

# **Medicare Claims/Liens and Medicare Set-Asides:**

What do they mean  
to your practice?

**Brett Newman**



**THE LIEN RESOLUTION GROUP**

PROTECTING PROCEEDS AND GOVERNMENT BENEFITS

# What is Medicare?

## A brief history

- In 1965 the United States Congress passed legislation to create the Medicare trust. Primarily, the trust was established to provide healthcare benefits for individuals and their spouses who worked for at least 10 years in Medicare covered employment and are 1) over 65, or 2) on Social Security Disability Income (SSDI) or 3) are in End Stage Renal Failure (ESRD).

# When do Medicare Benefits Begin?

- SSDI benefits do not begin until 5 months after the date of disability
- Eligibility is effective 24 months after the commencement of SSDI benefits
- Medicare enrollment occurs 29 months after the date of disability
- Age 65 or older eligibility is automatic if beneficiary has paid into system

# Medicare Secondary Payer Provisions

- Section 1862(b)(2) of the Social Security Act Regulation 42 USC 1395y(b):
  - (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 under a workmen’s compensation law or 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.

# MSP- The duty to protect Medicare's Interest interest

- Regulation 42 C.F.R.- 411.24 (b) CMS can make conditional payments for medical services for which another payer, such as a products liability or workers' compensation insurer is responsible, but has a statutory right to initiate recovery of these conditional payments
- ***Regulation 42 C.F.R.- 411.46 states that Medicare must be considered in any Workers' Compensation settlement when the client might rely on Medicare to cover any future medical costs related to the covered work injury.***

# Medicare Secondary Payer Provisions

- Medicare becomes the secondary payer to the settlement or award, and will not pay for future health benefits related to the injuries that led to the settlement or award.
- When future related health benefits are closed from a settlement, judgment or award, and the burden of health care is shifted to Medicare, by law, their interest must be protected.

# Medicare Secondary Payer Medicare Modernization Act

- Written into law in 2003
  - Amends the MSP and give any responsible party:
    - 1) Duty to inform Medicare of lawsuit
    - 2) Duty to Satisfy Lien
    - 3) Duty to make Medicare first payee of lawsuit
- *“The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity....that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity”*

# Medicare Step-By-Step Lien Process

1. Call case into ***Coordination of Benefits Office*** (COB) 800-999-1118. Give case specifics.
2. Then fax case to ***MSPRC*** 405-869-3309.
3. Once faxed wait 4 or 5 days and call ***MSPRC*** to confirm case was entered into the system and being worked. 866-677-7220.
4. You should then receive the conditional summary in approx. 45 days. You will probably get it quicker.



# Medicare Step-By-Step Lien Process (Continued)

5. Pull out all of the diagnosis codes not related to your clients injury/case. (fax it to me and we will do that for you at no charge)
6. Send the summary back to Medicare along with the case settlement breakdown of gross settlement, fees, disbs, etc.
7. Medicare will then mail you the final demand after they take off their procurement offset. (usually around 35% to 40%)
8. You then have 60 days to pay or you will get an unpleasant threatening letter from Dept. of Treasury.

# Waiver Requests of Medicare's Claim

1. All Beneficiary's have the right to appeal Medicare's claim amount.
2. The appeal must be made in writing.
3. A waiver form must be submitted along with a letter explaining why the waiver is being requested. ( waiver form attached)
4. Decisions are almost always based on financial hardship.

# Medicare Secondary Payer

## Medicare Medicaid and SCHIP Extension ACT (MMSEA)

- December 29, 2007 – President Bush signed into law the Medicare, Medicaid, and State Children’s Health Insurance Program Extension Act.
  - Section 111 adds new mandatory reporting requirements for group health plan arrangements and for liability insurance (including self insurance), no fault insurance and worker’s compensation plans.

# Section 111 – Phase One

- Insurers or Third Party Administrators for group health plans or self insured plans required to report the types of situations where their plan is primary to Medicare.

# Section 111 – Phase Two

- Requires all applicable plans (including WC, liability and no-fault insurance) to determine whether an injured individual making a claim is also a Medicare beneficiary, and if so, report the identity of the claimant to The Centers for Medicare and Medicaid services (CMS).

# Penalties for Non-Compliance

- Failure to comply with the reporting requirements of 2007 Act will result in a \$1,000 per day penalty per incident

# Combination of 2003 and 2007 Amendments to the MSP

- The combination of the provisions and amendments of the 2003 and 2007 Acts give Medicare a powerful means to recover its past interest and protect its future interest in a settlement, award or judgment.

# Who is at Risk?

- Beneficiary – loss of future medical coverage or dollar for dollar offset of their disability benefits
- Beneficiary's Attorney – The Office of General Counsel for CMS may demand or bring suit against the beneficiary's attorney for the full amount of the claim.



# How do you protect yourself?

- Properly protecting Medicare's future interest can be accomplished by several different methods.
- Although CMS has not given much direction on how to protect their future interests in general liability cases, they have issued a series of memorandums to assist the responsible parties in determining how and when to protect the agency's future interest in WC cases

## Protecting Medicare's future interest- a set aside arrangement

- The definition of a Medicare set arrangement is the calculation, funding and administration of a dollar amount that will protect Medicare's future interest at the time of settlement.
- Regardless of whether the settlement is comp or liability related CMS consider a set aside arrangement as an appropriate method to protect their interest.

# Three components of an MSA arrangement

## 1. Medicare Set-Aside Allocation

A Medicare Set-Aside Allocation is the documentation used to identify medical diagnoses and the need for future services both related and unrelated to the covered illness or injury

## 2. Method of Funding the MSA Account

The arrangement can be funded via lump sum or structured settlement

## 3. Method of Administering the MSA Account

The arrangement can be professionally or self administered

# When is an MSA required in a Workers Compensation Case?

- Primary payer is seeking to close out future medical benefits, and
  - 1) the injured individual is currently a Medicare beneficiary, or
  - 2) the injured individual is “reasonably expected” to be a Medicare recipient within 30 months of the date of settlement.

# Guidelines for WC MSAs: When is an MSA necessary?

***Reasonable Expectation*** includes but is not limited to:

- Individual has applied for Social Security Disability Benefits
- Individual has been denied SSD benefits and anticipates or is in the process of appealing &/or re-applying for SSD benefits
- Individual is at least 62 years and 6 months old
- Individual has ESRD Condition, but does not yet qualify for Medicare based upon ESRD

## Guidelines for WCMSAs:

When is it necessary to submit to CMS for their review and approval?

1. The settlement includes a “commutation” aspect where the primary payer is seeking to close future medical benefits
2. The injured individual is a Medicare beneficiary at time of settlement and settlement amount is greater than \$25,000
3. The injured individual is reasonably expected to be a Medicare recipient within 30 months of date of settlement, and the anticipated settlement for future expenses and disability/lost wages over the life or durations of the settlement agreement is expected to be greater than \$250,000

# Guidelines for WCMsAs:

## What information is needed to submit to CMS for approval?

### Supporting Documents for an Arrangement:

- Medical records and medical payouts for the last 2 years
- Client rated age and source of age statement (company letterhead)
- Any Life Care Plan and/or Medical Cost Projection that has already been completed on the injured individual
- Settlement - yes, no, or scheduled mediation/hearing date with estimated amount
- Proposed settlement documents
- Custodial account/Annuity information (company letterhead)
- Trust administration information (company letterhead)
- Jurisdictional limitation documentation

# WCMSA- Guidelines: Workload review

- The thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or “safe harbor” thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers’ compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare’s interest when settling any workers’ compensation case; even if review thresholds are not met, Medicare’s interest must always be considered.



# WCMSA- Guidelines: Workload review

- Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

# Tradition MSA Allocation: How to calculate the amount

- First Notice of Injury
- Medical records and medical payouts for the last 2 years
- Life Care Plan and/or Medical Cost Projection that has already been completed on the injured party, if available
- Rated Age (Actual Company letterhead documentation)

# WCMSA calculation and Submission: A review

## ➤ Medicare Evaluation Criteria:

- Determine Medicare eligibility/entitlement
- Research Medicare conditional payments and negotiate Medicare liens

## ➤ Set-Aside Allocation:

- Determined by:
  - ✓ Comprehensive review of medical and payment history
  - ✓ Physician recommendations
  - ✓ Standard of Care

## ➤ Submission and Approval:

- Submitted to the COBC
- Forwarded by COBC to the regional CMS office in injured workers current state of residence

# WCMSA Guidelines: Funding an MSA

- A single lump sum payment
- A structured set aside arrangement

A WC Medicare Set-aside Arrangement can be established as a structured arrangement, where payments are made to the arrangement on a defined schedule to cover expenses projected for future years. In a structured Medicare set-aside arrangement, monies are apportioned over fixed or definite periods of time. In such cases, Medicare will not agree to cover the beneficiary if there is no verification that the funds apportioned in the arrangement have been exhausted. Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the Medicare set-aside arrangement.

# WCMSA Guidelines: Administration

- An MSA can either be self administered or professionally administered. Regardless of the administrator a few guidelines need to be followed. To review the actual CMS published guidelines for administering an MSA please visit [www.hhs.gov](http://www.hhs.gov):
- An MSA should be placed in an interest bearing account.
- It should be administered by a competent administrator (the representative payee, a professional administrator, etc.). When a claimant designates a representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties must include that information in their Medicare Set-aside arrangement proposal to CMS.
- If it is permitted under State law and the claimant is self-administering his or her own CMS approved MSA they should submit an annual self-attestation form when monies have been exhausted.
- If the MSA has been approved by CMS, the administrator of the Set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the
- "If a claimant receives a Form 1099-INT for the interest income earned on his or her MSA account, the claimant or his/her administrator may withdraw an amount equal to the additional tax as a "cost that is directly related to the account" to cover the additional tax liability. This assumes that there is adequate documentation for the amount of incremental tax that the claimant must pay for the interest earned on this MSA. Moreover, such documentation should be submitted along with the annual accounting.
- The administrator of the CMS-approved MSA should not release Set-aside funds for any purpose other than the purpose for which the MSA was established.
- If the treating physician concludes that the claimant's medical condition has substantially improved, then the claimant (or the claimant's representative) 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 proposal may not be submitted until at least five years after a previous CMS approval letter and should be accompanied by all supporting documentation not previously submitted with the original WCMSA proposal. The CMS decision on the new proposal is final and not subject to administrative appeal.<sup>10</sup>
- **8 CMS Memo Ref: 10/15/04 Memo Q2**

# MSAs on Liability Cases

- Currently, CMS does not have a formal review process in place for MSAs on General Liability cases the same way it does for Worker's Compensation cases. The approval of General Liability MSAs is being handled by CMS' Regional Offices. Each of CMS' six regional offices has the **option** to review and approve General Liability MSAs.