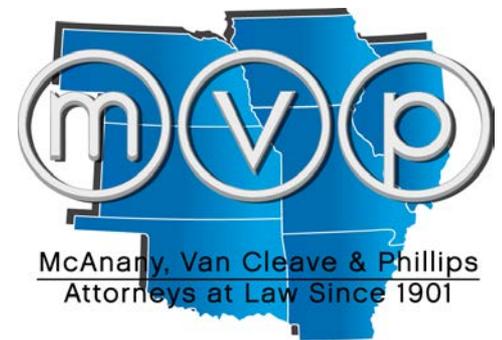


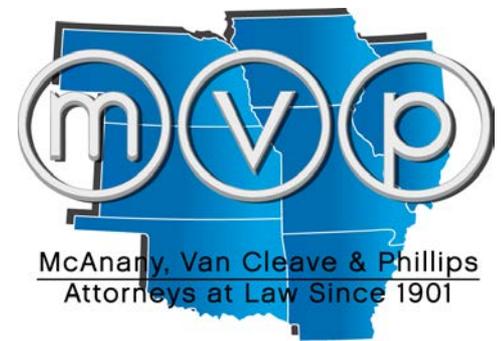
# MEDICARE SECONDARY PAYER ACT

# BACKGROUND:



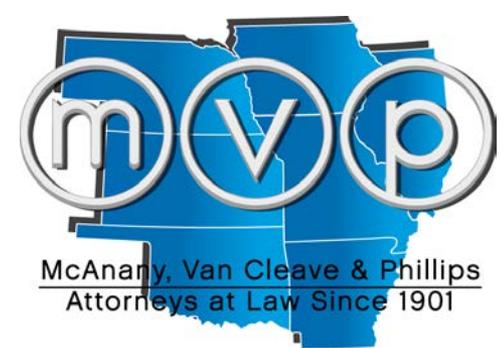
**As a federal cost-saving statute enacted in 1980 to combat increasing costs of Medicare, the MSP makes the government a secondary payer when a Medicare recipient has another source of primary insurance coverage. In 2003, the MSP was expanded to include other responsible sources, such as tortfeasors, as primary payers responsible for payment of the beneficiary's medical expenses.**

**Under the MSP, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made" by a primary payer. 42 USCA §1395y(b)(2). This statute implicates payment for past medical expenses (those incurred prior to a settlement, judgment or award) and future medical expenses (those incurred after a settlement, judgment, or award). Medicare's interests must be taken into account regarding both past medical and future medical expenses.**



# PAST MEDICAL: CONDITIONAL PAYMENTS

# STATUTORY AUTHORITY: 42 USC §1395Y(B)(2)-DEMONSTRATED RESPONSIBILITY

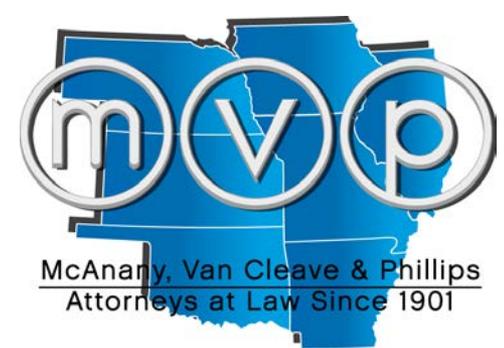


**Medicare has been given authority to make payment for an item or service if a primary plan has not made or cannot reasonably be expected to make payment promptly. 42 USC §1395y(b)(2)(B)(i).**

**These payments are conditioned on reimbursement from “a primary plan, and an entity that receives payment from a primary plan . . . if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.” 42 USC §1395y(b)(2)(B)(ii).**

**A primary plan’s responsibility for payment may be demonstrated by “a judgment, a payment conditioned upon the recipient’s compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.” 42 USC §1395y(b)(2)(B)(ii).**

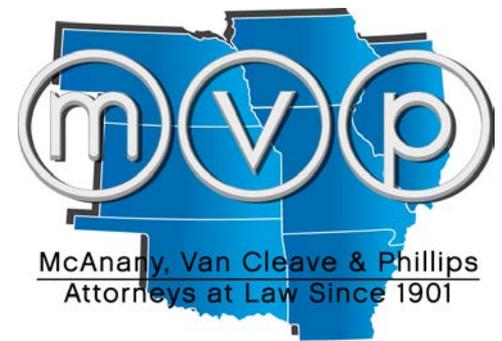
# STATUTORY AUTHORITY: 42 USC §1395Y(B)(2)-WHO CAN SUE



**Medicare may bring an action against “any or all entities that are or were required or responsible (directly as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment under a primary plan.”  
42 USC §1395y(b)(2)(B)(iii).**

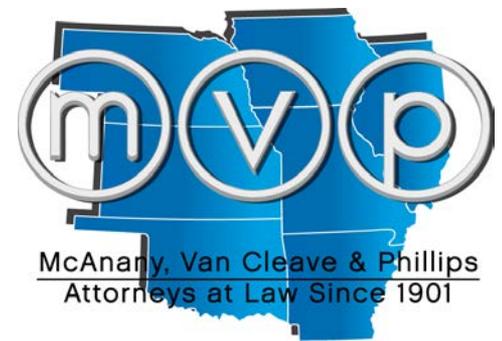
**In addition to a direct cause of action, Medicare is subrogated to any right of an individual or other entity to payment under a primary plan. 42 USC §1395y(b)(2)(B)(iv).**

STATUTORY AUTHORITY: 42  
USC §1395Y(B)(3)-WHO CAN  
SUE



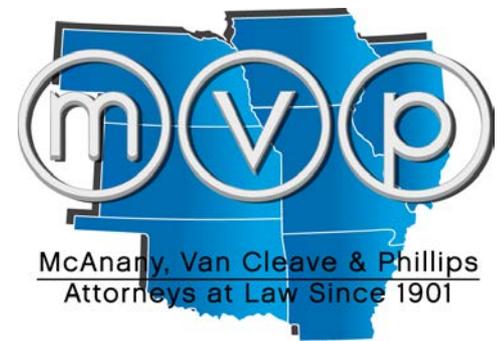
**Additionally, “There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement). “ 42 USC §1395y(b)(3)(A).**

# STATUTORY AUTHORITY: DOUBLE DAMAGES



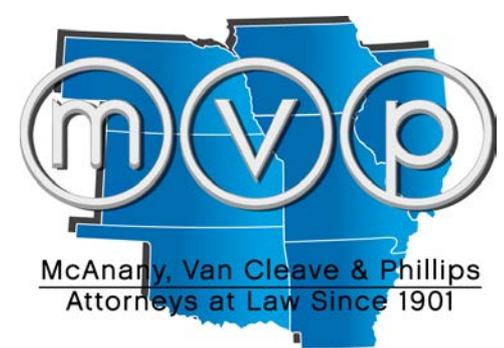
**Medicare may collect double damages.  
42 USC §1395y(b)(2)(B)(iii).**

STATUTORY AUTHORITY:  
STATUTE OF LIMITATIONS



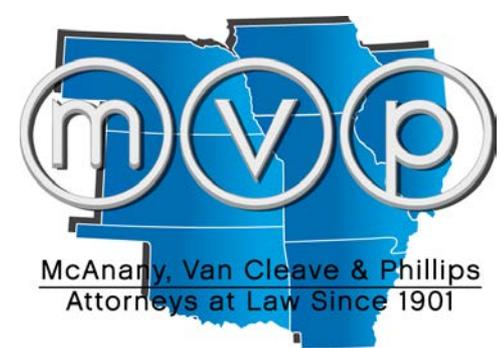
**Medicare has three years from the date of the receipt of notice of a settlement, judgment, award, or other payment made to bring an action for reimbursement. 42 USC §1395y(b)(2)(B)(iii).**

REGULATORY AUTHORITY:  
*CHEVRON* DEFERENCE



**Agency regulations interpreting statutes are given deference if (1) Congress has not “directly spoken to the precise question at issue,” and (2) the agency's interpretation is reasonable.**

# RECOVERY OF CONDITIONAL PAYMENTS 42 C.F.R §411.24

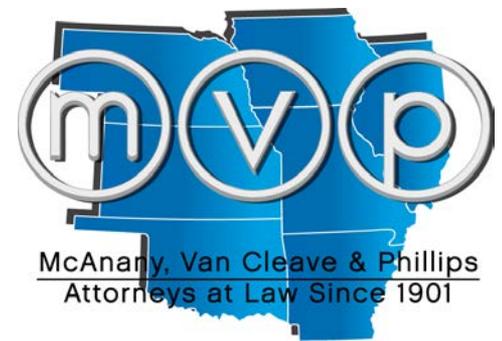


**CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.**

**Amount of recovery is the lesser of (a) the amount of the Medicare primary payment or (b) the full primary payment amount that the primary payer is obligated to pay**

**If legal action is necessary to recover from the primary payer, CMS may recover twice the amount of the Medicare primary payment.**

# RECOVERY OF CONDITIONAL PAYMENTS 42 C.F.R §411.24



**CMS has a right of action to recover its payment from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.**

**Must reimburse Medicare within 60 days. Interest may accrue from the date when notice or other information is received by CMS that payment has been or could be made under a primary plan.**

**If Medicare makes a conditional payment with respect to services for which the beneficiary has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.**

# RECOVERY OF CONDITIONAL PAYMENTS 42 C.F.R §411.24



## **Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement. 42 C.F.R §411.24.37**

- Recovery against the party that received payment:
  - General rule: Medicare reduces recovery for procurement costs if costs incurred because the claim was disputed and the costs are borne against the party against CMS seeks to recover.
  - Special rule: If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery is the lower of (a) the Medicare payment or (b) the total judgment or settlement amount, minus the party's total procurement cost.

LIMITATIONS ON MEDICARE  
PAYMENTS FOR SERVICES COVERED  
BY WORKERS' COMPENSATION. 42  
C.F.R. §411.40-47.



- Medicare does not pay for any service which payment has been made or can reasonably be expected to be made under a workers' compensation law or plan. 42 C.F.R §411.24.40
- Beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation. 42 C.F.R §411.24.43(a)

LIMITATIONS ON MEDICARE  
PAYMENTS FOR SERVICES COVERED  
BY WORKERS' COMPENSATION. 42  
C.F.R. §411.40-47.



**If a claim is denied for reasons other than not being a proper claim, Medicare will pay for the services if covered under Medicare. 42 C.F.R §411.24.43(d)**

**A conditional payment may be made if either:**

- The beneficiary has filed a proper claim, 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.
- The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

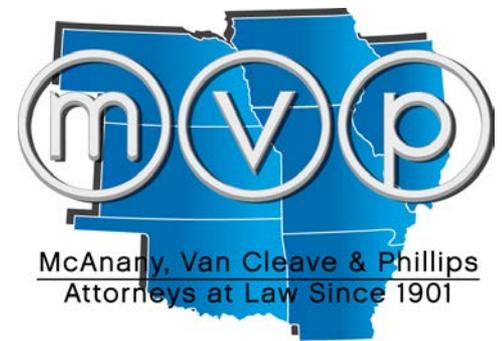
PRIVATE CAUSE OF ACTION AND  
EXTENSION TO MEDICARE  
ADVANTAGE PROGRAMS



***In re Avandia Marketing, Sales Practices, and Products Liability  
Litigation, 685 F.3d 353 (3rd Cir. 2012)***

***MSP Recovery, LLC v. Allstate Ins. Co., 835 F.3d 1351 (11th Cir.  
2016).***

# FUTURE MEDICAL: MSAS



## **Statutory Authority**

- Medicare may not pay for a beneficiary's medical expenses when payment "has been made *or can reasonably be expected to be made*" by a primary payer. 42 USCA §1395y(b)(2).
- No other statutory guidance

# REGULATORY AUTHORITY



**The regulations only address future medical under workers' compensation claims. The regulations are silent regarding future medical in liability claims. This is expected to change.**

**CMS has announced Notice of Proposed Rulemaking (NPRM) will be issued by September 2019.**

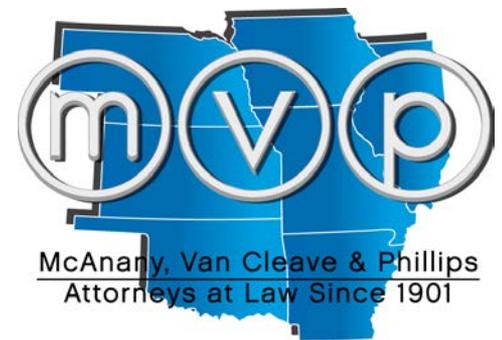
# REGULATORY AUTHORITY



**If a lump sum compensation award stipulates 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. C.F.R §411.24.46(a)**

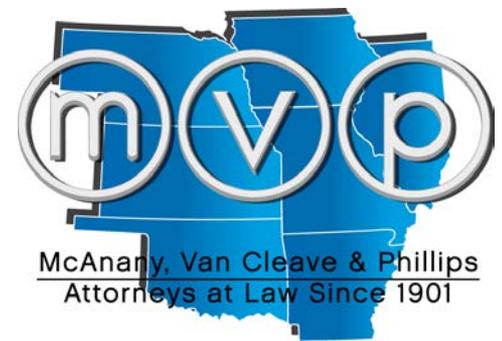
**Lump sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan. C.F.R §411.24.46(b)(1)**

# REGULATORY AUTHORITY



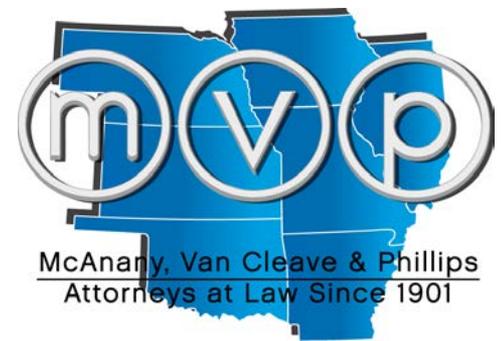
**“If settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits 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.F.R §411.24.46(b)(2)**

- Regulation indicates Medicare will not pay for treatment of that condition, but what if it does? Can Medicare disregard the settlement and seek reimbursement for all payments as conditional payments?



## BASIC RULE:

**If settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.  
C.F.R §411.24.46(d)(1)**

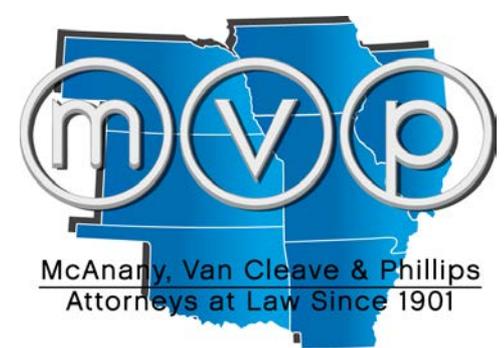


## EXCEPTION:

**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.**

**C.F.R §411.24.46(d)(2)**

# CMS PUBLICATIONS

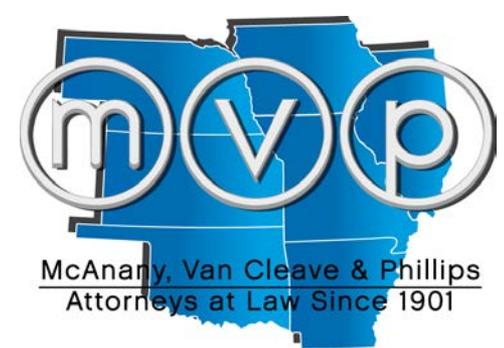


**Publications and information posted by CMS, such as the WCMSA Reference Guide, regional office memoranda or information on the CMS website is NOT given *Chevron*-style deference. Therefore, it has no force of law.**

**CMS only gives guidance in workers' compensation cases. There is no formal guidance in liability context, although CMS has repeatedly emphasized that while liability settlements and MSAs will not be reviewed for approval, the parties need to take Medicare's interest into account.**

**Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide reflects information compiled from all WCMSA Regional Office Memoranda and information provided on CMS website.**

# CMS PUBLICATIONS

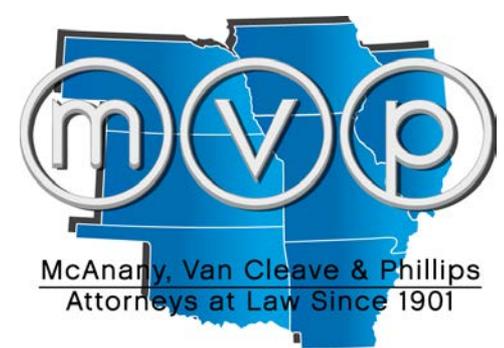


**CMS admits there is no statutory or regulatory requirement to submit WCMSA proposal to CMS for review in any case.**

**In many situations, the parties to a WC settlement choose to pursue a CMS-approved WCMSA amount in order to establish with certainty with respect to the amount that must be appropriately exhausted before Medicare begins to pay for care related to the WC settlement, judgment, award, or other payment.**

**Any claimant who receives a WC settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's interests with respect to future medicals into account. If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received a portion of a payment either directly or indirectly. Medicare may also refuse to pay for future medical expenses related to the WC injury until the entire settlement is exhausted.**

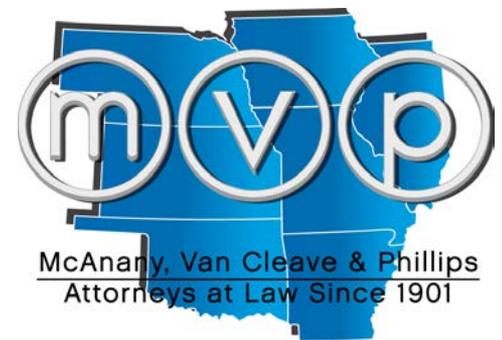
# CMS PUBLICATIONS



**Once the CMS-approved set-aside is exhausted and accurately accounted for to CMS, Medicare will pay primary for future Medicare-covered expenses related to the WC injury that exceed the approved set-aside amount.**

**The primary benefit of seeking CMS approval is “the certainty associated with CMS reviewing and approving the proposed amount with respect to the amount that must be appropriately exhausted.”**

**If the parties to a WC settlement stipulate to a WCMSA but do not receive CMS approval, CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses in the case, even if they would ordinarily have been covered by Medicare. However, if CMS approves the WCMSA and the account is later appropriately exhausted, Medicare will pay related medical bills for services otherwise covered and reimbursable by Medicare regardless of the amount of care the beneficiary continues to require.**



# CMS PUBLICATIONS

**CMS states establishing a WCMSA is not necessary when ALL of the following are true:**

- The employee is only being compensated for past medical expenses;
- There is no evidence that the individual is attempting to maximize the other aspects of the settlement; AND
- The employee'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.

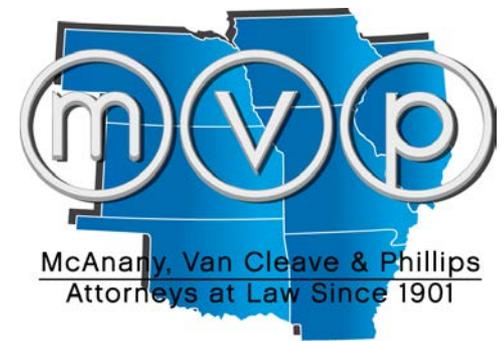
# CMS PUBLICATIONS



## **CMS threshold for review and approval of a WCMSA**

- Claimant is currently Medicare eligible and total settlement is over \$25,000
  - “Medicare eligible” includes:
    - Age 65 or older;
    - Receiving SSDI benefits for more than 24 months; or
    - End stage renal failure
- Claimant is reasonably expected to become Medicare eligible within 30 months and total settlement is over \$250,000
  - “Reasonably expected to become Medicare eligible” includes:
    - Age 62.5 or older;
    - Applied for SSDI benefits;
    - Appealing denial of SSDI benefits; or
    - End stage renal disease, but not yet qualified for Medicare based on that disease.

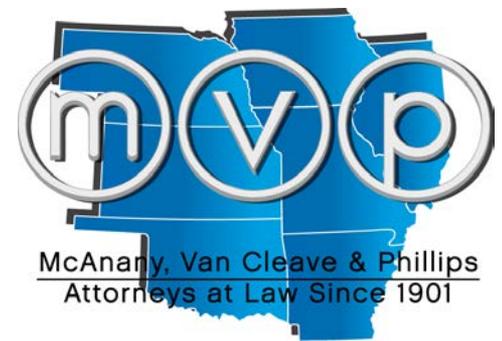
# CMS PUBLICATIONS



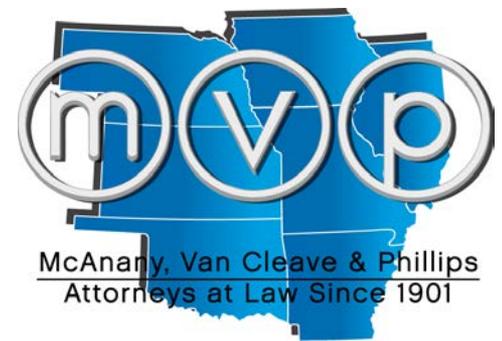
**CMS review thresholds are not a “safe harbor.” The parties must consider Medicare’s interests in all WC cases.**

**No statement in the settlement of the amount needed to fund the WCMSA is binding on CMS unless and until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount that adequately protects Medicare’s interests as specified by CMS as a result of its review.**

# CMS PUBLICATIONS



**CMS does not compromise or reduce future medical expenses related to a WC injury. Some submitters have argued that C.F.R §411.24.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a WC injury.**



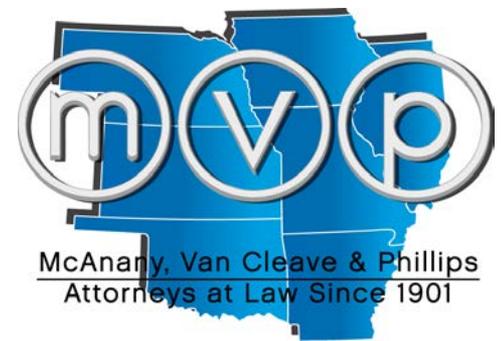
# RE-REVIEW PROCESS

**Available if:**

**The original determination contained obvious mistakes**

**Additional evidence is available that pre-dates the original submission**

# NEWLY EXPANDED RE-REVIEW PROCESS



**A party may seek re-review of previously approved WCMSA when**

- 1. amount differs by at least 10% or \$10,000, whichever is greater.**
- 2. The original submission occurred between one and four years before the date of Amended Review request**

**Can only request Amended Review once**

**Changes must include more than just substituting generic drug types for brand name**



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