



# CARR ALLISON

## MEDICARE COMPLIANCE NEWSLETTER

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### The Stricker Case: Does it Really Indicate an *Increased* Effort by Medicare to Collect Monies Owed Under the Medicare Secondary Payer Act?

by Melisa C. Zwilling, J.D.

In two words, not really. Medicare has been actively seeking reimbursement for conditional payment claims by filing similar court actions for several years. There are numerous reported cases in which Medicare has sought, and usually won, reimbursement. The Stricker case has caught the attention of so many employers, self-insureds, insurers and attorneys as a result of heightened awareness of Medicare's recovery rights under the Medicare Secondary Payer Act (MSPA) due to the passage of the Section 111 reporting requirements. It does not, however, mean that Medicare will now be operating in a manner that is different from how it has operated in the past regarding the collection of conditional payments.

In U.S. v. Stricker, CV-090PT-2423-E, filed December 1, 2009, in the U.S. District Court for the Northern District of Alabama, the Centers for Medicare and Medicaid Services ("CMS") and the Secretary of Health and Human Services, through the United States, initiated a lawsuit against defendant corporations, their insurers, plaintiffs, and plaintiffs' counsel to obtain recovery for conditional payments made pursuant to the MSPA. While prior lawsuits have *generally* sought reimbursement from plaintiffs or plaintiffs' counsel for failure to repay Medicare, (see, e.g., U.S. v. Harris, No. 5:08CV102, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va., March 26, 2009)), the Stricker case is slightly different in that it is the first which seeks reimbursement, *in a single action*, from ALL parties subject to MSP reimbursement obligations.

In Stricker, the plaintiffs settled their liability case against the defendant corporations in 2003 for approximately \$300 million. The complaint filed by the U.S. alleges that none of the 907 Medicare beneficiary plaintiffs reimbursed Medicare as they were legally obligated to do. Likewise, neither the plaintiffs' attorneys, the defendant corporations, nor their insurers researched Medicare's potential claims, notified Medicare of the settlement, or reimbursed Medicare for its conditionally paid claims. Therefore, the United States initiated suit, just before the statute of limitations expired, against all parties for double the amount of outstanding liens.

## Does The Stricker Case Indicate That MSAs are Needed in All Liability Only Cases Now?

Interestingly, the complaint seeks, in part, a declaratory judgment that future payments due under the settlement agreement must not be made until Medicare is first repaid for any conditional payments it has made on behalf of the beneficiaries. Some have expressed the belief that this lawsuit is an indication that Medicare is pursuing recovery for *post settlement* expenses and is an indication that Medicare Set-asides should also be used in liability cases. In fact, upon a close reading of the complaint coupled with an understanding of the MSPA and the Constitutional requirement of “standing” in order to assert a viable claim, it is clear that Medicare’s complaint is requesting reimbursement for medical expenses paid prior to the date of settlement, i.e., reimbursement for its conditional payments. (Keep in mind that there is a substantial difference between conditional payment claims and Medicare Set-asides. Conditional payment claims are for expenses Medicare has already paid on behalf of an injured individual up to the date of settlement and Medicare Set-asides are funds designated to pay future medical expenses for the individual from the date of settlement forward.)

The principle of standing is, very basically, that a party must have suffered, among other things, an injury in fact. If not, a federal court lacks jurisdiction to even entertain the proceedings. The injury must be an “invasion of a legally protected interest,” which must be: 1) “concrete and particularized,” and 2) “actual or imminent, not conjectural or hypothetical.” See Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61(1992). In the Stricker case, Medicare would not have constitutional standing to request, in this present action, that the court declare that Medicare is entitled to expenses which it has not yet even paid on behalf of Medicare claimants.

Money is still due and payable to the Stricker plaintiffs in annual installments through the year 2013. Medicare has requested the Court to declare that, instead of those future payments being made to the plaintiffs, they be paid to Medicare to reduce the amount owed in conditional payments. Since the remaining future payments are not adequate to satisfy Medicare’s conditional payment claims in this case, Medicare is also seeking to recover the remaining funds from the named defendants.

Further, one must keep in mind that the MSPA is based upon “primary payer” responsibility. In the liability context, once a settlement agreement has been reached between a defendant and claimant, the defendant is no longer a primary payer for the claimant’s medical expenses, assuming arguably that they were responsible for the payment of such expenses prior to the settlement agreement being reached. Unlike workers’ compensation defendants, liability defendants do not remain primary payers for the entire lifetime of a claimant. There is no similar legal duty imposed upon liability defendants to pay such expenses. As one federal court explained:

While the MSP is applicable to both workers’ compensation and personal injury tort claims settlements there is a difference in the manner in which each is considered by CMS. In the workers’ compensation context the obligation for the payment of medical expenses which may occur in the future arises from the workers’ compensation statute of the state rather than as a product of the settlement agreement itself.

Frazer v. Transcon. Ins. Co., 374 F. Supp. 2d 1067, 1073 (N.D. Ala. 2004) (adopted by, objection overruled by, and dismissed by Frazer v. CNA Ins. Co., 374 F. Supp. 2d 1067, (N.D. Ala. 2005)). Medicare is, however, unquestionably entitled to be reimbursed for any and all conditional payments made on behalf of a Medicare beneficiary up to the date that a liability case, or any case, is settled.

You will find no requirement within the MSPA, the Code of Federal Regulations or any other such legislation requiring Medicare Set-asides in any case. Utilizing a Medicare Set-aside **when appropriate**, how-

ever, is the best way to demonstrate that, at the time of settlement, Medicare's interests were adequately considered and protected.

If a substantial liability case is settled with a Medicare beneficiary who is likely to need future medical treatment related to the injury at issue, it is recommended that a reasonable portion of the settlement proceeds be designated to pay those expenses so it is clear that the burden is not being shifted to Medicare to do so. Parties may utilize a MSA allocation report or they may reach an agreement on their own concerning the amount that is reasonable in light of the total settlement.

Although the process for MSAs and obtaining the Centers for Medicare and Medicaid Services ("CMS") approval in workers' compensation cases is fairly established, the same is not true for liability cases. There is no "formal" process for CMS review of these cases. Individual CMS Regional Offices ("ROs") are vested with discretion to review liability cases to ensure that Medicare's interests are protected, or to not review such cases. Some CMS ROs have expressed a desire to review liability settlements in cases with Medicare beneficiaries if future medical treatment will be needed. Some will review such cases regardless of the amount while others will only review cases that settle for a very large amount of money. Some do not want to review liability cases at all. Further, review of liability cases can change from day to day depending on workload and availability. Although CMS review and approval may not be required, if available, obtaining CMS approval is certainly beneficial for all parties involved if a substantial amount of money is going to be paid specifically to cover medical expenses Medicare would otherwise cover. An individual inquiry may be made with the appropriate RO to see if review of a particular case is an option.

## Conclusion

Although notifying Medicare of claims involving Medicare beneficiaries is certainly not a new requirement, the process for reporting such claims has drastically changed with the implementation of Section 111. This reporting will allow Medicare to more easily identify claims for which it should only be a secondary payer so it can refrain from making payments for treatment related to the claim and to more easily collect on its conditional payments that are made since it will now know the identity of primary payers in more cases. The Stricker case does not, however, indicate that Medicare is going to start requiring that MSAs be utilized in all liability settlements.

We will continue to follow this and other cases concerning Medicare Secondary Payer issues and keep you informed of developments in this area. We have been providing MSA allocation reports and additional MSPA compliance services to our clients for over ten years and are happy to assist or answer any questions you may have in this area.

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## Liability Cases: You've Learned the Claimant is a Medicare Beneficiary Through the Query Process. What Next?

*by Melisa C. Zwillling, J.D.*

As all liability insurers and self-insurers (Responsible Reporting Entities or "RREs") should now be aware, mandatory reporting of certain claims to Medicare will begin very soon. The query process that will enable RREs to determine whether a claimant is a Medicare beneficiary and, if so, to report the claim once it settles or a payment has been made, became available July, 2009. But more must be done to ensure compliance with federal law than simply determining a claimant's status and reporting the claim to Medicare.

Once an RRE in a liability case has determined that the claimant is a Medicare beneficiary, we suggest in many large cases that steps be taken to determine as soon as possible whether Medicare will assert a conditional payment claim and, if so, the amount of such. A process involving the Coordination of Benefits Contractor (COBC) and the Medicare Secondary Payer Recovery Contractor (MSPRC) is in place through which a listing of the conditional payments Medicare has made related to a particular claim may be obtained. That information may be used during the mediation or settlement negotiation process.

Obtaining conditional payment claim information early on, before a settlement agreement has been reached, will allow time to request removal of any conditional payment claims that may be asserted improperly. For example, Medicare may request reimbursement for treatment that is not related to the injury at issue in a lawsuit. For such claims, there is a very specific administrative appeals process that has been set out in the Code of Federal Regulations that provides for the dispute and appeal of such improper claims. If an RRE waits to report the claim to Medicare pursuant to Section 111 requirements, *after* the settlement has already occurred, there will be insufficient time to dispute or appeal a claim. The law provides for a sixty day time period within which conditional payments must be repaid to Medicare before the matter is turned over for collections and is subject to interest and penalties. Further, if parties in a liability case proceed with settling a claim completely before determining the conditional payment claim amount, they will be "stuck" with the amount Medicare claims it is due (up to the amount of the settlement less claimant's attorney's fees). Few insurers or self-insureds want to settle a case without knowing exactly what will have to be paid.

In addition to the process we follow to determine the amount of a conditional payment claim which involves the MSPRC, claimants may go to MyMedicare.gov and print out a listing of all Medicare payments made on their behalf. An RRE may request that a claimant obtain this information before reaching a settlement agreement so all parties will have at least a general idea of the claims for which Medicare will likely require reimbursement. The main concern with this process is that it is not always available and the list of conditional payments Medicare has made is not always complete.

The attorneys at Carr Allison have been conducting conditional payment claim research and resolution for several years. We are very familiar with the administrative appeals process and have followed the same on behalf of our clients on numerous occasions. We have helped save clients a tremendous amount of money for claims erroneously asserted by Medicare. In addition, we are able to help clients determine whether a claimant is a Medicare beneficiary outside of the Section 111 query process. Please contact us at your convenience to discuss how we can be of assistance to you concerning these and any other MSP issues.

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## Exactly How Much Money Is Medicare Entitled to Recover for Conditional Payment Claims?

*by Melisa C. Zwillling, J.D.*

The amount Medicare is entitled to recover for conditional payments made on behalf of injured individuals in cases in which a primary payer exists is specifically set out in the Code of Federal Regulations. The relevant provisions state as follows:

42 C.F.R. § 411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

.....

(b) Right to initiate recovery. CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) Amount of recovery.

(1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment recipient, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) Methods of recovery. CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) Recovery from primary payers. CMS has a direct right of action to recover from any primary payer.

42 C.F.R. § 411.37 Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.

(a) Recovery against the party that received payment

(1) General rule. Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if—

(i) Procurement costs are incurred because the claim is disputed;  
and

(ii) Those costs are borne by the party against which HCFA seeks to recover.

(2) Special rule. If HCFA must file suit because the party that received payment opposes HCFA's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) Recovery against the third party payer. If HCFA seeks recovery from the third party payer, in accordance with § 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) Medicare payments are less than the judgment or settlement amount. If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) Medicare payments equal or exceed the judgment or settlement amount. If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) HCFA incurs procurement costs because of opposition to its recovery. If HCFA must bring suit against the party that received payment because that party opposes HCFA's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

In a nutshell, if the total settlement or judgment is MORE than Medicare's conditional payment claim amount, Medicare is entitled to its entire claim less a percentage of the claimant's attorney's fee (procurement costs). If the total settlement is LESS than the amount of Medicare's conditional payment claim, Medicare is entitled to the total settlement or judgment amount minus the claimant's attorney's fees (procurement costs). Thus, in accordance with the Regulations, if a claim is settled with a Medicare beneficiary for a total of \$10,000 and Medicare's conditional payment claim is \$45,000, Medicare would be entitled to recover \$10,000 minus the claimant's attorney's fees (generally between \$5,000 to \$7,000 in most states). This information should be taken into consideration when settling cases with Medicare beneficiaries.

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## Clarification Regarding the Proof of Representation Forms

There has been much confusion lately regarding the documentation necessary to research Medicare conditional payments made in workers' compensation and liability claims. Recently Carr Allison received confirmation regarding when Proof of Representation ("POR") forms should be used and by whom they need to be executed. POR forms should only be utilized by a Medicare beneficiary to designate someone to act on his or her behalf to research and resolve conditional payment claims which may be asserted by Medicare. If an individual or entity does not represent a Medicare beneficiary, then that individual or entity should not have a POR signed by the beneficiary. Doing such would be inappropriate and unwise, as the form states that the Representative will be acting on the beneficiary's behalf. As a pretty consistent rule, neither insurance carriers nor TPAs nor self-insurers act on behalf of a claimant nor do such entities "represent" claimants.

In the liability context, if an insurance carrier wishes to obtain conditional payment claim information itself and resolve such claims with Medicare, the carrier should obtain a Consent to Release form signed by the beneficiary allowing the release of the necessary information to the carrier. With that signed Consent, the

carrier should have the ability to research, negotiate and resolve conditional payment claims concerning that beneficiary with Medicare. If a TPA wishes to handle that process on behalf of the carrier, in addition to obtaining the signed Consent form allowing the carrier and TPA access to the claimant's information, the TPA should obtain a Letter of Authorization from the carrier stating that the TPA has the authority to act on the carrier's behalf.

If the carrier or TPA wishes to use another entity or vendor to perform conditional payment claim research and negotiation on its behalf, then it is advisable to have that entity named on the Consent to Release form as well. In addition, that separate entity must obtain a Letter of Authorization from the carrier (and TPA, if involved), that states that the separate entity has been hired by the carrier and/or TPA and is authorized to conduct conditional payment claim research and negotiation on its behalf.

If you have any questions concerning the Proof of Representation forms or Letters of Authorization, please do not hesitate to contact us.

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# CARR ALLISON MEDICARE COMPLIANCE DEPARTMENT

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## ABOUT US

The Medicare Compliance Group at Carr Allison is dedicated to assisting clients across the country with Medicare Secondary Payer issues including Section 111 Reporting, Conditional Payment Claim issues and Medicare Set-asides. Our number one priority is and has always been providing exceptional client service. We are truly dedicated to serving our clients well and ensuring compliance with complex federal laws while saving clients as much money as possible. Every client receives individualized, personal attention from experienced attorneys and staff who are familiar with the details of each file. Our medical personnel are readily available to answer medical questions about allocation reports and our attorneys are eager to discuss claims and provide sound, quality legal advice. We believe in complete accountability and frequently provide detailed status updates to our clients on every file. We view our clients as partners and friends, not simply as file numbers or sources of revenue.

In an area that is constantly changing, we make complete Medicare compliance as simple and worry-free as possible. We stay informed of recent and upcoming changes and issues involving the Medicare Secondary Payer Act and make certain that our clients stay informed as well. We welcome the opportunity to serve you and look forward to demonstrating why Carr Allison is the right choice for your organization.

## CARR ALLISON SERVICES

- Preparing Cost-Effective, Accurate Medicare Set-aside Allocation Reports
- Assisting with Medicare Issues in Workers' Compensation and Liability Cases
- Preparing Life Care Plans
- Prescription Drug Reviews
- Verifying Claimants' Public Benefits Status
- Providing Sound Legal Advice and Representation
- Obtaining CMS Approval of Settlements in Appropriate Cases
- Researching and Resolving Conditional Payment Claims
- Conducting Free Training for All Clients
- Section 111 Medicare Reporting Consultation
- Competitive Flat Fee Rates
- Online File Referral Process
- And Much More

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