

Considering Medicare's Interest When Settling Workers' Compensation Claims

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1. Overview.

The Centers for Medicare and Medicaid Services (CMS), of the United States Department of Health and Human Services, administers the federal health insurance plan known as Medicare. Coverage is available to individuals age 65 or older, and to individuals who have received Social Security disability benefits (SSDI) under Title II of the Social Security Act (Act) for 24 months. Section 1862(b)(2) of the Act, 42 U.S.C. §1395y(b)(2), herein referred to as the Medicare Secondary Payer Act (MSPA), and section 411.40 of the Code of Federal Regulations (herein CFR), 42 CFR 411.40, states that a Medicare payment may not be made for any item or service "to the extent that 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 ("promptly" is defined in 42 CFR 411.21 as "payment within 120 days after receipt of the claim"). CMS has become more pro-active in its effort to prevent the parties in a workers' compensation (WC) claim from shifting liability for the cost of a work related injury or illness to Medicare. The first comprehensive policy statement for enforcement of the MSPA, authored by Parashar Patel and entitled **Workers' Compensation: Commutation of Future Benefits** (commonly referred to as the "Patel Memorandum"), was prepared 7/23/01. On 4/22/03 the Director of CMS issued another document entitled **Medicare Secondary Payer - Workers' Compensation Frequently Asked Questions**, clarifying many of the questions raised by the Patel Memorandum, and on 5/23/03 a second clarifying memorandum entitled **Medicare Secondary Payer - Workers' Compensation Additional Frequently Asked Questions** was issued. Copies of these memoranda may be found and downloaded at the following web sites:

<http://www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf>
http://www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf
http://www.cms.hhs.gov/medicare/cob/pdf/wc_faqs2.pdf

The 4/22/03 memorandum highlights the current CMS enforcement effort by stating:

"Because Medicare does not pay for an individual's WC related expenses 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.**

...

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** (emphasis supplied).

2. Classes of Beneficiaries Affected.

Medicare approval of a WC settlement is **required** for the following classes of beneficiaries:

Class I: A claimant who is entitled to Medicare, regardless of the amount of the settlement;

Class II: A Claimant who is "reasonably expected" to become a Medicare beneficiary within 30 months of the settlement date and the total amount of the settlement (both indemnity and future medical costs) is more than \$250,000.00, without reduction to present cash value.

The 5/23/03 CMS memo clarifies the threshold criteria for Class II claimants by stating that "if a WC settlement is \$250,000.00 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". The same memo also states that "CMS will honor threshold levels that are in effect as of the date of a WC settlement" and, perhaps most importantly, **"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"** (emphasis supplied). See the 4/22/03 CMS memo for some guidelines and examples of what Medicare considers to be a "reasonable expectation" for Class II claimants.

3. Distinction Between Awards and Approved Settlement Agreements.

Medicare generally honors judicial decisions issued after a hearing on the merits of a WC case; however a distinction is made where a court or other adjudicator is only approving a settlement that essentially incorporates the agreement of the parties.

The 4/22/03 CMS memo states: “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.”

4. Medicare’s Right to Reimbursement for Payments Made.

(A) In General

The MSPA makes it clear that payments Medicare **has already made** for treatment for a work-related injury or occupational disease must either be reimbursed to or compromised with Medicare. See 42 U.S.C. 1395y(b)(2)(B)(i). Therefore, before settling a WC claim for an injured employee who is also a Medicare beneficiary (i.e., a person who is entitled to hospital insurance benefits under Part A or medical insurance benefits by enrolling in Part B), it is important to determine if Medicare has made any such payments. Such information may be obtained by contacting Medicare’s central coordination center at 1-800-999-1118 or by writing to the following address:

**Medicare - Coordination of Benefits Contractor
P.O. Box 5041
New York, NY 10274-0125**

(B) Conditional Payments

42 CFR 411.45 allows Medicare to make a “conditional” payment if the employee/beneficiary has filed a proper claim for benefits but the employer or carrier has denied the claim or simply will not pay promptly (recall “promptly” is defined in 42 CFR 411.21 as “payment within 120 days after receipt of the claim”), or where the beneficiary fails to file a proper claim because of physical or mental incapacity. However, Medicare retains a right of reimbursement for such payments if the WC claim is later found to be compensable or is settled.

(C) Consequences for Failure to Reimburse

Failure to reimburse Medicare could result in serious consequences. 42 CFR 411.24(b) grants CMS with a right to “initiate recovery as soon as it learns that payment has been made or could be made under workers’ compensation...”; 42 CFR 411.24(e) also grants CMS “a direct right of action to recover from any entity responsible for making a primary payment. **This includes an employer, insurance**

carrier, plan, program, or third party administrator” (emphasis supplied). Further, 42 CFR 411.24(g) provides that “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. If legal action becomes necessary CMS may recover **twice the amount** of the Medicare primary payment. See 42 CFR 411.24(c).

(D) Reimbursement in Disputed Cases - Apportionment Rules

How is a reimbursement claim handled when the compensation case is disputed?

42 C.F.R. 411.47 provides guidelines for apportionment of lump sum compromise settlements. Paragraph (a) provides that when 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. However if that is not the case the portion to be considered as payment for medical expenses is computed as follows:

1. Determine the ratio of the net settlement amount (after deducting reasonable and necessary costs and attorney fees incurred in procuring the settlement) to the total amount that would have been payable if the claim had not been compromised; then
2. Multiply that ratio by the total amount of medical expenses incurred as a result of the injury, up to the date of the settlement;
3. The product then becomes the medical allocation.

Paragraph (b) of this regulation provides a formula for determining the amount of the payment that is considered as medical expenses when conditional Medicare payments have been made and the beneficiary receives a compromise settlement. It is also possible that Medicare may be willing to negotiate its claim for reimbursement based upon the particular nature of the dispute in a given case, or possibly waive its claim altogether. See also 42 CFR 411.28 of the CFR dealing with waiver of recovery and compromise of claims.

5. Medicare Set-Aside Arrangements.

In cases involving a Class I or Class II beneficiary, if the parties make a reasonable allocation between medical expenses and “income replacement” (permanency, wage loss, etc.) in the lump sum settlement agreement, that allocation may be accepted by CMS under 42 CFR 411.47. When the settlement agreement covers anticipated future medical expenses and is intended to release the employer

or its WC carrier from further liability, a Medicare set-aside arrangement (MSA) is recommended.

If the parties believe the injured employee will not require future medical care a MSA may not be necessary; however the parties must be mindful of the following statements in the 4/22/03 CMS memo (answer to question 20):

“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.”

When future medical costs are clearly anticipated a MSA is generally required before CMS will consider approval of a settlement agreement. Only the cost of injury-related services that would otherwise be covered by Medicare need to be set aside. As a result of new legislation signed by President Bush 12/8/03, all Medicare beneficiaries will be eligible to receive prescription drug coverage beginning in 2006. Although the benefit is voluntary we recommend that the anticipated costs of necessary and causally related prescription medication be included in the allocation for future medical care, as well as anticipated costs for doctor visits to monitor the medication intake, to refill or change the prescriptions, to address any side effects caused by the medication, and for periodic blood tests.

If a significant amount of future medical care is contemplated it may be helpful to engage a consultant to develop a life care plan. A MSA may be administered by a third-party trustee (custodian) or self-administered by the beneficiary; however before submitting a self-administered MSA to CMS for approval it should first be determined whether or not the beneficiary is qualified to calculate what portion of the anticipated drug costs Medicare would be required to pay as well as the premiums, deductibles and coverage gaps that are covered in the new prescription drug legislation. Also, if the MSA is self-administered the beneficiary must place all funds set aside for future medical care in an interest bearing account insured by the Federal Deposit Insurance Corporation; all interest earned may be allowed to accrue in the account but must be used solely for medical expenses related to the injury that would otherwise be

reimbursable or paid for by Medicare. In addition the beneficiary must maintain accurate records of the distributions and expenditures from the account; these records should indicate the date of service, the diagnosis, the service received, who received the payment and the date of payment. It is also recommended that the beneficiary retain receipts or other evidence of the payments made from the account. Administrative fees and expenses for managing a custodial MSA and attorney fees specifically associated with establishing a MSA could be charged to the MSA provided they are related to the MSA itself, they are reasonable in amount, and they are incorporated in the proposed MSA submitted to and as approved by CMS.

In an approved, structured MSA where payments are made at regular intervals to cover medical expenses incurred during those periods, any excess funds not spent during a given period must be carried forward to the next period. On the other hand, if the funds for that period are depleted Medicare will not make any payments during that period until the contractor monitoring the individual's case can verify that such funds, including any carry-forward amount, have been properly used.

Here are some miscellaneous MSA guidelines:

1) Can the MSA be reduced if the injured employee's physical condition improves? The 4/22/03 CMS memo states that if the treating physician verifies the beneficiary's medical condition has substantially improved a written request for a reduction of the MSA may be submitted to the appropriate CMS regional office with supporting documentation. The decision of the regional office is final and not subject to administrative appeal.

2) If there was another source of possible payment for future medical expenses (for example, the employee's spouse obtains group insurance coverage and submits bills to that carrier for payment), would payments by that carrier be credited to and reduce the amount of the MSA? Medicare's position is that the full amount of the MSA must be spent for the employee's medical expenses before Medicare would become available to pay covered expenses after the MSA funds are depleted.

3) CMS has no formal appeals process for a rejected MSA submission. The parties are allowed to resubmit the proposed MSA with additional information and documentation. If this still does not satisfy CMS and the parties proceed to settle the case without CMS approval then Medicare will not recognize the settlement and no payments for services otherwise covered by Medicare will be made until the costs for such services exhaust the entire settlement proceeds.

4) A beneficiary cannot waive his or her right to Medicare benefits to avoid establishing a MSA.

5) What if the injured employee/beneficiary dies before the MSA is depleted? The 4/22/03 CMS memo states that once the contractor responsible for monitoring the case is certain all appropriate claims have been paid any funds remaining in the MSA may be disbursed according to state law. However it may be necessary to hold the MSA open for a period of time after death since providers “are allowed to submit their initial bill to Medicare for a period ranging from 15-27 months after the date of service”.

6. **Seeking CMS Approval.**

On 3/20/03 the Chicago Regional Office of CMS prepared a comprehensive document entitled ***Information Needed by CMS to Determine the Workers' Compensation Set-Aside Arrangements***; this document details all of the information that must be submitted to that office, including the name and address of the Branch manager to whom the information must be sent. A copy of this four-page document may be obtained from our office by sending an e-mail request to info@pichasal.com. The 4/22/03 CMS memo stated that regional offices should “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”. However, this is not a requirement.
