

# Medicare Secondary Payer Issues

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As everyone knows, it is imperative that each knight shall have a lady – for a knight without a lady is like a body without a soul. To whom would he dedicate his conquests? What vision sustain him when he sallies forth to do battle with ogres and with giants?<sup>3</sup>

## Introduction:<sup>4</sup>

Litigators, as a rule, prefer to focus on slaying the nursing home ogres and giants. After that battle, however, we must continue the fight or we may discover that we have lost the war. As Quixote fought *for* Aldonza, we must fight *for our clients* by minimizing liens after the case is settled or the verdict is taken.<sup>5</sup> (To put this in familiar terms, it isn't enough to simply reach "Mount Doom;" we must cast the ring into the fire). We do this to ensure that the recovery is paid to the innocent party and, where the victim remains alive, to improve the quality of his or her life.<sup>6</sup>

Initially, lawyers should always discuss potential liens with clients *before* filing suit. This allows the client to consider whether to bring the suit at all and, if suit is brought, what the case must settle for to satisfy potential liens. Some clients may decide to forego litigation if "the government is going to get everything anyway." If litigation goes forward after this conversation, the potential for having an unhappy client when funds are disbursed is diminished.<sup>7</sup>

In nursing home cases (and other injury cases), the injured party's recovery may be reduced if a third party financed the cost of long term care (e.g., the Medicare or Medicaid programs). Under those circumstances, payback issues must be considered. In death cases, liens and estate recovery issues must be considered. In injury cases, the issues requiring consideration are liens and continuity of public benefits. This paper addresses both with a view toward maximizing the client's recovery.

Since the focus of this conference is nursing home litigation, as a starting point, it is worth considering how nursing home care is funded. In 2001, 7% of all U.S. health care

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<sup>3</sup> D. Wasserman, *Man from La Mancha* 32 (Random House 1966).

<sup>4</sup> Many of the issues addressed in this paper were also addressed in Kennard Bennett's paper, *Settlement Issues in Nursing Home Cases: Medicare Liens, Medicaid, and Other Complications*, ATLA's Litigating Nursing Home Cases, April 20-21, 2001. Mr. Bennett's paper can be purchased through the ATLA exchange.

<sup>5</sup> This paper is limited to Medicare, Medicaid and eligibility issues. It does not focus on settlement strategies generally, or on other subrogation issues. For a discussion of settlement strategies in nursing home cases, see S. Horowitz, *Settlement Strategies*, Chapter 13 in *Nursing Home Litigation: Pretrial Practice and Trials* (Lawyers & Judges Publishing Company, Inc. 2001). For a general discussion of subrogation issues, see D. Roberts, *Subrogation* (Ohio Academy of Trial Lawyers, July 2003) (available for online purchase at <http://www.oatlaw.org/>); and see K. Canfield, *The Changing World of Collateral Sources, Subrogation and Reimbursement: Revisited* (Georgia Trial Lawyers Association, August 13, 1999).

<sup>6</sup> It is worth noting that the principal focus of Elder Law, as opposed to Estate Law, is on improving the quality of life for *living* Elders. See Takacs & McGuffey, *The Elder Centered Law Practice: What it is, How to Attain It*, presented at North Carolina Bar Association, *8<sup>th</sup> Annual Elder Law Symposium* (Feb. 27, 2004).

<sup>7</sup> We suggest that you make this disclosure in writing as part of your engagement letter.

expenses related to nursing home care.<sup>8</sup> \$98.9 billion was paid for nursing home care, with an additional \$33.2 billion on home health care.<sup>9</sup> Regarding nursing home care, consumers paid \$26.9 billion out of pocket and private insurers paid an additional \$7.5 billion.<sup>10</sup> Federal funds paid \$41.8 billion and State and Local government funds paid \$19 billion.<sup>11</sup>

In 2001, approximately 11.2% of nursing home care was funded by the Medicare program, while 47% was funded by the Medicaid program.<sup>12</sup> The remainder was funded privately, either with the resident's own funds or with a long term care insurance policy. The following table illustrates the payment trend from 1980 through 2001:

Year	Total <sup>13</sup>	Out-of-Pocket Payments	Third-Party Payments						Medicare	Medicaid
			Total	Private Health Insurance	Other Private Funds	Public				
						Total	Federal	State and Local		
<b>Amount in Billions</b>										
1980	\$17.7	\$7.1	\$10.6	\$0.2	\$0.8	\$9.6	\$5.7	\$3.9	\$0.3	\$8.9
1988	40.5	15.6	24.9	2.2	2.7	20.1	12.0	8.1	0.7	18.4
1990	52.7	19.8	32.9	3.1	3.9	25.9	15.8	10.2	1.7	23.2
1997	85.1	21.8	63.3	7.1	5.2	51.0	34.0	17.0	9.6	39.6
1998	89.1	24.9	64.2	7.4	4.6	52.3	35.0	17.2	10.2	40.1
1999	89.6	25.4	64.2	7.5	4.5	52.2	34.3	17.9	8.4	41.8
2000	93.8	26.2	67.6	7.3	4.1	56.2	37.7	18.5	9.5	44.6
2001	98.9	26.9	72.0	7.5	3.7	60.9	41.8	19.0	11.6	47.0
<b>Projected</b>										
2002	103.7	27.3	76.4	7.7	3.3	65.3	44.7	20.6	12.1	50.8
2003	108.2	28.3	79.9	8.2	3.3	68.4	46.5	21.9	11.8	54.0
2004	113.3	29.3	83.9	8.9	3.4	71.7	48.6	23.1	12.0	57.0
2012	178.8	41.1	137.6	16.0	3.8	117.8	80.5	37.2	21.2	91.9

Source: excerpts from *CMS National Health Accounts*, historical data at: <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp>; and projections at <http://www.cms.hhs.gov/statistics/nhe/projections-2002/t13.asp>.

In 2001, approximately 72% of the nursing home care provided was funded by third party payments, with that number climbing each year. Thus, it appears safe to presume that most clients who recover funds through nursing home litigation must address third-party payback issues related to participation in these programs.

<sup>8</sup> Nationally, in 2001, public funds paid for 46% of all health care costs. See CMS, National Health Accounts.

<sup>9</sup> See CMS National Health Accounts, Table 1, at <http://www.cms.hhs.gov/statistics/nhe/definitions-sources-methods/>. The figure for nursing home care is projected to reach \$166.4 Billion annually by 2011. See S. Heffler et al., *Health Spending Projections for 2001-2011: The Latest Outlook*, 21 *Health Affairs* 207, 208 (March/April 2002).

<sup>10</sup> See CMS National Health Accounts, Table 1, *supra*.

<sup>11</sup> *Id.*

<sup>12</sup> See CMS, National Health Accounts, Table 7, at <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp>.

<sup>13</sup> Table figures represent dollars in "Billions."

Among the issues that must be considered are:

- Medicare Liens;
- Medicaid Liens;
- Medicaid Estate Recovery;
- Continued Eligibility for Benefits; and
- Special Needs Trusts.

## Medicare and Medicaid Distinguished

Although Medicare and Medicaid are fundamentally different, few clients (and too few lawyers) understand the differences relating to eligibility, coverage and benefits for these two government programs. Medicare is an entitlement program and provides *little* assistance in funding the cost of long-term care.<sup>14</sup> It is often compared to health insurance and is designed for persons over 65 years of age, or who are disabled.<sup>15</sup> Medicare is funded through payroll deductions and premium payments.<sup>16</sup> Entitlement to Medicare is not affected by the amount of income or assets received or owned by the recipient.<sup>17</sup>

Medicare pays for critical care services such as hospitalization (Part A), and for physician services and durable medical equipment (Part B).<sup>18</sup> If during a “spell of illness”<sup>19</sup> a nursing home resident requires *skilled care*<sup>20</sup> following a qualifying hospitalization,<sup>21</sup> then Medicare will pay for 100% of (up to) the first 20 days, and will pay all but the daily deductible for (up to) the next 80 days.<sup>22</sup> In **2004**, the daily deductible is **\$109.50**. After the first 100 days, there is no Medicare coverage for nursing home care (absent a new spell of illness).

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<sup>14</sup> Medicare was established in 1965, under Title XVIII of the Social Security Act (42 U.S.C. § 1395), to pay medical expenses for persons who receive Social Security retirement benefits or Social Security disability income.

<sup>15</sup> See, generally, Part A, 42 C.F.R. § 406.10 to 406.13; Part B, 42 C.F.R. § 407.10.

<sup>16</sup> Part A is funded through payroll deductions and Part B is funded through monthly premiums. Part B premiums are generally deducted from the recipient’s monthly Social Security check. In **2004**, the Part B monthly premium is \$66.60.

<sup>17</sup> See J. Stein & A. Chiplin, *2003 Medicare Handbook* § 1.01 (Aspen). The Medicare Prescription Drug, Improvements and Modernization Act of 2003 (P.L. 108-173) (the “Medicare Act of 2003”), signed by President Bush on December 8, 2003, will alter this rule, somewhat, at least with respect to prescription drugs.

<sup>18</sup> Coverage for Parts A and B is summarized in the *2003 Medicare Handbook*, supra, at § 1.05.

<sup>19</sup> The phrase “spell illness” refers to the Medicare benefit period, which is defined at 42 C.F.R. § 409.60. In general terms, a benefit period is 90 days and begins on the first day the beneficiary receives inpatient care and ends 60 days after payments terminate for the condition that initiated the need for care. Thereafter, a new benefit period can begin. See *2003 Medicare Handbook* § 1.05[A][1].

<sup>20</sup> 42 C.F.R. § 409.32 to 409.33.

<sup>21</sup> A qualifying hospitalization is a three day stay, not counting the day of discharge. See 42 U.S.C. § 1395x(i); 42 C.F.R. § 409.30.

<sup>22</sup> 100 days are not guaranteed. If skilled care is no longer necessary, then Medicare may cover fewer than 100 days.

Assuming Medicare pays for the first 100 days of nursing home care, when it runs its course, Medicaid is the only government program that will pay the cost of nursing home care.

Unlike Medicare, Medicaid is a public assistance (welfare) program.<sup>23</sup> Medicaid eligibility is “means-tested.” Applicants are eligible only if other criteria are met and **countable** income and **countable** resources (assets) are below the eligibility limits. (“Countable” resources are those resources remaining after certain exclusions are taken into account.)<sup>24</sup> A sudden infusion of income or assets (e.g., a tort recovery) can result in a loss of benefits.

Medicaid eligibility rules will vary from State to State because Medicaid is a program jointly funded by the Federal and State governments.<sup>25</sup> While Congress establishes the Medicaid eligibility criteria, each state applies the criteria as it sees fit. The general criteria is that one must be **aged, blind, or disabled**,<sup>26</sup> have **no more than \$2,000 in countable resources**, and may retain exempt resources including the home place, an automobile, certain life insurance, burial spaces, and limited funds designated for incidental funeral expenses.<sup>27</sup> If the Medicaid applicant is married the limits are increased somewhat, depending on the criteria of the specific Medicaid program (in 2004, the Community Spouse Resource Allowance is up to \$92,760).<sup>28</sup>

Medicaid pays for a broad range of medical services, including hospitalization, prescription drugs, nursing home care and doctor visits. Although the focus here is “nursing home Medicaid,” it is worth noting that there are numerous Medicaid programs available to persons based on variations of income, resources, age, type of disability and institutionalization. In Georgia and Tennessee, applicants who receive Supplemental Security Income (SSI) payments (monthly cash assistance payments from the Social Security Administration to the low-income disabled to help pay for basic food/clothing/shelter needs) automatically receive Medicaid assistance.<sup>29</sup>

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<sup>23</sup> Medicaid was also established in 1965, under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), as a federal-state partnership designed to provide medical care to low-income persons who are aged, blind or disabled. Every state has voluntarily elected to participate in the Medicaid program, and the various states bear from 50% to 80% of the cost of such medical assistance. Regulations covering the Medicaid program generally appear at 42 C.F.R. Part 430 and at 20 C.F.R. Part 416.

<sup>24</sup> Other circumstances would include citizenship, state of residence and similar matters. In this paper, only financial criteria are considered.

<sup>25</sup> Here we consider the Federal rules as well as the Georgia and Tennessee eligibility rules. Counsel should consult an attorney experienced in Medicaid matters in the appropriate jurisdiction.

<sup>26</sup> O.C.G.A. §49-4-81.

<sup>27</sup> HCFA Transmittal 64 (included in the State Medicaid Manual) § 3257.B.4 (applying the same resource definition used in the SSI regulations); 42 U.S.C. §1382b; 20 C.F.R. §416.1210; O.C.G.A. §49-4-6(a); Volume II/MA, MT 1-01/02 §§2300 *et seq.*

<sup>28</sup> Although a thorough discussion of Medicaid Planning is beyond the scope of this paper, the CSRA is addressed at 42 U.S.C. § 1396r-5.

<sup>29</sup> 42 U.S.C. §1396a(a)(10)(A)(i)(II); Ga. Medicaid Manual, Volume II/MA, MT 1-01/02 §2111-1; Tenn. Comp. R. & Regs. 1200-13-12-.02(1)(c); 1200-13-13-.02(1)(c).

## Ethical Obligations to Creditors

Under Rule 1.15 of the Model Rules of Professional Conduct, the personal injury lawyer has a duty to his or her client's creditor if the creditor has an interest in settlement proceeds.<sup>30</sup> The ABA's version of Model Rule 1.15 is as follows:

(a) A lawyer shall hold property of clients or third persons that is in a lawyer's possession in connection with a representation separate from the lawyer's own property. Funds shall be kept in a separate account maintained in the state where the lawyer's office is situated, or elsewhere with the consent of the client or third person. Other property shall be identified as such and appropriately safeguarded. Complete records of such account funds and other property shall be kept by the lawyer and shall be preserved for a period of [five years] after termination of the representation.

(d) Upon receiving funds or other property in which a client or third person has an interest, a lawyer shall promptly notify the client or third person. Except as stated in this rule or otherwise permitted by law or by agreement with the client, a lawyer shall promptly deliver to the client or third person any funds or other property that the client or third person is entitled to receive and, upon request by the client or third person, shall promptly render a full accounting regarding such property.

(e) When in the course of representation a lawyer is in possession of property in which two or more persons (one of whom may be the lawyer) claim interests, the property shall be kept separate by the lawyer until the dispute is resolved. The lawyer shall promptly distribute all portions of the property as to which the interests are not in dispute.<sup>31</sup>

In his article, Cork differentiates between legal claims and equitable claims, concluding that the lawyer has no duty absent a valid interest in the proceeds (e.g., a perfected lien).<sup>32</sup> If there is a valid legal claim, then even if the client objects, the lawyer should disclose the existence of the settlement because Rule 1.15 takes precedence over client confidentiality in that instance.<sup>33</sup> Where there is no valid objection to the claim, the lawyer should pay the creditor even over the client's objection.<sup>34</sup> However, where the claim is disputed, several approaches may be considered. First, the lawyer may interplead the opposing claims. Second, the lawyer may hold the funds in trust until the dispute is resolved. Also, the lawyer may seek a declaratory judgment or attempt mediation. However, the lawyer may not unilaterally "settle" the dispute and may not simply sit on the money for a prolonged period of time.

Recently, in *In re Allen*, 2004 WL 231507 (Ind. 2004), the court disciplined counsel, finding that:

"Beginning in 1998, [attorney Young] represented a client on a claim for injuries she suffered in an automobile accident. During the proceedings, the client received \$4,786 in services from a chiropractor. Young and the client signed a "Doctor's Lien," which

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<sup>30</sup> C. Cork, *A Lawyer's Ethical Obligations When the Client's Creditors Claim a Share of the Tort Settlement Proceeds*, 39 *Tort Trial & Insurance Practice* L.J. 121, 123 (2003).

<sup>31</sup> In Tennessee, see T.R.P.C. Rule 1.15(b); in Georgia, see G.R.P.C. Rule 1.15(I).

<sup>32</sup> "The ethics opinions all agree that an interest includes undisputed statutory [e.g., Medicare and Medicaid] liens, ..." *Cork*, at 124.

<sup>33</sup> *Cork*, *supra*, p. 132.

<sup>34</sup> *Id.*, at 133, and authority cited at fn. 104.

provided, *inter alia*, that the respondent would "withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect" the chiropractor. Although \$2,021.29 of the chiropractor's bill was paid, a balance of \$2,764.71 remained when the client's case settled for \$50,000. The client advised Young that she thought the chiropractor had overcharged her for services. She directed Young to pay to the chiropractor only \$1,000 from the settlement proceeds. Pursuant to the client's instruction, Young disbursed only \$1,000 to the chiropractor despite the outstanding "Doctor's Lien" and the fact that the chiropractor claimed he was still owed \$2,764.71. Young then forwarded \$1,764 to the client from the settlement proceeds, which represented the claimed unpaid portion of the chiropractor's bill."

The court found that Young violated Rule 1.15. "Implicit in [Rule 1.15 is the obligation that] a lawyer hold disputed funds in trust until the dispute is resolved so that the lawyer can effect accurate disbursement. Moreover, as the Comment to Prof. Cond. R. 1.15(b) indicates, a lawyer should not unilaterally settle a dispute between his client and a third party." For violating the Rule, Young was subjected to public reprimand. A similar result was reached in State ex rel. Oklahoma Bar Ass'n v. Taylor, 71 P.3d 18 (Okla. 2003).<sup>35</sup>

The ethics opinions suggest that statutory liens are ignored at the lawyer's peril.

## **Medicare Liens & Medicare Secondary Payer**

### *The Current State of Affairs*

"We do not yet *know* all the basic laws: there is an expanding frontier of ignorance."<sup>36</sup>

"In 1980 Congress prohibited Medicare from paying for health services that are also covered by other insurers though its creation of the Medicare Secondary Payer (MSP) program."<sup>37</sup> The legislative history of the MSP provisions reveal that "it is expected that Medicare will ordinarily pay for the beneficiary's care in the usual manner and then seek reimbursement from the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined. H.R. Rep. No. 96-1167 (1980), *reprinted in* 1980 U.S.C.C.A.N. at 5752."<sup>38</sup> Medicare contends that the MSP program applies to recoveries from liability carriers,<sup>39</sup> and that it has both

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<sup>35</sup> "Where a lawyer knows there is a dispute over funds in his hands **and** he is unaware at the time of disbursement, under applicable law, who is actually entitled to the funds, he violates Rule 1.15(b) and/or (c) when he disburses the disputed funds to a disputant, even though in hindsight under the applicable law it might eventually be judicially decided the funds were disbursed correctly because one or more of the disputants had no valid claim to the funds or a portion thereof." *Taylor*, at 27.

<sup>36</sup> R. Feynman, *Six Easy Pieces: Essentials of Physics Explained By Its Most Brilliant Teacher*, 2 (Helix Books 1997, California Institute of Technology 1963).

<sup>37</sup> See *2003 Medicare Handbook*, *supra*, § 9.01; see also *Fanning v. U.S.*, 346 F.3d 386, 388 (3rd Cir. 2003); see also H. McCormick, *supra*, § 1:67 et seq.

<sup>38</sup> *Bird v. Thompson*, 2003 WL 21537748, \*2 (S.D. N.Y. 2003).

<sup>39</sup> 42 C.F.R. § 411.20(a)(2)(ii). The legislative history for the MSP statute indicates Congress's intent that Medicare recover conditional payments "from the liability insurer or any entity paid by the liability insurer." See H.R. Rep. No. 247, 101st Cong., 1st Sess. 1021 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2492.

a subrogation claim and a statutory cause of action to collect funds from any entity that is required to reimburse Medicare.<sup>40</sup> The “Medicare lien” or “Super Lien” is the 800 pound gorilla that all parties must address following settlement or verdict.<sup>41</sup>

The MSP claim springs into being when a liable third party makes payment.<sup>42</sup> The premise underlying the MSP program is that third parties may not shift the cost of medical expenses attributed to their wrong-doing from themselves to the tax-payers.<sup>43</sup> The MSP statute is codified at 42 U.S.C. § 1395y(b). The regulations implementing the MSP statute appear at 42 C.F.R. 411.20, et seq.

Before discussing how to address Medicare liens, a review of recent case law is in order.<sup>44</sup> Various courts have held that defendants in tort cases are not primary insurance plans and, thus, MSP does not apply.<sup>45</sup> For the reasons discussed below, reliance on holdings in those cases may not be prudent.

By way of example, a group of Medicare recipients, in *Mason v. American Tobacco Co.*, 346 F.3d 36 (2<sup>nd</sup> Cir. 2003), argued that tobacco companies were primary payers for health care services needed by Medicare beneficiaries suffering from tobacco-related illnesses. The Second Circuit, in ruling against the plaintiffs, reasoned:

Plaintiffs argue that each defendant in this action "is a self-insured plan as a matter of law because the corporate structure through which each conducts its business has the purpose and legal effect, in part, to assume legal liability for injury." Plaintiffs' Brief at 15. That is, the corporate form in and of itself is a means of self-insurance because it allows individual directors and shareholders to shift liability from themselves to the corporation. Or, as the plaintiffs put it, "it is commonly recognized that liability insurance and the

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<sup>40</sup> See 42 U.S.C. § 1395y(b)(2)(B)(ii) and (iii); and 1395y(b)(2)(C). See also 42 U.S.C. § 2651 to § 2653 (Medical Care Recovery Act). The United States, at least, takes the position that it has two causes of action. That position was criticized in *In re Dow Corning Corp.*, 250 B.R. 298 (Bkrcty. E.D. Mich. 2000), and in other cites cited therein. In practice, Medicare rarely joins a pending case, but its right to do so or to file a separate action means that it is not bound by state court actions. See T. Nyzio, *Medicare Recovery in Liability Cases*, South Carolina Lawyer, page 22 (May/June 1996).

<sup>41</sup> Medicare contends that its claim has priority all other claims. *Medicare Intermediary Manual* § 3418. All parties must take Medicare into account because CMS takes the position that Medicare is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party provider. 42 C.F.R. § 411.26 (emphasis added); see *U.S. v. Sosnowski*, 822 F.Supp. 570 (W.D. Wis. 1993) (where Medicare took a judgment against plaintiff and his attorney). Further, the United States may offset against moneys owed by the government, such as Social Security benefits. See 20 C.F.R. § 404.502; see also 31 U.S.C. § 3716. Plaintiff's lawyers should be aware of Medicare's claim. See, e.g., *Matter of Riley*, 1994 WL 413173 (Cal. Bar Ct. 1994) (Disciplinary hearing where State Bar's notice to show cause alleged that respondent knew or should have known that Medicare would have a lien against the settlement, and that he failed to honor Medicare's statutory lien).

<sup>42</sup> Medicare Intermediary Manual § 3418.6.

<sup>43</sup> *United States v. Baxter International, Inc.*, 345 F.3d 866, 875 (11<sup>th</sup> Cir. 2003).

<sup>44</sup> Numerous resources exist to aid litigators including the Nursing Home Law Letter. Subscribers receive the “E-Bulletin” which, on October 30, 2003, re-capped the MSP program.

<sup>45</sup> See e.g., *Thompson v. Goetzmann*, 315 F.3d 457 (5<sup>th</sup> Cir. 2002) (“an alleged tortfeasor who settles with a plaintiff is not, *ipso facto*, a “self-insurer” under the MSP statute”), reh'g, 337 F.3d 489 (2003); *United States v. Baxter Intern.*, *supra*; *Mason v. American Tobacco Company*, 346 F3d 36 (2<sup>nd</sup> Cir. 2003).



corporate structure accomplish the same ends, and are 'substitutes' for each other." Plaintiffs' Brief at 41. **The obvious problem with this approach is that it turns every corporation into an insurance company subject to suit under the MSP statute. But courts have uniformly rejected similar readings of the statute as seriously overbroad. The rejection is best stated in Philip Morris II: Its logical implication is that any [corporate] entity with a risk of legal liability which chooses to retain any portion of that risk, no matter how small, may be pursued under MSP on the ground that it is a "self-insured plan."** ... The practical effects of [this] conception of MSP liability would transform the statute, meant primarily for use against insurers, see Philip Morris [I], 116 F.Supp.2d at 146 n. 22, into the very "across-the-broad procedural vehicle for suing tortfeasors," which this Court has already declared impermissible. *Id.* at 135. Significantly, the Government is unable to provide any logically consistent way in which this outcome could be averted. Philip Morris II, 156 F.Supp.2d at 7-8.

*Mason, supra*, at 40 (emphasis added). The Court concluded that future amendments will be required for the statute to extend to the defendants in this action. *Id.*, at 43.

It took Congress only 36 days to develop the "future amendments" alluded to in *Mason*, altering its result. On December 8, 2003, President Bush signed the Medicare Act of 2003.<sup>46</sup> The revisions to the MSP program appear in Title III, at section 301.

Following passage of the Medicare Act of 2003, *Mason*, *Goetzmann* and *Baxter* are of questionable assistance. Congress undercut the reasoning in those decisions by crafting a new definition of primary insurance plan. Now, 42 U.S.C. § 1395y(b)(2) reads: "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." Thus, the hypothetical discussed in *Mason* is now reality and every business is now a self-insured plan.

The Medicare Act of 2003 makes other changes as well, in an attempt to close perceived "loop holes" in the MSP. For example, Section 301(b)(2) of the act makes it clear that a compromise, waiver or release, regardless of whether there is an admission of liability, will demonstrate a plan's responsibility to reimburse Medicare.<sup>47</sup> Reimbursement is no longer tied to anticipation of "prompt" payment; instead, the Medicare Act of 2003 provides that the Secretary may make conditional payments "if a primary plan ... has not made or cannot reasonably be expected to make payment with respect to such item or services promptly."<sup>48</sup>

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<sup>46</sup> Medicare Prescription Drug, Improvement and Modernization Act of 2003, P.L. No. 108-173, 117 Stat. 2066.

<sup>47</sup> This language, apparently responds to the Court's reasoning in *Goetzmann, supra*, 315 F.3d at 463; see also *In re Dow Corning Corp.*, 250 B.R. 298, 341-342 (Bkrtcy. E.D. Mich. 2000) (rejecting the government's argument that payment equates to an admission of liability; the court noted that defendants may settle cases for many reasons, some unrelated to actual tort liability).

<sup>48</sup> See *Thompson v. Goetzmann*, 2001 WL 771012 (N.D. Tex. 2001); *Goetzmann, supra*, 315 F.3d at 467.

While litigation may continue as various claimants seek to reduce Medicare claims, the Medicare Act of 2003 makes it difficult to forecast what arguments will be made and whether they will be successful.

One question that remains is whether attorneys have any liability for non-payment of Medicare liens. CMS, of course, will return to its stance in *Goetzmann* and pursue attorneys. However, neither the new definition of primary insurance plan nor CMS's enlarged power to pursue entities "responsible to make payment" place an *express* duty on private attorneys to act as Medicare's collection agent. Arguably, revised section 1395y(b)(2)(B)(iii) covers attorneys where it provides that "the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." One author argues that "an attorney does not owe Medicare the duty to protect its recovery claim against his or her client."<sup>49</sup> At first blush, this appears to be consistent with Model Rules of Professional Conduct Rule 1.2, 1.7 and 1.8.<sup>50</sup> Under this view, "if the client chooses to receive his or her portion of the insurance proceeds from his or her attorney and deal with Medicare directly, the MSP statute and regulations impose no penalty on the attorney."<sup>51</sup> The better position, however, seems to be the one discussed above which takes Rule 1.15(b) into account. The tail that may wag the dog is whether anyone is willing to test the water on this issue.

### *Dealing with the Medicare Claim*

The first opportunity to begin addressing Medicare liens is prior to filing the lawsuit. This is so because the MSP program is limited to reimbursement for medical expenses *caused* by the third party's conduct.<sup>52</sup> Thus, notice pleadings (were local practice

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<sup>49</sup> See *2003 Medicare Handbook, supra*, § 9.07[B]. This appears to be the minority view. See, e.g., T. Takacs, "Attorney Liable to Reimburse Medicare," *Elder Law FAX* (August 5, 2002), at <http://www.tn-elderlaw.com/prior/020805.html>. In *Durie v. State*, 751 So.2d 685 (Fla. App. 5 Dist. 2000), an attorney was convicted of larceny for structuring a settlement depriving Medicaid of its share of recovery after taking position that he owed Medicaid no duty. The same result could be expected in the context of Medicare liens. See also *Home Ins. Co. v. Wynn*, 229 Ga. App. 220 (1997). While *Wynn* is not a Medicare or Medicaid case, it stands for the proposition that a plaintiff (and her attorney) prosecuting a wrongful death case has a duty to other persons with an interest in the claim. If rights have been assigned by statute to Medicare and/or Medicaid, then the same reasoning might extend to litigants pursuing a recovery for medical expenses. See Medicare Secondary Payer Manual, Chapter 2, § 40.1 ("Subrogation literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary.").

<sup>50</sup> Rule 1.2 provides that the client directs the scope of litigation. Rule 1.7 precludes conflicts, Rule 1.8(f) precludes acceptance of compensation from a non-client without client approval, and Rule 1.8(g) precludes the making of aggregate settlements unless each client consents in writing.

<sup>51</sup> See *2003 Medicare Handbook, supra*, § 9.07[B]. This position is premised on a reading of *Zinman v. Shalala*, 835 F.Supp 1163, 1171 (N.D. Cal. 1993), *aff'd*, 67 F.3d 841 (9<sup>th</sup> Cir. 1995), where the court held that Medicare's claim is not a lien. Although no authority was found overruling *Zinman*, it is not difficult to find cases where CMS continues to allege that it possesses a lien.

<sup>52</sup> See, generally, 42 U.S.C. § 1395y(b)(2)(B)(ii), as amended by the Medicare Act of 2003. In terms of scope and proof, there is no distinction between CMS's subrogation claim and its direct claim. "[A]n

permits them) rather than detailed allegations of long term negligence may assist litigants seeking to minimize the scope of Medicare liens.<sup>53</sup> Another alternative is to file a private cause of action under the MSP statute. Congress amended the MSP statute, in the Omnibus Budget Reconciliation Act of 1986, to create an enforceable private cause of action for damages.<sup>54</sup> Successful plaintiffs are entitled to collect double the amount of damages that would otherwise be available from an entity that has not met its primary payer responsibility.<sup>55</sup> Judgment on this claim should liquidate the amount of Medicare's claim.

The next best time to begin planning to minimize Medicare liens is prior to settlement. "The attorney has some leverage in reducing the claim before settlement since he can argue that the settlement depends on resolving all claims. After settlement, it's too late to make this argument."<sup>56</sup> In pursuing this type of release, the procedures outlined below must nonetheless be followed.<sup>57</sup> For example, a plaintiff cannot side-step Medicare's claim review process by adding Medicare as a necessary party in pending litigation<sup>58</sup> or by compelling Medicare's participation in a settlement conference.<sup>59</sup>

Finally, before addressing specifics concerning how to deal with Medicare, consider seeking a judgment apportioning the recovery proceeds. Ordinarily, the Medicare lien attaches to the entire recovery. However, "[i]f the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are

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essential element of the government's MSP direct action ... is the proof that the primary payer is "required or responsible" to pay for "items or services" provided to a Medicare beneficiary. ... [T]he United States must (1) identify its Medicare beneficiaries; (2) specify the medical items or services it provided; and (3) plead and prove that the defendants are "required or responsible" to make the primary payment with respect to that beneficiary and those medical items or services." *In re Silicone Gel Breast Implants Products Liability Litigation (MDL 926)*, 174 F.Supp.2d 1242, 1251-1252 (N.D. Ala. 2001). The same limitations apply to CMS's claims under the Medical Care Recovery Act, 42 U.S.C. § 2651 et seq. *See In re Diet Drugs Products Liability Litigation*, 2001 WL 283163, \*7 (E.D. Pa. 2001).

<sup>53</sup> Note, however, that omission of a claim for Medical expenses will not protect the recovery. *See Medicare Intermediary Manual § 3420.B.*

<sup>54</sup> 42 U.S.C. § 1395y(b)(3).

<sup>55</sup> H. McCormick, *supra*, § 1:76.

<sup>56</sup> H. Margolis, *Elder Law: Settlement Options for Disabled Plaintiffs*,

<http://www.masslawyersweekly.com/reprints/milne072098.htm>.

<sup>57</sup> *See Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000) ("Insofar as [42 U.S.C.] § 405(h) ... demands the "channeling" of virtually all legal attacks through the agency, it assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts .... But this assurance comes at a price, namely, occasional individual, delay-related hardship. In the context of a massive, complex health and safety program such as Medicare, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations, any of which may become the subject of a legal challenge in any of several different courts, paying this price may seem justified.").

<sup>58</sup> *See Truett v. Bowman*, 288 F.Supp.2d 909 (W.D. Tenn. 2003).

<sup>59</sup> *See Hoste v. Shanty Creek Management, Inc.*, 246 F.Supp.2d 776 (W.D. Mich. 2002); *and see* later decision in same case at 246 F.Supp.2d 784 (W.D. Mich. 2002).

designated as payment for losses other than medical services.”<sup>60</sup> Attorneys should assume Medicare is wise to sham hearings and should not expect this strategy to work unless the issues are contested.

### *Claims for Medical Care Previously Provided*<sup>61</sup>

If there is (or may be)<sup>62</sup> a Medicare lien, then the issue is ascertaining the amount owed and whether it is negotiable.<sup>63</sup> In 2001, the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) centralized its efforts relating to the collection of data on Medicare Secondary Payment (MSP) issues.<sup>64</sup> The centralized office is known as Medicare Coordination of Benefits (COB). Information about COB is online at: <http://www.cms.gov/medicare/cob/>. COB contractors collect, manage, and report other insurance coverage “to prevent mistaken payment of Medicare benefits.”<sup>65</sup>

COB, in theory, simplifies the MSP process for attorneys. The attorney can call a toll-free number and the COB office directs the attorney to the lead contractor on the case. Alternatively, you can contact COB by mail. COB has customer service representatives available between 8:00 a.m. to 8:00 p.m., Eastern Standard Time, Monday through Friday. The toll free number is 1-800-999-1118 and the mailing address for written inquiries is: Medicare-COB, MSP Claims Investigation Project, P.O. Box 5041, New York, New York 10274-5041.<sup>66</sup>

An example of an initial letter to Medicare is as follows:

Re: [Name of Medicare Beneficiary and Medicare Number/Claim Number]
Dear Sirs:
Please be advised that this firm represents the above-named Medicare Beneficiary who [has filed suit against (or who has settled a claim against)] the following potentially responsible third-party: [identify third party]. The claim relates to injuries alleged to have

<sup>60</sup> Medicare Intermediary Manual § 3418.7; see also *Denekas v. Shalala*, 943 F.Supp. 1073 (S.D. Iowa 1996), citing *Zinman v. Shalala*, 835 F. Supp. 1163, 1167 (N.D. Cal.1993), *aff'd*, 67 F.3d 841 (9th Cir.1995).

<sup>61</sup> Here, the authors acknowledge Certified Elder Law Attorney Pi-Yi Mayo. Many of the thoughts expressed in this section appear in his paper *Medicare Liens*, presented at Texas Wesleyan University of Law's *Special Needs Trusts* program, April 4, 2003. Mr. Mayo's paper is found at: [http://www.pi-yimayo.com/papers/Special\\_Needs\\_Trusts-Medicare\\_Liens.pdf](http://www.pi-yimayo.com/papers/Special_Needs_Trusts-Medicare_Liens.pdf).

<sup>62</sup> If a client is over 65, disabled, or has End Stage Renal Disease, Medicare should be notified to see if an overpayment exists.

<sup>63</sup> Medicare will seek reimbursement up to the amount paid by Medicare for goods or services attributable to the injury caused by the third party.

<sup>64</sup> A partial history of MSP's centralization is recounted at R. Gilreath, *Tips for Handling Medicare Subrogation*, *The New Lawyer Forum*, Spring 2002, page 3 (ATLA). According to one author, the new “centralized” system is slower than the old system. See R. Bernstein, *Who is Responsible for Pre-Existing Liens and Claims*, Stetson University College of Law's Special Needs Trusts III, October 26, 2001.

<sup>65</sup> [http://www.cms.hhs.gov/medicare/cob/factsheets/fs\\_attorneys\\_msplaws.pdf](http://www.cms.hhs.gov/medicare/cob/factsheets/fs_attorneys_msplaws.pdf).

<sup>66</sup> [http://www.cms.gov/medicare/cob/attorneys/att\\_detail.asp](http://www.cms.gov/medicare/cob/attorneys/att_detail.asp).

occurred between [dates]. Please forward to me a written notice of the amount necessary to satisfy any Medicare claim related to this injury.

I am enclosing a self-addressed stamped envelope.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact me.<sup>67</sup>

MSP activities begin when a Medicare Intermediary (Part A), Carrier (Part B), or the Coordination of Benefits (COB) Contractor becomes aware of a situation where a Medicare beneficiary was involved in an accident that could or should be paid for by a liability or auto/no-fault insurance coverage. This notification may be received in several ways:

Correspondence from:

- the beneficiary<sup>68</sup>
- an attorney<sup>69</sup>
- an insurance company<sup>70</sup>
- a provider of service<sup>71</sup>

Where the COB Contractor is the first point of contact, it needs to obtain the following information to have a complete file and determine the lead role:

1. Liability Insurance information to include:
  - a. Address
  - b. Adjuster's name
  - c. Claim and/or policy number
  - d. Telephone number
  - e. Policy holder/wrongdoer

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<sup>67</sup> T. Begley & J. Jeffreys, *Medicare Set-Aside Arrangements*, Appendix 19I, in *Representing the Elderly Client* (Aspen Publishers, 2003 Supplement).

<sup>68</sup> See Medicare Intermediary Manual § 3418.4.

<sup>69</sup> Putting Medicare on notice early can speed up the settlement process later. Consider sending a letter of representation with a request for a summary of charges paid by Medicare as soon as you realize Medicare is involved. See Gilreath, *supra*.

<sup>70</sup> 42 C.F.R. § 411.25 requires that third party payers give notice to Medicare when making a payment. (A third party payer is an insurance policy, plan, or program that is primary to Medicare. 42 C.F.R. § 411.21). The notice must describe the specific situation and the circumstances, including type of coverage, and the time period during which the insurer is primary to Medicare.

<sup>71</sup> If a claim from a provider contains a Trauma/injury diagnosis code it will alert the COBC that an accident or traumatic injury may have occurred and the possibility of an MSP situation warrants development. This process is known as Trauma Code Development (TCD). If information is missing from the claim the COBC will initiate an MSP investigation. This process is intended to alert Medicare to a potential third party liability situation.

- f. Name of the liability Insurance Company
2. Med Pay Information if applicable
3. Attorney Information to include:
  - a. Name
  - b. Address
  - c. Telephone number
4. Nature of accident/who was at fault
5. Injuries sustained as a result of the accident
6. Any questions

If a settlement is reached prior to contacting COB, the following information must be provided to the lead contractor:<sup>72</sup>

- Authorization from your client to release Medicare specific paid claims data. If you do not have a release on file, a release form can be obtained from the COBC. Both you and your client must sign the release form. Please note that a release must be returned even if a settlement has not been reached.
- A copy of the settlement agreement indicating the settlement date and total amount of the award.
- An itemized statement of attorney fees and procurement costs.
- The name, address, and telephone number of the automobile or liability insurer involved, and if available, the policy number, claim number, and adjuster's name.
- If monies are available through personal injury/med-pay or another form of coverage, indicate the total coverage amount and an itemization of benefits paid.

Once this information is obtained, the Coordination of Benefits (COB) Contractor, GHI,<sup>73</sup> will update the Medicare system records and designate the lead role to assume the recovery effort functions. GHI is responsible for gathering any necessary information that is omitted. All written and telephone correspondence should be directed to the COB Contractor until the contractor that will take the lead role is determined.

The COB will use this information to set up your client's MSP file, assign the case to a COB contractor, and inform you and your client of the applicability of the MSP program and Medicare's recovery rights. You will receive a notice advising you of the Medicare contractor assigned to handle the specifics of the case to recovery (i.e., the lead contractor), Medicare's right of recovery, and a beneficiary consent to release form.<sup>74</sup> Once all case information is obtained by GHI, it will designate the lead role who will then assume the function of recouping the total Medicare overpayment. When this

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<sup>72</sup> [http://www.cms.hhs.gov/medicare/cob/factsheets/fs\\_attorneys\\_msplaws.asp](http://www.cms.hhs.gov/medicare/cob/factsheets/fs_attorneys_msplaws.asp).

<sup>73</sup> Group Health Incorporated (GHI) based in New York; see <http://www.ghi.com/index.html>.

<sup>74</sup> Medicare's form notice is Exhibit 10, Medicare Intermediary Manual § 3418.30. Its notice to attorneys is Exhibit 12.

process is complete, all further inquiries are made through the lead contractor.

In gathering Medicare's claim payment summary, the lead contractor canvasses other Medicare contractors to identify claims they have paid for your client. This process requires adequate time for the Medicare contractors to search their claims history and respond to the inquiry. Therefore, delayed notice to Medicare, especially for older claims, may slow down processing.<sup>75</sup> Medicare's interest cannot be determined until the beneficiary's record has been annotated with the specifics of the case.<sup>76</sup>

**Where contact information is necessary, see CMS's on-line Intermediary-Carrier Directory.** See <http://www.cms.hhs.gov/contacts/incardir.asp>. In the Southeast, the COBC contact information is as available at: <http://www.georgiamedicare.com/attorney.cfm#cob>.

The primary role for the contractor is to coordinate with the other intermediaries and carriers paying benefits for the beneficiary due to injuries sustained in the accident with a view toward identifying the total amount due Medicare.<sup>77</sup> Also, the lead contractor is responsible for responding to all correspondence received. The procedure normally takes approximately four to six weeks to allow for coordination with the COB Contractor and other Medicare Intermediary's and Carrier's to determine their involvement in the case and to obtain their responses in writing. The information contractors are responsible for securing is as follows:<sup>78</sup>

- Name of lead contractor;
- Name(s) of other Medicare contractors involved;
- Beneficiary's name;
- HICN;
- Date of the accident and/or illness;
- Name of liability insurer;
- Address of liability insurer;
- Name and address of liability insurer's agent/attorney;
- Name and address of beneficiary's lawyer/ representative;
- Specific information about the benefits paid on behalf of the beneficiary, broken out by contractor;
- A brief narrative of the circumstances giving rise to the claim;
- Letter of initial determination, containing notification of waiver and appeal rights;
- Any written request from the beneficiary or the beneficiary's representative requesting that Medicare reduce its claim, with reason for request;
- Any stated amount being offered to the Medicare program by beneficiary/attorney, if provided to you (this is information which the RO is ultimately responsible for retaining, since RO conducts negotiation);

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<sup>75</sup> Older cases can take longer to process because purged histories need to be ordered. Therefore, to avoid delays at the time of settlement, as soon as you are aware that Medicare has paid claims on a case, you should consider contacting Medicare.

<sup>76</sup> See *MSP Liability Documentation Checklist*, Exhibit 9, Medicare Intermediary Manual § 3418.30. As a practical matter although you should go through the process with the COB, if you know who your lead contractor is, copy them with the letter to COB and it will jump start the claim.

<sup>77</sup> Medicare Intermediary Manual § 3418.22.

<sup>78</sup> Medicare Intermediary Manual § 3418.27. As discussed elsewhere, where there is an interest in moving the claim forward, providing this information early may facilitate matters.

- A copy of the settlement agreement or documentation of the settlement reached;
- A statement of the procurement costs incurred;
- Where waiver is requested, documentation supporting claims of financial hardship or equity and good conscience;
- Itemization of out-of-pocket expenses incurred as a result of the accident, including dates and places of medical services, the nature of those services and the identification of providers, physicians, and suppliers.

When the settlement figures are made available to Medicare, Medicare will reduce the amount of the Medicare overpayment by a proportionate share of attorney fees as set forth in 42 C.F.R. § 411.37.<sup>79</sup> **This amount will be the amount Medicare will accept as full satisfaction of the Medicare overpayment.** Medicare's demand should be calculated as follows:

- Determine the ratio of the procurement costs to the total judgment or settlement.
- Apply this ratio to the Medicare payment. The product is the Medicare share of the procurement costs.
- Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.<sup>80</sup>

If payment is not made within 60 days after the receipt of the funds from the insurer, then Medicare can charge interest on the amount they deem they are owed.<sup>81</sup>

An example of a Medicare demand letter is as follows:

Medicare has determined that you are required to reimburse the Medicare program [a specified sum] for amounts it paid for items or services relating to your orthopedic bone screw settlement with AcroMed Corporation. Federal law requires Medicare beneficiaries who obtain a liability recovery to repay the United States the amount the Medicare program paid for conditions related to that recovery.... You must pay this amount within sixty (60) days of the date of this letter (by July 9, 2001).... If you do not pay this amount by July 9, 2001, you will be required to pay interest from the date of this letter. Interest will be calculated at the rate of 13.75% per annum in accordance with 42 C.F.R. 411.24(m). Interest will continue to accrue until the debt is paid, whether or not a waiver of recovery request or appeal is pending. If you do not pay this amount, the Medicare program may recover the amount from any Social Security or Railroad Retirement

<sup>79</sup> Medicare Intermediary Manual § 3418.8. Medicare will not calculate a reduction for procurement costs and will not send an "Initial Determination Letter" or "Demand Letter" until it receives the numbers on the final settlement. This demand letter will detail the claims paid by Medicare and the amount they will expect to be paid. Upon settlement of the case, the payment to Medicare should be made within 60 days. The procurement costs are attorney's fees and expenses incurred in pursuing the case. The case must be such that the payments received by the claimant are disputed. The calculations concerning how much reduction in the Medicare claim is possible can be very valuable in terms of knowledge for use in planning case strategy or settlement positions; however, the final result will not be known until the actual amount of the settlement is sent to Medicare.

<sup>80</sup> H. McCormick, *supra*, § 1:67. Where the Medicare payments equal or exceed the total judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs. *Id.*

<sup>81</sup> 42 C.F.R. § 411.24 (m)(2)(i); Medicare Intermediary Manual § 3418.28.



benefits to which you might otherwise be entitled, or the money may be recouped from payments Medicare would otherwise pay you.<sup>82</sup>

Due to the large number of cases that are being handled, the only time a case will be a priority and our procedures expedited is when there is a court date deadline. The normal time frame to respond to inquires is within 45 days. As stated above, if a final response to your inquiry cannot be made within 45 days from receipt, an interim response will be provided for notification that your request has been received and is being reviewed.

Once this letter is received by the lead contractor, a "Notice of Medicare's Potential Recovery" will be sent to the requesting party. Medicare will take about 2 months to determine the conditional payment amount. Until Medicare gives you its "final answer," any action you take relying on your own calculating of what is due Medicare, or in reliance on an unofficial estimate, may be problematic. During the course of its review, Medicare next sends a "Notice of Conditional Payment" that will list of each claim Medicare has paid and a total amount of the conditional payment.<sup>83</sup> The notice states that they will continue to check their records and will keep you informed of any updates. If the timeframe between receiving the Notice of Conditional Payment and the actual payment of the funds will be delayed, and if any new medical expenses were incurred, you should request a revised conditional payment notice. Until the check is paid to Medicare and a release is obtained, the amount of the conditional payment may be a moving target.<sup>84</sup>

In the event a settlement check is made out to a beneficiary, his/her attorney, and Medicare, then all endorsements must be on the check and sent to Medicare.<sup>85</sup> Medicare will then deposit the check, satisfy the debt, and issue a refund for the difference. The time frame to receive the refund is approximately 10-15 days. Medicare will not endorse settlement checks where Medicare has an interest without satisfying the debt first. **This endorsement will terminate Medicare's collection rights.**

*What to do when the Medicare Claim is too large:*

There are three lines of statutory authority that permit Medicare to accept less than the full amount of its claim: Section 1870(c) of the Social Security Act, §1862(b) of the Social Security Act, and the Federal Claims Collection Act (FCCA).<sup>86</sup> Each statute contains different criteria upon which decisions to compromise, waive, suspend, or terminate

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<sup>82</sup> *In re Orthopedic Bone Screw Products Liability Litigation*, 202 F.R.D. 154, 159 (E.D. Pa. 2001). For Medicare's *Standard Recovery/Initial Determination Letter to Beneficiary/Attorney*, see Exhibit 2, Medicare Intermediary Manual § 3418.30.

<sup>83</sup> Study CMS's claim carefully. Once [CMS believes] the charge is related, it will be up to you to explain why the charge is not related. ... Always backup any challenge you have with documentation, including medical records, or possibly even a letter of clarification from your client's treating doctor." Gilreath, *supra*, at 4.

<sup>84</sup> The release terminates Medicare's right of recovery. Medicare Intermediary Manual § 3418.10(C).

<sup>85</sup> Medicare Intermediary Manual § 3418.10(B).

<sup>86</sup> Respectively, 42 U.S.C. § 1395gg(c); 42 U.S.C. § 1395(b)(2)(B)(iv); and 31 U.S.C. § 3711.

Medicare's claim may be made.<sup>87</sup> Factors considered include out of pocket expenses incurred, age of the beneficiary, monthly income, expenses of the beneficiary; and physical and mental impairments of the beneficiary.<sup>88</sup>

If you seek a waiver or compromise in an amount greater than the procurement costs, then you will need to go through CMS; the COB Contractor does not have authority to reduce the lien. Authority to waive Medicare claims under §1862(b) and to compromise claims, or to suspend or terminate recovery action under FCCA, is reserved exclusively to CMS and/or Regional Office staffs.<sup>89</sup> After the amount of the claim has been determined, the settlement of all claims under \$100,000.00 is handled by the regional CMS office. Medicare claims over \$100,000.00 will be sent to the regional office but will be forwarded to the central office in Baltimore for compromise or waiver.<sup>90</sup> The process of seeking a waiver of the claim is a familiar one to those attorneys that have sought a waiver of overpayment in regular Social Security or Social Security Disability cases.<sup>91</sup>

*Waiver of Medicare's Claim under Section 1870(c):*

Where you believe that the recovery should be waived, the case must be referred to the Centers for Medicare and Medicaid Services (CMS) for consideration. In order to refer the case, Medicare must have the Medicare Overpayment Questionnaire completed and a letter from the attorney explaining the reason for the compromise. A waiver/partial waiver is requested the same; however, the case must be settled. The determination is made by the lead contractor/intermediary within 120 days.<sup>92</sup> The criteria for a waiver determination under the Social Security Act 1870(c)<sup>93</sup> are as follows:

CMS may waive all or part of its recovery in any case where an overpayment under title XVIII has been made with respect to a beneficiary:

- (a) Who is without fault, AND
- (b) When adjustment or recovery would either:
  - (1) Defeat the purpose of title II or title XVIII of the Act,  
OR
  - (2) Be against equity and good conscience.<sup>94</sup>

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<sup>87</sup> Medicare Intermediary Manual § 3418.13.

<sup>88</sup> Medicare Intermediary Manual § 3418.11 and 3818.13. The MIM provides several examples justifying a full or partial waiver of Medicare's claim. Conversely, factors that mitigate toward denial of a waiver include: Medicare asserted its right to recover before the settlement proceeds were disbursed (and there is correspondence in the case file which provides documentation of Medicare's timely assertion); beneficiary receives a large settlement; beneficiary's income exceeds his/her ordinary living expenses; after repaying Medicare and allowing for out-of-pocket medical costs (if such allowances are necessary), the beneficiary will be left with a substantial amount of the settlement proceeds; and beneficiary has substantial assets. *Id.*

<sup>89</sup> Medicare Intermediary Manual § 3418.6(E).

<sup>90</sup> 31 U.S.C. § 3711.

<sup>91</sup> Kauffman, *supra*, at 313.

<sup>92</sup> Medicare Intermediary Manual § 3418.18.

<sup>93</sup> 42 U.S.C. § 1395gg(c).

<sup>94</sup> Medicare Intermediary Manual § 3418.13.

The Medicare Intermediary Manual lists the following steps in considering a waiver under Section 1870(c) of the Social Security Act:

A. Beneficiary Must Submit Waiver Request.--The beneficiary must request a waiver in writing. Once the waiver request has been received, send the beneficiary and attorney the letter found at Exhibit 11 - Standard Letter Acknowledging Waiver Request. Use of this letter, not a substitute, is mandatory. The letter provides the beneficiary with a SSA 632-BK - Request for Waiver of Overpayment - (Exhibit 3) form, and acknowledges that the waiver request has been received. It also informs the beneficiary that a determination will be sent once it is reached.

B. Collect All Pertinent Data.-- Send the beneficiary an SSA-632-BK, (Exhibit 3), with appropriate supporting documentation. Retain a supply of these forms to enclose with Exhibit 11, per the instructions in paragraph A above. The beneficiary does not need to complete Section 1 - "Without Fault" - of the SSA-632-BK, since at this time, beneficiaries are deemed to be without fault.<sup>95</sup> At the time the SSA-632-BK - Request for Waiver of Overpayment - is submitted, the beneficiary must also provide supporting documentation for:

- o Procurement costs;
- o Accident-related out-of-pocket medical expenses incurred; and
- o Expenses and income information which demonstrate financial hardship (if the beneficiary is alleging financial hardship).

C. Apply Waiver Criteria.--Determine whether the beneficiary meets the criteria set forth in §3418.13.

D. If Waiver Criteria Are Met.--If granting a full waiver, send the letter shown in Exhibit 4. If granting a partial waiver, send the letter shown in Exhibit 5.

E. If Waiver Criteria Are Not Met.--Send the denial letter shown in Exhibit 6, providing a full explanation of the reasons for the denial.<sup>96</sup>

Liens do get waived. Attorneys Abramson and Brown reported they “were able to convince the government to waive its entire lien in a case in which it had paid more than \$250,000 in medical expenses. ... Available liability insurance amounted to \$100,000. The government initially requested \$66,000, after taking into account attorneys’ fees and costs. However, by writing a detailed letter with many exhibits, we were able to establish that reimbursement would be contrary to equity and good conscience and that it would cause the client an undue financial hardship.”<sup>97</sup>

#### *Waiver of Medicare’s Claim under Section 1862(b):*

Section 1862(b)<sup>98</sup> the Social Security Act grants the Secretary the right to waive MSP liability recoveries if doing so would be "in the best interests of the program." Authority to grant waivers under this section of the Act may be exercised only by CMS CO or RO staff. Waivers granted under this authority may not be appealed because they are confided to CMS’s discretion.<sup>99</sup>

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<sup>95</sup> This, in effect, makes the waiver determination a one-step process.

<sup>96</sup> Medicare Intermediary Manual § 3418.12.

<sup>97</sup> See M. Abramson & K. Brown, *Minimizing Liens and Maximizing Personal Injury Recoveries*, <http://www.ardb.com/articles/minilien.html>; citing 42 U.S.C. § 1395gg(c); 42 C.F.R. § 405.355.

<sup>98</sup> 42 U.S.C. § 1395y(b).

<sup>99</sup> 42 C.F.R. § 405.705(d); Medicare Intermediary Manual § 3418.15.

### *Compromise of Medicare's Claim:*

The amount of the Medicare claim may be compromised.<sup>100</sup> The Medicare Intermediary Manual provides the following instruction to attorneys seeking pre-suit compromise of a Medicare lien:

Pre-Settlement Negotiations, Compromises, and Discussions with Beneficiaries/Attorneys.-- The Federal Claims Collection Act grants Medicare the right to compromise its claims, or to suspend or terminate its recovery action. However, only HCFA claims collection officers to take this action. Consequently, contractors may not, under any circumstances, enter into negotiations (either pre- or post-settlement) with beneficiaries, or their attorneys or representatives, to compromise Medicare's claim. If beneficiaries, or their attorneys or representatives, wish to discuss arrangements by which Medicare's claim might be reduced (outside of a formal request for Medicare to waive its claim), instruct the party to either: (a) make its request for compromise in writing, then forward the request to your [Regional Office], or (b) refer the party directly to the appropriate RO staff person to handle the negotiation. You may advise an attorney and a beneficiary that Medicare's conditional payment must be considered during settlement negotiations with any third party. Federal law authorizes Medicare's priority right of recovery from liability settlement or judgment proceeds. (See §3418.)<sup>101</sup>

The Federal Claim Collection Act<sup>102</sup> gives Federal agencies the authority to compromise where:

- The cost of collection does not justify the enforced collection of the full amount of the claim;
- There is an inability to pay within a reasonable time on the part of the individual against whom the claim is made; or
- The chances of successful litigation are questionable, making it advisable to seek a compromise settlement.

These criteria apply to CMS's RO or CO staff only since Medicare contractors are not permitted to compromise Medicare claims. COB contractors are instructed that if a beneficiary, attorney, or beneficiary's representative offers to pay Medicare less than the full amount of its claim, they must inform the inquiring party/offeror of their rights to request waiver, appeal, or compromise of the claim. They must further advise them that while COB contractors may assist them in securing a waiver or appeal, the COB contractor may not compromise claims on behalf of the United States Government. Section 3418.6.E of the Medicare Intermediary Manual provides that a resolution through the FCCA is available through the RO at any time after it is known that Medicare has made conditional payments in a liability situation. When a beneficiary agrees to a compromise settlement under the FCCA, he or she agrees not to appeal the matter further.

### *Appeals:*

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<sup>100</sup> H. McCormick, *supra*, § 1:80 to § 1:81.

<sup>101</sup> Medicare Intermediary Manual § 3418.6(E).

<sup>102</sup> 31 U.S.C. § 3711.

Any writing expressing dissatisfaction with an overpayment determination is treated as an appeal.<sup>103</sup> If the beneficiary objects to Medicare's claim on the basis of hardship or inequity, CMS will treat the request as a request for a waiver.<sup>104</sup> Appeals are processed before waivers where both are clearly requested. The steps used in deciding appeals are outlined at Section 3419.4.D of the Medicare Intermediary Manual.

There are three types of initial determinations made within the context of the MSP program which generate appeal rights. The beneficiary may appeal:

- The existence of the overpayment;
- The amount of the overpayment; and
- A less than fully favorable determination of §1870(c) waiver request.

Negotiation of a compromise, or suspension or termination of collection action under the Federal Claims Collection Act by the RO, is not an initial determination, and, therefore generates no appeal rights.<sup>105</sup> A waiver granted under §1862(b) of the Social Security Act also generates no appeal rights.

The initial appeal is to an administrative law judge and must be taken within 60 days. The amount in controversy must exceed \$100.

#### *Litigation with Medicare:*

If the Medicare claim cannot be resolved to the plaintiff's satisfaction, court action may be necessary. However, a failure to first resort to the administrative procedures described above will result in a dismissal of the plaintiff's case. Before a lawsuit is filed, the beneficiary must secure an initial determination from the Commissioner of Social Security (Medicare). 42 C.F.R. § 405.704(b)(13); *see also Maresh ex rel. Maresh v. Thompson*, \_\_\_ F. Supp. 2d \_\_\_, 2003 WL 22659385 (N.D. Tex. 2003); *Wilson v. U.S.*, 58 Fed. Cl. 760 (2003).<sup>106</sup> This is jurisdictional.<sup>107</sup> Where a Plaintiff fails to present his or her claim to Medicare prior to bringing an action, it will be dismissed because plaintiff has not complied with the exhaustion requirements of the Medicare statutory scheme. *Baughan v. Thompson*, 2003 WL 22295354 (W.D. Va. 2003). In *Bird v. Thompson*, 2003 WL 21537748, \*4-5 (S.D. N.Y. 2003), the problem was succinctly described as follows:

Indisputably, 42 U.S.C. § 405(g), "to the exclusion of 28 U.S.C. § 1331, is the sole avenue for judicial review for all 'claim[s] arising under' the Medicare Act." Ringer, 466 U.S. at

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<sup>103</sup> Medicare Intermediary Manual § 3419.3.A.

<sup>104</sup> Medicare Intermediary Manual § 3419.3.B.

<sup>105</sup> See 42 CFR 405.705(d); Medicare Intermediary Manual § 3419.1.

<sup>106</sup> Of note, Federal question jurisdiction is present under 28 U.S.C. § 1331 where a party challenges the United States' attempt to recover settlement proceeds as repayment for Medicare costs under the Medicare Secondary Payer statute. *Fanning v. United States*, 202 F.R.D. 154, 169 (E.D.Pa.2001); *Hoste v. Shanty Creek Management, Inc.*, 246 F.Supp.2d 776 (W. D. Mich. 2002).

<sup>107</sup> *Cochran v. U.S. Health Care Financing Admin.*, 291 F.3d 775 (11<sup>th</sup> Cir. 2002) (holding that even a constitutional challenge must first go through the administrative process).

615, citing *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975). Section 405(g) provides that: Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party ... may obtain a review of such decision by a civil action [in a district court of the United States] commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [Secretary] may allow. (Emphasis added.)

The "final decision" requirement consists of two elements, one of which is waivable, and one of which is jurisdictional and nonwaivable. *Bowen v. City of New York*, 476 U.S. 467 (1986). "The waivable element is the requirement that the administrative remedies prescribed by the Secretary be exhausted. The nonwaivable element is the requirement that a claim for benefits shall have been presented to the Secretary. Absent such a claim there can be no decision of any type." *Matthews v. Eldridge*, 424 U.S. 319, 328 (1976). See also *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 15 (2000) (recognizing that "[Section] 405(g) contains the nonwaivable and nonexcusable requirement that an individual present a claim to the agency before raising it in court.").

...

Before initiating litigation, plaintiff must at a minimum present to the Secretary her claim to keep the entire proceeds of her personal injury settlement, and not reimburse the Secretary for Medicare benefits she has received.

### *Securing the Release:*

It is prudent to secure a Medicare release covering all parties and at least one court, denying plaintiff's motion for costs, places that responsibility squarely on the plaintiff.<sup>108</sup> Thus, after the amount due to Medicare is agreed upon, a check made payable to Medicare should be sent to the contractor that has lead role. After receipt of payment, if requested Medicare will send a release.

### *Statute of Limitations*

Neither the MSP Statute nor the Medical Care Recovery Act expressly designates a limitations period. "Claims asserted by the United States are ordinarily immune from any period of limitation unless Congress manifests an intent to the contrary."<sup>109</sup> At least two courts infer that Congressional intent is found at 28 U.S.C. § 2415, and that CMS's claims sounding in contract are subject to a six year limitation period, and claims sounding in tort limited to three years.<sup>110</sup> State statutes of limitation have no effect on CMS's assertion of a Medicare lien.<sup>111</sup> With regard to private actions under the MSP

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<sup>108</sup> *Liss v. Brigham Park Cooperative Apartments Sec. No. 3, Inc.*, 694 N.Y.S.2d 742 (N.Y.A.D. 2<sup>nd</sup> Dept. 1999). The likely rationale here is that while the defendant's expectation is a full release in exchange for settlement, absent Medicare's release, the defendant remains liable under the MSP statute and/or the Medical Care Recovery Act. See *In re Orthopedic Bone Screw Products Liability Litigation*, 176 F.R.D. 158, 179 (E.D. Pa. 1997) (A settlement and release does not extinguish the government's rights against a settling defendant).

<sup>109</sup> *In re Dow Corning Corp.*, 250 B.R. 298, 350 (Bkrtcy. E.D. Mich. 2000).

<sup>110</sup> *Id.*, at 350-351 ("it is uniformly recognized that Congress has enacted a statute of limitation which is applicable to Government claims made pursuant to the MCRA and the MSPA"); see also *Cockerham v. Garvin*, 768 F.2d 784, 787 (6<sup>th</sup> Cir. 1985). Incidentally, in the "Q&A" portion of the CMS website, CMS takes the position that the limitations period is six years.

<sup>111</sup> The statute itself includes no limitations period and state limitations periods do not bar the United States' claim. *U.S. v. Philip Morris Inc.*, 153 F.Supp.2d 32, 38 (D. D.C. 2001). See also *Ruthardt v. U.S.*, 303 F.3d 375 (1<sup>st</sup> Cir. 2002). There, in the context of the McCarran-Ferguson Act, the First Circuit

statute, courts should defer to state statutes of limitations when determining the length of the tail on a Medicare claim.<sup>112</sup> There, may, however, be a limited safe harbor, at least in instances where Medicare's intermediary has published a time limit on when claims must be filed. 42 C.F.R. § 411.24(f)(2) provides: "CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those services."<sup>113</sup> This appears to mitigate toward putting Medicare on notice early.

Finally, if the amount of the Medicare lien is unclear, hold back the full amount of the medical bills in question until the amount of the Medicare claim is clear.<sup>114</sup> Do not rely on your client to keep it. This will keep you from going back to your client to request the money after it has been spent.<sup>115</sup>

### *Future Medical Care*

**After Medicare recovers its overpayment amount, Medicare will pay as primary on all future bills submitted for services related to the same incident** (unless the judgment or settlement provides for payment of future medicals). Medicare has no liability or obligation to pay for any services related to the injury that were furnished before the date of settlement and that the beneficiary did not specifically identify to Medicare in writing before the release was executed.

The term Medicare Set Aside Arrangement, or Medicare Trust, is sometimes used to refer to an allocation of lump sum payments toward future Medicare-covered medical expenses. Medicare Set Aside Arrangements, while applicable in the context of worker's compensation, generally **do not** apply in the personal injury setting. The reason is that secondary payer status is retained for worker's compensation claims,<sup>116</sup> but there is no corresponding regulation in the personal injury setting.<sup>117</sup>

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found: "The Supreme Court long ago held that (presumptively) claims of the United States as sovereign cannot be defeated by state statutes of limitations."

<sup>112</sup> "It is well-established that federal courts should defer to state statutes of limitations where Congress has failed to provide an explicit limitation period." *Kingvision Pay Per View, Ltd. v. Wilson*, 83 F.Supp.2d 914 (W.D. Tenn. 2000); *see also Manning v. Utilities Mut. Ins. Co.*, 1999 WL 782569 (S.D. N.Y. 1999).

<sup>113</sup> Unfortunately, no cases were found interpreting the phrase "claims filing requirement."

<sup>114</sup> Although, for the moment, set-asides for future medicals are not an issue in the context of a personal injury or malpractice claim, it is nonetheless prudent to escrow the full amount necessary to satisfy Medicare's claim. In the context of a Medicare Set-aside arrangement, "it is common practice to settle the claim and escrow a sum equal to 2X the anticipated set-aside amount. Once Medicare has approved the set aside amount, the excess funds are released to the claimant." T. Begley & J. Jeffreys, *Medicare Set-Aside Arrangements*, § 19.05[B], in *Representing the Elderly Client* (Aspen Publishers, 2003 Supplement).

<sup>115</sup> Gilreath, *supra*, p. 4.

<sup>116</sup> 42 C.F.R. § 411.40 et seq.

<sup>117</sup> In an email dated January 19, 2004, Pi-Yi Mayo suggests: "Be on the look out for a new wrinkle were they are going to seek Medicare set aside trust on any case that has a recovery for future medical in it." For a discussion of Medicare Set Aside Arrangements, *see* S. Haines & T. Begley, *The Use of Medicare Set-aside Trusts in Workers' Compensation Settlements*, Fla. B. J., page 59 (May 2000), at

## **Conclusion**

The Medicare and Medicaid programs, potentially, may make claims against large portions of the recovery. This may reduce the payment of proceeds to the client and, as a result, you can win the battle but lose the war by failing to protect the recovery. The lesson here is that when the settlement check arrives, the work may have just begun.

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<http://www.flabar.org/DIVCOM/JN/JNJournal01.nsf/0/692731d767e1d5ec85256adb005d6300?OpenDocument>; and see T. Begley & J. Jeffreys, *Medicare Set-Aside Arrangements*, Chapter 19 in *Representing the Elderly Client* (Aspen Publishers, 2003 Supplement).