SYNERGY WHITE PAPER: Introduction to Medicare & Medicare Compliance under the Medicare Secondary Payer Act

By Jason D. Lazarus, J.D., LL.M., MSCC

Representing someone who is Medicare eligible automatically triggers concerns over the implications of compliance with the Medicare Secondary Payer Act (hereinafter MSP). For a trial lawyer's practice, ensuring compliance with the MSP when it comes to your law firm's practices at settlement is critical. Just as important though is understanding that a client who is a current Medicare beneficiary or reasonably expected to become one within 30 months should be educated about the MSP and protected from the ramifications of non-compliance. Regardless, the first step is understanding the general construct of the different Medicare coverages available to an injury victim.

Section 1: Medicare Program Overview

The Medicare program is made up of different parts.[1] Part A and Part B are thought of as 'traditional Medicare' which includes hospital insurance and medical insurance. Part A is the hospital insurance which covers inpatient care in hospitals and skilled nursing facilities (it does not cover custodial or long-term care – only Medicaid does). Part B benefits cover physician visits, durable medical equipment, and hospital outpatient care. It also covers some of the services Part A doesn't cover such as physical and occupational therapies as well as some home health care. Part D is prescription drug coverage that is provided by private insurers approved by and funded by Medicare. Part C (Medicare 'Advantage Plans' or MAOs) offers all of the

[1] SSDI beneficiaries receive Part A Medicare benefits which covers inpatient hospital services, home health and hospice benefits. Part B benefits cover physician's charges and SSDI beneficiaries may obtain coverage by paying a monthly premium. Part D provides coverage for most prescription drugs but it is a complicated system with a large co-pay called the donut hole.

coverages through Parts A, B and D but through a private insurer approved by Medicare. It is an alternative to the service fees for Parts A and B coverages which can be selected and purchased by a Medicare beneficiary.

There is a connection between Medicare eligibility and Social Security Disability Insurance (hereinafter SSDI). SSDI is the only way to get Medicare coverage prior to retirement age. This is pertinent as many injury victims become Medicare eligible by virtue of disability. Medicare and SSDI benefits are an entitlement and are not income or asset sensitive like Medicaid and SSI. Clients who meet Social Security's definition of disability and have paid in enough quarters into the system can receive disability benefits without regard to their financial situation.[2] The SSDI benefit program is funded by the workforce's contribution into FICA (Social Security) or self-employment taxes. Workers earn credits based on their work history and a worker must have enough credits to get SSDI benefits should they become disabled. Medicare is our federal health insurance program and as discussed above, is broken up into multiple parts. Medicare entitlement commences at age sixty-five or two years after becoming disabled under Social Security's definition of disability.

If an injury victim is a Medicare beneficiary, what is important to understand is that Medicare is always supposed to be a secondary payer, or the payer of "last resort, available only if no private insurer [is] liable."[3] But when a primary plan doesn't make payment, as is the situation with third-party liability cases, Medicare can pay but it is conditioned upon

[2] While most often we deal with someone who has a disability, Social Security Disability also provides death benefits. Additionally, a child who became disabled before age 22 and has remained continuously disabled since age 18 may receive disability benefits based on the work history of a disabled, deceased or retired parent as long as the child is disabled and unmarried.
[3] *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1240 (11th Cir. 2016).

reimbursement. This is what creates all of the issues when representing a Medicare beneficiary in a personal injury claim – application of MSP.

KEY TAKEAWAY: Medicare is comprised of different parts, with Part A and B providing traditional medical coverage, Part D providing prescription coverage, and Part C bundling all these services through a private insurer. A person can become eligible for Medicare before retirement age via SSDI if they meet the disability criteria and have sufficient work credits. Importantly, in personal injury cases involving a Medicare beneficiary, Medicare is the secondary payer or "payer of last resort," which means any payments it makes are conditioned on reimbursement, presenting complexities with the application of the Medicare Secondary Payer Act.

Section 2: Introduction to MSP Compliance

As the Eleventh Circuit has stated, it isn't just complex, but instead it is "notoriously complex".[4] Most lawyers find this area of the law very confusing at best and downright confounding at worst. This White Paper, and others, are an attempt to give a framework and guide to dealing with the most important issues when you represent a Medicare beneficiary.

A. Overview of the MSP

The MSP is a series of statutory provisions[5] enacted in 1980 as part of the Omnibus Reconciliation Act[6] with the goal of reducing federal health care costs. The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay.[7] The regulations that implement the MSP provide

[4] *MSPA CLAIMS 1, LLC v. Tower Hill Prime Ins. Co.*, 43 F. 4th 1259 (11th Cir. 2022).
[5] The provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 U.S.C. § 1395y(b)(6) (2007).
[6] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (Dec. 5, 1980).
[7] 42 CFR § 411.20(2) Part 411, Subpart B, (2007).

"[s]ection 1862(b)(2)(A)(ii) of the Act precludes Medicare payments for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following: (i) Workers' compensation; (ii) Liability insurance; (iii) No-fault insurance."[8]

There are two issues that arise when dealing with the application of the MSP: (1) Medicare payments made prior to the date of settlement (conditional payments) and (2) future Medicare payments for covered services (Medicare set asides). According to CMS, both are obligations in terms of compliance with the MSP which extends to both prior to settlement and into the future. The passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)[9] has triggered heightened concerns of all parties to a settlement involving a Medicare beneficiary. Part of this Act, Section 111,[10] extends the government's ability to enforce the Medicare Secondary Payer Act. As of April 1, 2011, a Responsible Reporting Entity/insurer (hereinafter RRE) who is a liability insurer, self-insurer, no-fault insurer and workers' compensation carriers must determine whether a claimant is a Medicare beneficiary ("entitled") and if so, provide certain information to the Secretary of Health and Human Services (hereinafter "Secretary") when the claim is resolved. This is the so-called Mandatory Insurer Requirement, MIR for short.[11]

B. Mandatory Insurer Reporting Requirement (MIR)

Under MMSEA, the RRE must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim. Failure of an

[8] *Id.*
[9] Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).
[10] 42 U.S.C. § 1395y(b)(7)-(8)
[11] *Id.*

applicable plan to comply with the reporting requirements potentially exposes them to a civil money penalty for each day of noncompliance with respect to each claim.[12] These reporting requirements make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties and potentially deny future Medicare covered services related to the injuries suffered.

The advent of MIR causes some very real and difficult problems for lawyers handling claims involving Medicare beneficiaries. For example, the biggest problem with the reporting requirement is the required disclosure of ICD medical diagnosis codes which identify the medical conditions that are injury related. These ICD codes can form the basis for the care potentially rejected by Medicare in the future. If the plaintiff and plaintiff counsel are unaware of the conditions disclosed by the defendant/insurer through the reporting process, there could be some serious problems when the plaintiff seeks medical care from Medicare in the future. For example, a plaintiff sustained back and neck injuries which were claimed as a part of their lawsuit. The plaintiff had pre-existing neck problems. The case is ultimately settled with the defendant paying nothing for the neck injury because they determined that the neck injury was primarily due to a pre-existing condition. Now the defendant/insurer reports the settlement and lists the ICD codes related to the neck injury even though they paid no settlement dollars towards that injury and rejected that part of the claim. The neck care could be rejected by Medicare in the future leaving the client with no set aside funds to pay for that care and no Medicare coverage either. Worse yet, your ability to negotiate a conditional payment made by Medicare may be complicated by including care that is unrelated. This issue is further exacerbated by the

[12] *Id.*

reporting data being submitted by outside reporting agents who are only providing initial case information without involvement of plaintiff counsel.

Another example is when the date of accident that is reported doesn't match up with what the plaintiff reports. The MIR requirements don't relieve the personal injury lawyer's obligation to report through the Benefits Coordination & Recovery Contractor (BCRC) and resolve the conditional payment. If the defendant insurer reports a date of accident that doesn't match with what was reported by plaintiff counsel, it could trigger a second and new conditional payment demand from Medicare. This often leads to frustration and complication in resolving the conditional payment obligation.

Every time I am consulted by other lawyers about this issue, I suggest that the parties should be collaborating on this aspect of the Medicare settlement process. If the plaintiff does not know what is being reported, then the scenarios above could easily occur. The practical problem is that defense counsel typically is unaware of what is being reported and the ICD codes aren't included in the release. Accordingly, there are no guarantees that even if the parties discuss this aspect of the reporting conundrum that the right codes will be reported. However, it still bears emphasis and discussion. Without focusing on this issue as part of the settlement process, a plaintiff, plaintiff lawyer or an elder law attorney involved in the case may find there are serious unintended repercussions that result.

1. MMSEA/MIR Release Language

In this new age of hypervigilance surrounding Medicare Compliance as a result of MIR, release language about protecting Medicare can be longer than the release itself. This language is frequently inaccurate or wholly inapplicable. In practice, I have seen language that mandates that the personal injury victim will not apply for Medicare or even Social Security Disability

benefits. Equally as bad, language is frequently included that places a burden on the plaintiff to comply with requirements that aren't mandated by any law. Most of the language improperly cites statutes or regulations that don't say anything relevant to the issues at hand.

Therefore, great care needs to be taken by the personal injury practitioner in terms of what is agreed upon and included in the release. Technically, there is nothing required by any law that needs to be addressed in the release as it relates to the MSP. Practically speaking though, language has to be there to placate the other side's misinformation about their own liability regarding many of the MSP related issues. It is simple to address these issues concisely and in a way that doesn't place any onerous obligations upon the plaintiff. Every case is different, and the facts dictate the use of different language each time but there is a core set of provisions that can be done in one simple paragraph to deal with the Medicare related issues at hand.

2. *MMSEA/MIR and Conditional Payments*

The stated intent of the new reporting requirements was to identify situations where Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The Medicare Secondary Payer Act (MSP) prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no fault insurance or a group health plan.[13] However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or can't be expected to be paid promptly.[14] These "conditional payments" are made

[13] 42 CFR § 411.20(2) Part 411, Subpart B, (2007).
[14] 42 U.S.C.S. § 1395y(b)(2)(B)

subject to being repaid when the primary payer pays.[15] When conditional payments are made by Medicare, the government has a right of recovery against the settlement proceeds.[16]

The Medicare Secondary Payer Act and the Mandatory Insurer Reporting requirements form a complex set of issues that personal injury lawyers must deal with. As a result, realizing that every settlement with a Medicare beneficiary of seven hundred and fifty dollars or more will be reported along with a variety of data points is critically important. Working collaboratively with the other side when it comes to these issues is recommended. Having incorrect or inaccurate information reported can cause both your client and your law firm issues.

KEY TAKEAWAY: The Medicare Secondary Payer Act (MSP) mandates Medicare as a secondary payer to other insurance plans. Key obligations under MSP include the resolution of conditional payments and the potential creation of Medicare Set-Asides for future care. The MMSEA enhanced MSP enforcement, requiring Responsible Reporting Entities to report the Medicare status of claimants upon settlement, further emphasizing the need for thorough MSP compliance in settlements involving Medicare beneficiaries.

Conclusion

In wrapping up this White Paper, you should better understand that navigating Medicare compliance under the MSP Act is a complex task for trial lawyers, demanding a deep knowledge of Medicare's various parts, their implications, and the relationship between SSDI and Medicare. The MSP Act, in particular, poses various challenges when it comes to compliance, with Medicare always being a secondary payer. The MSP's statutory provisions and the introduction

[15] *Id.*
[16] 42 U.S.C.S. § 1395y(b)(2)(B)(iii)

of the MMSEA have only added layers of complexity to this legal landscape. The MMSEA's Mandatory Insurer Reporting Requirement, in particular, presents unique challenges in the resolution of claims involving Medicare beneficiaries. Issues such as disclosure of medical diagnosis codes, alignment of accident reporting dates, and the complexities surrounding the settlement process necessitate an even greater need for collaboration between parties and precision in the language used in releases.

Understanding the intricacies of Medicare, the MSP, and related legislation like the MMSEA, is essential for a trial lawyer dealing with personal injury cases involving Medicare beneficiaries. Missteps can lead to costly and complex legal problems, but with the right understanding and careful handling, lawyers can better serve their clients while remaining compliant with these mandates. In other White Papers, I will delve into further detail on these complex issues, aiming to clarify and provide practical strategies to navigate the labyrinthine terrain of Medicare and MSP compliance. The goal of these White Papers is to arm trial lawyers with the necessary knowledge and tools to ensure that their clients' interests are protected. Equally as important, it can help trial lawyers and their practices remain free from the problems that can arise from non-compliance.

SYNERGY MSP COMPLIANCE PRACTICE TIP:

Develop a systematic process to identify Medicare beneficiaries in their practice and address potential issues. The process should start with identifying clients who are Medicare beneficiaries and those who may become Medicare eligible within 30 months of settlement. Obtain a copy of all award letters (including those from Social Security) and copies of Medicare cards to confirm the type of benefits they receive. From there, make sure to remember the **CAD** acronym.

Consult with the necessary MSP experts to resolve all conditional payments/Part C liens as well as address futures, **a**dvise the client about the MSP then **d**ocument your file.