MSA?

I Don’t Need No Stinkin’ MSA !

Wanna Bet?

Primary payers have the responsibility to pay a claim first. Hence the “primary”. This includes liability carriers in torts. Medicare is becoming more aggressive in pursuing recovery and protecting Medicare’s interests than in the past. This will have a significant impact on liability cases across the nation.

Medicare pays first for beneficiaries in the absence of other primary insurance or coverage. There are a limited number of circumstances under which Medicare may pay first when the beneficiary has other insurance coverage. This increases the importance of considering the interests of Medicare in every tort settlement.

In Fiscal Year (FY) 2015 alone, The Centers for Medicare & Medicaid Services (CMS) enforcement of the Medicare Secondary Payer (MSP) provisions saved the Medicare Program something close to $8.5 billion. Helping providers learn that accurate billing of the appropriate carrier can increase their revenue puts attorneys in the unique position to help limit losses for health providers trying to squeeze what income they can from a seemingly ever-shrinking pool of funds. An increase in provider, physician, and other supplier revenue – if you bill a primary plan before billing Medicare, is possible and these entities may enjoy substantially more favorable reimbursement rates. Additionally, these providers can be taught it is in their interest to properly coordinate health coverage claims in order to expedite the payment process and reduce administrative costs. It is imperative to remember that filing claims correctly the first time, may prevent future Medicare recovery efforts on claims.

Workers’ Compensation (WC) attorneys have been working with Medicare Set-Asides (MSAs) for quite some time and are familiar with the process and how to navigate it efficiently. With an increase in enforcement of MSP provisions, personal injury attorneys will become equally familiar with these rules and procedures. With the new focus on enforcement there are still a number of unsettled questions and there will certainly be a “learning curve”. In order to prepare attorneys whose experience does not include WC this presentation will introduce the process through the WC model as that is the most likely starting point for CMS in pursuing enforcement. After all, CMS needs a starting point themselves and if they begin this process efficiently they will at least start with something they already have in place and adapt it to new use.

WCMSAs are the known model, whereas the Liability MSA (LMSA) is the new kid on the block. How must they be addressed? What are the rules? Are there any rules? Where do we go from here – (now that all of the children have grown up – sorry that line always brings up more lyric)? As of October 1, 2017, providers are no longer permitted to bill Medicare for any injury-related medical treatment of beneficiaries. CMS denies these claims using a rejection code of “liability MSA in place”. This will impact every settlement reached after that date.

WC attorneys know how to handle the MSA situation in WC cases. A Liability MSA (LMSA), (sometimes No-fault MSA (NFMSA)) is not the same as the WCMSA. LMSAs require a different strategy, different timing, and will come under different CMS guidelines. Two big differences are immediately noted. The plaintiff attorney is in complete control of the LMSA and, at least for now, complying with CMS provisions for liability cases is much easier than for Worker’s Compensation. While it may be easier at this point, that does not guarantee it will remain so. To protect attorneys going forward, the information presented here will help.

Preparing for Medicare involvement requires a two-step analysis on the part of the parties to consider both (1) all medical expenses already incurred and paid by Medicare (conditional payments), and (2) the possibility of future medical expenses yet to be incurred that may be payable by Medicare, which are sometimes referred to under the catch-all phrase “Medicare Set Asides.” It is extremely important to include language in the settlement agreement explaining how the parties have considered Medicare’s interests.

The importance of appropriate language is shown by the fact that although the MSP statute and supporting federal regulations can be difficult to interpret, it is very clear that CMS can (and often will) pursue recovery from anyone who receives payment, directly or indirectly, from a settlement resolving medical liability where the burden is improperly shifted to Medicare. Such recovery efforts may be directed not only towards the Medicare beneficiary and the insurance carrier, but also to self-insureds, attorneys who are paid fees from the settlement, medical providers, or anyone else who has received a portion of a third-party payment.

There is, at present, no defined language that CMS accepts in settlements of injury torts outside the WC arena. With this understanding, the best place to start any journey is at a known point and that leads to the recommendation that the appropriate language for a WCMSA be adapted to the specific needs of any non-WC MSA when submitted to CMS. Using Medicare’s own language as a boilerplate will help with arguments of the parties having “taken Medicare’s interests into account”. While certainly not a guarantee, until Medicare defines the required language, such an effort at compliance will support an argument of appropriate diligence in compliance.

Remember the risk to Plaintiffs. Medicare may suspend a beneficiary’s coverage until an entire settlement has been exhausted. Even carriers’ liability may not necessarily be limited to the amount of the settlement. Medicare has the unique ability to seek reimbursement for conditional payments pursuant to what has been described as a “super lien,” which takes priority over any other primary payers. *See* 42 U.S.C. 1395y(b)(2)(B)(iii). It is critical to remember also that the MSP gives Medicare the legal right to seek double damages for reimbursement of conditional payments. Medicare also has certain subrogation rights. *See* 42 U.S.C. 1395y(b)(2)(B)(iv).

To protect yourself and your client:

Every intake form in every firm would benefit from review to ensure that four simple questions are asked of every client who may be involved in an injury tort (including self-insured parties):

(1) Is client a current Medicare beneficiary?

(2) Is client eligible for Medicare benefits within 30 months due to age?

(3) Has the client ever applied for, and therefore has a “reasonable expectation” of Medicare eligibility within 30 months, SSDI?

(4) Does client have end stage renal disease, blindness, HIV, or ALS?

It cannot be over-emphasized that best practices for attorneys representing Plaintiffs include always contacting the Benefits Coordination & Recovery Center (BCRC) first whenever you have a pending liability, no-fault, or workers’ compensation claim. Be prepared to provide the following information:

Beneficiary Information

Full Name

Health Insurance Claim Number (HICN)

Gender

Date of Birth

Complete address

Phone number

Case Information

Date of injury/accident, date of first exposure, ingestion or, implant

Description of alleged injury or illness or harm

Type of Claim (liability insurance, no-fault insurance, workers’ compensation)

Insurer/workers’ compensation entity name and address

Representative Information

Attorney or other representative name

Law firm name if representative is an attorney

Complete address and phone number

Once your case is reported to the BCRC and it has been established in their system, you will receive a “Rights and Responsibilities” Letter (RAR). The RAR is mailed to all parties associated with the case and includes, among other enclosures, a “Conditional Payment Letter” (CPL) providing information on items or services the BCRC has identified as being related to the pending Non-Group Health Plan (NGHP) claim. The conditional payment amount is not final and is, “conditioned” on acceptance of responsibility for payment by Medicare.

Attorneys are not required, or expected, to request an initial CPL, as it is generated automatically within 65 days of the issuance of the "Rights and Responsibilities" Letter. The CPL must be thoroughly examined to ensure that only case related claims are included. All claims included are those for which Medicare has made payments and expectes reimbursement. Non-injury related treatments that are the primary responsibility of Medicare are not reimbursable and must be identified to ensure a proper accounting of the Medicare lien.

After registration on the site, attorneys can obtain conditional payment information from the Medicare Secondary Payer Recovery Portal (MSPRP) using this link:

https://www.cob.cms.hhs.gov/MSPRP

Authorized MSPRP users may request access to view unmasked claims data that was previously only accessible to the beneficiary. If requesting this access you must complete the Identity Proofing and

Multi-Factor Authentication process on the MSPRP.

Attorneys who have experience working on settlements with Medicare beneficiaries are familiar with long wait times when working to finalize conditional payment amounts. It is also distressing to not have a final demand amount until after a settlement occurs. These challenges potentially will disappear based on a Nov. 9, 2015, CMS alert. Effective Jan. 1, 2016, parties are now able to obtain a final demand prior to settlement. This new access to current information will reduce the risk to beneficiaries, their counsel, and liability carriers.

How do you accomplish what has always been an impossible task? At any time 120 days prior to a settlement, judgment, or award, the parties notify CMS of the expected settlement date and amount. During this time, conditional payment information will be available on the Medicare Secondary Payer Recovery Portal (MSPRP). Payments by CMS for items and services must be posted to the portal no later than 15 days from the date they are made.

Within 65 days from notice, a “statement of reimbursement amount” will be available for download, which can be considered the final demand as long as you are in the “protected period” (65 days after CMS has received notice of your settlement, judgment, or award but before the 120-day period of when the settlement was to occur as stated by the parties). (N.B.: CMS has the authority to extend the 65-day period for an additional 30 days but only for exceptional circumstances, which should be rare.)

The portal will provide a final demand that is time and date stamped. It is critical the settlement occur within the next three business days for the demand to be valid. While three business days seems quick, the parties can re-download to have another three days but must do so before the expiration of the 120-day period.

To take advantage of being able to obtain a pre-settlement final demand, the following conditions must be met:

 You must, at least 65 days prior to the anticipated settlement, notify CMS of the expected settlement date and amount.

 You are an authorized user of the MSPRP or work with a vendor that is an authorized user. The pre-settlement final demand can be obtained only through the MSPRP.

 You must download the final statement of reimbursement amount within three business days of the settlement.

 You must submit settlement information through the MSPRP within 30 days of requesting the final conditional payment amount.

In an effort to protect Medicare against shifting the burden for ongoing medical care from primary payers to Medicare, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added certain mandatory reporting requirements for settlements involving Medicare beneficiaries by requiring the mandatory reporting of certain claims involving Medicare beneficiaries and the subsequent settlement of those claims. Medical treatment related to such reported claims is tracked by CPT medical codes. If a reported claim is settled without resolving the Medicare conditional payment lien or adequately considering Medicare’s interests with regard to ongoing medical care, then Medicare will be able to quickly and easily track such medical care as the CPT codes are submitted by medical providers seeking Medicare payment.

The 65-day period theoretically allows the Medicare contractor[1] enough time to retrieve all available medical claims affiliated with the date of accident. The payments are searched using CPT medical codes.

Medicare does allow for a reduction in the amount of conditional payment liens if the amount of settlement is less than the lien. Under 42 C.F.R. § 411.37(d), Medicare will generally reduce its recovery by procurement costs, with the total recovery not to exceed the amount of settlement. Effectively; Medicare takes the attorney’s fees and costs off the top, and then demands the entire remaining amount of settlement, leaving no net recovery to the plaintiff. Under this reduction, only the plaintiff’s attorney gets paid.

By way of example, assume the following:

**A liability claim is settled for $10,000.00, with $3,333.34 payable to the plaintiff’s attorney in fees and $125.00 in legal costs. However, the Medicare conditional payment lien is $35,000.00. Under this scenario, the “total procurement costs” would be considered $3,458.34, which is the total of attorney’s fees and costs. Because the settlement is less than the conditional payment, Medicare’s recovery would be reduced by the total procurement costs. [2] Thus, the net amount due to Medicare would be $6,541.66.**

**Considerations Specific to Liability Settlements Where Treatment is Complete**

The following provisions apply only to liability settlements:[5]

 ***Low Dollar Threshold ($*750*.00 Settlements)***

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In settlements of $750.00 or less, Medicare will not recover conditional payments it may have made from that settlement. The criteria to qualify include the following:

 The beneficiary’s settlement, judgment, award or other payment is related to an alleged physical trauma-based incident. (N.B.: The $750.00 threshold does not apply to cases involving alleged ingestion, implantation, or exposure);

 The liability insurance (including self-insurance) settlement, judgment, award, or other payment is $750.00 or less;

 The beneficiary has not received and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident; and

 Medicare has not previously issued a recovery demand letter.

Given these conditions, the $750.00 threshold would certainly not apply to cases where an insurer was paying or had paid medical bills directly or on an ongoing basis. The calculation of this minimum threshold is on an annual basis and is mandated by Section 202 of the SMART Act.

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 ***Certification from Treating Physician***

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If a treating physician certifies no future medical care is necessary related to that liability claim, then CMS will consider its interests protected with regard to future medicals. Please note that, per that memorandum, CMS will not provide confirmation in writing and simply recommends the settling parties keep a copy of the physician’s letter “on file.”

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 ***Fixed Percentage for Conditional Payments***

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CMS announced a new fixed percentage option available only to liability settlements of $5,000.00 or less. In such cases, a beneficiary who elects this option will be able to resolve Medicare’s recovery claim by paying Medicare 25% of the total liability insurance settlement, as opposed to using the traditional recovery process. The following criteria must be met:

 The liability insurance (including self-insurance) settlement is for a physical trauma based injury;

 The total liability settlement, judgment, award, or other payment is $5,000.00 or less;

 The beneficiary elects the option within the required timeframe and Medicare has not issued a demand letter or other request for reimbursement related to the incident; and

 The beneficiary has not received and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident.

Medicare has warned that if this option has been elected, there is no right to appeal the fixed payment amount or request a waiver of recovery for the fixed payment amount.

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***A Medicare Set-Aside Arrangement (MSA) is not required under the Medicare Secondary Payer Act.***

Even though there is no formal process for obtaining approval from CMS for a proposed MSA, the settling parties are still required to consider Medicare’s interests.

Without the benefit of a formal CMS review, the best option is to obtain some level of educated opinion as to whether an allocation for future medical care and/or MSA and Non-Covered Allocation (NCA) is necessary to protect Medicare’s interests and, if so, in what amount and to what extent.

It is advisable to engage a certified consultant with experienced in preparing MSAs/NCAs and projecting future medical expenses potentially covered by Medicare. Simply having a general life care plan prepared will not likely be sufficient because life c are plans generally do not consider collateral sources and therefore may not take into account what expenses are specifically anticipated to be covered by Medicare.

***In workers’ compensation claims, CMS is sometimes receptive to approval of a “zero allocation,” or zero-dollar ($0.00) allocation. The zero allocation is just that—no settlement money is allocated for future medicals. That’s great, but; because no formal MSA submission is allowed in liability settlements, no formal approval of a zero allocation is technically possible, either.***

**There may be, however, language included in the settlement release discussing why a zero allocation would be appropriate. This is generally based upon either a legal theory or argument that likely would have prevailed if the matter had gone to a hearing or trial where there would be no finding of liability and, therefore, no judgment, or a physician formally opines – in writing – that no medical care related to the injury has occurred or is expected and, therefore Medicare will not be assuming responsibility for third party liability.**

**There are, of course, other considerations. Life wouldn’t be complete without a little extra challenge. With all this focus on Medicare and LMSAs, it’s easy to overlook a substantial risk to clients of Plaintiff firms, costs related to injuries that are NOT covered by Medicare. In injury cases where home modifications are necessary to permit access to and within the home, attendant care, transportation, certain medications and equipment, hearing and dental care, and much more**

**is required to address all the non-covered expenses a client will be required to pay out-of-pocket.**

**Whether part of a WC or PI settlement it is important to have a NCA report as a companion to the MSA to assure that the settlement you secure for your client will actually cover all their injury related expenses in the future regardless of projected payment source.**

**We’ve hit the high notes, but the soprano has yet to sing.**

**There are three classes of funds that must be considered in every WC/PI settlement;**

1) **Medicare**

2) **Non-Medicare medical expenses**

3) **Non-medical expenses**

**A WCMSA or LMSA will protect your client from Medicare recovery if properly prepared and documented. A NCA, which will detail both medical and non-medical expenses yet to be faced by a Plaintiff, will also demonstrate to Medicare that due diligence was integrated into the estimations involved in the Plaintiff’s settlement. The combination of a MSA and NCA essentially details for carriers the Specials in any given matter. This will also help Plaintiff attorneys and firms to demonstrate a minimum threshold for carriers and does not include costs of recovery.**

Unfortunately there are no absolutes in any answers when it comes to the issues which must be considered when resolving liability claims involving Medicare issues. The government has placed the burden on the settling parties, particularly plaintiffs as a safety net against any shift of liability for medical expenses. However; despite the force of law governing these potential recoupments, Medicare has not yet provided a formal method to then review and sign off on what the parties have proposed. This gives the parties some flexibility in negotiating the terms of settlement, as long as Medicare’s interests are actually and legitimately considered.

[1] This is currently handled by the Medicare Secondary Payer Recovery Contractor (MSPRC).  Effective February 1, 2014, the responsibilities will be transitioned to the new Benefits Coordination & Recovery Center (BCRC)

[2] If the settlement had been greater than the amount of the conditional payment lien, then Medicare’s share of the proceeds would be reduced by Medicare’s percentage share of the total procurement costs.

[3] *In re: Avandia Mktg.*, 685 F.3d 353 (3d Cir. 2012), *cert. denied GlaxoSmithKline v. Humana Medical Plans, Inc.*, No. 12-690, 569 U.S. \_\_\_ (Apr. 15, 2013).

[4] The review thresholds for WCMSA submissions include settlements involving (1) a claimant who is already a Medicare recipient and the total amount of settlement is greater than $25,000.00 (commonly referred to as “Class I”) or (2) the total settlement amount exceeds $250,000.00 and there is a “reasonable expectation” that the claimant will be enrolled in Medicare within 30 months of the settlement date (commonly referred to as “Class II”).  “Reasonable expectation” applies to the following situations:  claimant has applied for Social Security Disability; claimant is appealing an adverse decision on an SSD application; or claimant is 62 years and 6 months old.  The total settlement amount includes attorney’s fees, any prior awards, and conditional payment amounts.

[5] For more information on these options, see the “Attorney Tool Kit” provided on the Medicare Secondary Payer Recovery Contractor website, found at [http://www.cms.gov/](https://web.archive.org/web/20160421080450/http:/www.cms.gov/).