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Workers' Compensation Report

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Smart Act Medicare Reforms Become Law

On January 10, 2013, President Obama signed into law the Strengthening Medicare and Repaying Taxpayers (SMART) Act. The SMART Act provides for significant reforms to the Medicare conditional payment process. The Centers for Medicare and Medicaid Services (CMS) will now be required to provide parties with binding conditional payment amounts prior to settlement and further allows for the review and appeal of conditional payment disputes. The Act also amends the SCHIP Reporting Act with regard to potential penalties.

A conditional payment exists when Medicare issues payment for medical services for which another payer is responsible. 42 C.F.R. 411.21. Medicare's authority to seek reimbursement for conditional payments is found in the Medicare Secondary Payer Act. 42 U.S.C. § 1395y(b). Where a primary plan, such as a workers' compensation plan, does not make prompt payment then Medicare will proceed to pay the medical expense and such payment "shall be conditioned on reimbursement." 42 U.S.C. § 1395y(b). By definition, the Medicare conditional payment issue arises in those workers' compensation claims where the claimant is a Medicare beneficiary either by age or by disability entitlement.

For many years parties have struggled with the delay and inefficiencies inherent in the conditional payments process. In many instances it would take 60 days or longer to acquire a conditional payment (lien) amount from the CMS. Often times the conditional payments demand letter issued by CMS would include charges for care unrelated to the workers' compensation claim or care for disputed treatment that was denied and is not being further compensated as an element of settlement. While the parties are currently able to seek a reconsideration of the conditional payments amount the scope of reconsideration is very narrow. Based upon reforms under the SMART Act parties will have additional remedies available in which to address these issues. Furthermore, CMS is now required to provide an efficient means in which to identify the conditional payments amount and "lock in" that amount prior to settlement.

Determination of Conditional Payment Amount

The claimant or applicable plan (insurers) will be allowed to notify the Secretary for Health and Human Services (HHS) within 120 days before the reasonably expected date of settlement, judgment, award or other payment. Upon notification the parties will be able to obtain a statement of the conditional payment amount through a website to be created by HHS. Where notice is provided to HHS within 120 days of settlement, judgment, award or other payment, CMS will have 65 days to produce a conditional demand letter. CMS may seek a 30 day extension of that deadline. Once the conditional payment amount is downloaded during this period the conditional payment amount shall be deemed the final conditional payment amount. Once the conditional payment amount is downloaded, the parties will have three business days to reach settlement. The download with the

conditional payments amount will be time and date stamped. Practically speaking, the parties will most likely reach a settlement contingent upon confirming the conditional payment amount. Where there is no dispute as to that amount the parties should then be able to document settlement within the three day deadline. If a complete settlement is not reached within the three day time frame then the parties will simply re-download the conditional payments amount when they are, in fact, ready to proceed with settlement.

Although a settlement in Illinois is not binding until approved by an arbitrator, this author does not believe that the parties will need to secure an approved contract within the three day deadline. Represented contracts are routinely approved by arbitrators without complication. In the event a settlement contains complex issues or terms that may be questioned by the arbitrator then the parties should be cognizant of the three day settlement deadline under the conditional payments process. Under a worst case scenario, if the contracts are rejected the parties will need to address reformulation of the settlement contracts to address the arbitrator's concerns and then re-confirm the conditional payments amount prior to resubmission of the contracts to the arbitrator for approval.

Reconsideration of Conditional Payment Amount

If the claimant, representative or applicable plan disagrees with the conditional payment amount, they may seek review by providing CMS with documentation identifying the discrepancies and further provide a proposal to resolve the discrepancy. In essence, the claimant, representative or applicable plan would submit documentation as to what they believe the proper conditional payment amount should be. The Secretary of HHS will have 11 business days upon receipt of such documentation and proposal to determine whether there is a reasonable basis to amend its conditional payments claim. If the Secretary of HHS does not make such a determination within 11 business days, then the proposal submitted by the claimant, representative or applicable plan shall be deemed accepted by HHS.

If the Secretary of HHS determines within 11 business days that there is not a discrepancy, then the Secretary must respond by providing documentation and show good cause why they are not agreeing to the proposal. The Act also requires that the Secretary of HHS establish an alternative manner in which to resolve the discrepancy.

Appeal

The SMART Act requires the Secretary of HHS to promulgate regulations setting forth a right of appeal and an appeals process under which the claimant representative or applicable plan may appeal the conditional payments determination.

Threshold Excluding Conditional Payment Reimbursement

Conditional payment reimbursement and mandatory reporting will not apply to any settlement, judgment or award from *liability insurance* arising from an alleged physical trauma based incident that falls below a single threshold amount to be calculated by the Secretary of HHS. The threshold will not apply to claims involving ingestion, implantation or exposure. The threshold amount will be calculated by the Secretary of HHS based upon the estimated cost of collection incurred by the United States for conditional payments arising from liability insurance. The threshold exemption is limited to liability insurance and will not apply to settlement of workers' compensation claims.

SCHIP Reporting Fines and Penalties

The current $1,000 a day penalty for violations of Mandatory Insurance Reporting (Section 111) is amended to provide that insurers "may" be subject to a civil money penalty up to $1,000 for each day of non-compliance as opposed to "shall" be subject to such penalty. The SMART Act further provides for an exception to penalties where the plan is able to show that it made good faith efforts to identify the beneficiary for Section 111 reporting purposes but was unable to identify the claimant as a Medicare beneficiary.

Three Year Statute of Limitations

Conditional payments recovery will be subject to a three year statute of limitation calculated from the date of receipt of notice of the settlement, judgment, award or other payment made, *i.e*., Section 111 reporting. It is unclear what impact the new statute of limitation will have regarding future medical expense and Medicare Set-Aside (MSA) accounts. The new statute of limitation is calculated based upon the date in which CMS receives notice of the settlement, judgment or award. If an employer and insurer cannot be held liable for "future" conditional payments more than three years after settlement, then it is plausible to argue that employers and insurers are protected where they fund three years of future medical expense in an MSA as opposed to future medical expense for life. It is highly unlikely that the Center for Medicare and Medicaid Services would ever concede that such an interpretation of the Act is proper. It is plausible, however, that an unintended consequence of the new statute of limitations will effectively bar CMS recovery under the Medicare Secondary Payer Act for future medical expense incurred more than three years post settlement.

Social Security and HIC Numbers

The SMART Act modifies requirements with regard to use of Social Security numbers and HIC numbers for purposes of mandatory insurance reporting. This provision takes effect 18 months after enactment; however, an extension may be sought by HHS as it explores alternatives to the use of Social Security and HIC numbers.

Conclusion

The SMART Act makes several substantial and procedural changes to the Medicare conditional payments process. These changes will provide for an expedited process in which to confirm and 'lock in' the conditional payments amount. Furthermore, parties will put a formal appeals process in place through which conditional payment disputes may be redressed.

About the Author

Bradford J. Peterson is a partner in the Urbana office of *Heyl, Royster, Voelker & Allen, P.C*. Brad concentrates his practice in the defense of workers' compensation, construction litigation, auto liability, premises liability and insurance coverage issues. In recent years, Brad has become a leader in the field on issues of Medicare Set Aside trusts and workers' compensation claims. He has written and spoken frequently on the issue. He was one of the first attorneys in the State of Illinois to publish an article regarding the application of the Medicare Secondary Payer Act to workers' compensation claims "Medicare, Workers' Compensation and Set Aside Trusts," *Southern Illinois Law Journal* (2002).

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