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LEGAL EYE | SECONDARY THOUGHTS

QUICK LOOK

- The government hasn't provided guidance on protecting Medicare's interests in liability settlements, but reporting mandates begin in January.
- Your carrier's risk tolerance will play heavily into how you handle these cases.
- Some CMS offices are willing to do prior reviews of settlements and set-asides.

Secondary Payer Protection

Medicare as a secondary payer must be protected for all liability claims, in and outside workers' comp.

BY JOHN V. D'ALUSIO

In July 2001, the Centers for Medicare and Medicaid Services (CMS) circulated the "Patel memorandum" (authored by Pashar Patel) notifying the P&C industry that Medicare set-aside allocations (MSAs) were now going to be "recommended" on workers' compensation claim settlements. Since then, there has been confusion regarding the best way to take Medicare's interests into consideration on non-

workers' comp claims (i.e., liability case settlements).

The problem is that CMS hasn't provided guidelines for a liability Medicare set-aside allocation review program. The workers' comp guidelines established by CMS for the use of MSAs in case settlements don't apply to liability claims. Still, the Medicare Secondary Payer law clearly applies to non-WC settlements.

With the upcoming Medicare, Medicaid and SCHIP Extension Act (MMSEA) Section 111 reporting requirements for liability claims that take effect on January 1, 2012, insurance carriers, self-insured entities, and captive insurers want to get some clarity on the issue.

Four Approaches to Set-Asides

There are several options when settling a case that involves a Medicare-entitled person or someone who will become Medicare-entitled at a time when the anticipated Medicare-covered future care will be needed. Much has to do with a risk management analysis of the claim and the insurer's tolerance for future exposure. Below are four approaches that can be considered the "risk management continuum" from the least defensible position to the most defensible.

1. If there is a low likelihood of future treatment related to the injury being settled, do not obtain an allocation, and pray that the claimant does not submit any future treatment bills to Medicare related to the injury for which you settled the claim.
2. Perform a "self-

allocation" and in the settlement document stipulate a certain amount of the settlement dollars for future medical treatment.

3. If there is negligence on the part of the defendant and a great deal of future medical exposure post-settlement, a professionally formulated allocation may be the best way to take Medicare's interests into consideration.
4. If the settlement is sufficiently large, consider not only a professional allocation but also a submission to CMS for their review and approval (depending upon the predilection of the individual CMS regional office where the claim is domiciled).

What Must Be Considered

Medicare Secondary Payment compliance can be thought of as a three-legged stool.

1. MMSEA Section 111 reporting
2. Medicare conditional payment reimbursement requirements
3. Future protection of Medicare post-settlement (MSAs)

The first two legs of the stool are statutory requirements.

MMSEA Section 111 reporting applies to all responsible reporting entities (RREs), essentially any company that is paying on a claim involving a Medicare-entitled claimant. CMS has

required quarterly reporting of workers' comp cases since January 1, 2010, and quarterly reporting of liability claims will become mandatory beginning on January 1, 2012. Each individual claim report may contain up to 132 data elements that must be captured in the underlying claims system of the RRE. If an RRE fails to report claims involving Medicare-entitled people, the law calls for a \$1,000 civil money penalty per day, per file with no ceiling.

In instances where it has made conditional payments, Medicare has a priority right of recovery. Further codification was added in Title 42 of the United States Code, as well as the Code of Federal Regulations (CFR), specifically 1395y(b)(2)(A)(ii) and Section 411.21-411.54. Medicare is authorized to make primary payments when it is a secondary payer only if a primary payer has yet to make "or cannot be reasonably expected to make" a prompt pay-

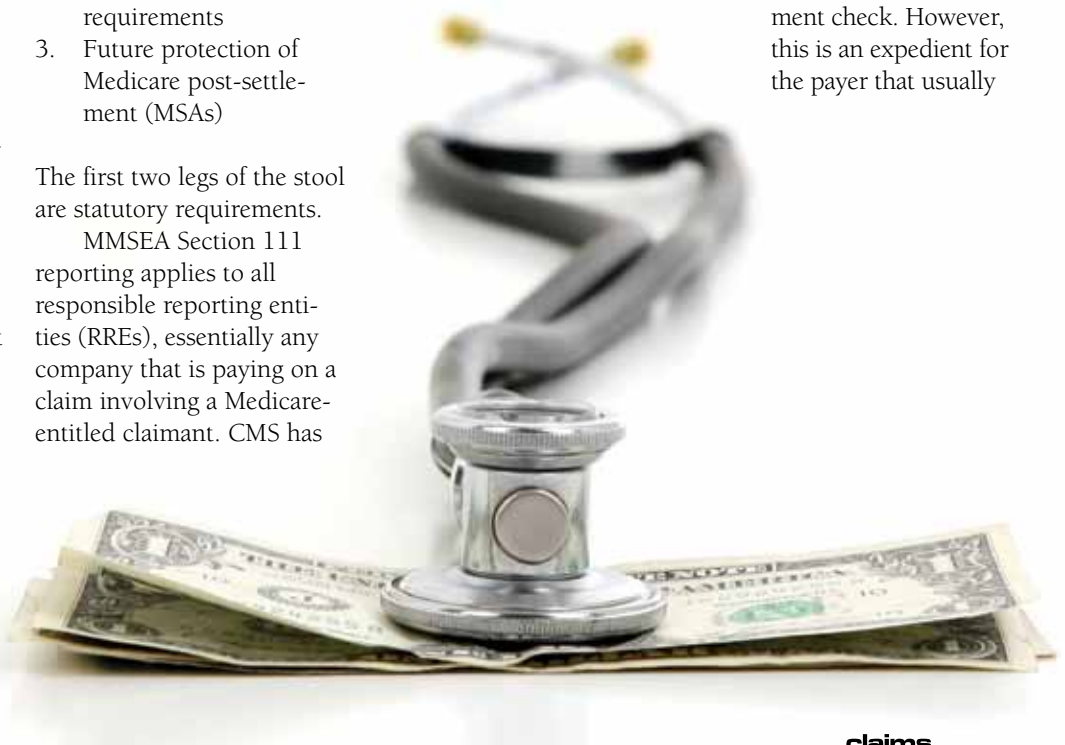
ment (within 120 days after receipt of the claim). Conditional payments are named so because they are conditioned upon reimbursement to Medicare.

The third leg of the stool, future protection of Medicare post-settlement, is a set of guidelines. When queried, CMS has indicated that a liability allocation is one way—but not the only way—to protect Medicare's future interests post-settlement. Since there are no present CMS guidelines for liability settlements on claims involving Medicare-entitled people, a liability MSA should not be thought the same as a workers' compensation MSA.

There are multiple factors to consider that are unique to liability cases. These include policy limits, comparative negligence, contributory negligence, procurement costs, and liability jurisprudence

A few things to keep in mind when considering a set-aside allocation include:

- A. Medicare can be listed as a payee on the settlement check. However, this is an expedient for the payer that usually



results in delaying the distribution of settlement proceeds to the claimant as the Medicare right of recovery amount is determined. The amount, if any, of conditional payments should be known or reasonably estimated prior to cutting the settlement check. Otherwise, if a large enough Medicare right of recovery exists, the settlement may be vitiated as a result of the amount owed to Medicare.

- B. It takes time to determine the amount Medicare may claim as conditional payments. The investigation should be initiated six months prior to settling a case, if possible. A week before mediation or trial is not the first time to begin considering Medicare's interests. Also, if future Medicare-covered treatment is likely post-settlement, an allocation is in order.
- C. Ideally, Medicare's right of recovery for conditional payments should be resolved prior to settling the general and special damages. The settlement may include a fully funded future treatment plan with all probable and likely services included, along with annuity (structured) payments flowing into a professionally managed custodian account.
- D. CMS can even be approached on large liability settlements for review and approval, but it depends on the office you are dealing with. For instance, the

CMS regional office in Philadelphia will most likely review any liability allocation sent to it, but the regional office in San Francisco will not accept any liability allocations for review. Therefore, you must know the proclivities of the CMS office when deciding to submit liability allocations for review and approval.

Points C and D above essentially constitute the gold standard for protecting Medicare's interests in liability settlements. However, there are costs and downsides associated with taking these approaches on every case. Obviously, this type of comprehensive consideration isn't practical for every settlement and should not be the norm.

Individual case factors will weigh heavily on how to apply a program designed to logically maintain the affirmative legal obligations Medicare enjoys as a secondary payer. So beware of the one-size-fits-all approach advocated by some MSA providers. **CA**

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A Brief History of MSP

Medicare Secondary Payer (MSP) is the term used by Medicare when it is not responsible for paying first. The original federal legislation that established Medicare's protection as a secondary payer when a primary payer exists is the Omnibus Budget Reconciliation Act of December 5, 1980. Further codification was added in Title 42 of the United States Code, as well as the Code of Federal Regulations (CFR), specifically, Section 411.20, which states that applicable lines of P&C insurance impacted by this law include:

- 1) Liability insurance (including self-insurance)
- 2) No-fault (PIP) insurance
- 3) Workers' compensation laws and plans.

From this section of the CFR, it is clear that the MSP does apply to liability claims as well as workers' compensation claims. Liability claims were included because settlements of these types of claims always involve irrevocable closure of future medical benefits (as both the "special damages" and "general damages" are always resolved simultaneously), and the liability area is approximately four times the size of the domestic WC market. Indeed, to exclude liability claims would have left a huge hole in Medicare's secondary payer protection. That certainly was not the intention of Congress when it extended secondary payer protection to Medicare.

The Medicare, Medicaid and SCHIP Extension Act (MMSEA), signed on December 29, 2007, mandates that claims involving Medicare-entitled individuals be reported so Medicare can pursue its right of conditional payment recovery in instances in which it made payment but a primary payer exists.

Section 111 of the MMSEA reporting was mandated for a primary reason: to alert CMS when the responsible reporting entity has claims involving Medicare-entitled individuals. Medicare can then check to determine if it has made any conditional payments on these cases. If it has made any that are consonant with the ICD-9 codes of the primary payer's claim, it will pursue its right of recovery against the primary payer.