Medicare Reporting Tips and Potential Pitfalls

In all liability settlements, judgments, and other similar payments, it remains imperative to determine whether the claimant is a Medicare beneficiary, and whether there is any expectation of future medical treatment related to the occurrence upon which the claim is based. The payment must be reported to Medicare, and all defense counsel should ensure that the liability insurer is properly informed of the claimant’s Medicare status and information so the Responsible Reporting Entity (RRE) may properly fulfill its Section 111 reporting obligations. While this article is by no means intended to be comprehensive in presenting all Medicare reporting requirements and pitfalls (indeed, hundreds of pages can, and have been, devoted to subparts of sections of the Social Security Act), there are areas that may easily be overlooked by practitioners. Two of these areas are: (1) the use of Liability Medicare Set-Asides; and (2) future reporting and medical expense funding obligations where the claimant was not a Medicare beneficiary at the time of the settlement, payment, or judgment. As all attorneys should be aware, Medicare is entitled to recovery of conditional payments for medical treatment made on behalf of patients where it can be established that another insurer should bear primary responsibility for those payments. The reasoning is that Medicare, utilizing tax dollars, should not pay for medical care or treatment where there is an insurer of a potential tortfeasor that should more properly be making those payments. Medicare makes conditional payments on behalf of injured persons to ensure that medical care is provided, but then has a right to recover those payments from any judgment, award, settlement or other payment, regardless of any admission of liability. As a result, those insurers who settle with injured parties who are Medicare beneficiaries must report those settlements to Medicare. Such settling insurers, including self-insured entities, are called RREs, or secondary payers. Medicare can impose stiff penalties on RREs that fail to timely report settlements involving Medicare.

Medicare’s Interest in Future Medical Payments

Medicare also has an interest in future payments that will be made on behalf of Medicare beneficiaries for injuries that may have been wrongfully caused. If Medicare becomes liable for future medical payments arising from an injury where there was a judgment, award, settlement, or similar payment to the plaintiff, Medicare may pursue the plaintiff, the plaintiff’s attorney, or the insurer who made the payment and recover up to 100% of the proceeds (plus fines and fees) to reimburse Medicare for medical payments made after the RREs’ payment to the plaintiff. In a case where future medical treatment is reasonably certain, the parties should consider a Liability Medicare Set Aside (LMSA) to ensure that Medicare’s future interest is protected.

Current handling of Liability Medicare Set Asides (LMSA) is an unsettled area for insurers and attorneys. Unlike set asides in workers’ compensation settings (WCMSAs), virtually no guidance has been provided by Medicare or the Centers for Medicare and Medicaid Services (CMS) as to how or when to create a set aside in a civil liability setting. WCMSAs are relatively simple; there will likely be a definite point at which payments
for treatment by a workers’ compensation carrier will end, and a portion of the settlement must be set aside to make future medical payments before Medicare will begin paying anything. CMS reviews and approves nearly all WCMSAs so there is certainty for the parties in the workers’ compensation area that Medicare’s interest is adequately protected. LMSAs, on the other hand, are only occasionally reviewed by CMS, and CMS’ review of LMSAs varies by region. In the Chicago region for example, LMSAs will only be reviewed if the settlement exceeds $250,000 and the plaintiff is a Medicare beneficiary, and even then only at the discretion of CMS. CMS’ failure to review a settlement has no impact on CMS’ right to future reimbursement.

LMSAs are not required by law. However, the protection of Medicare’s future interest is required by law. Practitioners should take note that LMSAs are CMS’ preferred method for protecting Medicare Trust Funds. CMS has released a handful of rules and memos regarding LMSAs that provide some guidance for when a LMSA should be utilized. LMSAs should always be considered where there is inadequate funding for future medical bills, which would put the Medicare trust funds in jeopardy. The rules and memos from CMS have provided that in cases where the plaintiff is not currently receiving any Medicare benefits, there is no obligation for a secondary payer to report the settlement to Medicare. In fact, CMS has explicitly stated that it does not want blanket reporting from secondary payers as a way for those secondary payers to “cover themselves,” and has indicated that it will monitor the reporting of secondary payers to ensure that this practice does not occur.

A regional CMS office based in Baltimore, Maryland issued an advisory memo on September 30, 2011, stating that if a certification is provided in writing from the Medicare beneficiary claimant’s treating physician that treatment for the alleged injury has been completed and future medical services will not be required, Medicare will consider its interest for future medical payments satisfied. This only applies in the situation where the claimant is a current Medicare beneficiary. This physician certification, along with an agreement regarding reimbursement for past medical payments by Medicare, may be enough to forgo any LMSA, and protect the RRE should the claimant in fact require future medical treatment for related injuries. Of course, the frequent situation of a claimant being certified at “maximum medical improvement” is not sufficient if that maximum improvement will require ongoing care and treatment related to the claimed injuries.

Future Medicare Concerns Where the Claimant is not a Current Medicare Beneficiary

But how should practitioners handle settlements or payments involving non-Medicare beneficiaries? The CMS has issued official statements that in a WCMSA situation, if the claimant is not currently a beneficiary of Medicare or Social Security, it is the responsibility of the secondary payer to determine if there is a reasonable expectation that the claimant will become a beneficiary within thirty (30) months of the settlement. If so, the secondary payer must monitor the benefit status of the claimant and report to Medicare if the claimant becomes a beneficiary within the 30 months. The reasoning is that eventually the workers’ compensation benefits will end and Medicare will be forced to take on the responsibility for medical payments. Medicare requires that this future expectation of medical treatment be accounted for in any settlement or payment.

There is no such definitive guidance in a LMSA, but it may be prudent to follow the same general guidance. Pursuant to section 1395y of the Social Security Act, there is no difference between Medicare’s right to recovery following a worker’s compensation settlement or a liability settlement. Medicare has a right to protect its trust funds equally in both types of cases. Practitioners should be aware that the same obligation to protect future payments from the Medicare trust funds exists where the claimant is not currently a Medicare beneficiary, but will reasonably become one within thirty (30) months of settlement. For RREs, including liability insurers, this can be especially concerning. As stated above, an RRE cannot report a settlement or payment to Medicare unless the claimant is a current Medicare beneficiary. However, the obligation of the RRE to report the settlement to CMS arises if that claimant in fact becomes a Medicare beneficiary at any point during that thirty (30) month window. Defense counsel must ensure that the insurer is aware at the time of the settlement or payment of the potential future obligation to report.
Recommendations

CMS considers it within the judgment of the attorneys handling the case to determine if there is a future interest of Medicare that should be protected. It is the responsibility of every attorney to evaluate these issues before the time of settlement, payment, or judgment and determine if a settlement, payment, or judgment needs to be reported. Likewise, every attorney must evaluate the proper course of action if there is any reasonable expectation of future medical treatment, or if the claimant is not currently a Medicare beneficiary and there is a reasonable expectation that the claimant will become one in the thirty (30) months following settlement, payment, or judgment.

It is also important to document in the settlement materials, if applicable, that these issues were considered by the parties. Whatever the medical treatment or Medicare beneficiary status of the claimant is, defense counsel should insist that the agreement and understanding of future treatment and beneficiary issues are plainly stated in the release or settlement documents, and made part of the settlement agreement. While it is clear that release and indemnification language should be present in any liability release where the claimant is a Medicare beneficiary, defense counsel should consider including language certifying that a claimant is not a beneficiary if that is the case, and that there is no reasonable expectation of becoming one in the next thirty (30) months. Counsel may also wish to consider obtaining a letter from the claimant’s treating physician(s) certifying that treatment for the alleged injury or injuries is complete, even where the claimant is not a current beneficiary, and there is no reasonable expectation of becoming one in the next thirty (30) months. It should be noted that where there are injuries to different areas of the body, a letter should be obtained from each treating physician treating those areas.

CMS and Medicare appear to be holding all the cards in that they require that any future interest be protected, but offer little to no guidance on how to protect that interest, and will likely not review any plan that litigants may agree to in order to satisfy that obligation. Claimants may be reluctant to set aside a portion of their recovery for Medicare reimbursement, especially if they are not currently Medicare beneficiaries. With the increasing attention being paid to the dwindling Medicare Trust Account, practitioners must ensure that these issues are considered.

Additional materials, information, and updates related to this topic may be found at:

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