A LITIGATOR'S GUIDE TO MEDICARE SECONDARY PAYER COMPLIANCE

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A NOTE CONCERNING THE PROGRAM MATERIALS

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I. HISTORY OF THE MEDICARE SECONDARY PAYER ACT

A. The Social Security Act of 1965

The Social Security Act of 1965 (Pub. L. 89-97), a key component of President Lyndon B. Johnson's "Great Society" legislative program, created Medicare, a government-sponsored health benefit program.

Medicare was established under Title XVIII of the Social Security Act (42 U.S.C. §1395, *et seq.*) to pay medical expenses for persons who receive Social Security retirement benefits or Social Security disability income. The idea of Medicare is to provide federal health insurance to individuals who lose their health coverage once they stop working because of retirement or disability.

1. Medicare beneficiaries.

Specifically, Medicare provides health insurance for individuals:

a. Age sixty-five and over;

b. Under age sixty-five who are receiving Social Security disability benefits (there is a five month waiting period after an individual is determined to be disabled before they begin to collect Social Security disability benefits (SSDI), and the individual must have received SSDI for twenty-four months to qualify for Medicare); and

c. Of any age who need dialysis or a kidney transplant for treatment of end-stage renal disease ("ESRD") or Amyotropic Lateral Sclerosis ("ALS," also known as Lou Gehrig's disease). People with ESRD and ALS, in contrast to persons with other causes of disability, do not have to collect disability benefits for twenty-four months in order to be eligible for Medicare.

To qualify for Medicare, an individual must have been a legal resident of the United States for at least five years.

2. Medicare parts.

Medicare has four parts.

a. Medicare Part A (hospital insurance).

Part A covers inpatient hospital stays (at least overnight), including critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals. It also covers brief stays for convalescence in skilled nursing facilities (but not custodial or long-term care), hospice, and home health care services.

b. Medicare Part B (medical insurance).

Part B covers medically-necessary physician services and outpatient care, as well as some preventative services to help maintain an individual's health and to keep certain illnesses from getting worse.

c. Medicare Part C (Medicare Advantage Plans).

Part C provides beneficiaries an option to obtain Medicare benefits through private health insurance plans approved and regulated by Medicare. Part C Medicare Advantage Plans include Parts A and B coverage and typically other benefits Medicare does not cover. Most Medicare Advantage Plans also now include Part D prescription drug benefits.

d. Medicare Part D (prescription drug coverage).

Part D covers the cost of prescription drugs. Beneficiaries choose the Part D Prescription Drug Plans in which they wish to enroll, if any. The plans, which vary in costs and drugs covered, are administered by private health insurance companies and can be either Medicare Advantage Plans or separate Medicare Prescription Drug Plans.

B. The Medicare Secondary Payer Act (1980)

On December 5, 1980, after fifteen years of ever-escalating Medicare costs, Congress enacted the Medicare Secondary Payer Act ("MSP Act") as a largely unnoticed part of the Omnibus Reconciliation Act of 1980 (Pub. L. 96-598), a large deficit reduction bill. *See* 42 U.S.C. §1395y, *et seq.* [Section 1862, *et seq*. of the Social Security Act] and 42 C.F.R. Part 411, *et seq*. for the applicable statutory and regulatory provisions.

1. Medicare as primary payer.

With three exceptions, Medicare originally paid a beneficiary's health care cost, even if the beneficiary had private health insurance or someone else was responsible for the beneficiary's injury or illness (*e.g*., a tortfeasor or tortfeasor's liability insurer). *See* Walters v. Leavitt, 376 F.Supp.2d 746, 750 (E.D. Mich. 2005).

The three original situations where Medicare was a secondary payer rather than the primary payer were when the beneficiary:

a. Received benefits from the Federal Black Lung Program;

b. Received workers' compensation benefits; or

c. Received covered heath care services through the Veterans Health Administration.

In those situations, Medicare would only pay for a beneficiary's health care costs after the Black Lung Program, workers' compensation policy or plan, or the Veterans Administration had paid all that it owed.

2. Intent of the MSP Act.

The intent of the MSP Act is to shift the primary burden of Medicare payments from the federal government to private sources of payment whenever possible. *See* U.S. v. Baxter International, Inc., 345 F.3d 866, 875 (11th Cir. 2003) (discussing the historical purpose of the MSP Act). It does this by creating additional situations where Medicare is a secondary payer rather than the primary payer.

3. Medicare as secondary payer.

With the passage of the MSP Act, Medicare is the secondary, rather than primary, payer for medical services whenever payment "has been made or can reasonably be expected to be made" by a primary plan. 42 U.S.C. §1395y(b)(2)(A).

a. Definition of "primary plan."

The MSP Act at 42 U.S.C. §1395y(b)(2)(A) defines a "primary plan" as:

i. A group health plan;

ii. A workmen's compensation law or plan;

iii. A liability insurance policy or plan (including a self-insured plan); or

iv. No fault insurance.

b. Question of self-insureds as primary plans.

Eventually the question arose under the MSP Act as to whether a tortfeasor without a formal self-insurance plan constituted a primary plan. A string of court decisions held that alleged tortfeasors did not constitute primary plans. *See e.g.*, Thompson v. Goetzmann, 315 F.3d 457 (5th Cir. 2002) ("an alleged tortfeasor who settles with a plaintiff is not, *ipso facto,* a 'self-insurer' under the MSP statute"), *reh'g,* 337 F.3d 489 (2003); U.S. v. Philip Morris, Inc., 156 F.Supp.2d 1, 8 (D.D.C.2001) ("neither in its brief nor in its complaint does the Government describe the actual circumstances in which 'a tortfeasor that elects to carry its own risk of liability in a lawsuit rather than to claim against its insurance [would], by that election, make itself subject to an MSP claim'"); In re Orthopedic Bone Screw Prods. Liab. Litig., 202 F.R.D. 154, 163 (E.D.Pa.2001) ("MSP was not meant to encompass alleged tortfeasors who merely fund liability settlements with their own assets or corporate borrowings.").

C. Medicare Prescription Drug, Improvement, and Modernization Act (2003)

Late in 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) ("MMA"). While best known for the new Medicare Prescription Drug Benefit (MMA, §301, 117 Stat. at 2071), MMA also clarified the MSP Act with regard to self-insureds and closed other perceived "loop holes" in the MSP Act.

1. Clarification of self-insureds as primary plans.

MMA added the following definitional sentence to the MSP Act:

> 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.

MMA §301(b)(1); 42 U.S.C. §1395y(b)(2).

The definitional sentence was added to the MSP Act to remedy the effects of "[r]ecent court decisions' that would allow 'firms that self-insure for product liability' to be 'able to avoid paying Medicare for past medical payments related to the claim.'" Brown v. Thompson, 374 F.3d 253, 262 (4th Cir. 2004).

2. Closure of other perceived "loop hole."

Section 301(b)(2) of MMA makes it clear that a primary plan's responsibility to reimburse Medicare may be demonstrated by "a payment conditioned upon the recipient's compromise, waiver or

release (whether or not there is an admission of liability)." 42 U.S.C. §1395y(b)(2)(B)(ii); MMA, §301, 117 Stat. at 2222.

3. MMA amendments of the MSP Act apply retroactively.

In the relevant subsections of MMA, Congress expressly stated that the amendments of the MSP Act were "clarifying" and "technical." *See* MMA §301(a)-(b). As such, Congress provided that these clarifying and technical amendments are effective retroactively from the date of the original MSP Act enactment (*i.e*., December 5, 1980). MMA, §301, 117 Stat. at 2221-22.

D. Medicare, Medicaid, and SCHIP Extension Act (2007)

In December 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") was enacted (Pub. L. 110-173). MMSEA amended the MSP Act to impose new mandatory electronic reporting duties on group health plans that provide coverage to Medicare beneficiaries (42 U.S.C. §1395y(b)(7)), as well as on workers' compensation plans, no-fault insurance, and liability insurance providers (including self-insureds) that pay settlements, judgments, awards, or other payments to Medicare beneficiaries (42 U.S.C. §1395y(b)(8)).

Although there were reporting requirements prior to MMSEA (*see*, *e.g.,* 42 C.F.R.§411.25), Medicare did not have an efficient mechanism to identify situations where its responsibility should have been secondary. The idea behind the MMSEA reporting requirements is to provide Medicare with a national database of information it can use to initiate reimbursement claims and to avoid unnecessary future medical payments.

E. Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012

At the end of 2012, Congress passed the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 ("MIA/SMART Act"). The Act consists of what originally were two separate bills the Medicare IVIG Access Act (H.R. 1845) and the Strengthening Medicare and Repaying Taxpayers Act of 2011 (the "SMART Act") (H.R. 1063). The two bills were combined for passage.

1. Title II of MIA/SMART Act.

The former SMART Act is found in Title II of the combined Act. It amends Title XVIII of the Social Security Act with respect to the application of the Medicare Secondary Payer rules (42 U.S.C. §1395y (b)). The amendments are intended to strengthen and protect Medicare beneficiaries and the Medicare Trust Fund by improving and increasing the efficiency of the Medicare Secondary Payer recovery process.

2. Specific Amendments to MSP Act.

When fully implemented, the MIA/SMART Act amendments will:

a. Allow parties to obtain a final demand amount from Medicare before settlement;

b. Establish a right of appeal and appeal process for applicable plans, including self-insured entities;

c. Establish an annually calculated reimbursement and reporting threshold;

d. Change the $1,000 per day reporting penalty for noncompliance from mandatory to discretionary;

e. Relax use of Social Security and Health Care Identification numbers in reporting claims and settlements to Medicare and in determining a claimant's Medicare status; and

f. Impose a three-year statute of limitations on conditional payment recovery actions by the government.

II. ADMINISTRATION OF MEDICARE

A. The Social Security Administration

The Social Security Administration, an independent agency of the Executive Branch, has the responsibility for determining an individual's Medicare eligibility and for processing premium payments.

B. The Centers for Medicare and Medicaid Services

The Medicare program itself is administered by The Centers for Medicare and Medicaid Services ("CMS"), a component of the Department of Health and Human Services ("DHHS"). CMS is headquartered in Woodlawn, Maryland, and has ten regional offices, which each cover various states.

C. Pertinent CMS Sub-entities

CMS has established two sub-entities – The Coordination of Benefits Contractor and the Medicare Secondary Payer Recovery Contractor – which currently have responsibility for Medicare Secondary Payer issues. At some point in the not too distant future, CMS plans to combine the activities of the two contractors into one new contractor.

1. The Coordination of Benefits Contractor ("COBC").

The COBC is a centralized coordination of benefits operation, which is responsible for the performance of activities that support

the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The CBOC is primarily an information-gathering entity that updates the CMS systems and databases used in the claims payment and recovery processes. The COBC does not process claims or answer claims-specific inquiries, nor does it handle Medicare Secondary Payer ("MSP") recoveries.

2. The Medicare Secondary Payer Recovery Contractor ("MSPRC").

The MSPRC is responsible for the recovery of amounts owed to Medicare as a result of settlements, judgments, awards, or other payments by liability insurance (including self-insurance), no-fault insurance, or workers' compensation. The MSPRC is not directly involved in Medicare's coordination of benefits activities.

3. The Medicare Secondary Payer Business Program Operations Contract.

On September 27, 2012, CMS awarded a Medicare Secondary Payer Business Program Operations Contract to Integriguard LLC, doing business as HMS Federal. According to the contract award notice, this contractor will consolidate the coordination of benefits and Medicare Secondary Payer recovery operations of the COBC and the MSPRC into one entity. CMS hopes that by merging the COBC and the MSPRC, they can provide a single point of contact, improve data and debt collection, and enhance customer service. CMS has not yet announced a timeline as to when the new contractor will take over the combined operations of the COBC and the MSPRC.

III. CONDITIONAL PAYMENT COMPLIANCE

A. Medicare's Authority to Make Conditional Payments

Even when it is a secondary payer, Medicare may make primary payments for medical services if the primary plan (*i.e.*, a group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan, (including a self-insured), or no-fault insurance) did not pay, or cannot reasonably be expected to issue payment, "promptly." 42 U.S.C. §1395y(b)(2)(A)(i).

1. Definition of "promptly."

"Promptly" is defined as within 120 days of the earlier of the date of an insurance claim or the date of medical service. 42 C.F.R. §411.50(b).

2. Medicare’s right of reimbursement.

Primary payments made by Medicare when it is a secondary payer are considered "conditional." Medicare is to be reimbursed its conditional payments when payment by the primary plan "has been or could be made." 42 C.F.R. §411.24(b).

3. Reason for conditional payments.

Conditional payments by Medicare ensure that the beneficiary receives needed medical care while issues with the primary plan are unresolved (*e.g.*, during litigation against a party who allegedly caused the beneficiary's injuries that require medical attention).

B. Required Repayment of Medicare

1. Reimbursement by the beneficiary.

If the beneficiary receives payment from a primary plan pursuant to a settlement, judgment, award, or other payment, the beneficiary must reimburse Medicare for any conditional payments Medicare had made on behalf of the beneficiary. 42 U.S.C. §1395y(b)(2)(B)(ii); 42 C.F.R. §411.24(g).

2. Reimbursement by the primary plan.

If the beneficiary does not reimburse Medicare, the primary plan must reimburse Medicare for any conditional payments if "it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." 42 U.S.C. §1395y(b)(2)(B)(ii).

If it is so demonstrated, the primary plan must reimburse Medicare "even though it has already reimbursed the beneficiary." 42 C.F.R. §411.24(i).

a. Demonstrated responsibility.

A primary plan's responsibility for such a payment "may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release . . . of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means." *Id.*; 42 C.F.R. §411.22. Other means includes a settlement, award, or contractual obligation. *Id*.

b. No finding or admission of liability needed.

A judgment, settlement, waiver or release will be determinative of a primary plan's responsibility to repay a conditional payment whether or not it includes a

determination or admission of liability. 42 U.S.C. §1395y(b)(2)(B)(ii).

C. Recovery by Medicare of Conditional Payments

If Medicare is not reimbursed in full for its conditional payments it has various choices on how to proceed to recoup its conditional payments.

1. It may recover from benefits owed by HHS to beneficiary.

Medicare may decide to recover the owed amount (including accrued interest) from:

a. Any Social Security benefits the beneficiary or other party might otherwise be entitled;

b. Railroad Retirement benefits the beneficiary or other party might otherwise be entitled; and/or

c. From future Medicare payments the beneficiary might otherwise be entitled.

2. It may refer collection matter to the Treasury Department.

Medicare may refer the collection matter to the Department of the Treasury for other collection actions.

a. The Debt Collection Improvement Act of 1996 ("DCIA") requires federal agencies to refer debts to the Department of the Treasury for recovery actions, including collection by offset against any monies otherwise payable to debtor by any federal agency.

b. Under the DCIA and other statutes (31 U.S.C. §3720A), the Internal Revenue Service may collect MSP Act repayment debts by offsetting against tax refunds owed to responsible individual or entity.

3. It may refer collection matter to the Justice Department.

Medicare may refer the collection matter to the Department of Justice for legal action.

a. Justice may sue entities responsible for making payment.

In order to recover conditional payments for Medicare, the United States may bring an independent enforcement action against any or all entities that are or were required to pay the medical expense under a primary plan. 42 U.S.C. §1395y(b)(2)(B)(iii).

- Double damages are recoverable from primary plan

  If it is necessary for Medicare to take legal action to recover its conditional payments from a primary plan, Medicare may recover double damages, on top of any payment the primary plan has already made to the beneficiary. *Id.*; 42 C.F.R. §411.24(i)(1).

b. Justice may sue entities that received payment from a primary plan.

   The United States also is authorized to bring recovery actions on behalf of Medicare against "any other entity that has received payment from a primary plan," including any "beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." 42 U.S.C. §1395y(b)(2)(B)(iii); 42 C.F.R. §411.24(g).

   - Recovery is lesser of conditional payment and amount received from primary plan

     In an action against the recipient of a primary payment, Medicare may recover the lesser of the conditional payment made by Medicare and the amount of the primary payment received by the recipient. 42 C.F.R. §411.24(c).

c. Medicare has both a subrogation claim and a statutory direct cause of action.

   Medicare has both a subrogation claim and a separate statutory direct cause of action to collect funds from any entity that is required to reimburse Medicare. *See* 42 U.S.C. §1395y(b)(2)(B)(iii) and (iv); and 1395y(b)(2)(C). *See also* 42 U.S.C. §2651 to §2653 (Medical Care Recovery Act).

   i. Statutory cause of action is paramount.

      Medicare's recovery right takes precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to the rights of other entities because Medicare’s direct right of recovery is explicitly prescribed in federal law and other entities’ recovery rights are based on either state law or subrogation rights.

ii. Subrogation claim is normal.

If Medicare exercises its subrogation rights, Medicare is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the alleged tortfeasor (and the alleged tortfeasor's liability insurance).

IV. PROTECTING MEDICARE'S FUTURE INTERESTS

A. Consideration of Future Medical Expenses

The duty to protect Medicare's interests when engaging in the resolution or settlement of a personal injury claim includes taking into consideration future medical expenses if the claimant is enrolled in the Medicare program, is eligible for enrollment in the program, or has a reasonable expectation of being eligible for enrollment in the program.

The argument goes that Medicare is prohibited from covering any future injury-related medical expenses if the settlement included compensation for those expenses, and in that situation retains its status as "secondary payer" after the claimant's liability claim is settled. That "secondary payer" status continues until the future medical services for which payment was made from the settlement have been provided to the claimant and paid for by the claimant out of his or her settlement proceeds.

If a beneficiary's treating physician certifies in writing that no future medical treatment is required, Medicare will consider its future interest satisfied.

1. Absence of statutory authority on allocation of settlements for future medical expenses.

There is no statutory authority to determine what portion of a settlement represents payment for future medical expenses absent an allocation in the settlement itself. Nor is Medicare bound by an allocation for future medical expenses made by the parties in a settlement agreement. Medicare may disregard any allocation and make its own calculation as to the cost of future medicals.

a. Medicare will not accept any settlement that results in a contrived shift to Medicare of responsibilities for a claimant's future medical care.

b. The fact that a settlement does not specify payment for future medical services does not mean that they are not funded.

c. The risk is that if a fair amount is not allocated to future medicals, Medicare will not pay a beneficiary's future medical expenses related to the settled claim.

2. Medicare Set Aside Arrangements

One way to protect Medicare's interests regarding future medical claims is to use a Medicare Set Aside Arrangement (MSA). A MSA is an agreed amount of settlement funds "set-aside" in order to pay for future expenses where Medicare is a secondary payer. Neither the MSP Act nor the regulations mandate MSAs, but CMS has indicated that MSAs are a favored way of protecting Medicare's future interests.

a. Process in place to approve certain workers' compensation MSAs.

Upon request, Medicare Regional Offices will review and approve the adequacy of a workers' compensation settlement that includes a MSA if the settlement:

i. Exceeds $25,000 and the claimant is currently eligible for Medicare or

ii. Is for more than $250,000 and the claimant can reasonably be expected to become eligible for Medicare within thirty months.

The $25,000 and $250,000 settlement amounts are benchmarks with regard to submitting workers' compensation MSA documentation to Medicare for review. Medicare maintains that its interest still must be considered for all workers' compensation settlements of all amounts.

Once approved, Medicare will not pay any medical expenses for the beneficiary's injury until the set-aside amount is exhausted.

b. No process in place for MSAs in liability cases.

At present, there are no national guidelines for approval of liability MSAs. It is up to the Regional Offices of CMS to review proposed liability MSAs on a discretionary basis.

3. Advance notice of proposed rulemaking for liability cases.

On June 15, 2012, CMS published an advance notice of proposed rulemaking to solicit comments on seven options Medicare is considering making available for protecting Medicare's future interests in liability cases. August 14, 2012, was the deadline for

comments. No timeline has been announced for when Medicare may issue any rules.

V. STEPS FOR MEDICARE SECONDARY PAYER COMPLIANCE

A. Step 1: Determine if Claimant Is a Medicare Beneficiary

It is best to begin investigating a person's Medicare status as soon as a claim/suit becomes known. Most Medicare beneficiaries are at least age sixty-five, but it must be remembered that an individual of almost any age may be enrolled in the Medicare program.

1. If represent claimant/plaintiff.

a. Ask client about Medicare status.

At the beginning of your representation, you should ask the client if they:

i. Have been receiving Medicare benefits;

ii. Have been receiving Social Security Disability or have applied for or are currently appealing the denial of Social Security Disability; or

iii. Have a reasonable expectation of receiving Medicare benefits within the next thirty months.

A reasonable expectation includes where the client:

(a) Is sixty-two and one half years of age or older;

(b) Is currently receiving Social Security Disability benefits (SSD);

(c) Has applied for SSD benefits; or

(d) Has been denied SSD benefits, but anticipates appealing that decision.

b. Copy client’s Medicare Card if he/she is a Medicare beneficiary.

When an eligible individual enrolls in Medicare, he/she is issued a Medicare Card, which includes the beneficiary’s "Medicare Claim Number," also known as "HICN", and the effective dates of the beneficiary’s Medicare coverages. If the client is a Medicare beneficiary, you should make a copy of the front and back of their Medicare Card for the file.

c. Inform client about duties and risks if he/she is a Medicare beneficiary.

It also is a very good idea to explain early on to a client who is a Medicare beneficiary that:

i. He/she is responsible for reimbursing Medicare's conditional payments out of any settlement or judgment;

ii. If Medicare is not reimbursed, he/she remains liable for the amount of the conditional payments;

iii. Medicare can collect the recovery claim through a collection action or deductions from the client's

(a) Social Security benefits,

(b) Railroad Retirement benefits,

(c) Tax refunds, or

(d) Other U.S. Treasury payments to which he/she is entitled; and

iv. He/she risks termination of future Medicare benefits if he/she fails to protect Medicare as a secondary payer.

d. Document discussions with client about MSP duties and risks.

Given the risks of non-compliance with the Medicare Secondary Payer Act, it is important to make sure that the client is aware of them, and you will want to document that awareness in the file. The best way to document that you have made the client aware of the risks of non-compliance with the Medicare Secondary Payer Act is to provide the client with a letter setting forth the risks of non-compliance and have the client sign a copy of the letter as an acknowledgment of their receipt and review of the letter.

e. Document client's representations that he/she is not a Medicare beneficiary.

If the client tells you that he/she is not a Medicare beneficiary, has not pursued Social Security disability benefits, and does not have a reasonable expectation of receiving Medicare benefits within the next thirty months, you should document those representations in the file. The strongest way to document the representations is to have the client

sign a statement that he/she is not a Medicare beneficiary and does not have a reasonable expectation of becoming one in the next thirty months.

f. Obtain executed Social Security Consent to Release Form from claimant/plaintiff.

Just because a client says that they are not a Medicare beneficiary does not mean that they are not a Medicare beneficiary. Sometimes people just get the facts wrong. One way to check on the Medicare status of a client is to have them execute a Social Security Consent to Release Form (SSA 3288). This form authorizes the Social Security Administration to provide the claimant/plaintiff's SSD status and entitlement dates for Medicare, SSD benefits, or any other Social Security benefits. A sample Social Security Consent to Release Form can be found at www.ssa.gov/online/ssa-3288.pdf.

g. Recheck claimant/plaintiff's Medicare status.

Claimant/plaintiff's Medicare beneficiary status may change during course of their claim/suit; so you should repeatedly verify their Medicare status, particularly at settlement time.

2. If represent defendant.

a. Serve written discovery concerning plaintiff's Medicare status.

For claims in litigation, you should serve written discovery (interrogatories asking about status, etc. and document requests asking for Medicare Card, etc.). In addition to asking whether the plaintiff is entitled to Medicare benefits and the date on which the plaintiff first became entitled to receive such benefits, you should seek in discovery the plaintiff's full first and last name, date of birth, gender, and HICN or Social Security Number (SSN). Your document requests should include requests instructing the plaintiff to produce copies of any and all correspondence they have had with Medicare, including copies of any conditional payment documents, etc.

In federal cases, you should try to ask the court to grant permission for you to issue the interrogatories addressing the Medicare status of the plaintiff as "special interrogatories" that do not count against the limited number of interrogatories permitted under Rule 33 of the Federal Rules of Civil Procedure.

b. Use of case management and scheduling orders.

Another way to try to obtain the needed information concerning the plaintiff's Medicare status is to request that the court issue a case management order (CMO) and/or scheduling order that requires the provision of the information. Some courts involved in mass tort litigation, specifically asbestos litigation, already have such orders in place. As a practical matter, defense counsel retained by insurance companies should not institute, negotiate, or approve Medicare CMOs without involving and obtaining approval from the insurance carrier.

c. Use questionnaire for claims where suit has not been filed.

For claims where a suit has not been filed, you should consider giving the claimant a questionnaire asking the claimant to provide their HICN, state whether they have ever applied for Medicare or SSD benefits, disclose any diagnosis for End-Stage Renal Disease or ALS, and the other items you would include in formal discovery.

d. Request executed Social Security Consent to Release Form from claimant/plaintiff.

In addition to serving written discovery or using a claimant questionnaire, you should request the claimant/plaintiff to complete a Social Security Consent to Release Form (SSA 3288). This form authorizes the Social Security Administration to provide the claimant/ plaintiff's SSD status and entitlement dates for Medicare, SSD benefits, or any other Social Security benefits. A sample Social Security Consent to Release Form (SSA 3288) can be found at www.ssa.gov/online/ssa-3288.pdf.

e. Use the COBC's Electronic Query Process System.

A claimant/plaintiff's Medicare beneficiary status can also be confirmed by submitting an electronic query to the COBC. Only a RRE (or its registered Section 111 reporting agent) is permitted access to the Query Process system. Thus, you would have to rely upon either the defendant, if an RRE, or defendant's insurer to submit an electronic query. In order to make a query, the claimant/plaintiff's SSN or HICN, birth date, and gender are required. If the query identifies the claimant/plaintiff as a Medicare beneficiary, a response is returned indicating that the claimant/plaintiff was "matched" to a beneficiary in CMS' database. Because of privacy concerns, the system does not provide the actual date of Medicare entitlement and

enrollment, or the basis of the claimant/plaintiff's entitlement.

f. Have discussions with opposing counsel about MSP compliance.

If it is determined that the claimant/plaintiff is a Medicare beneficiary or likely to become one, you should have discussions early on with claimant/plaintiff's counsel about the need to comply with MSP reimbursement and reporting requirements. The sooner you start a dialogue on MSP issues, the less likely they are to cause delay and problems with resolution of the claim/suit.

***Note*:** Claimant/plaintiff's Medicare beneficiary status may change during course of their claim/suit; so you should repeatedly verify their Medicare status.

You also need to check on the Medicare status of other claimants/plaintiffs beyond the principal "injured party" (*e.g.*, a loss of consortium claimant/plaintiff) because their claim may also trigger compliance issues.

B. Step 2: Report Claim to the COBC

If the claimant/plaintiff is a Medicare beneficiary, the claim/suit should be reported immediately to the COBC.

1. If represent claimant/plaintiff.

You should report the claim/suit to the COBC. The reporting may be done via phone (1-800-999-1118, Monday-Friday 8a.m.-8p.m. (ET)) or mail (MEDICARE – Coordination of Benefits, P.O. Box 33847, Detroit, MI 48232-5847). You should be prepared to provide the following information to the COBC when reporting the claim/suit:

a. Beneficiary information.

i. Beneficiary's name.

ii. Beneficiary's HICN.

iii. Beneficiary's gender and date of birth.

iv. Beneficiary's address and phone number.

b. Case information.

i. Date of injury/accident, date of first exposure, ingestion or, implant.

ii. Description of alleged injury or illness or harm.

iii. Type of claim (liability insurance, no-fault insurance, worker's compensation).

iv. Name and address of insurer/worker's compensation plan.

c. Beneficiary's representative information.

i. Your name as the beneficiary's representative/ attorney.

ii. The law firm's name.

iii. Your address and phone number.

2. If represent defendant.

Traditionally, reporting is done by claimant/plaintiff's counsel, but any party to claim can report a claim/suit to the COBC, and you should report the claim/suit if it has not been reported by claimant/plaintiff's counsel. See above for reporting details.

C. Step 3: Submit Authorization(s) to the MSPRC

Medicare does not release information from a beneficiary's records without appropriate authorization to do so.

1. If represent claimant/plaintiff.

- Submit a Proof of Representation authorization.

  You should submit to the MSPRC a "Proof of Representation" authorization executed by claimant. Model "Proof of Representation" language can be found at www.msprc.info/forms/ProofofRepresentation.pdf.

  A "Proof of Representation" authorization informs Medicare that the beneficiary (the claimant/plaintiff) has given another individual or entity (such as an attorney) the authority to represent them and act on their behalf with respect to their claim/suit. An individual or entity who has had their "Proof of Representation" verified by Medicare will be able to receive or submit information/requests on behalf of the beneficiary, including responding to requests from the MSPRC, receiving copies of all mail related to the case (*e.g.*, the Rights and Responsibilities letter, the Conditional Payment Letter, the Final Demand letter, etc.), and filing an appeal (if appropriate).

2. If represent defendant.

- Submit a Consent to Release authorization

  You should submit to the MSPRC a "Consent to Release" authorization executed by claimant. Model "Consent to Release" language can be found at www.msprc.info/forms/ConsenttoRelease.pdf.

  A submitted "Consent to Release" notifies Medicare that a beneficiary has given another individual or entity authority to receive information related to the beneficiary's injury and/or illness for a limited period of time. A "Consent to Release" does not authorize the individual/entity to act on behalf of the beneficiary. Once a submitted "Consent to Release" has been verified by Medicare, the individual or entity will be able to receive copies of all mail sent by Medicare related to the case (*e.g.*, the Rights and Responsibilities letter, the Conditional Payment Letter, the Final Demand letter, etc.).

  ***Note*:** "Proof of Representation" and "Consent to Release" authorizations can be faxed (405-869-3309), mailed (MSPRC – NGHP, P.O. Box 138832, Oklahoma City, OK 73113), or submitted to the MSPRC through the Medicare Secondary Payer Recovery Portal (MSPRP). One must first go through a multi-step registration process to utilize the MSPRP. For registration see https://www.cob.cms.hhs.gov/MSPRP/.

D. Step 4: Receive and Review "Rights and Responsibilities Letter"

Within two weeks of reporting claim/suit to the COBC, the MSPRC will issue a "Rights and Responsibilities Letter" directed to the beneficiary. The "Rights and Responsibilities Letter" sets forth the:

- Beneficiary's name;
- Beneficiary's Medicare number;
- Case identification number;
- Insurer claim number;
- Insurer policy number; and
- Date of incident.

It also provides information on the following:

- What happens when a Medicare beneficiary files an insurance or workers' compensation claim;
- What information the MSPRC needs from the plaintiff/claimant;
- What information the plaintiff/claimant can expect from MSPRC and when;
- How and when the plaintiff/claimant is able to elect a fixed percentage option for repayment; and
- How to contact the MSPRC.

A link to a sample "Rights and Responsibilities Letter" can be found at www.msprc.info/.

1. If represent claimant/plaintiff.

   You should ask the client for copy of "Rights and Responsibilities Letter" if you have not directly received the letter from the MSPRC. It is helpful to have a copy of the Rights and Responsibilities Letter because it contains the Case Identification Number employed by Medicare.

2. If represent defendant.

   You will be sent a copy of the "Rights and Responsibilities Letter" if you submitted an executed "Consent to Release" authorization that has been verified by Medicare. If you have not yet submitted a "Consent to Release" or your submitted "Consent to Release" has not yet been verified by Medicare, you should request a copy of the "Rights and Responsibilities Letter" from claimant/plaintiff's counsel. You will want to have a copy of the Rights and Responsibilities Letter because it contains the Case Identification Number employed by Medicare.

E. Step 5: Identify Conditional Payments Made by Medicare

Under current practice, Medicare will send a Conditional Payment Letter (CPL) to all authorized parties approximately sixty-five days after the Rights and Responsibilities Letter. The CPL will identify the payments Medicare considers conditional and subject to repayment by the defendant. The stated conditional payment amount is a preliminary reimbursement amount. Medicare's final calculation of the amount it is owed could be more or less than the amount set forth in the CPL. A link to a sample CPL can be found at www.msprc.info/.

Enclosed with a "Conditional Payment Letter" is a Payment Summary Form or itemization. The itemization indicates how much Medicare has

paid to-date for injury-related expenses. The itemization usually separates the claims into Medicare Part A and Part B payments and indicates the provider name, diagnosis codes, dates of service, total charges and conditional payments. Medicare Part D prescription expenses may also be included in the itemization of conditional payments.

1. If represent claimant/plaintiff.

    a. Review payment summary form.

        You should review all of the itemizations on the Payment Summary Form for accuracy. Particular attention must be paid to the diagnosis codes to confirm that they are related to the claimant/plaintiff's alleged injury. More often than not, you can find unrelated codes. The goal is to make sure that unrelated costs are not included and that related costs are not missing. If you are unsure if a treatment or service is related, you can check the diagnosis codes at www.icd9data.com. Depending on the volume and complexity of the itemized payments, it may be prudent to retain a specialist lien resolution firm such as Garretson Resolution Group or Gould & Lamb to review the Payment Summary Form.

    b. Dispute unrelated treatments or services.

        If you believe that any of the itemized treatments or services should be removed from Medicare's conditional payment amount, you will need to inform the MSPRC. The easiest way to do that is to send the MSPRC a letter contending that certain treatments or services are unrelated to the beneficiary's claim/suit along with a copy of the itemization with the unrelated treatments or services lined out. A dispute of payments also can be made online through the MSPRP. The MSPRC may not agree with a challenge, particularly if the diagnosis codes are the same or similar to the injuries claimed in the claim/suit. If the MSPRC does not agree, you will need to submit to the MSPRC medical records or other documents that support the contention that the treatments or services are unrelated to the client's claim/suit. The burden is on you and your client to satisfy the MSPRC. While it does take time and effort to review and dispute the conditional payment amount, the reductions achieved can be significant.

    c. Consider self-calculated conditional payment option.

        At this point, before resolution of the claim or suit, claimant/plaintiff may elect the self-calculated conditional payment option for physical trauma based injury where the liability settlement, judgment, award, or other payment is

expected to be and ultimately is $25,000 or less and claimant/plaintiff's treatment has been completed and no further treatment is expected. Go to www.msprc.info/ for a detailed discussion of the self-calculated conditional payment option.

2. If represent defendant.

   a. Review payment summary form.

      Although currently only the beneficiary may directly dispute Medicare's conditional payment amount, you also should review the itemized treatments and services on the Payment Summary Form for accuracy. Having an accurate conditional payment amount may better facilitate resolution of the claim/suit and lessen compliance difficulties, which are in the defendant's best interests.

   b. Discuss unrelated treatments or services with opposing counsel.

      If you believe that any treatments or services are unrelated to the claimant/plaintiff's claim/suit, you should discuss them with the claimant/plaintiff's counsel.

      ***Note*:** If significant time has passed since receipt of initial CPL, the parties should obtain an updated CPL. Up-to-date conditional payment amounts can be accessed by the beneficiary on the MyMedicare.gov website (plaintiff/ claimant's counsel will need to gain access through his or her client) and by registered parties through the MSPRP. It is also possible to request an update CPL through the MSPRP.

      There also is a Self-Service Information feature on the MSPRC's Customer Service Line, 1-866-677-7220. This feature gives callers the ability to obtain the most up-to-date "Conditional Payment" and "Final Demand" letters, as well as the dates those letters were issued, without having to speak with a Customer Service Representative. This feature is available twenty-four hours a day, seven days a week, with no wait time. Callers will need the following information to utilize the feature:

      - Case identification number (found on all MSPRC correspondence);
      - Beneficiary's date of birth;
      - First five letters of the beneficiary's last name as it appears on his/her Medicare card; and

- Last four digits of the beneficiary's Social Security number (or full Medicare number).

F. Step 6: Resolve Claimant/Plaintiff's Claim/Suit

Eventually, the claim/suit will need to be resolved. Most claims/suits are resolved by a settlement. Some suits, however, are resolved though a trial. Depending on whether the resolution is by settlement or trial, different considerations will apply.

1. Settlement.

a. If represent claimant/plaintiff.

i. Address and agree upon procedure for reimbursing Medicare.

In settlement talks, you should explicitly address and agree upon a procedure for reimbursing Medicare's conditional payments. That procedure (*i.e*., who, how, and when reimbursement will be made) should be included in the settlement agreement.

- Fixed Percentage Payment Option

Upon settlement for $5,000 or less of a claim or suit for a physical trauma injury, the client may choose to resolve Medicare's conditional payment recovery claim by paying a flat 25 percent of the total liability settlement instead of using the current, traditional recovery process. Under the Fixed Percentage Option, neither the Medicare conditional payment amount nor the client's procurement costs impacts the amount due Medicare. You should document in the claim/suit file your discussion with the client about the option and the decision to use or not the option. For a detailed discussion of the fixed percentage payment option, go to www.msprc.info/.

ii. Consider protection of Medicare's future interests.

You also should agree on the need or not for a Medicare Set Aside or other arrangement to address future medical expenses for your client's injury or illness (*NB,* not all medical expenses are covered by Medicare, you only need to consider future medical expenses that may be covered by

Medicare). Third-party consultants can be a help with Medicare Set Asides.

(a) Include in settlement agreement a specific statement of the amount of the settlement allocated for future medical expenses related to client's injury or a statement that no amount is allocated for future medical expenses.

(b) Ensure that the client is equipped to comply with a Medicare Set Aside or other future medical expense arrangement, if one is chosen.

b. If represent defendant.

i. Propose procedure for reimbursing Medicare.

In making a settlement offer, you should explicitly propose a procedure for reimbursing Medicare, including making reimbursement of Medicare an express condition of settlement. One option is to require claimant/plaintiff's counsel to deposit into his or her client trust account a sufficient portion of the settlement proceeds to pay Medicare's claim before the remaining funds are distributed to the claimant/plaintiff. Another option would be for the defendant or defendant's insurer to directly pay Medicare out of the settlement proceeds. If there is insurance for the claim/suit, you also will want to confer with your client's insurer on its preferred reimbursement approach before starting settlement negotiations.

ii. Propose other MSP compliance terms.

You also should include Medicare Secondary Payer-specific terms in your settlement offer, such as:

(a) Agreement that claimant/plaintiff will report settlement to the MSPRC;

(b) Confidentiality provision that permits mandatory electronic reporting of settlement amount to the COBC by the defendant and/or defendant's insurer;

(c) Agreement that claimant/plaintiff will indemnify/hold harmless defendant and/or

defendant's insurer for any reimbursement claims by Medicare;

(d) Waiver by claimant/plaintiff of private cause of action against defendant and/or defendant's insurer under the Medicare Secondary Payer Act; and

(e) Proper release language (*NB,* a release of medicals where none have been alleged can trigger a reporting obligation under MMSEA).

If a reimbursement procedure and other compliance terms are not agreed to as a part of settlement negotiations, it can be very hard for a defendant to add the procedure and terms later as a part of the settlement agreement drafting process. So it is important to include whatever reimbursement procedure and other compliance terms are wanted in the settlement offer.

iii. Consider protection of Medicare's future interests.

You will need to consider protection of Medicare's future interests and agree on the need or not for a Medicare Set Aside or other arrangement to address future medical expenses for claimant/plaintiff's injury.

iv. Document reimbursement procedure and compliance terms in settlement agreement.

Include in the written settlement agreement a specific description of the agreed upon process for Medicare reimbursement (*i.e*., who, how, and when reimbursement will be made) and all of the other Medicare Secondary Payer-specific terms agreed to as a part of the settlement negotiations, including a specific statement of the amount of the settlement allocated for future medical expenses related to claimant/plaintiff's injury or a statement that no amount is allocated for future medical expenses.

2. Trial.

a. If represent claimant/plaintiff.

i. Medicare recognizes allocations by court order on the merits.

Generally, Medicare seeks recovery of conditional payments from liability settlements or awards without regard to how the settlement or award allocates the payment/damages between medical and non-medical expenses. However, if the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the designation and not seek recovery from portions of the court award that are designated as payment for losses other than medical services.

ii. Use jury instructions/special verdict form.

If a case goes to trial, jury instructions/special verdict form should be used to allocate any damages awarded plaintiff between medical and non-medical damages and any medical damages between past and future amounts.

b. If represent defendant.

See above.

G. Step 7: Report Settlement/Judgment

Once there is a resolution of a claim/suit involving a Medicare beneficiary, the settlement, judgment, award, or other payment needs to be reported to the MSPRC.

1. If represent claimant/plaintiff.

You should report the resolution of the claim/suit using the MSPRC's Final Settlement Detail Document (www.msprc.info/forms/Final_Settlement_Detail.pdf). The information to be reported is:

- Date of settlement, judgment, award, or other payment;
- Settlement/judgment/award/other payment amount;
- Attorney's Fees (borne by the beneficiary); and
- Other procurement costs borne by the beneficiary (itemized).

The information can be mailed to the MSPRC at the address found on the Final Settlement Detail Document or uploaded onto the MSPRP.

- Procurement costs reduction

  Where a resolved matter was in dispute, the MSPRC takes attorney fees and other procurement costs borne by the beneficiary into account when computing a demand amount (*see* 42 C.F.R. §411.37). The only costs that may be included in the procurement cost are those the beneficiary incurred to obtain the settlement, judgment, award, or other payment.

  i. Medicare payments are less than judgment or settlement amount.

     When Medicare payments are less than the judgment or settlement amount, Medicare's recovery amount is reduced by the ratio of procurement costs to the total settlement or judgment. 42 C.F.R. §411.37(c).

  ii. Medicare recovery equals or exceeds judgment or settlement amount.

     When Medicare's recovery amount is equal to or exceeds the judgment or settlement amount, Medicare's recovery is the entire settlement or judgment less total procurement costs. 42 C.F.R. §411.37(d).

  iii. Procurement costs exceed judgment or settlement amount.

     If the procurement costs exceed the amount of the settlement, judgment, award or other payment, Medicare will not seek a refund if the settlement, judgment, award or other payment is $5,000 or less.

  iv. Medicare brings suit for reimbursement.

     If Medicare must bring suit in order to obtain reimbursement from the beneficiary, the procurement cost reduction is eliminated.

2. If represent defendant.

   You should confirm with claimant/plaintiff's counsel that he/she has made the required reporting of the resolution of the claim/suit to the MSPRC. You also should determine if your client and/or your client's insurer is a Responsible Reporting Entity (RRE) under Section 111, and, if so, assist your client and/or your client's insurer in making the mandatory electronic reporting of settlement,

judgment, award, or other payment if it meets current threshold and timeline.

H. Step 8: Receive and Review Final Demand Letter

Within forty-five days of receiving notice of settlement, judgment, award, or other payment, the MSPRC will issue a Final Demand Letter, which includes the amount owed to Medicare in reimbursement of Medicare's conditional payments. Generally, Medicare reduces the amount a beneficiary is required to repay to take into account the costs (such as attorney's fees) paid by the beneficiary to obtain his or her liability recovery. The Final Demand Letter also includes:

- An explanation of why the beneficiary needs to repay Medicare and the way Medicare determined the amount the beneficiary is required to repay;
- Instructions for repaying Medicare if the beneficiary agrees that Medicare made conditional payments and accepts the amount Medicare has determined the beneficiary owes in reimbursement;
- Instructions for requesting waiver of recovery (for the full or a part of the amount of the demand) or appeal (if the beneficiary disagrees that conditional payments exists or with the amount Medicare has determined the beneficiary owes);
- Interest charges that apply if the beneficiary does not repay Medicare within sixty days from the date of the letter and certain actions Medicare may decide to take if the beneficiary fails to repay the amount owed; and
- A list of the payments Medicare made related to the beneficiary's liability recovery.

A link to a sample Final Demand Letter can be found at www.msprc.info/.

1. If represent claimant/plaintiff.

   As with the CPL, you should review the Final Demand Letter to confirm that only case related medical costs are included in amount demanded by Medicare. If you believe that any of the itemized treatments or services should be removed from Medicare's final payment amount, you will need to appeal Medicare's determination.

2. If represent defendant.

   Although currently only the beneficiary may directly dispute Medicare's conditional payment amount, you also should review the Final Demand Letter for accuracy. If you believe that any treatments or services making up the Final Demand amount are

unrelated to the claimant/plaintiff's claim/suit, you should discuss them with the claimant/plaintiff's counsel.

3. Upcoming MIA/SMART Act changes.

Under present practice, Medicare does not issue a final demand for reimbursement of the conditional payments until after there is a settlement, judgment, award, or other payment resolving the Medicare beneficiary's liability claim against the party allegedly responsible for his or her injuries that prompted Medicare's payments. The uncertainty over the final amount of Medicare's claim for reimbursement can hamper settlement of claims involving Medicare beneficiaries.

a. Accessing conditional payment information via a website.

Section 201 of the MIA/SMART Act redresses this problem by calling for a new password protected website from which a final conditional payment amount (including provider or supplier names, diagnosis codes (if any), dates of service, and conditional payment amounts) can be downloaded before resolution of beneficiaries liability claim.

b. Providing Medicare notice of expected date of settlement, judgment, etc.

The Act charges Medicare with promulgating final regulations to carry out the new website-related provisions within nine months after the date of its enactment, *i.e*., by October 10, 2013 (President Obama signed the MIA/SMART Act into law on January 10, 2013). Once the new regulations and process becomes effective, a Medicare beneficiary/claimant or primary payer may, any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify Medicare that a payment is reasonably expected and the expected date of the payment. Medicare then will have a response period of sixty-five days (which Medicare can extend another thirty days if it determines that additional time is required to address payments) in which to post conditional payments on the website.

c. Using website download as final conditional payment amount.

A Medicare beneficiary/claimant and/or primary payer also may download a statement of conditional payments made by Medicare relating to a potential settlement, judgment, award, or other payment. A downloaded statement (referred to in the Act as a "statement of reimbursement

amount") will constitute the final conditional payment amount recoverable by Medicare if the following conditions are met:

- The statement was downloaded during the "protected period," which is the period after Medicare's response period (the sixty-five-day or ninety-five-day period) up to the notified date of the expected resolution of the dispute or lawsuit;

- The settlement, judgment, award, or other payment occurs within the protected period;

- The statement was downloaded within three business days of the settlement, judgment, award, or other payment; and

- The statement was the last statement downloaded from the website.

d. Establishing a reimbursement and reporting threshold.

Currently, regardless of how small a settlement, judgment, award, or other payment is, the terms of the Medicare Secondary Payer Act still entitles Medicare to reimbursement of conditional payments it has made on behalf of a Medicare beneficiary. It would, however, be wasteful for the government to pursue small claims that would cost more to pursue than what possibly could be recovered. To ensure that that does not happen, Section 202 of the MIA/SMART Act establishes a threshold for exemption from conditional payment reimbursement.

Beginning with the year 2014, Medicare will be required to calculate and publish on an annual basis a single threshold amount under which the cost of seeking repayment of a conditional payment would be expected to be more than the expected recovery. If a settlement, judgment, award, or other payment by a liability insurer or self-insured for an alleged physical trauma-based incident (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a Medicare beneficiary/claimant is below the single threshold amount for the year involved, no reimbursement of conditional payments by Medicare or mandatory reporting to Medicare are required.

I. Step 9: Pay Demand Amount, Appeal Demand Amount and/or Seek Waiver

Payment is due Medicare within sixty days of the Final Demand Letter. If the demand amount is not paid within sixty days of the Final Demand

Letter, interest will be due and owing for each full thirty day period the debt remains unresolved. 42 C.F.R. §411.24(m). Also, if a response is not received within sixty days of the letter, Medicare may initiate additional recovery procedures without further notice, including referral to the Department of Justice for legal action and/or the Department of the Treasury for other collection actions.

1. If represent claimant/plaintiff.

   You should see to it that Medicare is paid the demand amount within sixty days of the Final Demand Letter so as to stop the accrual of interest. You also should consider whether to appeal the amount demanded in the Final Demand Letter and/or request a full or partial waiver from Medicare. Even after making payment to Medicare, the client can appeal Medicare's demand amount or seek a hardship waiver. If an appeal or request for hardship waiver is successful, Medicare will refund any excess amounts the beneficiary has paid.

   a. Pay amount demanded.

      Medicare should be paid timely to avoid accrual of interest (*i.e*., within sixty days of the Final Demand Letter). When making payment, the check or money order should be made payable to "Medicare" and sent to the MSPRC at the address set forth at the end of the Final Demand Letter. The beneficiary's name and Medicare number (HICN) should be included on the check. Also, a copy of the Final Demand Letter should be included with the payment.

      i. Settlement/judgment check payable to multiple parties.

         If the payment check is also payable to parties other than Medicare (*e.g*., claimant/plaintiff and/or claimant/plaintiff's counsel), the check should be fully endorsed prior to sending it to the MSPRC for deposit. The MSPRC will distribute any excess funds it has collected over and above the final demand amount.

      ii. Installment payments.

         If the client cannot repay Medicare in one payment, you may ask Medicare to consider whether to allow the client to pay in regular installments. Medicare may agree to the client making monthly installment payments of principal and interest. If Medicare agrees to installment payments, it will have the client sign an installment payment agreement. As

long as the debt remains outstanding, interest will accrue.

b. Appeal final demand amount.

A beneficiary has the right to appeal Medicare's demand amount if they disagree that they owe Medicare reimbursement under the Medicare Secondary Payer Act, or if they disagree with Medicare's demand amount. 42 U.S.C. §1395ff.

i. Appeal deadline.

The beneficiary will have 120 days from receipt of the Final Demand Letter to file an appeal. The MSPRC assumes that the beneficiary received the Final Demand Letter within five days of the date of the letter unless it is furnished with proof to the contrary.

ii. Appeal process.

To file an appeal on behalf of the client, you should send the MSPRC a letter explaining why you think the amount demanded by Medicare is incorrect and/or any reason(s) why you disagree with Medicare's determination of the demand amount. The letter should be mailed to:

Medicare Secondary Payer Recovery Contractor
Liability
PO Box 138832
Oklahoma City, OK 73113

Once the MSPRC receives an appeal challenging Medicare's demand amount, it will decide whether its determination that the beneficiary must repay Medicare the demand amount is correct and send a letter that explains the reasons for its decision. The letter will also explain the steps the beneficiary will need to follow to appeal that decision if it is less than fully favorable to the beneficiary.

iii. Levels of appeal.

There is a five level appeal system with regard to the MSP claim for reimbursement. The first appeal is to the MSPRC (the recovery contractor). The second goes to an independent contractor for reevaluation. The third level is submitted to an administrative law judge, then to the fourth level at

the Medicare Appeals Council, Departmental Appeals Board. If satisfaction still has not been achieved, the matter may be appealed to the U.S. District Court. Failure to follow the administrative procedure could result in a waiver of the beneficiary's appeal rights.

c. Seek hardship waiver.

A beneficiary has the right to request that Medicare waive in full or in part recovery of the amount demanded in the Final Demand Letter. 42 U.S.C. §1395y(b)(2)(B)(v). The right to request a waiver is separate from the right to appeal Medicare's determination, and a beneficiary may request both a waiver and an appeal at the same time.

i. Basis for hardship waiver.

Medicare may waive recovery of the amount owed if the beneficiary can show that they meet both of the following conditions:

- beneficiary is without fault and
- recovery would either
  - defeat the purposes of the Medicare Act or
  - be against equity and good conscience.

As a general principle, Medicare beneficiaries are deemed to be not at fault in the MSP liability context. Thus, the issue in waiver requests tends to be whether recovery by Medicare would defeat the purposes of the Act or violate equity and good conscience.

(a) Defeat purposes of Medicare Act.

The purposes of the Medicare Act would be defeated if recovery would deprive a person of income required for ordinary and necessary expenses. 20 C.F.R. §404.508. An individual's "ordinary and necessary expenses" include: "[f]ixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance ..., taxes, installment payments, etc."; "[m]edical, hospitalization, and other similar expenses"; "[e]xpenses for the support of

others for whom the individual is legally responsible"; and "[o]ther miscellaneous expenses which may reasonably be considered as part of the individual's standard of living." 20 C.F.R. §404.508(a)(1)-(4).

(b) Be against equity and good conscience.

"Equity and good conscience" refers to the total effect upon the beneficiary of granting or not granting a full or partial waiver. The factors Medicare will consider in applying the standard include:

- The degree to which the beneficiary contributed to causing the conditional payment;
- How much of a financial hardship the recovery will cause;
- How much the beneficiary's standard of living would be changed;
- If Medicare's recovery amount exceeds the settlement amount;
- If the beneficiary is able to pay out-of-pocket accident related expenses that are not covered by Medicare; and
- Whether the beneficiary changed their position to their material detriment as a result of the conditional payment or as a result of erroneous information supplied to the beneficiary by Medicare.

A requested hardship waiver will be denied even to a beneficiary who is so poor as to be receiving SSI, if he/she was so poor before the injury resulting in the liability claim

ii. Requesting a hardship waiver.

If you believe that these conditions apply to the client, you should send the MSPRC a letter that explains why you think the client should receive a

waiver of recovery of the amount they owe. The letter should be mailed to:

Medicare Secondary Payer Recovery Contractor
Liability
PO Box 138832
Oklahoma City, OK 73113

If you request a waiver, the MSPRC will send you a form asking for more specific information about the client's income, assets, expenses, and the reasons why you believe the client should receive a waiver.

iii. Appeal of denial of waiver request.

If the MSPRC denies a request for a waiver, it will send a letter that explains the reason(s) for its decision and the steps the client will need to follow to appeal that decision if it is less than fully favorable to the client. The beneficiary has 120 days from receipt of Medicare's determination letter to request a redetermination (*i.e*, to appeal Medicare's waiver of recovery determination). Unless shown otherwise, Medicare will assume that the determination letter was received five days after the date of the letter. A request for redetermination must be in writing and must explain why it is believed that Medicare's determination was in error. Any supporting information or other evidence should be sent with the request for redetermination.

***Note*:** A waiver request or appeal will forestall a recovery action. Medicare will not initiate any recovery action while a waiver request or appeal is pending, but interest will continue to accrue on any unpaid amounts.

2. If represent defendant.

If defendant or defendant's insurer does not directly pay Medicare, you should obtain confirmation of payment by claimant/plaintiff.

3. Upcoming MIA/SMART Act changes.

Currently, a primary payer cannot appeal, that is challenge, Medicare's final demand amount. Section 201 of the MIA/SMART Act requires Medicare to promulgate regulations establishing a right of appeal and appeals process under which a primary payer (or an attorney, agent, or third party administrator on behalf of the primary payer) may appeal determinations by Medicare of its entitlement to conditional payment reimbursement.

VI. MANDATORY ELECTRONIC REPORTING

A. MMSEA Reporting Requirements

The MMSEA Section 111 mandatory electronic reporting requirements apply to all group health plans, workers' compensation plans, liability insurance providers (including self-insurance), and no-fault insurance (collectively referred to as "Responsible Reporting Entities" or "RREs").

The reporting requirements will increase Medicare's ability to identify individuals who received Medicare payments and to recoup conditionally paid benefits. They also will enable Medicare to possibly refuse payment of future medical expenses relating to the injuries that were the subject of the resolved liability claim.

1. RREs must register with Medicare.

   To make reports, RREs must first register with Medicare online at www.Section111.cms.hhs.gov. The general deadline for registering has passed (September 30, 2009, for non-group health plans), but RREs that missed the deadline can still register online. The registration process itself may take weeks because it can include a file data exchange testing process.

2. Triggers of reporting obligation.

   The first reporting trigger is a determination that the claimant is a Medicare beneficiary. If the claimant is a Medicare beneficiary, reporting must be made <u>after</u> the RRE:

   - Assumes responsibility to pay, on an ongoing basis, for the claimant’s medical expenses associated with the claim; or
   - Has entered into a settlement, judgment, award or other payment to or for the benefit of the claimant.

   RREs must report regardless of any determination of liability in the settlement, judgment, or award. *See* 42 C.F.R. §411.22(b)(2). A disclaimer of liability within a settlement document does not alleviate the RRE’s reporting requirement. Likewise, a statement in a settlement, judgment, or award that there are "no medicals" does not eliminate the RRE’s reporting requirement if the claimant originally claimed medicals. Reporting also must be made if a liability settlement, judgment, award or other payment <u>has the effect of releasing claims for medical expenses</u> even if there was not express claim for personal injury or medicals.

3. Reporting thresholds and timeline.

On June 20, 2012, Medicare announced the following revised thresholds and timeline for reporting liability settlements, judgments, awards and other payments:

Total Payment Obligation to Claimant (TPOC)	TPOC Date On or After	Reporting Required in Quarter Begining
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
TPOCs over $5,000	October 1, 2012	January 1, 2013
TPOCs over $2,000	October 1, 2013	January 1, 2014
TPOCs over $300	October 1, 2014	January 1, 2015

4. RREs may contract with third-parties to handle reporting.

A RRE may contract with a third-party to act as an agent for reporting purposes. Agents may include, but are not limited to, data service companies, consulting companies or similar entities that can create and submit reports on behalf of the RRE. A RRE, however, may not shift its Section 111 reporting responsibility to an agent, by contract or otherwise. The RRE remains solely responsible and accountable for complying with the reporting requirements and for the accuracy of data submitted.

5. Penalty for reporting noncompliance.

As originally enacted, the mandatory reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. §1395y(b)(8)) included a mandatory civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. Section 203 of the MIA/SMART Act changed the penalty to a discretionary civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant.

B. Upcoming MIA/SMART Act Changes

- Creating reporting safe harbors

Section 203 of the MIA/SMART Act provides that within sixty days of enactment (by March 11, 2013), Medicare is to publish notice in the Federal Register soliciting proposals for the specification of practices for which a reporting noncompliance penalty will and will not be imposed, including not imposing sanctions for good faith efforts to identify a Medicare beneficiary for reporting purposes. After considering submitted proposals, Medicare shall publish in the Federal Register, including a sixty-day period for comment, proposed specified practices for which noncompliance penalties

will and will not be imposed. After considering any public comments received, Medicare shall issue final rules specifying such practices.