

Navigating Settlements Involving Medicare Beneficiaries



By *Nicholas M. Wiczorek and Eugenia L. Liu*

With certain amendments to the Medicare Secondary Payer Statute (MSP) going into effect on October 1, 2010, settlements involving Medicare beneficiaries will be more difficult to navigate.

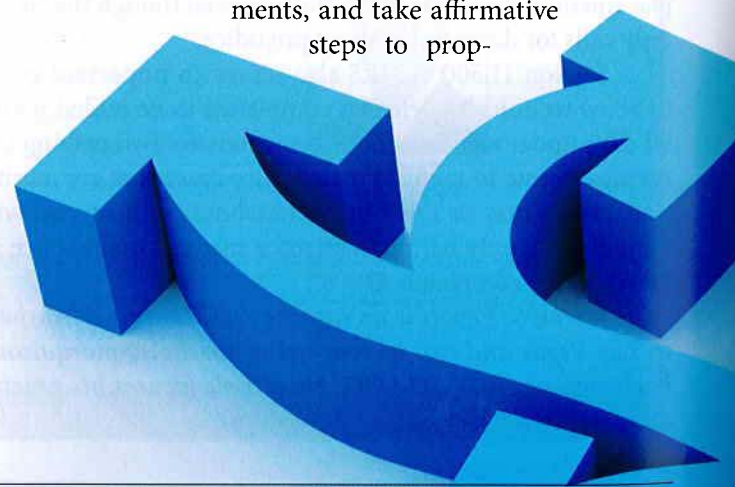
On December 29, 2007, President George W. Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007, Public Law No. 110-173 (MMSEA), adding additional enforcement options to the MSP. The MSP authorizes the Medicare program, under certain instances, to make a conditional payment for the beneficiary's medical care when payment by a liability insurance, no-fault insurance, or worker's compensation plan does not occur "promptly." However, those payments are then subject to reimbursement once it has been demonstrated that the primary plan has or had responsibility for the payment. The United States may initiate recovery of Medicare conditional payments when it learns the payment "had been or could be made." 42 C.F.R. § 411.24(b). Section 111 of the 2007 amendments added mandatory reporting requirements with respect to Medicare beneficiaries who receive a settlement, judgment, award, or other type of payment from these plans.

With these changes, legal counsel handling claims involving Medicare beneficiaries now have a heightened obligation to assist their clients or carriers in determining the Medicare enrollment status of plaintiffs/claimants and to handle settlements or payments to Medicare beneficiaries appropri-

ately. Private business and insurance providers are now routinely placing their legal counsel on notice of the mandatory reporting requirements and demanding specific language or protocols in settlement agreements in liability cases that serves as a precondition to settlement payment. For example, certain business and insurer clients are demanding that settlement agreements include language comparable to the following:

This settlement is based upon a good faith determination of the parties to resolve a disputed claim. The parties have not shifted responsibility of medical treatment to Medicare in contravention of 42 U.S.C. § 1395y(b). The parties resolved this matter in compliance with both state and federal law.

A careful and thorough analysis of the legislation, the applicable section 111 mandatory reporting user guide, and accompanying reporting requirements is essential to avoid downstream risk arising from non-reported or non-compliant settlements and payments. Legal counsel must be familiar with the reporting requirements of section 111 of the MMSEA, as well as the reimbursement requirements, and take affirmative steps to prop-



erly report and document settlements and payments involving Medicare beneficiaries. However, the following provides a broad overview of the issues that counsel now face.

Obtaining conditional payment information

If Medicare makes conditional payments on behalf of a party to a claim or litigation, information about that conditional payment will be critical in evaluating or reaching any settlement or payments. For instance, a case that is valued at \$10,000 may look very different if Medicare has made a conditional payment of \$20,000 and there is a possibility that it may seek to recover that entire amount. Legal counsel may obtain conditional payment information under a six step process:

1. Is your plaintiff/claimant a Medicare beneficiary? Typically, a plaintiff/claimant who is 65 years of age or over will be a Medicare beneficiary. However, a Medicare beneficiary can also be someone who has certain disabilities or end stage renal disease. You can also obtain plaintiff/claimant's health information claim number. If you have the plaintiff/claimant's social security number, a call can be made to Medicare's Coordination of Benefits Contractor (COBC) at 1 (800) 999-1118.

2. Notify the COBC of the claim, which may be made by phone or in writing, and coordinate with other parties in doing so. You must provide the plaintiff/claimant's full name, Medicare number and/or social security number, date of accident, description of injury and ICD-9 code(s), name/addresses of the primary payer, and plaintiff/claimant's legal representative. The COBC will then notify the Medicare Secondary Payer Recovery Contractor (MSPRC) of the claim.

3. MSPRC will issue a rights and responsibilities letter to the Medicare beneficiary.

4. Within 65 days of the date of the rights and responsibilities letter, MSPRC will issue a conditional payment letter to the Medicare beneficiary and any

authorized parties. Because MSPRC only issues the letter to authorized parties, you must ensure that the appropriate authorization form has been submitted (i.e., "proof of representation" or "consent to release"). This is an *interim* conditional payment demand, and should contain a detailed list of the claims that had been paid by Medicare.

5. Once the conditional payment letter has been issued, counsel for plaintiff/claimant will typically negotiate which payments are related to the injuries in the case in an effort to adjust or reduce the claims of injuries and/or the amount of the lien. Counsel should review the listing of the claim services for accuracy (i.e., check for double billing, correct service dates, consistency between type of injury and claim, or other possible grounds to challenge Medicare's claimed services). Medical reports and independent medical examination letter reports detailing pre-existing conditions may be useful in negotiating the lien amount.

6. The final executed settlement agreement must be sent to the MSPRC before final conditional payments are made. MSPRC will issue a "final demand," which requires payment within 60 days. If payment is not tendered within 60 days, interest may be assessed from the date of the final demand letter, and the matter may be subject to an official collection action if no payment is received within 120 days.

Mandatory reporting requirements

The mandatory reporting requirements under section 111 of MMSEA will ensure that Medicare is made aware of all settlements and payments to Medicare beneficiaries so that it can seek reimbursement for any conditional payments. The mandatory reporting requirements fall on a variety of potential parties. An entity is generally considered a responsible reporting entity (RRE) if it funds and pays for a settlement, judgment, award, or payment to a Medicare beneficiary. RREs that are required to comply include liability insurance plans, self-insured entities, no-fault insurance plans, and workers compensation plans. The reporting requirements include providing information relating to the Medicare beneficiary, all claimants who are non-Medicare beneficiaries, legal representatives of the beneficiaries and claimants, and ongoing responsibilities for medicals, as well as the amount of the settlement, judgment, award, or other payment or total payment obligation to the claimant. At the moment, there are interim reporting thresholds for certain RREs and certain types of payments. Counsel working with liability insurance plans, self-insured entities, no-fault insurance plans, and workers compensation plans should review the applicable section 111 mandatory reporting user guide to determine whether any of the interim thresholds apply and whether the settlement or payment in their case is exempt from reporting at this time.

Navigating continued on page 22

Navigating *continued from page 21*

Penalties for non-compliance

The penalties for non-compliance with the section 111 reporting requirements or the reimbursement requirements are severe. On the reporting front, the statute provides for a civil penalty of \$1,000 for each day of non-compliance. On the reimbursement front, there are civil enforcement actions and the possibility of double damages.

Each of the steps outlined above requires a careful review and analysis of the published regulations, statutes, and user guides. Such an analysis is outside of the scope of this article. For the purposes of counsel involved in litigation or claims negotiation/resolution with eligible parties, the critical obligation is to consider the parties to the claims and suits and exercise due diligence when counsel suspects that Medicare payments may be involved. The consequences of failing to comply with these regulations could result in a true settlement hangover to both counsel and clients. **G**

Nicholas M. Wiczorek is a partner in the Las Vegas office of Morris Polich & Purdy, LLP and represents clients in diverse practice areas including professional liability, medical device products liability, and civil litigation.

Eugenia L. Liu is a partner in the firm's Los Angeles office and emphasizes her practice in the long-term care area.

This article was previously published in *Communiqué*, the official publication of the Clark County Bar Association. © Clark County Bar Association.