

Peoria County Bar Association
2006 Continuing Legal Education Series

Medicare Secondary Payer Statute
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I. MEDICARE AS A SECONDARY PAYER

A. Introduction

In recent years, settlements under the Illinois Workers' Compensation Act, 820 ILCS 305/1, *et seq.*, have been complicated by the Medicare secondary payer statute (MSP), 42 U.S.C. §1395y(b), and regulations (42 C.F.R. §411.20). If a settlement falls within the threshold set by Medicare, special consideration must be taken to ensure that Medicare is reimbursed for past medical payments and protected from future medical payments that stem from a compensable work-related injury. The administrative mechanism used to protect Medicare from future payments is referred to as a Medicare set-aside arrangement (MSA).

The failure to take the appropriate action, including approval of the settlement by Medicare, can expose the employer, insurer, and their counsel to double damages and duplicate payment for medical bills. In addition, the claimant may be precluded from obtaining Medicare payment for medical bills that would have been paid if prior approval of the settlement had been obtained.

At the outset, it should be noted that consultation with Medicare about future medical payments need only be made when a case is concluded by settlement, and the injured worker's medical rights under §8(a) of the Illinois Worker's Compensation Act are closed. If a claimant's medical rights remain open because the case is tried or remain open in the settlement contract, Medicare need not be consulted. See the October 15, 2004 CMS memo, Q&A 6.

B. Origins of Medicare

In 1965, the Social Security Act, 42 U.S.C. §670, *et seq.*, established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while federal assistance to the state Medicaid programs was administered by the Social and Rehabilitation Service (SRS). The SSA and the SRS were agencies in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration (HCFA) was created under the HEW to coordinate Medicare and Medicaid. In 1980, the HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In June 2001, the HCFA was renamed the Centers for Medicare and Medicaid Services (CMS). See www.cms.hhs.gov/about/history.

C. Statutory Authority

42 U.S.C. 1395y(b)(2)

(http://caselaw.lp.findlaw.com/scripts/ts_search.pl?title=42&sec=1395y)

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph

(B), with respect to any item or service to the extent that -

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made, or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or

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plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) Conditional payment

(i) Repayment required

Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iii) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(v) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

See, 42 C.F.R. 411, et seq.

1. Medicare as Secondary Payer

The intent of the Medicare secondary payer statute is relatively simple. 42 U.S.C. §1395y(b)(2) provides that Medicare is not required to pay for any item or service to the extent that payment has been made, or can reasonably be expected to be made, under a workers' compensation law or plan. See also 42 C.F.R. Part 411.

2. Conditional Payments by Medicare

If Medicare determines that the workers' compensation insurer will not pay promptly (within 120 days), providers and suppliers may submit claims to Medicare, and Medicare may make a conditional payment. However, when the proceeds from the settlement become available, Medicare has priority right of recovery as discussed below. 42 U.S.C. 1395y(b)(2)(B).

D. CMS Memoranda

Although the Medicare secondary payer statute has been in existence for quite some time, in the last few years, the CMS has become aggressive in its efforts to require payments and reimbursement by employers and workers' compensation insurers. In furtherance of these efforts, the CMS has issued several key memoranda setting forth its policy concerning its status as a secondary payer. References to these memoranda are made throughout this article:

1. memo of July 23, 2001, from the Deputy Director of the Purchasing Policy Group (available at www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf);
2. memo of April 22, 2003 to all regional administrators from the CMS director Thomas L. Grissom with answers to frequently asked questions (available at www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf);
3. answers to frequently asked questions issued May 23, 2003, by the Director of the Center for Medicare Management (available at www.cms.hhs.gov/medicare/cob/pdf/wc_faqs2.pdf); and
4. memo of the CMS policies regarding administrative fees and attorney costs from the Director of the Center for Medicare Management, dated May 7, 2004 (available at www.cms.hhs.gov/medicare/cob/providers/wcadminfees5-7-04.pdf).

5. memo of October 15, 2004 to all regional administrators from director of Financial Services Group Gerald Walters (available at www.cms.hhs.gov/medicare/cob/pdf/wc_faqs101504.pdf);
6. memo of July 11, 2005 to all regional administrators from director of Financial Services Group Gerald Walters (available at www.cms.hhs.gov/medicare/cob/pdf/Memo071105.pdf);
7. memo of December 30, 2005 to all regional administrators from director of Financial Services Group Gerald Walters (<http://www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf>);

See also the Medicare Secondary Payer Manual www.cms.hhs.gov/manuals/105_msp/msp105index.asp.

II. CLASSES OF CASES REQUIRING CONSULTATION WITH MEDICARE

There are three types of cases in which contact with and approval by Medicare is required: (a) Medicare has made prior payment; (b) the claimant is eligible for Medicare and the settlement is \$10,000 or more; or (c) the settlement meets the 30-month/\$250,000 threshold set forth by the CMS. If a claim falls within any of these classes, special settlement arrangements must be made to ensure that Medicare's interests are protected, and Medicare must approve settlement of these cases.

As of July 11, 2005, the CMS considers these thresholds as part of its "workload review" and not substantive "safe harbor" thresholds. All settlements must be drafted to insure that Medicare is a secondary payer to Medicare. See the July 11, 2005 CMS memo, Q&A 1, 2. Thus, even if the settlement does not fall within the thresholds set forth below and approval is not sought, an allocation of a portion of the settlement to reasonably anticipated future medical expenses is prudent.

It should be noted that the CMS considers the thresholds discussed below as subject to review and adjustment. Changes in the CMS thresholds will be published at its website at www.cms.hhs.gov/medicare/cob/attorneys/att_wc.asp.

A. Medicare Has Made Prior Payments

As stated above, Medicare has a priority right of reimbursement for any medical expenses it paid that should have been paid by the workers' compensation carrier. The Medicare secondary payer statute and the regulations require that if the beneficiary or other party receives a third-party payment, the beneficiary or other party must reimburse Medicare within 60 days. 42 C.F.R. §411.24(h). Further, if a third-party payer learns that the CMS has made a Medicare primary payment for services for which the third-party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim. 42 C.F.R. §411.25(a). Thus, there is an affirmative duty on the part of the workers' compensation carrier to reimburse Medicare when it becomes aware that Medicare paid bills that were the responsibility of the workers' compensation carrier.

B. Claimant Is Medicare Eligible and the Settlement is \$10,000 or More

Claimants who are eligible for Medicare are

1. 65 or older;
2. on Social Security disability for 24 months or longer; or
3. suffering from a qualifying end stage renal disorder.

The CMS refers to this type of beneficiary as a Class I beneficiary. In order to fall within this threshold, it is not necessary that medical bills have already been paid by Medicare, only that the claimant be eligible for Medicare benefits. Social Security Disability recipients are automatically eligible for Medicare benefits after receiving benefits for 24 months. In fact, Social Security will automatically enroll a Social Security disability recipient for Medicare benefits after the 24-month period expires.

Effective July 1, 2005, the CMS will no longer review workers' compensation settlement proposals where the total settlement is less than \$10,000. It is important to note that the CMS now considers its thresholds as "workload review" thresholds and not "safe harbor" thresholds. Presumably, this means that despite the fact that it refuses to review such settlements, it does not waive any of its rights under the Medicare Secondary Payer statute.

In its July 1, 2005 memo, the CMS states that the total settlement amount for purposes of the thresholds includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments. Further, payout totals for all annuities should be used rather than the cost or present value of the annuities. Finally, any previously settled portion of the workers' compensation claim must be included when computing the total settlement amount. Past medical expenses are not included.

In its December 30, 2005 memo, the CMS announced that the total settlement amount for purposes of the thresholds must include amounts paid for prescription drugs paid as a part of the settlement and that may be prescribed in the future. The includable amount for prescription drugs is limited to those drugs that are for the treatment of the work related injury that are covered by the Medicare Part D as a result of the implementation of the Medicare Modernization Act of 2003 (MMA).

C. Claimant Meets \$250,000/30-Month Threshold

If a claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000, then approval by the CMS of the workers' compensation settlement is required. The CMS refers to this type of beneficiary as a Class II beneficiary. Claimants who do not satisfy this threshold need not submit their settlements to the CMS for approval. However, the CMS made clear in its July 11, 2005 memo that this threshold is a "workload threshold" and not a

substantive “safe harbor” threshold. All settlements are required to set-aside sufficient funds in the settlement to protect Medicare from reasonably anticipated Medicare covered medical expenses.

The CMS’s first statement regarding the thresholds for workers’ compensation cases settled by injured workers who are not yet Medicare beneficiaries was expressed in its memo of July 23, 2001. Several factors are to be considered in determining whether there is a “reasonable expectation” of Medicare enrollment within 30 months. Those factors include:

1. the individual has applied for Social Security disability benefits;
2. the individual has been denied Social Security disability benefits but anticipates appealing that decision;
3. the individual is in the process of appealing and/or re-filing for Social Security disability benefits;
4. the individual is 62 years and 6 months old (*i.e.*, may be eligible for Medicare based on his or her age within 30 months); or
5. the individual has an end stage renal disease (ESRD) condition but does not yet qualify for Medicare based on ESRD.

If any of the above criteria are met, the settlement should be treated as satisfying the 30-month threshold. See the April 22, 2003 CMS memo, Q&A 2.

The \$250,000 threshold includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments (see the July 11, 2005 CMS memo, Q&A 2). Payment of past medical expenses is not included in the \$250,000 threshold. If settlement is paid in a structure and the total payments are greater than \$250,000, then the threshold is met. This is true even if the cost of the structured settlement is less than \$250,000. See the April 22, 2003 CMS memo, Q&A 17.

Both conditions must be met in order to fall within the threshold. In other words, if the claimant is expected to become a Medicare beneficiary within 30 months but the total settlement is less than \$250,000, then a CMS-approved Medicare set-aside arrangement is unnecessary. See the May 23, 2003 CMS memo, Q&A1. Prior to July 11, 2005, the CMS assumed that when a non-Medicare settlement does not meet the 30-month/\$250,000 threshold, that individual will completely exhaust his or her settlement by the time Medicare eligibility is reached. See the April 22, 2003 CMS memo, Q&A3. In its memo of July 11, 2005, the CMS reversed this approach and stated that any funds from a workers’ compensation settlement attributable to future medical expenses that are remaining at the time the claimant becomes Medicare eligible must be used to pay for Medicare-covered expenses. Only then will the CMS pay for Medicare-covered expenses.

It is important to note that the CMS stated in its memo of May 23, 2003 that the thresholds are subject to change if it determines that Medicare’s interests are not being protected. However, the CMS specifically stated that it would honor the thresholds in place at the time of the workers’

compensation settlement. Further when the thresholds are not met, the CMS will not provide verification letters confirming that approval of a workers' compensation settlement is not necessary. This position was affirmed in the CMS memo of July 11, 2005.

III. EXCEPTIONS AND SPECIAL SITUATIONS

A. Settlement Prior to CMS Approval

In its memo dated July 11, 2005, the CMS blessed the idea of settling a workers' compensation claim prior to the CMS approval of a MSA in order to end the continuation of indemnity payments while waiting for the CMS approval. This is accomplished by closing out the indemnity portion of the settlement and leaving open the settlement of medical expenses pending a determination by the CMS on the proposed MSA.

In the same memo, the CMS comments that settlement of a workers' compensation claim in its entirety prior to the CMS approval is not binding on the CMS. Only the approval of a MSA by the CMS and the submission of proof that the MSA was funded in the approved amount would limit the denial of related claims to the amount in the MSA.

B. Accepted Cases without Compensation for Future Medical

In its memo dated April 22, 2003, the CMS established one that it is not necessary for the parties to establish a set-aside arrangement for Medicare if all of the following criteria are met:

1. The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (*i.e.*, for services furnished prior to the settlement).
2. There is no evidence that the individual is attempting to maximize the other aspects of the settlement (*e.g.*, the lost wages and disability portions of the settlement) to Medicare's detriment.
3. The individual's treating physicians conclude (in writing) that, to a reasonable degree of medical certainty, the individual will no longer require any Medicare-covered treatments related to the workers' compensation injury. See the April 22, 2003 CMS memo, Q&A 20.

The language of this exception is cause for concern because it gives the CMS a basis to reject the settlement if it determines that the settlement was made to Medicare's detriment. Thus, the use of this exception should be made with the recognition that there is risk that the CMS might challenge the settlement despite a perceived compliance with the policy statement.

C. Disputed Cases

Medicare classifies workers' compensation settlements as either "commutation" or "compromise cases" or both. Commutation cases are settlement awards intended to compensate individuals for future medical expenses required because of a work-related injury or disease. In contrast, compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the

date of settlement (*i.e.*, future medical expenses) are commutation cases. It is possible for a single lump-sum settlement agreement to be both a compromise case and a commutation case. It is important to note that set-aside arrangements are used only in commutation settlements, not settlements that are solely compromise cases. See the July 31, 2001 CMS memo.

Several factors will be considered by the CMS when determining whether a case is truly disputed. These include whether there was a pre-existing condition, whether the accident was work-related, whether the individual was acting as an employee or performing work-related duties at the time the accident occurred, and the causal relationship. Medicare will generally honor judicial decisions issued by a court of competent jurisdiction after a hearing on the merits of a workers' compensation case. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (*e.g.*, lost wages), then Medicare will accept that designation. However, a distinction must be made when a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. Medicare cannot accept the terms of the settlement as to an allocation of funds of any type if the settlement does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered, Medicare will refuse to pay for services related to the workers' compensation injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire settlement. Medicare will also assert a recovery claim, if appropriate. See the April 22, 2003 CMS memo, Q&A 3.

D. Waiver of Medicare by the Workers' Compensation Settlement Contract

The CMS will not approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement. See the April 22, 2003 CMS memo, Q&A 18.

E. Up-Front Settlement Instead of Set-Aside Arrangement

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when the workers' compensation carrier did not pay promptly. See the July 31, 2001 CMS memo, Q&A 8 and the October 15, 2004 CMS memo, Q&A 3.

E. Third-Party Claims

To the extent that a liability settlement relieves a workers' compensation carrier from any future medical expenses, a Medicare set-aside arrangement approved by the CMS is appropriate. The set-aside requires sufficient funds to cover future medical expenses incurred once the total third-party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further work-related medical services. A Medicare set-aside arrangement is also unnecessary if the medical portion of the workers' compensation claim remains open and workers' compensation continues to be responsible for related services once the liability settlement is exhausted. See the April 22, 2003 CMS memo, Q&A 19.

Although it is beyond the scope of this chapter, two cases are noteworthy regarding the issue of civil tort claims. In *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003), the Fifth Circuit Court of Appeals addressed the issue of whether the Medicare secondary payer statute applied to civil claims. *Thompson* involved a claimant who had two hip replacement surgeries paid by Medicare. Claimant filed a products liability suit against the manufacturer of the prosthesis used in the first surgery claiming it was defective. The CMS sought reimbursement for the bills it paid from the proceeds of the products liability action. The court held that the CMS was not entitled to recovery from the proceeds of the products liability action under the MSP. It ruled that the manufacturer was not a "primary plan" within the meaning of the MSP and that the product liability defendant was not required to "pay promptly" as required by the statute.

It is significant that the court in *Thompson* relied on the "pay promptly" language of the statute. This language was amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub.L. 108-173, 117 Stat. 2066, and the "promptly" portion of the statute was removed. It would be surprising if the CMS did not use this amendment to make another attempt at extending the MSP to general civil tort claims.

The issue was addressed again in *United States of America v. Baxter International, Inc.*, 345 F.3d 866 (11th Cir. 2003). *Baxter* involved a class-action products liability suit against manufacturers of silicone breast implants. The CMS sought recovery for medical bills it paid on behalf of Medicare beneficiaries who received silicone breast implants. The district court dismissed the CMS's complaint, but the Eleventh Circuit reversed and remanded the case finding that Medicare had a right of recovery

F. Coverage Through Group Health Plans, Managed Care Plans and Veterans' Administration

Even though a claimant may have other health coverage through a group health plan, managed care plan or VA coverage, the CMS requires a MSA. In its July 11, 2005 memo, the CMS states that a MSA is still appropriate because such other coverage could be canceled or reduced or the claimant might elect not to take advantage of the coverage.

IV. SET-ASIDE ARRANGEMENTS

A. Set-Aside Arrangements To Protect Medicare from Future Medical Payments

Although the Medicare secondary payer statute requires that all workers' compensation settlements adequately consider Medicare's interests, neither the MSP nor the regulations mandate what particular type of administrative mechanism should be used to protect Medicare's interests. Medicare requires that funds be set aside to pay for future medical bills incurred because of a work-related condition. These funds are referred to by the CMS as "set-aside arrangements." Set-aside arrangements are used in commutation cases, in which an injured individual is disabled by the event for which workers' compensation is making payment but the individual will not become entitled to Medicare until some time after the workers' compensations settlement is made. See the July 23, 2001 CMS memo. The CMS has stated specifically that set-

aside arrangements are used only in commutation settlements, not settlements that are solely compromise cases. See the July 23, 2001 CMS memo.

Medicare contemplates that set-aside arrangements will be either in the form of a lump sum or a structured annuity. See the October 15, 2004 CMS memo, Q&A 5. The set-aside should be an amount sufficient to pay for reasonably expected, causally-related medical bills for the life expectancy of the petitioner. See the July 23, 2001 CMS memo, Q&A 6. Set-aside arrangements are most often used in those cases in which the injured worker is relatively young and has an impairment that seriously restricts his or her daily living. The set-aside is usually not created until the injured worker has stabilized so that it can be determined, based on past experience, what the future medical expenses are expected to be. See the July 23, 2001 CMS memo, Q&A 6. Medical expenses are to be based on either the workers' compensation fee schedule (for states that have such schedules) or the full actual charges. See the October 15, 2004 memo, Q&A 1. The CMS does not require that a MSA be indexed for inflation nor may a MSA be discounted to present value. See the October 15, 2004 memo, Q&A 4.

The CMS does not compromise or reduce future medical expenses. It asserts that the language in 42 C.F.R. 411.47 relates only to conditional (past) payments and not future medical expenses related to a workers' compensation injury. This position presumably applies to compromise settlements submitted for approval without a MSA. See the July 11, 2005 memo, Q&A 11.

Initially the CMS stated that Medicare set-aside funds are not to be used to pay medical bills until the claimant actually becomes eligible for Medicare. Bills incurred prior to Medicare eligibility must be paid from another source. See the May 23, 2003 CMS memo, Q&A 4. This policy changed in its memo of July 11, 2005, Q&A 3. The CMS position is that funds from an approved MSA may be used prior to the claimant becoming a Medicare beneficiary because the amount of the MSA was priced based on the date of the expected settlement. However, the use of MSA funds is limited to expenses that are related to the workers' compensation claim and that would be covered by Medicare if he were a Medicare beneficiary. The same set-aside administration and reporting requirements apply to this use of the funds as if the claimant was a Medicare beneficiary.

A MSA must be kept in an interest bearing account. See CMS memo of July, 23 2001 Q&A 7 and CMS memo of July 11, 2005 Q&A 6, 13. Tax on this interest may be paid from the MSA as a cost that is directly related to the account. Adequate documentation of the tax is required.

If a claimant loses his entitlement to Medicare after a MSA has been approved and funded, the CMS will not release the MSA funds but will allow the funds to be used for medical expenses related to the work injury that would be Medicare-covered if the claimant was a Medicare beneficiary. The same set-aside administration and reporting requirements apply to this use of the funds as if the claimant was a Medicare beneficiary. See the July 11, 2005 memo, Q&A 9.

If the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary may submit a new MSA proposal covering future expected medical expenses. Such proposals must justify at least a 25% reduction in the outstanding MSA

funds. In addition, such proposals may not be submitted until at least five years after a previous CMS approval.

Beginning January 1, 2006, Medicare will begin its Part D prescription drug coverage due to the passage of the Medicare Modernization Act of 2003. As set forth in its memo of December 30, 2005, beginning January 1, 2006, all workers' compensation settlements must consider and protect Medicare's interest when future treatment includes prescription drugs along with future medical services that would otherwise be reimbursable by Medicare.

Medicare set aside arrangements submitted to the CMS after should include separate allocations for: (1) future medical treatment and (2) future drug prescription treatment. The cover letter should include an explanation as to how the amount allocated to future prescriptions was calculated. If the cover letter does not include an amount for future prescription drug treatment, and the treatment records show that the claimant has been prescribed drugs and/or may need drugs related to the work injury in the future, then the CMS will conclude that the parties to the settlement have not adequately considered Medicare's interests. If there is no indication in the records that the claimant will need future treatment with prescription drugs, then the CMS will accept that Medicare's interests have been adequately protected. CMS Memo (December 30, 2005), Q & A 1, 2.

Beginning January 1, 2007, the CMS will begin to independently price for future prescription drug treatment for set aside arrangements it receives after January 1, 2007. Set aside arrangements submitted after that date must include separate allocations for future medical treatment and future drug prescription treatment as described above. In addition, the submission must include a payment history of payments made by the workers' compensation carrier for prescription drugs. If the injury occurred less than 2 years prior to the date of the submission, the history should include payments from the date of the injury to the date of the submission. If the injury occurred more than 2 years prior to the date of the submission, the history should include the last two years of payments. CMS Memo (December 30, 2005), Q & A 5.

Set aside arrangements that have already been approved by or submitted to the CMS prior to January 1, 2006, do not have to be resubmitted due to Part D coverage. CMS Memo (December 30, 2005), Q & A 7.

B. Set-Aside Administration

Although the purpose of the set-aside is simple, the administration of set-asides is quite complex. The regulations require that

[i]f 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. 42 C.F.R. §411.46(a).

When the CMS regional office approves a set-aside arrangement, the office will check the National Medicare Enrollment database on a monthly basis in order to determine when an injured

individual actually becomes enrolled in Medicare. See the July 31, 2001 CMS memo, Q&A 3. Once the CMS regional office verifies that the injured individual has actually been enrolled in Medicare, the office will assign a contractor responsible for monitoring the individual's case. In Illinois, this contractor may be contacted at

AdminaStar Federal
225 N. Michigan Ave.
22nd Floor
P.O. Box 812912
Chicago, IL 60618
Phone: 312/297-4618
www.adminastar.com

When the injured individual has actually been enrolled in Medicare, the CMS regional office must provide the coordination of benefits contractor (COBC) with identifying information to add a workers' compensation record to a common working file.

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for ensuring/verifying that the funds allocated to the set-aside arrangement were expended on medical services for Medicare-covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

In structured set-aside arrangements, the CMS will not make any payments until the contractor monitoring the case can verify that the funds apportioned to that period of time, including any amounts carried forward, have been exhausted. See the April 22, 2003 CMS memo, Q&A 9 and Q&A10.

The CMS permits set-aside arrangements to be self-administered but cautions that self-administered set-asides must comply with all the formal rules and requirements as with any other set-aside arrangement. See the April 22, 2003 CMS memo, Q&A 8.

Set-aside arrangements must be administered by a competent administrator. When an individual has a designated payee, appointed guardian, or otherwise had been declared incompetent, the settlement parties must include that information in their Medicare set-aside arrangement proposal. See the October 15, 2004 CMS memo, Q&A 2.

In a policy change expressed in its May 7, 2004, memo, the CMS stated that administrative fees/expenses and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement cannot be charged to the set-aside arrangement. These funds must come from some other source that is completely separate from the set-aside. This memo reversed an earlier policy statement set forth in its memo April 21, 2003 and is to be applied prospectively.

C. [12.16] Submission of Settlement to Medicare for Approval

Once the settlement is agreed on by the parties, various materials must be submitted to Medicare so that approval can be obtained. The CMS has authority under the regulations to review a proposed settlement including a set-aside arrangement and can give a written opinion, on which the parties can rely, regarding whether the workers' compensation settlement has adequately considered Medicare's interests. See the July 31, 2001 CMS memo, Q&A 3.

Obviously, the proposed settlement should not be submitted to the CMS before it has been approved by the parties. Once the CMS approves a settlement, it is unlikely to agree to a modification of the terms that reduces the set-aside for future medical payments.

The CMS has created a check list detailing the information to be submitted to obtain settlement approval. See www.cms.hhs.gov/medicare/cob/pdf/wcchecklist.pdf. The CMS has also created a sample submission that outlines the information required and provides examples of the type of information to be submitted. See www.cms.hhs.gov/medicare/cob/pdf/attwc_sample.pdf.

A cover letter should be submitted with the settlement documents outlining the following information:

Claimant Information including:

- Name
- Address, telephone, fax and email address
- Health insurance claim number (HICN)
- Social Security number (SSN)
- Gender
- Date of birth
- Proposed settlement date
- Age
- Median rated age and documentation from life insurance companies
- Life expectancy
- (See www.cdc.gov/nchs/products/pubs/pubd/lftbls/life/1966.htm)

Entitlement information

Indicate whether claimant is entitled to Medicare Part A (hospital insurance) and/or Part B (medical insurance). If the claimant is not a current Medicare beneficiary, describe how the claimant satisfied the current non-beneficiary threshold.

Injury Information

- Description of injury
- Date of injury
- Diagnosis codes

MSA Administrator

Claimant's Attorney

Employer

Employer Attorney

Workers' compensation insurance carrier

State of jurisdiction and venue

Total workers' compensation settlement and payout structure

Proposed MSA exclusive of administrative fees

MSA fees and expenses

MSA calculation method i.e. fee schedule or full charges

Consent to release form signed by claimant

Life Care Plan

Medicare will consider a life care plan from a non-treating physician if the physician does all of the following:

1. examines the workers' compensation claimant;
2. reviews the claimant's medical records;
3. contacts any of the claimant's treating physicians (if applicable);
4. is available to answer the CMS's questions;
5. prepares a report that summarizes the above; and
6. offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury.

The CMS does not consider such a life care plan automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question, such as contrary evidence or internal conflicts, or if the plan is not credible on its face. See the April 22, 2003 CMS memo, Q&A 15.

Example life care plans are available at [www.prc-usa.com/pdfs/Jane Doe Life Care Plan.pdf](http://www.prc-usa.com/pdfs/Jane%20Doe%20Life%20Care%20Plan.pdf) and www.mkapple.com/sample_life_care_plan.html.

Proposed WC Settlement Agreement - Provide a copy of the proposed settlement agreement.

Set-aside agreement

Medical records

Medical records should be provided that outlines the current medical that the claimant regularly receives. The record should show that the work-related condition is stable. Medical documentation should be supported by a minimum of two years of medical documentation and back to the date of the work related injury. The records should describe the expected recovery, the projected recovery period and the date at which the patient achieved maximum medical improvement.

The records and reports should also identify the specific types of medical services, the frequency/duration of the medical services/items and the projected costs of the medical services/items related to the work injury/disease that are expected in the future in light of the claimant's condition. ICD-9 diagnosis codes should be included, if available.

Workers' compensation payment history (including prescriptions after January 1, 2007)

The CMS recently created a central depository for workers' compensation settlement approvals. All proposed workers' compensation settlements should be submitted to:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 660
New York, NY 10274-0660
Attention: WCMSA

D. Criteria Used by the CMS To Evaluate Proposed Settlement

If Medicare has already made conditional payments, its repayment has to be taken into account, in addition to the following criteria that will be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the cost of a work-related injury or illness to Medicare:

1. date of entitlement to Medicare;
2. basis for Medicare entitlement;
3. type and severity of injury or illness;
4. age of beneficiary;
5. workers' compensation classification of beneficiary;
6. prior medical expenses paid by the workers' compensation carrier due to the injury or illness in the one- or two-year period after the condition has stabilized;
7. amount of lump sum or of structured settlement;
8. whether the commutation is for the beneficiary's lifetime or for a specific time period;

9. whether the beneficiary is living at home, living in a nursing home, or receiving assisted living care; and
10. whether the expected expenses for Medicare-covered items and services are appropriate in light of the beneficiary's condition. See the July 31, 2001 CMS memo, Q&A 5.

E. Speed of Approval

The CMS regional offices claim to seek to review and make a decision regarding proposed workers' compensation settlements within 45 to 60 days from the time that all necessary/required documentation has been submitted. See the April 22, 2003 CMS memo, Q&A 6. In practice, the time for approval varies greatly and is frequently much longer than claimed by the CMS.

F. Appeals

The CMS memo of July 11, 2005 makes clear that the CMS has no formal appeals process for rejection of a Medicare set-aside arrangement. However, if the claimant or submitter believes that there is additional evidence not previously considered by the CMS that would warrant a change in the CMS determination, the claimant or the submitter may resubmit the case with the additional evidence and request a re-evaluation. If the additional information does not convince the CMS to approve the set-aside arrangement and the parties proceed to settle the case despite the objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. When Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. See the April 22, 2003 CMS memo, Q&A 14.

V. FAILURE TO COMPLY — ENFORCEMENT

There are two bad things that can happen if the Medicare secondary payer statute is ignored. First, the claimant may not be able to get medical bills paid by Medicare that might have otherwise been paid if Medicare had been considered. Second, the MSP provides for direct action by the CMS to recover conditional payments and for a private cause of action against the workers' compensation carrier for failure to provide primary payment or appropriate reimbursement. 42 U.S.C. §1395y(b)(3)(A); 42 C.F.R. §411.24. Actions may be brought within three years from the date that the item of service was provided. 42 U.S.C. §1395y(b)(2)(B).

Pursuant to 42 C.F.R. §411.24(g), the CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received a third-party payment. Moreover, pursuant to 42 C.F.R. §411.26, the CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a third-party payer. Therefore, pursuant to 42 C.F.R. §411.24(b), the CMS may initiate recovery against the parties listed under 42 C.F.R.

§411.26 as soon as it learns that payment has been made or could be made under workers' compensation.

The CMS claims it has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third-party payment directly or indirectly. 42 C.F.R. §§411.24(b), 411.24(e), 411.24(g); 42 C.F.R. 411.26. See the April 22, 2003 CMS memo, Q&A 13 and Q&A 22.

Double damages are available only if the CMS initiates legal action to recover conditional payments. 42 C.F.R. §411.24(c). Damages are not limited to the amount of the settlement but extend to all payments made by the CMS for work-related charges. 42 C.F.R. 411.24. Accordingly, an insurer could potentially be required to make triple payment, once to the claimant and double to the CMS in litigation to recoup conditional payments.

VI. MEDICARE CONTACTS

The first report of attorney representation of a Medicare beneficiary for a workers' compensation claim should be made to the Centers for Medicare and Medicaid Services Coordination of Benefits (COB) Contractor. Attorneys can call the COB Contractor from 8am – 8pm, Monday – Friday, eastern time at 800/999-1118. More information is available at <http://cms.hhs.gov/medicare/cob>.

Settling parties should also contact the CMS regional office responsible for a particular state for approval of a Medicare set-aside arrangement. The inquiry should be directed to the attention of the “Regional Office Medicare Secondary Payer Coordinator,” who will forward the inquiry to the appropriate regional office if a transfer is necessary. See the April 22, 2003 CMS memo, Q&A 23.

VII. CONCLUSION

The Medicare secondary payer statute places significant risk on the parties and their counsel for failing to consider Medicare's interests in a workers' compensation settlement if the claimant is currently eligible for Medicare or the settlement satisfies the 30-month/\$250,000 threshold. If applicable, the MSP requires that the proposed settlement be submitted and approved by the CMS.

VIII. Credits

Portions of this article were published by the Illinois Institute for Continuing Legal Education as part of its 2004-2005 Illinois Worker' Compensation Handbook (<http://www.iicle.com>).

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