if they paid the medical expenses upon which the claim is based. The statute creates a cause of action in favor of the state—separate and distinct from any cause of action the applicant may have against a tortfeasor or other party responsible for the medical expenses.¹

Anytime your office is involved in this type of case, do not rely on the parties to determine if Medicaid has paid any claims in the case. The best practice is to contact the agency and get a written reply stating if any benefits were paid and the correct amount of Medicaid payments. The complicating factor in dealing with a Medicaid subrogation claim is that there are two types of claims: one claim for acute care expenses, and another for long term care expenses and claims. In order to handle these claims, two different offices must be contacted.

The Texas Health and Human Services Commission (HHSC) may pay reasonable and necessary attorney fees of fifteen percent (15%) of the entire amount recovered on behalf of the HHSC, and reasonable expenses, to a person authorized to recover amounts from third parties. The HHSC may pay prorated expenses not to exceed ten percent (10%) of the entire amount recovered on behalf of the HHSC if attorney fees are allowed in the case.²

A. Acute care claims

The Texas Medicaid & Healthcare Partnership (TMHP) contracts with the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to administer third-party liability cases. To ensure that the Texas Medicaid Program and the Children with Special Health Care Needs (CSHCN) Services Program are the payers of last resort, TMHP performs post-payment investigations of potential casualty and liability cases. TMHP is responsible for recovering Medicaid's and CSHCN Services Program's expenditures in casualty cases involving Medicaid and CSHCN Services Program clients.

If you are representing a Medicaid or CSHCN Services Program client in a third-party claim or action for damages for personal injuries and you need to determine the amount owed to Medicaid, you must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid or CSHCN Services Program client, or from the date on which a potential third party is identified. The TMHP website at <http://www.tmhp.com> has a "Tort Response Form" that prescribes all of the data necessary for TMHP to process the client's information. To navigate to the Tort Response Form, click on "Providers" and then on "Third-Party Liability." If you send a letter then the following information must be included:

1. The Medicaid or CSHCN Services Program client's name, address, and identifying information.
2. The name and address of any third party or third-party health insurer against whom a third-party claim is or may be asserted for injuries to the Medicaid or CSHCN Services Program client.
3. The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the Medicaid or CSHCN Services Program client for which a third party may be liable for payment, whether or not the claim was submitted to or paid by TMHP.

An HHSC Authorization for Use and Release of Health Information Form must be completed before TMHP can release any confidential medical information on Medicaid and CSHCN Services Program clients. A copy of the form can be found on TMHP's website at <http://www.tmhp.com>. Once you notify TMHP, they are required by their contract with the State to reply to your request within ten days. They will typically send out a "Notice of Subrogation." Within an additional ten days, they should send out an "amount letter." This letter will include a itemized list of the bills paid by Medicaid. The reply will contain the amount that Medicaid has paid on behalf of the client.

If any of the information described above is unknown at the time the initial notice is filed, it should be indicated on the notice and revised if and when the information becomes known. If you are inquiring about an acute care claim write to them at:

TMHP Tort Department
PO Box 202948
Austin, TX, 78720-2948
1-800-846-7307, option #3
Fax: 512-514-4225

Upon reaching a final settlement in the case, the amount of the settlement should be disclosed to TMHP. It can be faxed or mailed to them at the address and number above. Although all final issues should be handled in writing, the staff at TMHP will go over most

of the information in a phone conference once the proper release is obtained in their office. As with the Medicare claim, it is possible that the amount of the Medicaid claim can increase during the time the initial contact is made and the final payment is sent. If any significant amount of time passes, it is always prudent to get a revised confirmation.

You can obtain the reduction in the claim for the procurement costs and attorney fees in most cases. However, TMHP says they are not required to give the reduction in all cases that appear to contradict the regulations cited below. In some cases, TMHP says that they will even make *Ahlborn*³ type reductions in the claim, based on the facts of the case. Representatives of TMHP repeatedly stated that each case is handled on a case-by-case basis considering the individual facts of a particular case.

In the event that an agreement cannot be made with TMHP, the case will then be go to the next level: consideration by a HHSC regional attorney. You can ask TMHP to forward your case to HHSC or you can email a copy of your information to Christy Dillman at christy.dillman@HHSC.state.tx.us. Ms. Dillman is the secretary for Region 3 of the HHSC regional attorney's office. She will then assign your case to a regional attorney to handle the further negotiations on your matter. In the event that a settlement cannot be reached with regional attorney, then the case will be forwarded to the Attorney General's office. The attorney responsible for these cases is George Jennings. He may be contacted at 512-475-4094.

B.Long Term Care Claims

The recovery of a claim for long term care expenses is handled by the Health and Human Services Commission. The regulations begin at 1 TEX. ADMIN. CODE §354.2301 (2004). In order to find out the amount of the claim, you should contact the Manager of the Third Party Recovery Health and Human Services Commission. To get a dollar amount, you can fax or mail your request. Typically, you will receive a reply within one week. The person to contact is:

Gayle Sandoval Manager of DAD's Third Party Recovery (TPR)
P.O. Box 149081
Austin, Texas 78714-9081
Mail Code E-400
512-430-2200, option #4
Fax 512-438-3400

If you are seeking a reduction or waiver in the amount of the claim, then you should contact the staff attorney:

Barry Browning – staff attorney at DHS
P.O. Box 149030 Austin, Texas 78714-9030
Mail Code W-615
512-438-3126
Fax-512-5136

Mr. Browning handles the negotiations for reductions in Long Term Medicaid Claims. He is generally very easy to reach by phone and will discuss the issues and explain what information he requires to make a decision on your claim. Specifically, if you are seeking a reduction under the *Ahlborn* case, he requests that you send him a two- or three-page description of the facts and of the calculations you use to determine the ratios of the recovery to the actual damages in the case.

C. Applicant's Duties

Under the current rules, the applicant has affirmative duties to inform the Health and Human Services Commission within 60 days of any unsettled tort claim or of any private accident or sickness, insurance coverage, or of a potential cause of action that would affect the medical needs of the applicant. The failure to fulfill this obligation is a class C misdemeanor.⁴

D. Attorney Duty to Inform Medicaid

The regulations⁵ require that an attorney representing a client in a third-party claim or action for damages must send written notice of representation within 45 days from the date the attorney undertakes representation of the client or from the date a potential third party is identified. This requirement must be met regardless of whether a legal action has been filed. The written notice must be signed by the attorney or representative of the recipient and must include the following specific information:

1. The name, address, and identifying information of the recipient (either the date of birth and the Social Security number, or the date of birth and the Medicaid identification number);
2. The name and address of any third party or third party health insurer against whom a third party claim is or may be asserted for injuries to the Medicaid applicant or recipient;
3. The name and address of any health care provider who has asserted a claim for payment provided to the Medicaid applicant or recipient for medical services provided to the Medicaid applicant or recipient for which a third party may be liable for payment, whether or not the claim may have been submitted to or paid by the Commission; and
4. If any of the information required by this section of the rules is unknown at the time the initial notice is filed, this should be indicated on the notice, and revised if and when the information becomes known.

E. Limit on Attorney Fees

The regulations limit the amount of attorney fees that can be charged. An attorney is prohibited from charging a higher rate to the client per a fee contract on the part of the recovery that is payable to Medicaid. In other words, if the amount payable to Medicaid were equal to the entire amount of the recovery, Medicaid would take the

position that no matter what agreement you made with your client, your total fee would be limited to the fifteen percent that the regulations allow. The state takes the position that the amount that you recover for Medicaid and the amount you recover for your client are two legally separate pools of money. And, on the portion of the recovery that represents the state's claim, an attorney cannot charge more than fifteen percent. The relevant portion of the statute is printed below.

§354.2332 Distribution of Recoveries

(e) The amount recovered on behalf of the Commission, for which attorney fees are authorized under this section, must be deducted from the total amount of the recovery *before attorney fees and expenses are deducted* under the terms of the recipient's contract (emphasis added).

F. Waiver of Attorney Fees

The regulations also address when Medicaid may waive any amounts owed to the agency. Medicaid is a joint Federal and State program and Texas is required to collect the money owed to the Federal government as well as the portion that goes to Texas. The Commissioner has the authority to waive all or part of the federal matching share of the Commission's right to recovery from liable third parties *only if* the cost of recovery exceeds the amount which could be recovered.

The Commissioner has the authority to waive all or part of the state's right to recover from liable third parties when the Commissioner finds that enforcement of the state's right of recovery would tend to defeat the purpose of public assistance. This is the part of the regulations that allows for a waiver or reduction, in some cases, of the amount that a claimant is required to repay the State.

However, if the State waves recovery, the plaintiff's attorney must waive his attorney fees over that portion. No attorney fees will be paid if the Commissioner waives a portion of or the entire recovery made on behalf of the Medicaid program.

Lastly, you cannot escape any part of the claim simply by how the recovery is characterized. Medicaid will base the amount they demand on the gross amount of any recovery without regard to whether the damages were for pain and suffering or medical bills. However, recent case law has placed restrictions on the ability of the State to claim the entire amount of the recovery as reimbursement in certain instances, which are discussed below.⁶

G. Balance Billing

Generally, Texas law prohibits providers from accepting Medicaid payment for services furnished to an injured person and also seeking additional payment from a liable third party. Medicaid reimbursement rates are very low, but providers are not allowed to seek the difference between the private pay rate and the Medicaid pay rate. The practice of doing so is called "balance billing."⁷ Medicaid participating providers must accept the Medicaid payment as payment in full. This means that, in most instances,

providers accepting Medicaid waive their right to bill Medicaid beneficiaries for any amounts over the Medicaid payment—even in the event of a large third-party settlement. Where a third party may be liable for a client's medical expenses, the providers much choose between the certainty of Medicaid payment and the chance of higher payment from the settlement. Thus, service providers are not able to assert a lien over settlement proceeds when the provider has already received payment from Medicaid. Both federal and state Medicaid laws provide that “the service provider accepts the terms of the contract—specifically that the Medicaid amount is payment in full.”

III. MEDICARE’S SUBROGATION CLAIM

A. Medicare Secondary Payer Statute

The legislation governing the Medicare program prohibits Medicare from paying for services to the extent that payment has been made, or reasonably can be expected to be made, from worker's compensation, liability or no-fault insurance, or employer group health plans.⁸ The statute is commonly referred to as the Medicare Secondary Payer Statute (MSP). If payment is made by Medicare because a bill was submitted to Medicare and the existence of the alternate insurer was not know at the time the bill was submitted, the payment is called a Medicare Conditional Payment. Medicare is entitled to seek repayment of the amount paid, less a proportionate share of the procurement costs—even if the case is settled and the defendant does not admit to any liability.⁹ If the claimant receives any payment from the defendant, then Medicare is entitled to repayment. Medicare has both a subrogation claim,¹⁰ as well as statutorily created cause of action to collect directly against the “entity” that is required to pay for any such medical care.¹¹

Medicare is only entitled to recover from payments made for medical services. There is no right of recovery for any monies received by the claimant for any damages other than medical bills. If the case is settled without an adjudication by a court or jury, Medicare will not recognize any apportionment by the parties in the settlement that allocates the monies between pain and suffering or future medical. Medicare will seek recovery of the full amount of the conditional payment less the procurement costs.¹² It is not possible to escape Medicare recovery by simply characterizing the settlement funds as recovery for a reason other than medical bills in the settlement documents.¹³

B. Attorney Responsibility For Payment Of Medicare Claim

In the publication, The Medicare Handbook,¹⁴ the authors take the position that an attorney in a personal injury case has *no duty* to protect Medicare’s property interest in a client’s personal injury award. The authors note that Medicare takes the position that personal injury attorneys have a statutory obligation to “affirmatively assist Medicare” in recovering conditional payments. However, the authors make the case that an attorney is obligated to give the client the proceeds from the settlement if the client so chooses and the Medicare Secondary Payor (MSP) statutes and regulations impose no penalty on the attorney for doing so.

In that publication, the authors explain that position based on a careful reading of the statute and subsequent federal district court rulings. Their position is that CMS has wrongfully claimed that the MSP statute gives Medicare claims the status of liens. They assert that CMS incorrectly asserts that certain punitive powers that exist to punish insurance companies for noncompliance with the MSP claims extend to attorneys as well. The following is the author's attempt to explain the position but this entire section is based on the idea set forth by the authors of aforementioned Handbook.

To evaluate the position taken in the Handbook, the statute itself must be carefully studied. But the premise of the position is not subject to dispute. In a nationwide class action suit, *Zinman v. Shalala*,¹⁵ the district court ordered Medicare to stop using the term "lien" to describe its reimbursement claim in its collection efforts. The lack of lien status means that an attorney does not owe Medicare any duty to protect its right of recovery. The argument is bolstered by the facts set out below.

The regulations impose a duty on the *beneficiary* to cooperate with Medicare, and if the CMS's recovery action is unsuccessful because the beneficiary does not cooperate, then CMS may recover from the beneficiary.¹⁶ The regulations impose a duty on third party payers to notify Medicare when a payment is made, or should have been made, by the third party and the third party learns that Medicare has also issued a payment. The notice must describe the specific situation and the circumstances, including the particular type of insurance coverage and, if appropriate, the time period during which the insurer is primary to Medicare.¹⁷ CMS attempted to bolster its lien claim by promulgating a regulation that would have imposed a duty on the beneficiary *or his representative* to notify Medicare if an insurance claim was pending; the regulation, however, was never finalized.¹⁸ Because an attorney has no duty to contact, notify, or cooperate with CMS, it would be difficult to understand how any duty to protect CMS's claim would supercede the duty that an attorney owes to his or her client. Based on the position taken by the Handbook authors, they offer:

[I]f the client chooses to receive his portion of the insurance proceeds from his attorney and deal with Medicare directly, the MSP statute and regulations impose no penalty on the attorney. Under ethical rules of practice, the attorney should advise his client of MSP recovery program, but the client should then be allowed to decide whether she wants her attorney to pay Medicare directly or disburse the proceeds so that she can handle the MSP claim herself. The client should be advised of the possibility of collection action or termination of future benefits if the MSP recovery claim is not paid. She should also be advised of the possibility of qualifying for a waiver of MSP recovery . . . if she received the proceeds from her attorney and used them for necessary items.¹⁹

The Handbook continues with an examination and comparison of the specific language of several sections of the regulations dealing with this matter. The regulations impose a duty on the beneficiary *or other party* to reimburse Medicare within 60 days of

receiving a third-party payment.²⁰ The term “other party” is described as including physicians and attorneys.²¹ Therefore, if the attorney is in possession of liability proceeds, then CMS has a right of recovery against the attorney to obtain those proceeds. This section most likely refers to a doctor or hospital that has already been paid by Medicare for a claim and later receives a payment from a third party medical insurance plan. It is difficult to envision a situation where an attorney would receive proceeds from a third party payer and take possession of the monies directly. The only time a attorney is likely to hold such proceeds is in a trust account for the benefit of a client.

Evidence for this position can be found in the statutes and regulations that give Medicare the right to recover against an insurer that has already paid a claim and the ability to collect only the proceeds that remain in the hands of an attorney. The federal statute authorizing a private cause of action against a primary plan empowers Medicare to recover an amount double the amount otherwise allowed from the plan under these circumstances.²² A primary plan is defined as 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.²³ The regulations authorize CMS to recover its payment amount from a “third party payer” even if the payer has already reimbursed the beneficiary or other party.²⁴ However, as set forth above, the regulations only require that an entity reimburse Medicare for any third party payment the entity receives.²⁵ The same section that requires an entity to reimburse Medicare is subject to the provision in the regulations that reduces Medicare’s claim to the amount of the total judgement or settlement minus the party’s total procurement costs.²⁶ This means that even if Medicare seeks to recover the third party payment from an attorney, the agency will still allow the deduction of attorney fees if the claim is disputed. In the past, CMS has advanced the position that it could recover the amount of their claim plus additional amounts from a entity such as an attorney. Currently, the Medicare website (see below) warns attorneys of “responsibilities and obligations” they have to report under the MSP that appear to be lacking in the statute and regulations. The website further cautions that Medicare must be paid prior to any disbursements of funds to a client. CMS tells its contractors in the Medicare Intermediary Manual (MIM) at §3418.6 (B)(1) to notify the beneficiary and his or her attorney of his or her responsibility to notify Medicare of both the intent to file a claim and of the settlement amount, if a settlement is awarded.

In summary, the position set forth in the Handbook is that because the statues and regulations empower CMS to collect amounts in excess of the conditional payments from third party payers (insurance companies) and does not allow such punitive recoveries from other entities (attorneys), that if an attorney has received a recovery (such as in a trust account) and then disbursed the proceeds to a client minus allowable procurement fees (attorney fees), then the attorney would have no further obligation to Medicare. There are contrary positions by other authors.²⁷ The counter arguments are based on the ABA’s Model Rules of Professional Conduct Rule 1.15. The ABA's position states that if Medicare had a true lien, then the attorney is required to turn over the

proceeds that he has in his possession to the third party (Medicare).

There is a recently decided district court case that could have implications on this matter.²⁸ The Court rejected a motion to dismiss from an attorney who had notified CMS of the settlement but disbursed proceeds from a settlement to his client. After the attorney notified CMS of the settlement, CMS sued the attorney for recovery of the money claimed by CMS under the MSP statute and the court refused to grant the attorney's motion to dismiss.

IV. PROCEDURE FOR PAYING A CLAIM

A. Providing Notice of Potential MSP Case

Once you realize that Medicare may have a claim, then the problem becomes how do you find out how much Medicare is asserting and is it possible to negotiate the amount to a lower figure? Because of some fairly recent changes in how Medicare handles the reimbursement process, the act of just finding out how much your client owes has become complicated. Usually, an attorney is in a hurry to settle the case and to get the funds from the defendant. This is why **Medicare urges everyone to put the agency on notice as soon as an attorney accepts a new case.**

The Centers for Medicare & Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), has an initiative to centralize the collection of data for dealing with Medicare Secondary Payment (MSP) issues. The initiative is called Medicare Coordination of Benefits (COB). COB is a central point of notification and an in-taker of all data required to accurately determine Medicare's proper payer status. The Medicare website at www.cms.hhs.gov/EmployerServices/02_COBandYou.asp links to a Fact sheet for attorneys. The agency explains the COB program's purpose as:

[T]o identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor (CBC) collects, manages, and reports other insurance coverage. The CBC must be notified of situations where medical services rendered to a beneficiary are related to a workers' compensation injury, automobile accident, or other liability because in these instances, another payer has the primary responsibility for payment of medical claims related to the injury. **Both you and your client have significant responsibilities and obligations under the Medicare Secondary Payer (MSP) laws to report these situations, and your participation is vital in ensuring the integrity of the Medicare Trust Funds.** (emphasis added).

On this same website, Medicare makes the assertion that:

"Medicare's claim must be paid up-front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party. If Medicare is not repaid in a timely manner, interest may be assessed. The law requires repayment within 60 days of their receipt of

funds (42 CAR 411.24h) however, the program applies this regulation 60 days from the issuance date of their demand for payment.”

B. Step One

If you are starting a new auto/no-fault, liability, or workers' compensation case, or have a general liability question, you can contact the COB office by phone or mail. They have customer service representatives available to provide you with service from 8:00 a.m. to 8:00 p.m., Eastern Standard Time, Monday through Friday. The toll free number is 1-800-999-1118 and the mailing address for written inquiries is:

MEDICARE – Coordination of Benefits Contractor
MSP Claims Investigation Project
P.O. Box 5-41
New York, NY 10274-5041

When contacting the COB contractor, you should have the following information:

1. Your client's name;
2. The beneficiary's 9 digit HIM number (usually their Social Security Number plus an alpha suffix and can be found on the beneficiary's red, white and blue Medicare Health Insurance Card);
3. Date of accident/incident;
4. Description of illness/injury;
5. Name and address of the other insurance plus policy number if known (e.g., workers' compensation carrier, auto/no-fault insurance carrier, etc.);
6. Name and address of legal representative;
7. A detailed listing of the claimed injuries or medical problems **and** the date of incident;
8. A completed "consent to release form," signed by the Medicare beneficiary you may obtain a recommended, but not mandatory, form at www.MSPRC.info; and
9. Any other relevant insurance information.

Medicare asserts that this first step is necessary in order to allow the agency to set up an electronic file for the case. The attorney should receive correspondence from the COB office indicating that the file is set up and ready to go. If the attorney does not hear back the COB office within two weeks, the attorney may write or call them at (800)

999-1118 to find out the status of the file. **Even though all of CMS's materials tell you not to call, you should always make your first contact by phone.** If they require clarification, or additional information, they will be able to request it during your call and you will be able to conclude the call knowing that your case file has been established. Always document your records with the date and name of the individual with whom you were speaking. The COB will conduct the initial research and assign jurisdiction for all cases to the Medicare Secondary Payer Recovery Contractor (MSPRC). Effective October 2, 2006, the Centers for Medicare & Medicaid Services (CMS) transitioned all Medicare Secondary Payer (MSP) recovery workloads to a national MSPRC. Once assigned jurisdiction by the COB, the actual case work will be with the MSPRC. All attorneys, beneficiaries, and insurance companies must now contact the MSPRC to discuss updated conditional payment amounts, provide settlement information, and work on any issue to bring a case to closure.

C. Step Two

The second step is to ask the Medicare Secondary Payer Recovery Contractor (MSPRC) for the amount of its subrogation claim. This is done by requesting a "conditional pay letter" from the MSPRC. An attorney can write a letter to:

MSPRC-NGHP
P.O. Box 138832
Oklahoma City, OK 73113

When writing, always ask for a conditional pay letter. It is also important to include a consent to release form in your letter as well. You can also fax a copy of the completed privacy release to the MSPRC at (405) 869-3309. Allow approximately two weeks for the release to be scanned into the system and call them at (866) 677-7220 to request a listing of Medicare's conditional payments. The MSPRC has 45 days to respond to written correspondence and contractors usually need every single moment of that time period. You should call them two weeks after faxing or mailing the request to MSPRC to ensure they received it and to confirm that you are in line to receive a reply.

D. Step Three

Once this letter is received by the MSPRC, a "Notice of Medicare's Conditional Payment" will be sent. That notice will include a list of each conditional payment Medicare has paid to date and a total amount of the conditional payment will be sent to the requesting party. In most cases, Medicare will take at least two months to determine the conditional payment amount and, once received, it is the responsibility of the attorney, and when possible the Medicare beneficiary, to review the Conditional Payment listing and notify the MSPRC of claims which he or she believes to be unrelated to what was claimed/released in the case. Any action taken in reliance upon the amount that is owed to Medicare without waiting for an official reply from Medicare is apt to be fraught with problems. The notice states that the agency will continue to check their records and will keep you informed of any updates. If the time frame between receiving the Notice of

Medicare's Conditional Payment and settlement is significant, and particularly if the incident happened within the last two years, or the client is still being treated, providers may still be submitting claims. Thus, the amount may increase when MSPRC reviews payments again to issue the actual demand for payment. Medicare is secondary payer from the date of incident through the date of settlement and providers have a little over two years to submit claims for payment; this means that it is always possible that claims for those dates of service may be received and paid. Once the demand is issued, Medicare usually does not negotiate that amount. If the attorney knows of remaining outstanding bills and does not inform CMS about them before the demand is issued, then the program can go back and recover for those services.

E. Step Four

Once the attorney has settled the litigation case and reached an agreement with the MSPRC on related conditional payments, he or she should send a packet to the MSPRC. That packet should include a copy of the settlement release that provides the date and amount of settlement, the attorney's fee agreement with the client, an itemized list of the litigation expenses, and the transmittal letter should ask the MSPRC for a "final demand." All correspondence to the CBC and the MSPRC should include the full name and Medicare number of the Medicare beneficiary along with the date of incident. Once the attorney receives the final demand, he or she may simply write a check and send it in to the MSPRC.

The MSPRC is only empowered to reduce Medicare's subrogation claim by attorney fees and litigation expenses (42 C.F.R. §411.37). However, prior to issuing the formal demand for payment, the agency will remove some charges from the conditional pay letter, at the attorney's request, if the attorney disputes the charges and the MSPRC agrees that they should be removed. If the attorney wants to dispute the charges, he or she should communicate to the MSPRC which charges should be removed and why. If the MSPRC agrees to remove the disputed charges, the MSPRC will do so and then send a new conditional pay letter.

If the attorney is asking for a compromise of the Medicare subrogation claim (which can be done pre- or post-settlement) beyond the amount of attorney fees and litigation expenses, then the MSPRC will send the file to a Regional Office of the Centers for Medicare and Medicaid Services (CMS) for its consideration. The negotiation over these issues seems likely to be protracted. Furthermore, CMS must refer every favorable compromise determination of debt of \$100,000 or more to the Department of Justice (DOJ) for a final determination.

F. Procurement Costs

In the above discussion, mention was made of the amount of the conditional payment being reduced by the "procurement costs."²⁹ The procurement costs are attorney's fees and expenses incurred in pursuing the case. The case must be such that the payments received by the claimant are disputed. Recovery made under PIP or no-fault insurance coverage will not be eligible for a reduction of the Medicare claim unless

such payments are in dispute.³⁰ The calculations concerning how much reduction in the Medicare claim is possible is useful for planning case strategy or settlement positions; however, the final result will not be known until the actual amount of the settlement is sent to Medicare. Only after receiving the numbers on the final settlement, will Medicare send an "Initial Determination Letter or Demand Letter," which will include calculations of the reduction allowed for procurement costs. This letter will detail the claims paid by Medicare and the amount the agency expects to be paid. Upon settlement of the case, the payment to Medicare should be made within 60 days. If payment is not made within 60 days after the receipt of the funds, then Medicare can charge interest on the amount they deem they are owed.³¹ After receipt of payment, if requested, Medicare will send a release.

G. Waiver or Compromise of the Claim

If a reason exists that you need to seek a waiver or compromise of the Medicare claim for an amount greater than the procurement costs, it will be impossible to settle the claim with the Contractor. There are three statutory authorities under which Medicare may accept less than the full amount of its claim: Section 1870(c) of the Social Security Act; §1862(b) of the Social Security Act; and the Federal Claims Collection Act (FCCA). Each statute contains different criteria upon which decisions to compromise, waive, suspend, or terminate Medicare's claim may be made.³² Medicare contractors have authority to consider beneficiary requests for waivers under §1870(c) of the Social Security Act. Authority to waive Medicare claims under §1862(b) and to compromise claims, or to suspend or terminate recovery action under FCCA, is reserved exclusively to CMS and/or Regional Office staff.

The process of seeking a further waiver of the claim is a familiar one to those attorneys that have sought a waiver of overpayment in regular Social Security or Social Security Disability cases.³³

After the amount of the claim has been determined, the settlement of all claims that do not exceed \$100,000.00 must be handled by the regional CMS office. Claims in excess of \$100,000.00 will be sent to the regional office but will be forwarded to the central office in Baltimore for compromise or waiver.

V. MEDICARE SET-ASIDE ARRANGEMENTS OR TRUSTS

Federal Law provides Medicare, which is administered through the Center for Medicare Services (CMS), expansive rights with regard to claimants who are, or will become eligible for Medicare benefits. The Medicare Secondary Payer (MSP) statute 42 U.S.C §1395y, and regulations 42 C.F.R §411.20 *et. seq.* make Medicare a secondary payer for any medical services for which payments have been made, or can reasonably be expected to be made promptly under a workers' compensation (WC) law or insurance plan.

CMS also has an interest in the portion of the settlement intended to cover *future*

medical benefits because, prior to the settlement, the workers' compensation carrier or third-party may also be the responsible party for paying the injured party's future medical expenses. Once the settlement is complete, CMS does not want the injured person looking to Medicare as the primary payer of the injured party's medical expenses related to his or her injury unless the injured party has exhausted all the proceeds from the settlement on his or her medical care that is related to the injury for which the settlement was obtained.

CMS protects its interests in workers' compensation and third party liability settlements by requiring a certain amount of a settlement be specifically set aside for payment of future medical benefits that Medicare would otherwise pay. The vehicle to satisfy the requirements of CMS to set aside the proceeds of the settlement has become known as a **Medicare Set Aside Arrangement or Trust (MSA)**. The MSA becomes the primary payer of medical expenses until such time as the proceeds in the MSA are exhausted; at that time, Medicare resumes the primary payer role. If no amount of the settlement is set aside from the settlement, or too little of the settlement is set aside, CMS may refuse to provide any Medicare-covered services related to the injury until the entire amount of the settlement is exhausted. CMS will also consider the entire amount of the settlement to be allocated to future medical expenses unless the agency approves an MSA allocation amount.

On July 23, 2001, the Central Office of CMS issued written guidelines in an attempt to provide some uniform guidance on the application of the MSP regulations. CMS has published eight additional memoranda defining and refining CMS's policies and procedures for the use, submission, approval and administration of MSA's related to Workers' Compensation cases only. The author has a previous paper that discusses all of the information and specifics of these memos.³⁴

These memos provide the only expression from CMS to date on how an MSA should be created and only in the context of a Workers' Compensation Case. To date **there is no specific written guidance for how a MSA can be created for third-party liability case.** The only guidance for MSAs in a third-party context must be gleaned from CMS's direction in workers' compensation matters.

A. Procedure

Once a settlement is obtained, the amount to be placed in the MSA "the allocation" must be calculated. The amount is determined by considering the claimant's past medical treatment, current condition, and the reasonable probability of future medical treatment that is a result of the injury that is the basis of the lawsuit. Additionally, only medical expenses that would be covered by Medicare are considered along with the claimant's actual life expectancy or rated age. The evidence used to obtain the recovery such as life care plans or physician statements must be submitted to CMS as well. Once a figure is determined, that amount is submitted to CMS for approval. One of the more difficult aspects of the process is that there is no practical

procedure for appealing a decision by CMS on the acceptance or rejection of a proposal.³⁵

MSA's can be formal trusts with a Trustee or they can be informal arrangements such as a segregated bank account which is self-administered by the claimant. Because the decisions involved in administering an MSA account include an evaluation as to what medical expenses are related to the injury and what expenses are payable by Medicare, it is highly recommended that the MSA be administered by a competent professional administrator. Failure to properly administer the MSA may result in the claimant being denied Medicare coverage for future medical bills.

Another complication arises if the MSA beneficiary is also currently a Medicaid beneficiary, or will possibly need to qualify for Medicaid in the future. Medicaid restricts the amount of available resources that an applicant can own to less than \$2,000.00 in value. **The value contained in the MSA will be considered an available resource by Medicaid and will disqualify the beneficiary from the Medicaid program if the value of the MSA exceeds \$2,000.00.** In this situation, the MSA must be contained inside a Special Needs Trust or the beneficiary will lose Medicaid eligibility for the remainder of his or her life. This can lead to further complications in cases with a small recovery. To date CMS had not created any deminimis standard for the creation of an MSA. In cases with a small recovery, but one in which the value of the MSA will exceed \$2,000.00, the use of a Pooled Trust Account may be the only solution.

B. Funding

The amount required to be funded into the MSA can be provided by a qualified structure annuity or by a cash payment. If a structure is utilized, in order to be a qualified structure, it must be purchased at the time of settlement by the Defendant in the suit or purchased by the Administrator of a Qualified Settlement Agreement or Trust. CMS requires that "seed money" an amount that will cover the first two years of anticipated medical payments be placed in the MSA in the form of a cash payment. The remainder of the funding, if provided by a qualified structure must be placed in the MSA annually on a set anniversary date that cannot be more than a year from the settlement. The proceeds contained in the MSA cannot be used to pay any fees for the establishment or ongoing administration of the MSA. In some cases, this means that a second structure may be utilized to pay the administration expenses for the remainder of the beneficiary's life.

VI. MEDICARE, MEDICAID SCHIP EXTENSION ACT OF 2007 (MMSEA)

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173) amends the Medicare Secondary Payer (MSP) provisions of the Social Security Act (Section 1862(b) of the Social Security Act; 42 U.S.C. 1395y(b)) to provide for mandatory reporting for group health plan arrangements, liability insurance (including self-insurance), no-fault insurance, and workers' compensation plans. The MMSEA, in a nutshell, is a new requirement that payors in personal injury cases must determine if an

individual that has instituted a claim against any “Responsible Reporting Entities” (RREs), or against anyone insured by an RRE is eligible for Medicare benefits.³⁶ If the claimant is entitled to benefits under the Medicare program, then the RRE must submit certain information about the claimant to CMS. The information that has to be reported, at a minimum, will include the identity of the claimant and his or her social security number. The effective date of the statute is July 1, 2009, but because the system for reporting the data to CMS is so complicated, RRE’s were not actually required to report until April 1, 2010.³⁷ The penalties for failing to comply with the new law are harsh. RRE’s can be subject to a fine of \$1,000.00 a day for each day on noncompliance.

The MMSEA has nothing to do with the requirement of protecting Medicare’s interest in liability cases. The obligation to protect Medicare’s interest has been an ongoing obligation since 1980 when the Medicare Secondary Payer Statute was created by the Omnibus Reconciliation Act of 1980. The new law only gives Medicare more information about who is receiving the proceeds and the circumstances that led to the recovery or settlement. It has no direct effect on tort plaintiffs and their attorneys.

VII. CONCLUSION

Obtaining a settlement or winning a case for your client may seem like a perfect ending, but in many instances this is only the beginning of a case. It is now necessary for plaintiff and defense attorneys alike to have a working knowledge of Medicare and Medicaid claim resolution. Even with an emerging industry eager to assist attorneys with these issues, it is important for attorneys to keep these issues in mind during settlement negotiations. As these issues continue to delay the settlement of claims, plaintiffs' attorneys are left with open-ended cases.

By understanding the basics of claim resolution, attorneys can facilitate a quicker ending to a case. You can make a determination as to whether it is in your client's best interest to handle the claims yourself or hire someone with the special knowledge to handle the complex issues. By knowing who to contact, you can assist your client in resolving these issues in their favor.

The status of the law dealing with resolution issues is in a state of flux at this time. The best that you can do for your clients is to learn the rules as they exist today, but be aware that the rules are going to change. It is possible the entire field of claims resolution will evolve into a such a specialized area that even small settlements will require the hiring of outside entities to assist the personal injury attorney in finishing the case. This is certainly the case now in large cases or multi-plaintiff litigation. The utilization of new techniques such as Qualified Settlement Funds and MSA’s are just the beginning of the new and innovative means that can be used in this area. The good news is that as the complexity of this area of law evolves, the ability to find the information necessary or to hire persons with the expertise to assist you in these cases

will become increasingly easier. Ultimately, having a basic understanding of the issues surrounding claim resolution will allow the personal injury attorney to quickly obtain the best settlements for clients and to get the money into the client's hands as soon as possible.

1. Tex. Dep't of Health v. Buckner, 950 S.W. 2d 216 (Tex. App. 1997) (no writ).
2. 1 TEX. ADMIN. CODE § 354.2332 (2008).
3. Ark. Dep't of Health and Hum. Servs. v. Ahlborn, 547 U.S. 268 (2006).
4. TEX. HUM. RES. CODE ANN. § 32.033(b) (2008).
5. 1 TEX. ADMIN. CODE § 354.2315 (2008).
6. *Id.* at § 354.2332.
7. *Id.* at §§ 354.2321, 354.2322.
8. 42 U.S.C. § 1395y(b) (2008); 42 C.F.R. §§ 411.20 42, 411.50 (2008).
9. 42 C.F.R. § 411.37 (a) (2008).
10. 42 U.S.C. § 1395y(b)(B) (iii) (2008).
11. *Id.* at § 1395y(b)(B)(ii).
12. *Centers for Medicare and Medicaid Services, Medicare Intermediary Manual § 3418.7*, available at <http://www.cms.hhs.gov>.
13. Randal Kauffman, The War of the Cockatrice, 60 Texas Bar J. 311 (April 1997).
14. Center for Medicare Advocacy, Inc., *The 2009 Medicare Handbook*, 9-16 (2009).
15. 835 F. Supp. 1163, 1171 (N.D. Cal. 1993), *aff'd*, 67 F.3rd 841 (9th Cir. 1995).
16. 42 C.F.R. § 411.23 (2008).
17. *Id.* at § 411.25.
18. "Without Fault" and Waiver of Recovery from an Individual as it Applies to Medicare Overpayment Liability, 63 Fed. Reg. 14,506 (March 25, 1998).
19. Center for Medicare Advocacy, Inc., *The 2009 Medicare Handbook*, 9-16 (2009).
20. 42 C.F.R. § 411.24(h) (2008).
21. *Id.* at § 411.25(g) (2008).
22. 42 U.S.C. § 1395y(b)(3) (A).

23. *Id.*
24. 42 C.F.R. § 411.24(i) (2008).
25. *Id.* at § 411.24(h).
26. *Id.* at § 411.37.
27. David McGuffey & Timothy Takacs, Medicare Secondary Payer Issues 24 (2004).
28. U.S. v. Harris, Civil Action No. 5:08CV102 (United States District Court, Northern District of West Virginia) (Nov. 13, 2008).
29. *Centers for Medicare and Medicaid Services*, Medicare Intermediary Manual § 3418.7, available at <http://www.cms.hhs.gov>.
30. 42 C.F.R. § 411.37(a)(i) (2008).
31. 42 C.F.R. § 411.24 (m)(2)(i) (2008).
32. *Centers for Medicare and Medicaid Services*, Medicare Intermediary Manual § 3418.7, available at <http://www.cms.hhs.gov>.
33. Randal Kauffman, The War of the Cockatrice, 60 Texas Bar J. 311 (April 1997).
34. Pi-Yi Mayo, Medicare Set Aside Paper 2007, pi-yimayo.com.
35. *Id.*
36. John J. Campbell, Mandatory Insurance Reporting Under the MMSEA (MMSCHIP) 3, www.jjcelderlaw.com/MSABulletin.html, (May 18, 2009).
37. *Id.* at 10.