

*Alternate Sources of Compensation*

# The Medicare Secondary Payer Statute

by William E. Pipkin, Jr.

Questions have arisen regarding settlement of workers compensation claims and the impact of the Medicare Secondary Payer (MSP) provisions thereon. The differing statutes among the states regarding settlement of an employee's rights to medical benefits under workers compensation result in some variation in application of the MSP. Generally, the law and public policy favor settlement of disputes among parties and an end to litigation. Although properly approved settlements of workers comp claims are generally binding upon the parties, the same principle does not necessarily bind the federal government, in particular the Centers for Medicare and Medicaid Services (CMS).

## Medicare Secondary Payer Provisions

Medicare Secondary Payer refers to situations in which a carrier or program other than Medicare is primarily responsible for providing health care benefits to a claimant. These sources of payment include workers compensation, third

party tortfeasors, or health care insurance. By law, when Medicare beneficiaries have one of these alternative sources of payment, such payment must first come from such sources. In 1996 Congress initiated the Medicare Integrity Program, which was established to help reduce payment errors and protect and strengthen the Medicare Trust Fund. The CMS and the contractors retained by them work in areas such as the MSP program to improve payment accuracy. The MSP program is intended to collect information on the proper order of payers, and make sure CMS makes primary Medicare payment only for those claims where it has primary responsibility.

Coordination of Benefit (COB) contractors, retained by CMS, assume responsibility for much of the investigation of Medicare claims. They employ a variety of methods and programs to identify situations in which another payer source has the legal obligation to provide health care for a beneficiary, which obligation is primary, or superior, to that of CMS. Other contractors, such as Medicare Programs Safeguard Contractors, perform activities such as fraud review and MSP determinations, as part of the Medicare Integrity Program.

Here is the manner in which the contractors proceed in investigating Medicare claims, to determine whether the payment obligation

properly belongs elsewhere. When CMS receives a claim for medical benefits, a questionnaire is sent to the medical services provider to collect information on the existence of other insurance that may be primary to Medicare. When a claim is submitted with an explanation of benefits from an insurer other than CMS, a questionnaire is then sent to the beneficiary. When a diagnosis appears on a Medicare claim that indicates a traumatic accident, injury, or illness for which there might be additional coverage, the beneficiary is sent a questionnaire to collect relevant information.

The beneficiary is responsible for taking whatever action is necessary to obtain benefits under a workers compensation system, such as filing a claim in a timely manner and furnishing all necessary information, where payment under that system can reasonably be expected. See the *Medicare Intermediary Manual—Part Three*, section 3407 (this manual is available online at [http://www.cms.hhs.gov/manuals/12\\_int/a3400toc.asp](http://www.cms.hhs.gov/manuals/12_int/a3400toc.asp)). If the claimant's failure to properly and timely pursue benefits under workers comp results in the loss of those benefits, it is the position of CMS that it is not responsible for paying benefits to the extent that such benefits could reasonably have been expected under workers comp. Under circumstances where CMS has made a conditional Medicare payment, however, when the proceeds from the primary payer become available through settlement or otherwise, CMS has a priority right of recovery. 42 U.S.C. §1395y(b)(2)(B). According to the CMS, all workers comp cases that involve a Medicare beneficiary must be reported to its regional office or the COB contractor.

## Civil Remedies Available to the Government

When mistaken Medicare primary payments are discovered, actions to recover the amount of the payments from other insurers are undertaken. Civil remedies available to the federal government for pursuing civil claims for collection can be found in four statutes: the False Claims Act, the Civil Monetary Penalties Act, the Medical Care Recovery Act, and the Federal Claims Collection Act.

CMS publications refer to the False Claims Act, 31 U.S.C. §3729(a), as the government's primary enforcement tool. However, the FCA covers only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard of the truth or falsity of the



William E. Pipkin, Jr., is with the Mobile, Alabama office of Sirote & Permutt, P.C. He is a member of DRI, the Alabama Defense Lawyers Association, and the Alabama Workers' Compensation Defense Lawyers Association. Bill practices in the areas of workers compensation, products liability, and transportation and maritime defense.

claim, or deliberate ignorance of the truth or falsity of the claim. The FCA does not cover mistakes, errors, or negligence. The Civil Monetary Penalties Act, 42 U.S.C. §1320a-7a, 42 C.F.R. §402.1 *et seq.*, has the same elements. Although the remedies in these two statutes are appropriate for efforts to collect overpayments and improper payments to Medicare beneficiaries, providers, and suppliers, they are not proper for efforts to collect conditional payments by CMS.

The Medical Care Recovery Act does not provide for the recovery of Medicare payments in circumstances involving workers compensation. See 42 U.S.C. §2651(a) (MCRA applies only in situations involving tort liability). That leaves the Federal Claims Collection Act, 31 U.S.C. §3711, which provides that the head of a legislative agency shall try to collect a claim of the U.S. Government for money arising out of the activities of the agency. The FCA clearly covers claims by the government against Medicare beneficiaries and against providers and suppliers for the recovery of overpayments.

### Medicare Secondary Payment Statute

CMS can assert a claim for recovery of conditional payments, as defined by 42 U.S.C. §1395y(b)(2)(B), which claim is provided for under 42 U.S.C. §1395y(b)(2)(B)(ii). CMS may make conditional payments if it determines that the primary payer will not make payment “promptly” (which is defined by Medicare as within 120 days). A “conditional payment” is defined as “a Medicare payment for services for which another payer is responsible, made either on the bases set forth in [42 U.S.C. §1395y(b)(2)(B) and in 42 C.F.R. §411.32], or because [CMS] did not know that the other coverage existed.” 42 C.F.R. §411.21. With regard to workers compensation benefits, CMS notes that there is frequently a long delay between the injury and recovery of benefits where compensability is contested and, to avoid hardship to the beneficiary, conditional Medicare payments may be made. There is no discussion about when or to whom information regarding characterization of such a payment as “conditional” is conveyed, but apparently the beneficiary/claimant is informed.

In circumstances where CMS is aware of the existence of the third party payer, the characterization of a payment by CMS as “conditional” must be established at the time the payment is made. See 42 U.S.C. §1395y(b)(2)(B)(i).

Otherwise, CMS is prohibited by section 1395y(b)(2)(A) from making such a payment. Cases applying this statute with regard to payments made by CMS to claimants who had pending or potential tort claims against third parties have held that such payments are not necessarily “conditional” as defined by section 1395y(b)(2)(A)(ii) unless “payment... can reasonably be expected to be made promptly... under a workmen’s compensation law or plan.” *Thompson v. Goetzmann*, 315 F.3d 457, 461 (5th Cir. 2002); but see, *Brown v. Thompson*, 252 F.Supp.2d 312 (E.D.Va. 2003). The courts

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have reasoned that payment by alleged third party tortfeasors in cases involving disputed claims cannot reasonably be expected, and certainly there is no reasonable expectation that such payment will be prompt. See *id.*; *Evanston Hospital v. Hauck*, 1 F.3d 540 (7th Cir. 1993); *In re Diet Drugs Products Liability Litigation*, 2001 Westlaw 283163 (E.D.Pa.); but see, 42 C.F.R. §411.45(b), and *Brown v. Thompson, supra*.

A Medicare payment is only “conditional” and the government only becomes a “secondary payer” if the above conditions are met. *In re Diet Drugs Products Liability Litigation, supra*, citing *Evanston Hospital v. Hauck, supra*; see also, *Thompson v. Goetzmann, supra*. Therefore, CMS’ authority to recover under section 1395y(b)(2)(B)(ii) does not arise. Although there are no cases applying this statute to disputed workers compensation claims, it would appear that CMS has no reasonable expectation of prompt payment in such cases and therefore should not be able to elevate itself to secondary payer status under the definition of section 1395y(b)(2)(A). But see, *Brown v. Thompson, supra*.

In the context of tort claims, it is the position of CMS that any payments by a liability insurer (except payments under a no-fault clause in a non-automobile policy) constitute

liability insurance payments and that CMS is entitled to reimbursement for its payments from the proceeds of any award or settlement, whether or not there has been a determination or admission of liability and regardless of how such payments may be characterized (*i.e.*, loss of consortium, pain and suffering, etc.). See *Brown v. Thompson, supra*, and *Holle v. Moline Public Hospital*, 598 F.Supp. 1017 (C.D.Ill. 1984) (both involving recovery by Medicare against a beneficiary’s third party recovery); but see, 42 U.S.C. §1395y(b)(2)(B)(iii).

### CMS’ Right to Recovery

CMS is entitled to recover any payment it makes pursuant to 42 U.S.C. §1395y(b)(2)(A), which payments shall be conditioned on reimbursement to the appropriate Medicare Trust Fund. 42 U.S.C. §1395y(b)(2)(B)(i). The statute provides that the United States shall be subrogated to any right, under section 1395y(b)(2), of the claimant/employee to payment under workers compensation, to the extent of Medicare payments made. 42 U.S.C. §1395y(b)(2)(B)(iii). CMS is subrogated to any individual, attorney, private insurer or other entity entitled to payment by a third party payer for services for which CMS paid. 42 C.F.R. §411.26. The statute further provides that the United States may bring an action against “any entity which is required or responsible” (including, under some circumstances, a third party administrator) by a workers compensation act to recover Medicare payments. 42 U.S.C. §1395y(b)(2)(B)(ii).

It is the position of CMS that “all Medicare payments are conditioned on reimbursement to the appropriate trust fund, when notice or other information is received that payment with respect to such items could be made under a workers’ compensation law or plan.” *Medicare Intermediary Manual*, section 3407.9; see 42 U.S.C. §1395y(b)(2)(B)(i). The statute gives CMS whatever rights the claimant/beneficiary had against the employer and the workers’ compensation carrier. CMS says that the federal government may recover, directly from employers and workers compensation carriers, the Medicare benefits it paid for services that are reimbursable under workers comp and may do so regardless of whether the beneficiary files a comp claim. 42 C.F.R. §411.24(l). CMS may join or intervene in any workers comp claim where the compensability of the injury is at issue.

CMS instructs its personnel that, upon learning that a beneficiary has accepted a compro-

mise workers compensation settlement, they are to reopen the prior allowance and determine the amount of any overpayment. They are then to recover from the claimant/beneficiary any Medicare payments determined to have also been paid for by the lump-sum settlement. 42 U.S.C. §1395y(b)(2)(B)(ii); 42 C.F.R. §411.26(b). CMS further instructs that “in general, medical expenses incurred after the date of the final release of a lump sum compromise settlement are reimbursed under Medicare.” *Medicare Intermediary Manual*, section 3416. However, if the settlement allocates a certain amount for future medical expenses, that amount must be exhausted before CMS will begin payment. Further, if it appears that a settlement is an attempt to shift to CMS the responsibility for the payment of medical expenses for the treatment of a work-related condition, it will not be recognized by CMS. *Medicare Intermediary Manual*; 42 C.F.R. §411.46(b)(2).

CMS does not have rights against the employer or its workers compensation carrier greater than those provided to the employee under the particular state’s workers compensation act. See 42 U.S.C. §1395y(b)(2)(B)(iii). The secondary payer statutes simply allow CMS, should it so desire, to step into the shoes of the employee/beneficiary in an effort to pursue recovery of Medicare benefits that CMS believes are properly due under workers comp. *Id.*; *Medicare Intermediary Manual*, section 3407.9; CMS April 22, 2003 memorandum.

An important distinction must be drawn between CMS’ efforts to recover from a beneficiary/claimant and from an employer/carrier. Where a beneficiary/claimant receives payments from workers compensation, CMS may recover from the beneficiary/claimant

without having to prove that the payments were for the items paid by CMS. This is because the beneficiary/claimant, by accepting Medicare benefits, has agreed that CMS may recover such if they are later determined to be the responsibility of another source such as workers compensation. 42 C.F.R. §411.43(a). Specifically, “If the beneficiary . . . receives a third party payment, the beneficiary . . . must reimburse Medicare within 60 days.” 42 C.F.R. §411.24(h). Although there is a provision whereby, if CMS does not receive reimbursement from the beneficiary, “the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary” [42 C.F.R. 411.24(i)], this does not apply to workers compensation. Rather, this applies to liability insurance settlements, which are distinct from workers comp. See 42 C.F.R. §411.20(a). Liability insurance is defined as insurance that provides payment based on legal liability and includes automobile liability insurance, uninsured and under insured motorist insurance, homeowners’ liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. 42 C.F.R. §411.50. Therefore, CMS bears the same burden of proof, with regard to any claim against the workers compensation employer/carrier, as did the employee. The statute allows CMS three years from the date the medical treatment was provided within which to file a claim for recovery. 42 U.S.C. §1395y(b)(2)(B)(v).

The MSP statute creates a private cause of action for damages where “a primary plan . . . fails to provide for primary payment (or appropriate reimbursement).” 42 U.S.C. §1395y(b)(3). This is to discourage primary payers from sitting back and letting CMS take the lead; it appears intended for situations involving group

health plans whose primary responsibility for a beneficiary’s medical treatment is clear and undisputed. This section is apparently applicable to workers compensation claims where the employer/carrier’s liability is clear and uncontested.

The private cause of action is available to the beneficiary/claimant against the primary payer and provides for double damages. CMS may assert this claim should the beneficiary fail to do so; it may also recover double damages. 42 C.F.R. §411.24(c)(2). However, CMS may only recover double damages where the government can prove that the primary payer had knowledge of CMS’ conditional payment. *In re Silicone Gel Breast Implants Products Liability Litigation*, 174 F.Supp.2d 1242 (N.D.Ala. 2001); see also, *Health Insurance Association of America v. Shalala*, 23 F.3d 412 (D.C.Cir. 1994) (neither of these cases involved workers compensation). CMS may not bring a direct action pursuant to section 1395y(b)(2)(B)(ii) against an employer/carrier which has already satisfied its contractual obligations to the claimant/beneficiary. *In re Silicone Gel*, 174 F.Supp.2d at 1256.

CMS must bring a subrogation action pursuant to section 1395y(b)(3) and must prove that the third party payer knew or should have known about CMS’ conditional payment at the time payment (settlement) was made to the beneficiary. *Id.*; see also, 42 C.F.R. §411.25 (if third party payer learns the CMS has made a Medicare payment which third party payer should have made, it must notify CMS). The third party payer is not required to undertake an investigation for the benefit of the government to discover CMS’ involvement. *In re Silicone Gel*, 174 F.Supp.2d at 1257.

As a prerequisite to pursuing a direct action pursuant to section 1395y(b)(2)(B)(ii) against

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a third party payer, the government must first attempt to recover from the beneficiary. 174 F.Supp.2d at 1258. Obviously claims under sections 1395y(b)(2)(B)(ii) and 1395y(b)(3) differ in that the latter arises when the third party payer has made no payment whatsoever, and the former arises when the third party payer makes payment but does not do so to CMS.

### Settlements Closing Future Medical Benefits

CMS sent a letter to its associate regional administrators on July 23, 2001, entitled "Workers Compensation: Commutation of Future Benefits" (this letter is available online at <http://www.cms.hhs.gov/medicare/cob/pdf/wcfuturebene.pdf>). The letter notes that CMS makes a distinction between lump-sum workers comp settlements that involve commutations of future medical benefits and those that involve a compromise between the comp carrier and the injured individual. The letter specifically provides that Medicare set-aside arrangements are used *only* in workers compensation cases that possess a commutation aspect and are not used in comp cases that are exclusively compromise cases.

The CMS letter notes that one of the factors used by CMS for distinguishing compromise from commutation cases is the absence of controversy over whether a workers compensation carrier is liable. However, the letter further provides that the presence of a controversy over the issue of compensability does not automatically mean that a workers comp case involves a compromise as opposed to a commutation. The letter notes that generally settlement offers in compromise cases are relatively low and may not distinguish those amounts paid for disability benefits from those paid for medical benefits. The letter acknowledges that compromise settlements between a comp carrier and an employee often involve disputes over issues such as pre-existing condition, employment status, or "arising out of or in the course of employment."

The foregoing discussion notwithstanding, the CMS letter sets forth a definition for commutation cases whereby *any settlement which intends to compensate an individual for any medical expenses which might be incurred after the date of the settlement is considered by Medicare to be a commutation case.* See *Medicare Intermediary Manual*, section 3407 D.

The letter notes that set-aside arrangements

are most often used in those cases where the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. The aforementioned definition is further set forth at 42 C.F.R. §411.46, which provides:

If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the in-

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jury or disease equal the amount of the lump-sum payment.

The letter notes that this position is further reflected in section 3407.8 of the *Medicare Intermediary Manual*, which provides:

When a beneficiary accepts a lump-sum payment that represents a commutation of *all* future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment.

A lump-sum compromise settlement is defined by Medicare as "A settlement that provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested." *Medicare Intermediary Manual*, section 3407.1 E.

The CMS letter sets forth an apparent policy statement that "it is not in Medicare's best

interests to review every workers' compensation settlement nationwide in order to protect Medicare's interest" and sets forth the circumstances under which Medicare's interest should be considered.

Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests when the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, **and** the anticipated **total** settlement amount for future medical expenses **and** disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000.00.

The letter further provides:

Injured individuals who are already Medicare beneficiaries **must** always consider Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds \$250,000.00. That is, **ALL WC PAYMENTS** regardless of amount **must** be considered for current Medicare beneficiaries.

The letter sets forth the criteria that CMS uses to determine whether the amount of a lump-sum or structured settlement has sufficiently considered CMS' interests. The avowed purpose of CMS' evaluation of the proposed settlement amount is to determine whether there has been an attempt to shift liability for the cost of work-related injury or illness from the workers compensation carrier to Medicare. *Medicare Intermediary Manual*, sections 3407.6 and 3407.7. The factors to be considered are as follows: 1) date of entitlement to Medicare; 2) basis for Medicare entitlement (disability, end stage renal disease, or age); 3) type and severity of injury or illness (look to see whether the individual is expected to recover or whether his or her medical condition is expected to deteriorate); 4) age of beneficiary; 5) workers compensation classification of the beneficiary (*e.g.*, permanent partial, permanent total disability); 6) prior medical expenses paid by workers comp due to the injury or illness in the one or two year period after the condition has stabilized; 7) amount of lump sum or amount of structured settlement; 8) whether the commutation is for the beneficiary's lifetime or for a specific time period (review state law regarding the length of time workers compensation is obligated to provide medical benefits for the claimant); 9) whether the beneficiary is living at home, in a nursing home, or receiving assisted living care, etc.; and

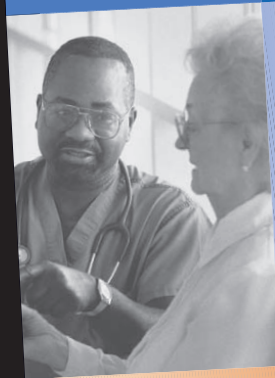
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## COMMITTEE PERSPECTIVES

## Workers Compensation

10) the propriety of the relation between expected expenses for Medicare-covered items and services, in light of the beneficiary's condition.

The CMS letter of July 23, 2001 provides that certain documentation is required before the regional office can provide a written opinion regarding the sufficiency of a proposed Medicare set-aside arrangement. The documentation includes: "a copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual's estimated life span, then a rated age may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. Also, documentation which gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care)." It is this written confirmation from CMS that protects the workers compensation claimant/Medicare beneficiary by establishing the parameters for future Medicare benefits after settlement of the workers comp claim closing future medicals. A Medicare set-aside trust or other similar arrangement allocating a portion of a workers compensation commutation settlement to future medical treatment in the amount agreed upon with Medicare may then be established.

On April 22, 2003, the Director of CMS issued a memorandum to all Regional Administrators addressing frequently asked questions with regard to workers compensation settlements and the Medicare Secondary Payer provisions. (This memorandum is available online at [http://www.cms.hhs.gov/medicare/cob/pdf/wc\\_faqs.pdf](http://www.cms.hhs.gov/medicare/cob/pdf/wc_faqs.pdf).) The Medicare Secondary Payer provisions in this memorandum apply primarily to the employee/claimant, the employee/claimant's attorney, and others who receive the proceeds from any workers compensation settlement agreement.

The memorandum states that CMS will generally honor judicial decisions issued after a hearing on the merits by a court in a workers compensation matter. However, CMS draws a distinction between a hearing on the merits and a proceeding where the court is simply approving a settlement that incorporates an agreement between the parties. With regard to CMS' recovery of funds, the memorandum states:

The CMS has a direct priority right of recov-

ery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly.

CMS cites as authority for this position 42 C.F.R. §411.24(g). The memorandum also provides that "pursuant to 42 C.F.R. 411.26, CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney or any other entity entitled to payment by a third party payer." It therefore appears that CMS' right of recovery is limited to those individuals or entities who have received or are entitled to receive payment from the third party payer, such as an employer workers compensation carrier or other insurer.

Although the examples and issues addressed in the recent CMS memorandum indicate that CMS will seek recovery only from those individuals or entities who have received or are entitled to receive proceeds from a workers compensation settlement, statutory portions of the Social Security Act and the Medicare Secondary Payer provisions do indicate that employers, their workers comp insurers, and other insurers are potentially liable in certain circumstances discussed more thoroughly above.

It appears that the July 23, 2001 CMS letter is a program policy letter, as it appears intended to coordinate and convey agency policies, guidelines, and interpretations to agency employees and interested members of the public. See *American Mining Congress v. Mine Safety & Health Administration*, 995 F.2d 1106, 1112-13 (D.C. Cir. 1993). The precise status and authority of this letter are unclear (*i.e.*, interpretive rule or legislative rule). However, the letter and the April 22, 2003 memorandum certainly provide the most recent and comprehensive discussion of the CMS' position with regard to workers compensation settlement agreements that provide for the closure of future medical benefits.

## Conclusion

Medicare set-aside arrangements are called for in very limited circumstances. There are several clear circumstances where CMS should be notified when a workers compensation settlement involves the termination of a claimant's rights to future medical benefits. Although the responsibility for notifying CMS rests with the claimant/beneficiary, prudence dictates that the employer/carrier's counsel should determine whether CMS needs to be notified or otherwise involved. **FD**