

12

Medicare Secondary Payer Statute

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I. Medicare as a Secondary Payer

- A. [12.1] Introduction
- B. [12.2] Origins of Medicare
- C. Statutory Authority
 - 1. [12.3] Medicare as Secondary Payer
 - 2. [12.4] Conditional Payments by Medicare
- D. [12.5] CMS Memoranda

II. [12.6] Classes of Cases Requiring Consultation with Medicare

- A. [12.7] Medicare Has Made Prior Payments
- B. [12.8] Claimant Is Medicare Eligible
- C. [12.9] Claimant Meets \$250,000/30-Month Threshold

III. Exceptions and Special Situations

- A. [12.10] Accepted Cases Without Compensation for Future Medical
- B. [12.11] Disputed Cases
- C. [12.12] Waiver of Medicare by the Workers' Compensation Settlement Contract
- D. [12.13] Third-Party Claims

IV. Set-Aside Arrangements

- A. [12.14] Set-Aside Arrangements To Protect Medicare from Future Medical Payments
- B. [12.15] Set-Aside Administration
- C. [12.16] Submission of Settlement to Medicare for Approval
- D. [12.17] Criteria Used by CMS To Evaluate Proposed Settlement
- E. [12.18] Speed of Approval
- F. [12.19] Up-Front Settlement Instead of Set-Aside Arrangement
- G. [12.20] Appeals

V. [12.21] Failure To Comply — Enforcement

VI. [12.22] Medicare Contacts

VII. [12.23] Conclusion

I. MEDICARE AS A SECONDARY PAYER

A. [12.1] Introduction

In recent years, settlements under the Illinois Workers' Compensation Act, 820 ILCS 305/1, *et seq.*, have been complicated by the Medicare secondary payer statute (MSP), 42 U.S.C. §1395y(b), and regulations, 42 C.F.R. §411.20. If a settlement falls within the threshold set by Medicare, special consideration must be taken to ensure that Medicare is reimbursed for past medical payments and protected from future medical payments that stem from a compensable work-related injury. The administrative mechanism used to protect Medicare from future payments is referred to as a "set-aside arrangement."

The failure to take the appropriate action, including approval of the settlement by Medicare, can expose the employer, insurer, and their counsel to double damages and duplicate payment for medical bills. In addition, the claimant may be precluded from obtaining Medicare payment for medical bills that would have been paid if prior approval of the settlement had been obtained.

At the outset, it should be noted that consultation with Medicare about future medical payments need be made only when a case is concluded by settlement and the injured worker's medical rights under §8(a) of the Illinois Worker's Compensation Act are closed. If a claimant's medical rights remain open because the case is tried or remain open in the settlement contract, Medicare need not be consulted.

B. [12.2] Origins of Medicare

In 1965, the Social Security Act, 42 U.S.C. §670, *et seq.*, established both Medicare and Medicaid. Medicare was a responsibility of the Social Security Administration (SSA), while federal assistance to the state Medicaid programs was administered by the Social and Rehabilitation Service (SRS). The SSA and the SRS were agencies in the Department of Health, Education, and Welfare (HEW). In 1977, the Health Care Financing Administration (HCFA) was created under the HEW to coordinate Medicare and Medicaid. In 1980, the HEW was divided into the Department of Education and the Department of Health and Human Services (HHS). In June 2001, the HCFA was renamed the Centers for Medicare and Medicaid Services (CMS). See www.cms.hhs.gov/about/history.

C. Statutory Authority

1. [12.3] Medicare as Secondary Payer

The intent of the Medicare secondary payer statute is relatively simple. 42 U.S.C. §1395y(b)(2) provides that Medicare is not required to pay for any item or service to the extent that payment has been made, or can reasonably be expected to be made, under a workers' compensation law or plan.

Section 1395y(b)(2) states:

Medicare secondary payer.

(A) In general. Payment under this title [42 U.S.C. §§ 1395 et seq.] may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that —

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) 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.

In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

See also 42 C.F.R. Part 411.

2. [12.4] Conditional Payments by Medicare

If Medicare determines that the workers' compensation insurer will not pay promptly (within 120 days), providers and suppliers may submit claims to Medicare, and Medicare may make a conditional payment. However, when the proceeds from the settlement become available, Medicare has priority right of recovery as discussed in §12.21 below. 42 U.S.C. 1395y(b)(2)(B).

D. [12.5] CMS Memoranda

Although the Medicare secondary payer statute has been in existence for quite some time, in the last few years, the Centers for Medicare and Medicaid Services has become aggressive in its efforts to require payments and reimbursement by employers and workers' compensation insurers. In furtherance of these efforts, the CMS has issued four key memoranda setting forth its policy concerning its status as a secondary payer. References to these memoranda are made throughout this article:

1. CMS Memo (July 23, 2001), from the Deputy Director of the Purchasing Policy Group, available at www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf;
2. CMS Memo (April 22, 2003), answers to frequently asked questions, issued by the Director of the Center for Medicare Management, available at www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf;

3. CMS Memo (May 23, 2003), answers to frequently asked questions, issued by the Director of the Center for Medicare Management; and
4. CMS Memo (May 7, 2004), CMS policies regarding administrative fees and attorney costs, from the Director of the Center for Medicare Management, available at www.cms.hhs.gov/medicare/cob/providers/wcadminfees5-7-04.pdf.

See also the MEDICARE SECONDARY PAYER MANUAL at www.cms.hhs.gov/manuals/105_msp/msp105index.asp.

II. [12.6] CLASSES OF CASES REQUIRING CONSULTATION WITH MEDICARE

There are three types of cases in which contact with and approval by Medicare is required: (a) Medicare has made prior payment; (b) the claimant is eligible for Medicare; or (c) the settlement meets the 30-month/\$250,000 threshold set forth by the Centers for Medicare and Medicaid Services. If a claim falls within any of these classes, special settlement arrangements must be made to ensure that Medicare's interests are protected, and Medicare must approve settlement of these cases.

A. [12.7] Medicare Has Made Prior Payments

As stated in §12.4 above, Medicare has a priority right of reimbursement for any medical expenses it paid that should have been paid by the workers' compensation carrier. The Medicare secondary payer statute and the regulations require that if the beneficiary or other party receives a third-party payment, the beneficiary or other party must reimburse Medicare within 60 days. 42 C.F.R. §411.24(h). Further, if a third-party payer learns that the Centers for Medicare and Medicaid Services has made a Medicare primary payment for services for which the third-party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim. 42 C.F.R. §411.25(a). Thus, there is an affirmative duty on the part of the workers' compensation carrier to reimburse Medicare when it becomes aware that Medicare paid bills that were the responsibility of the workers' compensation carrier.

B. [12.8] Claimant Is Medicare Eligible

Claimants who are eligible for Medicare are

1. 65 or older;
2. on Social Security disability for 24 months or longer; or
3. suffering from a qualifying end stage renal disorder.

In order to fall within this threshold, it is not necessary that medical bills have already been paid by Medicare, only that the claimant be eligible for Medicare benefits. Social security disability recipients are automatically eligible for Medicare benefits after receiving benefits for 24 months. In fact, social security will automatically enroll a social security disability recipient for Medicare benefits after the 24-month period expires.

There is no dollar amount threshold for this class of case. If a claimant is eligible for Medicare, the Centers for Medicare and Medicaid Services must be consulted when a case is settled regardless of the dollar amount of the settlement unless the case falls within the exception described in §12.10 below. There has been some discussion by the CMS of setting a dollar-amount threshold for this class of case, but as of 2004, none has been established.

C. [12.9] Claimant Meets \$250,000/30-Month Threshold

If a claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000, then approval by the Centers for Medicare and Medicaid Services of the workers' compensation settlement is required.

The CMS' first statement regarding the thresholds for workers' compensation cases settled by injured workers who are not yet Medicare beneficiaries was expressed in its memo of July 23, 2001, available at www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf. Several factors are to be considered in determining whether there is a "reasonable expectation" of Medicare enrollment within 30 months:

1. The individual has applied for social security disability benefits.
2. The individual has been denied social security disability benefits but anticipates appealing that decision.
3. The individual is in the process of appealing and/or re-filing for social security disability benefits.
4. The individual is 62 years and 6 months old (*i.e.*, may be eligible for Medicare based on his or her age within 30 months).
5. The individual has an end stage renal disease (ESRD) condition but does not yet qualify for Medicare based on ESRD.

If any of the above criteria are met, the settlement should be treated as satisfying the 30-month threshold. See CMS Memo (Apr. 22, 2003), Q & A 2, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

The \$250,000 threshold includes future medical payments and indemnity. Payment of past medical expenses is not included in the \$250,000 threshold. If settlement is paid in a structure and the total payments are greater than \$250,000, then the threshold is met. This is true even if the cost of the structured settlement is less than \$250,000. See CMS Memo (Apr. 23, 2003), *supra*, Q & A 17.

Both conditions must be met in order to fall within the threshold. In other words, if the claimant is expected to become a Medicare beneficiary within 30 months but the total settlement is less than \$250,000, then a CMS-approved Medicare set-aside arrangement is unnecessary. CMS Memo (May 23, 2003), Q & A 1. The CMS assumes that when a non-Medicare settlement does not meet the 30-month/\$250,000 threshold, that individual will completely exhaust his or her settlement by the time Medicare eligibility is reached. See CMS Memo (May 23, 2003), *supra*, Q & A 3.

The CMS will not provide verification letters confirming that approval of a Medicare set-aside arrangement is unnecessary. See CMS Memo (May 23, 2003), *supra*, Q & A 2.

III. EXCEPTIONS AND SPECIAL SITUATIONS

A. [12.10] Accepted Cases Without Compensation for Future Medical

In CMS Memo (April 22, 2003), www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf, the Centers for Medicare and Medicaid Services established one exception to the approval requirement for cases that fall within the thresholds described in §§12.8 and 12.9 above. It is not necessary for the parties to establish a set-aside arrangement for Medicare if all of the following criteria are met:

1. 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).
2. 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.
3. 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 workers' compensation injury. See CMS Memo (Apr. 22, 2003), *supra*, Q & A 20.

The language of this exception is cause for concern because it gives the CMS a basis to reject the settlement if it determines that the settlement was made to Medicare's detriment. Thus, the use of this exception should be made with the recognition that there is risk that the CMS might challenge the settlement despite a perceived compliance with the policy statement.

B. [12.11] Disputed Cases

Medicare classifies workers' compensation settlements as either "commutation" or "compromise" cases or both. Commutation cases are settlement awards intended to compensate

individuals for future medical expenses required because of a work-related injury or disease. In contrast, compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (*i.e.*, future medical expenses) are commutation cases. It is possible for a single lump-sum settlement agreement to be both a compromise case and a commutation case. It is important to note that set-aside arrangements are used only in commutation settlements, not settlements that are solely compromise cases. See www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf.

Several factors will be considered by the Centers for Medicare and Medicaid Services when determining whether a case is truly disputed. These include whether there was a preexisting condition, whether the accident was work-related, whether the individual was acting as an employee or performing work-related duties at the time the accident occurred, and the causal relationship. Medicare will generally honor judicial decisions issued by a court of competent jurisdiction after a hearing on the merits of a workers' compensation case. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (*e.g.*, lost wages), then Medicare will accept that designation. However, a distinction must be made when a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. 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 workers' compensation injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire settlement. Medicare will also assert a recovery claim, if appropriate. See CMS Memo (Apr. 22, 2003), Q & A 3, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

C. [12.12] Waiver of Medicare by the Workers' Compensation Settlement Contract

The Centers for Medicare and Medicaid Services cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement. See CMS Memo (Apr. 22, 2003), Q & A 18, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

D. [12.13] Third-Party Claims

To the extent that a liability settlement relieves a workers' compensation carrier from any future medical expenses, a Medicare set-aside arrangement approved by the Centers for Medicare and Medicaid Services is appropriate. The set-aside requires sufficient funds to cover future medical expenses incurred once the total third-party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further work-related medical services. A Medicare set-aside arrangement is also unnecessary if the medical portion of the workers' compensation claim remains open and workers' compensation continues to be responsible for related services once the liability settlement is exhausted. See CMS Memo (Apr. 22, 2003), Q & A 19, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

Although it is beyond the scope of this chapter, two cases are noteworthy regarding the issue of civil tort claims. In *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003), the Fifth Circuit Court of Appeals addressed the issue of whether the Medicare secondary payer statute applied to civil claims. *Thompson* involved a claimant who had two hip replacement surgeries paid by Medicare. The claimant filed a product liability suit against the manufacturer of the prosthesis used in the first surgery, claiming it was defective. The CMS sought reimbursement for the bills it paid from the proceeds of the product liability action. The court held that the CMS was not entitled to recovery from the proceeds of the product liability action under the MSP. It ruled that the manufacturer was not a “primary plan” within the meaning of the MSP and that the product liability defendant was not required to “pay promptly” as required by the statute.

It is significant that the court in *Thompson* relied on the “pay promptly” language of the statute. This language was amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub.L. 108-173, 117 Stat. 2066, and the “promptly” portion of the statute was removed. It would be surprising if the CMS did not use this amendment to make another attempt at extending the MSP to general civil tort claims.

The issue was addressed again in *United States v. Baxter International, Inc.*, 345 F.3d 866 (11th Cir. 2003), *cert. denied*, 124 S.Ct. 2907 (2004). *Baxter* involved a class action product liability suit against manufacturers of silicone breast implants. The CMS sought recovery for medical bills it paid on behalf of Medicare beneficiaries who received silicone breast implants. The district court dismissed the CMS’ complaint, but the Eleventh Circuit reversed and remanded the case, finding that Medicare had a right of recovery. Obviously, the case is important because it extended the MSP to civil class-action settlements.

IV. SET-ASIDE ARRANGEMENTS

A. [12.14] Set-Aside Arrangements To Protect Medicare from Future Medical Payments

Although the Medicare secondary payer statute requires that all workers’ compensation settlements adequately consider Medicare’s interests, neither the MSP nor the regulations mandate what particular type of administrative mechanism should be used to protect Medicare’s interests. Medicare requires that funds be set aside to pay for future medical bills incurred because of a work-related condition. These funds are referred to by the Centers for Medicare and Medicaid Services as “set-aside arrangements.” Set-aside arrangements are used in commutation cases, in which an injured individual is disabled by the event for which workers’ compensation is making payment but the individual will not become entitled to Medicare until some time after the workers’ compensations settlement is made. See CMS Memo (July 23, 2001), www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf.

Medicare contemplates that set-aside arrangements will be either in the form of a lump sum or a structured annuity. The set-aside should be an amount sufficient to pay for reasonably expected, causally related medical bills for the life expectancy of the petitioner. See CMS Memo, *supra*, Q & A 6. Set-aside arrangements are most often used in those cases in which the injured worker is relatively young and has an impairment that seriously restricts his or her daily living. The set-aside is usually not created until the injured worker has stabilized so that it can be determined, based on past experience, what the future medical expenses are expected to be. *Id.*

It is important to understand that Medicare set-aside funds are not to be used to pay medical bills until the claimant actually becomes eligible for Medicare. Bills incurred prior to Medicare eligibility must be paid from another source. CMS Memo (May 23, 2003), Q & A 4.

With the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, consideration of expenses for prescription medications will almost certainly at some point be part of the set-aside arrangement. Medicare is to begin covering prescription drugs in 2006. As of 2004, the policies and procedures for including the costs of prescription medications in a set-aside arrangement have not yet been clarified by the CMS. The issue is complicated because the exact amount to be paid by Medicare will depend on the premium paid by the recipient.

B. [12.15] Set-Aside Administration

Although the purpose of the set-aside is simple, the administration of set-asides is quite complex. The regulations require that

[i]f a lump-sum compensation award stipulates that 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. 42 C.F.R. §411.46(a).

As set forth in Q & A 3 in CMS Memo (July 23, 2001), www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf, when the Centers for Medicare and Medicaid Services regional office approves a set-aside arrangement, the office will check the national Medicare Enrollment Database on a monthly basis in order to determine when an injured individual actually becomes enrolled in Medicare. Once the CMS regional office verifies that the injured individual has actually been enrolled in Medicare, the office will assign a contractor responsible for monitoring the individual's case. In Illinois, this contractor may be contacted at

AdminaStar Federal
225 N. Michigan Ave., Ste. 600
Chicago, IL 60601
Phone: 312/297-4500 or 312/938-6266
www.adminastar.com

When the injured individual has actually been enrolled in Medicare, the CMS regional office must provide the coordination of benefits contractor (COBC) with identifying information to add a workers' compensation record to a common working file.

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for ensuring/verifying that the funds allocated to the set-aside arrangement were

expended on medical services for Medicare-covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

In structured set-aside arrangements, the CMS will not make any payments until the contractor monitoring the case can verify that the funds apportioned to that period of time, including any amounts carried forward, have been exhausted. See CMS Memo (Apr. 22, 2003), Q & A 9, 10, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

The CMS permits set-aside arrangements to be self-administered but cautions that self-administered set-asides must comply with all the formal rules and requirements as with any other set-aside arrangement. See CMS Memo (Apr. 22, 2001), *supra*, Q & A 8.

In a recent policy change expressed in CMS Memo (May 7, 2004), www.cms.hhs.gov/medicare/cob/providers/wcadminfees5-7-04.pdf, the CMS stated that administrative fees/expenses and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement cannot be charged to the set-aside arrangement. These funds must come from some other source that is completely separate from the set-aside.

C. [12.16] Submission of Settlement to Medicare for Approval

Once the settlement is agreed on by the parties, various materials must be submitted to Medicare so that approval can be obtained. The Centers for Medicare and Medicaid Services has authority under the regulations to review a proposed settlement including a set-aside arrangement and can give a written opinion, on which the parties can rely, regarding whether the workers' compensation settlement has adequately considered Medicare's interests. See CMS Memo (July 23, 2001), Q & A 3, www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf.

Obviously, the proposed settlement should not be submitted to the CMS before it has been approved by the parties. Once the CMS approves a settlement, it is unlikely to agree to a modification of the terms that reduces the set-aside for future medical payments.

At a minimum, the documentation submitted to the CMS regional office for approval should include

1. a proposed settlement agreement;
2. a life care plan (if available);
3. an estimate of the injured individual's life span; and
4. documentation giving the basis for the amounts of projected expenses for Medicare-covered services and services not covered, including medical records and physical reports. See CMS Memo (July 23, 2001), *supra*, Q & A 10.

Medicare will consider a life care plan from a non-treating physician if the physician does all of the following:

1. examines the workers' compensation claimant;
2. reviews the claimant's medical records;
3. contacts any of the claimant's treating physicians (if applicable);
4. is available to answer the CMS' questions;
5. prepares a report that summarizes the above; and
6. offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury.

The CMS does not consider such a life care plan automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question, such as contrary evidence or internal conflicts, or if the plan is not credible on its face. See CMS Memo (Apr. 22, 2003), Q & A 15, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

Example life care plans are available at www.prc-usa.com/pdfs/Jane%20Doe%20Life%20Care%20Plan.pdf (case sensitive).

The CMS recently created a central depository for workers' compensation settlement approvals. All proposed workers' compensation settlements should be submitted to

MEDICARE — COB
Voluntary Agreement Project
P.O. Box 660
New York, NY 10274-0660

D. [12.17] Criteria Used by CMS To Evaluate Proposed Settlement

If Medicare has already made conditional payments, its repayment has to be taken into account, in addition to the following criteria that will be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the cost of a work-related injury or illness to Medicare:

1. date of entitlement to Medicare;
2. basis for Medicare entitlement;
3. type and severity of injury or illness;
4. age of beneficiary;

5. workers' compensation classification of beneficiary;
6. prior medical expenses paid by the workers' compensation carrier due to the injury or illness in the one- or two-year period after the condition has stabilized;
7. amount of lump-sum or of structured settlement;
8. whether the commutation is for the beneficiary's lifetime or for a specific time period;
9. whether the beneficiary is living at home, living in a nursing home, or receiving assisted living care; and
10. whether the expected expenses for Medicare-covered items and services are appropriate in light of the beneficiary's condition. See CMS Memo (July 23, 2001), Q & A 5, www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf.

E. [12.18] Speed of Approval

The Centers for Medicare and Medicaid Services regional offices claim to seek to review and make a decision regarding proposed workers' compensation settlements within 45 to 60 days from the time that all necessary/required documentation has been submitted. See CMS Memo (Apr. 22, 2003), Q & A 6, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf. In practice, the time for approval varies greatly and is frequently much longer than claimed by the CMS.

F. [12.19] Up-Front Settlement Instead of Set-Aside Arrangement

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when the workers' compensation carrier did not pay promptly. See CMS Memo (July 23, 2001), Q & A 8, www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf.

G. [12.20] Appeals

The Centers for Medicare and Medicaid Services has no formal appeals process for rejection of a Medicare set-aside arrangement. However, when the CMS does not believe that a proposed set-aside adequately protects Medicare's interests, the parties may provide additional information/documentation in order to justify their proposal. If the additional information does not convince the CMS to approve the set-aside arrangement and the parties proceed to settle the case despite the objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. When Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. See CMS Memo (Apr. 22, 2003), Q & A 14, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

V. [12.21] FAILURE TO COMPLY — ENFORCEMENT

There are two bad things that can happen if the Medicare secondary payer statute is ignored. First, the claimant may not be able to get medical bills paid by Medicare that might have otherwise been paid if Medicare had been considered. Second, the MSP provides for direct action by the Centers for Medicare and Medicaid Services to recover conditional payments and for a private cause of action against the workers' compensation carrier for failure to provide primary payment or appropriate reimbursement. 42 U.S.C. §1395y(b)(3)(A); 42 C.F.R. §411.24. Actions may be brought within three years from the date that the item of service was provided. 42 U.S.C. §1395y(b)(2)(B).

Pursuant to 42 C.F.R. §411.24(g), the 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. Moreover, pursuant to 42 C.F.R. §411.26, the CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a third-party payer. Therefore, pursuant to 42 C.F.R. §411.24(b), the CMS may initiate recovery against the parties listed under 42 C.F.R. §411.26 as soon as it learns that payment has been made or could be made under workers' compensation.

The CMS claims it has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third-party payment directly or indirectly. 42 C.F.R. §§411.24(b), 411.24(e), 411.24(g), 411.26. See CMS Memo (Apr. 22, 2003), Q & A 13, 22, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

Double damages are available only if the CMS initiates legal action to recover conditional payments. 42 C.F.R. §411.24(c). Damages are not limited to the amount of the settlement but extend to all payments made by the CMS for work-related charges. *Id.* Accordingly, an insurer could potentially be required to make triple payment, once to the claimant and double to the CMS in litigation to recoup conditional payments.

VI. [12.22] MEDICARE CONTACTS

The first report of attorney representation of a Medicare beneficiary for a workers' compensation claim should be made to the Centers for Medicare and Medicaid Services Coordination of Benefits (COB) Contractor. Attorneys can call the COB Contractor from 8 a.m. – 8 p.m., Monday – Friday, Eastern time at 800/999-1118. More information is available at <http://cms.hhs.gov/medicare/cob>.

Settling parties should also contact the CMS regional office responsible for a particular state for approval of a Medicare set-aside arrangement. The inquiry should be directed to the attention of the "Regional Office Medicare Secondary Payer Coordinator," who will forward the inquiry to the appropriate regional office if a transfer is necessary. See CMS Memo (Apr. 22, 2003), Q & A 23, www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf.

VII. [12.23] CONCLUSION

The Medicare secondary payer statute places significant risk on the parties and their counsel for failing to consider Medicare's interests in a workers' compensation settlement if the claimant is currently eligible for Medicare or the settlement satisfies the 30-month/\$250,000 threshold. If applicable, the MSP requires that the proposed settlement be submitted and approved by the Centers for Medicare and Medicaid Services.

