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Medicare and Medicaid Liens in Personal Injury Cases

Resolving Healthcare Liens or Claims for Reimbursement, Maximizing Settlement Awards

WEDNESDAY, MAY 11, 2022

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

John V. Cattie, Jr., Founding Member, **Cattie & Gonzalez**, Charlotte, NC

Catherine E. Goldhaber, Partner-in-Charge, **Hawkins Parnell & Young**, Chicago, IL

David L. (Dave) Place, JD, Owner, **The Place Firm**, Elizabethtown, KY

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TODAY'S AGENDA

Medicare Parts A and B

Medicare Part C

Medicare Part D

Future Medicals and Medicare Set-Asides

Medicaid

MEDICARE PARTS A & B - OVERVIEW

Medicare	WHO'S ELIGIBLE?	BENEFITS/CHARACTERISTICS
Part A (hospital insurance) **Administered by the Centers for Medicare and Medicaid Services (CMS).**	Age 65 or > & eligible for Social Security retirement or are qualified railroad retirement beneficiaries. Under age 65 and entitled to Social Security or railroad retirement disability for at least 25 months, or suffer from end-stage renal disease (ESRD) or ALS ("Lou Gehrig's") disease benefits. Age 65 or > who don't qualify under the means above may voluntarily enroll in Part A but are required to meet certain other requirements and pay a premium for coverage.	Typically covers: inpatient hospital visits, skilled nursing facility treatment, some home health services if ordered by a physician, and hospice care. Most qualifying individuals are automatically enrolled in Part A upon reaching age 65 and enrolling for Social Security benefits. Voluntary enrollment is only available to individuals meeting certain residency requirements and already enrolled in Part B.
Part B (medical insurance) **Administered by the Centers for Medicare and Medicaid services (CMS).**	All persons entitled to Part A. Persons not entitled to Part A who: are age 65 or older, U.S. resident, U.S. citizen, or alien lawfully admitted to the U.S. and living in the U.S. for 5 years preceding coverage request. "Environmental exposure affected individuals" as defined by § 10323(a) of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).	Typically covers: provider medical services, preventative services, medical supplies, and other outpatient healthcare services not covered by Part A. Requires most beneficiaries to pay a monthly premium to receive Part B benefits. Persons entitled to Part A are automatically enrolled in Part B unless they request to decline enrollment.

MEDICARE PARTS A & B - BASICS

42 U.S.C. §1395y(b)(2) - Reimbursement

"[P]ayment may not be made . . . with respect to any [medical] item or service . . . to the extent that payment has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance plan (including self-insured) or no-fault insurance."

42 U.S.C. § 1395y(b)(8)(A) - Reporting

MMSEA Section 111, all insurers—liability, no-fault, and workers' compensation—as well as self-insurers, collectively referred to as "responsible reporting entities," (RREs), must report information regarding payments made to Medicare beneficiaries and other data to ensure proper coordination of benefits with the Medicare program

MEDICARE SECONDARY PAYER – CONSEQUENCES FOR FAILURE TO ADDRESS

- Exposure for All Parties:
- Lawsuit plus double damages
  - Feds may file suit to recover its conditional payment amount, plus double damages, plus interest.
  - 42 C.F.R. § 411.24(c)(2)
  - 42 C.F.R. § 411.24(m)
- Joining in action
  - Medicare has a separate subrogation right to join or intervene into any action related to events that required payment for medical care.
  - 42 U.S.C. § 411.26(b)

MEDICARE SECONDARY PAYER – CONSEQUENCES FOR FAILURE TO ADDRESS

- Exposure for Plaintiff Only:
- Benefit offsets
  - Medicare may recover against the beneficiary's Social Security benefits, Railroad Retirement benefits, or tax refunds.
- Loss of benefits
  - Medicare may refuse to pay for future medical care for the settlement related injury.
  - 42 C.F.R. § 411.24(d)

MEDICARE SECONDARY PAYER – CONSEQUENCES FOR FAILURE TO ADDRESS

- Exposure for Payer Only:
- Civil Monetary Penalties
  - May be assessed penalty up to $1,000 per day per claim not reported timely under MMSEA Section
  - 42 U.S.C. § 1395y(b)(8)(E)(i)
  - Final regulations forthcoming

CONSEQUENCES FOR FAILURE TO ADDRESS - U.S. V. ANGINO (2019 U.S. DIST. LEXIS 30499; 2019 WL 931695)

FACTS

PI case filed against pharmacy and medical care center for distribution of incorrect prescription medication that caused harm to plaintiff after ingestion.

Plaintiff settled lawsuit assuming Medicare's lien totaled $1,212.00 based on a conditional payment amount. After reporting settlement, CMS issued a final demand in the amount of $84,353.00 → $53,295.14 post procurement cost offset.

Plaintiff did not pay the final demand amount, filed suit in U.S. district court challenging the amount but lost due to failing to exhaust admin remedies.

Before the plaintiff lost his action, CMS filed a separate suit against the plaintiff's estate and the plaintiff's attorney in the personal injury action. CMS sought full reimbursement of the $84,353.00 plus interest, arguing that the law (42 CFR § 411.37(e)) allows CMS to not provide a procurement offset when it "must file" suit to recover its final demand amount.

CONSEQUENCES FOR FAILURE TO ADDRESS - EXAMPLES OF RECENT DOJ ACTION

Recently, the US Department of Justice (DOJ) has pursued/resolved at least 4 cases with law firms for alleged non-compliance with MSP obligations

June 2018: Firm allegedly failed to repay conditional payments for 9 clients. Ultimately settled for $28,000, was required to designate and train an employee responsible for ensuring MSP debts were paid, and to review debts every 6 months with the employee to ensure compliance.

March 2019: Firm allegedly failed to repay conditional payments for one client receiving a $1.15 million settlement. The case settled for $250,000 and the same conditions as the June 2018 settlement.

November 2019: Firm allegedly failed to repay conditional payments for six clients, 4 of whom were either referred or part of a co-counsel arrangement. The firm was required to repay $91,406.98, with the U.S. DOJ noting that attorneys still had responsibilities, even if the cases has been referred out or part of co-counsel agreement.

January 2020: Firm allegedly failed to repay conditional payments for 8 clients. Ultimately settled for $6,604.59, was required to designate and train an employee responsible for ensuring MSP debts were paid, to review debts every 6 months with the employee to ensure compliance, and to provide written certifications of compliance.

ATTORNEY LIABILITY

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 primary payment. 42 C.F.R. §411.24(g)

United States v. Weinberg, 2002 U.S. Dist. LEXIS 12289 (E.E. Pa. July 1, 2002).

United States v. Harris, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. March 26, 2009) affirmed, 334 F. App'x 569 (4th Cir. 2009).

Denekas v. Shalala, 943 F. Supp. 1073 (S.D. Iowa 1996).

The United States may … collect double damages against any [ ] entity … that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

Humana v. Paris Blank LLP, 2016 U.S. Dist. LEXIS 61814

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FOR IMMEDIATE RELEASE

Monday, June 18, 2018

Philadelphia Personal Injury Law Firm Agrees to Start Compliance Program and Reimburse the United States for Clients' Medicare Debts

ATTORNEY INDEPENDENTLY LIABILITY

- "When an attorney fails to reimburse Medicare, the United States can recover from the attorney—even if the attorney already transmitted the proceeds to the client."

- "Congress enacted these rules to ensure timely repayment from responsible parties, and we intend to hold attorneys accountable for failing to make good on their obligations.

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ATTORNEY'S DUTY TO REPAY

FOR IMMEDIATE RELEASE Monday, March 18, 2019

Maryland Law Firm Meyers, Rodbell & Rosenbaum, P.A., Agrees to Pay the United States $250,000 to Settle Claims that it Did Not Reimburse Medicare for Payments Made on Behalf of a Firm Client

"We intend to hold attorneys accountable for failing to make good on their obligations to repay Medicare for its conditional payments."

"[T]hose receiving the proceeds of the settlement or judgment, including the injured person's attorney, are required to repay Medicare for the conditional payments."

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CANNOT SHIFT RESPONSIBILITY

FOR IMMEDIATE RELEASE

Monday, November 4, 2019

Baltimore Plaintiffs' Law Firm Saiontz & Kirk, P.A., Pays the United States Over $90,000 to Settle Allegations that it Failed to Reimburse Medicare For Payments Made on Behalf of Firm Clients

"Plaintiffs' attorneys cannot refer a case to or enter into a joint representation agreement with co-counsel and simply wash their hands clean of their obligations to reimburse Medicare for its conditional payments."

"We intend to hold attorneys accountable for failing to make good on their obligations to repay Medicare for its conditional payments, regardless of whether they were the ones primarily handling the litigation for the plaintiff."

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PROSECUTIONS CONTINUE

FOR IMMEDIATE RELEASE Wednesday, January 8, 2020

Philadelphia-Based Personal Injury Law Firm Agrees to Resolve Allegations of Unpaid Medicare Debts

"This settlement agreement should remind personal injury lawyers and others of their obligation to reimburse Medicare when they receive settlement or judgment proceeds for their clients."

"Lawyers need to set a good example and follow the rules of the road for Medicare reimbursement. If they don't, we will move aggressively to recover the money for taxpayers."

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DOJ SETTLEMENT COMPONENTS

In each of these cases the Department of Justice not only required lump sum settlement payments from the respective law firms, but they also required each firm to institute specific Medicare file handling protocols. These protocols are identical in each case.

- Designate a person at the firm responsible for paying Medicare secondary payer debts;
- Train the employee to ensure that the firm pays these debts on a timely
  basis; and
- Review any additional outstanding debts to ensure compliance.

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BEWARE THE BIG BAD WOLFISH!

"U.S. Attorney Robert K. Hur commended Eric Wolfish, Assistant Regional Counsel, United States Department of Health and Human Services, Office of the General Counsel, Region III, for his work in the investigation."
March 18, 2019

"U.S. Attorney Robert K. Hur commended Eric Wolfish, Assistant Regional Counsel, United States Department of Health and Human Services, Office of the General Counsel, Region III, for his work in the investigation."
November 4, 2019

THE UNITED STATES DEPARTMENT of JUSTICE

"The case was handled by Assistant U.S. Attorney Michael S. Macko, acting upon a referral from Eric S. Wolfish, Assistant Regional Counsel for the United States Dept. of Health and Human Services, Office of the General Counsel, Region III."
January 8, 2020

PROMOTION – Special Assistant U.S. Attorney
February 2020

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REGULATORY AUTHORITY

"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 primary payment."

42 C.F.R. §411.24(g)

- United States v. Weinberg, 2002 U.S. Dist. LEXIS 12289 (E.E. Pa. July 1, 2002).
- United States v. Harris, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. March 26, 2009) affirmed, 334 F. App'x 569 (4th Cir. 2009).
- Denekas v. Shalala, 943 F. Supp. 1073 (S.D. Iowa 1996).

"If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified."

42 C.F.R. §411.24(c)(2)

BEST PRACTICES – MEDICARE PARTS A & B

Beneficiary & Counsel	"Primary Plan" – Insurer	All Stakeholders
• Screen clients for Medicare entitlement • Contact BCRC to confirm entitlement status and open a recovery claim • Provide proof to defendant that the recovery claim has been opened • Request updated conditional payment listings and audit claims for relatedness • Request final demand letter after settlement • Ensure payment of final demand amount is made to Medicare within 60 days of issuance of final demand	• Collect information to screen plaintiff for potential Medicare entitlement • Obtain proof that recovery claim has been opened • Ensure payment has been made to Medicare in satisfaction of its final demand • Report payments to Medicare beneficiaries in compliance with MMSEA Section 111 • Collect proof of payment of final demand	• Screen plaintiffs for Medicare eligibility • Coordinate initial reporting to BCRC to prevent creation of duplicate recovery claims • Coordinate MMSEA reporting information for consistency (ICD – 10 codes and related injury diagnoses) • Coordinate and document payment of final demand to Medicare

AUDIT & DISPUTE

- Contact Medicare noting which claims are not related and why.
- If the injury claimed is complex in nature, provide medical records to support your dispute
- Hospital Acquired Conditions
- Is unrelated care “bundled” with related care?
- Do not use a highlighter as Medicare scans their documents in and thus highlighting does not show up.
- Don't forget to send your Correspondence Cover Sheet.

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HOSPITAL ACQUIRED CONDITIONS

- HAC 01 Tab – Foreign Object Retained After Surgery ICD-10-CM diagnosis code list
- HAC 02 Tab – Air Embolism ICD-10-CM diagnosis code list
- HAC 03 Tab – Blood Incompatibility ICD-10-CM diagnosis code list
- HAC 04 Tab – Stage III and IV Pressure Ulcers ICD-10-CM diagnosis code list
- HAC 05 Tab – Falls and Trauma ICD-10-CM diagnosis code list
- HAC 06 Tab – Catheter-Associated Urinary Tract Infection (UTI) ICD-10-CM diagnosis code list
- HAC 07 Tab – Vascular Catheter-Associated Infection ICD-10-CM diagnosis code list
- HAC 08 Tab - Surgical Site Infection (SSI)-Mediastinitis Following Coronary Artery Bypass Graft (CABG) ICD-10-CM diagnosis and ICD-10-PCS procedure code lists
- HAC 09 Tab – Manifestations of Poor Glycemic Control ICD-10-CM diagnosis code list
- HAC 10 Tab – Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) with Total Knee or Hip Replacement ICD-10-CM diagnosis and ICD-10-PCS procedure code lists
- HAC 11 Tab – Surgical Site Infection (SSI) Following Bariatric Surgery ICD-10-CM diagnosis and ICD-10-PCS procedure code lists
- HAC 12 Tab – Surgical Site Infection (SSI) Following Certain Orthopedic Procedures of Spine, Shoulder or Elbow ICD-10-CM diagnosis and ICD-10-PCS procedure code lists
- HAC 13 Tab - Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) Procedures ICD-10-CM diagnosis and ICD-10-PCS procedure code lists
- HAC 14 Tab – *Iatrogenic Pneumothorax with Venous Catheterization ICD-10-CM diagnosis and ICD-10-PCS procedure code lists

- Specific items/ ICD-10 codes that Medicare should not have paid.
- Apply facts of specific case and extrapolate from this list when disputing.

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

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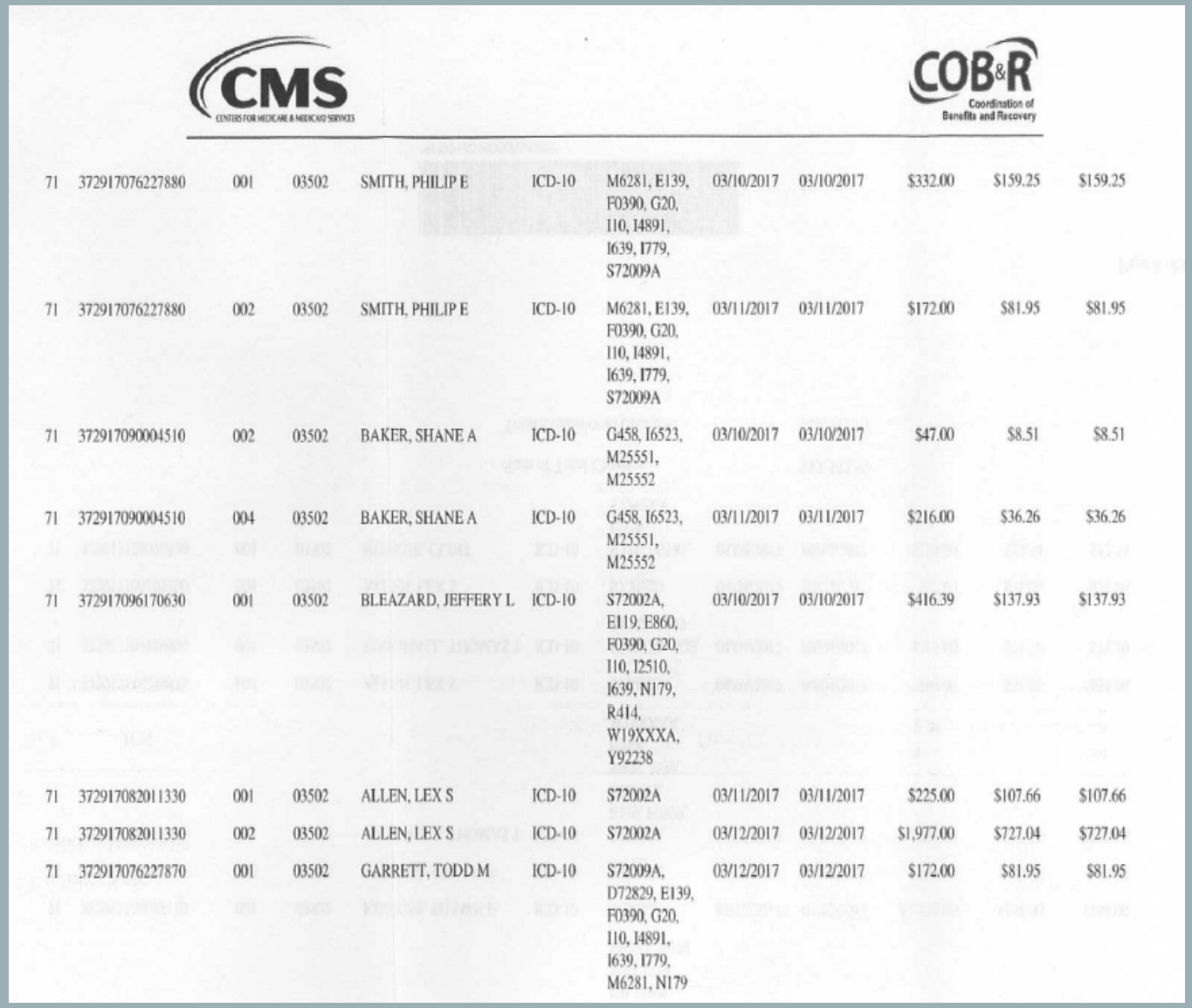
BUNDLED CHARGES



CMS — CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R — Coordination of Benefits and Recovery

71	372917076227880	001	03502	SMITH, PHILIP E	ICD-10	M6281, E139, F0390, G20, I10, I4891, I639, I779, S72009A	03/10/2017	03/10/2017	$332.00	$159.25	$159.25
71	372917076227880	002	03502	SMITH, PHILIP E	ICD-10	M6281, E139, F0390, G20, I10, I4891, I639, I779, S72009A	03/11/2017	03/11/2017	$172.00	$81.95	$81.95
71	372917090004510	002	03502	BAKER, SHANE A	ICD-10	G458, I6523, M25551, M25552	03/10/2017	03/10/2017	$47.00	$8.51	$8.51
71	372917090004510	004	03502	BAKER, SHANE A	ICD-10	G458, I6523, M25551, M25552	03/11/2017	03/11/2017	$216.00	$36.26	$36.26
71	372917096170630	001	03502	BLEAZARD, JEFFERY L	ICD-10	S72002A, E119, E860, F0390, G20, I10, I2510, I639, N179, R414, W19XXXA, Y92238	03/10/2017	03/10/2017	$416.39	$137.93	$137.93
71	372917082011330	001	03502	ALLEN, LEX S	ICD-10	S72002A	03/11/2017	03/11/2017	$225.00	$107.66	$107.66
71	372917082011330	002	03502	ALLEN, LEX S	ICD-10	S72002A	03/12/2017	03/12/2017	$1,977.00	$727.04	$727.04
71	372917076227870	001	03502	GARRETT, TODD M	ICD-10	S72009A, D72829, E139, F0390, G20, I10, I4891, I639, I779, M6281, N179	03/12/2017	03/12/2017	$172.00	$81.95	$81.95

"The statutory phrase 'an item or service' clearly does not refer to multiple medical treatments just because they appear under one charge."

Cal. Ins. Guar. Ass'n v. Burwell

United States District Court for the Central District of California

January 5, 2017, Decided; January 5, 2017, Filed

Case No 2:15-cv-01113-ODW (FFMx)

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BEST PRACTICES – RELEASE LANGUAGE
MAYO V. NYU LANGONE MED. CTR. 2018 NY SLIP OP 30456(U)

- Med mal settlement for $725,000 with Medicare lien of $1,811.95, final lien believed to be $2,824.50, remainder paid to estate executor, care of attorneys
- Release signed and mailed to defendant – same date CMS sent its final lien letter seeking $145,764.08
- ALJ found plaintiff was responsible for conditional payments & interest
- Insurer and defendant did not sign agreement as required therein
- Plaintiff successfully moved to void agreement
- Contract "effective upon execution by the parties"
- Defendant drafted
- Grounds of mutual mistake with error substantial to prevent a meeting of the minds

MSPRP - FUNCTIONALITY

- FREE
- Same tool used by all lien resolution vendors
- Full file management
- Reporting
- Auditing/Disputing
- Correspondence
- Pre-mediation final claim amount
- First and second level appeals
- Wavier/Compromise/Refund requests
- Live viewing of CMS file actions
- Up to date claim amounts
- Liability
- No-Fault

USE IT!

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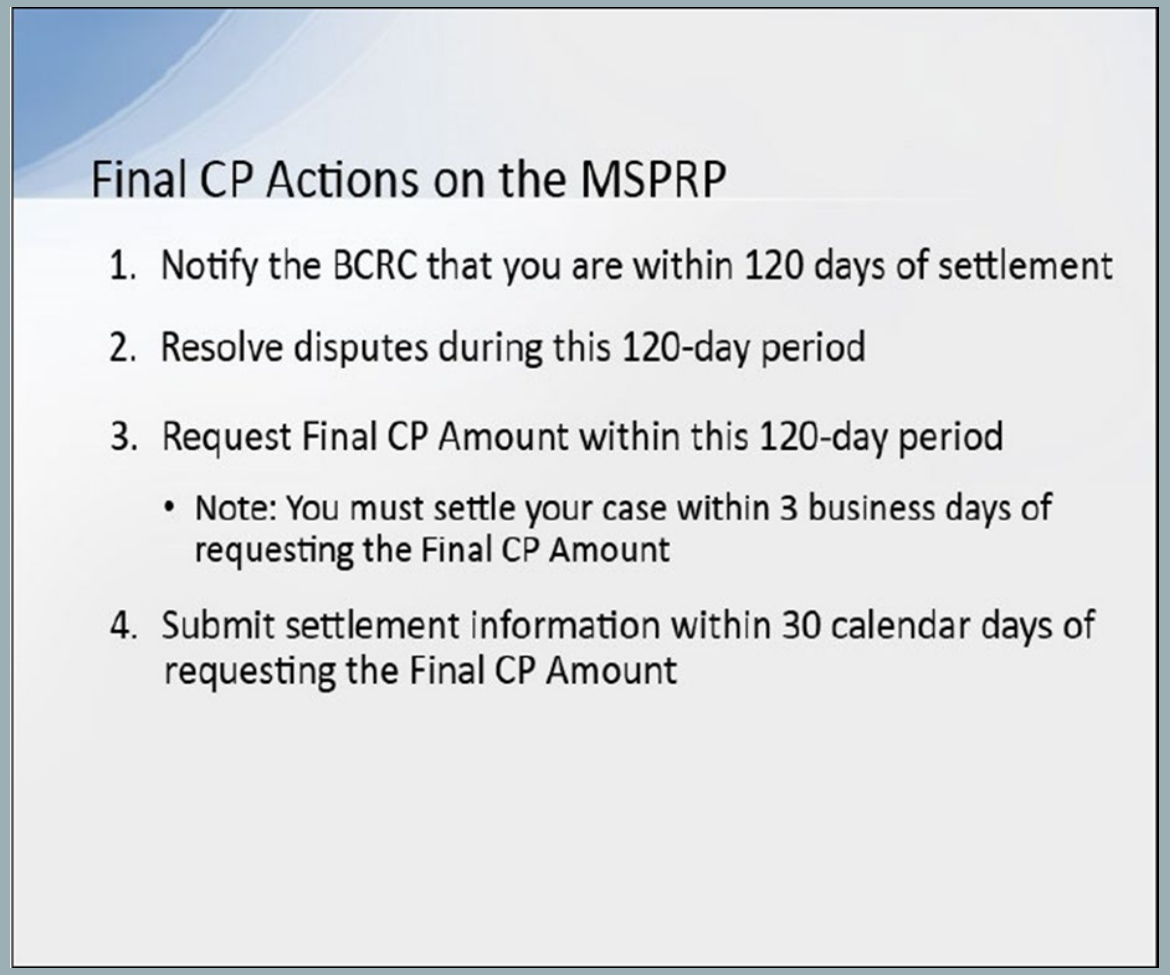
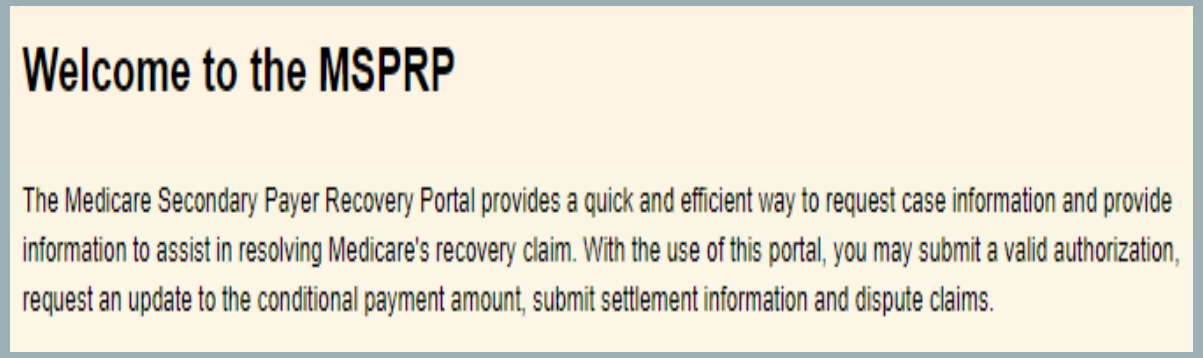
PRE-MEDIATION





- Must have access to the Medicare Secondary Payer Recovery Portal (MSPRP)

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

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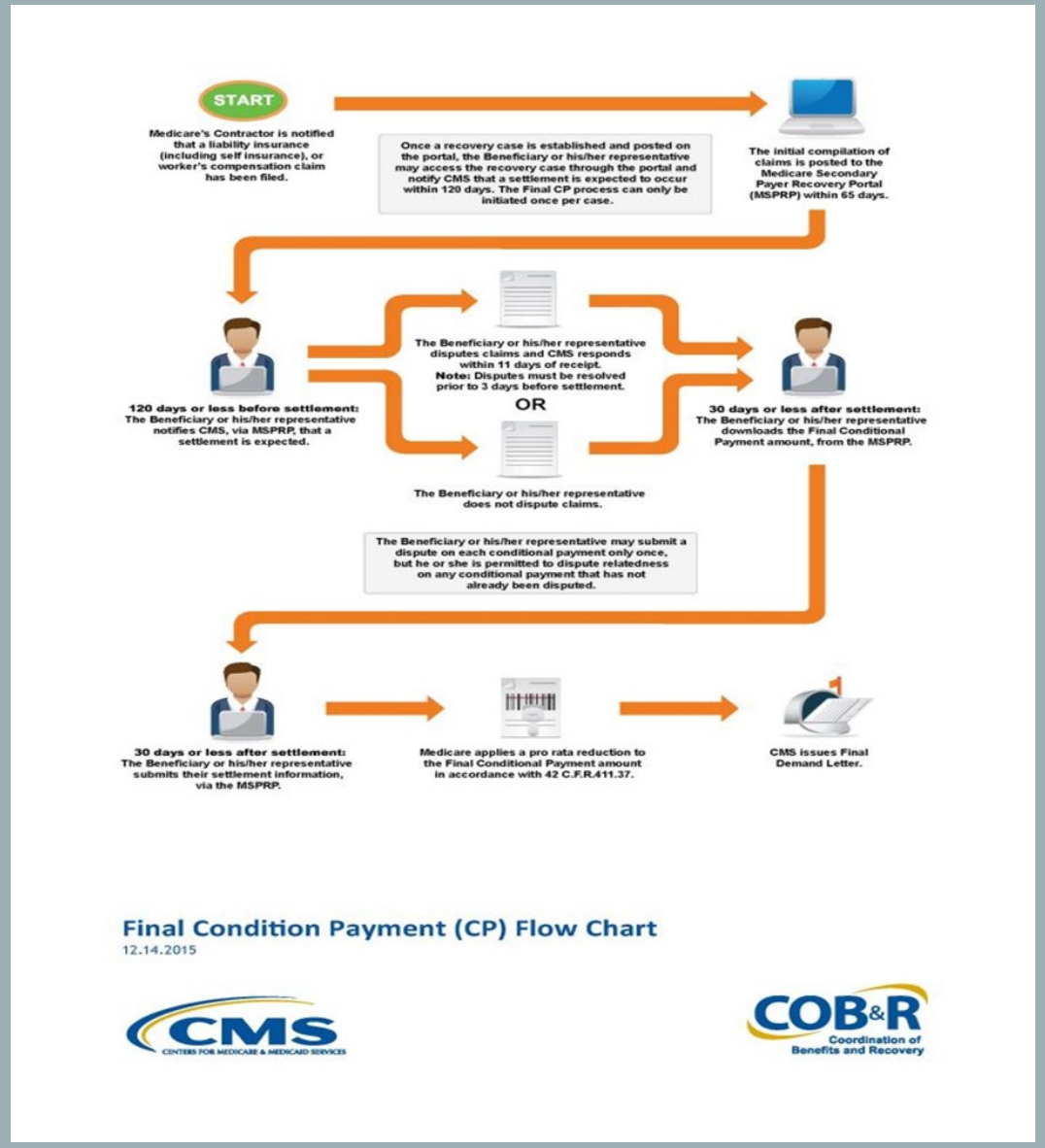
FINAL CONDITIONAL PAYMENT PROCESS



- 120 Days from anticipated settlement
- Only one "dispute" available during this period
  - BCRC must respond within 11 days or dispute is automatically granted
- Download letter immediately
  - Amount is final for 3 days (including day of download)
- Calculate Medicare repayment during mediation
- Report settlement to BCRC via portal within 30 days
- BCRC will send a written Final Demand

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DURING MEDIATION

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

Mon Oct 17 2016

Beneficiary Name:	XXXXXXX
Medicare Number:	XXXXXXX
Case Identification Number:	XXXXXXX
Insurer Claim Number:	
Insurer Policy Number:	XXXXXXX
Date of Incident:	XXXXXXX
Final Conditional Payment Amount:	$ XXXXXXX

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

Subject: Final Conditional Payment Amount for Final Conditional Payment Case

Dear XXXXXXX:

This letter has been electronically generated. It will not be mailed separately to you or your attorney or other representatives that may be on file. If you have any questions regarding this letter and are represented by an attorney or other representative, you may wish to talk to him or her before contacting us.

This letter notifies you of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments for Medicare Part A and Part B Fee-for-Service claims have been made that we believe are related to your case for the date of incident listed above.

As of the date of this letter, and based upon the available information, Medicare has identified $ XXXXX as the Final Conditional Payment Amount. This amount will not increase as long as:

1. You provide notice of settlement information ***on the Medicare Secondary Payer Recovery Portal (MSPRP)*** by 11/16/2016, and
2. Your actual settlement date is within 3 business days of the Final Conditional Payment Requested date of 10/17/2016.

Failure to provide this information timely will result in new claims potentially being added to your case causing your conditional payment amount to increase.

You will find a listing of Part A and Part B Fee-for-Service claims that comprise this total is enclosed with this letter and we have posted this conditional payment information under the "MyMSP" tab of the www.mymedicare.gov website.

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the

NGHP PO BOX 138832 OKLAHOMA CITY, OK 73113 **SGLEPLNGHP**

- Confirms amount is FINAL for 3 business days.
- Provides date by which notification to BCRC of settlement is required
- Useful to prevent insurance carrier from delaying settlement funds until receipt of the "Final Demand."

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FINAL DEMAND

- Once you settle your case advise Medicare.
- Download the "Final Settlement Detail Document“
  - https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Medicares-Recovery-Process/Downloads/Final-Settlement-Detail.pdf
  - Provide the information on company letterhead
  - Total amount of the settlement
  - Total Amount of Med-Pay or PIP
  - Attorney Fee Amount paid by the beneficiary
  - Additional Procurement Expenses Paid by the Beneficiary
    - Attached itemized list of these expenses
  - Date the Case was Settled

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REPAYMENT CALCULATIONS

42 C.F.R. 411.37(c)

- Medicare payments are less than the judgment or settlement.
  - Add (Attorney's Fees) and (Costs) = Total Procurement Costs
  - (Total Procurement Costs) / (Gross Settlement Amount) = Ratio
  - Multiply (Lien Amount) by (Ratio) = Reduction Amount
  - (Lien Amount)-(Reduction Amount) = Medicare Demand

42 C.F.R. 411.37(d)

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- Medicare payments equal or exceed the judgment or settlement.
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  - (Gross Settlement)-(Total Procurement Costs) = Medicare Demand

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PAYMENT

- Pay demand amount within 60 days or the lien will accrue interest.
- Request for Appeal or Waiver does not toll interest.
- Interest is due and payable for each full 30 day period the debt remains unresolved.
- By law, all payments are applied to interest first, principal second. 42 C.F.R.411.24(m)
- After receiving payment, Medicare will send a letter stating the lien has been reduced to zero and the case is closed.

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MINIMIZING THE FINANCIAL IMPACT

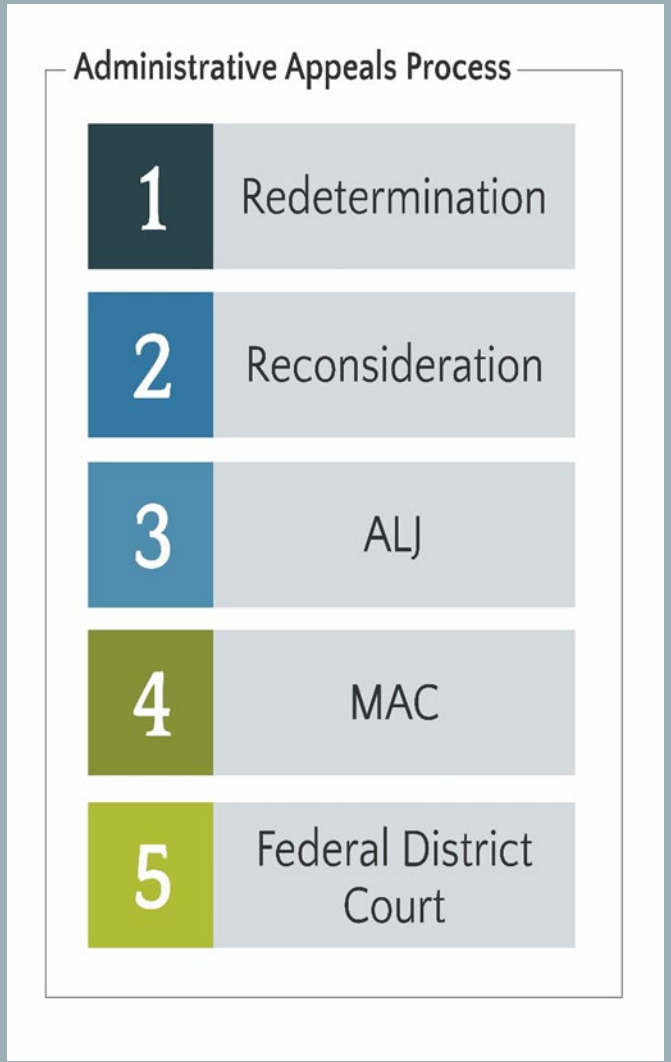
Dispute Conditional Payments	Compromises
• Medicare only entitled for payments from time of injury to settlement • Only entitled to recoupment of medical expenses from litigation – related injury • Use medical records and ICD – 10 tools • Audit each conditional payment letter and "strike through" the unrelated charges	• 42 C.F.R. § 401.613 allows CMS to accept less than full payment • Criteria at 42 C.F.R. § 401.613 (b) and (c) • May be made in writing to BCRC any time • Considered on case by case basis and may take between 3 – 6 months

Procurement Offset	Waivers
• Medicare must offset its lien by a % equal to the % of the settlement value devoted to attorney's fees and case expenses	• Allowed under Section 1870(c) of the Social Security Act • Filed only after final demand • Made in writing to BCRC with form SSA-632-BK, and supporting documentation • Primarily based on financial hardship • Decision generally takes 120 days from request

MINIMIZING THE FINANCIAL IMPACT

Administrative Appeals

- Must be submitted post final demand
- Final demand amount should still be paid within 60 days of issuance
- Waivers and Compromises focus on principles of equity – appeals center on errors or legal arguments
- Contest unrelated charges/duplicate charges, incorrect settlement information considered, incorrect procurement offset applied
- Time for filing
  - 120 days from final demand
  - 180 days from redetermination
  - 60 days from reconsideration decision
  - 60 days from the ALJ decision
  - 60 days from the MAC decision



MMSEA SECTION 111 REPORTING
AKA MANDATORY INSURER REPORTING (MIR)

Insurers and self-insureds, collectively referred to as “responsible reporting entities,” (RREs), must report information regarding payments made to Medicare beneficiaries.

Required if:
1) claimant is entitled to Medicare and
2) a payment is made to or on behalf of the claimant

Reporting obligation triggered when:
1) RRE accepts ongoing responsibility for medicals (ORM) or
2) makes a total payment obligation to claimant (TPOC).

Reporting occurs electronically through the BCRC during a specific 7-day window each quarter (calendar).

The RRE may perform reporting or engage a reporting agent, but the RRE maintains liability for compliant reporting.

MMSEA SECTION 111 REPORTING
AKA MANDATORY INSURER REPORTING (MIR)

Reporting Threshold	Derivative Plaintiffs	Exposure Cases
• Per Section 202 of the SMART Act, each year CMS must establish a minimum threshold or "safe harbor" for physical – trauma based liability cases, below which no reimbursement or MMSEA reporting requirements apply. • Currently, the minimum threshold is $750. • There are no MMSEA reporting or Medicare reimbursement obligations for physical trauma – based settlements with gross settlement values of $750 or less. • Threshold for reporting Worker's Compensation claims is $300. • Exposure case considerations.	• If medicals were pled, claimed or released for a Medicare enrolled derivative plaintiff, then the RRE has a reporting obligation on the derivative plaintiff and should report the full settlement value. • If medicals were pled, claimed or released for the primary plaintiff, who is not Medicare enrolled, and the derivative plaintiff is Medicare enrolled, the RRE has a reporting obligation on the derivative plaintiff and should report the full settlement value. • The RRE may use a no injury code (NOINJ) to report derivative plaintiffs no medical expenses were incurred.	• There is no reporting requirement when the injury was caused by exposure, ingestion or implantation before 12/5/1980 and all of the following are true: • All exposure or ingestion ended, or the implant was removed before 12/5/1980; • Exposure, ingestion, or an implant on or after 12/5/1980 has not been claimed in the most recently amended operative complaint (or comparable supplemental pleading) and/or specifically released; and • There is no release for the exposure, ingestion, or an implant on or after 12/5/1980; or where there is a release, it is a broad general release, which effectively releases exposure or ingestion on or after 12/5/1980. The rule also applies if the broad general release involves an implant.

MMSEA SECTION 111 REPORTING - CIVIL MONETARY PENALTIES

On 2/28/2020, CMS issued NPRM re: Civil Monetary Penalties (CMPs) Proposed Rule (85 FR 8793)

- CMS can issue CMPs against Non-Group Health Plans (worker's comp, liability insurer, etc.) when:
  - Entity fails to register as a Responsible Reporting Entity
  - Entity fails to report a Total Payment Obligation to Claimant (settlement, judgment, award) within 1 year of the settlement, etc.
  - Entity response to CMS recovery efforts contradicts entity's Section 111 reporting
  - Entity exceeds error tolerance threshold in any of 4 out of 8 reports
- CMPs will not be issued if NGHP is unable to obtain information necessary for reporting from the individual and entity has made records of good faith attempt to obtain that information
- Monetary Penalties of NGHPs:
  - Up to $1,000 per day per individual that should have been reported (max $365,000 per individual per year)
  - Up to $1,000 per day per individual for response contradicting reporting (max $365,000 per individual per year)
  - Tiered approach for exceeding error threshold: 25% of max penalty for one period. 50% if exceeds for 2 consecutive periods, 75% for 3 consecutive, 100% for 4

MMSEA SECTION 111 REPORTING - CIVIL MONETARY PENALTIES

How to Avoid Civil Monetary Penalties:

Ensure Primary Payer Clients are …

- Registered with CMS as Responsible Reporting Entities
- Reporting settlements in excess of the reporting threshold (current / past)
- Checking reported settlements and correct any reporting errors
    - A report with an error is not a report
- If the claimant will not provide necessary reporting information, documents the refusal and efforts to obtain the information
- Recommend comprehensive MIR audit of current process and protocols

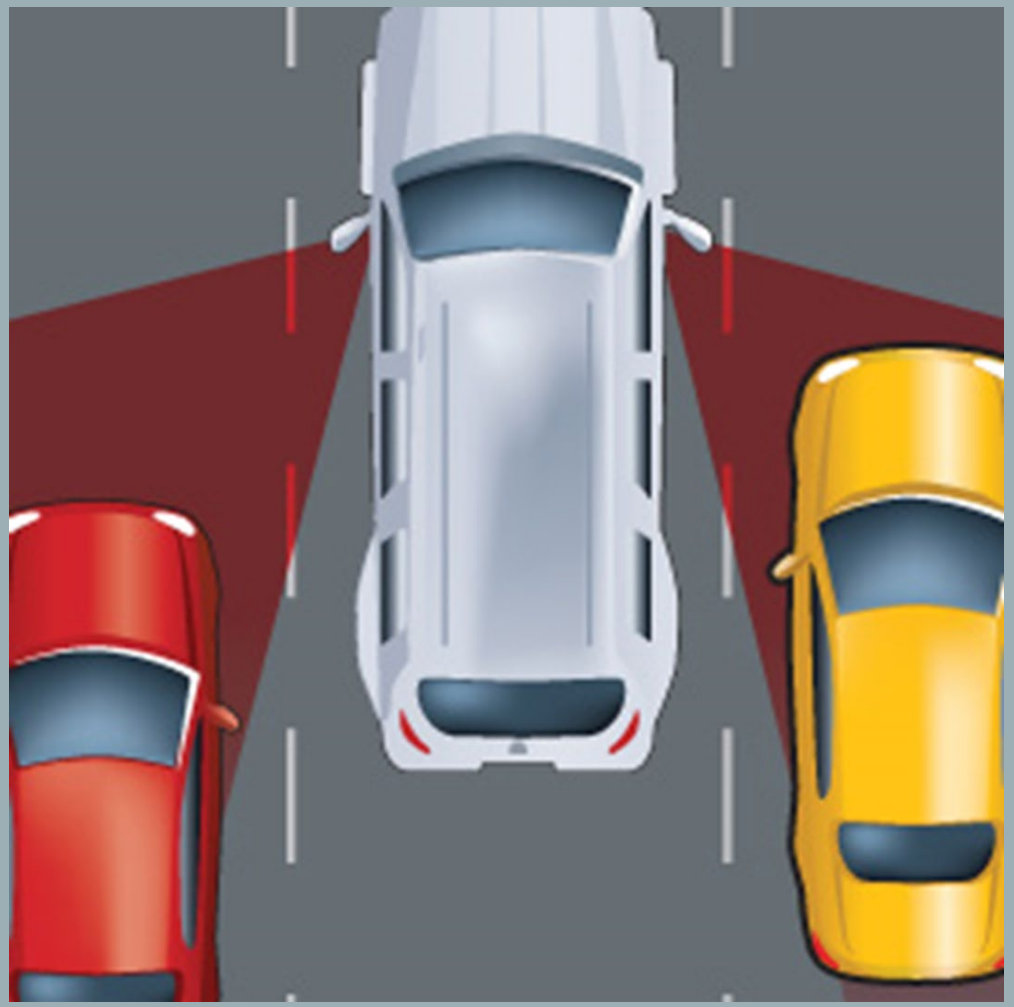
MEDICARE PART C (AKA MEDICARE ADVANTAGE) BEST PRACTICES

- Use PAID Act query to determine plaintiff enrollment status (Medicare A/B v. Part C)
  - Verify entitlement status through traditional means (web portal, screenings, etc.)
  - Take note when Medicare A/B payments made one year but not subsequently
- Comply with any notice requirements
  - 42 C.F.R. § 422.108(b) puts notice burden on the Part C plan
  - However, beneficiary may have contractual notice obligations
- Account for administrative differences
  - BCRC does not handle Part C recovery actions
  - Resolution occurs directly with plan and/or its private recovery contractor
- Utilize traditional Medicare resolution and reduction methods
- Excepting the administrative remedies, utilize the offset provisions, dispute process and any other pre – administrative recourse tactics to reduce the lien in the same manner as traditional Medicare
- Know the jurisprudence in your jurisdiction

MEDICARE PART D (AKA MEDICARE PDP) BEST PRACTICES

- Use PAID Act query to determine plaintiff enrollment status (Medicare Parts A, B, or C)
  - Verify entitlement status through traditional means (web portal, screenings, etc.)
  - If Medicare eligible or confirmed enrolled, Part D is almost certainly in play
- Identify Part D plan
  - Client screening questionnaire, copies of insurance cards, discovery, review of pharmacy records and/or medical records and bills
  - Companies administering Part D plans can be identified by region
  - Be aware of potential for Part C plan to provide Part D benefits
- Address identified Part D implications prior to settlement and payment of proceeds
- Part D plans are relegated to a "pay and chase" recovery method due to unclear guidance, increasing potential for the issue to come up after funds are disbursed
- Know the jurisprudence in your jurisdiction

FUTURE MEDICALS AND MEDICARE SET-ASIDES (MSA)



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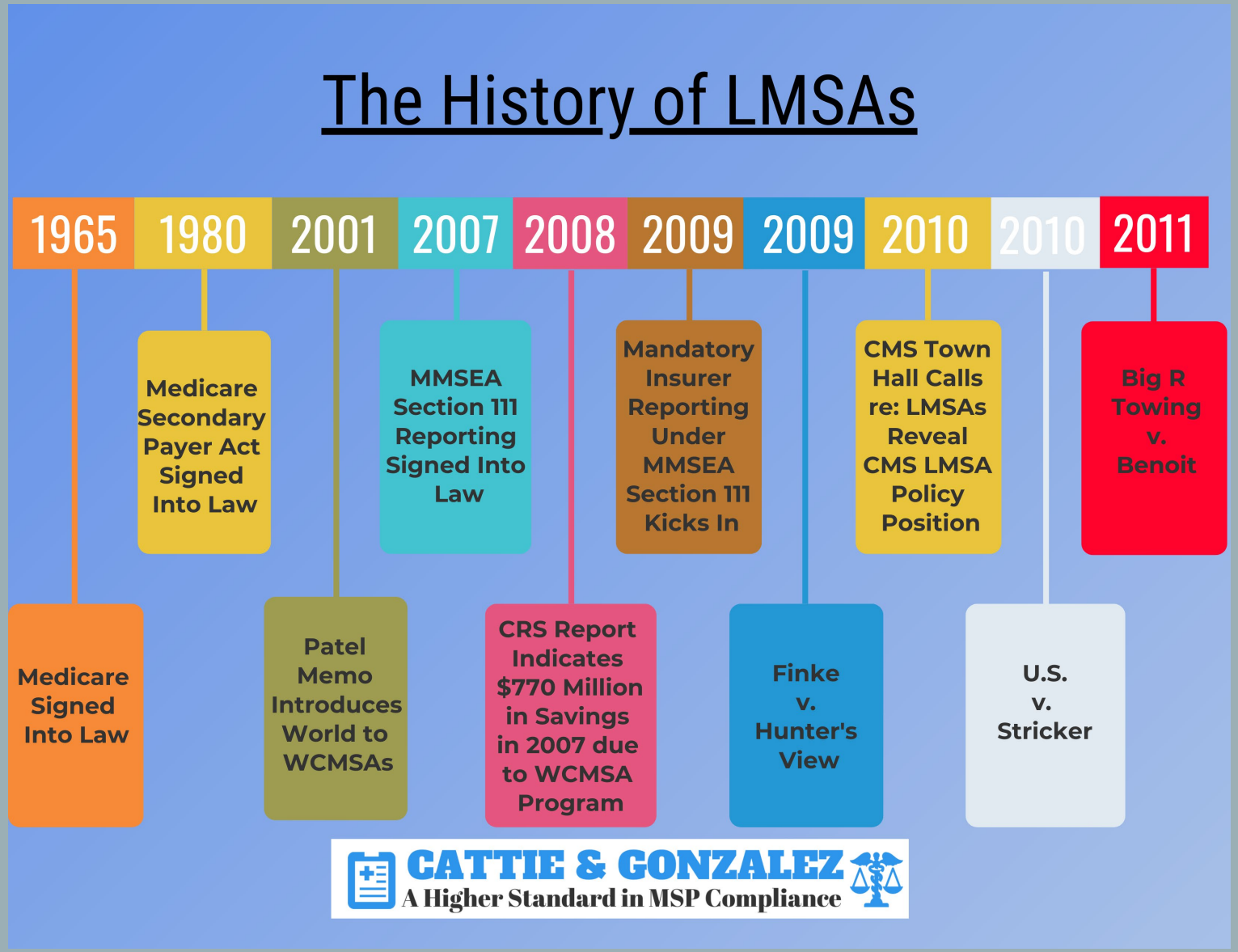
FUTURE MEDICALS AND MEDICARE SET-ASIDES (MSA)

"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 – payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

42 U.S.C. § 1395y(b)(2)(A)(ii)

FUTURE MEDICALS AND MEDICARE SET-ASIDES (MSA)



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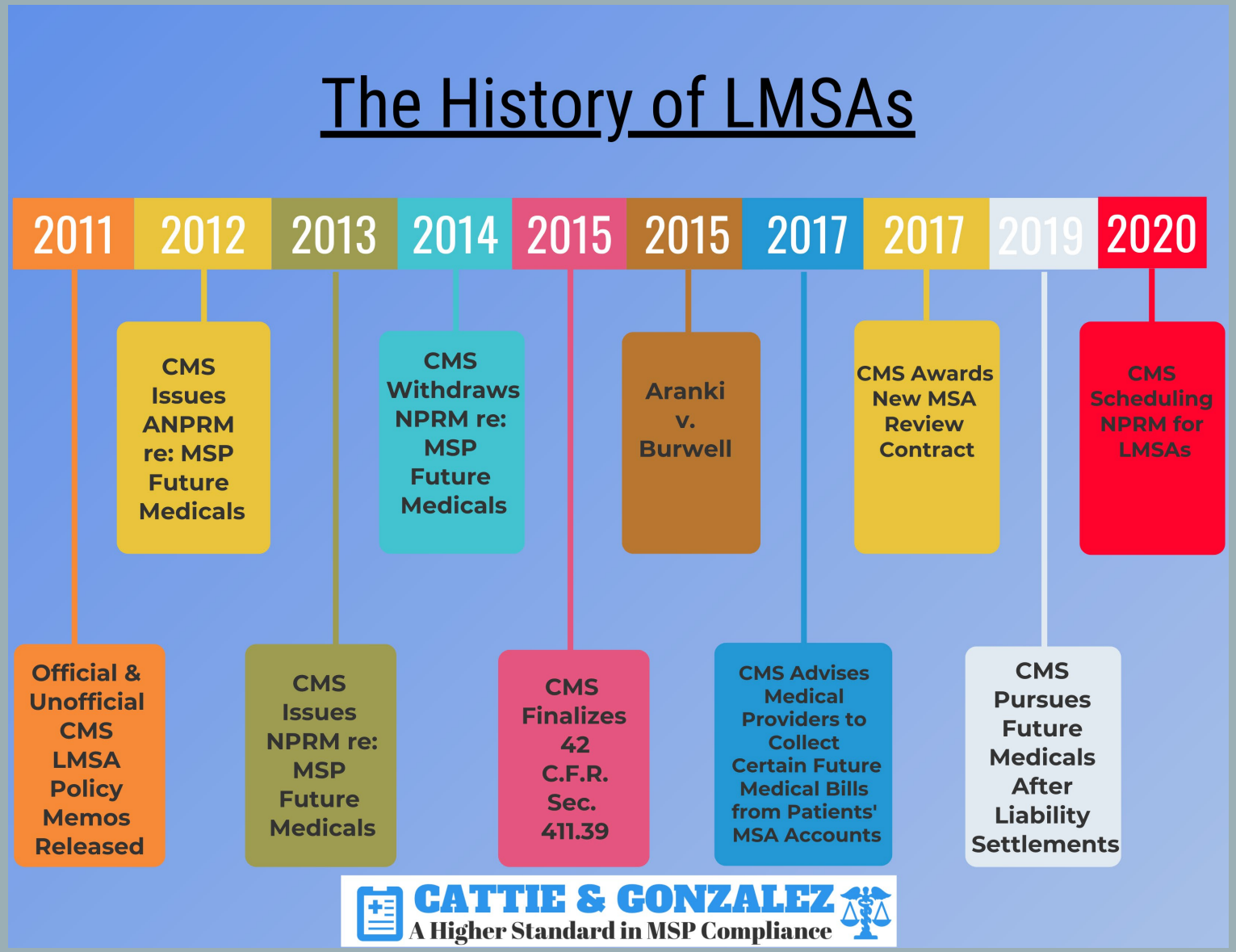

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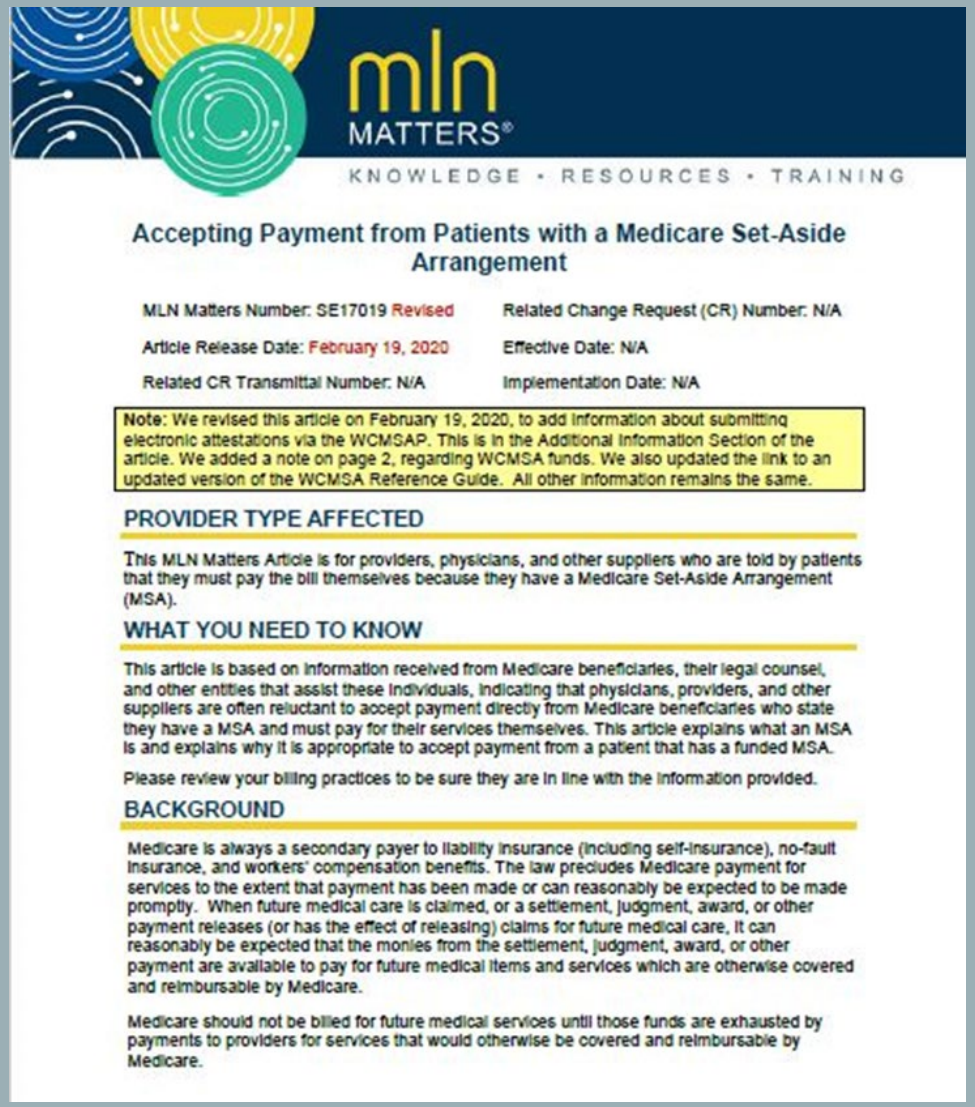

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Accepting Payment from Patients with a Medicare Set-Aside Arrangement

MLN Matters Number: SE17019 Revised | Related Change Request (CR) Number: N/A

Article Release Date: February 19, 2020 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

Note: We revised this article on February 19, 2020, to add information about submitting electronic attestations via the WCMSAP. This is in the Additional Information Section of the article. We added a note on page 2, regarding WCMSA funds. We also updated the link to an updated version of the WCMSA Reference Guide. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

WHAT YOU NEED TO KNOW

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what an MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

BACKGROUND

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

Medicare has notified providers how to collect payment from a patient's MSA account.

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Medicare Summary Notice
for Part B (Medical Insurance)

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

[redacted]

THIS IS NOT A BILL

Notice for [redacted]	
Medicare Number	[redacted]
Date of This Notice	**April 27, 2018**
Claims Processed Between	**January 13 - April 27, 2018**

Your Claims & Costs This Period

Did Medicare Approve All Services? **NO**

Number of Services Medicare Denied **1**

See claims starting on page 3. Look for NO in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$382.70**

Facilities with Claims This Period

August 01, 2017 - February 13, 2018

[redacted]

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **$183.00** deductible for 2017. You have now met **$111.96** of your **$183.00** deductible for 2018.

Be Informed!

Medicare has started mailing new Medicare cards to everyone with Medicare. You don't need to do anything to get your new card. Medicare will mail your new card to the address you have on file with Social Security. Visit Medicare.gov/newcard to learn more.

[redacted]

January 02, 2018

[redacted]

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G0463-PO)	NO	$229.00	$0.00	$0.00	**$229.00**	E,F
Total for Claim [redacted]		$229.00	$0.00	$0.00	**$229.00**	E,F,G

February 13, 2018

[redacted]

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G0463-PO)	Yes	$229.00	$229.00	$0.00	**$111.96**	H
Total for Claim [redacted]		$229.00	$229.00	$0.00	**$111.96**	G,I

Notes for Claims Above

E Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies).

F Medicare does not pay for this item or service.

G The amount Medicare paid the provider for this claim is $0.00.

H $111.96 of this approved amount has been applied toward your deductible.

I This information is being sent to [redacted] Send any questions regarding your benefits to them.

The Liability Medicare Set-Aside (LMSA) Meter

What's Your Current Temperature?

CMS Creates Formal Review Process

I'll begin addressing LMSAs when CMS launches a formal review process.

Only When I Have To

I address LMSAs only when the other side requires me to address LMSAs.

Only When My Client Brings It Up

I address LMSAs only when my client asks about it.

Regulations Must Change

I'll begin addressing LMSAs when CMS issues regulations about LMSAs.

Medicare Cases Only

I address LMSAs on all cases involving a current Medicare beneficiary.

Law Must Change

I'll begin addressing LMSAs when the law changes to require LMSAs.

Medicare or Almost on Medicare

I address LMSAs on all cases involving a current Medicare beneficiary or "reasonable expectation" of Medicare enrollment within 30 months.

Plausible Deniability

I've heard about LMSAs, but I'll keep my head in the sand for now.

Medicare, Almost Medicare or Life Care Plan

I address LMSAs when case involves current Medicare beneficiary, "reasonable expectation" of Medicare enrollment or a life care plan exists.

It will be a cold day in hell ...

LMSAs are never needed!

Whenever Future Medicals are Released

I address LMSAs when case involves release of future medicals.

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MEDICAID LIEN RESOLUTION – THE BASICS

- Federal statutes require that states implement "lien" laws
  - 42 U.S.C. § 1396a et seq.
- Anti-lien statute prohibits Medicaid liens on personal property prior to death
  - 42 U.S.C. § 1396p(a)(1)(A)
- 53 implementing agencies with individual statutory schemes
- Both fed and state have a stake in recovering 3rd party liability payments
- 70% of Medicaid beneficiaries receive benefits from a managed care organization (MCO)

MEDICAID LIEN RESOLUTION – HISTORY

Ahlborn	Wos	BBA 2013	BBA 2018
The anti-lien statute prohibits state Medicaid plans from recovering lien amounts from the personal property of beneficiaries. Personal property = settlement proceeds not attributable to payment for past medical expenses.	States and Medicaid agencies must establish and utilize a non-arbitrary process for determining which part of a beneficiary's settlement is payment for past medical expenses.	Section 202(b) of the Bipartisan Budget Act of 2013 negates Ahlborn & Wos, and allows states to recover entire lien amounts from the entire amount of a beneficiary's settlement proceeds.	The provisions of the BBA of 2013 did not become effective until October 2017. Three months later, Section 53102 of the Bipartisan Budget Act of 2018 permanently repealed the 2013 changes. Ahlborn and Wos are again valid SCOTUS rulings.

MEDICAID LIEN RESOLUTION – GALLARDO V. MARSTILLER

MEDICAID LIEN RESOLUTION – KEY CONSIDERATIONS

- Medicaid Managed Care Organization (MCO)
  - 47 states use MCOs and approx. 70% of Medicaid beneficiaries are enrolled
  - 50% of states contract with 6 or more MCOs annually
- Notice Requirements
  - Plaintiffs have affirmative notice requirement (federal mandate)
  - Defendants have reporting requirements in some states
- Medical Assistance Intercept System (MAIS)
  - System electronically matches Medicaid beneficiaries to GL and WC claims
  - Designed to intercept GSV of $500 or more
- Audit, Dispute, and Offsets
  - Audits and dispute procedures apply
  - Automatic offset for procurement costs varies state to state
- Administrative Remedies
  - Vary state to state
- Benefit Protection
  - Beneficiary could lose Medicaid via settlement unless action taken

MEDICAID LIEN RESOLUTION – BEST PRACTICES

- Know your state statutes, rules, and process
- Identify Medicaid beneficiaries early and comply with notice requirements
- Use SCOTUS case law to obtain best results
- Protect future Medicaid benefits post-settlement

LIST OF ACRONYMS

Acronym	Full Terminology
CMS	Centers for Medicare and Medicaid Services
MSP	Medicare Secondary Payer
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
BCRC	Benefits Coordination and Recovery Center
ICD	International Classification of Diseases (ICD – 10 is "Tenth Revision")
ALJ	Administrative Law Judge
MAC	Medicare Appeals Council
RRE	Responsible Reporting Entities
ORM	Ongoing Responsibility for Medicals
TPOC	Total Payment Obligation to Claimant
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
MSPRP	Medicare Secondary Payer Recovery Portal
CP	Conditional Payment
CPL	Conditional Payment Letter
CPN	Conditional Payment Notice
LMSA	Liability Medicare Set Aside
ANPRM	Advanced Notice of Proposed Rulemaking
NPRM	Notice of Proposed Rulemaking
WCMSA	Workers Compensation Medicare Set Aside
HHS	U.S. Department of Health and Human Services
SPARC	Secondary Payer Advancement, Rationalization, and Clarification Act
FPL	Federal Poverty Level
ACA	Patient Protection and Affordable Care Act
BBA	Bipartisan Budget Act
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MMC	Medicaid Managed Care
MCO	Managed Care Organization
CMP	Civil Money Penalty

THANK YOU!

CATTIE & GONZALEZ
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John V. Cattie, Jr.
jcattie@cattielaw.com

HAWKINS PARNELL
Hawkins Parnell & Young, LLP

Catherine E. Goldhaber
cgoldhaber@hpylaw.com

THE PLACE FIRM
PLAINTIFF LIEN RESOLUTION COUNSEL

Dave Place
dave@theplacefirm.com