

## LIABILITY CASES & MEDICARE COMPLIANCE

### *Understanding How The Medicare Secondary Payer Statute Applies to Liability Primary Payers*

by Mark Popolizio, J.D.

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

This amendment to the Medicare Secondary Payer Statute (MSP) is the latest salvo in Medicare’s campaign to strengthen its rights against all primary payers. In 2001, the Centers for Medicare and Medicaid Services (CMS) released the “Patel Memo” setting the stage for Medicare to take a more involved role in the workers’ compensation (WC) arena.<sup>1</sup> Through the Patel Memo, CMS introduced the Medicare Set-Aside (MSA) arrangement as the recommended vehicle for WC primary payers to protect Medicare’s “future interests” in WC settlements. CMS has since released eight additional memos further solidifying and expanding the MSA concept in WC cases. In addition, CMS has increased enforcement activities regarding conditional payment reimbursement in WC cases.

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

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

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

#### **I. Liability Primary Payers Are Required to Reimburse Medicare For Conditional Payments**

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

Under the MSP, a “primary plan” includes “*an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance... An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.*”<sup>2</sup>

Several forms of insurance fall under the umbrella of “liability insurance” including, but not limited to,

automobile, self-insurance, uninsured motorist, underinsured motorist, homeowners, malpractice, product liability, general casualty, medical payments coverage, medical expense coverage and no-fault.<sup>3</sup>

The next issue for consideration involves Medicare “conditional payments.” The general rule is that Medicare will not make payment for medical services if “*payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a state or under an automobile or liability policy or plan (including self-insurance) or under no fault insurance.*”<sup>4</sup> However, Medicare may make “conditional payment” if a primary plan “*has not made or cannot reasonably be expected to make payment... promptly.*”<sup>5</sup> Any such payment made by Medicare “*shall be conditioned on reimbursement to the appropriate Trust Fund.*”<sup>6</sup>

Thus, a “conditional payment” can be defined as a payment made by Medicare for services for which another payer is responsible.<sup>7</sup> Conditional payments can arise in a variety of ways. In the liability setting, they typically arise from the fact that most liability claims are denied and, thus, the primary payer does not provide medical services for an injured party’s accident related injuries. Accordingly, if the injured party is a Medicare beneficiary then Medicare often times ends up providing and paying for the treatment.

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

Pursuant to 42 U.S.C. § 1395y(b)(2)(B)(ii), primary payers, and an entity that receives payment from a primary plan, are obligated to reimburse Medicare for conditional payments when it is demonstrated that a primary plan “*has or had a responsibility*” to make payment. A primary plan’s “responsibility” may be “demonstrated” by a “*judgment*” or “*a payment conditioned upon a recipient’s compromise, waiver and release.*”<sup>8</sup> A “*settlement*” or “*contractual obligation*” is further evidence of “responsibility” under the MSP.<sup>9</sup> It is important to note that this obligation applies “*whether or not there is a determination or admission of liability.*”<sup>10</sup> Thus, even denied claims are included under the statute.

With respect to repayment, if CMS does not need to take legal action, the amount of recoverable conditional payments is the lesser of either the Medicare primary

payment, or the amount of the full primary payment that the primary payer is obligated to pay.<sup>11</sup> If it is necessary for CMS to take legal action, Medicare may recover twice the amount of the Medicare primary payment.<sup>12</sup> Medicare’s claim may be reduced by procurement costs.<sup>13</sup>

Medicare has broad enforcement rights under the MSP. For example, Medicare has a direct right against all primary payers responsible for making payment<sup>14</sup> and any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer.<sup>15</sup> Medicare also has a subrogation right, as well as rights of joinder and intervention.<sup>16</sup>

**Primary payers are also currently required to place Medicare on “notice” of claims implicating its interests.** According to 42 C.F.R. 411.25(a), primary payers are obligated to place Medicare on notice “*if it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer had made or should have made primary payment... .*”<sup>17</sup>

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

This amendment to the MSP becomes effective July 1, 2009 for all primary payers except for group health plans for which the effective date is January 1, 2009.<sup>18</sup>

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

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

It is important to note that key aspects of Senate Bill 2499 remain unknown or unclear at this time. For instance, further direction is needed as to exactly what

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

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

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

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

## **II. Liability Cases & Medicare’s “Future Interests”**

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

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

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

### **A. The MSA in WC Cases – How It Works**

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

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

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

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

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

CMS has established specific MSA “review thresholds” in WC cases defining when it is appropriate to submit a

formal MSA proposal to CMS for review and approval. CMS' current review thresholds *for WC cases* are as follows:

- (1) The claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is greater than \$25,000; or
- (2) The claimant is not a Medicare beneficiary at the time of the settlement but has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the total settlement amount is greater than \$250,000.

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

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

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

As a result, WC primary payers have been left to develop their own approaches and protocols regarding cases falling outside of CMS' official review thresholds (these are commonly referred to as "non-threshold" cases). Most in the industry are of the opinion that inclusion of a MSA is not necessary in every non-threshold case. Nonetheless, it is widely recognized that inclusion of a "non-threshold" MSA may be applicable in certain instances.

Determining exactly when to include a non-threshold MSA involves consideration of many different factors. For example, it has become common to include a non-threshold MSA in cases where Medicare's interests are already implicated at the time of the settlement, or will be in close proximity of the settlement. An example of the former scenario would be a settlement involving a Medicare beneficiary where the total settlement is \$25,000 or less. Examples of the later situation would include cases settling for \$250,000 or less involving a 64 year old claimant who is not yet a Medicare beneficiary, or a claimant who is a SSD beneficiary at the time of the settlement but whose Medicare benefits have not yet commenced.

In the above examples the claimant is either already on Medicare or will become Medicare entitled at a known time in close proximity to the settlement. However, Medicare entitlement is *not* the only factor for consideration. There may very well be other facts and circumstances supporting the inclusion of a non-threshold MSA. The issue should be considered on a case by case basis.<sup>31</sup> Formal approval of a non-threshold MSA by CMS is not required.

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

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

The claimant can only use the MSA account to pay for post settlement medical services and items related to the claim that would otherwise be covered by Medicare. CMS requires annual reporting regarding expenditures issued from the MSA account. A complete examination of the MSA allocation, funding and administration options, as well as CMS' various requirements related thereto, are beyond the scope of this article.<sup>32</sup>

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

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

On the first level, the issue must be measured in relation with the MSP’s *current* statutory and regulatory framework. In this regard, it is important to note that 42 C.F.R. § 411.46 which gave rise to the MSA in WC falls under the WC section of the C.F.R.<sup>33</sup> Furthermore, the actual text of the regulation references “*work related injury or disease*”<sup>34</sup> and “*workers’ compensation benefits.*”<sup>35</sup> In addition, the Patel Memo itself speaks in terms of *WC cases* and actually references 42 C.F.R. § 411.46.

From the author’s review, the MSP does not contain any specific provisions directly addressing *future* medicals in liability cases. Specifically, the liability equivalent of 42 C.F.R. § 411.46 does not seem to exist under the liability provisions of the MSP. The author is unaware of any judicial decisions or other administrative proclamation requiring the establishment of a MSA in the liability context. Furthermore, CMS has not released any memoranda or other written policy proclamation directly on point.<sup>36</sup>

As part of the national discussion on Senate Bill 2499, the author has become aware of a perception in some quarters that the new legislation now “requires” liability MSAs. However, in the author’s opinion Senate Bill 2499 standing alone, from a pure textual standpoint, does *not* “require” MSAs in liability cases. The legislative text does not speak to the issue of future medicals at all. Rather, Senate Bill 2499 addresses the obligations of primary payers to determine a claimant’s Medicare entitlement status and to place Medicare on notice of such entitlement. As such, from a textual standpoint Senate Bill 2499 is not the liability equivalent of 42 C.F.R. § 411.46 – the later of which clearly speaks to the issue of future medicals in WC cases.

Notwithstanding, the author fully recognizes that there is always the possibility that CMS may somehow use Senate Bill 2499 as a “springboard” to issue subsequent directives formally *requiring* MSAs in liability cases. Although from the author’s perspective the actual text of

Senate Bill 2499 would not appear to really provide much “spring” for any such directive given the absence of any specific provisions addressing the issue of future medicals. By way of contrast, 42 C.F.R. § 411.46 placed the issue of future medicals in WC cases on a silver platter for CMS back in 2001.

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

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

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

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

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

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

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

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

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

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

If the decision is made to consider Medicare's future interests as part of the settlement process, the **second step** involves determining exactly which settlements will be implicated. That is, in the absence of CMS guidelines or "thresholds" where and how should liability primary payers draw the lines? On this point, liability primary payers essentially end up in the same boat as their WC

brethren in their dealing with non-threshold cases. Accordingly, it is incumbent upon liability primary payers to develop their own protocols regarding when direct measures will be employed to protect Medicare's future interests as part of a liability settlement – either through a liability MSA or some other arrangement. In this regard, CMS' WC review thresholds may serve as a helpful starting point.

Once internal protocols are set, the **third step** involves addressing certain necessary issues from a practical standpoint. These considerations include: (a) deciding on the exact method to be used to designate future medicals, (b) assuring that the designated funds are used properly by the plaintiff, and (c) addressing issues of responsibility and liability in the event that the plaintiff fails to utilize the funds as designated.<sup>40</sup> In the absence of specific directives and prior precedent, the ultimate approach to be utilized is really a call to be made by each liability primary payer.

In exploring the options, the following may be helpful in developing an actual approach to the issue:<sup>41</sup>

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

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

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

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

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

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

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

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

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

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

**Include settlement language addressing all Medicare related matters**

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

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

**Conclusion**

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

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

**About the Author**

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# SERVICE SPOTLIGHT

**NuQuest/Bridge Pointe** can assist you in meeting your obligations to determine a claimant's Medicare status in workers' compensation, liability and no-fault cases. Additionally, we offer a full spectrum of conditional payment resolution, Medicare set-aside (MSA) and medical cost projection services.

## Liability Conditional Payment Services

Provides tools and expertise to assist parties to a liability settlement with regard to consideration of Medicare's interests concerning injury related Medicare payments made prior to the settlement date. Our services include the following:

- Obtaining necessary releases
- Determination of Medicare and Social Security entitlement status
- Case reporting to the Medicare Coordination of Benefits Contractor (COBC)
- Conditional Payment Inquiry to the Medicare Secondary Payer Recovery Contractor (MSPRC)
- Estimate of Medicare conditional payments
- Review of Medicare's claims and request for removal of inappropriate claims

## Liability MSA or Liability Cost Projection

Provides tools and expertise to assist parties to a liability settlement with regard to consideration of Medicare's interests concerning future anticipated injury related care. Our services include the following:

- Obtaining necessary releases
- Determination of Medicare and Social Security entitlement status
- Case reporting to the Medicare Coordination of Benefits Contractor (COBC),
- Conditional Payment Inquiry to the Medicare Secondary Payer Recovery Contractor (MSPRC)
- Liability MSA allocation or Liability cost projection

For information regarding these and other services provided by NuQuest/Bridge Pointe please contact our office at 866-858-7161, or visit our website, [www.NQBP.com](http://www.NQBP.com).

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## Endnotes

<sup>1</sup> Parasher B. Patel, CMS Memorandum to All Regional Administrators, "Workers' Compensation Commutation of Future Benefits," July 23, 2001.

<sup>2</sup> 42 U.S.C. § 1395y(2)(A).

<sup>3</sup> See, 42 C.F.R. § 411.50.

<sup>4</sup> 42 U.S.C. § 1395y(b)(2)(A)(ii).

<sup>5</sup> 42 U.S.C. § 1395y(b)(2)(B)(i).

<sup>6</sup> Id.

<sup>7</sup> See, 42 C.F.R. § 411.21

<sup>8</sup> 42 U.S.C. § 1395y(b)(2)(B)(ii).

<sup>9</sup> 42 C.F.R. § 411.22 (b)(3).

<sup>10</sup> 42 U.S.C. § 1395y(b)(2)(B)(ii).

<sup>11</sup> 42 C.F.R. § 411.24(c)(i)(ii).

<sup>12</sup> 42 U.S.C. § 1395y (b) (2)(B)(ii), 42 C.F.R. § 411.24 (c)(2).

<sup>13</sup> 42 C.F.R. § 411.37.

<sup>14</sup> 42 U.S.C. § 1395y (b)(2)(B)(ii).

<sup>15</sup> 42 C.F.R. § 411.24(g).

<sup>16</sup> 42 C.F.R. § 411.26.

<sup>17</sup> The author recently provided a detailed overview of the "notice" issue in relation to recent amendments made to the C.F.R. earlier this year. Please see the author's article *Protecting Medicare's Interests for Conditional Payments: The Time Is Now*, NuQuest/Bridge Pointe "Settlement News," March 2008. This article can be obtained by logging onto [www.NQBP.com](http://www.NQBP.com) (select "Resource Library" and then choose "Newsletters").

<sup>18</sup> It should be noted that the requirements regarding group health plans are treated separately under Senate Bill 2499. This article does *not* address the requirements of Senate Bill 2499 in relation to the group health context.

<sup>19</sup> These requirements apply to workers' compensation, liability insurance (including self-insurance), and no-fault insurance and includes "the fiduciary or administrator for such law, plan, or arrangement." See, Senate Bill 2499, Medicare, Medicaid, and SCHIP Extension Act of 2007, Section 111(a)(8)(F).

<sup>20</sup> Senate Bill 2499, Medicare, Medicaid, and SCHIP Extension Act of 2007, Section 111(a)(8)(A)(i).

<sup>21</sup> Id., Section 111(a)(8)(C).

<sup>22</sup> Id., Section 111 (a) (8)(E)(i).

<sup>23</sup> Id., Section 111(a)(8)(B)(ii).

<sup>24</sup> For a detailed analysis of Senate Bill 2499, please see the author's article *Just in Time for the New Year ... New Amendments to the Medicare Secondary Payer Statute*, NuQuest/Bridge Pointe "Settlement News," January 2008. This article can be obtained by logging onto [www.NQBP.com](http://www.NQBP.com) (select "Resource Library" and then choose "Newsletters").

<sup>25</sup> Author's definition.

<sup>26</sup> Parasher B. Patel, CMS Memorandum to All Regional Administrators, "*Workers' Compensation Commutation of Future Benefits*," July 23, 2001.

<sup>27</sup> See, Parasher B. Patel, CMS Memorandum to All Regional Administrators, "*Workers' Compensation Commutation of Future Benefits*," July 23, 2001, p. 4-6; Thomas L. Grissom, CMS Memorandum to All Regional Administrators, "*Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*," April 22, 2003, FAQ Nos. 2 and 17; Gerald Walters, CMS Memorandum to All Regional Administrators, "*Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions*," July 11, 2005, FAQ Nos. 1 and 2; and Gerald Walters, CMS Memorandum to All Regional Administrators, "*Workers' Compensation Medicare Set-Aside Arrangement (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries*," April 25, 2006. Please note that CMS has reserved the right to adjust, modify or even eliminate the review thresholds.

<sup>28</sup> Gerald Walters, CMS Memorandum to All Regional Administrators, "*Workers' Compensation Medicare Set-Aside Arrangement (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries*," April 25, 2006.

<sup>29</sup> Thomas L. Grissom, CMS Memorandum to All Regional Administrators, "*Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*," April 22, 2003, FAQ No. 2.

<sup>30</sup> See, Gerald Walters, CMS Memorandum to All Regional Administrators, "*Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions*," July 11, 2005, FAQ Nos. 1 and 2 and CMS Memorandum to All Regional Administrators, "*Workers' Compensation Medicare Set-Aside Arrangement (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries*," April 25, 2006.

<sup>31</sup> An excellent overview of the whole non-threshold area is addressed by Patty Meifert in her article entitled *MSP Compliance in Settlements NOT Meeting the CMS Review Thresholds: Options for Primary Payers*. This article can be obtained by logging onto [www.NQBP.com](http://www.NQBP.com) (select "Resource Library" and then choose "Articles").

<sup>32</sup> A comprehensive and practical analysis of the MSA process and the various requirements related thereto is contained in an excellent article authored by Patty Meifert entitled "*The Workers' Compensation Medicare Set-Aside Arrangement: Protecting Medicare's Interests*," *The Journal of Legal Nurse Consulting*, Vol. 18, Number 3, Summer 2007.

<sup>33</sup> This section is entitled: *Subpart C: Limitations on Medicare Payment for Services Covered Under Workers' Compensation*.

<sup>34</sup> 42 C.F.R. §411.46(a).

<sup>35</sup> 42 C.F.R. §411.46(d)(2).

<sup>36</sup> The author notes that there is a reference to liability settlements in CMS' memorandum dated April 22, 2003. Thomas L. Grissom, CMS Memorandum to All Regional Administrators, "*Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*," April 22, 2003, FAQ No. 19.

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

<sup>37</sup> Medi-Pro Seminars, LLC, October, 2005, Orlando, Florida. By way of note, a definition of what may constitute a "larger" settlement was never really enunciated to any appreciable degree.

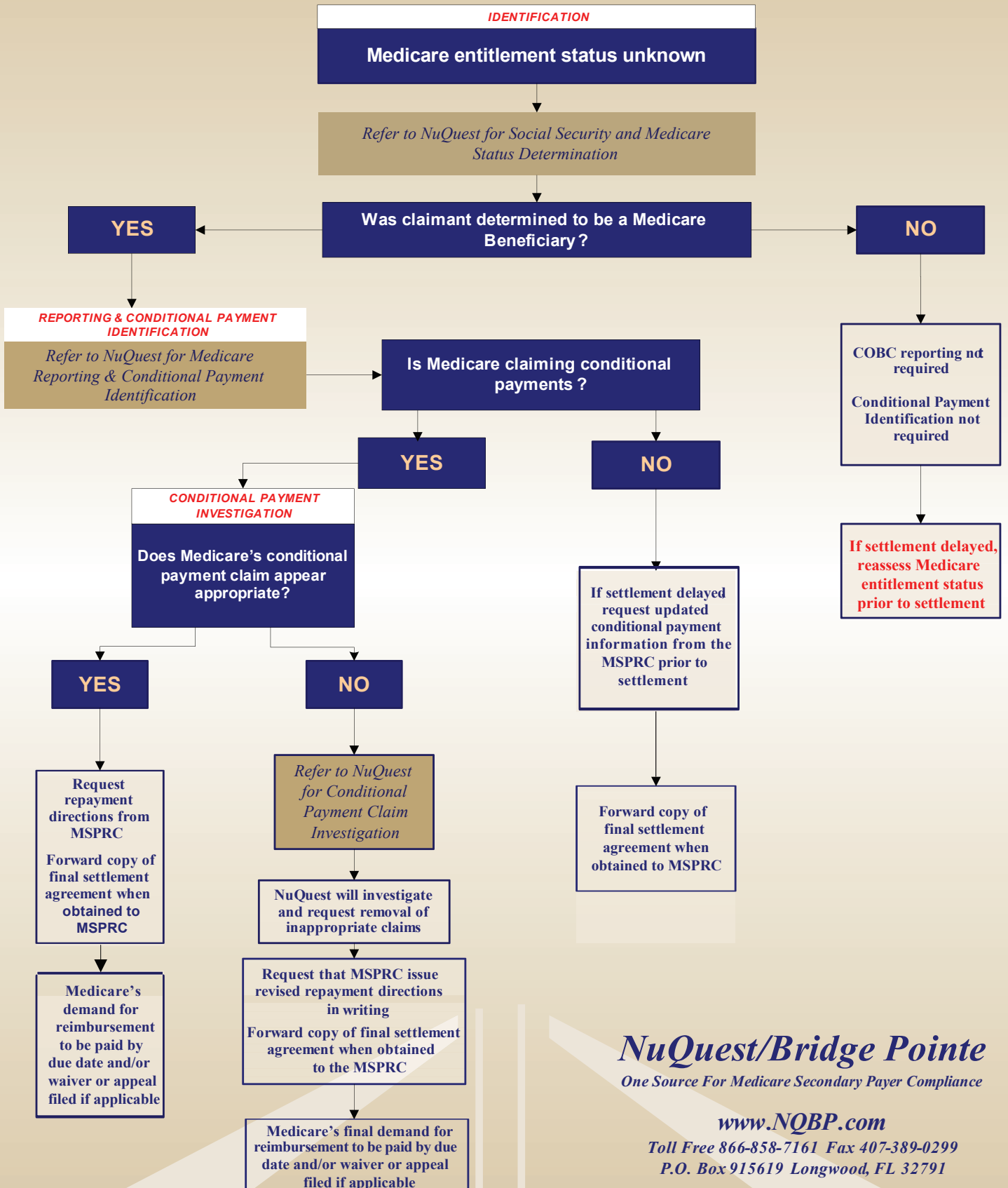
<sup>38</sup> See the article entitled *Considering Medicare's Interests in Liability Cases: Will the Real Expert Please Stand Up*, Patty Meifert & Robert T. Lewis. This article can be obtained by logging onto [www.NQBP.com](http://www.NQBP.com) (select "Resource Library" and then choose "Articles").

<sup>39</sup> Id.

<sup>40</sup> Id. The author wishes to acknowledge that the proposed approach he outlines under "step three" is essentially an adoption in large part of the proposed approach proffered by the credited authors in their prior article, with certain modifications made by the author to take into account his own perspective on the issue and events that have subsequently occurred. The author wishes to note that permission was obtained from the credited authors in this regard.

<sup>41</sup> The author's comments and acknowledgment in footnote 40 are hereby restated.

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