MANDATORY INSURER REPORTING: A PRIMER FOR RESPONSIBLE REPORTING ENTITIES

INTRODUCTION

Liability insurers, self-insured entities, and third party administrators should be aware of how Medicare's right to reimbursement may pose a risk of future liability and a significant obstacle to resolving cases. Consider the following scenario: a seventy (70) year-old woman, Mary, slips and falls in a hallway at Hamilton High School. As a result, she breaks her hip. Mary's injuries require that she seek treatment and undergo surgery to repair her hip. Mary makes a claim against the school's general liability carrier, who subsequently settles with Mary for $300,000. The carrier disburses the full settlement amount, closes the file, and leaves Mary and her attorney responsible for reimbursing Medicare for the medical payments Medicare paid. Months later, Medicare asserts its right to reimbursement of the $150,000 in medical expenses provided to Mary as result of her slip and fall. However, Mary has already paid her attorney's contingency fee, and she has no surplus left from the settlement to reimburse Medicare. The question then becomes – Can the liability carrier be forced to disburse an additional $150,000 to reimburse Medicare despite having already paid the settlement? In light of the recent Amendments to the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), the answer, unfortunately, is "Yes."

These Amendments were enacted to make certain that Medicare is made whole from the tortfeasor responsible for causing Medicare claimants' injuries. The Amendments effectively shift the responsibility of reimbursing Medicare from plaintiffs' attorneys to the insurance carriers. The carriers are required to assume a more aggressive role to enforce the reimbursement of conditional payments to Medicare in settlements, or risk exposure to civil penalties of $1,000 per day fines for non-compliance with the reporting requirements.[1]

This article will discuss the pitfalls of the Medicare Secondary Payer Act ("MSP"), and, more specifically, how the recently enacted Amendments to the MMSEA changes the obligations of insurance companies, self-insured entities, and third-party administrators in reporting losses and settlements to Medicare. This article will also provide guidance to the carriers, and those who work on behalf of carriers, for navigating the settlement of claims where Medicare has a right to reimbursement, to ensure that all parties are in compliance with the MMSEA requirements.

MEDICARE OVERVIEW

Medicare is an entitlement program providing medical benefits to aged and disabled individuals.[2] Specifically, Medicare is available to: (1) persons 65 years or older who are eligible for Social Security; (2) disabled or injured persons who are eligible to receive Social Security Disability; (3) persons with permanent kidney failure; and, (4) persons who purchase Medicare coverage. Medicare is administered by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the Federal Department of Health and Human Services.[3]

The applicable sections of the Medicare Secondary Payer provisions were originally enacted in the early 1980s.[4] In 2003, Congress fortified the Medicare Secondary Payer statute, 42 U.S.C. Section 1395y, out of concern for Medicare's rising costs. The MSP provisions assign primary responsibility for medical bills of Medicare recipients to private health plans when a Medicare recipient is also covered by private insurance.[5] This responsibility is assigned without regard to a patient's Medicare entitlement.[6] These private plans are considered "primary" under the MSP provisions.[7]

Generally, Medicare is a secondary payer in two situations. First, Medicare is a secondary payer to Group Health Plans ("GHPs") for Medicare Beneficiaries who: (1) are age 65 and older and who have GHP coverage on the basis of their own or their spouse's current employment with an employer that has at least 20 employees; (2) are younger than 65 and disabled and who have GHP coverage on the basis of their own or a family member's current employment with an employer having at least 100 employees; or (3) have End Stage Renal Disease (ESRD) and who have GHP coverage on any basis.[8] Second, Medicare is a secondary payer to certain types of "non-GHP" insurance coverage, such as liability insurance, including self-insurance, no-fault insurance, and workers' compensation benefit payments.[9]

Medicare is intended to be a "secondary payer" after all other entities responsible for paying the covered medical expenses have exhausted the covered expenses. Medicare, as the secondary payer, conditionally pays for the claimant's treatment with the expectation that the responsible liability carrier will later reimburse Medicare. Medicare, then, has a cause of action against the primarily responsible party/carrier for recovery of the amounts paid by Medicare.[10]

A Medicare beneficiary who receives payments from a primary payer must reimburse Medicare within 60 days of receiving payment from a settlement or judgment.[11] To that end, the Center for Medicare and Medicaid's ("CMS") right to seek recovery accrues when a primary payer settles a claim, or when a judgment is reached."[12] CMS cannot demand reimbursement until the beneficiary's claim is settled.[13]

Enactment of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA")

In order to ensure that Medicare discovers settlements and judgment payments in underlying lawsuits so that it can be reimbursed, the Federal Government recently amended the MSP provisions pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). The MMSEA has drastically changed the obligations of insurers and third party administrators ("TPAs") in tort liability cases. Section 111 adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan arrangements, as well as for Medicare beneficiaries who receive settlements, judgments, awards, or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation.[14]

This duty to report all payments made to Medicare beneficiaries begins on **January 1, 2011**.[15] It imposes a statutory obligation on carriers to investigate whether a plaintiff or claimant is entitled to receive benefits under Medicare, to determine the amount to be reimbursed to Medicare, and to report payment amounts and other information to Medicare.[16] Importantly, Section 111 simply *adds* reporting rules; it does not eliminate any existing statutory provisions or regulations.

Who Must Report Pursuant to the MMSEA – "RREs"

The Amendments to the MSP provisions require certain entities, referred to as "Responsible Reporting Entities" ("RREs"), to report to Medicare specified information regarding GHP arrangements and "non-GHP" arrangements, including applicable and responsible liability insurance.[17] RREs are defined as anyone who funds and pays, in whole or part, a settlement, judgment, award, or other payment to a Medicare beneficiary.[18] RREs include liability, no-fault, and workers' compensation insurers, as well as self-insured entities and TPAs.[19] While RREs may designate an agent to do the investigation and actual reporting on behalf of the RRE, RREs cannot contract away their duties to the agent.[20] RREs still remain responsible for information submitted to Medicare, and are subject to penalties for failure to comply with the statute.[21]

When to Report

Beginning **January 1, 2011**, RREs will begin live reporting of settlements, judgment, awards, and other payments, and report on a quarterly basis thereafter.[22] However, the initial live report is retroactive, and must include to those claims involving a settlement, judgment, award, or other payment or Medicare beneficiaries on or after **October 1, 2010**.[23]

RREs will submit their initial claim files containing information for all liability insurance claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award or other payment date is **October 1, 2010,** or thereafter.[24] Initial claim files must include claims on which ongoing responsibility for medical payments exists as of **January 1, 2010**, and subsequent, regardless of the date of an initial acceptance of payment responsibility.[25] Subsequent quarterly file submissions are to contain only new or changed claim information.[26]

What Must Be Reported Pursuant to the MMSEA

Settlements, judgments, awards, or other payments made to a Medicare beneficiary on or after **October 1, 2010**, must be reported, regardless of whether it is a one-time payment, a structured settlement, or an annuity.[27] Moreover, any ongoing payment responsibility, such as the payment of medical bills as they arise, must be reported by RREs for those assumed payments occurring on or before **January 1, 2010**.[28]

Reporting Overview

The RREs will make these reports, also known as "Claim Input Files," electronically by way of the Coordinator of Benefits Secure Website ("COBSW").[29] The Claim Input File is the data set transmitted by the RRE to the COBC that is used to report insurance claim information where the injured party is a Medicare beneficiary, and medicals are claimed and/or released, or the settlement, judgment, award, or other payment has the effect of releasing medicals.[30] Claim information is reported: (1) after the RRE's ongoing responsibility for medicals ("ORM") has been assumed, or (2) after the total payment obligation to the claimant ("TPOC") for the settlement, judgment award, or other payment has occurred.[31]

"Ongoing Responsibility for Medicals" Reporting

RREs must report claim information where ongoing responsibility for medical services ("ORMs") related to a claim will be assumed by the RRE on or after **January 1, 2010.**[32] Where the assumption of ongoing responsibility for medicals occurred prior to **January 1, 2010**, and continued on or after **January 1, 2010**, reporting is also required.[33]

The trigger for reporting ORMs is the date the RRE has made a determination to assume the responsibility for the Medicare beneficiary's ongoing medicals.[34] This reporting obligation is not triggered when or after the first payment of medicals have been paid.[35] Medical payments do not actually have to be paid on the claim for this reporting responsibility to be required.[36]

In referring to "ongoing" responsibility for medical records, "ongoing" is not related to "ongoing reporting," or repeated reporting of claims, but, rather, the RRE's responsibility to pay on an ongoing basis for the Medicare beneficiary's medicals associated with the claim.[37] This responsibility typically only applies to workers' compensation claims and no-fault claims. No-fault claims include those claims involving Medical Payments Coverage ("Med Pay") and Personal Injury Protection ("PIP") payments. If an RRE has assumed these payments, the RRE is reimbursing the provider of services (the doctor, hospital, etc.) or the injured parties for specific treatment or medical treatment as they are presented. When the RRE ends its ongoing assumption of the Claimant's medicals (*e.g.*, a no-fault limit is reached, the injured worker is healed and back to work), then the RRE must report the termination date of the assumption of the ongoing medicals.[38]

Moreover, the RRE is not to report each time it pays for medical services for the Medicare beneficiary.[39] Additionally, the actual amounts paid for the services are not reported; the RRE is simply required to report that the ongoing medicals have been assumed by the RRE and the termination date. Nor is the RRE required to submit this same claim information for each quarter.[40] Once the RRE makes the first report and receives a positive response that the record was accepted, the RRE is not required to report until the RRE ends its assumption of the medicals, or a settlement is reached.[41]

If there was no particular settlement or judgment with the claim, then reporting the termination date is all that is needed with respect to the Section 111 requirements.[42] However, if the RRE has assumed the responsibility for the ongoing medicals, and later reaches a settlement, then the termination date and the settlement must be reported in two separate reports.[43]

"Total Payment Obligation to the Claimant" Reporting

The Total Payment Obligation to the Claimant Medicare beneficiary ("TPOC") refers to the dollar amount of a settlement, judgment, award, or other payment to the plaintiff or claimant, in addition to/apart from ongoing medical responsibility. TPOC payments require only one reporting event if there is only one TPOC payment. Upon a settlement, judgment, award, or other payment to the claimant occurring on or after **October 1, 2010**, the RRE is required to submit the report only once, regardless of whether it is funded through a single payment, an annuity, or a structured settlement.[44] TPOC reports are required by anyone who received medical treatment, regardless of whether or not there is an admission or determination of liability, and even if the parties, or the court, do not specifically allocate the payment to medicals.

Dollar Amount Thresholds

In addition to the reporting requirements of the MMSEA previously discussed, the CMS has also established interim reporting thresholds for purposes of Section 111 reporting.[45] RREs must adhere to these requirements when determining what claim information should be submitted on initial and subsequent quarterly update Claim Input Files. These thresholds are solely for purposes of the required reporting responsibilities pursuant to the Section 111 MSP reporting requirements for carriers. These thresholds are not exceptions, and do not act as a "safe harbor" with respect to any other obligation or responsibility of any individual or entity with respect to the Medicare Secondary Payer provisions.[46] These thresholds are simply interim thresholds in place while the CMS is implementing the Section 111 reporting process.[47]

For example, the MMSEA provides that judgments or settlements of **$5,000.00 or less paid prior to January 1, 2012**, do not have to be reported.[48] Moreover, judgments or settlements of **$2,000.00 or less paid between January 1, 2012, through December 31, 2012,** do not have to be reported.[49] Settlements or judgments of **$600.00 or less paid between January 1, 2013, through December 31, 2013**, do not have to be reported.[50] The MMSEA also specifies that no threshold applies to claims for **settlements or judgments paid on or after January 1, 2014**; therefore, all claims must be reported, regardless of the settlement or judgment amount.[51]

Importantly, although these thresholds do not require the RRE to report the judgments or settlements set forth above, the RREs still have an obligation to ensure that Medicare is reimbursed for the conditional payments made in conjunction with these claims. As such, it follows that RREs are subject to file reimbursement lawsuits in the event that Medicare is not reimbursed for these claims. Accordingly, RREs must be cognizant of the reimbursemen obligation in order to reduce its exposure to future lawsuits.

Initial & Quarterly File Submissions

RREs are required to make live reportings by electronically submitting the initial Claim Input File beginning **January 1, 2011**.[52] The report includes the identity of the Medicare Beneficiary, his or her gender, Social Security Number, Health Insurance Claim Number ("HICN"), and date of birth, as well as the injury, accident, or incident at issue. This report consists of a file containing information for all claims where the injured party is/was a Medicare beneficiary, and medicals are claimed and/or released through a settlement, judgment, award, or other payment on or after October 1, 2010, regardless of the assigned date for the RRE's first submission.[53] The RRE must also report on claims for which the RRE has an ongoing responsibility for medicals as of **January 1, 2010,** and subsequent, even when the assumption of ongoing responsibility occurred prior to **January 1, 2010**.[54] Where the assumption of ongoing responsibility for medicals occurred prior to **January 1, 2010**, and continued on or after **January 1, 2010**, reporting is also required.[55]

Claim Input Files must be submitted on a quarterly basis, four times a year.[56] RREs must include International Classifications of Disease, 9th Revision, Clinical Modification (ICD-9) codes on Claim Input Files submitted on or after **January 1, 2011**.[57] The COBC will, then, use this information to map this description to an ICD-9 diagnosis code for use by other Medicare contractors in claim processing and recovery efforts.

CMS allows the use of up to five (5) ICD-9 codes to characterize the injuries related to the accident.[58] The CMS benefits coordinator contractor will enter this information into the CMS database and create a working file. This information is, then, transmitted to the Medicare Secondary Payer Recovery Contractor ("MSPRC"), who assembles the data and issues the interim payment statements to the Medicare beneficiary. As discussed more fully below,[59] it is recommended that the RRE obtain a signed consent from the Medicare beneficiary in order to receive these statements and track the conditional payments made throughout the discovery process and settlement negotiations.[60]

Fines and Penalties for Failure to Report Pursuant to the MMSEA

It is critical that all RREs are aware that noncompliance with the reporting requirements of Section 111 exposes RREs to particularly harsh penalties. Medicare's right to reimbursement accrues when the RRE pays for an expense that Medicare initially paid.[61] As such, in order to enforce its subrogation rights, CMS has the right to initiate recovery efforts for conditional payments as soon as it learns that a settlement, judgment, award, or other payment has been made, or could be made, by any of the plans responsible for primary payment.[62] Therefore, CMS can bring an action against "any or all entities that are or were required or responsible" for primary payments and that fail to reimburse Medicare for the payments.[63]

For example, in the recent case of *U.S. v. Harris,*[64] the U.S. District Court for the Northern District of West Virginia held that a plaintiff's attorney became liable to Medicare immediately when he made payment to his client, a Medicare beneficiary. Mr. Harris' client in a personal injury case had received Medicare benefits in the amount of $22,549.67. The plaintiff's attorney settled the personal injury action for $25,000. He then distributed the settlement proceeds without reimbursing Medicare for its conditional payments. Medicare reduced its claim to $10,253.59, taking into account Mr. Harris' attorney's fees, costs, and the amount of the settlement. Having already disbursed the settlement funds, Mr. Harris ignored Medicare's rights. Thereafter, Medicare pursued Mr. Harris in court to recover its conditional payment.

The court granted summary judgment for the government stating that, "the statute provides, in part, that "the United States may recover . . . from any entity that has <u>received</u> payment from a primary plan or from the proceeds of a primary plan's payment to any entity."[65] Therefore, "CMS has a right of action to recover its payments from <u>any</u> entity, including a beneficiary, provider, supplier, physician, attorney, State agency, or private insurer that has received a primary payment."[66] Accordingly, the court entered judgment against the plaintiff's attorney in the amount of $11,367.78, plus the amount of interest.[67]

As this case illustrates, anyone, including attorneys, who exercises control over settlement funds is advised to take every measure to protect Medicare's rights, as any involved entity could be the subject of similar lawsuit. During settlement negotiations, RREs and defense counsel should stress to claimants' and plaintiffs' attorneys that they, too, can be held personally liable for their clients' conditional Medicare payments.

Moreover, the penalties available to CMS to recover the Medicare conditional payments are severe. CMS can pursue a reimbursement lawsuit against a primary payer within six (6) years from the date a claimant is paid, and is entitled to recover double damages, attorneys' fees, and interest.[68] If Medicare is not timely reimbursed, the carrier is still required to reimburse Medicare

two times the reimbursement amount, even if a primary payer has already paid the Medicare beneficiary.[69]

For example, the U.S. Department of Justice recently filed a suit on this precise issue in the United States District Court for the Northern District of Alabama. In *U.S. v. Stricker*,[70] several attorneys, corporations, and insurers settled a large class action involving 907 Medicare beneficiaries. However, Medicare's conditional payments were not reimbursed. The class action was settled for approximately $300 million, and now the Department of Justice is seeking double damages against all parties as a result of the failure to reimburse Medicare. Accordingly, this case illustrates the government's ability and willingness to file suit against RREs for the timely recovery of Medicare conditional payments.

Additionally, the Secondary Payer Act provides a private cause of action for Medicare beneficiaries. Like Medicare's right to initiate suit, a Medicare beneficiary can sue a primary payer that fails to reimburse Medicare or otherwise make primary payment.[71] The Act provides that a Medicare beneficiary's claim against a primary payer "shall be in an amount double the amount otherwise provided."[72] As it stands today, this private cause of action is not limited to RREs.[73] Any party involved in a settlement agreement, including plaintiffs' attorneys and defense attorneys, are equally responsible and are exposed to liability.[74] Therefore, it is absolutely critical that all parties involved in the settlement maintain an open dialogue regarding the amount to be reimbursed to Medicare in order to insulate each entity from a private cause of action.

Finally, there are stiff penalties involved for an RRE's failure to timely report Medicare claims. Specifically, an RRE shall be subject to a civil money penalty of $1,000 per day per claimant/plaintiff for failing to report the Medicare claims later or altogether.[75]

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HANDLING MARY'S CLAIM: A STEP-BY-STEP GUIDE

In light of this overview, let us turn back to our hypothetical involving Mary. Imagine that you just received notice of Mary's claim. You are aware of the Medicare reporting obligations and want to know how to proceed. What is the next step? Is Mary a Medicare recipient? What actions do you need to take to ensure compliance with the reporting requirements? How do you go about facilitating a settlement in light of these new reporting provisions? Below is a step-by-step guide to follow from notice of the claim until the final settlement.

Step 1: Determine Whether Mary is a Medicare Beneficiary or Entitled to Medicare Benefits

The first action a claims adjuster should take upon receipt of a new claim or case is to determine whether the claimant is entitled to receive benefits under Medicare. Because these new reporting requirements only apply to Medicare beneficiaries, this step is critical in determining whether the RRE is subject to the mandatory reporting guidelines. As a rule of thumb, Medicare will likely be involved when the claimant is over the age of sixty-five (65) or disabled. Nevertheless, the adjuster must investigate whether the claimant is entitled to Medicare benefits, and can do so in several ways.

Turning to our hypothetical, the adjuster should first simply ask Mary, or Mary's counsel, if Mary is a Medicare recipient. At that time, the adjuster should also submit a written request to Mary's counsel in order to obtain the necessary Medicare information, specifically (1) the claimant's full legal name; (2) the claimant's Social Security Number or Health Insurance Claim Number ("HICN"); (3) the claimant's date of birth; (4) the date of the incident; and, (5) all health care benefits received by Mary, or those which Mary will become eligible to receive as a result of injuries related to the incident. The easiest way to obtain this information is to submit a "Consent to Release" form to Mary, which, ideally should be sent out upon first learning of the claim. A sample "Consent to Release" form is attached as Appendix "A."

If the matter is in suit, the defense attorney can simply issue written discovery requesting the above-noted information. For example, below are sample interrogatories that could be used:

1. Are you eligible to receive Medicare benefits?
2. Has Medicare provided any benefits to you or any of your health-care providers related to your medical treatment for alleged injuries that are the subject of this lawsuit?
3. If you answered yes to either 1 or 2 above, please provide the following information:

    a. Your full legal name;
    b. Your HICN or Medicare number;
    c. Your date of birth;
    d. Your Social Security number;
    e. Any ICD-9 diagnosis code(s) pertaining to your treatment; and,
    f. All other information relevant to items 1 – 132 of the Medicare Claim Input File Detail Record, as provided in the MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Act.

4. Do you expect to be a Medicare beneficiary within the next five (5) years?

It is also important to note that a plaintiff can now be compelled to provide the requested information, pursuant to a decision made by the United States District Court in the District of Nebraska. In *Seger v. Tank Connection, LLC*,[76] after the plaintiff refused to provide information regarding his receipt of Medicare benefits, the defendant filed a motion to compel plaintiff's answers to interrogatories, including his Social Security Number or Medicare Health Insurance Claim number (HICN). The defendant claimed it needed the information to aid its insurer in complying with the Section 111 requirements, and to evaluate the plaintiff's claims. The plaintiff argued pursuant to 42 U.S.C. § 1395y(b)(8), the Medicare information of a claimant or beneficiary is not required to be provided until "after the claim is resolved through a settlement, judgment, award or other payment."

The court found that the defendant met its burden of proving the relevance of the requested information, and that there was no harm to the plaintiff in providing the information sooner than required by the MMSEA.[77] Further, the court recognized that the defendant needed to know the outer limits of the plaintiff's medical expenses even though such information could be estimated from the medical records already provided by the plaintiff.[78] The court ordered the plaintiff to provide identifying information along with either his Medicare HICN or Social Security number so the defendant's insurance company could comply with the MMSEA.[79]

Therefore, not only is it in the best interests for the plaintiff or claimant to provide this information from the beginning of a claim, based on *Seger*, there is some authority to compel the

claimant or plaintiff to sign a written consent form. As such, if the case is in suit and Mary's attorney refuses to provide a signed "Consent to Release" form, Mary can be compelled by a court to provide the necessary information to the defense attorney.

It should also be noted that when communicating with a claimant, such as Mary, the adjuster cannot rely upon a claimant's statement that he or she is not a Medicare beneficiary. Instead, the MMSEA requires that an adjuster independently verify that the claimant is, in fact, not a Medicare beneficiary. An adjuster, therefore, cannot simply take the claimant's word that he or she is not a Medicare beneficiary. Hence, the best way to confirm the status of an injured party is for the RRE to submit a Query Input File to the COBC.[80] If CMS does not recognize a claimant as a Medicare recipient, the adjuster has no duty to report the claim.

Moreover, in the event that a claimant, such as Mary, is not a Medicare recipient, the adjuster is, nevertheless, subject to an ongoing duty to ascertain her status, such as if she becomes a Medicare beneficiary in the course of the settlement negotiations or the litigation process. An adjuster can simply renew his or her Query Input File prior to a settlement to determine if the claimant's status changed. Upon learning that the claimant became a Medicare beneficiary, then the adjuster must report this information to CMS. This continuing obligation rests squarely upon the RREs, as there is no reciprocal obligation upon the claimant to provide notice of the status change to the RRE. In the event that the RRE fails to uphold this continuing obligation and, subsequently, learns that it is dealing with a Medicare beneficiary, it could be liable for fines and penalties.[81] Therefore, it is advisable for the adjuster to develop a protocol for determining a claimant's status, and to track a claimant's Medicare eligibility.

Step 2: Place CMS on Notice

Once the adjuster learns in his or her investigation that a claimant, such as Mary, is a Medicare beneficiary, the adjuster must place the COBC on notice of the loss.[82] Notably, the RRE does not need a claimant's approval to give this notice.[83] Moreover, the trigger to report involves whether there is an expectation of the RRE making a payment for medical expenses.[84]

As previously discussed, if the RRE is an adjuster for the workers' compensation claim or the no-fault claim, it has certain reporting responsibilities when it assumes responsibility for the claimant's medical bills, even when the claim pre-dates the effective January 1, 2010, date for the MMSEA. For example, if Mary's accident occurred on December 15, 2009, and the RRE assumes her medical payments on January 15, 2010, the RRE has an obligation to report, as the assumption of Mary's medicals occurred on or after January 1, 2010. To change the hypothetical, if the RRE assumed Mary's medical payments on December 20, 2009, the RRE would be responsible for reporting the claim because where the assumption of ongoing responsibility for medicals occurred prior to January 1, 2010, and continued on or through January 1, 2010, reporting is required. In both situations, the RRE would be obligated to report the settlement or judgment of this claim, pursuant to the MMSEA provisions.

However, say Mary's accident occurred on August 15, 2009, the RRE assumed Mary's medical payments on September 1, 2009, and that the RRE's responsibility for her medical payments ended December 1, 2009. Under these facts, the RRE has no obligation to report because the RRE's ongoing responsibility for payments ended prior to January 1, 2010.

After CMS has been placed on notice of Mary's loss, the Medicare Secondary Payer Recovery Contractor ("MSPRC") will issue a "Rights and Responsibilities" letter. This letter, a sample of which is attached as Appendix "B," sets forth the date of the loss, explains why Medicare is entitled to reimbursement, and provides the claimant with the conditional payment amount to date.

Thereafter, the MSPRC will issue to Mary interim payment statements, known as "Conditional Payment Estimates." By securing a "Consent to Release" form, a claims adjuster can directly obtain copies of these statements in order to track the conditional payments made by CMS on Mary's claim as the claim proceeds.

Once Mary provides the signed "Consent to Release" form, the RRE can forward the signed authorization to the MSPRC to request that the Conditional Payment Estimates be sent directly to it. Directly receiving these statements is the most efficient way for a claims adjuster to track conditional payments made throughout the settlement process. The adjuster can also send a letter to CMS requesting the conditional payment amount. In response, CMS will issue a "Conditional Payment Letter" identifying the total amount of conditional payments made. A sample "Conditional Payment Letter" is attached as Appendix "C."

Step 3: Maintain Reporting Responsibilities Between the Initial Filing and the Settlement of the Claim

After the initial report is filed, the adjuster is also required to submit quarterly file submissions to the COBSW pursuant to the schedule provided by the COBC upon registration. These reports are to contain only new or changed claim information from the last submitted report.[85] Therefore, the adjuster for Mary's claim should adhere to these requirements, and submit updates quarterly as the claim progresses.

For adjusters handling the workers' compensation or no-fault aspects of Mary's claim where Mary's medical bills have been assumed, the adjuster must report only the start date of the obligation and then monitor the claim until the medical payment obligation has ended.[86] At that point, the RRE must report the termination of medical payments.[87] The MMSEA does not require interim reporting between the initial report and the final report.[88]

In addition to these reporting requirements, the liability adjuster should track the conditional payment statements and maintain a running balance throughout the claim. By doing so, the adjuster aids in settlement negotiations by providing an approximation of the conditional payments made by Medicare and how much of the settlement will need to be allocated or set aside to reimburse Medicare.

Step 4: Closely Examine the Conditional Payment Statements to Distinguish Between Related and Non-Related Benefits Paid

The conditional payment statements will not only include the costs for Mary's medical treatment related to her accident, but will also include those costs paid by Medicare that are unrelated to the underlying accident. For example, in Mary's case, the Medicare statement may include treatment costs for Mary's breast cancer, in addition to the costs to treat her hip injury associated with her slip and fall. Therefore, it is absolutely critical for an adjuster or defense

attorney to closely examine these statements, and work with Mary's attorney in distinguishing the amounts paid towards Mary's fall-related injuries and those that are unrelated to her fall. If the parties do not engage in these conversations, an insurer may be responsible for reimbursing this inflated amount, despite many of the charges being unrelated to Mary's injury.

Once the parties have agreed to the actual reimbursement amount, CMS can be put on notice of that amount. It is also advisable for Mary's attorney and the claims adjuster/defense attorney to agree upon the ICD-9 Codes to use and report to CMS. Therefore, once a settlement or judgment is reached, the parties will already be in agreement about the total amount of conditional payments made towards Mary's claim and the ICD-9 codes to be used, both of which will expedite the settlement process.

Step 5: Reaching a Settlement or Judgment

Assume that approximately a year after Mary's claim was first reported, the parties are able to reach a settlement. Now, the adjuster must submit a final report to the COBSW advising of the settlement. At that time of settlement, Mary is required to supply the information regarding the specific settlement terms. Additionally, upon receipt of this information, Mary will be informed of CMS's subrogation rights for the amount of conditional payments made as of that date. This right to subrogation must be satisfied to the extent of the total amounts paid.

It is also at this time that an adjuster administering workers' compensation or no-fault claims is required to electronically report any settlement, award, judgment or other payment to the CMS once the RRE has reached a "total payment obligation to the claimant."[89] It does not matter if the RRE has actually distributed the settlement funds. The CMS wants to know the total obligation to the claimant, even if the funds are withheld, so that the CMS can begin the recovery process as it deems appropriate. While MMSEA obligates anyone connected with the claim, whether litigated or non-litigated, to report it to the CMS, the MMSEA specifically mandates that the RRE report the settlement amount. This obligation is critical, as it rests solely with the RRE, and cannot be transferred to the claimant or the claimant's attorney.

After receiving notification of a settlement, award, or judgment, the CMS will issue a demand for payment. However, as previously indicated, the CMS has no obligation to respond with this demand pursuant to any timeframe. Hence, waiting for the demand amount could take several weeks.

Step 6: Explore Available Avenues to Reduce the Total Amount to be Reimbursed to Medicare

It is important to note that there is no allocation of fault by the CMS in a liability settlement. The CMS ignores the parties' allocation in a private settlement agreement or by court order, and ignores the availability of tort defenses.[90] A recent illustrative case is *Hadden v. United States*.[91] In that case, the U.S. District Court for the Western District of Kentucky dismissed a suit brought by the plaintiff, in appealing administrative decisions by Medicare, denying a waiver/compromise of recovery for conditional payments. In 2004, Mr. Hadden, the plaintiff, sustained serious personal injuries when he was struck by a public utility vehicle after it had swerved to miss another vehicle that ran a stop sign. The Plaintiff ultimately settled the underlying case with the public utility and the total settlement amount was $135,000.00.

Subsequent to the accident, the plaintiff's medical expenses were conditionally paid by Medicare.

Medicare, through CMS, assessed the plaintiff's conditional payments in the amount of $62,338.07, and sought recovery of that amount against him. The plaintiff sent a letter to CMS and requested a waiver of any conditional payments made by Medicare,[92] based upon the argument of comparative fault. In this case, the plaintiff put forward the argument to CMS that a reasonable fault allocation would be 10% to the public utility vehicle and 90% to the vehicle that ran the stop sign which caused the public utility vehicle to swerve and injure the plaintiff. Therefore, the plaintiff's position was that CMS could recover no more than 10% of the conditional payment amount. CMS denied the request for a waiver of the repayment of the conditional payments.

The court in *Hadden* dismissed the plaintiff's suit against Medicare seeking a waiver/compromise of conditional payments, and held that the primary payer in this case is the insurer who paid the settlement amount between plaintiff and the defendant. More importantly, the court advised that the underlying claim in this case was not adjudicated on the merits, but, rather, was settled. In other words, had plaintiff wanted equitable allocation and subrogation principles to apply in this case, then he should have proceeded to trial on the merits of his tort claim in state court, as any allocation of liability proposed by plaintiff would be purely speculative.

Accordingly, this case suggests that the CMS may consider fault allocation if a judgment is entered on merits of the case, which would limit CMS's reimbursement to the percentage of fault allocated to the RRE's insured. In contrast, with cases that have simply settled, CMS will not consider how the parties have allocated fault, and the RRE will be held liable for the entire amount of conditional payments paid.

However, there are some ways that claimants, such as Mary, may be able to reduce the CMS demand for reimbursement. One way is by filing a hardship petition.[93] This is essentially a petition setting forth any extraordinary circumstances that may warrant a reduction of the amount to be reimbursed to Medicare. Such discretion is, of course, up to CMS. Section 111 also provides that the conditional payments can be reduced by the procurement costs associated with retaining an attorney to assist with the process, as previously stated.[94] With the exception of these two narrow reductions, the amount of the Medicare conditional payments must be paid in full.

It is also advisable for the parties, particularly Mary's attorney, to attempt to negotiate with Medicare in efforts to reduce the total amount of the conditional payments. As previously discussed, the first step in this process is to closely examine Medicare's demand and clearly distinguish the charges associated with the underlying accident from the medical payments made for the treatment of an unrelated illness or condition. This step ensures that the RRE disburses settlement funds allocated only for those payments related to the claimant's injury-related treatment.

Step 7: Manage Risk Through Carefully Drafted Release Language

Because the Section 111 Amendments are new and because there is little case law on the subject, the extent to which the release language will insulate defense attorneys and RREs from future reimbursement suits is unclear. However, many legal commentators discussing the subject have opined that carefully drafting language in the release may guard against the potential risks associated with the Section 111 Amendments.[95] At a minimum, such language may serve as evidence that the parties considered what party should absorb the risk in the event that Medicare is not reimbursed. Accordingly, our best advice is to include language similar to the sample language we have provided below in order to provide further protection to RREs and defense attorneys.

First, when drafting the release, identify the values for each component of damages, including both past and future damages. It is also important that the parties allocate an amount of money greater than the conditional payment amount to past and future medical expenses in the release. By doing so, the parties can ensure that the amount allocated will cover those expenses should the final recovery demand, which is issued after a settlement is reached, is more than the conditional payment amount.

Turning back to Mary's claim, assume that Mary and Hamilton High School reach a final settlement of $300,000. Below is sample language:

> The Undersigned fully understands and hereby acknowledges that the payment by Defendant of the consideration of $300,000 encompasses payment for and intends the resolution of each specific damages claims of the undersigned as follows:
>
> Past Medical Treatment, Rehabilitative and Therapy Services, and Prescription Expenses: $150,000;
>
> Past Wage Loss and other past non-medical related economic damages: $15,000;
>
> Future Medical Treatment, Rehabilitative and Therapy Services, and Prescription Expenses: $50,000;
>
> Future Wage Loss and other non-medical related economic damages: $15,000;
>
> Pain and Suffering: $70,000.

In addition to setting forth the specific amounts allocated to past and future medical treatment, and other damages, it is also important to warrant that both parties have protected Medicare's interests in the settlement. Below is sample language that should satisfy this requirement:

> The undersigned and Defendant acknowledge that in reaching this agreement they have considered Medicare's interest in recovering the conditional payments made by Medicare for medical treatment, rehabilitative and therapy services, and prescription expenses provided in the past ("past Medicare Benefits") to the undersigned for the related injuries that arise out of the Action and that are specifically identified herein. The undersigned and Defendant further acknowledge that in reaching this agreement they have protected Medicare's interests so as to avoid shifting to Medicare the responsibility for payment of medical treatment, rehabilitative and therapy services, and prescription expenses in the future ("future Medicare Benefits") for treatment of injuries that arise out of the Action and that are specifically identified herein.

As previously discussed, it is important to work with Mary's attorney in order to agree on what ICD-9 codes are associated with the claims. Once the parties have reached an agreement, the terms of the Release should reflect what ICD-9 Codes related to Mary's claim, which indicate the "related" injuries for the past conditional payments. The parties should also include a brief description of each "related" injury. Up to five (5) codes can be designated by the parties. The following clause illustrates how this language can be drafted in the release:

> The undersigned hereby acknowledges and fully understands that the injuries arising out of the Action that required past medical treatment, rehabilitative and therapy services, and prescription expenses and Prescription Medications are limited to:
>
> [IDC-9 Code #1] [Description of the Alleged Injury]
>
> [IDC-9 Code #2] [Description of the Alleged Injury]
>
> [IDC-9 Code #3] [Description of the Alleged Injury]
>
> [IDC-9 Code #4] [Description of the Alleged Injury]
>
> [IDC-9 Code #5] [Description of the Alleged Injury]

In order to protect your client from costs associated with future medical expenses associated with Mary's related injuries, it is important to also specify those ICD-9 Codes that will require future treatment. By doing so, you are ensuring that your client has contemplated this future treatment and attempted to protect Medicare from having to make any future conditional payments. You can go so far as to include language obligating Mary to exhaust the settlement dollars allocated for future treatment before seeking payment from Medicare. The sample language below provides this protection:

> The undersigned agrees and fully understands that a portion of the consideration agreed to be paid by the Defendant includes an amount of $30,000 for future medical treatment, rehabilitation and therapy expenses, and prescription medications. The undersigned agrees that the contemplated future medical treatment, rehabilitation and therapy expenses, and prescription medication for which $50,000 is paid, is limited to the following conditions: [LIST THE ICD-9 CODES] [Description of Alleged Injuries].
>
> The undersigned agrees that she will exhaust the $50,000 received for the future related injuries before CMS is billed and/or becomes responsible for the payment of any future Medicare Benefits for the future related injuries.

As previously indicated, the Section 111 Amendments provide claimants, such as Mary, a private cause of action.[96] Therefore, it is particularly important to include language in the release requiring a claimant, such as Mary, to waive this private cause of action once the settlement agreement is signed. Below is sample language:

> FOR AND IN CONSIDERATION of the aforesaid payment, and as a condition of this Release, the undersigned agreed agrees, represents, and warrants as follows:
>
> That this is a full and final release applying to all unknown and unanticipated injuries or damages, including any and all claims now existing or which may arise in the future, arising out of said transaction or event, as well as those not known or disclosed; the undersigned expressly waives any right or claim of right to assert hereafter that any claim, demand, obligation, and/or cause of action, through ignorance, oversight, or error, been omitted from the terms of this Release, and further expressly waives any right or claim of right that he may have under the law of any jurisdiction that releases such as those herein given do not apply to unknown or unstated claims. It is the express intent of the undersigned to waive any and all claims that he has against the persons and entities herein released, including any which are presently unknown, unsuspected, unanticipated, or undisclosed.
>
> The undersigned hereby expressly waives any right or claim of right to pursue a private cause of action that the undersigned may have pursuant to 42 U.S.C. 1395y(b)(3)(A) against the Releasees, and their respective subsidiary and parent corporations, officers, directors, agents, servants, employees, predecessors, successors, and assigns. The undersigned agrees and fully understands that she is hereby expressly waiving any right or claim of right under 42 U.S.C. 1395y(b)(3)(A), notwithstanding any actions taken, whatever they may be, by Medicare and/or CMS and/or their contractors after the date of the execution of this agreement including a suspension of the undersigned's Medicare benefits, or any type of reimbursement action against the undersigned, or for any reason whatsoever.

This language not only provides that Mary waive any and all rights to pursue an action against your client for unknown or unanticipated damages related to her claim, but the second paragraph explicitly provides that Mary agrees to forego pursuing a private cause of action against your client as it relates to the reimbursement of Medicare. Such language is important, in that it expressly prevents Mary from pursuing the avenues available to her under Section 111 to recover amounts that subsequently become due to Medicare. Moreover, it provides that Mary agrees and acknowledges the possibility of a suspension of her Medicare benefits after the Release has been executed.

Step 8: Establishing Medicare's Interest with Regard to Future Medicals

Another lingering issue is what reimbursement rights Medicare has with respect to future medical expenses paid after settlement funds have been disbursed. Thus far, CMS has yet to provide any clear guidance on how to consider Medicare's interests in liability claims. In light of the MMSEA and Secondary Payers Act's severe penalties, this lack of guidance and uncertainty is particularly troubling in the context in personal injury claims, especially with respect to future Medicare-covered costs and expenses.

Therefore, the best method of protection is setting aside funds to satisfy expected future medicals in order to protect Medicare's interests for future expenses in liability cases. Such "Medicare set-asides" are not currently required in personal injury liability claims, but are likely the best alternative to protect RREs from being forced to issue subsequent payments towards future medical expenses after a settlement or judgment. It has been suggested by many legal commentators that parties should consider setting aside monies for future medicals in the following circumstances: (1) when a claimant is a current Medicare beneficiary; (2) if the claimant has applied for Social Security Disability Insurance, or is in the process of applying; (3) if the claimant has applied for Social Security Disability Insurance and has been denied, and anticipates reapplying; (4) if the claimant is over sixty-five (65) years old and is Medicare eligible; and/or (5) there is a reasonable expectation that the claimant will be receiving Medicare benefits in the next thirty (30) months and the amount of the settlement is $250,000 or more.

In order to determine the amount of funds to set aside, the adjuster or defense attorney should work with Mary's attorney to prepare a detailed report breaking down all future medical and prescription drug expenses, based on Mary's life expectancy, that would normally be covered by Medicare. The parties can look to the medical reports and Medicare claims payment history in order to reach an appropriate medical expense set aside. The amount agreed upon can be expressly enumerated in the release, and the report can be attached as an exhibit to the release. Moreover, it is also advisable to include a cooperation clause in the release, which places a continuing obligation on Mary's attorney to advise of any changes in Mary's treatment as it may relate to the settlement and medical expense set-aside.

Once a figure is negotiated and explained, the RRE has two options to set the monies aside. One way is to hire a custodial account manager to manage the Medicare set-aside, in trust, pursuant to the CMS guidelines. Another method is to allow the Claimant to manage the set aside allocation. Regardless of the method chosen by the parties, the Release should fully set forth how the parties intend to administer and maintain the funds for the medical set aside.

Another possible option in handling a medical set aside is to involve CMS in the settlement proceedings as soon as possible, as the Medicare Contractor's involvement may allow the parties to negotiate a reasonable set-aside amount with CMS. As previously stated, the parties may be able to persuade the Medicare Contractor to participate in the negotiations and agree, not only to the Medicare reimbursement amount, but also for any future medical expenses. Claims adjusters must also keep in mind that the negotiated amount(s) must be sufficient to demonstrate that Medicare's interests have reasonably been considered.

Step 9: Determine When to Issue the Settlement Draft

When the parties reach a settlement agreement, the next question becomes whether distribution of the proceeds should occur before CMS issues its demand for reimbursement. The underlying issue is that while the CMS requires prompt reimbursement for the conditional payments paid, the CMS has no reciprocal obligation to timely issue its demand for reimbursement. The reporting requirements under the MMSEA will, no doubt, hinder RREs from distributing the settlement when they do not have adequate assurance that they will not have to pay again, as the MMSEA requires an RRE to pay the reimbursement amount even if it has already paid the Medicare beneficiary.[97]

There are several methods an RRE can use to protect itself from future liability for failure to reimburse Medicare after a settlement is reached. As previously discussed, one method is to get the Medicare Contractor involved in the settlement negotiations. This way the Medicare Contractor can participate in the settlement by identifying the amount of the past and future medical expenses, and can even sign off on the agreement so as to document the final, agreed-upon reimbursement amount. Under this method, the RRE can issue a check directly to Medicare for reimbursement with assurances that it will not be liable for any future damages relative to the amount owed. However, practically speaking, it may be difficult to compel the Medicare Contractor's assistance.

Therefore, the next best option for the RRE is simply to retain the settlement funds until the CMS has issued their final demand for payment, which is known as the "Recovery Demand Letter." A sample "Recovery Demand Letter" is attached at Appendix "D." Even though the CMS has no obligation to issue its demand for payment within any particular timeframe, this method ensures that the RRE knows the exact amount requested from the CMS and will protect itself from a potential action from CMS in the future. Once the parties know of the final amount to be reimbursed, the RRE can then issue a check directly to Medicare for that amount. It is also a good idea to attach the "Recovery Demand Letter" as an Exhibit to the release. Of course, the drawback to withholding the settlement funds until receiving Medicare's final demand is that costs will continue to increase and the claims will undoubtedly take longer to close, shelf lives of claims will increase, and settlements may be rejected or abandoned during this waiting period.

In application to our hypothetical involving Mary, the adjuster would need to hold onto the settlement funds in order to wait for the "Recovery Demand Letter." As previously stated, the CMS has no mandatory timeframe with which to issue its demand for reimbursement, leaving the claim open at the mercy of the CMS. Once the CMS receives notice of the settlement, the data is then sent to the MSPRC for recovery processing, which could add months to the delay in providing a reimbursement demand.

While an RRE can protect itself by withholding the settlement funds until the final Medicare demand is made, the adjuster, and his client's attorney, can include particular language in the settlement release with Mary in order to further protect the client's interests. For example, the settlement can include strong indemnity language that states that the Claimant and/or the Claimant's attorney will resolve all liens and ensure that Medicare will be the first party paid from the settlement proceeds. Below is sample language that can be used:

> Releasor and the undersigned counsel for Releasor represent that any and all medical liens and/or claims arising from medical expenses, including conditional payments and/or liens by any health insurer, Medicare, Medicaid, or any other third parties incurred as a result of this incident made the basis of this suit, will be satisfied by the Releasor **prior** to the distribution of the settlement proceeds to the Releasor.
>
> Releasor and the undersigned counsel for Releasor further agree and covenant to release, indemnify, and hold harmless the Released Parties from any liens, claims, or subrogation claims which may arise or may have heretofore arisen in favor of any financial institution, medical provider, doctors, hospitals, chiropractors, health insurers, Medicare, Medicaid, other insurer, or any other third party, by operation of law or equity, for medical expenses, disability benefits, or any other charge or expense, directly or indirectly relating to the incidents that form the basis of this Agreement.[98]

Because the new reporting requirements effectively shift the burden to the RREs to ensure that any Medicare conditional payments are satisfied from settlement proceeds, it is unclear how such indemnity language would stand in court, and whether such responsibilities can be contracted away in a settlement agreement. Despite this uncertainty, including the aforementioned language in a settlement release would indicate that the parties contemplated who would absorb the risk in terms of reimbursing Medicare for the conditional payments made, and may cushion the RRE from further penalties.

Step 10: Issuing the Settlement Draft & Closing the File

One way to issue to the settlement draft is to list Medicare as the payee on the settlement check so that Medicare can deposit the check, and return the proceeds to a claimant, such as Mary. However, the recommended method is to issue two checks: one made payable to Medicare and Mary for the reimbursement amount, and the other to Mary and Mary's attorney. However, the adjuster should insist that the claimant's attorney hold his check in escrow until the MSPRC acknowledges receipt of the check and releases the RRE. Medicare will acknowledge receipt of the check by issuing an "Acknowledgement of Full Payment" letter to the claimant indicating that Medicare considers the claim resolved and has closed its file. A sample "Acknowledgment of Full Payment" letter is attached as Appendix "E." Upon receipt of this closing letter, claimant's counsel may, then, deposit the check.

Regardless of the settlement terms, the adjuster is strongly advised to follow up with Mary and her attorney to confirm they reimbursed Medicare within **60 days** of receipt of the settlement proceeds to avoid any penalties. Once this information is confirmed, the adjuster can close the file.

SECTION 111'S IMPACT ON THESETTLEMENT OF "NUISANCE VALUE" AND "LOW LIABILITY" CLAIMS

Because the conditional payments made must be fully satisfied from the settlement, the minimum threshold settlement amount for a personal injury claim involving a Medicare beneficiary must equal the reimbursement amount. The practical effect of this rule is that "nuisance value" settlements will have to be an amount in excess of the amount paid by Medicare. Otherwise, claimants would refuse to settle "nuisance value" cases, as they would effectively receive no money from the settlement.

For example, let's change Mary's hypothetical and assume that Mary's medical treatment is $1,800. Also assume that Medicare paid $1,000 in conditional payments. As the claims adjuster, you know Mary's claim could be settled for $2,000. However, even if the parties agree to settle the matter for $2,000, your client could ultimately be responsible for reimbursing Medicare for the $1,000 it paid in conditional payments towards Mary's claim, even after the settlement proceeds have been disbursed to Mary.

Or, consider a "low liability" claim, or a claim where your client is minimally negligent but the benefits paid by Medicare are high. Assume that Medicare made $250,000 in conditional payments for Mary's injury-related medical treatment, but the parties agree to settle the case for $25,000 to dispose of the matter. As previously indicated, Medicare does not look to the allocation of liability or the available tort defenses, as Medicare is entitled to be fully reimbursed for the conditional payments made. Therefore, not only will your client pay the $25,000 to settle the case, it could also be subject to a reimbursement lawsuit for the $250,000 in Medicare benefits paid, plus attorney's fees, applicable penalties, fines, and interest, should Medicare not be reimbursed.

In light of these recent Amendments, "nuisance value" and "low liability" claims will not only be increasingly difficult to settle, but will subject RREs to potential reimbursement suits. Moreover, these claims will likely lead to a significant increase in defense costs. Accordingly, an RRE must always be cognizant of these risks when settling "nuisance value" and "low liability" claims, and take the appropriate steps to protect itself from a reimbursement suit.

PENDING LEGISLATION: H.R. 4796, THE MEDICARE SECONDARY PAYER ENHANCEMENT ACT OF 2010

Lastly, it should be noted that on March 9, 2010, Representative Patrick Murphy (D-PA) introduced H.R. 4796, the Medicare Secondary Payer Enhancement Act of 2010,[99] into the U.S. House of Representatives. H.R. 4796 is currently in the stages of the legislative process, having been referred to the House Energy and Commerce Committee on March 9, 2010. H.R. 4796 proposes several changes to the Medicare Secondary Payer Act and reporting under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

One of the proposed changes would allow a claimant to voluntarily submit a proposal of conditional payment calculations to the CMS at least ninety (90) days prior to settlement, judgment, award or other payment that estimates the amount of medical care payable by Medicare related to the injury/claim, computing reimbursement based on available billing data.

CMS would be empowered to review and contest the submission, but if CMS does not do so within ninety (90) days, the amount is deemed to be the MSP payment amount for all conditional payments related to the claim.

Moreover, a claimant and applicable plan would have the option of requesting a final demand letter from CMS for conditional payments within one-hundred twenty (120) days of settlement, judgment, award or other payment. CMS has sixty (60) days to respond to such a request, and if the claimant or applicable plan reimburses CMS within sixty (60) days of the response, the reimbursement is deemed to satisfy obligations of the claimant and applicable plan for conditional payments.

Moreover, the proposed changes to Section 111 reporting would: (1) require CMS to implement a Section 111 reporting process that excludes the reporting of health insurance claim numbers and Social Security numbers, (2) set a statute of limitations on MSP recovery actions at three (3) years following submission of the Section 111 report; (4) establish a minimum threshold for MSP recovery actions at settlements, judgments, awards or other payments valued at $5,000; (5) modify the current Section 111 penalty provisions to provide the government with discretion to impose penalties; and (6) require the U.S. Department of Health and Human Services to develop safe harbors for meeting reporting requirements.

As set forth above, HR 4796 would significantly streamline the process to expedite reimbursement to Medicare, and would provide considerable protection for RREs. Moreover, it would remedy some of the concerns associated with the Section 111 reporting requirements, and allow RREs to expeditiously resolve claims. Because of the potential H.R. 4796 may have on RREs with respect to the Section 111 Amendments, it will be important to monitor the status of H.R. 4796.

COMMONLY ASKED QUESTIONS

With the enactment of any new legislation comes a host of new questions and concerns for the parties involved. To help alleviate some of those issues, this portion of the article will address commonly asked questions and answers regarding the Section 111 reporting requirements.

Q: Is a reporting still required for deceased Medicare beneficiaries?

Yes. If the beneficiary is deceased and received Medicare benefits related to the incident, the RRE must report the individual or entity.[100]

Q: What if the Claimant is a Medicare beneficiary, but medical care is not part of the claim, such as a property damage claim?

No. RREs are not required to report on a file which did not claim medical expenses.[101] These claims would include property damage claims or business disputes.

Q: What about settlements involving multiple defendants? Who reports then?

Reporting is to be done on a beneficiary-by-beneficiary basis. As such, it is possible that an RRE will submit more than one record for a particular individual in a particular submission window. This will depend on the number of policies at issue for an RRE and the type of insurance involved.

For example, an RRE may handle a workers' compensation claim and the liability claim for a Medicare beneficiary. Then, the RRE would need to report the workers' compensation claim as ORM reporting, and would also need to report the TPOC reporting once the claim settles or a judgment reached.

In a case involving multiple defendants, all RREs remain responsible for their own reporting – even when the parties agree that one RRE will issue payment for a settlement or judgment.[102]

Q: What about reporting structured settlements?

A structured settlement or annuity is considered a single payment obligation, or TPOC reporting.[103] If it was funded before January 1, 2010, it does not have to be reported. However, if it was approved or funded after January 1, 2010, it must be reported, but only once. The amount to be reported is the amount of the total payout.

Q: Does confidentiality language in settlement agreements preclude RREs from reporting?

No. CMS refers to two statutory regulations, 42 CFR § 411.23 and 42 CFR §411.24, as authority for requiring Medicare beneficiaries to fully cooperate with the COBC, which obligates them to release such information to Medicare.[104]

Q: What if the accident did not occur in the United States? Must the RRE still report?

Yes. The geographic location of the underlying incident has no bearing on whether an RRE is required to report.[105] If the individual returns to United States for medical care, and Medicare covers the individual's medical payments, the RRE will be required to report.

Q: Can an RRE that is responsible for Med Pay payments or PIP payments forward doctors bills to Medicare? Or, is coverage for Med Pay and PIP benefits considered primary insurance, which requires the Med Pay or PIP RRE primarily responsible for the bills?

Medicare views Med Pay and PIP coverage, types of no-fault insurance, as primary coverage in terms of satisfying doctors' and hospital bills for Medicare beneficiaries.[106] Therefore, Med Pay limits and PIP limits must be exhausted before an RRE can forward those bills to Medicare for payment.[107] In the event that these RREs fail to pay these bills and Medicare subsequently satisfies those

bills, Medicare has the right to seek reimbursement even if the applicable limits are, by then, exhausted.[108]

Q: Are there confidentiality concerns about the exchange of data regarding Medicare Information and/or Social Security Numbers throughout the course of a claim? What about HIPAA ("Health Insurance Portability and Accountability Act")?

The collection of Social Security Numbers and/or Health Insurance Claim Numbers (HICNs) for purposes of coordinating benefits with Medicare is a required, legitimate, and necessary use of Social Security Numbers under federal law, and is thus permitted by HIPAA.[109] Moreover, CMS maintains the position that the exchange of such information during the query process does not require the Claimant's signed release or authorization and, therefore, does not violate HIPAA.

Q: What if there is nothing new to report on a claim when the quarterly file submission is due?

The RRE may, but is not required, to submit an "empty" claim record, which indicates that there are no changes.[110] Instructions for submitting such reports can be found in the User Manual.

Q: What if the case goes to trial, but the jury returns a defense verdict? Must the RRE report?

If no judgment is entered against your client and your client is not required to make any payments, then no report is due.[111]

Q: What if the jury returns a verdict for the Plaintiff, but the case is subsequently appealed? How does the appeal affect the reporting requirements?

If any payment is made after the return of a verdict, then the RRE must report the same to CMS.[112] However, if payment is pending in light of the appeal, then no reporting is required until the appeal is resolved or a settlement reached.[113]

Q: Do these new reporting statutes apply to Medicaid claimants, as well?

No. The Section 111 reporting requirements refer to "Medicare Secondary Payors."[114] They are exclusively limited to the recovery of Medicare payments, and do not apply to state Medicaid programs.

CONCLUSION

As a result of these Amendments, tort cases that involve a Medicare beneficiary need to be handled differently from all other personal injury claims. These rules relating to Medicare reimbursement are cumbersome, lack finality, work against long-established settlement practices, and subject the RREs to severe civil penalties in the event of non-compliance. Clearly, these changes bring a bevy of new challenges for RRE's and defense attorneys. Settlements will likely

be delayed and claims left open while the parties are coordinating the details of the settlement. The MMSEA has particular implications with "nuisance value" cases, as such cases will be more difficult to resolve, as well as reserving set-asides for future medical costs covered by Medicare.

In light of these considerations, RREs must adapt their current practices to ensure that they in compliance with the new reporting requirements. A key component to that success is for insurance carriers, self-insured entities, and third-party administrators to properly train its adjusters who may have occasion to come across Medicare eligible claimants. RREs should develop and implement MSP eligibility questions as part of their standard claim investigation, and should even consider distributing a standard from to every claimant that requests information to determine whether the claimant is Medicare eligible. Moreover, it is advisable for adjusters to immediately report to the Coordinator of Benefits upon learning that a claimant is Medicare eligible, provide periodic updates to the Coordinator of Benefits as the claim progresses, and obtain a "Consent to Release" form from the claimant and/or his or her attorney.

RREs should thoroughly train claims adjusters to know of the new reporting requirements and enhance their system to include diaries for important reporting dates to ensure compliance. Finally, all risk managers and insurance advisors should educate their senior management about claims involving Medicare eligible claimants and the potential impact such claims have upon their organizations. All RREs are also encouraged to become actively involved in bringing about the needed reforms that will Medicare is properly reimbursed.

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*Please visit our website at www.koponairdo.com, where we have placed an electronic version of "Mandatory Insurer Reporting: A Primer for Responsible Reporting Entities" in our electronic law library. We will be updating our online law library regularly. Thank you for your continued support.

Endnotes

[1] 42 U.S.C. § 1395y(b)(2)(B)(8).

[2] MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Worker's Compensation User Guide (hereinafter "User Guide"), Volume 3.1, July 12, 2010, at 14. A copy of the guide is available at: http://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3.1.pdf.

[3] User Guide, at 14.

[4] User Guide, at 14.

[5] CMS website, http://www.cms.hhs.gov/mandatoryinsrep/.

[6] CMS website, http://www.cms.hhs.gov/mandatoryinsrep/.

[7] CMS website, http://www.cms.hhs.gov/mandatoryinsrep/.

[8] CMS website , http://www.cms.hhs.gov/mandatoryinsrep/. In this case, Medicare is secondary for a 30 month "coordination" period. *See* 42 U.S.C. 1395y(b)(7) & (8).

[9] CMS website , http://www.cms.hhs.gov/mandatoryinsrep/ .

[10] 42 U.S.C. § 1395y(b)(2); 42 C.F.R. §§ 411.20-.37.

[11] 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24 (h).

[12] 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24 (b).

[13] Medicare Secondary Payer ("MSP") Manual, Ch. 1 § 10.

[14] User Guide, at 9.

[15] User Guide, at 18.

[16] User Guide, at 102.

[17] CMS website , http://www.cms.hhs.gov/mandatoryinsrep/

[18] 42 U.S.C. 1395y(b)(8).

[19] User Guide, at 30-32.

[20] User Guide, at 30-32.

[21] User Guide, at 30-32.

[22] User Guide, at 16. In order to begin the reporting process, self-insurance, no-fault insurance, self-insureds, and others who are designated as RREs were required to register with the CMS's Coordinator of Benefits ("COB") by September 30, 2009. Registration can be completed by accessing the CMS website at www.Section111.cms.hhs.gov.

[23] User Guide, at 18.

[24] User Guide, at 18.

[25] User Guide, at 18.

[26] User Guide, at 18.

[27] User Guide, at 18.

[28] User Guide, at 18.

[29] User Guide, at 40.

[30] User Guide, at 40.

[31] User Guide, at 44.

[32] User Guide, at 75.

[33] User Guide, at 46.

[34] User Guide, at 84.

[35] User Guide, at 84.

[36] User Guide, at 84.

[37] User Guide, at 84.

[38] User Guide, at 84.

[39] User Guide, at 85.

[40] User Guide, at 85.

[41] User Guide, at 85.

[42] User Guide, at 85.

[43] User Guide, at 85.

[44] User Guide, at 97.

[45] User Guide, at 61.

[46] User Guide, at 61.

[47] User Guide, at 61.

[48] User Guide, at 61.

[49] User Guide, at 61.

[50] User Guide, at 61.

[51] User Guide, at 61.

[52] User Guide, at 16.

[53] User Guide, at 47.

[54] User Guide, at. 47.

[55] User Guide, at 47.

[56] User Guide, at 71.

[57] The ICD-9 Codes are accessible online: http://icd9cm.chrisendres.com/.

[58] User Guide, at 38.

[59] *See infra,* pgs. 8-9.

[60] User Guide, at 102.

[61] 42 U.S.C.1395y(b)(7)(E).

[62] *See* 42 U.S.C. § 1395y(b)(8)(D)(i)-(ii).

[63] 42 U.S.C. § 1395y(b)(8)(D)(i)-(ii).

[64] *U.S. v. Harris*, 2009 U.S. Dist. LEXIS 23956, 2009 WL 891931 (N.D. W.Va. 2009).

[65] 42 U.S.C. § 1395y(b)(2)(B)(iii)(emphasis added).

[66] 42 CFR § 411.24(g)(emphasis added).

[67] 2009 U.S. Dist. LEXIS 23956, 2009 WL 891931 (N.D. W.Va. 2009).

[68] 42 U.S.C. § 1395y(b)(2)(B)(i)-(iii); 42 C.F.R. § 411.24(c)(2), (h), (m).

[69] 42 C.F. R. §411.24 (i).

[70] *U.S. v. Stricker*, et al., Case No. 1:09-cv-02423-KOB (USDCT AL).

[71] 42 U.S.C. §1395y(b)(3(A).

[72] 42 U.S.C. §1395y(b)(3)(A).

[73] *See* 42 C.F.R. §411.24(g).

[74] *See* 42 C.F.R. §411.24(g).

[75] 42 U.S.C. § 1395y(b)(8)(D)(i)-(ii).

[76] *Seger v. Tank Connection, LLC*, 2010 U.S. Dist. LEXIS 49013 (D. Neb. Apr. 22, 2010).

[77] *Seger v. Tank Connection, LLC*, 2010 U.S. Dist. LEXIS 49013 (D. Neb. Apr. 22, 2010).

[78] *Seger v. Tank Connection, LLC*, 2010 U.S. Dist. LEXIS 49013 (D. Neb. Apr. 22, 2010).

[79] *Seger v. Tank Connection, LLC*, 2010 U.S. Dist. LEXIS 49013 (D. Neb. Apr. 22, 2010).

[80] *See* User Guide, pg. 15 for a discussion of submitting a Query Input File.

[81] *See supra*, pg. 6 for a discussion of the civil penalties under the MMSEA.

[82] *See* 42 C.F.R. § 411.25(a). For a sample letter, please refer to the MSPC website: http://www.msprc.info.

[83] User Guide, at 95.

[84] User Guide, at 95.

[85] User Guide, at 16.

[86] User Guide, at 75.

[87] User Guide, at 75.

[88] User Guide, at 75.

[89] *See* User Guide at 111.

[90] User Guide, at 95.

[91] *Hadden v. US*, 2009 U.S. Dist LEXIS 69383 (August 6, 2009).

[92] *See* 42 C.F.R. 411.28.

[93] 42 C.F.R. §411.37(c).

[94] 42 C.F.R. §411.37(c).

[95] *See* Jeffrey J. Signor, *A Look Behind the Federal Government's New Efforts to Track and Recover Medicare Liens*, Erie Bar Journal, Dec. 2008; Roy Franco, Jeffrey J. Signor, Thomas S. Thornton III, *Resolution of a Case with a Medicare Claimant,* For the Defense, May 2009; M. Christopher Eagen, *New Reporting Requirements under the Medicare Secondary Payer Statute*, IADC Medical Defense and Health Law and Legislative, Judicial and Government Affairs Committees, IADC Webinar, July 2009; Christopher S. Berdy, W. Steven Nichols, *The Medicare, Medicaid, and SCHIP Extension Act of 2007: A Practitioner's Introduction to Resolution of a Personal Injury Liability Claims Involving Medicare Beneficiaries,* Aug 2009; Paul Celeo, Mark Bernstein, *Emerging Law: Medicare Secondary Payer and Medicaid Tort Recovery Policies and Procedures*, Housing Authority Defense Attorneys 2010 Annual Seminar, September 22, 2010.

[96] 42 U.S.C. 1395y(b)(3)(a).

[97] 42 U.S.C. § 1395y(b)(7) & (8).

[98] For more sample release language, see the MSPC website: http://www.msprc.info .

[99] The full text of H.R. 4796 can be found at: http://www.govtrack.us/congress/billtext.xpd?bill=h111-4796.

[100] 42 U.S.C. § 1395y(b)(8)(D)(i)-(ii).

[101]User Guide, at 95; *See also* 42 U.S.C. 1395yb)(7)(i-ii).

[102] User Guide, at 25, 94.

[103] User Guide, at 93.

[104] *See* 42 CFR § 411.23; 42 CFR §411.24.

[105] User Guide, at 96.

[106] User Guide, at 94.

[107] User Guide, at 94.

[108] User Guide, at 94.

[109] *See* 42 U.S.C. §§ 1395y(b)(1)(A)(iv);1395(b)(8)(F).

[110] User Guide, at 69.

[111] User Manual, at 95.

[112] User Manual, at 97.

[113] User Manual, at 97.

[114] *See* 42 U.S.C. 1395y(b)(7).

APPENDIX A

MSPRC

Medicare Secondary Payer
Recovery Contract

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CONSENT TO RELEASE FORM

I, _____ hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement to the individual(s) and/or firm(s) listed below:
PLEASE CHECK:

☐ Claimant's attorney _____
(Name and/or firm)

☐ Insurance carrier _____
(Name and/or company)

☐ Other _____ _____
(Explain) (Name and/or firm)

How long can we give out the information? **(Check one Block)**

☐ Ongoing, beginning _____
Month/Date/Year

☐ Limited time _____ through _____
Month/Date/Year Month/Date/Year

☐ One time only

_____ _____
Claimant's Signature Date Signed

_____ _____
Date of Injury Medicare Number

If your Power of Attorney (POA) or legal representative signs this form for you, a copy of their POA or representation papers must be sent to us with this form.

Completion and signing of this consent form:

- Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- Allows release of Medicare claims and other information related to your injury/illness.
- Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address below.

Medicare Secondary Payer Contractor
PO Box 33828, Detroit MI 48232-3828

APPENDIX B

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Learn about your letter at *www.msprc.info*

RE: Name:
HIC#:
Date of Incident:
Debt Identification No:
Demand Amount:

Dear

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us.

We are writing to you because we recently learned that you have made a liability claim relating to an illness, injury or incident occurring on or about and obtained a recovery. We have determined that you are required to repay the Medicare program for the cost of medical care it paid relating to your liability recovery. (The term "recovery" includes a settlement, judgment, award or any other type of recovery.)

We hope that you will find answers to some of the questions you may have about this letter below. Parts I and II of this letter explain the federal law that requires you to pay Medicare back and the way we determined the amount you are required to repay. We have provided instructions for repaying Medicare in Part III of this letter. You have the right to appeal our determination if you disagree with it, and you also have the right to request that the Medicare program waive recovery of the amount you owe in full or in part. Instructions for requesting waiver of recovery and appeal are provided in Part IV of this letter. Part V of this letter explains the interest charges that apply if you do not repay Medicare within sixty (60) days from the date of this letter and tells you about certain actions Medicare may decide to take if you fail to repay the amount you owe. Finally, Part VI identifies whom you should contact if you have questions about this letter.

I. Why am I required to repay Medicare?

You are required to repay Medicare because Medicare paid for medical care you received related to your liability recovery. The Medicare Secondary Payer (MSP) law allows Medicare to pay for medical care received by a Medicare beneficiary who has or may have a liability claim. However, the law also requires Medicare to recover those payments if payment of a liability settlement, judgment, recovery, or award has been or could be made. Congress passed the MSP law because it wanted to make sure that the Medicare Trust Funds would have enough money to pay for medical care that beneficiaries may need in the future. Congress decided that, if a liability recovery was available to pay for a Medicare beneficiary's medical care, then that money should be used to pay for the care and any amounts already paid by Medicare should be refunded to the Medicare Trust Funds.
If you would like to read the MSP law, you can find it in Title 42 of the United States Code, Section 1395y(b)(2). You can also find the regulations that explain how the Medicare program recovers amounts it is owed under the MSP law in Title 42 of the Code of Federal Regulations, beginning at Section 411.20. You can also learn more about how the MSP law works by contacting your local Social Security office or by visiting www.medicare.gov.

II. How did Medicare decide how much money I owe?
The Medicare program paid for medical care related to your liability recovery. We have enclosed a list of the payments Medicare made related to your recovery with this letter. The Medicare program generally reduces the amount a Medicare beneficiary is required to repay to take into account the costs (such as Attorney's fees) paid by the beneficiary to obtain his or her liability recovery. You can find the formula we use to decide how much the amount of this reduction should be at 42 C.F.R., sub-section 411.37. We have applied the formula and determined that the amount you owe Medicare is . This letter relates only to money paid from your current recovery. If, in the future, you receive additional money from this liability recovery, or any other liability recovery, you must let us know.

III. What do I need to do to repay Medicare the amount I owe?
You must repay Medicare within sixty (60) days of the date of this letter . Please send a check or money order for , made payable to **Medicare**, to us at the address listed at the end of this letter. Please make sure to include your name and Medicare number on the check or money order and include a copy of this letter with your payment.

The amount requested in this letter may not include payments received prior to the issuance of this demand letter dated . Upon issuing a check, please deduct previous payments made to the MSPRC for the above referenced debt.

IV. What rights do I have if I disagree with the amount this letter says I owe or think that I should not have to pay Medicare back for some other reason?
Right to Request a Waiver – You have the right to request that the Medicare program waive recovery of the amount you owe in full or in part. Your right to request a waiver is separate from your right to appeal our determination, and you may request both a waiver and an appeal at the same time. The Medicare program may waive recovery of the amount you owe if you can show that you meet both of the following conditions**:**

1. This overpayment (for purposes of requesting waiver of recovery, the amount you owe is considered an overpayment) was not your fault, because the information you gave us with your claims for Medicare benefits was correct and

complete as far as you knew; and when the Medicare payment was made, you thought that it was the right payment;

AND

2. Paying back this money would cause financial hardship or would be unfair for some other reason.

If you believe that both of these conditions apply to you, you should send us a letter that explains why you think you should receive a waiver of the amount you owe. If you request a waiver, we will send you a form asking for more specific information about your income, assets, expenses, and the reasons why you believe you should receive a waiver. If we are unable to grant your request for a waiver, we will send you a letter that explains the reason(s) for our decision and the steps you will need to follow to appeal that decision if it is less than fully favorable to you.

Right to Appeal – You also have the right to appeal our determination if you disagree that you owe Medicare as explained in Part I of this letter, or if you disagree with the amount that you owe Medicare as explained in Part II of this letter. To file an appeal, you should send us a letter explaining why you think the amount you owe Medicare is incorrect and/or any reason(s) why you disagree with our determination. Once we receive your request for appeal, we will decide whether our determination that you must repay Medicare is correct and send you a letter that explains the reasons for our decision. Our letter will also explain the steps you will need to follow to appeal that decision if it is less than fully favorable to you.
You have 120 days from receipt of this letter to file an appeal. We must assume that you received this letter within five (5) days of the date of the letter unless you furnish us with proof to the contrary.

If you do not already have an attorney or other representative and you want help with your appeal or request for waiver, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your case. There are groups, such as lawyer referral services that can help you find a lawyer. There are also groups, such as legal aid services, that will provide free legal services if you qualify.

V. What happens if I do not repay Medicare the amount I owe?
Please note that, if you do not repay Medicare in full by **,** you will be required to pay interest on any remaining balance, from the date of this letter, at a rate of per year. If the debt is not fully resolved within 60 days of the date of this letter, interest is due and payable for each full 30 day period the debt remains unresolved. By law, all payments are applied to interest first, principal second. You can find the regulation that explains interest charges at 42 C.F.R., sub-section 411.24(m). To avoid having to pay interest, you should repay Medicare in full within sixty (60) days of the date of this letter, even if you decide to request a full or partial waiver of the amount you owe or decide to appeal our determination (see Part IV) of this letter). If you receive a waiver of recovery or if you are successful in appealing our decision, Medicare will refund amounts you have already paid.

If you are unable to repay Medicare in one payment, you may ask us to consider whether to allow you to pay in regular installments. If you make installment payments, you should be aware that your payments will be applied to any interest due first and then to the outstanding principal amount.

You should also be aware that if you do not repay Medicare in full, it may decide to recover any amounts you owe (including accrued interest) from any Social Security or Railroad Retirement benefits to which you might otherwise be entitled, or from future Medicare payments. Your failure to respond as requested within sixty (60) days of the date of this letter may result in the initiation of additional recovery procedures without further notice, including referral to the Department of Justice for legal action and/or the Department of the Treasury for other collection actions. You should be aware that the Debt Collection Improvement Act of 1996 requires Federal Agencies to refer debts to the Department of the Treasury or its designated debt collection center for recovery actions including collection by offset against any monies otherwise payable to the debtor by any agency of the United States and through other collection methods. Under this and other authorities (31 U.S.C. 3720A), the Internal Revenue Service may collect this debt by offset against tax refunds owed to individuals or other entities. Please be advised that Medicare does not refer debts to Treasury for collection if they are the subject of an administrative appeal or judicial review. Before Medicare refers your debt to Treasury you will be provided with notice of the intended referral, including information concerning appropriate steps to avoid referral.

VI. Who should I contact if I have questions about this letter?

This office is the Medicare contractor responsible for handling your case. If you have any questions about this letter, or questions about Medicare's recovery rights in general, please contact MSPRC LIABILITY at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired) or the address listed below. Please also make sure that any letters you send us include your name, your Medicare Health Insurance Claim Number (this is the number found on your red, white, and blue Medicare card), and the date of the illness, injury or incident. Providing us with this information will help us respond more quickly to any questions you may have.

Sincerely**,**

Enclosure: Payment Summary Form
cc:

APPENDIX C

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Learn about your letter at *www.msprc.info*

insert name
insert address 1
insert address 2
insert city, state, zip code

Beneficiary:
Medicare Number:
Date of Incident:

Dear insert name:

Please note that, if we know you have an attorney or individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not shown as a "cc" at the end of this letter (indicating that he/she is receiving a copy), please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other person in this matter you may wish to talk to your representative before contacting us.

This letter follows a previous letter notifying you/your attorney of Medicare's priority right to recovery as defined under the Medicare Secondary Payer provisions. Because you were involved in an automobile, slip and fall, medical malpractice, or some other type of liability claim, the medical expenses are subject to reimbursement to Medicare from proceeds received pursuant to third party liability settlements, awards, judgments, or recovery.

However, we request that you/your attorney refrain from sending any monies to Medicare prior to submission of settlement information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays.

Currently, Medicare has paid in conditional payments related to your claim. Attached you/your attorney will find a listing of claims that comprise this total. Please take a look at this listing and let us know if you/your attorney disagree with the inclusion of any claim in whole or in part and explain the reasons why you/your attorney disagree(s).

Please be advised that we are still investigating this case file to obtain any other outstanding Medicare conditional payments. Therefore, the enclosed listing of current conditional payments (including a response of zero amount) is not a final listing and will need to be updated once we receive final settlement information from you. It would be in your best interest to keep Medicare's payments and the statutory obligations to satisfy Medicare in mind when the final dollar amount is negotiated and accepted in resolution of this claim with the third party.

If the case has settled, please furnish our office with a copy of:

1) The settlement agreement from the third party payer showing the total amount the settlement, signed and dated, AND

2) Your closing statement reflecting the actual amount of the attorney's fees and cost (excluding medical bills)

If you have any questions concerning this matter, please call the Medicare Secondary Payer Recovery Contractor (MSPRC) at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary's name and Medicare health insurance claim number.

Medicare Secondary Payer Recovery Contractor
<select option>
PO Box <select option>
Oklahoma City, OK 73113

Sincerely,

MSPRC insert title

insert site identifier

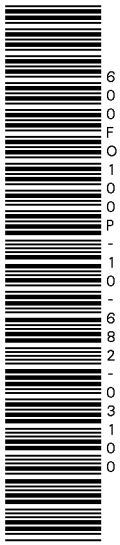
insert cc:

APPENDIX D

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Learn about your letter at *www.msprc.info*



RE: Name:
HIC#:
Date of Incident:
Debt Identification No.:
Demand Amount:

Dear :

This letter follows our earlier communication in which we advised you that you would have to repay Medicare for services paid conditionally related to the above-referenced beneficiary's liability claim. Medicare has a claim and is seeking recovery in the amount of .

The Medicare Secondary Payer (MSP) provisions of the statute, 42 U.S.C. 1395y(b)(2), preclude Medicare from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under an automobile or liability insurance policy or plan (including a self-insured plan)." However, Medicare will pay for a beneficiary's covered medical expenses when the third party payer does not pay promptly, conditioned on reimbursement to Medicare from proceeds received from a third party liability settlement, award, judgment or recovery. In your case, Medicare made a conditional payment in the amount of A list of the claims used to arrive at this total is enclosed.

Please mail a check or money order in the amount of , made payable to **Medicare** at:

The amount requested in this letter may not include payments received prior to the issuance of this demand letter dated . Upon issuing a check, please deduct previous payments made to the MSPRC for the above referenced debt.

Exercising Common Law authority and consistent with the Federal Claims Collection Act, interest will be assessed if this debt is not repaid in full within 60 days of the date of this letter. See also, 42 C.F.R. 411.24(m) for provisions specific to interest on MSP debt. If the debt is not fully resolved within 60 days of the date of this letter, interest is due and payable for each full 30 day period the debt remains unresolved. Interest will be assessed at an annual rate of . By law, all payments are applied to interest first, principal second.

Your failure to respond as requested within sixty (60) days of the date of this letter may result in the initiation of additional recovery procedures without further notice, including referral to the Department of Justice for legal action and/or the Department of the Treasury for other collection actions. You should be aware that the Debt Collection Improvement Act of 1996 requires Federal Agencies to refer debts to the Department of the Treasury or its designated debt collection center for recovery actions including collection by offset against any monies otherwise payable to the debtor by any agency of the United States and through other collection methods. Under this and other authorities (31 U.S.C. 3720A), the Internal Revenue Service may collect this debt by offset against tax refunds owed to individuals or other entities.

If the amount repaid for any services that appear on the enclosed payment summary is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined. If benefits have already been paid to the beneficiary or the provider of the services shown on the payment summary, provide an explanation of benefits or record of payment that includes the amount paid, date of services paid, dates paid, and name of payee.

If you have any questions about this letter, you may contact MSPRC LIABILITY at 1-866-677-7220 or the address above to discuss the repayment.

Sincerely,

Enclosure: Payment Summary Form
cc:

SGLDILNGHP

APPENDIX E

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Learn about your letter at *www.msprc.info*

Beneficiary:
Medicare Number:
Date of Incident:

Dear :

We have received check number in the amount of .

This amount has been applied to the outstanding debt due Medicare. The principal amount of the debt and interest (if applicable) has been reduced to zero and our file is being closed.

If a refund is due it will be processed and forwarded to the appropriate party under separate cover. If the original check submitted to Medicare had multiple payees it will be the attorney and/or beneficiary's responsibility to disburse the funds to all other payees.

If you have any questions concerning this matter, please call the Medicare Secondary Payer Recovery Contractor (MSPRC) at (TTY/TDD: for the hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary's name and Medicare health insurance claim number.

Sincerely,

cc:

SGL NGHP