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# Navigating Through the Fog: Medicare, Future Medicals & Liability Settlements

The extent to which settling parties must consider Medicare's interests in medicals in a liability settlement continues to be unclear. The incremental process the Centers for Medicare and Medicaid Services (CMS) has pursued since 2001 has yielded a Medicare Set-Aside (MSA) review process for workers' compensation, a mandatory reporting process for the reporting of almost all liability, workers' compensation and no-fault settlements, and a comprehensive Medicare conditional payment process with dedicated recovery contractors, but no specific guidance on the consideration of post-settlement future medicals in a liability case.

CMS has nonetheless signaled its intention to expand its voluntary MSA review process to liability settlements. This paper navigates through the fog to explore CMS authority to regulate in this area, a history of official CMS policy in relation to liability settlements and future medicals, considerations for CMS in developing a policy addressing future medicals, and guidance to the liability practitioner in considering Medicare's interests where CMS has yet to articulate a clear set of guidelines.

## CMS Authority

Questions regarding future medical considerations tend to focus on whether CMS has the authority, either statutorily or regulatory, to implement a Liability Medicare Set-Aside (LMSA) review process. However, the root question is whether CMS has the authority to deny payment for injury related medical care after a liability settlement or can otherwise seek reimbursement from the settling parties for post-settlement injury-related medical care.

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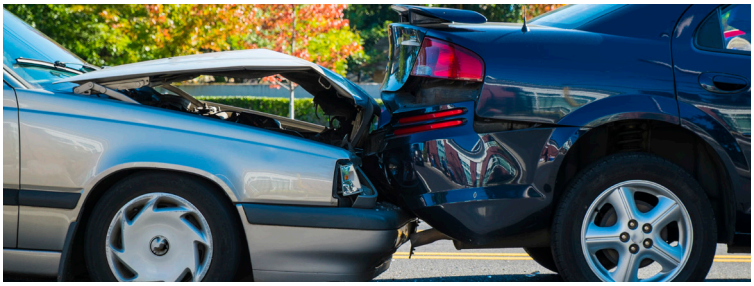
Almost two decades ago, both CMS and workers' compensation practitioners focused on this question and the interpretation made was that CMS had such authority, at least in the workers' compensation context. Practitioners encouraged CMS to implement a review process which would approve a portion of the workers' compensation settlement to fully protecting Medicare's interest, rather than assuming the entire settlement is available to pay future medicals. The review process which CMS subsequently created provides certainty for workers' compensation parties to settle cases without fear that Medicare will seek payment for medical care beyond the CMS-approved MSA amount or otherwise seek reimbursement from the settlement funds.



Accordingly, the question for liability practitioners is whether CMS has the same authority to deny payment for injury-related medical care or seek recovery for payments made after a liability settlement. If so, then just like with workers' compensation, liability practitioners can be expected to ask CMS for a review process to have the same confidence that only a portion of the settlement is allocated to future medicals.

## CMS AUTHORITY UNDER THE MSP ACT

In general, CMS cites the following provision under the Medicare Secondary Payer Act as its basis to deny payment for post-settlement medical, whether workers' compensation, no-fault or liability:

> Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that . . .
>
> . . . (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. 42 U.S.C. § 1395y(b)(2)

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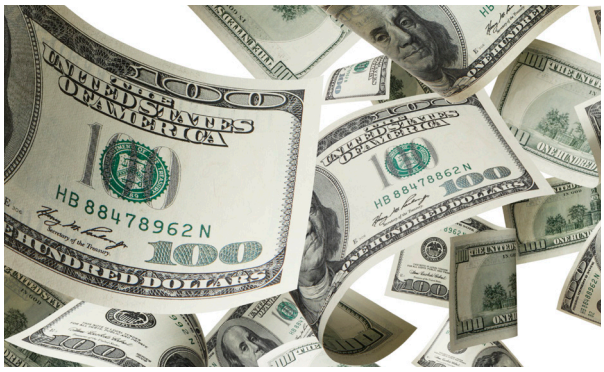
*CMS ANPRM Provides Insight into CMS's Interpretation of its Authority*

While subsequently withdrawn, the June 15, 2012 Advanced Notice of Proposed Rulemaking (ANPRM) provides background on CMS's position regarding responsibility for payment of medical care post liability settlement and its authority to either deny payment for injury-related medical care or seek reimbursement for injury-related payments made:

> Primary payment responsibility on the part of workers' compensation, liability insurance (including self-insurance), and no-fault insurance is generally demonstrated by settlements, judgments, awards, or other payments. When a "settlement" occurs, the "settlement" is subject to the MSP statute because a "payment has been made" with respect to medical care related to that "settlement." By law, Medicare is subrogated to any right of an individual or any other entity to payment for items or services under a primary plan, to the extent of Medicare's payments for such medical items and services. Moreover, section 1862(b)(2)(B)(iii) of the Act provides a direct right of action to recover Medicare's conditional payments. This direct right of action, which is separate and independent from Medicare's statutory subrogation rights, may be brought to recover conditional payments against any or all entities that are or were responsible for making payment for the items and services under a primary plan. The government may also recover under the direct right of action from any entity that has received payment from a primary plan or the proceeds of a primary plan's payment to any entity.
>
> Under its rights of subrogation and direct right of action, Medicare recovers for conditional payments related to the "settlement," regardless of when the items and services are provided. Further, Medicare is prohibited from making payment when payment has been made (that is, if the beneficiary obtains a "settlement"). Medicare remains the secondary payer until the "settlement" proceeds are appropriately exhausted. It is important to note that the designation future medical care ("future medicals") is a term specifically used to reference medical items and services provided after the date of "settlement."

The most notable aspect of this statement is CMS's position that it remains the secondary payer "until the 'settlement' proceeds are appropriately exhausted." If this is an appropriate interpretation of the agency's authority, then a CMS-approved LMSA would, just as in workers' compensation, provide for an amount less than the full settlement amount to be allocated to future medical care.



Although CMS takes this position, Tower MSA Partners is not aware of CMS routinely denying injury-related medical care post settlement or seeking reimbursement for post-settlement injury-related medical care stemming from liability settlements. We are also not aware of any cases challenging CMS's authority in this regard, likely because of the aforementioned lack of denying payment or seeking reimbursement.

Accordingly, outstanding questions remain over CMS's authority to deny payment or seek reimbursement for post-liability settlement injury-related medical. Additionally, if CMS has the authority to seek reimbursement, does a claim for reimbursement extend not only to the claimant, but also the primary plan and possibly the claimant's attorney? There are reasonable arguments on both sides of these issues, however, without judicial interpretation, uncertainty remains as to CMS's authority.

## CMS LMSA Review Policy

Without judicial interpretation of CMS's authority, we are left to official CMS guidance. Unfortunately, CMS memos or policy announcements have been sparse on the issue of LMSAs. While since 2001 when the WCMSA review process was introduced, a few of the 10 CMS Regional Offices have also voluntarily reviewed LMSAs, there has never existed an official CMS policy on consideration of future medicals in liability settlements.

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The following is a review of official CMS actions regarding LMSA reviews:

**9/30/2011** — CMS Memo provides criteria for when a CMS Regional Office will not review an LMSA, namely a physician certifies in writing that injury-related treatment has been completed as of the date of settlement and no future medical care will be required.

**6/15/2012** — CMS issues an Advanced Notice of Proposed Rulemaking (ANPRM) announcing its intent to issue formal regulations regarding considering Medicare's interest in future medicals stemming from a liability settlement. The ANPRM provides for several options for considering Medicare's interests. A comment period begins with stakeholders providing comments to CMS.

**10/2014** — CMS withdraws the ANPRM

**Early 2017** — CMS announces an RFP for the new Workers' Compensation Review Contractor (WCRC) which includes an optional provision to expand MSA reviews to liability as early as 7/1/2018.

**10/2017** — CMS releases a statement that it is considering expanding it voluntary WCMSA review process to liability and no-fault insurance. The statement indicates CMS will work closely with the stakeholder community to identify how best to implement this potential expansion of voluntary MSA reviews.

Despite CMS having the ability under the Workers' Compensation Review Contractor contract to conduct LMSA reviews, Tower MSA Partners does not believe CMS will move forward with such an expansion in 2018. Nonetheless, we do expect CMS to expand its voluntary review process to liability at some point over the next two years. In so doing, CMS will have to address the following in its review policy:

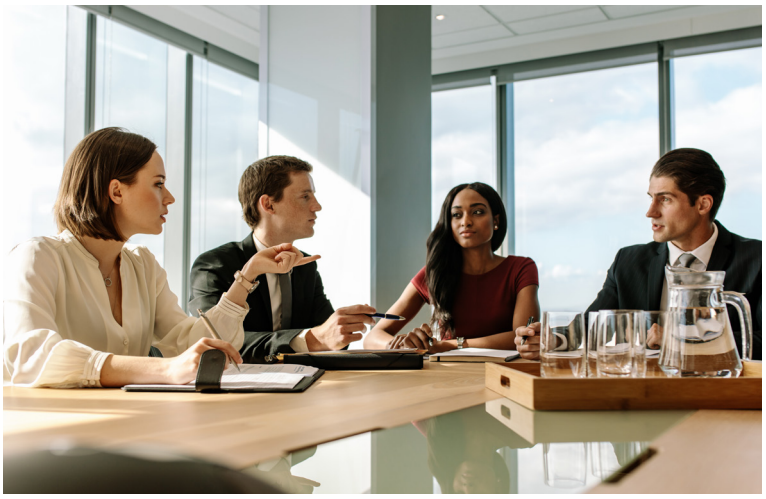
- Review thresholds
- Allocation of the MSA based upon a compromise formula
- Documentation required to submit to CMS with a LMSA proposal
- Whether the LMSA review will occur pre- or post-settlement
- Timeline for LMSA policy implementation
- Multiple defendant and mass tort settlements
- Pricing of medical in an LMSA (usual and customary vs. Medicare rates)

It is anticipated that CMS will provide policy guidance, similar to the WCMSA Reference Guide, prior to a start date for reviews.

Through its involvement with the National Alliance of Medicare Set-Aside Professionals (NAMSAP), Tower MSA Partners plans to dialogue with CMS regarding the expansion of MSA reviews to liability to ensure that any final process is one that reasonably balances the interests of the settling parties with those of Medicare.

## Guidance for Settling Parties and LMSAs

What are settling parties to do given that no CMS LMSA review policy or process currently exists? Tower MSA recommends the following:



- Identify whether the claimant is a Medicare beneficiary or has a reasonable expectation of Medicare eligibility within 30 months.
- If the claimant is a Medicare beneficiary or has a reasonable expectation of Medicare eligibility within 30 months, evaluate the necessity of future injury-related medical care. Is future medical care claimed in the settlement demand or alleged in the pleadings?
- If there is a necessity of future injury-related medical care, will this burden likely be shifted to Medicare? (For example, does the claimant have a source other than Medicare to pay future injury-related medical care, i.e. group health plan, which will likely cover future injury-related medical?)
- If the burden of future injury-related medical care will likely be shifted to Medicare, then consider whether there are sufficient settlement funds to allocate a portion of the settlement to fully fund future medicals. If so, then consider an LMSA as part of the settlement. If there are insufficient funds to fully fund future medicals, then consider an apportionment of the future medical allocation in relation to other damages allocated in the settlement.

- Document the file and settlement/release in regard to steps taken to consider Medicare's interest. If an LMSA or other type of allocation for future medical has been included in the settlement, ensure the plaintiff is aware of his or her responsibilities in utilizing those funds for future medical expenses. Also, if the LMSA has been apportioned, document the reasons why such a reduction was taken. If no LMSA or allocation for future medical has been included in the settlement, then ensure the plaintiff is aware of the potential implications for future payments by Medicare for injury-related medical care. Also, document why no such allocation has been included in the settlement/release.
- Besides the future medical considerations, remember as well to investigate and resolve Medicare conditional payments, including payments made through Part C Medicare Advantage Plans.

Ultimately, with the lack of CMS guidance, determining whether to include an LMSA as part of settlement is a risk management decision by both the primary plan (insurance carrier or self-insured entity) and the plaintiff and their attorney. Tower MSA Partners can provide consultation to all parties in understanding CMS's claimed authority under the MSP Act and recommendations for considering Medicare's interests within this authority. Please contact Tower MSA Partners at (888) 331-4941 or info@towermsa.com for a consultation.

# Daniel M. Anders

## CHIEF COMPLIANCE OFFICER
## TOWER MSA PARTNERS

As Chief Compliance Officer for Tower MSA Partners, Daniel Anders, Esq. oversees all aspects of regulatory compliance associated with the Medicare Secondary Payer (MSP) status and local, state and federal laws. His responsibilities include ensuring the integrity and quality of Tower's other services and products, including its Medicare Set-Aside (MSA) program.

With more than a decade of experience in working with employers, insurers, third-party administrators, attorneys and claimants, Dan provides education and consultation to Tower's clients on all aspects of MSP compliance. He has presented at industry conferences and written a number of articles and blog posts on compliance issues.

An attorney and certified Medicare Set-Aside Consultant, Dan joined Tower in 2016. He previously served as Senior Vice President of MSP Compliance for Examworks Clinical Solutions and he has extensive litigation experience from his earlier position with the Chicago law firm of Wiedner & McAuliff.

He is a member of the Illinois State Bar Association and the National Alliance of Medicare Set-Aside Professionals (NAMSAP), where he serves on the legislative committee.  Dan earned his Juris Doctor degree from Chicago-Kent College of Law and his bachelor's degree from Loyola University.

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