Medicare Subrogation

a.k.a. - Medicare Secondary Payer Liability and No-Fault

Public Information Available at No Charge

Sally Stalcup
Region 6
MSP Regional Coordinator

The History of MSP

• 7/1/66	Medicare	Worker's Comp, VA, Black Lung, Federal Programs
• 12/5/80	OBRA	Auto-Medical, No-Fault, Liability
• 10/1/81	OBRA-81	ESRD
• 10/1/83	TEFRA	Working Aged
• 1/1/85	DEFRA	Working Aged
• 5/1/86	COBRA	Working Aged
• 1/1/87	OBRA-86	Disability
• 1997	BBA	Various

The History of MSP, continued

- 12/8/03 MMA
  Technical/Clarifying Amendments

- 2007 MSP Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42 U.S.C. 1395y(b)(7) 42 U.S.C. 1395y(b)(8))

MSP Resources

- Section 1862 (42 U.S. C. 1395y) of the Social Security Act (the "Act").
- Section 1870 of the Act, Overpayment on Behalf of Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individual
- REGULATIONS:
- 42 CFR Part 405, 405.900's
- 42 CFR Part 411, Exclusions from Medicare and Limitations on Medicare Payment, Subparts B-H
- Subpart B- Insurance Coverage that Limits Medicare payment: General Provisions
- Subpart C - Limitations on Medicare Payment for Services Covered Under
- Workers' Compensation
- Subpart D - Limitations on Medicare Payment for Services Covered Under
- Liability or No-Fault Insurance
- Subpart E - Limitations on Payment for Services Covered Under Group Health
- Plans: General Provisions
- Subpart F - Special Rules: Individuals Eligible or Entitled on the Basis of ESRD
- Who are also covered under group health plans
- Subpart G - Special Rules: Aged Beneficiaries and Spouses who are also covered
- Under Group Health Plans
- Subpart H: Special Rules: Disabled Beneficiaries who are also covered under
- Large Group Health Plans

- Subpart C of 42 CFR Part 405, for regulations to Section 1870 Wavier of Recovery

- 42 CFR Part 411.37 Amount of Medicare recovery when a third party payment is made as a result of a result of a settlement, judgment or award.

- PUBLICATIONS:
- Medicare and Other Health Benefits: Your Guide as to Who Pays First
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services
- These publications can be found on the Internet at www.Medicare.gov

Legal Authority for Recovery

- Section 1862(b)-(2)(A)(ii) of the Social Security Act
- Medicare Prescription Drug and Modernization Act of 2003
- 42 CFR 411
  - 42 CFR 411.20
  - 42 CFR 411.100
  - 42 CFR 411.170
  - 42 CFR 411.200

Notable Changes – www.MSPRC.info

- Effective for cases established on or after October 1, 2009, the "Right to Recovery Letter" issued when a claim for liability insurance (including self-insurance), no-fault insurance, or workers' compensation is reported to CMS' Coordination of Benefits Contractor (COBC) will no longer be issued by the COBC. The letter has been revised, renamed (it is now the "Medicare Secondary Payer Rights and Responsibilities" letter) and will be issued by the MSPRC.
  Note: If you received a "Right to Recovery Letter" issued by the COBC and dated on or before September 30, 2009, you may follow the instruction in that letter regarding submitting a "Consent to Release" document.

Notable Changes – www.MSPRC.info

- Effective October 1, 2009, the MSPRC will issue information concerning interim conditional payment amounts automatically (that is, without receiving a request for such information) as soon as an interim conditional payment amount is available. If you have an outstanding request for a conditional payment letter (CPL) for a case established prior to October 1, 2009, the request will be processed in the order received. For all new cases, the Medicare beneficiary and any authorized individuals will receive the CPL within 65 days of the issuance of the "Rights and Responsibilities Letter." Please refer to the discussion in the "Rights and Responsibilities Letter" or the "Rights and Responsibilities Brochure" for further information.

www.MSPRC.info

- Final Settlement Detail Document
- Check Remittance
- SSA-632 Request for Waiver
- Medicare (CMS) W-9

Mandatory Insurer Reporting

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
See 42 U.S.C. 1395y(b)(7)&(b)(8))

- Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan (GHP) arrangements and for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation.
- Section 111 adds reporting rules; it does not eliminate any existing statutory provisions or regulations.
- The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment.

- **For all CMS instructions visit www.cms.hhs.gov/MandatoryInsRep**

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8):

- **Who Must Report:** "an applicable plan." , "...[T]he term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement: (i) Liability insurance (including self-insurance). (ii) No fault insurance. (iii) workers' compensation laws or plans."

- **What Must Be Reported:** The identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

- **For all CMS instructions visit www.cms.hhs.gov/MandatoryInsRep**

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8). For all CMS instructions visit www.cms.hhs.gov/MandatoryInsRep :

- Add reporting rules; do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment.
- Include penalties for noncompliance.
- Who must report: "an applicable plan." "...[T]he term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement: (i) Liability insurance (including self-insurance). (ii) No fault insurance. (iii) Workers' compensation laws or plans."
- What must be reported: the identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim.
- When/how reporting must be done:
- • In a form and manner, including frequency, specified by the Secretary.
- • Information shall be submitted within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).
- • Submissions will be in an electronic format.

2010 Town Hall Teleconference Dates

- **All town hall teleconferences are held from 1:00pm to 3:00pm EST unless otherwise noted.**
-
- **Visit www.cms.hhs.gov/MandatoryInsRep for dates**
- Call in time for all calls: 1:00 PM – 3:00 PM Eastern Time
- Participation is by telephone only. Call-in line for all calls: 800-603-1774
- Pass code for all calls: SECTION 111
- Please begin dialing in approximately 20-30 minutes before the call due to the large number of participants.
- Questions for the call: Please submit questions as soon as possible to:
- PL110-173SEC111-comments@cms.hhs.gov.

"Consent to Release" vs. "Proof of Representation" What's the Difference?

- Proof of Representation--The beneficiary has authorized the individual or entity (including an attorney) to act on the beneficiary's behalf. The representative has no independent standing, but may receive or submit information/requests on behalf of the beneficiary, including responding to requests from the MSPRC, receiving a copy of the recovery demand letter if Medicare has a recovery claim, and filing an appeal (if appropriate) when that beneficiary is involved in a liability, workers' compensation, or auto/no-fault situation.

- Under these circumstances, the exchange of information is a two way street. The individual or entity may provide necessary information to or interact with the MSPRC, on behalf of the beneficiary, in order to resolve Medicare's Recovery Claim.

Proof of Representation
What is required?

- Beneficiary non-attorney representatives.
  - The beneficiary must: Provide his/her name as shown on his/her Medicare card,
  - Provide his/her Medicare Health Insurance Claim Number (HICN)(the number on the Medicare card),
  - Appoint the representative in writing,
  - Specify the following information for the representative: name, type of representative, firm/company name (if applicable), address, telephone number,
  - Sign and date the appointment,

- The representative must sign and date the document to show that he/she has agreed to represent the beneficiary.

Proof of Representation
What is required?

- Beneficiary attorney representatives may submit their retainer agreement with the beneficiary if:
- The retainer agreement is on attorney letterhead or accompanied by a cover note on letterhead,
- The retainer agreement is signed by the beneficiary,
- The beneficiary's name and Medicare Health Insurance Claim Number (HICN) are printed at the top of the form (this may be added after the retainer agreement is signed), and
- The retainer agreement is signed or countersigned and dated by the attorney.
- Beneficiary attorneys may also provide the same proof of representation as non-attorneys if they wish to do so.

Proof of Representation
What is required?

- Beneficiary guardians, conservators, power of attorney, Medicare representative payees.
- Guardian or Conservator -Submit proper court documents for status as a guardian or conservator.
- Power of Attorney -Submit power of attorney documents for power of attorney status –if the beneficiary is incompetent you must have a durable power of attorney.
- Representative Payee –Notify the MSPRC if you are the representative payee for the Medicare beneficiary, and the MSPRC will verify this status within CMS' systems.

Proof of Representation
What is required?

- Situations where the beneficiary's representative (representative payee, conservator, guardian, power of attorney) has hired an attorney or the beneficiary's attorney has referred the case to another attorney
- Beneficiary's representative has hired an attorney --The attorney must submit both the necessary proof of representation document or retainer agreement from the beneficiary's representative andthe documentation required from representative payees, conservators, guardians, power of attorney.
- Beneficiary attorney refers a matter to another attorney -The second attorney must have a letter from the first attorney showing his/her association on the beneficiary's claim and the necessary proof of representation document or retainer agreement from the beneficiary to the first attorney.

- In other words, you must have an appropriate chain of authorization. We need to be able to link the beneficiary to you.

Proof of Representation
What is required?

- <u>Deceased beneficiaries</u>
- If a beneficiary is deceased before resolution of a Medicare secondary payer recovery claim associated with a liability insurance (including self-insurance), no-fault insurance or workers' compensation settlement, judgment, award, or other payment, new proof of representation on behalf of the beneficiary's estate must be submitted. If there is no will or formal estate, the document or documents must be signed by an individual who is entitled under state law to pursue the applicable claim.
- Where state law requires court documentation to establish such status, provide that documentation. Where no such state requirement exists, and a will is available, provide the initial page of the will, the page(s) showing the executor, and the notarized signature page(s).

Proof of Representation
What is required?

- Workers' Compensation or No-Fault Insurance vs. Liability Insurance (Including Self-Insurance)
- The MSPRC will provide conditional payment information to a workers' compensation entity/carrier or no-fault insurer without a consent to release document.
- The MSPRC will not provide conditional payment information to a liability insurer (including self-insurance) without a proper consent to release document. (This includes any attempt to request such information through a Freedom of Information Act (FOIA) request.)

Proof of Representation
What is required?

- Agents for insurers or workers' compensation carriers–
- Agents must have a beneficiary specific statement (including the beneficiary's name and HICN) on the insurer or workers' compensation entity's letterhead that the agent is representing the insurer or workers' compensation carrier with respect to a claim involving the identified Medicare beneficiary.
- The MSPRC will routinely provide a conditional payment letter (CPL) to the no-fault insurer or workers' compensation entity/carrier as soon as the conditional payment information is available if the MSPRC has the insurer or workers' compensation entity name and address. Requesting such information specifically through an agent will delay receipt of the CPL.

"Proof of Representation" Model Language

- **Type of Medicare Beneficiary Representative (Check one below and then print the requested information):**
- ( ) Individual other than an Attorney: Name: _____
- ( ) Attorney* Relationship to the Medicare Beneficiary: _____
- ( ) Guardian* Firm or Company Name: _____
- ( ) Conservator* Address: _____
- ( ) Power of Attorney* _____
- Telephone: _____
- * Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit www.msprc.info for further instructions.
- **Medicare Beneficiary Information and Signature/Date:**
- Beneficiary's Name (please print exactly as shown on your Medicare card): _____
- Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____
- Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers'
- compensation claim: _____
- Beneficiary Signature: _____ Date signed: _____
- **Representative Signature/Date:**
- Representative's Signature: _____ Date signed: _____

"Consent to Release" vs. "Proof of Representation" What's the Difference?

- Consent to Release–The beneficiary has authorized an individual or entity to receive certain information from the MSPRC for a limited period of time. The release does not give the individual or entity the authority to act on behalf of the beneficiary.
- Under these circumstances, the exchange of information is a one-way street. The beneficiary has authorized the MSPRC to provide privacy protected data to the specified individual/entity, BUT this does not authorize the individual/entity requesting information to act on behalf of/make decisions on behalf of the beneficiary

"Consent to Release" Model Language

- I, _____(print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:
- CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:
- (If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)
- ( ) Insurance Company ( ) Workers' Compensation Carrier ( ) Other _____
- (Explain)
- Name of entity: _____
- Contact for above entity: _____
- Address: _____
- Telephone: _____
- CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.):
- ( ) One Year ( ) Two Years ( ) Other _____ (Provide a specific period of time)
- I understand that I may revoke this "consent to release information" at any time, in writing.
- MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:
- Beneficiary Signature: _____ Date signed: _____
- Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit www.msprc.info for further instructions.
- Medicare Number (The number on your Medicare card.): _____ Date of Injury/Illness: _____

Federal Tort Claim Act Cases

- All Federal Tort Claim Act (FTCA) cases are handled by Betty Noble in CMS Central Office. Please contact:

  Betty Noble

  CMS

  7500Security Blvd, Mail Stop C3-13-00

  Baltimore, Maryland 21244-1850

  (410) 786-6475

Global or Multi-Jurisdictional Cases

- If your case involves a product liability case with a global settlement please contact Sally Stalcup before you contact the COBC.
- If you are participating in multi-jurisdictional, or multi-client global product liability case, please contact Sally Stalcup before contacting the COBC.

Three Issues Can be Appealed

- The existence of the overpayment
- The amount of the overpayment
- A less than fully favorable determination of an 1870(c) waiver request

**An appeal may only be requested by an entity deemed "party to an appeal"

What If I Want to Negotiate With Medicare?

- **Waiver Option #1: §1870(c) Waiver** Contractor-based waiver decision based upon two key considerations:
  1. Financial Hardship
  2. Equity & Good Conscience
- **Compromises**
  Federal Claims Collection Act – handled by CMS Regional Offices
- **Waiver Option #2: §1862(b) Waiver** Only CMS can consider §1862(b) waivers. Must be in best interest of the Medicare Program and is virtually never used.

Waivers

Limited Availability

-- The beneficiary

-- A surviving spouse or dependent who is entitled to either :

a) Social Security Disability Insurance Payments (Title II)

or

b) Medicare

Compromises

- The Federal Claims Collections Act provides CMS with authority to compromise claims – pre or post settlement.
- Contractors have no compromise authority.
- CMS must refer every favorable compromise determination of a debt of $100,000.00 or more to the Department of Justice (DOJ) for final determination.

Compromise - **WHAT TO SEND**

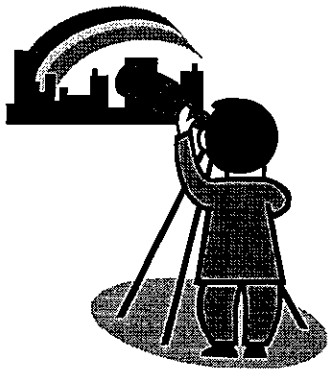
- Medicare Beneficiary Full Name, Medicare number, date of incident/ingestion/exposure
- Settlement specifics - a copy of the settlement agreement from the third party showing the total amount of the settlement, signed and dated by your client, and your closing settlement reflecting the actual amount of attorney's fees and case expenses.
- Valid privacy release or a copy of your representation contract signed by the Medicare beneficiary
- Incident/case related facts which you believe support a favorable decision
- Medicare beneficiary financial information such as monthly income and expenses, assets & debts, documentation of loss of income due to what was claimed and/or released in the settlement, judgment, or award, expenses for widened doorways, ramps, absence of Medigap insurance, and/or other medical out-of-pocket expenses, etc.
- Any information you believe will support a favorable decision.

Confidentiality

- Confidentiality clauses, while not illegal, are contrary to public policy; therefore, no agreement may contain such a clause except when DOJ advises that it would be recommended in the course of litigation.

Future Medicals

Liability & Workers' Compensation



- Medicare must be protected any time a Medicare beneficiary recovers for future medicals.
- There is no formal CMS review process in the liability arena as there is for Worker' Compensation. **However,** CMS does expect the funds to be exhausted on otherwise Medicare covered services related to what was claimed/released before Medicare is ever billed. CMS review is decided on a case by case basis.

Medicare Set-Asides - - -

- Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines liability insurance. Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those funds are available to pay for Medicare covered future services **related to what was claimed and/or released in the settlement, judgment, or award**. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered by Medicare.

Medicare Set-Asides - - -

- The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded.
- The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded.

Medicare Set-Asides - - - Cont.

- While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc, we are frequently asked how one would 'know'. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any otherwise Medicare covered, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is by no means all inclusive.

Medicare Set-Asides - - -

- We use the phrase "case related" because we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare's right of recovery, and the prohibition from billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) of the Social Security Act.

Otherwise Medicare Covered

- "Otherwise covered" means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust fund. For example, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate.

Medicare Set-Asides **IN LIABILITY CASES**

- At this time, the Centers for Medicare & Medicaid Services (CMS) is not soliciting cases to review solely because of the language provided in a general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. We do however urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.
- There is no formal CMS review process in the liability arena as there is for Worker' Compensation, however Regional Offices do review most submitted set-aside proposals.
- On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

Interest

- Remember, interest accrues on amount owed Medicare after 60 days of settlement. (Medicare assess interest 60 days from the date of their demand)

  45 CFR §30.13, 30.14(a)

  42 CFR §411.24(h)
- Consider the impact of interest on any decision to pursue a waiver or compromise.

I DIDN'T KNOW MY CLIENT HAD MEDICARE

<u>Suspect Medicare's Involvement</u>

- Any time your client is 65+
- Any time your client is disabled

Who Else?
•Medicare Managed Care Plans

If the Medicare beneficiary is enrolled in a Medicare Managed Care plan you should contact that plan apart from your notice to COBC to determine their recovery interest. Usually that plan will have made any payments for related claims.

For More Information:

www.cms.hhs.gov/MandatoryInsRep

www.cms.hhs.gov/Medicare/COBC

www.MSPRC.info

CMS Contact Information

- Group Health Plan/Liability/Future Medicals
  Sally Stalcup (214) 767-6415
- Workers' Compensation (214) 767-6402
- COBC (800) 999-1118
- MSPRC (866) 677-7220