

Resolution of Medicare Conditional Payments

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Introduction to Conditional Payment Resolution under the MSP

Congress has given the Centers for Medicare and Medicaid Services (hereinafter CMS) both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from “any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan.”¹ Furthermore, CMS is authorized under federal law to bring actions against “any other entity that has received payment from a primary plan.”² Personal injury lawyers have been sued under this provision for failing to repay a Medicare lien. Most ominously, CMS may seek to recover double damages if it brings an independent cause of action.³ Given all of the foregoing, Medicare subrogation law is a problematic area for personal injury practitioners. The MSPA⁴ presents liability concerns for personal injury practitioners because of its complexity, and the difficulty in dealing with Medicare’s subrogation bureaucracy.⁵

The government is very serious about its reimbursement rights when it comes to Medicare conditional payments. As an example, in *U.S. v. Harris*, a November 2008 opinion, a personal injury plaintiff lawyer lost his motion to dismiss against the U.S. Government in a suit

¹ 42 U.S.C. § 1395y(b)(2)(B)(iii) (2007).

² *Id.*

³ 42 U.S.C. § 1395y(b)(2)(B)(iii) (2007).

⁴ 42 U.S.C. § 1395y(b)(2)(B)

⁵ For a good discussion of the issues relating to conditional payments see Jonathan Allan Klein & Annmarie M. Liermann, *Medicare Lien Interests in Liability Settlements – Easy Solutions to Help Resolve Medicare Reimbursement Issues for Beneficiaries and Insurers*, Medicare Secondary Payer Act Reform Task Force (2007).
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involving the failure to satisfy a Medicare subrogation claim.⁶ The plaintiff, the United States of America, filed for declaratory judgment and money damages against the personal injury attorney owed to the Centers for Medicare and Medicaid Services by virtue of 3rd party payments made to a Medicare beneficiary.⁷ The personal injury attorney had settled a claim for a Medicare beneficiary (James Ritchea) for \$25,000.⁸ Medicare had made conditional payments in the amount of \$22,549.67. After settlement, plaintiff counsel sent Medicare the details of the settlement and Medicare calculated they were owed approximately \$10,253.59 out of the \$25,000.⁹ Plaintiff counsel failed to pay this amount and the Government filed suit.

A motion to dismiss filed by plaintiff counsel was denied by the United States District Court for the Northern District of West Virginia despite plaintiff counsel's arguments that he had no personal liability. Plaintiff counsel argued that he could not be held liable individually under 42 U.S.C. 1395y(b)(2) because he forwarded the details of the settlement to the government and thus the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed. The court pointed out that the government may under 42 U.S.C. 1395y(b)(2)(B)(iii) "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." Further, the court pointed to the federal regulations implementing the MSPA which state that CMS has a right of action to recover its payments from any entity including an attorney.¹⁰ Subsequently, the U.S. Government filed a motion for summary judgment against plaintiff counsel. The United States District Court, in March of 2009, granted the motion for summary judgment against plaintiff

⁶ *U.S. v. Harris*, No. 5:08CV102, 2009 WL 891931 (N.D. W.Va. Mar. 26, 2009), *aff'd* 334 Fed. Appx 569 (4th Cir. 2009).

⁷ *Id.* at *1.

⁸ *Id.*

⁹ *Id.*

¹⁰ *See* 42 C.F.R. 411.24 (g).

counsel and held that the Government was entitled to a judgment in the amount of \$11,367.78 plus interest.¹¹

Resolution of the government's interests concerning conditional payment obligations is simple in application but time consuming. The process of reporting the settlement starts with contacting the BCRC (Benefits Coordination Recovery Contractor).¹² This starts prior to settlement so that you can obtain and review a conditional payment letter (CPL).¹³ These letters are preliminary and can't be relied upon to as a final demand to pay Medicare from. However, they are necessary to review and audit for removal of unrelated care. Once settlement is achieved, Medicare must be given the details regarding settlement so that they issue a final demand. Once the final demand is issued, Medicare must be paid its final demand amount regardless of whether an appeal, compromise or waiver is sought.¹⁴ Paying the final demand amount within sixty days of issuance is required or interest begins to accrue at over ten percent (10%) and ultimately it is referred to the U.S. Treasury for an enforcement action to recover the unpaid amount if not addressed.¹⁵

KEY TAKEAWAY: Under the Medicare Secondary Payer Act (MSPA), the Centers for Medicare and Medicaid Services (CMS) has robust powers to recover its payments, including the ability to sue personal injury lawyers directly and seek double damages. The U.S. government is diligent in enforcing its rights to be reimbursed for these payments, and a failure to properly navigate the system can lead to severe financial and

¹¹ *U.S. v. Harris*, No. 5:08CV102, 2009 WL 891931 at *5.

¹² See <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Attorney-Services.html>.

¹³ See <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Conditional-Payment-Information/Conditional-Payment-Information.html>.

¹⁴ *Id.*

¹⁵ 42 C.F.R. 411.24(m).

legal consequences. Lawyers must initiate the resolution process by contacting the Benefits Coordination Recovery Contractor (BCRC) and carefully auditing any conditional payment letters, which are not final and should not be relied upon. The final demand amount issued by Medicare must be paid within 60 days to avoid accruing interest and potential legal action. Therefore, caution, thoroughness, and an understanding of the law are crucial for personal injury practitioners handling Medicare subrogation issues.

Resolution of Conditional Payments – Appeal, Compromise or Waiver

The repayment formula for Medicare is set by the Code of Federal Regulations. Sections 411.37(c) & (d) prescribes a reduction for procurement costs.¹⁶ The formula doesn't take into account liability-related issues in the case, caps on damages or policy limits. The end result can be that the entire settlement must be used to reimburse Medicare. The only alternative is to appeal, which requires you to go through four levels of internal Medicare appeals before you ever get to step foot before a federal judge or compromise/waiver. There is plenty of case law requiring exhaustion of the internal Medicare appeals processes which means that Medicare appeals are a lengthy and unattractive resolution method.¹⁷ What makes them even more unattractive is the fact that interest continues to accrue during the appeal so long as the final demand amount remains unpaid.

An alternative resolution method is to request a compromise or waiver post payment of the final demand. By paying Medicare their final demand and requesting compromise/waiver,

¹⁶ 42 C.F.R. 411.37(c) &(d).

¹⁷ A perfect example of this is *Alcorn v. Pepples* out of the Western District of Kentucky. In *Alcorn*, the court held that "Alcorn's claim with respect to the Secretary arises under the Medicare Act because it rests on the repayment obligations set forth under 42 U.S.C. § 1395y. She therefore must exhaust the administrative remedies established under the Medicare Act before this court may exercise subject matter jurisdiction over her claim." *Alcorn v. Pepples*, 2011 U.S. Dist. LEXIS 19627 (W.D. Ky. Feb. 25, 2011).

the interest meter stops running. If Medicare grants a compromise or waiver, they actually issue a refund back to the Medicare beneficiary (typically payable to their legal counsel who made payment to satisfy the final demand). There are three viable ways to request a compromise/waiver. The first is via Section 1870(c) of the Social Security Act which is the financial hardship waiver and is evaluated by the BCRC.¹⁸ The second is via section 1862(b) of the Social Security Act which is the “best interest of the program” waiver and is evaluated by CMS itself.¹⁹ The third way is under the Federal Claims Collection Act and the compromise request is evaluated by CMS.²⁰ If any of these are successfully granted, Medicare will refund the amount that was paid via the final demand or a portion thereof depending on whether it is a full waiver or just a compromise.

KEY TAKEAWAY: There is a rigid and often problematic Medicare repayment formula dictated by the Code of Federal Regulations. The formula is particularly unforgiving as it does not consider liability issues, damage caps, or policy limits, potentially consuming an entire settlement amount. Appeals are a lengthy and burdensome process, comprised of four levels of internal Medicare appeals before one can appear before a federal judge, all while interest accumulates on the unpaid final demand amount. An alternative to this protracted process is paying the final Medicare demand upfront to halt the accrual of interest, then requesting a compromise or waiver. Three specific methods are available: 1) financial hardship waivers (evaluated by the Benefits Coordination Recovery Contractor (BCRC) under Section 1870(c)), 2) "best interest of the program" waivers (evaluated by CMS under Section 1862(b)), and 3) “compromise” under the Federal

¹⁸ 42 U.S.C. § 1395gg

¹⁹ 42 U.S.C § 1395y

²⁰ 31 U.S.C. § 3711

Claims Collection Act, (evaluated by CMS). If successful, these could result in a refund of some or all of the final demand amount paid to Medicare, making it a potentially quicker and more appealing option for resolving repayment issues.

Mistakes & Pitfalls to Avoid in Resolving Conditional Payments

The Department of Justice has pursued law firms for failure to properly reimburse Medicare when it has made a conditional payment. There are certainly some clear mistakes to avoid when it comes to resolution of Medicare conditional payments. The first mistake to avoid is relying upon a conditional payment letter's dollar figure when settling a case. The second mistake to avoid is using the wrong resolution mechanism when it comes to Medicare. The following two examples of mistakes made in both of these situations are relevant to help avoid falling into these same traps.

You Can't Rely Upon a Conditional Payment Letter

In 2019, a Maryland personal injury law firm settled a claim brought by the United States Department of Justice for claims related to failing to reimburse Medicare for payments made on behalf of one of the firm's clients. The facts of this Medicare resolution issue are important to demonstrate why you can never rely upon the amount you get from Medicare before submitting your final settlement details and receiving a final demand. The law firm in question represented a Medicare beneficiary in a medical malpractice action. Apparently, according to the settlement agreement, in and prior to 2012, Medicare made conditional payments to healthcare providers to satisfy medical bills for a client of the firm. Accordingly, they properly notified Medicare of the case by reporting it to the BCRC. Medicare's interim recovery amount according to a conditional payment letter the firm received was \$14,990. The firm indicated that the amount

was confirmed via mail, the phone and the portal. The case eventually settled for \$1,150,000 with the law firm relying upon the \$14,990 figure in resolving the case. Medicare was properly notified of the settlement by the law firm and was presented with written information about the settlement. Sixty days later, Medicare issued a final demand indicating the amount owed was \$330,000.00 instead of \$14,990 as previously detailed in the conditional payment letter.

The problem here is settling the case and relying upon a conditional payment letter which didn't bind Medicare. In response to the final demand, the law firm filed an administrative appeal with Medicare challenging the amount owed that unsurprisingly was denied. After losing their appeal, the U.S. Attorney's office sent a letter to the firm claiming that over \$330,000 was due and indicating that interest would be tacked on as well. The law firm ultimately turned the matter over to their malpractice insurance carrier. The government and the law firm's malpractice insurance carrier settled the matter for \$250,00.00. In the press release related to the resolution, the government stated that the settlement should "remind attorneys not to disburse settlement proceeds until receipt of a final demand from Medicare to pay the outstanding debt." So, the moral of the story is that you can't rely upon a conditional payment letter, only a final demand letter will bind Medicare to an amount due to satisfy a conditional payment claim.

You Must Use the Proper Resolution Process

In yet another example of Medicare conditional payment resolution issues, a Houston law firm and its managing partner were sued by the government for failing to pay back a Medicare conditional payment. This is a unique situation though as plaintiff counsel did properly report the settlement to Medicare and attempted to resolve it, albeit through improper channels. In March of 2020, the United States Attorney in Texas filed suit on behalf of the Centers for Medicare and Medicaid Services (CMS) against the firm and the managing partner to recover the

unpaid conditional payments plus interest, fees and costs. While it has become commonplace for the Department of Justice to pursue lawyers and law firms for failing to reimburse Medicare conditional payments in the recent past, those were situations where Medicare's right to reimbursement was completely ignored. Here that was not the case; instead, the law firm notified CMS' Benefits Coordination & Recovery Center (BCRC) of the lawsuit and communicated with them about settlement but ultimately the firm disagreed with the final demand amount. Instead of requesting an appeal, compromise or waiver, the matter was addressed in Texas state court. It is a cautionary tale in terms of following proper procedures if one does decide to challenge the amount owed to Medicare under the Medicare Secondary Payer Act (MSP).

Attorney Stephen P. Carrigan and his firm represented Tomas Tijerina in a personal injury lawsuit related to a car accident in April of 2014. In April of 2016, Mr. Carrigan's firm notified the BCRC about Tijerina's accident, his resulting injuries and lawsuit to recover damages. In March of 2017, Carrigan properly notified BCRC that the personal injury case had been settled for \$70,000.00. The next month, in April, BCRC sent out an Initial Determination with a payment summary detailing the \$46,244.74 that Medicare was claiming as required reimbursement. That same month, Carrigan filed a motion in Texas state court challenging the amount asserted by Medicare and notified Medicare of the pending action in state court. In July of 2017, Medicare issued its Final Demand letter for \$47,343.05 which included the related medical expenses plus statutory accrued interest. In August of 2017, Carrigan sent to Medicare an order issued by the state court that reduced Medicare's Conditional Payments by 90% down to \$4,700 along with a check for the \$4,700.

That brings us to March of 2020 where the U.S. Attorney, Ryan Patrick, filed suit against Carrigan and his firm in the United States District Court for the Southern District of Texas. Central to the lawsuit is the issue of the Texas state court lacking jurisdiction to adjudicate Medicare's recovery of conditional payments under federal law. In the complaint, Mr. Patrick pointed to sovereign immunity and the fact that the Texas state court lacked subject matter jurisdiction related to conditional payments made under the MSP. He outlined that proper challenges, disputes or attempts to reduce/avoid reimbursement due to Medicare for conditional payments must go through the administrative appeal process set out in the Medicare Act and regulations. According to the complaint, only after exhaustion of those administrative remedies can a claim be made to a United States District Court, which has exclusive subject matter jurisdiction to hear claims under the MSP. There is plenty of case law on that point and it is a winning argument. The complaint also laid out the liability for an attorney who fails to reimburse Medicare under 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(g).

While the matter was ultimately settled, it is very likely that the suit by the government would have been successful, and the attorney would be liable for the full lien amount plus interest, fees and costs. The fact that the state court had no jurisdiction and based its order on applying Ahlborn, a Medicaid lien decision, to a Medicare conditional payment means there is little likelihood that the federal district court would have respected the state court's ruling. Sovereign immunity and preemption by federal law alone prevents the state court ruling from being given any consideration at all by the federal court.

This all could have easily been avoided by paying the final demand and then seeking a compromise/waiver. By doing so, you prevent the interest meter from continuing to run and eliminate the need to engage in lengthy appeals involving exhaustion of administrative remedies

within Medicare. If Medicare grants a compromise or waiver, they issue a refund back to the Medicare beneficiary. As discussed in the previous section, there are three viable ways to request a compromise/waiver. The first is via Section 1870(c) of the Social Security Act which is the financial hardship waiver and is evaluated by the BCRC.²¹ The second is via section 1862(b) of the Social Security Act which is the “best interest of the program” waiver and is evaluated by CMS itself.²² The third way is under the Federal Claims Collection Act and the compromise request is evaluated by CMS.²³ If any of these are successfully granted, Medicare will refund the amount that was paid via the final demand or a portion thereof depending on whether it is a full waiver or just a compromise.

The critical takeaway is that an attorney must use the proper channels for challenging conditional payments owed to Medicare. There are multiple considerations before deciding to appeal or seek a compromise/waiver of conditional payments. Certain steps are necessary to resolve a conditional payment which includes audit/verification of the amount after receiving the conditional payment letter and securing a final demand by providing final settlement details to Medicare. Failure to resolve a conditional payment exposes a trial lawyer to personal liability for the amount of the conditional payment and the government does pursue lawyers individually if they fail to reimburse Medicare, so be very careful when it comes to dealing with Medicare as you do not want to become a cautionary tale. You and your firm never want to be in this position or have the possibility of a double damages claim by the government. The key here is to work with competent experts when it comes to Medicare compliance. Lien resolution companies

²¹ 42 U.S.C. § 1395gg

²² 42 U.S.C. § 1395y

²³ 31 U.S.C. § 3711

specialize in protecting law firms against this sort of precise scenario by being a law firm's Medicare compliance expert partner.

KEY TAKEAWAY: Attorneys must exercise extreme caution and due diligence when dealing with Medicare conditional payments in settlements. Firstly, reliance on conditional payment letters as final figures is a serious mistake; only a final demand from Medicare confirms the amount due. Secondly, it is crucial to use proper legal channels and mechanisms to challenge or appeal these payments. Failing to do so can result in significant legal repercussions, including personal liability and legal action from the government. The section highlights two cautionary tales that demonstrate the risks of mishandling Medicare issues. To mitigate such risks, lawyers should consider working with specialized lien resolution companies that can guide them through the complex landscape of Medicare compliance, from the audit and verification of conditional payment amounts to the strategic utilization of appeal or compromise/waiver options. Ignoring these guidelines may not only jeopardize the financial viability of a settlement but could also expose attorneys to punitive damages and professional embarrassment.

Conclusion

To summarize, resolution of a Medicare conditional payment is either by following the reduction formulas found in the Code of Federal Regulations or by appeal, waiver and/or compromise. There are multiple considerations before deciding to appeal or seek a compromise/waiver of conditional payments. Certain steps are necessary to resolve a conditional payment which includes audit/verification of the amount after receiving the conditional payment letter and securing a final demand by providing final settlement details to Medicare. Failure to resolve a conditional payment exposes a trial lawyer to personal liability

for the amount of the conditional payment and the government does pursue lawyers individually if they fail to reimburse Medicare.

In addition to traditional Medicare liens, Medicare Advantage (Part C) plans also present distinct challenges that require unique resolution strategies. Understanding these nuances is crucial for effective lien resolution. If you are interested in learning more about Part C plan liens, contact Synergy today for our other white paper.