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The Medicare Secondary Payer Act
September 22, 2011 - Metairie, LA
September 30, 2011 – Baton Rouge, LA
Presented By:
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MSP Compliance and Medical Administration working together

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Three Separate Yet Interrelated Obligations

- Re-pay conditional payments
  (i.e. Medicare's lien – everyone's responsibility). Note the detailed re-payment procedures and penalties for non-payment
- Protect Medicare's post settlement interest – MSA's, etc. Again, everyone's responsibility – note the lack of statutory guidance on procedure
- MMSEA § 111 reporting procedure – the defendants' responsibility – severe fine - $1000.00/day

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Recent Developments

- On May 11, 2011 a new CMS memo was issued. CMS stated, for the first time (attached):
  "Submission of a WCMSA proposal for review and approval is a recommended process. There are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review."
- The memo goes on to state that the MSA web site is a "...dedicated workers' compensation Web site…". I take this to mean it is not meant to govern liability cases.
- Finally, and maybe most importantly the $25,000 and $250,000 thresholds "do not constitute a substantive dollar or 'safe harbor' threshold".

Summary of Conditional Payments

- Make sure the claim is reported to COBC – see the attached brochure found at www.msprc.info . Phone calls are answered fairly quickly. Plaintiff attorneys send in the Consent to Release and Proof of Representation forms – attached.
- Wait for the RAR letter and follow its directions.
- After about 2-3 months go to the www.mymedicare.gov website to get an idea of the conditional payments. It is supposed to be updated every 10 days.

Conditional Payments cont.

- Plaintiff attorney must send all settlements to MSPRC along with their contract and costs. Settlements cannot be conditional because the Final Demand Letter starts the date that interest at 11.35% begins.
- Wait for the final demand letter and pay Medicare directly (all of this is in the RAR letter).
- Note the difference between Conditional Payment Letters and Conditional Payment Notices – attached.

Contesting the Conditional Payments CMS Reports

- Be aggressive if you disagree with the amounts in the CPL, CPN, or on the www.mymedicare.gov web portal. Note the attached letter to Michele Earney. The CPL was for over $24,000.00
- MSPRC will reduce the Conditional Payment amount if shown that they are wrong. You will need to talk to them and show why they are wrong – medically.
- Don't argue third party fault or victim fault.
- Argue causation if you have medical records to back you up – e.g. a statement from the treating physician.

Reductions in Conditional Payments

- In Zinman* and Hadden*, CMS took the position that it was entitled reimbursement, less recovery costs, despite arguments like the made whole doctrine, due process, third party fault, etc. The courts agreed.

**Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995)

**Hadden v. U.S.A.*, USDC, W.D.Ky. (08-06-09) Lexis 69383 (on appeals in the 6th Cir)

Hadden – Request for Waiver

- The trial court, in denying Hadden's request for a waiver said:

"**Upon request, CMS may waive recovery of conditional payments made by Medicare. See 20 C.F.R. s 404.506. Under the Social Security Act, waiver of recovery may be granted where (1) a claimant is without fault and (2) recovery would either defeat the purposes of Title II or would be against equity and good conscience. 42 U.S.C. s 404(b). A recovery would defeat the purposes of Title II if it caused the claimant to suffer financial hardship by depriving him of income required for ordinary and necessary living expenses." 20 C.F.R. § 404.508.**

- **“Indeed, the (Medicare Appeal) Council found …Further, after repaying Medicare in full and deducting attorney's fees, the appellant retains $43,647.58 of the settlement proceeds.” Hadden’s damages were approx. $1mil but settled for $125,000. due to hit and run driver being primarily at fault**
- **<u>“In other words, had Plaintiff wanted equitable allocation and subrogation principles to apply in this case, then he should have proceeded to trial on the merits of his tort claim in state court.”</u>**
- Reductions are not easily obtained.

- “The only situation in which Medicare recognizes allocation of payments to non-medical losses is when payment is based on a court order on the merits…Medicare will accept the Court’s designation.”. But see *Bradley v. Sebelius* a case in which the court gave little deference to the manuals.

Who Should be Concerned About Protecting Medicare?

- Ms. Stalcup stated in the e-mail attached:
- “<u>All parties</u> in a liability case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving liability cases that include future medical expenses.”

Are MSAs Necessary?

- NO! Note attached CMS letter of May 11, 2011
- But they are the preferred method of protecting Medicare's post settlement/judgment interests.
- There is a formal non-mandatory approval process for workers' compensation MSAs but not for liability cases.
- No rules or guidelines regarding Liability Set Asides – but refer back to the purpose of the MSP: no double dipping.

Important Note From the Bradley v. Sebelius Decision

- When there are no binding rules* pertaining to how a settlement is to be divided amongst the plaintiffs, the test is one of "reasonableness".
- The Medicare Field Manuals were essentially ignored by the court.
- CMS, although invited to participate in settlement discussions – did not – citing the Field Manuals.
- Settlements have long been encouraged (in contrast to the district court decision in Hadden v USA – now on appeal).

***Remember that the CMS memo of May 11, 2011 referred to the CMS MSA web site as a "dedicated workers' compensation Web site". Therefore as of now there are only guidelines for WCMSA's and no rules for Liability MSAs.**

Duty of Care Owed to Medicare

- E-mails from Ms. Sally Stalcup, and statements made by Ms. Barbara Wright during the Medicare Medicaid and SCHIPP Extension Act of 2007 (MMSEA) all say basically the same thing: the duty owed to Medicare is one of "good faith" and "reasonableness". Paper your file that you have acted reasonably. This falls right in line with the Bradley decision: use reason and good faith.

Ms. Stalcup Information

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- When asking Ms. Stalcup if the use of a professional evaluator was necessary she said no, but:
- "If the settlement, judgment or award…provides funds for future medical services, and a set-aside proposal is either not submitted to Medicare, or Medicare elects not to review the submission, <u>this sounds like one method of documenting everyone's records to show that good faith effort was put into protecting the Medicare Trust Fund."</u>

I have a copy of all e-mails on file. I also have copies of Power Point she prepared.

Summary of Duty to Medicare

– *The point: Failure to take <u>reasonable</u> steps to protect Medicare's interest is a problem for the plaintiff attorneys and defendants. They have so far dodged a bullet. We'll talk about "reasonable" later.*

Issues Not Recognized by CMS

- CMS won't reduce MSA allocation based upon:
  - Causation
  - Third party fault
  - Apportionment of fault

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What Does Reasonable Care Mean?

- This involves a decision tree analysis:
- Is the plaintiff on Medicare at the time of settlement?
- If not, try to get the treating physician to put in writing that "within a reasonable degree of medical certainty, the claimant will not be disabled from gainful employment as a result of injuries sustained in the accident".
- Even if the claimant has or will have surgery, the doctor can give the same opinion.
- If the claimant is on SSDI is it because of the injuries sustained in the accident?
- If so get a professional to evaluate the amount needed for future care that is both "Medicare Allowable" and "related to the accident".

Reasonable Care con't

- Whether defense or plaintiff attorney, have the claimant sign a release that they understand that the set-aside funds are to be used solely for "Medicare allowable" expenses "related to" the accident.
- Give the plaintiff information where he/she can get help and advise (e.g. Specialty Metrics). Of course this is not free.
- Other examples?

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Some Methods to Settle Cases

- First, there is little guidance on this.
- Use the following cases as a guide:
  - Bradley v. Sebelius – involve CMS in the negotiations;
  - Big R Towing – have the judge determine the amount of the MSA, involve CMS in the case and have the Judge order that plaintiff spend the funds corectly;
- If the sum is large have it professionally administered. This is not a trust account but an account which is under the control of an professional administrator. This too comes at a cost – maybe.

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Professional Administration

- What is expected of an administrator: that they know what is not covered by Medicare.
- Note 42 CFR 411.15: 6 pages of line items not covered by Medicare under any circumstances – who knows this? A high school graduate? A lawyer? No – only a professional whose fees cannot be paid out of the set-aside. But presumably be paid out of a non-MSA account. Note the following cases at the extremes of the spectrum:
  - *USA v. Stricker*, USDC, ND, Al. - a high profile case
  - *USA v. Harris* – a small insignificant case

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Consequences of Improper Management of Allocated Funds

- Suppose the claimant is ill-equipped to administer the funds. I recently spoke with a very good plaintiff attorney who said a client whose case was settled several years ago, was recently turned down by Medicare for treatment because it was related to the original accident. The claimant came knocking at his attorney's door. CMS may do the same: look at the deep pocket in a few years – especially with the ability to instantaneously cross check per the new reporting requirements per the MMSEA § 111. See Administering Set Asides: http://www.cms.gov/WorkersCompAgencyServices/07_administeringwcmsas.asp#TopOfPage

My Prediction – Liability for Mismanagement of an Allocation

- For example:
  - Plaintiff sustains a serious to catastrophic injury;
  - A substantial amount is allocated (either by a formal set-aside approved or not approved by CMS);
  - The plaintiff's counsel and/or the entities funding the allocation know or at least should know that this plaintiff doesn't have the intelligence to properly handle the funds and account to Medicare for the handling of the funds;
  - The funds are spent inappropriately – innocently or otherwise and the fund is depleted;
  - Do the funding entities and plaintiff's counsel have responsibilities? I think that argument will be made as CMS loses cases and looks for other means of recovery.

FYI

Medicare Advantage Plans (Medicare Part C) do not have the same rights as CMS.

Note: *Care Choices HMO v. Engstrom*, 330 F. 3rd 786 (6th cir.2003);*Humana Medical Plan, Inc. v Mary Reale*, # 10-21493 – Civ. 2011 WL 335341, January 31, 2011 (D. S.D. Fla.); *Nott v. Aetna U.S. Healthcare, Inc.*, 305 F. Supp. 565 (E.D. Penn. 2004)

Medicare, Medicaid, and SCHIPP Extension Act of 2007

- Remember the first part spoke about the "Primary Plan". The MMSEA §111 is addressed only to Responsible Reporting Entities – RREs. RREs are the defendants only. Sec. 111 requires reporting by RREs of any payment to a Medicare beneficiary (not a potential beneficiary, or someone who is waiting for Medicare to kick in) within a specific time frame or be subject to a $1000.00 per day fine.

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What Must Be Reported and When

- The first thing to report is very basic information on the claimant: this allows CMS to determine if the claimant is a Medicare beneficiary. The suggested form is quite simple. https://www.cms.gov/MandatoryInsRep/Downloads/NGHHICNSSNNGHPForm.pdf
- Does Sec. 111 mandate that claimants give their SS#? No. But there are some U.S. District Court cases that say differently.
- The only time a payment of future medical expenses must be reported is if the payee is a current or past Medicare beneficiary.

New User Guide and Final Timelines and Thresholds

A more in-depth discussion of the legal issues surrounding the MSP repayment obligations and the MMSEA 111 obligations is in the first 20 or so pages of the current MMSEA User's Guide – which is actually 271 pages.

https://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3.2.pdf

The revised guidelines and timelines (which now take effect across the board starting October 1, 2011) can be found at:

https://www.cms.gov/MandatoryInsRep/Downloads/RevTimelineTPOC110910.pdf

THE END

Any questions?