Wisconsin Worker's Compensation Claims

The Medicare Secondary Payer Statute and Its Impact on Wisconsin Worker's Compensation Claims

by Attorney Philip Lehner
E-mail: wclawyer@mindspring.com

GRAHOVAC & KALLENBACH, S.C.
Racine, Wisconsin

Presented to the
Risk and Insurance Management Society, Inc.
Wisconsin Chapter Meeting
at Green Lake, Wisconsin
November 5, 2003

GRAHOVAC & KALLENBACH S.C.
ATTORNEYS

GRAHOVAC & KALLENBACH, S.C., 6233 Bankers Road, Suite 11, Racine, WI 53403 Phone: (262) 551-2050

This paper was presented to the PESI 2003 Wisconsin Worker's Compensation Practice Seminar on May 9 and 16, 2003. Since then it has been revised and supplemented. The present version was last revised on November 3, 2003.

Table of Contents

Appendix

1.0 General Background: The MSP Statute

The Medicare Secondary Payer (MSP) statute was passed by Congress in 1981 to address problems with cost-shifting of medical costs to Medicare in situations when some alternate source should be the primary payer and Medicare should be the secondary payer.[1] The alternate sources as primary payer for medical services are things such as group health benefits, worker's compensation benefits, liability insurance benefits, etc. The MSP statute is § 1862(b)(2) of the Social Security Act, and it is part of the United States Code at 42 U.S.C. § 1395y(b)(2):

> **Sec. 1395y. - Exclusions from coverage and medicare as secondary payer**
>
> (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 promptly (as determined in accordance with regulations) *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.
>
> In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. [Emphasis added.][2]

The Medicare Secondary Payer (MSP) statute is administered by the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS), as part of their Coordination of Benefits (COB) initiative. Note that CMS was formerly known as the

[1] 42 U.S.C. §1395y, available at: http://www4.law.cornell.edu/uscode/42/1395y.html.
[2] 42 U.S.C. §1395y(b)(2)(A), available at: http://www4.law.cornell.edu/uscode/42/1395y.html. The MSP statute did not change the law as to worker's compensation, since the Social Security Act already provided that Medicare is secondary to worker's compensation.

Health Care Financing Administration (HCFA). Some of the Medicare manuals still refer to CMS as HCFA.

Note that the MSP statute only deals with Medicare, not Medicaid. Medicaid is a totally separate program and it presently has nothing to do with the issues addressed in this paper.[3]

It is only in the last few years that CMS became more aggressive in dealing with situations in which it appears that worker's compensation insurers are trying to shift off liability for treatment expense to Medicare. There are a couple of theories about why this only recently became a significant issue, when Medicare has always been secondary to worker's compensation coverage.

It is probably significant that a May 2001 report by the U.S. General Accounting Office (GAO) concluded certain federal benefit programs, such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), are losing a *lot* of money because of payment errors relating to worker's compensation claims. The study also addressed issues as to payment errors by Medicare on worker's compensation claims, and noted that there is particularly a problem with settlements on worker's compensation claims.[4]

In July 2001, CMS issued a guidance document for the CMS Regional Offices to give some direction in identifying and dealing with worker's compensation claims that involve settlements, when Medicare is, or may be in the future, liable for treatment expenses that result from the injury.[5]

Most recently, in January 2003, the HHS Office of the Inspector General (OIG) reported on a survey of Medicare payments to workers' compensation recipients in Florida.[6] The report concluded that CMS is not doing very well in identifying claims in which worker's compensation should be the primary payer, and on settled claims Medicare is paying for services that should be paid from the proceeds of the settlement on the worker's compensation claim.

Therefore, in studying this subject we are dealing with several different levels of source materials. Listed in order of legal significance we have:

1) The MSP statute itself: 42 U.S.C. § 1395y(b)(2).

---

[3] As described on the CMS Web site:

> Medicaid is an assistance program. Medical bills are paid from federal, state and local tax funds. It serves low-income people of every age. Patients usually pay no part of costs for covered medical expenses. A small co-payment is sometimes required. Medicaid is a federal-state program. It varies from state to state. It is run by state and local governments within federal guidelines.

[4] *Workers' Compensation — Action Needed to Reduce Payment Errors in SSA Disability and Other Programs,* U.S. General Accounting Office, May 2001, GAO-01-367, available at: http://www.access.gpo.gov/su_docs/aces/aces160.shtml.

[5] *Workers' Compensation: Commutation of Future Benefits*, Memorandum by Deputy Director of Purchasing Policy Group, CMS, July 23, 2001. The complete memorandum appears in attached Appendix A.

[6] *Survey of Medicare Payments to Workers' Compensation Recipients in the State of Florida*, HHS Office of the Inspector General, January 2003, A-04-01-07003, available at: http://oig.hhs.gov/oas/reports/region4/40107003.pdf.

2) The federal regulations by HSS under the MSP statute: 42 C.F.R. 411.20–411.47 (*Exclusions from Medicare and Limitations on Medicare Payment*).[7] Regulations by an administrative agency have the force of law, but they are only valid insofar as they are authorized by the statutes.

3) The published manuals by CMS, such as the *Medicare Intermediary Manual* and the *Medicare Carriers Manual*. As of October 2003, there is a new *Medicare Secondary Payer Manual* (CMS Pub. 100-5).[8] As described in the CMS Web site, the *Medicare Secondary Payer Manual* is a new manual that replaces current Medicare Secondary Payer instructions for Medicare providers and contractors. Corresponding sections within current manuals will be removed.

4) The policy statements by CMS, such as the *Workers' Compensation: Commutation of Future Benefits*, Memorandum by Parashar B. Patel, Deputy Director of Purchasing Policy Group, CMS, July 23, 2001, hereafter "the CMS guidance document of July 2001."[9] We now also have two memorandums by CMS in question/answer format, to respond to frequently asked questions (FAQs), dated April 21, 2003, and May 23, 2003 (hereafter "the CMS FAQs of April 2003" and "the CMS FAQs of May 2003").[10]

You need to keep in mind that interpretations of the law by CMS are only valid insofar as they are consistent with the statutes and regulations. There are presently some issues as to overreaching by CMS, and some of the policy statements by CMS do not appear to be consistent with the statute and regulations.

2.0 Medicare Eligibility and Coverage

There are basically three groups of people who qualify for Medicare benefits:

1) people age 65 or older who are receiving Social Security retirement benefits;

2) people who qualify for Social Security disability insurance (SSDI) benefits, with Medicare coverage beginning 24 months after they qualify for such benefits; and

3) people with end-stage renal disease (ESRD).

Because of the current problems with the national economy, the number of people receiving SSDI benefits is rapidly escalating.

> Millions of low-skilled workers have turned to federal disability pay as a refuge from layoffs in recent years, doubling the

[7] The regulations appear in attached Appendix C.
[8] The new *Medicare Secondary Payer Manual* is available at: http://cms.hhs.gov/manuals/105_msp/msp105index.asp.
[9] The complete guidance document appears in attached Appendix A.
[10] The memorandum of April 21, 2003, is attached as Appendix D and the memorandum of May 23, 2003, is attached as Appendix E.

benefit's cost and, with little notice, making it by far the government's biggest income-support program.

Most of those qualifying for the benefits, part of the Social Security system, never got past high school and held jobs like factory worker, waitress, store clerk, laborer or health care aide. Their numbers have grown to 5.42 million today from 3 million in 1990, swelling the program's costs to $60 billion last year. That far surpasses unemployment insurance or food stamps or any other similar program.

"Show me a high school dropout, particularly a male, who is over the age of 40 and is not working and there is a 40 to 45 percent chance that he is on Social Security disability insurance," said David H. Autor, an economist at the Massachusetts Institute of Technology.

It is not that disabling injuries are occurring more frequently. Research by a number of economists indicates that the growing numbers signal instead a reliance on disability benefits by low-end workers who had ignored their ailments as long as their limited skills brought them steady employment. Some who would have gone on welfare now apply for disability pay instead.

"When you are a person who has lost a job, and you can't find another and you are home sitting on the couch," said Morley White, an administrative law judge in Cleveland who rules on disability claims, "you become preoccupied with ailments that do qualify in many cases as legal disability but while you were working did not come into your mind."[11]

To deal with the issues presented in this paper, you need to have at least some idea of what Medicare covers.

What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. You must meet certain conditions.

What is Medicare Part B?

Medicare Part B (Medical Insurance) helps cover your doctors' services, and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home

[11] *Disability seen as refuge from layoffs*, Milwaukee Journal Sentinel, Sept. 2, 2002.

> health care. Part B helps pay for these covered services and supplies when they are medically necessary.[12]

Note that Medicare does not cover some services and supplies that may be significant on a worker's compensation claim. For example, Medicare does not cover custodial care when that is the only kind of care needed.[13] Medicare also does not cover most prescription drugs.[14] Medicare provides only very limited coverage for home health care. Outpatient mental health care is covered, but with a co-payment of 50% of the Medicare-approved amount, if the provider accepts Medicare assignment.[15]

3.0 Identifying Claims Subject to the MSP Statute

3.1 Claims Involving Past Treatment Expense Paid by Medicare

Whenever Medicare paid for past treatment expense that should have been paid as part of a worker's compensation claim, you are required to reimburse Medicare for the payments it made. If you are resolving a claim on a compromise settlement, then you need to address Medicare's reimbursement claim and decide how you are going to handle that claim, as described below.

The federal regulations provide that it does not matter if CMS put the parties on notice of payments made by Medicare that would appear to be for treatment of an employment injury. The worker's compensation insurer, as a third party payer, has an affirmative duty to notify CMS

---

[12] *Your Medicare Benefits 2002*, CMS brochure, available at: http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf.

[13] As described by CMS:

> Medicare does not cover custodial care when that is the only kind of care you need. Care is considered custodial when it is for the purpose of helping you with activities of daily living or meeting personal needs and could be done safely and reasonably by people without professional skills or training. For example, custodial care includes help getting in and out of bed, bathing, dressing, eating, and taking medicine. Medicare does cover limited skilled nursing facility care under certain conditions.
>
> Most nursing home care is custodial care. Generally, Medicare does not cover custodial care. Medicare Part A only covers skilled care given in a certified skilled nursing facility (SNF). You must meet certain conditions and coverage is limited.

Your Medicare Benefits 2002, CMS brochure, available at: http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf. Also note that custodial care is not compensable as treatment expense under the Wisconsin Worker's Compensation Act. *Mednicoff v. ILHR Department*, 54 Wis. 2d 7, 12, 194 N.W.2d 670 (1972).

[14] As described by CMS:

> Medicare does **not** cover most prescription drugs. Medicare covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on Medicare-covered prescription drugs.

Your Medicare Benefits 2002, CMS brochure, available at: http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf.

[15] *Your Medicare Benefits 2002*, CMS brochure, available at: http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf.

that Medicare paid for services that should have been paid by the worker's compensation insurer.[16]

However, the administrative rule would arguably apply only to conceded employment injuries, when the payments by Medicare were for treatment that was directed to cure or relieve the effects of the employment injury. Conversely, if the insurer has a valid basis to argue that: (1) there was no compensable employment injury, or (2) the treatment was *not* directed to cure or relieve the effects of a conceded employment injury, then it questionable whether the insurer has any duty to give notice to Medicare under the administrative rule.

3.2 Claims Involving Future Treatment Expense Potentially Payable by Medicare

3.21 Threshhold Issue as to Current or Potential Eligibility for Medicare

In July 2001, the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS) issued a memorandum to provide guidance to the CMS Regional Offices (ROs) on identifying and dealing with worker's compensation claims that involve settlements, when Medicare is, or may be in the future, liable for treatment expenses that result from the injury. The first issue to be addressed is the employee's current or potential eligibility for Medicare benefits. As noted in the CMS guidance document of July 2001:

> **Question 1**:
>
> **(c) In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare's interests be considered before the parties can settle the case?**
>
> The answer to question 1(c) is, it is not in Medicare's best interests to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests when the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, **and** the anticipated **total** settlement amount for future medical expenses **and** disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.[3]
>
> [3] Please note that the review thresholds (i.e., 30 months and $250,000) will be subject to adjustment once CMS has experience reviewing these matters under these instructions.
>
> For example, if the injured individual is designated by WC as a Permanent Total disabled individual, has filed for Social Security

[16] 42 C.F.R. 411.25. (See attached Appendix C.)

> disability, and the settlement apportions $25,000 per year (combined for both future medical expenses **and** disability/lost wages) for the next 20 years, then the RO should review that WC settlement because the total settlement amount over the life of the settlement agreement is greater than $250,000 ($25,000 x 20 years = $500,000) and the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date. If the injured individual in this example fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 CFR 411.46 once the injured individual actually becomes entitled to Medicare.
>
> **NOTE:**
> Injured individuals who are already Medicare beneficiaries **must** always consider Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, **ALL WC PAYMENTS** regardless of amount **must** be considered for current Medicare beneficiaries.

Workers' Compensation: Commutation of Future Benefits, Memorandum by Parashar B. Patel, Deputy Director of Purchasing Policy Group, CMS, July 23, 2001, hereafter "the CMS guidance document of July 2001." The complete guidance document appears in attached Appendix A.

To summarize, CMS takes the position that you are supposed to consider Medicare's interests whenever you are resolving a worker's compensation claim on a settlement that closes out future treatment expense, and in which:

1) the injured employee has a "reasonable expectation"[17] of Medicare enrollment within 30 months of the settlement date, *and* the gross total amount payable on the settlement is more than $250,000,[18] **or**

2) the injured employee is already eligible for Medicare.

3.22 Secondary Issue as to Type of Settlement on WC Claim: Commutations and Compromises

You then have to address the issue as to the type of settlement that is being used to resolve the claim. The CMS guidance document of July 2001 distinguishes between two types of settlement agreements: commutations and compromises. CMS says that we must set money aside for future treatment expense on commutations, in the types of situations described above.

Basically, a commutation is described as a type of settlement that provides for payment of a lump-sum amount in lieu of periodic payments that would otherwise be due. As described by CMS, a commutation would be used on a claim in which there is conceded liability.[19]

[17] The standards for a "reasonable expectation" of Medicare eligibility are discussed in the CMS FAQs of April 2003, Question/Answer 2. (Refer to attached Appendix D.)
[18] Computing the total dollar value of the settlement when you have a structured settlement is discussed in the CMS FAQs of April 2003, Question/Answer 17. (Refer to attached Appendix D.)

A compromise is described as a settlement of a claim when there is a liability dispute. CMS notes that a compromise only compensates an individual for past or present treatment expense, and would not ordinarily include compensation for future treatment expense. However, in Wisconsin, a full, final and complete compromise settlement of a claim *would* include a termination of the worker's compensation insurer's liability for any future treatment expense, although it may not actually include additional compensation that is specifically intended for future treatment expense. Thus, the distinctions recognized by CMS, as between a commutation and a compromise, are difficult to relate to Wisconsin worker's compensation law.

Nevertheless, for practical purposes the distinctions recognized by CMS may be rather simple to apply. The CMS FAQs of April 2003 say that, if settlement agreement is intended to compensate the individual for future treatment expense, then it is a commutation and you must set aside money for future treatment expense:

> **4) What's the difference between commutation and compromise cases? And can a single WC case possess both?**
>
> **Answer:** When a settlement includes compensation for future medical expenses, it is referred to as a "WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.
>
> *Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.*
>
> **Example:** The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services. [Emphasis added.]

In Wisconsin, any full, final and complete compromise settlement of all claims would terminate liability for future treatment expense.[20] Therefore, on a complete compromise it can be argued that you must set aside money for future treatment expense that would otherwise be payable by Medicare, if the facts of the case show the need for continued care related to the employment injury. If claims for future treatment expense are instead left open, then you have limited compromise settlement and you don't have to worry about setting aside some amount for future treatment expense.

However, what if you have a full, final, and complete compromise of all claims that does not include compensation for future treatment expense? In such cases the HHS regulations provide

---

[19] Wisconsin law does permit a worker's compensation insurer to finalize its liability on a *conceded* claim in certain limited situations, but only in the discretion of the Department. Wis. Stat. § 102.32. To the best of my knowledge the Department does not routinely authorize such "settlements."

[20] *Schenkoski v. LIRC*, 203 Wis. 2d 109, 552 N.W.2d 120 (Ct. App. 1996).

that Medicare should pay future treatment expenses.[21] On that basis CMS should waive any requirement to set aside money for future treatment expense. Nevertheless, there are some problems with these situations, as discussed at page 21 below.

4.0 Dealing with Medicare Claims Under the MSP Statute

4.1 Reimbursement of Amounts Paid by Medicare for Past Treatment Expense

If Medicare has already paid for treatment expense that should have been paid by a worker's compensation insurer, then Medicare must be reimbursed for any conditional payments. This is something you particularly need to deal with at the time of a settlement on the claim.

The procedure is relatively straightforward and is described in the *COB Contractor MSP Laws and Third Party Payers Fact Sheet for Attorneys*. That document is attached at end of this outline as Appendix B.

When dealing with a Medicare reimbursement claim for amounts Medicare has already paid, you are not dealing directly with CMS. Such claims are instead handled by CMS contractors. If you have not already been contacted by a CMS contractor, you then need to begin by contacting the CMS Coordination of Benefits Contractor (COBC). You should mail or fax the following information to the COBC:

- ✓ a description of your role on the claim;
- ✓ the name and Social Security number of the claimant;
- ✓ the date of injury;
- ✓ the nature of the claim (i.e, that it is a worker's compensation claim);
- ✓ the nature of the injuries;
- ✓ the information about the worker's compensation insurer — name, address, phone number claim number, claims adjuster's name (if known); and
- ✓ the information as to the legal representatives, if any, of both the claimant and the worker's compensation insurer — name, address, and phone number.

You may contact the COB contractor at:

Medicare-COB
MSP Claims Investigation Project
P.O. Box 5041
New York, New York 10274-5041

The COB contractor opens a file on the claim and determines which lead contractor would be responsible for the claim in a particular state. You then receive a notice advising you of the Medicare contractor assigned to handle the specifics of the case to recovery (i.e., the lead

[21] 42 C.F.R. 411.46(d). (See attached Appendix C, page 7.)

contractor), Medicare's right of recovery, and a beneficiary consent to release form. Once this process is complete, all further inquiries are made through the lead contractor.

For Medicare in Wisconsin, the CMS contract intermediary is United Government Services, LLC (UGS), for Part A (hospital) Medicare coverage. Part B (medical) coverage is administered by Wisconsin Physicians Service (WPS).

However, for reimbursement claims under the Medicare Secondary Payer provisions, United Government Services, LLC (UGS), is the lead contractor for both Part A and Part B claims. You will probably end up dealing with the UGS office in Virginia that handles MSP claims for several states, including Wisconsin:

> United Government Services, LLC
> Attn.: Medicare Secondary Payer Unit
> P.O. Box 12201
> Roanoke, VA 24023-2201
>
> Phone: (540) 767-7117
> Fax: (540) 767-7008

For questions or problems regarding a claim:

> Ms. Ella Spillman, Medicare Secondary Payer Supervisor
> Phone: (540) 767-7074

When the claim is finally settled, you again need to write to UGS, to provide information regarding the terms of the settlement, including the settlement date, amount of the settlement, and attorneys fees/costs. Note that in determining Medicare's interests, they are willing to take a reduced amount after deduction of "procurements costs," such as attorneys fees and costs in prosecuting the underlying worker's compensation claim. On small claims they may even be willing to waive their reimbursement claim.

When you do make payment to UGS on a claim, you will need to have their federal employer identification number:

> United Government Services, LLC
> FEIN: 39-1946735

There are obviously some problems that arise when you have a contested claim that is being resolved on a compromise basis, but Medicare paid some of the treatment expense on the claim, since you then have to determine how much Medicare should be reimbursed out of the total settlement. CMS now has a manual to provide guidance to its intermediary contractors in applying the federal regulations under the Medicare Secondary Payer statute: the *Medicare Secondary Payer Manual*.[22]

[22] *Medicare Secondary Payer Manual*, available at: http://cms.hhs.gov/manuals/105_msp/msp105index.asp.

The *Medicare Secondary Payer Manual* explains how its intermediary contractors should review a compromise settlement of a worker's compensation claim to determine how much Medicare should receive for reimbursement. The regulations under the Medicare Secondary Payer statute include a formula to apply in analyzing a compromise settlement that fails to apportion the amount of the settlement between treatment expense and indemnity expense. It essentially says you look at the amount of the settlement as a percentage of the total value of the claim if it was conceded.[23] You then apply that percentage to the bills paid by Medicare.

For example, as described in the *Medicare Secondary Payer Manual*:

> If a WC agency approves a lump sum settlement of a case where compensability is contested, the lump sum settlement is deemed to be a WC payment, even if the settlement agreement stipulates that there is no WC liability. (See §40.3.4.)
>
> If it appears that a settlement represents an attempt to shift to Medicare the responsibility for the payment of medical expenses for the treatment of a work-related condition, it will not be recognized. Settlements of this type may occur, for example, when the parties attempt to maximize the amount of disability benefits paid an injured employee under WC by releasing the WC carrier from liability for a particular course of treatment, despite facts showing a relationship between the work injury and the condition that necessitated the treatment. In such cases, the FI or carrier determines that the services could have been paid for under WC and are, therefore, not payable under Medicare.
>
> EXAMPLE
>
> A WC settlement paid for $6,000 of the total medical expenses. The $18,000 in medical expenses included $1,500 in charges for services not covered under Medicare, $7,500 in charges for services covered under Medicare Part B, and $9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers' compensation payment rate, that is, in amounts the provider or supplier must accept as payment in full.
>
> The Medicare allowed charge for physicians' services was $7,000 and Medicare paid $5,600 (80 percent of the reasonable charge). The Part B deductible had been met. The Medicare payment rate for the hospital services was $8,000. Medicare paid the hospital $7,480 ($8,000 minus the Part A deductible of $520)
>
> In this situation, the beneficiary's payments totaled $3,920.

[23] 42 C.F.R. 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim. (The regulation appears in attached Appendix C.)

Services not covered under Medicare	$1,500
Excess of physicians' charges over reasonable charges	$500
Medicare Part B coinsurance	$1,400
Part A deductible	$520
Total	$3,920

The Medicare overpayment, for which the beneficiary is liable, would be $2,080 ($6,000-$3,920).[24]

Thus, in the above example Medicare paid a total of $13,080 ($5,600 + $7,480), but upon applying the foregoing analysis its claim for reimbursement would be computed at only $2,080.

Finally, in working with a Medicare contracted intermediary, you need to understand that they have some latitude in resolving claims for reimbursement. As noted in the *Medicare Secondary Payer Manual*:

> **40.2.3 - Medicare Paid for Services Which Should Have Been Paid for by Workers' Compensation**
>
> (Rev. 1, 10-01-03)
>
> B3-3334.2, A3-3417.2, B3-3334
>
> In any case in which it is clear that Medicare paid for services that should have been paid for by the WC carrier, the FI or carrier requests that the WC carrier reimburse the Medicare program for the amounts improperly paid by Medicare.
>
> If it is determined that payment has been made for services covered by WC, the FI or carrier initiates recovery of the overpayment. Sections 40.2.2 and 40.2.3 provide guidelines for recovery of Medicare payments in some of the more common situations. However, since the circumstances in which work-related issues arise vary greatly, it is impossible to provide definitive rules to cover every situation. *Therefore, the FI or carrier must use judgment and discretion in applying the guidelines.* [Emphasis added.]

To summarize, you should be in a position to negotiate with the CMS lead contractor on reimbursement claims for past treatment expense that was paid by Medicare, just as you would with any other subrogated insurer.

[24] *Medicare Secondary Payer Manual*, Ch. 7, § 40.3.4 – Effect of Lump Sum Compromise Settlement. There are several other examples that are instructive.

4.2 Settlements Involving Future Treatment Expense

As described above, the CMS guidance document of July 2001 defines the specific situations in which a claim is being resolved on a final settlement, and the settlement includes compensation for future treatment expense. In the types of situations described in the CMS guidance document, we are supposed to set aside some specific amount to cover future treatment expense. Specifically, we are to set aside an amount for the type of future treatment expense that would be for Medicare-covered services.

We are supposed to establish a Medicare set-aside agreement to administer the money and apply it on future treatment expense for Medicare-covered services. Such agreements are commonly referred to as Medicare set-aside custodial agreements or Medicare set-aside trusts.[25] The set-aside agreement must then be submitted to a CMS Regional Office for approval.

It should be noted that such set-aside agreements are not specifically authorized by the MSP statute or the HHS regulations. They are instead an "administrative mechanism" based upon CMS's interpretation of the MSP statute and the corresponding regulations.[26]

Once a set-aside agreement is approved by CMS, Medicare suspends payment for any treatment expense on the claim until the fund administered under the set-aside agreement has been entirely used up on payment of treatment expense for Medicare-covered services.

You would presumably begin by drafting a Compromise Agreement that provides for some amount to be set aside and to be administered under a set-aside agreement that is to be approved by CMS at a later time.[27] You would then submit the Compromise Agreement to the Worker's Compensation Division, DWD, for approval. Once the settlement is approved, you would need to establish a set-aside agreement and submit it for approval by the CMS Regional Office in Chicago.

Establishing a Medicare set-aside agreement for future treatment expense and obtaining approval from CMS is a rather complex process. There are now a number of national vendors marketing their services in providing assistance on some or all of the various parts of the process. Because of the complexity involved, you may want to give serious consideration to relying upon experienced vendors operating on a national level, who have developed expertise in dealing with such situations. Some worker's compensation insurers now have lists of approved vendors for dealing with these situations.

---

[25] The distinction, if any, is elusive. Some commentators have indicated that a set-aside custodial agreement is funded by a lump-sum amount, while a set-aside trust is funded by purchasing an annuity. The phrase used in the CMS guidance document of July 2001 is, "set-aside arrangement." For this paper I use the general description, "Medicare set-aside agreement."

[26] *Workers' Compensation: Commutation of Future Benefits*, Memorandum by Deputy Director of Purchasing Policy Group, CMS, July 23, 2001, pg. 1, footnote 1. The complete memorandum appears in attached Appendix A.

[27] You should probably avoid referencing a specific amount to be set aside, as discussed in the section below on *Problem Areas and Some Practical Considerations* at page 20.

Some of the entities involved on a national basis are listed below, for handling various aspects of Medicare set-aside agreements. *Keep in mind that I am not personally endorsing or recommending any of these entities.*

4.21 Projecting the Cost of Future Treatment Expense

The first step in the process is to project the cost of future treatment expense, so you know how much money is to be set aside in a trust. This is ordinarily done by someone with medical training.

There are a number of national vendors available to project the cost of future treatment expense. For example,

Gould & Lamb Healthcare Consultants, LLC
6404 Manatee Ave W., Suite E
Bradenton, FL 34209
Phone: (941) 798-2098
Fax: (941) 798-3403
Web site: http://www.gouldandlamb.com

Their Web site describes their services as including the following:

> **Medicare Set-Aside Arrangements:**
>
> Our Medicare Set-Aside services provide total compliance with the Medicare Secondary Payer Statute. Gould & Lamb offers a complete solution to Insurance Carriers, Defense & Plaintiff attorneys and T.P.A.'s when settling Workers' Compensation claims with Medicare exposure. Our complete service offering can assist in carrying your WC settlement through the entire CMS approval process.
>
> The services include: Medicare/Social Security research, Medicare Lien Negotiation, Set-Aside Allocation (future medical projections or a Life Care Plan that includes the required Medicare Funds projection), Settlement Options, Electronic Record Storage, management of the Medicare funds, and submission/tracking of the entire package up through approval of the CMS Regional Offices.
>
> These services can also be unbundled to meet the evolving needs of any organization. Our Set-Aside Allocations provide the same in-depth research and defensible work product that clients have come to expect from G&L. This has been a key factor in our success with the CMS Regional Offices. Gould & Lamb's Set-Aside Allocations provide Medicare with a complete and accurate picture of the future medical expenses and utilize Medicare's reimbursement guidelines to calculate Medicare's future exposure on those services. Our total service offering is rounded out through partnerships with some of the nation's leading law firms, settlement brokers, and custodial payer organizations with extensive experience in Secondary Payer Statute

> compliance. Our turnaround time and cost to complete these services is often half that of our competitors'.

Note that the CMS guidance document of July 2001 repeatedly refers to using life care plans to estimate the cost of care for life, for determining how much money has to be set aside for future treatment expense that would otherwise be payable by Medicare. However, the CMS guidance document does acknowledge that in some states there may not be liability for lifetime care.[28] In reviewing Wisconsin settlements, CMS needs to be aware of the fact that there would only be liability for lifetime care on permanent total disability claims. On any claims other than permanent total disability, there would only be liability for treatment expense for the 12-year statute of limitations.[29]

4.22 Selecting an Administrator

You need an administrator to administer a Medicare set-aside agreement. Administrators are sometimes referred to as the custodian or trustee. The administrator has various duties that include:

- ✓ paying the bills for treatment expense that would otherwise be covered by Medicare;[30]
- ✓ forwarding an annual accounting to the CMS contractor responsible for monitoring the case;[31] and
- ✓ forwarding a complete, final accounting to the CMS contractor once the money in the set-aside is depleted because of payments for services that would otherwise be covered by Medicare.[32]

The administrator pays for treatment expense that would otherwise be paid by Medicare, based upon rates established by worker's compensation fee schedules, unless the set-aside agreement is established on the basis of paying full actual charges.[33] There are no fee schedules under the Wisconsin Worker's Compensation Act. Wisconsin instead uses certified databases for limiting treatment costs.[34]

There are some national companies available to administer Medicare set-aside agreements. For example:

Fidelity Fiduciary Company
P.O. Box 94717
Birmingham, AL 35220-4717
Phone: (800) 288-2387

---

[28] *Workers' Compensation: Commutation of Future Benefits*, Memorandum by Deputy Director of Purchasing Policy Group, CMS, July 23, 2001, pg. 11, Question 6/Answer. (See attached Appendix A.)
[29] Wis. Stat. § 102.17(4). The present 12-year statute of limitations applies to all injuries since May 13, 1980.
[30] CMS guidance document of July 2001, Question/Answer 3. (See attached Appendix A at page 7.)
[31] CMS guidance document of July 2001, Question/Answer 3. (See attached Appendix A at page 7.)
[32] CMS guidance document of July 2001, Question/Answer 9. (See attached Appendix A at page 12–13.)
[33] CMS guidance document of July 2001, Question/Answer 9. (See attached Appendix A at page 12.)
[34] Wis. Stat. § 102.16(2) and Wis. Admin. Code § DWD 80.72. A list of the certified databases is available at: http://www.dwd.state.wi.us/wc/insurance/radiology/databaselist.pdf.

For more information contact:
Jim Trull, FFC owner/administrator: jtrull@ffcadministrators.com

Note that is also possible to have a self-administered set-aside agreement, in which the employee would be responsible for applying the money in the fund on Medicare-covered services.[35] The CMS Regional Office in Chicago has some specific guidelines for self-administered set-aside agreements.

Self-administered set-aside agreements would seem to be an exceptionally bad idea, unless you are dealing with a very small amount of money in funding the set-aside agreement. First of all, a self-administered set-aside agreement assumes that the injured employee is responsible enough to only use the money as intended, for treatment expense, rather than just spending it. That is always possible, but rarely likely. The injured employee would need to clearly understand which bills for treatment expense are ones that would otherwise be covered by Medicare. The injured employee would have to be capable of submitting accountings to the CMS contractor, annually and then when the funds are depleted. Finally, if the treatment expense is only to be paid at rates limited by the Worker's Compensation Act, the injured employee has no access to a certified database. It is also very unlikely the injured employee would be capable of interpreting and applying database amounts, even if access to a database was available.

4.23 Drafting a Set-Aside Agreement

Medicare set-aside agreements present a number of complex issues. You may want to seriously consider contracting with an attorney who has extensive experience in drafting such agreements. There are now a number of law firms in the country that are involved in drafting of Medicare set-aside agreements on a national basis. Some of the attorneys that seem to be nationally prominent on these matters are:

Attorney Bennett L. Pugh
Carr Allison
100 Vestavia Parkway, Suite 200, Birmingham, AL 35216
Phone: (205) 949-2940, Fax: 205-822-2057
Web site: http://www.carrallison.com/
E-mail: blp@carrallison.com

(See Medicare Issues in Workers' Compensation Settlements by Attorneys Bennett L. Pugh and Melisa C. George, available at: http://www.bna.com/bnabooks/ababna/annual/2002/pugh.doc)

[35] *Workers' Compensation: Commutation of Future Benefits*, Memorandum by Deputy Director of Purchasing Policy Group, CMS, July 23, 2001, pg. 1, footnote 1; available at http://cms.hhs.gov/medicare/cob/pdf/wcfubene.pdf. The complete memorandum appears in attached Appendix A.

Sagrillo Hammond & Dineen, LLC
1330 17th Street, Suite 100
Denver, Colorado 80202
Phone: (303) 825-4900
Web site: http://shdcolorado.lawoffice.com/

Attorney Susan G. Haines
Haines & Campbell, P.C.
501 South Cherry Street, Suite 900
Denver, Colorado 80246
Phone: (303) 321-0388 -or- (888) 321-0388
Fax: (303) 321-5731
Web site: http://www.haineselderlaw.com/ (The Web site offers several papers by Attorney Haines on the subject of Medicare set-aside agreements.)

4.24 Submitting the Settlement to CMS for Approval

There are ten CMS Regional Offices. For Wisconsin claims, Medicare set-aside agreements are submitted for approval to the Chicago Regional Office:

Centers for Medicare & Medicaid Services (CMS) — Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Phone: (312) 886-6432

Contact person on Wisconsin claims:

Janice Edwards, Medicare Secondary Payer Regional Office Coordinator,
Worker's Compensation Contact[36]
Phone: (312) 886-3256

The criteria for approval of a set-aside agreement is described in the CMS guidance document of July 2001 at pages 8–10 (Question 5/Answer).[37] You would want to provide CMS with the following documents:

- ✓ the Compromise Agreement;
- ✓ the Order by the Department approving the compromise settlement (if it has already been approved);
- ✓ the set-aside agreement (or proposed agreement);

[36] CMS FAQs of April 2003. (See attached Appendix D at page 11.)
[37] See attached Appendix A.

- ✓ a projection of the future treatment expense, including a projection of the employee's life expectancy if you are dealing with a life care plan;
- ✓ an itemization of past treatment expense paid by the worker's compensation insurer;
- ✓ a recent medical report declaring an end of healing and evaluating permanency; and
- ✓ any reports on independent medical exams.

You should consider also providing CMS with some background information about Wisconsin law and the facts of the case, in explaining the basis for the compromise settlement. It might also be useful to provide information as to the estimated total value of the claim if it was paid as a conceded claim. Finally, if you are only projecting future treatment expense for the statute of limitations period, you should probably make that clear to CMS.[38]

4.25 Problem Areas and Some Practical Considerations

On a practical basis there are numerous problems that you encounter in trying to comply with the CMS requirements for Medicare set-aside agreements. There are substantial delays in obtaining review and approval of such agreements by the CMS Regional Office in Chicago. It appears that it is taking at least 6 to 9 months, and perhaps much longer, to obtain approval. On that basis you would need to first finalize a compromise settlement by obtaining approval of the Worker's Compensation Division, DWD, and then deal with the set-aside agreement.

You then have to deal with issues such as how you are going to handle the situation if CMS rejects your proposed settlement because they feel you have not set aside enough money to cover the future treatment expense. Is the worker's compensation insurer then going to come up with the additional money required to fund the set-aside agreement? If not, how are you going to handle the situation?

One possibility would be to provide in the Compromise Agreement that, if CMS does not approve the proposed amount for the set-aside agreement, then that portion of the Compromise Agreement is void and the Compromise Agreement shall instead be a limited compromise settlement, with future treatment expense left open for services that would be covered by Medicare.

It is probably a better practice to draft a Compromise Agreement that provides for a set-aside agreement to be approved by the CMS at a later date, with that set-aside agreement to be funded by the worker's compensation insurer in an amount necessary to meet the requirements CMS, but without referencing any specific amount in the Compromise Agreement itself. Omitting reference in the Compromise Agreement to any specific amount to be set aside also avoids the problem of having to estimate the amount of the future treatment expense at this stage of the

[38] In Wisconsin, on any claims other than permanent total disability, there would only be liability for treatment expense for the 12-year statute of limitations. Wis. Stat. § 102.17(4). The present 12-year statute of limitations applies to all injuries since May 13, 1980.

settlement, since that is probably better dealt with a later time when you are actually establishing the set-aside agreement.

5.0 Possible Alternatives to Set-Aside Agreements for Future Treatment Expense

5.1 Exemption for Certain Compromise Settlements

The CMS guidance document of July 2001 recognizes that on a compromise settlement based on a liability dispute, the employee may be taking a substantial reduction in the value of the claim. CMS is willing to consider that in determining the amount, if any, that has to be set aside for future treatment expense that would otherwise be payable by Medicare. As noted in the *Medicare Secondary Payer Manual*:

> **40.3.4 - Effect of Lump Sum Compromise Settlement**
>
> (Rev. 1, 10-01-03)
>
> A3-3416, B3-3333.1, B3-2370.7, A3-3407.7, A3-3413, B3-3331.4, B3-2370.8, A3-3407.8, A3-3416.1, B3-3333.2, HO-289.22, HO-289.7, HO-289.8, SNF-330.1, SNF-326.1, SNF-326.2 HH-250.21, HH-250.7, HH-250.8
>
> Negotiated compromise settlements of WC claims, by their very nature, provide less than full benefits for both income replacement and medical expenses. If the beneficiary agrees to a compromise lump sum settlement, i.e., a settlement which provides less in total compensation than the individual would have received if the claim had not been compromised, **and** the settlement has given reasonable recognition to the income replacement objectives of the WC law, the settlement may be accepted as a basis for applying the WC limitations.
>
> . . .
>
> If the individual signed a final release of all rights under WC (which precludes the possibility of further WC benefits) medical expenses incurred after the date of the final release are reimbursable under Medicare.[39]

CMS considers a true compromise settlement to be one based upon a liability dispute (i.e., a dispute as to whether the individual sustained an injury arising out of the employment), although it is also possible to have a dispute as the nature and extent of liability. As discussed below, CMS also appears to recognize compromise settlements based upon such disputes.

[39] *Medicare Secondary Payer Manual*, Ch. 7, § 40.3.4, available at: http://cms.hhs.gov/manuals/105_msp/msp105index.asp.

On a true compromise settlement, CMS is supposed to accept the settlement and continue to pay for future treatment for Medicare-covered services. The applicable administrative rule, 42 C.F.R. 411.46(d), provides:

> (d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—
>
> *(1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.*
>
> (2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses. [Emphasis added.]

CMS should even be willing to waive any requirement for a set-aside agreement when the compromise settlement is based upon a dispute as to the nature and extent of resulting disability, rather than a liability dispute as to whether there was a compensable injury. One of the examples provided in the *Medicare Secondary Payer Manual* describes a fact situation involving a compromise settlement on a conceded compensable injury, with a later dispute as to the extent of disability, in which Medicare would accept full responsibility for future treatment expense on the claim:

> **EXAMPLE 3**
>
> In July, 1998, Mr. Y, age 30, was involved in an accident at work sustaining injury to his neck, back, right arm and legs. Beginning with the date of the accident, the WC carrier paid Mr. Y weekly benefits of $207 for temporary disability and also paid all of his medical expenses.
>
> In 2000, Mr. Y became entitled to Medicare based on disability. In July 2002, the WC insurer decided to terminate Mr. Y's medical and disability payments based on medical advice that his continuing impairments were not attributable to the work injury. By this time, the insurer has paid a total of $90,000 for Mr. Y's medical care.
>
> Mr. Y contested the termination of his WC benefits, and the case was settled by compromise. A lump sum of $46,000 ($6,000 of which was designated as attorneys' fees) was paid to Mr. Y. As part of the settlement agreement, Mr. Y signed a final release that stipulated that future medical expenses were "in dispute" and that they were to be assumed by Mr. Y "as his sole responsibility."

> The fact that Mr. Y accepted, and the State WC agency approved, a relatively small lump sum payment, compared with what Mr. Y would have received had his WC claim been approved in full, indicates that there was doubt as to the compensability of the injury. There was no indication that the lump sum was intended to be payment for future medical expenses, nor do these facts indicate that the settlement represented an attempt to shift the responsibility for future medical expenses from WC to Medicare.
>
> Therefore, Mr. Y's signing of the final release of all rights under WC makes it possible for medical expenses incurred **after** the date of settlement to be reimbursed under Medicare.[40]

In summary, CMS will reject compromise settlements that attempt to shift responsibility for future treatment expense to Medicare. However, a true compromise settlement in Wisconsin would frequently not include compensation intended for future treatment expense. A worker's compensation insurer may have a solid basis for compromising a claim for a substantially reduced amount. In Wisconsin, there are additional safeguards under present law because you can't even get Department approval of a compromise settlement unless you have a *bona fide* dispute that meets the Department's standards.[41]

Even the CMS guidance document of July 2001 acknowledges:

> It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.
>
> Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.
>
> One of the distinctions that Medicare's regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump-sum cases are commutations of

[40] *Medicare Secondary Payer Manual*, Ch. 7, § 40.3.4.
[41] Wis. Admin. Code § DWD 80.03.

future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump-sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump-sum settlements should not automatically be considered as commutation cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation. WC commutation cases are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case.[42]

The CMS FAQs of April 2003 then provided some further clarification on this issue:

4) What's the difference between commutation and compromise cases? And can a single WC case possess both?

Answer: When a settlement includes compensation for future medical expenses, it is referred to as a " WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.

[42] *Workers' Compensation: Commutation of Future Benefits*, Memorandum by Deputy Director of Purchasing Policy Group, CMS, July 23, 2001, pgs. 2–3. The complete memorandum appears in attached Appendix A.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.

. . .

20) If the settling parties of a WC case contend that a WC settlement is not intended to compensate an injured individual for future medical expenses, does CMS still require that a Medicare set-aside arrangement be established?

Answer: It is unnecessary for the individual to establish a set-aside arrangement for Medicare if all of the following are true:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);
b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and
c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

However, if Medicare made any conditional payments for work-related services furnished prior to settlement, then Medicare would require recovery of those payments. In addition, Medicare will not pay for any services furnished prior to the date of the settlement for which it has not already paid.

Therefore, if you have genuine compromise settlement of the type described by CMS, then it is questionable whether you need to even need to submit the compromise settlement to CMS with a request for them to waive any claims. CMS does not presently appear to have any procedures in place to review such compromise settlements, and to issue a ruling that no set-aside agreement would be required.

5.2 Limited Compromise Agreements Leaving Open Future Treatment Expense

One simple alternative to a Medicare set-aside agreement is to leave open future treatment expense. That is, instead of a full, final and complete compromise settlement of all claims, you instead do a limited compromise settlement that leaves open claims for future treatment expense, at least to the extent that such treatment would be for Medicare-covered services. Since the settlement does not finalize claims for future treatment expense, it does not potentially shift the costs of future treatment to Medicare and you don't have to worry about any type of set-aside agreement.

The downside is that such limited compromise settlements are highly unattractive to worker's compensation insurers, since they are not closing out the claim on a final settlement.

5.3 Hold-Harmless and Indemnification Agreements

You could agree as part of a compromise settlement that the worker's compensation insurer will hold harmless and indemnify the employee on any claims by Medicare. You then gamble on whether CMS will ever find out about the claim.

You also have the problem of how you are going to deal with the situation in which CMS does find out about the compromise settlement, it applies a formula to determine how much of the settlement is for future treatment expense, and it then suspends the employee's Medicare coverage for any treatment expense relating to the claim until the employee can provide proof that he or she paid that amount on future treatment expense.[43] If CMS does suspend the employee's Medicare coverage in such a situation, what obligation, if any, does the worker's compensation insurer have under a hold-harmless and indemnification agreement?

The other alternative is to have the employee agree to hold harmless and indemnify the employer and the worker's compensation insurer on any claims by Medicare. This would, at best, only be appropriate for a very limited number of cases.

For example, assume that Medicare paid $5,000 on past treatment expense, the employee is no longer receiving any treatment for the employment injury, and the claim is resolved for $50,000 on a full, final and complete compromise settlement of all claims. Assume further that the employee's attorney intends to negotiate with the Medicare contract intermediary, United Government Services, LLC, to work out a settlement on the bills that were paid by Medicare. In such a situation it might make sense to agree that the employee will hold harmless and indemnify the employer and worker's compensation insurer for any claims by Medicare. In such a case you should probably include a provision in the Compromise Agreement for some amount to be paid into the trust account of the employee's attorney, to be applied on satisfying any reimbursement claim by Medicare and with the balance remaining to be paid to the employee.

However, any time where there is significantly more substantial exposure on a possible claim by Medicare, on a practical basis it is highly unlikely that the employee would have the financial resources to hold harmless and indemnify the employer and the worker's compensation insurer, especially in view of the remedies available to Medicare as discussed below.

5.4 Identify an Alternate Primary Payer to Cover Future Treatment Expense

There will be at least some cases in which there would be some other entity that would be responsible for future treatment expense on a clam. For example, if the employee retained continued coverage through a group health insurance plan, then on claims for treatment expense that group health coverage would be primary and Medicare would be secondary. In at least a limited number of cases such coverage would be available through the employee's former

[43] 42 C.F.R. 411.46 & 411.47.

employer, or through coverage available to the employee's spouse. If a group health insurer would be primary on liability for future treatment expense, then you should not need a set-aside agreement since Medicare would not be liable for future treatment expense.

5.5 Allocate a Specific Amount for Future Treatment Expense

You might consider drafting a compromise settlement that provides a specific amount is allocated to future treatment expense. If CMS does find out about the settlement, Medicare will not pay for any further treatment expense on the claim until the employee pays for additional treatment expense in an amount equal to the allocation for future treatment expense in the compromise settlement.[44] However, it will reject compromise settlements that attempt to shift responsibility for future treatment expense to Medicare by failing to allocate enough for future treatment expense.[45] CMS will then do its own apportionment to determine how much should be allocated to future treatment expense.[46]

The employee would, of course, need to be aware he/she is assuming the risk that CMS may suspend Medicare coverage as described above.

5.6 Ignore Medicare — Take Your Chances

The last alternative would be to just ignore the interests of Medicare, and resolve a claim on a full, final, and complete compromise settlement. At this point we simply don't know, on a practical basis, what sort of risks are inherent. The remedies available to Medicare are discussed below.

However, is it realistic to expect that CMS is going to aggressively pursue its rights on a substantial number of worker's compensation claims? Does CMS have the funding and the resources it needs in order to do so? If so, who is at risk?

The law provides that Medicare has the right to pursue claims against various different parties to the worker's compensation claim if: (1) Medicare paid bills that should have been paid by worker's compensation, or (2) there has been an attempt to shift responsibility off to Medicare on future treatment expense that should be paid by the worker's compensation insurer. However, if CMS does find out about the compromise settlement, it appears that on a practical basis the remedy available to them is: (1) to apply a formula to determine how much of the settlement is for future treatment expense; and (2) to then suspend the employee's Medicare coverage for any treatment expense relating to the claim, until the employee can provide proof that he or she paid that amount on future treatment expense. If that is the likely outcome, the risk is then being assumed by the employee.

If the employee does end up having Medicare suspend coverage on future treatment expense, the employee may then want to pursue a malpractice claim against his/her attorney. On that basis the Compromise Agreement should probably include a provision stating that the employee has

[44] 42 C.F.R. 411.46 Lump-sum payments.
[45] 42 C.F.R. 411.46(b)(2) and 411.47(a).
[46] 42 C.F.R. 411.47(a).

been advised of the risks resulting from possible future claims by Medicare, and the employee still wishes to go ahead with finalizing the claim on a compromise settlement.

In deciding whether to resolve a claim on a complete compromise settlement, *without* establishing a set-aside agreement for future treatment expense to be approved by CMS, you should consider what issues exist as to future treatment expense. For example, if the employee has concluded treatment for the employment injury and the only recommendation for future care is a home exercise program and some over-the-counter medications, then Medicare would not appear to have any potential liability for future treatment expense.

Consider, for example, a claim in which the employee has concluded treatment, but has continuing complaints of chronic pain and is now addicted to prescription pain medication that costs several hundred dollar a month. Under present law, Medicare only has extremely limited coverage for a very small number of prescription drugs, so Medicare would not be liable for the ongoing cost of the pain medications.[47] On such a claim Medicare would not have potential liability for future treatment expense.

On the other hand, there are some types of employment injuries that present special concerns about future treatment expense that would potentially be a liability for Medicare. A few obvious examples include:

- injuries with a prospect for future surgery, especially major surgery;
- joint replacements, such as partial or total knee or hip replacements, since there is a strong probability that the surgery will have to be repeated at a later date;
- permanent brain injuries;
- injuries causing paraplegia or quadriplegia; and
- serious respiratory conditions.

On such claims you have to give serious consideration to whether you want to risk ignoring Medicare and resolving the claim without a set-aside agreement.

6.0 Consequences of Failing to Resolve Claims with CMS — What's the Worst That Could Happen?

6.1 Past Medical Services Paid by Medicare

CMS has a variety of remedies available when they find out that Medicare made conditional payments for services that should have been paid by a primary payer such as a worker's compensation insurer. As described in the MSP statute:

[47] As described by CMS:

> Medicare does **not** cover most prescription drugs. Medicare covers a limited number of outpatient prescription drugs. Your pharmacy or doctor must accept assignment on Medicare-covered prescription drugs.

Your Medicare Benefits 2002, CMS brochure, available at: http://www.medicare.gov/Publications/Pubs/pdf/10116.pdf.

(b) Medicare as secondary payer

. . .

(2) Medicare secondary payer

. . .

(B) Conditional payment

. . .

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, *the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.* The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iii) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(iv) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.[48]

The corresponding regulations provide:

[48] 42 U.S.C. § 1395y(b)(2)(B)(ii).

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

(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 third party payment recipient, the amount of the third party 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.*

. . .

(e) Recovery from third parties. CMS has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

. . .

(g) Recovery from parties that receive third party payments. CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment. [Emphasis added.]

42 C.F.R. 411.26 Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) Right to intervene. CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

Thus, CMS may seek recovery against the primary payer for double the amount they paid in Medicare benefits. In attempting to recover the Medicare benefits that were paid, "CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid." This raises some very interesting issues as how CMS would go about intervening in a Wisconsin worker's compensation claim.

There is an interesting federal case that deals with the issue of double damages on a reimbursement claim by Medicare, although it involves a personal injury action in circuit court instead of a worker's compensation claim. In *U.S. v. Sosnowski*, 822 F.Supp 570 (W.D. Wis. 1993), Sosnowski sustained injuries in a motor vehicle accident. Sosnowski sued Kurth and his liability insurer on a negligence action in circuit court. Medicare paid a total of $15,066.68 on treatment expense, so Sosnowski's action in circuit court joined the Medicare contract intermediaries, Wisconsin Physicians Service (WPS) and Blue Cross & Blue Shield (BCBS). Neither WPS nor BCBS responded in the action so the circuit court held they were in default. Sosnowski settled his claim for $25,000, representing the policy limits of the liability insurer. Sosnowski did not reimburse Medicare for any of the payments it made.

The United States then sued Sosnowski and his attorney, Weis, together with the liability insurer and their insured driver, in federal court on a claim for double damages equal to $30,133.36. The insured driver was dismissed from the action. On a motion for summary judgment the United States sought judgment against Sosnowski and his attorney, Weis. The court granted summary judgment against Sosnowski and Weiss, but only for $15,066.68, and not for double damages. The court pointed out that the MSP statute authorizes double damages on a claim against a primary payer, such as a liability insurer, but that statutory provision would not apply to Sosnowski or Weiss, and the United States was not claiming judgment against the liability insurer.[49]

Finally, you have to keep in mind that the federal law provides a subrogation interest for payments by Medicare. A federal subrogation interest would presumably be subject to the defenses that existed on the underlying claim, just like any other subrogation interest. Thus, if a worker's compensation claim is resolved on a compromise settlement and the United States sued the parties in federal court, as in the *Sosnowski* case described above, the defendants would still appear to have the defenses that were available on the underlying worker's compensation claim.

That is, the MSP statute only applies: (1) if there was a compensable employment injury, and (2) to treatment expense that is directed to cure or relieve the effects of an employment injury. If either of those criteria are disputed by the insurer, then the issues would have to be litigated. Thus, it appears that the federal court would have to apply Wisconsin law under the Worker's Compensation Act to resolve any disputed issues as to liability (i.e., as to whether there was a compensable injury arising out of the employment) or as to the nature and extent of injury, since those issues would impact on how much money, if any, that Medicare would be entitled to recover on its reimbursement claim.

Finally, in addition to the types of suits by the United States as described above, the MSP statute also provides for a private cause of action for double damages:

> (3) Enforcement
>
> (A) Private cause of action
>
> *There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the*

[49] 42 U.S.C. §§ 1395y(b)(1), 1395y(b)(3)(A), 1395y(b)(2)(B)ii.

> *case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).*[50]

Thus, it is possible for an injured employee to sue a primary payer, such as a worker's compensation insurer, for double damages.[51] Such private actions may also be in the form of class actions. Several class actions have been filed in federal district court in Alabama. Two of those lawsuits have already been dismissed. A third lawsuit, *Penny Frazer v. CNA Insurance*, CV-02-PWG-1684-W (United States District Court for the Northern District of Alabama Western Divisional Area filed July 15, 2002), is still pending. In *Frazier*, the complaint alleges that a class of defendant insurance carriers, third party administrators, and self-insured employers, violated the MSP statute by resolving claims with settlements that terminated liability for treatment expense, but without an MSP set-aside agreement.[52] The lawsuit seeks to reopen all settlements since 1981, when the MSP statute was enacted to the present. At this point it is simply impossible to evaluate whether such class actions really pose a serious threat.

6.2 Settlement of Claim That Terminates Liability for Future Treatment Expense

If you resolve a claim on a compromise settlement that terminates the worker's compensation insurer's liability for future treatment expense, then Medicare again has several remedies available. If you resolve a claim on a compromise settlement that terminates liability for future treatment expense and the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.[53]

In Wisconsin, a full, final, complete compromise settlement would ordinarily not include any allocation of the amount of the settlement, either as between indemnity and medical benefits or between past and future treatment expense. Even if there is a specific allocation of an amount to represent future treatment expense, Medicare may determine that amount to be insufficient. In such cases, Medicare is supposed to apply a formula to determine how much of the settlement amount represents future treatment expense, and then Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the settlement allocated to future medical expenses.[54]

The formula applied by Medicare, to determine how much of a settlement should be considered to be future treatment expense, basically requires them to start by computing a ratio of the amount of the settlement to the amount that would have been payable as worker's compensation

---

[50] 42 U.S.C. § 1395y(b)(3)(A).
[51] See, for example, *Manning v. Utilities Mutual Ins. Co., Inc.*, 254 F.3d 387, 2001 U.S. App. LEXIS 13781 (2nd Cir. 2001). The decision is available from http://www.ca2.uscourts.gov/ (search in *Decisions* for Docket No. 00-9219).
[52] The description of the case is by UWC — Strategic Services on Unemployment & Worker's Compensation (http://uwcstrategy.org/).
[53] 42 C.F.R. 411.46 Lump-sum payments.
[54] 42 C.F.R. 411.46 & 411.47.

benefits if the claim had not been compromised. You have to wonder how a federal agency would have any chance of determining the total value of a Wisconsin worker's compensation claim if it was entirely paid on a conceded basis. Even beyond that, how would they possibly be in a position to factor in the disputed issues that were the basis for the compromise settlement?

It appears that CMS is proposing to ignore the regulation providing for analysis of a settlement to allocate an amount for future treatment expense. Question/Answer 3 of the CMS FAQs of April 2003 state that:

> **3) How does Medicare determine its interests in WC cases when the parties to the settlement do not explicitly state how much of the settlement is for past medical expenses and how much is for future medical expenses?**
>
> **Answer:** A settlement that does not specifically account for past versus future medical expenses will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.
>
> **Example:** A beneficiary is paid $50,000 by a WC carrier, and the parties to the settlement do not specify what the $50,000 is intended to pay for. If there is no CMS approved Medicare set-aside arrangement, Medicare will consider any amount remaining after recovery of its conditional payments as compensation for future medical expenses.
>
> Additionally, please note that any allocations made for lost wages, pre-settlement medical expenses, future medical expenses, or any other settlement designations that do not consider Medicare's interests, will not be approved by Medicare.

Aside from suspending the employee's Medicare coverage as described above, what other remedies may CMS pursue? The statutes cited in the preceding section all relate to CMS seeking to recover for past payments by Medicare for amounts that should have been made by Medicare. If you resolve a claim on a compromise settlement, without providing for a set-aside agreement for future treatment expense that is to be approved by CMS, what can CMS do about it? You are dealing with future treatment expense so it is difficult to see how CMS has authority to seek recovery for *future* treatment expense under the statutes cited above.

It appears that CMS would first have to wait until there is some additional treatment expense, and to then pay the bills under Medicare. CMS could then seek to recover the amounts paid by Medicare. However, it is questionable whether CMS has the authority to pay additional treatment expense under the circumstances. First of all, the regulations provide that Medicare may make "conditional payments" in certain situations:

> **42 C.F.R. 411.45 Basis for conditional Medicare payment in workers' compensation cases.**
>
> A conditional Medicare payment may be made under either of the following circumstances:
>
> (a) The beneficiary has filed a proper claim for workers' compensation benefits, but the intermediary or carrier determines

> that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.
>
> (b) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

Does CMS have authority to make conditional payments under the above regulation when the worker's compensation claim has been finalized on a compromise settlement? It does not appear so. Furthermore, 42 C.F.R. 411.46(d) specifically states:

> (d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—
>
> (1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.
>
> (2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, *Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.*

There is then another regulation that deals with lump-sum settlements where the amount allocated to future treatment expense is not sufficient and CMS may do its own apportionment.[55] Thus, under the HHS regulations it appears that CMS is *not* supposed to make conditional payments for treatment expense on a worker's compensation claim if the claim has been resolved on a compromise settlement. If CMS does not make any payment on bills then it is difficult to see how it has any remedy available against the worker's compensation insurer that settled the case.

Thus, it is the employee who is assuming the risks since the regulations provide that CMS is supposed to refuse payment for future treatment expense until the future treatment expense equals the amount allocated in the compromise settlement, or as determined by CMS under its own apportionment pursuant to 42 C.F.R. 411.47.

7.0 Sources for Additional Information

The United States Code (USC) is available through the Legal Information Institute at Cornell Law School at:

http://www4.law.cornell.edu/uscode/

[55] 42 C.F.R. 411.47.

The Code of Federal Regulations (C.F.R.) is available through the Legal Information Institute at Cornell Law School at:

http://cfr.law.cornell.edu/cfr/

Note that 42 C.F.R. 411.20–411.47 (Exclusions from Medicare and Limitations on Medicare Payment) appear in attached Appendix C.

Medicare.gov — "The official U.S. government site for people with Medicare":

http://www.medicare.gov/

Information about the CMS Medicare Coordination of Benefits (COB) initiative is available at:

http://www.cms.hhs.gov/medicare/cob/

The *Medicare Secondary Payer Manual* (CMS Pub. 100-5) is available at:

http://cms.hhs.gov/manuals/105_msp/msp105index.asp

Note that it is so large it must be downloaded in seven separate chapters. However, Chapter 7, Section 40 — *Overpayment Due to Worker's Compensation Coverage* is the main part that pertains to the present subject.

8.0 Conclusion

CMS has a legitimate interest in seeking reimbursement for Medicare benefits that are paid in situations where the bills should have been paid as part of a worker's compensation claim. However, there are some problems with attempts by CMS to protect the interests of Medicare on compromise settlements of worker's compensation claims that finalize liability for *future* treatment expense.

Regulations by HHS under the MSP statute require CMS to recognize true compromise settlements on worker's compensation claims, and to accept liability for future treatment expense on such claims.[56] Efforts by CMS to convince us that we need to set aside money for future treatment expense on compromise settlements of worker's compensation claims may be misguided, as least as to compromise settlements in Wisconsin.

In some states it is possible for a worker's compensation insurer to finalize its liability on conceded claims by a settlement that provides for a lump-sum payment in lieu of the periodic payments that would otherwise be required. Such "commutations" on conceded claims are of legitimate concern to CMS when they finalize the liability of the worker's compensation insurer and thereby shift liability for future treatment expense to Medicare. However, such commutations are not part of Wisconsin law. Compromise settlements of Wisconsin claims present entirely different issues, especially since we have a state agency applying stringent standards that require a *bona fide* dispute to obtain approval of a compromise settlement. Indeed, even CMS recognizes that true compromise settlements are *not* subject to the requirements for set-aside agreements.[57]

[56] 42 C.F.R. 411.46(d)(1).

[57] The CMS guidance document of July 2001 notes at page 2:

> It is important to note that set-aside arrangements are only used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

However, there is a significant problem in that CMS has now "clarified" the distinction between commutations and compromises, and the present definition of a compromise is far too restrictive.[58] Only a limited number of compromises would fall within the CMS current definition of a pure compromise that does not contain any commutation aspects.

As discussed above, there are some serious issues as to whether CMS has legal authority, under the MSP statute and the corresponding regulations by HHS, to require us to establish set-aside agreements and to obtain approval from CMS on compromise settlements under the Worker's Compensation Act. Finally, there are also some serious issues as to what remedies CMS has available under federal law if we fail to comply with their demands for set-aside agreements on compromise settlements.

Attorney Philip Lehner
E-mail: wclawyer@mindspring.com

GRAHOVAC & KALLENBACH, S.C.
6233 Bankers Road, Suite 11
Racine, Wisconsin 53403
(262) 551-2050

About the author . . .
Philip Lehner received his undergraduate degree from Northwestern University in 1970 and his J.D. from the University of Wisconsin Law School in 1973. He practices with the Racine firm of GRAHOVAC & KALLENBACH, S.C. His practice is limited exclusively to the defense of worker's compensation claims for employers and insurance carriers throughout the state. He is a frequent lecturer and author on Wisconsin worker's compensation law and claims management. He served as the chairperson of the Wisconsin Manufacturers & Commerce (WMC) Worker's Compensation Council for 1994–1999. He is the president of the Wisconsin Association of Worker's Compensation Attorneys for 2003.

PL-c:\my documents\wcmemos\medicare secondary payer stat.doc (Rev. as of 11/3/03)

(See attached Appendix A.)
[58] CMS FAQs of April 2003: Question/Answer 4 and Question/Answer 20.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Jul 23 2001

To: All Associate Regional Administrators
Attention: Division of Medicare

From: Deputy Director
Purchasing Policy Group
Center for Medicare Management

SUBJECT: Workers' Compensation: Commutation of Future Benefits

Medicare's regulations (42 CFR 411.46) and manuals (MIM§§ 3407.7&3407.8 and MCM §§2370.7 & 2370.8) make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the Workers' Compensation (WC) carrier and the injured individual. This Regional Office letter clarifies the Centers for Medicare & Medicaid Services (CMS) policy regarding a number of questions raised recently by several Regional Offices (RO) concerning how the RO should evaluate and approve WC lump sum settlements to help ensure that Medicare's interests are properly considered.

Regional Office staff may choose to consult with the Regional Office's Office of the General Counsel (OGC) on WC cases because these cases may entail many legal questions. OGC should become involved in WC cases if there are legal issues which need to be evaluated or if there is a request to compromise Medicare's recovery claim or if the Federal Claims Collection Act (FCCA) delegations require such consultation. Because most WC carriers typically dispute liability in WC compromise cases, it is very common that Medicare later finds that it has already made conditional payments. (A conditional payment means a Medicare payment for which another payer is responsible.) If Medicare's conditional payments are more than $100,000 and the beneficiary also wishes Medicare to compromise its recovery under FCCA (31U.S.C.3711), the case must be referred to Central Office and then forwarded to the Department of Justice. It is important to note in all WC compromise cases that all pre-settlement and post-settlement requests to compromise **any** Medicare recovery claim amounts must be submitted to the RO for appropriate action. Regional Offices must comply with general CMS rules regarding collection of debts (please reference the Administrator's March 27, 2000 memo re: New instructions detailing your responsibilities for monies owed to the government).

Medicare is secondary payer to WC, therefore, it is in Medicare's best interests to learn the existence of WC situations as soon as possible in order to avoid making mistaken payments. The use of administrative mechanisms[1] sometimes referred to by attorneys as Medicare Set-Aside Trusts (hereafter referred to as "set-aside arrangements") in WC

[1] Although 42 C.F.R. 411.46 requires that all WC settlements must adequately consider Medicare's interests, 42 C.F.R. 411.46 does not mandate what particular type of administrative mechanism should be used to set-aside monies for Medicare including a self-administered arrangement (State law permitting). Of course, if an arrangement is self-administered, then the injured individual/beneficiary must adhere to the same rules/requirements as any other administrator of a set-aside arrangement.

commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. Medicare learns of the existence of a primary payer (WC) as soon as possible when Medicare reviews a proposed set-aside arrangement at or about the time of WC settlement. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.

One of the distinctions that Medicare's regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump-sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump-sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump-sum settlements should not automatically be considered as commutation cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.

WC commutation cases are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case.

Generally, parties to WC commutation cases agree on a lump sum amount in exchange for giving up the usual continuing payments by WC for lost wages and for lifetime medical care related to the injuries. Such lump sum amounts are usually requested because the beneficiary wishes to use the funds for some specific purpose. For example, the individual's home may need to be remodeled to accommodate a wheelchair or, more typically, he or she is so disabled that lifetime attendant care is needed. In these latter cases, the injured individual seeks a lump sum payment so that such care can be arranged with certainty in the future. The amount of the lump sum is typically established by using a life care plan[2] and actuarial methods to determine the individual's life expectancy. When WC has accepted full liability in a case prior to the creation of a set-aside arrangement, the likelihood of any Medicare conditional payments being made is reduced.

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. These set-aside arrangements are typically not created until the individual's condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.

Medicare regulations at 42 CFR 411.46 state that:

[2] If a life care plan is not used to justify the injured individual's future medical expenses, then the injured individual or his/her representative must present other alternative evidence that sufficiently justifies the amounts set-aside for Medicare.

> "If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment."

In addition the Medicare manuals (.3407.8 of the MIM, .2370.8 of the MCM) state:

> "When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment."

Questions that have been raised are paraphrased below.

Question 1:

> **(a) Does the Medicare program have a claim against a lump sum WC payment before an individual's Medicare entitlement?**
>
> **(b) If not, can the Medicare program give a written opinion on the sufficiency of a set-aside arrangement even if the individual is not as yet entitled to Medicare?**
>
> **(c) In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare's interests be considered before the parties can settle the case?**

Answer:

These questions have been raised by attorneys who wish to devise set-aside arrangements, which represent amounts for medical items, and services that would ordinarily be covered by Medicare and are specified for future medical treatment for work-related illness or injuries. The attorneys are concerned that Medicare will not pay once the individual becomes entitled to Medicare, because the lump-sum included payment for future medical treatment.

The answer to Question 1(a) is no, Medicare cannot make a formal determination until the individual actually becomes entitled to Medicare. However, the attorneys are correct that once the individual becomes entitled, Medicare payment may not be made

to the extent of Medicare's interests in the lump sum payment per 42 CFR 411.46 or a set-aside arrangement that adequately considers Medicare's interests in the lump sum payment.

The answer to Question 1(b) is that the RO (with consultation from the Regional OGC, if necessary) can review a proposed settlement including a set-aside arrangement and can give a written opinion on which the potential beneficiary and the attorney can rely, regarding whether the WC settlement has adequately considered Medicare's interests per 42 CFR 411.46. These settlements should all be handled on a case-by-case basis, as each situation is different. If there are several years prior to Medicare entitlement, the RO should use its best judgment regarding what Medicare utilization might be once there is Medicare entitlement. This decision should be based on the documentation obtained as stated in the answer to Question 10. Once the RO has given written assurance that the set-aside arrangement is sufficient to satisfy the requirements at 42 CFR 411.46, when the set-aside arrangement is established and the settlement is approved, the RO, should then set up a procedure to follow the case.

The answer to question 1(c) is, it is not in Medicare's best interests to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests when the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, **and** the anticipated **total** settlement amount for future medical expenses **and** disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.[3]

For example, if the injured individual is designated by WC as a Permanent Total disabled individual, has filed for Social Security disability, and the settlement apportions $25,000 per year (combined for both future medical expenses **and** disability/lost wages) for the next 20 years, then the RO should review that WC settlement because the total settlement amount over the life of the settlement agreement is greater than $250,000 ($25,000 x 20 years = $500,000) and the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date. If the injured individual in this example fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 CFR 411.46 once the injured individual actually becomes entitled to Medicare.

NOTE:
Injured individuals who are already Medicare beneficiaries **must** always consider

[3] Please note that the review thresholds (i.e., 30 months and $250,000) will be subject to adjustment once CMS has experience reviewing these matters under these instructions.

Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, **ALL WC PAYMENTS** regardless of amount **must** be considered for current Medicare beneficiaries.

Question 2:

Should a "system of records" be established for the documentation that the RO and contractors receive/collect concerning these set-aside arrangements?

Answer:

Yes. CMS' Division of Benefit Coordination is in the process of establishing a "system of records" via the Federal Register process, which will provide legal authority to maintain records on individuals that are not enrolled in Medicare. The RO will be responsible for maintaining or "housing" the records for every arrangement on which the RO provides a written opinion. Please note that these records are not subject to Freedom of Information Act requests and may not be disseminated to the public.

Question 3:

Once the set-aside arrangement has been approved by the RO (with consultation from the Regional OGC, if necessary), what is the subsequent role of the ROs and contractors?

Answer:

When the RO approves a set-aside arrangement (with consultation from the regional OGC, if necessary), the RO will check on a monthly basis the National Medicare Enrollment database in order to determine when an injured individual actually becomes enrolled in Medicare. Once the RO verifies that the injured individual has actually been enrolled in Medicare, the RO will assign a contractor responsible for monitoring the individual's case. The RO will assign the contractor based on the injured individual's State of residence.

When the injured individual has actually been enrolled in Medicare, the RO **must** provide the Coordination of Benefits Contractor (COBC) with identifying information to add a WC record to Common Working File. The RO must exercise one of the following options: 1) Fax the information to the COBC; or 2) Submit through an Electronic Correspondence Referral System (ECRS) inquiry. At a minimum, the RO must indicate that this is a WC set-aside arrangement case, and include the following information:

Beneficiary Name
Beneficiary HIC
Date of Incident
DX code(s): If you do not have dx codes readily available, you must include a description of the illness/injury. **Note:** Do not forward to COB without a dx or description.
Administrator of Trust
Claimant Attorney Information

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for insuring/verifying that the funds allocated to the set-aside arrangement were expended on medical services for Medicare covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

Question 4:

What types of measures should the RO and the contractors take to ensure that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been depleted?

Answer:

Generally, set-aside arrangements that are designed as lump sums (i.e., the arrangement is funded by the WC settlement all at once) present less of a problem to monitor than structured arrangements. Medicare would not make any payments for individuals that possess lump sum arrangements until all of the funds within the arrangement have been depleted. For example, if a set-aside arrangement were established for $90,000, Medicare would not make any payments until the entire $90,000 (plus interest, if applicable) were exhausted on the individual's medical care (for Medicare covered services only).

Structured set-aside arrangements generally apportion settlement monies over fixed or defined periods of time. For example, a structured arrangement may be designed to disburse $20,000 per year over the next ten years for an individual's medical care (for Medicare-covered services only). If the $20,000 allocated on January 1 for Year One were fully exhausted on August 31, Medicare may make payments for the services performed after August 31 once the contractor responsible for monitoring the

individual's case can verify that the entire $20,000 (plus interest, if applicable) is exhausted. However, when the structured arrangement allocates money for the start of Year Two (i.e., on January 1) Medicare would not make any payments for services performed until Year Two's allocation was completely exhausted.

In every set-aside arrangement case the contractor responsible for monitoring the individual's case (with assistance from the RO, if necessary) should ensure that Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the arrangement have truly been exhausted.

NOTE:
Until the individual actually becomes entitled to Medicare, the set-aside arrangement fund must **not** be used to pay the individual's expenses. That is, an individual's medical expenses must be paid from some other source besides the set-aside arrangement when the individual is not a Medicare beneficiary. Once the individual actually becomes entitled to Medicare, then the administrator of the arrangement is permitted to make payments for the individual's medical care (for Medicare-covered services only) from the arrangement.

If the contractor monitoring the individual's case discovers that payments from the set-aside arrangement have been used to pay for services that are not covered by Medicare or for administrative expenses that exceed those approved by the RO (see Question 11), then the contractor will not pay the Medicare claims. The contractor must provide the evidence of the unauthorized expenditures to the RO for investigation. If the RO determines that the expenditures were contrary to the RO's written opinion on the sufficiency of the arrangement, then the RO will notify the administrator of the arrangement that the RO's informal approval of the arrangement is withdrawn until such time as the funds used for non-Medicare expenses and/or unapproved administrative expenses are restored to the set-aside arrangement.

Question 5:

What are the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken its interests into account?

Answer:

The following criteria should be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the

cost of a work-related injury or illness to Medicare. Specifically, is the amount allocated for future medical expenses reasonable? If Medicare has already made conditional payments their repayment also has to be taken into account.

1. Date of entitlement to Medicare.

2. Basis for Medicare entitlement (disability, ESRD or age)-- If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.

3. Type and severity of injury or illness-- Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?

4. Age of beneficiary-- Acquire an evaluation of whether his/her condition would shorten the life span.

5. WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).

6. Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized-- If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.

7. Amount of lump sum or amount of structured settlement-- Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.

8. Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis?-- Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for

services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services related to the accident or illness?

9. Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.?-- If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.

10. Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition?-- Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost $20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare's interests into account.

The attorney for the individual for whom the arrangement is set-up should be advised that Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of WC.

NOTE:
Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts.

Page 11 – All Associate Regional Administrators

Question 6:

Some attorneys have indicated that a set-aside arrangement should only contemplate three to five years of estimated Medicare covered items or services. Would this be reasonable?

Answer:

No. To protect the Medicare Trust Fund, a set-aside arrangement should be funded based on the expected life expectancy of the individual unless the State law specifically limits the length of time that WC covers work related conditions. If an estimate of the beneficiary's estimated longevity was not submitted, one must be obtained.

Question 7:

What other issues should be considered?

Answer:

The lump sum amount should be interest bearing and indexed to account for inflation consistent with how Medicare calculates its growth in spending. Provision should also be made in the settlement agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the set-aside arrangement. (For example if outpatient prescription drugs become more widely covered.) If the beneficiary belongs to a Health Maintenance Organization that may not be coordinating benefits based on WC entitlement, the settlement should still set-aside funds for Medicare covered services in case the beneficiary converts to a fee for service plan.

Question 8:

Is it permissible for Medicare to accept an up-front cash settlement instead of a set-aside arrangement?

Answer:

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when WC did not pay promptly. Thus, when future benefits are included in a WC settlement agreement, Medicare cannot pay until the medical expenses related to the injury or

disease equal the amount of the settlement allocated to future medical expenses or the amount included for medical expenses in the set-aside arrangement has been exhausted.

Question 9:

How do providers and suppliers obtain payment for the services covered by the set-aside arrangement?

Answer:

There are two distinct methods for providers, physicians and other suppliers to obtain payment for WC covered services when funds are held in a set-aside arrangement. Determining which distinct payment method applies depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charges or WC fee schedule amounts (i.e., were the injured individual's medical expenses determined based on full actual charge estimates or WC fee schedule estimates).

When a set-aside arrangement's settlement agreement contains specific provisions establishing that the WC carrier will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan, and when the RO reviews and approves the sufficiency of the arrangement based on the WC plan's WC fee schedules, then, providers, physicians and other suppliers will be paid based on what would normally be payable under the WC plan (i.e., under the WC fee schedule). Therefore, providers, physicians and other suppliers would not be permitted to bill the arrangement more than the WC fee schedule rate. For example, if a provider's full charge for a particular service is $100 and the WC carrier normally pays $65 for that particular service, then the arrangement should only pay $65. However, when an arrangement's settlement agreement does **not** contain specific provisions ensuring that the arrangement cannot be charged more than what would normally be payable under the WC plan, then providers, physicians and other suppliers are permitted to bill the arrangement their full charges. It is important to note that when an arrangement's settlement agreement does not contain specific provisions ensuring that providers, physicians and other suppliers cannot bill the arrangement more than the WC fee schedule amounts, then the RO must review the sufficiency of that particular arrangement based upon full actual charge estimates.

Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts. If the arrangement is based upon WC fee schedule amounts, then, the RO cannot provide a written opinion on the

sufficiency of an arrangement until the arrangement's settlement agreement contains specific provisions that establish that the WC carrier can and will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan. The WC carrier must require all entities and individuals that accept WC payments to agree not to charge the arrangement more than what the WC plan would normally pay.

If a WC carrier is unable to enforce the requirement that the arrangement can only be charged the WC fee schedule rates, then the RO will evaluate whether an arrangement reasonably covers/considers Medicare's interest based on whether the future medical expenses billed to the arrangement are enough to cover the actual expenses for the services at issue. If State WC laws do not provide a particular WC carrier with the legal authority to enforce that requirement, then the RO can still provide a written opinion on the sufficiency of the arrangement so long as future medical expenses are evaluated by the RO using full actual charge estimates, not WC fee schedule amounts.

If the arrangement is constructed based upon full actual charge estimates, then the RO must determine whether the proposed amount to be placed in the arrangement for future medical expenses and administrative costs (see Question 11) is sufficient to cover the actual charges for the services at issue (rather than an amount equal to what would have been the Medicare approved amount for a particular service).

Once the arrangement has been depleted because of payments for otherwise Medicare covered services, a complete accounting must be provided to the contractor responsible for monitoring the individual's case and if the payments have been properly made Medicare can then be billed.

Question 10:

Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a set-aside arrangement?

Answer:

Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:

A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual's estimated life span, then a "rated age" may be obtainable from life insurance companies for injuries/illnesses sustained by other

similarly situated individuals. Also, documentation which gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

The RO may require additional documentation, if necessary and approved by CO.

Question 11:

How does the RO determine whether or not the administrative fees and expenses charged to the arrangement are reasonable?

Answer:

Before a proposed arrangement can be approved, the RO must determine whether the administrative fees and expenses to be charged to the arrangement are reasonable. The RO must be notified (in writing) of all proposed administrative fees prior to the RO providing its written assurance that the set-aside arrangement is sufficient to satisfy the requirements of 42 CFR 411.46. If the administrative fees are determined to be unreasonable, the RO must withhold its approval of the set-aside arrangement. The amount of the approved arrangement must include both the estimated medical expenses plus the amount of administrative fees found to be reasonable.

Question 12:

What impact will arrangements have on Medicare payment systems and procedures?

Answer:

Because an arrangement's purpose is to pay for all services related to the individual's work-related injury or disease, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the set-aside arrangement. Arrangements are established in order to pay for **all** medical expenses resulting from work-related injuries or diseases; arrangements are not designed to simply pay portions of medical expenses for work-related injuries or diseases.

When arrangements are designed as lump sum commutations (i.e., the arrangement is designed in a manner that the WC settlement is paid into the arrangement all at once, see Question #4 above), Medicare would not make any payments for that individual's

medical expenses (for work-related injuries or diseases) until all the funds (including interest) within the arrangement have been completely exhausted. These same basic principles also apply to structured commutations (see Question #4 above).

When providers, physicians and other suppliers submit claims to Medicare related to the individual's work-related injury or disease, claims processing contractors should deny those claims and instruct the entity or individual to seek payment from the administrator of the arrangement. Since the injured individual will be a Medicare beneficiary at the time when the provider, physician, or other supplier submits the claim to Medicare, the contractor responsible for monitoring the individual's case will have already updated the Common Working File to indicate that the injured individual's claims should be denied. However, when a provider, physician or other supplier submits any claims that are for injuries or diseases that **are not** work-related, then contractors should process those claims like they would any other claim for Medicare payment.

When the administrator of an arrangement refuses to make payment on a provider's, physician's or other supplier's claim because the administrator of the arrangement asserts the services are for injuries or diseases that are not work-related (or when the administrator of the arrangement denies the claim for any other reason), and the provider, physician or other supplier, subsequent to the administrator's denial, submits the claim to Medicare, then the contractor should consult the RO in order to determine whether Medicare should pay the claim. If a determination to deny the claim is made, then Medicare's regular administrative appeals process for claim denials would apply to the claim.

Please note that Central Office is planning to have a contractor assist ROs in monitoring and processing (however, not evaluating) these set-aside arrangement cases as early as possible in Fiscal Year 2002. Further instructions will be issued at that time.
Regional Office staff's questions on these issues should be directed to Fred Grabau at (410) 786-0206. We will issue additional guidance as necessary.

s/ Parashar B. Patel

Parashar B. Patel

cc: Regional Administrators
Gerry Nicholson, Benefits Operations Group
Liz Richter, Financial Services Group

COB Contractor MSP Laws and Third Party Payers Fact Sheet for Attorneys

The purposes of the Medicare Coordination of Benefits (COB) program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor (COBC) collects, manages, and reports other insurance coverage. The COBC must be notified of situations where medical services rendered to a beneficiary are related to a workers' compensation injury, automobile accident, or other liability because in these instances, another payer has the primary responsibility for payment of medical claims related to the injury. Both you and your client have significant responsibilities and obligations under the Medicare Secondary Payer (MSP) laws to report these situations, and your participation is vital in ensuring the integrity of the Medicare Trust Funds.

MSP Laws and Third Party Payers

MSP laws are applicable to situations where a beneficiary may file a claim and/or a civil action against a third party seeking damages for injuries received and medical expenses incurred as a result of that illness/injury. Per 42 U.S.C. 1395y(b) (2) and 1862 (b) (2)(A)(ii) of the Act, Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation (WC) plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Medicare may pay for a beneficiary's covered medical expenses conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement, award, judgement, or recovery. In these instances, a pro rata share of procurement costs reduces Medicare's reimbursement. This conditional payment is made if it is determined that the liability or no-fault insurer will not pay "promptly." Implementing regulations of the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, establish that "promptly" means 120 days from (1) the date a claim is filed with an insurer or a lien is filed against a potential liability settlement or (2) the date the service was furnished or the date of a hospital discharge. See 42 C.F.R. §411.50(b).

If an MSP liability situation is identified after the Medicare claim is paid primary, the beneficiary may be required to reimburse Medicare. The claim may be reprocessed or adjusted to reflect Medicare as the secondary payer.

It is in your client's best interest to keep Medicare's claims interest in mind during the negotiation and settlement process with the third party. Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party. If Medicare is not repaid in a timely manner, interest may be assessed.

Fact Sheet: Attorney V1.0
08/28/01

Notifying Medicare of Other Insurance

Medicare must be notified when the possibility exists that another insurer may have the responsibility of primary payer for your client's health care costs. All MSP inquiries including the reporting of potential MSP situations, invalid insurance information, and general MSP questions/concerns should be directed to the COBC's office. Use our toll-free lines: 1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired. Customer Service Representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Time, except holidays. Written correspondence should be addressed to: Medicare-COB, MSP Claims Investigation Project, P.O. Box 5041, New York, New York 10274-5041.

When contacting the COBC, please provide the following:

- Your client's name
- Your client's Medicare Health Insurance Claim Number (HICN) or Social Security number (SSN)
- Date of accident/incident
- Description of illness/injury
- Name and address of the other insurance (e.g., workers' compensation carrier, auto/no-fault insurance carrier, etc.)
- Name and address of legal representative

The above information will provide the COBC with the information necessary to expedite the MSP Claims Investigation process. Upon receipt of this information, the COBC will apply it to your client's Medicare record, assign the case to a Medicare contractor, and inform you and your client of the applicability of the MSP program and Medicare's recovery rights. You will receive a notice advising you of the Medicare contractor assigned to handle the specifics of the case to recovery (i.e., the lead contractor), Medicare's right of recovery, and a beneficiary consent to release form. Once this process is complete, all further inquiries are made through the lead contractor.

In order to gather Medicare's claim payment summary, the lead contractor canvasses other Medicare contractors to identify claims they have paid for your client. This process requires adequate time for the Medicare contractors to search their claims history and respond to the inquiry. Therefore, the sooner you notify Medicare of the incident, the faster Medicare can serve you and your client. Medicare's interest cannot be determined until the beneficiary's record has been annotated with the specifics of the case.

Notifying Medicare of a Settlement

If a settlement has already been reached, the following information must be provided to the lead contractor:

1. Authorization from your client to release Medicare specific paid claims data. If you do not have a release on file, a release form can be obtained from the COBC. Both

you and your client must sign the release form. Please note that a release must be returned even if a settlement has not been reached.
2. A copy of the settlement agreement indicating the settlement date and total amount of the award.
3. An itemized statement of attorney fees and procurement costs.
4. The name, address, and telephone number of the automobile or liability insurer involved, and if available, the policy number, claim number, and adjuster's name.
5. If monies are available through personal injury/med-pay or another form of coverage, indicate the total coverage amount and an itemization of benefits paid.

Visit the COBC Web Site

For more information about the COBC and the MSP Claims Investigation Project, visit our Web site at http://www.hcfa.gov/medicare/cob.

Code of Federal Regulations (CFR)

TITLE 42—PUBLIC HEALTH HUMAN SERVICES
PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT
Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

Sec. 411.20 Basis and scope.

(a) Statutory basis. (1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to—

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) Scope. This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

Sec. 411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

Coverage or covered services, when used in connection with third party payments, means services for which a third party payer would pay if a proper claim were filed.

Monthly capitation payment means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

Plan means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

Prompt or promptly, when used in connection with third party payments, except as provided in Sec. 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

Third party payer means an insurance policy, plan, or program that is primary to Medicare.

Third party payment means payment by a third party payer for services that are also covered under Medicare.

[60 FR 45361, Aug. 31, 1995]

Sec. 411.23 Beneficiary's cooperation.

(a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 45361, Aug. 31, 1995]

Sec. 411.24 Recovery of conditional payments.

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

(a) Release of information. The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(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 third party payment recipient, the amount of the third party 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 third parties. CMS has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

(f) Claims filing requirements. (1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) Recovery from parties that receive third party payments. CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

(h) Reimbursement to Medicare. If the beneficiary or other party receives a third party payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) Special rules. (1) In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of Sec. 411.37(b) applies.

(j) Recovery against Medicaid agency. If a third party payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the third party payment, whichever is less.

(k) Recovery against Medicare contractor. If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, CMS may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) Recovery when there is failure to file a proper claim. (1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a

third party payer, and Medicare is unable to recover from the third party payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions: (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) CMS will not recover from providers or suppliers that are in compliance with the requirements of Sec. 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) Interest charges. (1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision—

(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by CMS and is charged until reimbursement is made; and

(iii) The rate of interest is that provided at 42 CFR 405.376(d).

Sec. 411.25 Third party payer's notice of mistaken Medicare primary payment.

(a) If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in Sec. 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to CMS. Otherwise, the insurer, underwriter, or third party administrator must give the notice.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45361, 45362, Aug. 31, 1995]

Sec. 411.26 Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) Right to intervene. CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

[54 FR 41734, Oct. 11, 1989; as amended at 55 FR 1820, Jan. 19, 1990]

Sec. 411.28 Waiver of recovery and compromise of claims.

(a) CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in subpart F of part 401 and Sec. 405.376 of this chapter.

(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

Sec. 411.30 Effect of third party payment on benefit utilization and deductibles.

(a) Benefit utilization. Inpatient psychiatric hospital and SNF care that is paid for by a third party payer is not counted against the number of inpatient care days available to the beneficiary under Medicare Part A.

(b) Deductibles. Expenses for Medicare covered services that are paid for by third party payers are credited toward the Medicare Part A and Part B deductibles.

[54 FR 41734, Oct. 11, 1989, as amended at 61 FR 63749, Dec. 2, 1996]

Sec. 411.31 Authority to bill third party payers for full charges.

(a) The fact that Medicare payments are limited to the DRG amount, or the reasonable charge, reasonable cost, capitation or fee schedule rate, does not affect the amount that a third party payer may pay.

(b) With respect to workers' compensation plans, no-fault insurers, and employer group health plans, a provider or supplier may bill its full charges and expect those charges to be paid unless there are limits imposed by laws other than title XVIII of the Act or by agreements with the third party payer.

Sec. 411.32 Basis for Medicare secondary payments.

(a) Basic rules. (1) Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in Sec. 411.33, to supplement the third party payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under Sec. 411.33(e).

(b) Exception. Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges.

(c) General limitation: Failure to file a proper claim. When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable under Sec. 411.33 if the third party payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

Sec. 411.33 Amount of Medicare secondary payment.

(a) Services for which CMS pays on a Medicare fee schedule or reasonable charge basis. The Medicare secondary payment is the lowest of the following:

(1) The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the third party payer.

(2) The amount that Medicare would pay if the services were not covered by a third party payer.

(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the third party payer's allowable charge (without regard to any deductible or co-insurance imposed by the policy or plan) minus the amount actually paid by the third party payer.

(b) Example: An individual received treatment from a physician for which the physician charged $175. The third party payer allowed $150 of the charge and paid 80 percent of this amount or $120. The Medicare fee schedule for this treatment is $125. The individual's Part B deductible had been met. As secondary payer, Medicare pays the lowest of the following amounts:

(1) Excess of actual charge minus the third party payment: $175- 120=$55.

(2) Amount Medicare would pay if the services were not covered by a third party payer: .80x$125=$100.

(3) Third party payer's allowable charge without regard to its coinsurance (since that amount is higher than the Medicare fee schedule in this case) minus amount paid by the third party payer: $150-120=$30.

The Medicare payment is $30.

(c)–(d) [Reserved]

(e) Services reimbursed on a basis other than fee schedule, reasonable charge, or monthly capitation rate. The Medicare secondary payment is the lowest of the following:

(1) The gross amount payable by Medicare (that is, the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the third party payer), minus the applicable Medicare deductible and coinsurance amounts.

(2) The gross amount payable by Medicare, minus the amount paid by the third party payer.

(3) The provider's charges (or the amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the third party payer.

(4) The provider's charges (or the amount the provider is obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

(f) Examples: (1) A hospital furnished 7 days of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totaled $2,800. The third party payer paid $2,360. No part of the Medicare inpatient hospital deductible of $520 had been met. If the gross amount payable by Medicare in this case is $2,700, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare inpatient hospital deductible: $2,700-$520=$2,180.

(ii) The gross amount payable by Medicare minus the third party payment: $2,700-$2,360=$340.

(iii) The provider's charges minus the third party payment: $2,800- $2,360=$440.

(iv) The provider's charges minus the Medicare deductible: $2,800- $520=$2,280. Medicare's secondary payment is $340 and the combined payment made by the third party payer and Medicare on behalf of the beneficiary is $2,700. The $520 deductible was satisfied by the third party payment so that the beneficiary incurred no out-of-pocket expenses.

(2) A hospital furnished 1 day of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totalled $750. The third party payer paid $450. No part of the Medicare inpatient hospital deductible had been met previously. The third party payment is credited toward that deductible. If the gross amount payable by Medicare in this case is $850, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare deductible: $850-$520=$330.

(ii) The gross amount payable by Medicare minus the third party payment: $850-$450=$400.

(iii) The provider's charges minus the third party payment: $750- $450=$300.

(iv) The provider's charges minus the Medicare deductible: $750- $520=$230. Medicare's secondary payment is $230, and the combined payment made by the third party payer and Medicare on behalf of the beneficiary is $680. The hospital may bill the beneficiary $70 (the $520 deductible minus the $450 third party payment). This fully discharges the beneficiary's deductible obligation.

(3) An ESRD beneficiary received 8 dialysis treatments for which a facility charged $160 per treatment for a total of $1,280. No part of the beneficiary's $75 Part B deductible had been met. The third party payer paid $1,024 for Medicare-covered services. The composite rate per dialysis treatment at this facility is $131 or $1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of the following:

(i) The gross amount payable by Medicare minus the applicable Medicare deductible and coinsurance: $1,048-$75-$194.60=$778.40. (The coinsurance is calculated as follows: $1,048 composite rate-$75 deductible=$973x.20=$194.60).

(ii) The gross amount payable by Medicare minus the third party payment: $1,048-$1,024=$24.

(iii) The provider's charges minus the third party payment: $1,280- $1,024=$256.

(iv) The provider's charge minus the Medicare deductible and coinsurance: $1,280-$75-$194.60=1010.40. Medicare pays $24. The beneficiary's Medicare deductible and coinsurance were met by the third party payment.

(4) A hospital furnished 5 days of inpatient care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services were $4,000 and the gross amount payable was $3,500. The provider agreed to accept $3,000 from the third party as payment in full. The third party payer paid $2,900 due to a deductible requirement under the third party plan. Medicare considers the amount the provider is obligated to accept as full payment ($3,000) to be the provider charges. The Medicare secondary payment is the lowest of the following:

(i) The gross amount payable by Medicare minus the Medicare inpatient deductible: $3,500-$520=$2,980.

(ii) The gross amount payable by Medicare minus the third party payment: $3,500-$2,900=$600.

(iii) The provider's charge minus the third party payment: $3,000- $2,900=$100.

(iv) The provider's charges minus the Medicare inpatient deductible: $3,000-$520=$2,480. The Medicare secondary payment is $100. When Medicare is the secondary payer, the combined payment made by the third party payer and Medicare on behalf of the beneficiary is $3,000. The beneficiary has no liability for Medicare-covered services since the third party payment satisfied the $520 deductible.

Sec. 411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.

(a) Definition. As used in this section Medicare-covered services means services for which Medicare benefits are payable or would be payable except for the Medicare deductible and coinsurance provisions and the amounts payable by the third party payer.

(b) Applicability. This section applies when a workers' compensation plan, a no-fault insurer or an employer group health plan is primary to Medicare.

(c) Basic rule. Except as provided in paragraph (d) of this section, the amounts the provider or supplier may collect or seek to collect, for the Medicare-covered services from the beneficiary or any entity other than the workers' compensation plan, the no-fault insurer, or the employer plan and Medicare, are limited to the following:

(1) The amount paid or payable by the third party payer to the beneficiary. If this amount exceeds the amount payable by Medicare (without regard to deductible or coinsurance), the provider or supplier may retain the third party payment in full without violating the terms of the provider agreement or the conditions of assignment.

(2) The amount, if any, by which the applicable Medicare deductible and coinsurance amounts exceed any third party payment made or due to the beneficiary or to the provider or supplier for the medical services.

(3) The amount of any charges that may be made to a beneficiary under Sec. 413.35 of this chapter when cost limits are applied to the services, or under Sec. 489.32 of this chapter when the services are partially covered, but only to the extent that the third party payer is not responsible for those charges.

(d) Exception. The limitations of paragraph (c) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or claimed payment under Sec. 424.64 of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45362, Aug. 31, 1995]

Sec. 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 CMS seeks to recover.

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

(b) Recovery against the third party payer. If CMS seeks recovery from the third party payer, in accordance with Sec. 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) CMS incurs procurement costs because of opposition to its recovery. If CMS must bring suit against the party that received payment because that party opposes CMS'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.

Sec. 411.40 General provisions.

(a) Definition. ``Workers' compensation plan of the United States'' includes the workers' compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees' Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

(b) Limitations on Medicare payment. (1) Medicare does not pay for any services for which—

(i) Payment has been made, or can reasonably be expected to be made promptly under a workers' compensation law or plan of the United States or a state; or

(ii) Payment could be made under the Federal Black Lung Program, but is precluded solely because the provider of the services has failed to secure, from the Department of Labor, a provider number to include in the claim.

(2) If the payment for a service may not be made under workers' compensation because the service is furnished by a source not authorized to provide that service under the particular workers' compensation program, Medicare pays for the service if it is a covered service.

(3) Medicare makes secondary payments in accordance with Sec. 411.32 and Sec. 411.33.

Sec. 411.43 Beneficiary's responsibility with respect to workers' compensation.

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation.

(b) Except as specified in Sec. 411.45(a), Medicare does not pay until the beneficiary has exhausted his or her remedies under workers' compensation.

(c) Except as specified in Sec. 411.45(b), Medicare does not pay for services that would have been covered under workers' compensation if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper claim, Medicare pays for the services if they are covered under Medicare.

Sec. 411.45 Basis for conditional Medicare payment in workers' compensation cases.

A conditional Medicare payment may be made under either of the following circumstances:

(a) The beneficiary has filed a proper claim for workers' compensation benefits, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.

(b) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

Sec. 411.46 Lump-sum payments.

(a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(b) Lump-sum compromise settlement.

(1) A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan.

(2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

(c) Lump-sum compromise settlement: Effect on services furnished before the date of settlement. Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in Sec. 411.47.

(d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—

(1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.

(2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

Sec. 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.

(a) Determining amount of compromise settlement considered as a payment for medical expenses. (1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable

recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

(2) If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:

(i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.

(ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.

Example: As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers' compensation payment would have been $24,000 if the case had not been compromised. The medical expenses amounted to $18,000. The workers' compensation carrier made a settlement with the beneficiary under which it paid $8,000 in total. A separate award was made for legal fees. Since the workers' compensation compromise settlement was for one-third of the amount which would have been payable under workers' compensation had the case not been compromised ($8,000/$24,000=\1/3\), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (\1/3\x$18,000=$6,000).

(b) Determining the amount of the Medicare overpayment. When conditional Medicare payments have been made, and the beneficiary receives a compromise settlement payment, the Medicare overpayment is determined as set forth in this paragraph (b). The amount of the workers' compensation payment that is considered to be for medical expenses (as determined under paragraph (a) of this section) is applied, at the workers' compensation rate of payment prevailing in the particular jurisdiction, in the following order:

(1) First to any beneficiary payments for services payable under workers' compensation but not covered under Medicare.

(2) Then to any beneficiary payments for services payable under workers' compensation and also covered under Medicare Part B. (These include deductible and coinsurance amounts and, in unassigned cases, the charge in excess of the reasonable charge.)

(3) Last to any beneficiary payments for services payable under workers' compensation and also covered under Medicare Part A. (These include Part A deductible and coinsurance amounts and charges for services furnished after benefits are exhausted.)

The difference between the amount of the workers' compensation payment for medical expenses and any beneficiary payments constitutes the Medicare overpayment. The beneficiary is liable for that amount.

Example: In the example in paragraph (a) of this section, it was determined that the workers' compensation settlement paid for $6,000 of the total medical expenses. The $18,000 in medical expenses included $1,500 in charges for services not covered under Medicare, $7,500 in charges for services covered under Medicare Part B, and $9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers' compensation payment rate, that is, in amounts the provider or supplier must accept as payment in full.

The Medicare reasonable charge for physicians' services was $7,000 and Medicare paid $5,600 (80 percent of the reasonable charge). The Part B deductible had been met. The Medicare payment rate for the hospital services was $8,000. Medicare paid the hospital $7,480 ($8,000—the Part A deductible of $520).

In this situation, the beneficiary's payments totalled $3,920:

Services not covered under Medicare	$1,500
Excess of physicians' charges over reasonable charges	500
Medicare Part B coinsurance	1,400
Part A deductible	520
Total	3,920

The Medicare overpayment, for which the beneficiary is liable, would be $2,080 ($6,000-$3,920).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicare Management

APR 21 2003

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer -- Workers' Compensation (WC) Frequently Asked Questions

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1) **What statutory law, regulations, or Federal case law supports/allows CMS to review proposed settlements of injured workers who are not Medicare beneficiaries?**

Answer: Section 1862(b)(2) of the Social Security Act (the Act) (42 USC 1395y(b)(2)) requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation (WC) law or plan. Medicare does not pay for an individual's WC related medical services when that individual received a WC settlement, judgment, or award that includes funds for future medical expenses, until all such funds are properly expended.

Because Medicare does not pay for an individual's WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in that individual's interests to consider Medicare at the time of settlement. Once CMS agrees to a Medicare set-aside amount, the individual can be certain that Medicare's interests have been appropriately considered.

2) When dealing with a WC case, what is "a reasonable expectation" of Medicare enrollment within 30 months?

Answer: Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are not limited to:

a) The individual has applied for Social Security Disability Benefits;
b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

3) How does Medicare determine its interests in WC cases when the parties to the settlement do not explicitly state how much of the settlement is for past medical expenses and how much is for future medical expenses?

Answer: A settlement that does not specifically account for past versus future medical expenses will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.

Example: A beneficiary is paid $50,000 by a WC carrier, and the parties to the settlement do not specify what the $50,000 is intended to pay for. If there is no CMS approved Medicare set-aside arrangement, Medicare will consider any amount remaining after recovery of its conditional payments as compensation for future medical expenses.

Additionally, please note that any allocations made for lost wages, pre-settlement medical expenses, future medical expenses, or any other settlement designations that do not consider Medicare's interests, will not be approved by Medicare.

4) What's the difference between commutation and compromise cases? And can a single WC case possess both?

Answer: When a settlement includes compensation for future medical expenses, it is referred to as a " WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.

5) When a state WC judge approves a WC settlement, will Medicare accept the terms of that settlement?

Answer: Medicare will generally honor judicial decisions issued after a hearing on the merits of a WC case by a court of competent jurisdiction. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

However, a distinction must be made where a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. Medicare cannot accept the terms of the settlement as to an allocation of funds of any type if the settlement does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire WC settlement. Medicare will also assert a recovery claim, if appropriate.

6) What is the expected time frame for the regional offices (ROs) to review and make their decisions regarding proposed WC settlements?

Answer: ROs seek to review and make a decision regarding proposed WC settlements within 45 to 60 days, from the time that all necessary/required documentation has been submitted.

7) May administrative fees/expenses for administration of the Medicare set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement be charged to the set-aside arrangement?

Answer: Yes, such fees and costs may be charged to the arrangement if all the following are true:

a) They are related to the Medicare set-aside itself;
b) They are reasonable in amount; and
c) They are included in the proposed Medicare set-aside arrangement submitted to CMS and incorporated into the Medicare set-aside approved by CMS.

It is important to note that all administrative fees and other costs and expenses associated with the disability/lost wages portion of the settlement and/or the portion of the settlement that provides for medical services that are not covered by Medicare cannot be charged to the Medicare set-aside arrangement.

Note: This question and answer does not address attorney fees and costs in connection with procurement of the WC settlement from the WC carrier.

8) May a beneficiary self-administer his or her own Medicare set-aside arrangement?

Answer: Yes, if this is permitted under state law. It should be noted though, that a self-administered arrangement is subject to the same rules/requirements as any other set-aside arrangement.

9) In WC cases that use structured Medicare set-aside arrangements (i.e., settlement monies are apportioned over fixed or defined periods of time), will Medicare agree to cover the beneficiary when it has not been verified whether the funds as apportioned in the arrangement have been exhausted?

Answer: No, 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.

Additionally, please note that any structured set-aside arrangement agreed to by the parties will not be approved by Medicare if the settlement has not adequately considered Medicare's interests.

10) In a structured Medicare set-aside arrangement where payments are made at regular intervals to cover expenses incurred during those periods, how should an administrator account for unspent funds during a given period?

Answer: If funds are not exhausted during a given period then the excess funds must be carried forward to the next period. The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.

Example: A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2003 the injured individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2004. Therefore, in 2004 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2004. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

11) If a beneficiary or injured individual's physical condition substantially improves, may the administrator of the Medicare set-aside arrangement release or reduce the amounts of the set-aside?

Answer: The administrator of the CMS approved Medicare set-aside arrangement cannot release or reduce the set-aside amounts without approval from CMS. If the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary (or his/her representative) may submit a written request to the appropriate CMS RO asking for a reduction of the Medicare set-aside arrangement. This request must include supporting documentation from the treating physician(s). Once the RO receives all pertinent documentation, the RO will then evaluate the request and make a decision. The RO decision is final and not subject to administrative appeal.

12) What are an attorney's ethical and legal obligations when his or her client effectively ignores Medicare's interests in a WC case?

Answer: Attorneys should consult their national, state, and local bar associations for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26.

13) From where can CMS recover funds if Medicare's interests are ignored in a WC case?

Answer: The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly. The CMS also has a subrogation right with respect to any such third party payment. See, for example, 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26.

14) If Medicare rejects a proposed Medicare set-aside arrangement, how can the parties to a WC settlement appeal this rejection?

Answer: The CMS has no formal appeals process for rejection of a Medicare set-aside arrangement. However, when CMS does not believe that a proposed set-aside adequately protects Medicare's interests, the parties may provide the RO with additional information/documentation in order to justify their proposal. If the additional information does not convince the RO to approve the set-aside arrangement, and the parties proceed to settle the case despite the ROs objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as WC settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. At this point, when Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. Information on applicable appeal rights is provided at the time of each claim denial.

15) When the parties to a WC settlement present CMS with documentation that is intended to support and justify their proposed Medicare set-aside amounts, will Medicare accept a "life care plan" or similar evaluation prepared by a non-treating physician?

Answer: Yes, Medicare will consider accepting a life care plan or similar evaluation from a non-treating physician, if the physician does all of the following:

a) Examines the WC claimant;
b) Reviews the claimant's medical records;
c) Contacts any of the claimant's treating physicians (if applicable);
d) Is available to answer CMS' questions;
e) Prepares a report that summarizes the above; and
f) Offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury.

Please note that such a life care plan or evaluation is not automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question for some reason, such as contrary evidence, internal conflicts, or if the plan is not credible on its face.

16) If a current Medicare beneficiary has outstanding WC related claims that were not paid prior to the settlement and are not covered in that settlement, will Medicare or the Medicare set-aside arrangement pay those claims?

Answer: No, Medicare cannot pay because it is secondary to the WC settlement and the Medicare set-aside arrangement cannot pay because it is created solely for future medical expenses related to the WC case. Medical expenses incurred prior to the

settlement need to be accounted for in the compromise portion of the settlement. These services should be known to the parties. The provider/supplier will typically have billed Medicare and/or the WC carrier for these services and the beneficiary's representative will have made inquiries about outstanding related claims.

In addition, to the extent Medicare has made any conditional payments, Medicare will recover those payments pursuant to 42 CFR 411.47.

17) When an annuity is included in a settlement for an injured individual (who is not yet a Medicare beneficiary), how does Medicare determine whether the value of the annuity meets the $250,000 monetary threshold?

Answer: Medicare determines the value of an annuity based on how much the annuity is expected to pay over the life of the settlement, not on the Present Day Value (PDV) or cost of funding that annuity.

Example: A settlement is to pay $15,000 per year for the next 20 years to an individual who has a "reasonable expectation" of Medicare enrollment within 30 months. This settlement is to be funded with an annuity that will cost $175,000. The RO will review this settlement because the total settlement to be paid is greater than $250,000 ($15,000 per year x 20 years = $300,000). It is immaterial for Medicare's purposes that the PDV or cost ($175,000) to fund this settlement is less than $250,000.

18) Is there a means by which an injured individual can permanently waive his or her right to certain specific services related to a WC case, and thereby reduce the amount of a Medicare set-aside arrangement?

Answer: No, the ROs cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement.

19) Does CMS require that a Medicare set-aside arrangement be established in situations that involve both a WC claim and a third party liability claim?

Answer: Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that

the beneficiary does not require any further WC claim related medical services. A Medicare set-aside arrangement is also unnecessary if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.

20) If the settling parties of a WC case contend that a WC settlement is not intended to compensate an injured individual for future medical expenses, does CMS still require that a Medicare set-aside arrangement be established?

Answer: It is unnecessary for the individual to establish a set-aside arrangement for Medicare if all of the following are true:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);
b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and
c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

However, if Medicare made any conditional payments for work-related services furnished prior to settlement, then Medicare would require recovery of those payments. In addition, Medicare will not pay for any services furnished prior to the date of the settlement for which it has not already paid.

21) If a beneficiary or injured individual dies before the Medicare set-aside arrangement is completely exhausted, what happens to the remaining money?

Answer: Once the RO and the contractor responsible for monitoring the beneficiary's case ensure that all of the beneficiary's claims have been paid, then any amount left over in the beneficiary's Medicare set-aside arrangement may be disbursed pursuant to state law, once Medicare's interests have been protected. This may involve holding the Medicare set-aside arrangement open for some period after the date of death, as providers, physicians, and other suppliers are permitted to submit their initial bill to Medicare for a period ranging from 15-27 months after the date of service.

22) What happens if one of the parties settling a WC case refuses to involve CMS, even though Medicare has an interest in the case?

Answer: In these situations, the "cooperative" settling party should notify the appropriate CMS RO. Where the RO believes it is appropriate, the RO will then send the "uncooperative" party a letter (via certified mail) conveying that Medicare's interests must be considered in the WC settlement.

The ROs should inform the "uncooperative" settling party that: "Pursuant to 42 CFR 411.24(g), CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received a third party payment. Moreover, pursuant to 42 CFR 411.26, CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a third party payer. Therefore, pursuant to 42 CFR 411.24(b), CMS may initiate recovery against the parties listed under 42 CFR 411.26 as soon as it learns that payment has been made or could be made under workers' compensation."

Additionally, if Medicare's interests are not adequately considered in any settlement, then Medicare may refuse to pay for services related to the WC injury until such time as expenses for such services have exhausted the amount of the entire WC settlement.

23) Who should the parties settling a WC case contact in the RO?

Answer: The first report of attorney representation of a Medicare beneficiary for a WC claim should be made to the CMS Coordination of Benefits (COB) Contractor. Attorneys can call the COB Contractor from 8am-8pm, Monday - Friday, Eastern Time; the toll-free number is 1-800-999-1118.

Settling parties should also contact the CMS RO responsible for a particular state (contact information is provided in an attachment to these questions and answers) for approval of a Medicare set-aside arrangement. The inquiry should be directed to the attention of the Regional Office Medicare Secondary Payer Coordinator, who will forward the inquiry to the appropriate RO if a transfer is necessary. (WC set-aside responsibilities are generally, but not always, assigned based upon RO responsibility for contractor oversight over the lead fiscal intermediary for WC recoveries for a particular state. This may or may not be the same RO as the one with general responsibilities for a particular state.)

Page 10 – All Regional Administrators

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

Thomas L. Grissom

Attachment

Page 11 – All Regional Administrators

cc: All ARA's for Financial Management
ARA for DHPP RO VII
All RO MSP Coordinators

bcc: Paul Olenick
Martha Kuespert
Fred Grabau
Eve Fisher
Tina Merritt
Barbara Wright
Betty Noble
Hugh Hill
Joan Fowler
Harry Gamble
Donna Kettish

MEDICARE SECONDARY PAYER REGIONAL OFFICE COORDINATORS
(WORKERS' COMPENSATION CONTACTS)

NAME	REGIONAL OFFICE	PHONE
James Bryant	I--Boston	617-565-1331
Thomas Hatchfield		617-565-1254
Sedric Goutier		617-565-1228
Jerry Kerr	II--New York	212-264-3760
	III--Philadelphia	
Catherine McCoy		215-861-4250
Maria Kuehn		215-861-4306
Juanita Dixon	IV--Atlanta	404-562-7313
Geraldine Taylor		404-562-7311
	V--Chicago	
Janice Edwards		312-886-3256
Barry Thomas	VI--Dallas	214-767-6455
Doug Rundle	VII--Kansas City	816-426-5783
Cindy Christensen	VIII--Denver	303-844-7095
Rosie Sagum	IX--San Francisco	415-744-3655
Tom Bosserman		415-744-4907
Jean Tsutakawa	X--Seattle	206-615-2382
Jonella Windell		206-615-2385

Note: If the caller is simply contacting Medicare for the first time in order to report workers' compensation coverage (as opposed to seeking out RO approval of a proposed Medicare set-aside arrangement), then the caller should contact the Coordination of Benefits Contractor at 1-800-999-1118.

STATES IN EACH REGION

I.	BOSTON	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	VI.	DALLAS	Arkansas Louisiana New Mexico Oklahoma Texas
II.	NEW YORK	New Jersey New York Puerto Rico Virgin Islands	VII.	KANSAS CITY	Iowa Kansas Missouri Nebraska
III.	PHILA.	Delaware Dist. Of Columbia Maryland Pennsylvania Virginia West Virginia	VIII.	DENVER	Colorado Montana North Dakota South Dakota Wyoming
IV.	ATLANTA	Alabama North Carolina South Carolina Florida Georgia Kentucky Mississippi Tennessee	XI.	SAN FRAN	American Samoa Arizona California Guam Hawaii Nevada
V.	CHICAGO	Illinois Indiana Michigan Minnesota Ohio Wisconsin	X.	SEATTLE	Alaska Idaho Oregon Washington Utah

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

DATE: May 23 2003

7500 Security Boulevard
Baltimore, MD 21244-1850

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer -- Workers' Compensation (WC) Additional Frequently Asked Questions

TO: All Regional Administrators

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1.) What are the review thresholds set by the July 23, 2001 All Associate Regional Administrators (ARA) letter concerning WC Commutation of Future Benefits?

Answer: They state that to the extent a WC settlement meets both of the criteria (i.e., the settlement is greater than $250,000 AND the claimant is reasonably expected to become a Medicare beneficiary within 30 months of the settlement date), then a CMS-approved Medicare set-aside arrangement is appropriate. However, if a WC settlement is $250,000 or less OR where the claimant of that settlement is not reasonably expected to become a Medicare beneficiary within 30 months of the settlement date, then a CMS-approved Medicare set-aside arrangement is unnecessary.

Additional Information: Please note that the current review thresholds are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected.

2.) When an injured individual's WC settlement does not meet the current review thresholds, will the Regional Offices (RO) provide the settling parties with "verification" letters confirming that approval of a Medicare set-aside arrangement is unnecessary?

Answer: No, the ROs will not provide "verification" letters. However, the CMS will honor threshold levels that are in effect as of the date of a WC settlement. (See the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits.)

3.) An injured individual, who does not have a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, settles his/her WC case for less than $250,000. Once this individual becomes a Medicare beneficiary, will CMS pay for services that are otherwise reimbursable under Medicare, that are related to the WC injury, even though funds still remain in the individual's settlement?

Answer: Yes. When an individual's settlement does not meet both thresholds Medicare will make payment for WC related services that are otherwise reimbursable under Medicare once the individual enrolls in Medicare.

Page 2 – All Regional Administrators I-X

Additional Information: The CMS assumes that when a non-Medicare eligible claimant's WC settlement does not meet the 30-month and $250,000 thresholds, typically that individual will completely exhaust his/her settlement by the time Medicare eligibility is reached. Also, according to various members of the WC community, most settlements for these individuals are in the range of $10,000 to $50,000. Therefore, the amount of money in the settlement that is actually being provided for an individual's medical care normally will be appropriately exhausted before the individual becomes a Medicare beneficiary.

Please note that the current review thresholds (see the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits) are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected.

4.) Will CMS treat WC cases that were settled prior to the issuance of the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits in the same manner as those settled after the review threshold guidelines were established?

Answer: Yes. For WC settlements that do not meet the review thresholds, Medicare will make payment for WC related services that are otherwise reimbursable under Medicare, once the individual becomes enrolled in Medicare. This will be done regardless of when the settlement actually occurred. However, a reopening of claims (see 42 C.F.R. 405.750 and 405.841) that Medicare previously denied for these individuals will not be granted, nor will the CMS change any decisions already made with respect to settlements which pre-date July 23, 2001.

Additional Information: When the CMS issued the July 23, 200l ARA letter, it established review thresholds for WC cases settled by injured individuals who are not yet Medicare beneficiaries. This was done in order to organize and prioritize workloads for its ROs and to convey to its ROs that it is not in Medicare's best interests to review WC settlements that do not meet the review thresholds.

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

s/ Thomas L. Grissom

Thomas L. Grissom

cc: All ARA's for Financial Management
ARA for DHPP RO VII
All RO MSP Coordinators