Navigating the Language of Medicare Settlement

A Workers’ Compensation Continuing Education Course

October 19, 2016
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Presenter

Lavonya Chapman, Esq. RN
Medicare Secondary Payer Compliance Counsel
Every settlement agreement must address

- Mandatory Insurer Reporting
- Conditional Payment Resolution
- Medicare Set-Aside Allocation
Mandatory Insurer Reporting (MIR)
Confirm Medicare beneficiary status

Has the Responsible Reporting Entity (RRE) (e.g., employer, carrier, defendant, insurer) submitted claimant data through query process?

Yes

- Has the claimant been identified as a current Medicare recipient?
- Has the RRE reported the case to the Centers for Medicare and Medicaid Services (CMS) via Mandatory Insurer Reporting (MIR) quarterly cycle?
Claimant/Plaintiff/Releasor is a Medicare Beneficiary, and the defendant/Respondent/Employer/Released Party has, or will, report this settlement to CMS pursuant to The Medicare, Medicaid and SCHIP Extension Act (MMSEA) as well as notify CMS of the settlement pursuant to 42 CFR §411.250.
Has the RRE accepted Ongoing Responsibility for Medical (ORM)?

**Yes**

- Date of ORM acceptance?
- ICD-9 or ICD-10 codes last reported?
- Has ORM been terminated? Why?
Sample Settlement Language:

Claimant/Plaintiff/Releasor is currently a Medicare Beneficiary, and the parties either know or reasonably expect that Medicare Conditional Payments have been made.

The parties agree that of the settlement proceeds, $____________ shall be held in escrow by the Defendant/Respondent/Employer/Released Party to resolve any Conditional Payments. Any excess or balance in the escrow account after Conditional Payments have been resolved shall be disbursed to the Claimant/Plaintiff’s attorney.
Verify Total Payment Obligation to Claimant (TPOC)

Has a TPOC (settlement, judgment, award or other payment) taken place?

Yes

• Date reported?
• Amount of TPOC reported?
• Has ORM been terminated?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Date of ORM termination?</td>
<td>Specific reason why?</td>
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Claimant/Plaintiff/Releasor acknowledges that any decision regarding entitlement to Social Security Benefits or Medicare/Medicaid benefits including the amount and duration of payments and offset reimbursement for prior payments is exclusively within the jurisdiction of the Social Security Administration, the United States Government, and the United States Federal courts and is determined by Federal Law and Regulations. As such, the United States Government is not bound by any of the terms of this Settlement Agreement.
Conditional payments resolution
Verify Medicare beneficiary status type

A, B  Traditional Medicare

C  Advantage plan

D  Prescription plan
Part A and B (traditional Medicare) beneficiary status

- Has the Center for Medicare and Medicaid Services (CMS) provided either the Benefits Coordination and Recovery Center (BCRC) with a Conditional Payment Letter or the Commercial Repayment Center (CRC) with a Conditional Payment Notice asking for reimbursement of conditional payment?

- Has either of the parties disputed any of the payments requested by Medicare?

- What is the status of request for redetermination, reconsideration, ALJ hearing or Appeals Council?
  - If disputes and appeals have been exhausted, has either party received a final demand or final determination?
Determine responsible party for reimbursing Medicare

If disputes and appeals have been exhausted, and either party has received a demand or initial determination from BCRC or CRC:

- Who is responsible for reimbursing Medicare its conditional payments within 60 days of final demand or final determination?
- Has the opposing party provided you with proof of payment and closure letter?
In reaching this agreement, the parties have paid considerable attention to Claimant/Plaintiff/Releasor entitlement to Social Security disability benefits pursuant to 42 U.S.C. §423, and receipt of Medicare or Medicaid benefits under 42 U.S.C. §1395y, as well as the entitlement of the Centers for Medicare and Medicaid Services to subrogation and intervention, pursuant to 42 U.S.C. §1395y(b)(2), to recover any overpayment made by Medicare.

It is not the purpose of this settlement agreement to shift to traditional Medicare, a Medicare Advantage plan, or Medicaid the responsibility for payment of medical expenses for the treatment of injury-related conditions. Instead, this settlement agreement is intended to provide Claimant/Plaintiff/Releasor a lump sum which will foreclose Defendant/Respondent/Employer/Released Party’s responsibility for future payments of all injury-related medical expenses.
Part C (Advantage Plan) beneficiary status

Has Advantage Plan been contacted?
- Received its request for reimbursement?
- Disputed request for reimbursement?
- Received final demand?
- Agreed who will be responsible for paying?
- Demanded proof or payment and closure letter?
Part D (Prescription Plan) beneficiary status

Has the Prescription Plan been contacted?
• Received its request for reimbursement?
• Disputed request for reimbursement?
• Received final demand?
• Agreed who will be responsible for paying?
• Demanded proof or payment and closure letter?
Claimant/Plaintiff/Releasor acknowledges that CMS (traditional Medicare) and/or a Medicare Advantage plan (MAP) has a right to recover any conditional payments from the total settlement amount which were not resolved at the time of the settlement and may have a right to recovery of the entire settlement amount.

Claimant/Plaintiff/Releasor accept that risk and agree to hold harmless and indemnify the Defendant/Respondent/Employer/Released Party for any Medicare conditional payments reimbursement demanded or required by the CMS’ Benefits Coordination & Recovery Center or Commercial Repayment Center, Department of Treasury, collection agency or any other governmental entity, that may be uncovered and demanded in the future. Should traditional Medicare or a Medicare Advantage plan make a claim for conditional payments, Claimant/Plaintiff/Releasor shall not use any of the Medicare Set-Aside allocation funds to pay for said conditional payments.
Private Cause of Action pursuant to 42 USC Section 1395y(b)(3)(A)

Waiver of private cause of action for double damages for failure to provide primary payment or reimbursement.
Claimant/Plaintiff/Releasor agrees to hold harmless and indemnify Defendant/Respondent/Employer/Released Party from any cause of action, including, but not limited to, an action to recover or recoup Medicare benefits or loss of Medicare benefits, if CMS determines that the money set aside was spent inappropriately or for any recovery sought by Medicare, including past, present and future conditional payments.
Claimant/Plaintiff/Releasor understands that should CMS (Medicare) and/or MAP find that related conditional payments were not reimbursed and that Medicare's current interests were not adequately protected, CMS (Medicare) and/or MAP may require the Claimant/Plaintiff/Releasor to expend up to the entire settlement amount on Medicare reimbursable expenses related to the injury before Medicare or the MAP will provide coverage for the injury.

Claimant/Plaintiff/Releasor voluntarily accepts this risk and waives any and all claims of any nature and/or damages against the Released Parties and the Released Parties carrier(s) should Medicare and/or a MAP take such action, including, but not limited to a Private Cause of Action against the Defendant/Respondent/Employer/Released Party or its insurer(s) under the Medicare Secondary Payer Act (MSP) pursuant to 42 USC §1395y(b)(3)(A).
Medicare Set-aside Allocations (MSA)
Determine Medicare beneficiary status

- Is the claimant a current Medicare beneficiary?

- Does the claimant anticipate becoming a Medicare beneficiary within 30 months of settlement due to age, date of birth (DOB) or diagnosis?

- Is there no expectation of Medicare eligibility within 30 months of settlement?
The Parties agree that out of the total settlement amount, $______ shall be allocated to release all liability for future Medicare covered medical expenses, pursuant to the Medicare Set-Aside Summary. In addition, the parties reach this compromise based upon careful consideration of all of the medical reports and opinions, as well as Claimant/Plaintiff/Releasor’s personal knowledge of his/her condition and symptoms.

It is not the intention of the Defendant/Respondent/Employer/Released Party to shift responsibility of future medical benefits to the Federal Government. The MSA Funds for future Medicare-covered expenses is intended directly for payment of these expenses. Upon receipt of tangible evidence that the Medicare-reimbursable expenses exceed the MSA Fund, those expenses will be forwarded to Medicare for payment of covered expenses with proper documentation, provided the Claimant/Plaintiff/Releasor satisfies all of the Medicare program requirements at that time.
Medicare beneficiary and case settling for more than $25,000

- Have parties agreed to set aside amount?
- What is the life expectancy?
- What fee schedule was used to project future costs?
- How much for medical care?
- How much for prescription?
If MSA is to be or has been CMS approved

The Parties agree that the Medicare Set-Aside Allocation shall be submitted to Centers for Medicare and Medicaid Services (“CMS”) for review and approval as part of the requirements of this settlement. Any costs and expenses associated with the process of submitting the Medicare Allocation to CMS shall be paid by Defendant/Respondent/Employer/Released Party.

Defendant/Respondent/Employer/Released Party hereby acknowledges responsibility for the amount approved by CMS for the Medicare Allocation and agrees to pay any difference between the Medicare Allocation outlined herein and the amount approved by CMS pursuant to the terms for payment outlined above.
Medicare eligibility within 30 months of settlement, case settling for over $250,000

- Have parties agreed to set aside amount?
- What is the life expectancy?
- What fee schedule was used to project future costs?
- How much for medical care?
- How much for prescription?
Parties have agreed to set aside amount

- Has CMS approved a set aside allocation?
- How will such allocation be funded, lump sum or annuitized?
- How will it be administered, self or professionally?
Sample MSA Settlement Language

Prior to CMS approval

Approval of the proposed MSA in this settlement by the appropriate State authority may be sought prior to approval of the proposed MSA by CMS. Claimant/Plaintiff/Releasor acknowledges responsibility for, and shall hold Defendant/Respondent/Employer/Released Party harmless for, payment of all medical expenses, Medicare covered or otherwise, following this settlement but prior to CMS approval.

Claimant/Plaintiff/Releasor accepts responsibility for obtaining CMS approval of reimbursement for those medical expenses from the Medicare Allocation after receipt of the Medicare Allocation funds and CMS approval.
Claimant/Plaintiff/Releasor understands and agrees that s/he is administering the Medicare Set-Aside Allocation as a self-administered plan and that the Medicare Allocation shall be paid pursuant to the terms dictated by CMS:

- Separate interest bearing bank account
- Fee Schedule
- What may not be paid out of the MSA funds
- Accurate record keeping
- CMS annual report
Sample Private Cause of Action Waiver

Should CMS determines that the money set aside was spent inappropriately or was insufficiently funded, Claimant/Plaintiff/Releasor waives any and all claims of any nature and/or damages against the Defendant/Respondent/Employer/Released Party should Medicare and/or a MAP take such action, including, but not limited to a Private Cause of Action against the Defendant/Respondent/Employer/Released Party or its insurer(s) under the Medicare Secondary Payer Act (MSP) pursuant to 42 USC §1395y(b)(3)(A).
False Claims Action pursuant to 31 USC Section 3729

Waiver of false claims action for triple damages for presenting or causing to present to an agent of the United States a claim for payment; which claim was false or fraudulent; or knew to be false or fraudulent.
Thank you

Questions?

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