Dealing With Carriers Under Medicare's More Watchful Eye

With Medicare tracking settlements more closely, insurance carriers worried about potential exposure want to check your work. With online and offline options, it's important to understand the process and anticipate the potential challenges of handling a case for a Medicare beneficiary.

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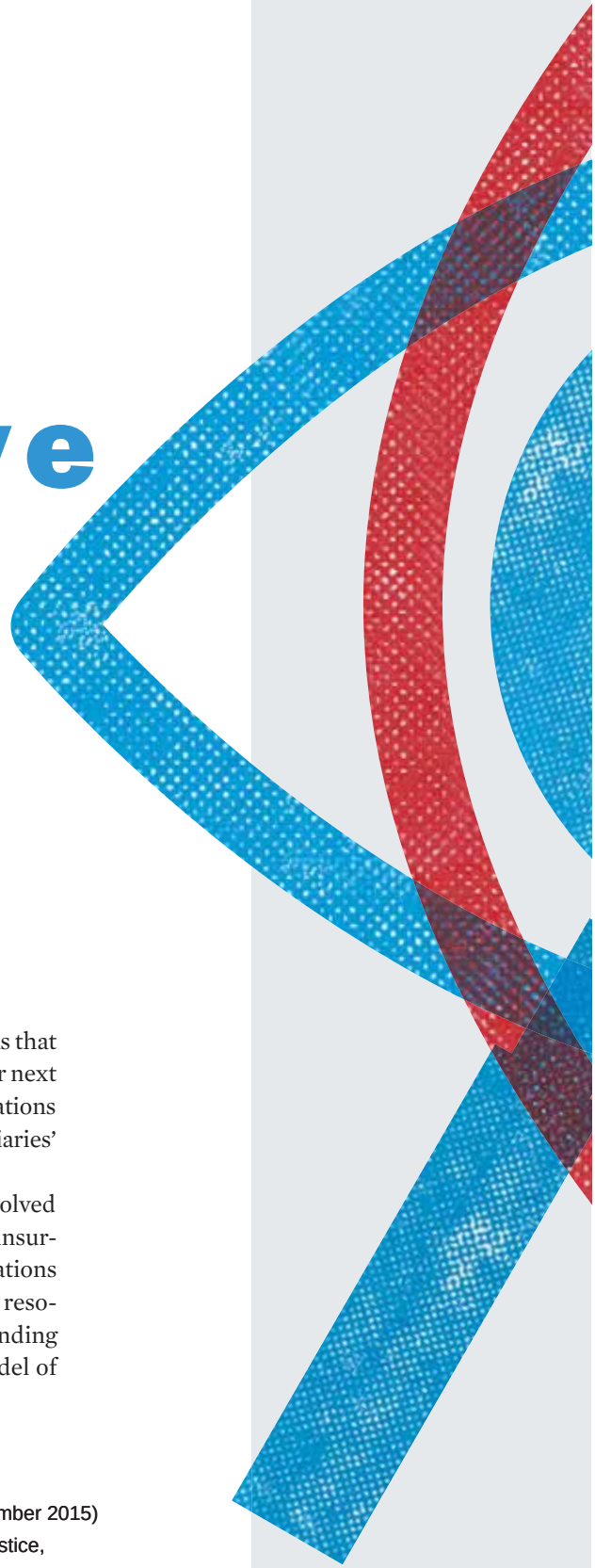
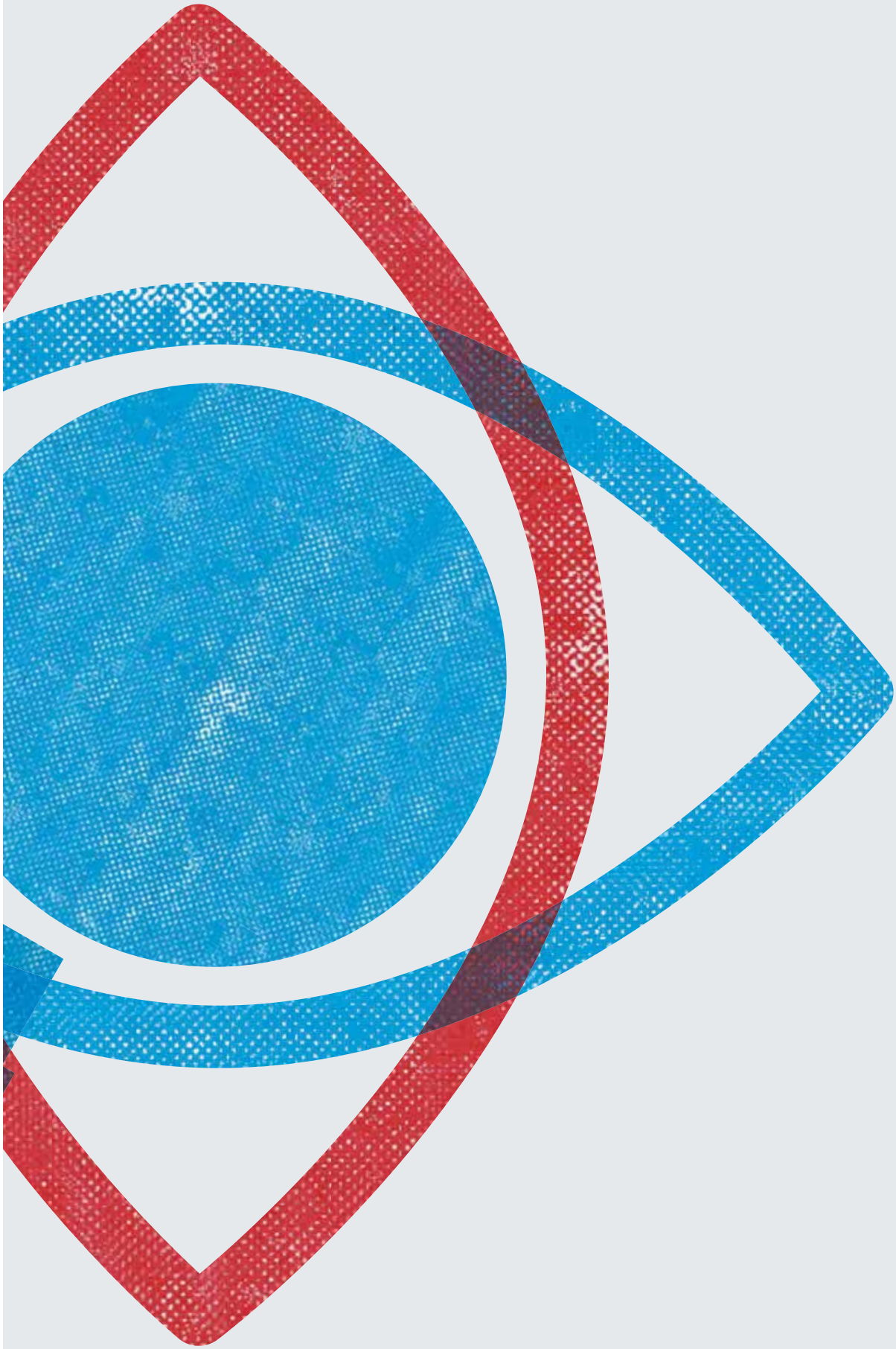


More than 44 million Americans receive Medicare coverage. As that number continues to grow, there is a distinct possibility that your next client will be a Medicare beneficiary. Medicare's rules and regulations have a tremendous impact on resolving your client's case and Medicare beneficiaries' cases that will likely follow.

Medicare laws set forth requirements that implicate almost every entity involved in a Medicare beneficiary's liability case. Some of these entities—especially insurance carriers—have begun invoking many of Medicare's long-standing regulations and newer reporting requirements as a way to interject themselves into the resolution process. Attorneys handling liability cases must have a basic understanding of Medicare's processes and requirements—which have been labeled a "model of un-clarity"[1]—and anticipate potential hurdles in resolving issues.



TAKEAWAYS

Medicare Recovery Claims Process

Offline

- Provide initial notification to CMS
- Review the Rights and Responsibilities letter from CMS for requested information
- You will receive a conditional payment letter within 65 days
- Once a settlement, judgment, or award is final, send the settlement information to CMS
- CMS will send a final demand
- You have 60 days to pay the amount or appeal before interest accrues

Online

- Report a claim at https://www.cob.cms.hhs.gov/MSPRP
- CMS will post conditional payment information within 65 days
- Notify CMS that settlement or award is expected to occur within 120 days and request final conditional payment information
- CMS will post a final conditional payment amount
- Lodge disputes through the portal, which are resolved within 11 business days
- Within three days of the settlement or award, download a conditional payment summary form that constitutes the final conditional payment amount
- Within 30 days of the settlement or award, submit settlement documents, and CMS will issue a final demand

Medicare Processing 1.0 and 2.0

The Medicare Secondary Payer Act (MSP)[2] makes Medicare a "secondary payer" in liability cases, but in practice, Medicare often makes initial medical payments on behalf of an injured beneficiary. However, when an automobile, general liability, or no-fault insurance provider later makes or "can reasonably be expected to" make a payment under the policy, these carriers become the primary payers. Medicare's payments become conditional, and Medicare possesses a "recovery claim" to recoup these conditional payments.[3]

These recovery claims are handled by the Centers for Medicare and Medicaid Services (CMS) through the Benefits Coordination & Recovery Center (BCRC). The process of dealing with CMS is becoming increasingly complicated because it is in the midst of an electronic overhaul, courtesy of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2012.[4] The SMART Act requires Medicare to create an electronic portal to allow beneficiaries and their attorneys to manage Medicare liability claims and to obtain up-to-date payment information in advance of settlement.[5] Although full compliance will not be in place until Jan. 1, 2016, CMS created an online portal in 2012 and recently enacted regulations for electronic claims processing.[6] Despite the online option, CMS has not indicated that it intends to eliminate mail and telephone claims handling.

Whichever approach you prefer, your first task is to determine whether your client is a Medicare beneficiary or is likely to become one in the near future. At the first interview, find out whether your client is in his or her early sixties or currently receives Social Security Disability. There is no such thing as starting too early when dealing with CMS. It is important to talk to your client about Medicare's recovery claim process and explain that Medicare issues can take significant time to resolve.

THE OFFLINE PROCESS. For attorneys who would rather avoid the online portal, the standard offline process is roughly as follows:

1. Contact CMS's BCRC immediately, and provide an initial notification to Medicare. CMS will require the beneficiary's Medicare ID number; the case information, including date of injury, description of injury, and type of claim; and the attorney's information.[7] Everything submitted to CMS by mail or fax should contain the beneficiary's Medicare ID number to ensure it is placed in the correct file.
   TIP: Given the new reporting requirements, it is possible that a carrier already notified CMS. If so, check that the date of injury is correct. If the dates are different, address this issue as early in the process as possible.
2. Submit proof of representation when you contact CMS. This must contain your signature, the beneficiary's signature, and the beneficiary's Medicare ID number. CMS offers a sample proof of representation document on its website.[8]
3. You will receive a Rights and Responsibilities letter from CMS within several weeks of your initial notification. The letter will outline any requisite information and will include a cover page that you can use to submit future correspondence.
   TIP: It is not uncommon for paperwork to get lost within CMS, so call to ensure CMS has what it needs. Unfortunately, if the file is incomplete, no one will contact you or the beneficiary. You also should find out whether any other files have been opened regarding the beneficiary for the claim at issue. CMS will sometimes open one file related to no-fault insurance, and open a separate file related to liability insurance.
4. Within 65 days of receiving the Rights and Responsibilities letter, you should receive a conditional payment letter. If you believe the letter contains unrelated claims or inappropriate information, cross out those claims and return the letter to CMS with supporting documentation. CMS will notify you when it has finished its review.
5. Once a settlement, judgment, or award is final, quickly send the settlement information to CMS, including the date of the settlement, a copy of a settlement statement indicating attorney fees and costs, the insurance carrier's information, and a copy of the settlement agreement. Be sure to hold at least the amount of the conditional payment letter in trust, although there have been rare cases where CMS has ultimately demanded more than the conditional payment amount.
6. CMS will send a final demand, which will include reductions for attorney fees and costs. You have 60 days to either pay the amount or appeal the final demand letter before interest accrues. If you choose to appeal, forms for appeal are available on the CMS website. Appeals are rarely granted.

THE ONLINE PROCESS. CMS's online portal allows attorneys to submit information electronically and gives a 185-day window from reporting the claim to receiving the final conditional payment amount. Under the offline process, it currently is not possible to get a final conditional payment amount

before finalizing the settlement. Although the portal will not be fully functional until 2016, it is active, and the process for using it is spelled out in the Code of Federal Regulations.[9] To use the online portal, you should take the following steps:

1. Register an account in the Web portal at https://www.cob.cms.hhs.gov/MSPRP. It should be a corporate account if your firm has an Employer Identification Number.
2. Once in the portal, you can report a claim and submit proof of representation online. CMS will post conditional payment information to the portal within 65 days of receiving this notice.
3. Any time after the conditional payment information is posted, you can notify CMS that settlement or award is expected to occur within 120 days and request final conditional payment information. This should be processed relatively quickly compared to the traditional, offline method. Per the SMART Act, unless your client received interim covered treatment or you dispute the claim, this should be the final conditional payment amount.
4. CMS will post a final conditional payment amount. If you dispute the proposed final conditional payment amount, you can lodge it through the portal, and it will be resolved within 11 business days.
5. Within three days of the date of settlement or award, you may download a time-and-date stamped conditional payment summary form that formally "constitutes Medicare's final conditional payment amount." This is perhaps the most significant change in the Medicare reporting process—you should know how much Medicare is seeking before consummating settlement.
6. Within 30 days of the settlement or award, you can submit settlement documents, and CMS will apply the appropriate reductions and issue a final demand.

If the new portal works as advertised, attorneys should find the process of interfacing with CMS more streamlined. The same may not be true for dealing with opposing parties and their carriers.

Medicare's New and Not-So-New Requirements

Though Medicare rules may be in flux,[10] for 25 years the MSP has provided a direct right of recovery and a subrogation right that is superior to virtually any other claims, liens, or asserted rights regarding payments made for a Medicare beneficiary's care.[11] However, recently insurance providers and other primary payers have been scrutinizing cases involving Medicare beneficiaries. This is probably a result of legislative regulations that are just now coming into full effect, most notably Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)[12] and the SMART Act.

Insurance carriers have begun invoking many of Medicare's long-standing regulations and newer reporting requirements as a way to **interject themselves** into the resolution process.

Under current Medicare provisions, virtually all liability claims that include Medicare beneficiaries must be reported to CMS.[13] The SMART Act requires that an annual threshold amount be set to trigger reimbursement or reporting obligations. These threshold amounts are now $1,000 or less.[14]

While CMS has always maintained that Medicare beneficiaries or their attorneys must report liability claims, the MMSEA now requires "non-group health plans"—including liability and no-fault insurance carriers—to notify CMS of any potential Medicare claim.[15] Although these carriers could face a $1,000 per day penalty for failure to notify CMS, CMS is still establishing when penalties would be appropriate and what constitutes noncompliance.[16]

With a specific duty to report in place, some insurers are focusing more on long-standing Medicare regulations. For more than a decade, CMS has had a right to recover payments from *any entity*, including a Medicare beneficiary's attorney, and any primary payer, including insurance carriers.[17]

These same regulations codify a long-understood obligation: It is the responsibility of the beneficiary, including the attorney receiving payment, to reimburse Medicare after receiving funds from a primary payer.[18] Attorneys should also evaluate their state's ethical rules and advisory opinions—many states place additional duties on attorneys concerning the handling of client funds and the reimbursement of government payers and other providers.

Although there have been few substantial changes in the Medicare framework for parties' obligations or

CMS's power to recover payments, CMS's close tracking of Medicare claims in liability cases causes some carriers to seek a more active role in paying Medicare, which in turn can create issues for beneficiaries' attorneys.

Challenges a Beneficiary's Attorney Faces

In typical litigation involving Medicare beneficiaries, carriers issue a settlement draft to the beneficiary and attorney for the full settlement amount. Consistent with their duty to pay Medicare, attorneys then place a sufficient amount of the draft in their trust account to cover the conditional payment amount, and ultimately pay Medicare pursuant to the final demand. However, with Medicare taking a more active role in monitoring Medicare claims, carriers seem preoccupied with potential exposure from a Medicare recovery action, which is equally possible, if not more probable, against a beneficiary's attorney.[19]

In several instances, insurers have attempted to deviate from a standard practice that comports with both the attorney's duties and Medicare's rules and regulations. Some carriers ask for a copy of the conditional payment letter early in litigation under the pretense of wanting to ensure Medicare has been properly notified. Carriers may also ask an attorney to have the beneficiary sign a CMS Consent to Release form, entitling the carrier to any conditional payment information. To the extent the carrier needs to ensure notice, the SMART Act has made it easier. CMS requires only a Medicare beneficiary's first initial, surname, birthdate, gender, and last five digits of a Social Security number to report a claim.[20]

Recently, carriers have tried to assert that they must pay Medicare directly. There is simply no basis in the regulations or law. And by allowing a carrier to pay Medicare directly, a beneficiary's attorney could be relinquishing a statutory duty to pay Medicare and an ethical duty to protect the client's interest by way of negotiating with Medicare. At least one federal court denied a motion to enforce a settlement agreement when the defendant's carrier insisted it make a check payable directly to Medicare. The court rejected any notion that the MSP requires Medicare be named on a settlement check.[21] Direct payment could also raise prickly issues under various state ethics rules, because a check that never passes through a trust account or to a client might not be a recovery for contingent fee purposes. Carriers also have demanded that checks be made out to the beneficiary and to Medicare. In addition to many of the problems already discussed, attorneys will find themselves in the untenable position of having to get Medicare—an entity that takes 65 days to write a letter—to endorse and return a check.

Carriers have also proposed holding back the conditional payment amount and remitting those funds to the attorney after receiving the final demand. This accomplishes nothing for the carrier other than retaining additional interest, which, when considering the time value of money over the span of hundreds or thousands of cases, could amount to millions of dollars for the carrier. The attorney is still paying Medicare directly, so it offers no more protection to the carrier. Additionally, through the new online portal, the final conditional payment amount would be available before settlement. But it does create a problem for attorneys. They must trust the check will arrive, clear, and get to CMS within the requisite 60 days after the final demand letter.

Finding a Way Forward

There is no doubt that as a result of Section 111 of the MMSEA, CMS is taking a more active role in tracking Medicare claims, and that liability and no-fault insurance carriers are specifically held accountable for reporting potential Medicare claims. In light of this legislation, insurance carriers are taking steps to ensure that CMS is aware of potential claims involving Medicare beneficiaries.

Carriers' recent actions do more than provide notice—they allow carriers to exercise unprecedented and problematic influence over an attorney's negotiation with Medicare.

Given the ever increasing number of Americans who receive Medicare benefits, consider establishing a firm-wide policy on how to deal with carriers who attempt to take an active role in satisfying Medicare's recovery claim. If your next client is a Medicare beneficiary, and the opposing party's carrier does not remit the entire settlement check, the best position might be to agree to hold the Medicare conditional payment amount in trust, have the beneficiary sign a hold-harmless provision, and copy the carrier on the correspondence to Medicare enclosing final payment. By understanding Medicare's requirements and timelines, and anticipating potential hurdles, you'll be able to resolve your client's case in the most streamlined way possible. T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Notes

1. *Estate of Urso v. Thompson*, 309 F. Supp. 2d 253, 259 (D. Conn. 2004).
2. 42 U.S.C. §1395y(b) (2015).
3. *Id.*
4. Pub. L. No. 112-242, 126 Stat. 2374 (2013).
5. *Id.*

6. 42 C.F.R. §411.39 (2013).
7. Ctrs. for Medicare & Medicaid Servs. (CMS), *Reporting a Case*, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Reporting-a-Case/Reporting-a-Case.html. The telephone number for reporting to BCRC is (855) 798-2627, the fax number is (405) 869-3309, and the address is MEDICARE Data Collections, P.O. Box 138897, Oklahoma City, OK 73113.
8. CMS, *Proof of Representation Liability Insurance, No-Fault Insurance, or Workers' Compensation*, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Proofof Representation.pdf.
9. 42 C.F.R. §411.39.
10. In addition to the relevant statutes and regulations, CMS has intricate guidelines, alerts, and FAQs on its website for many issues involving Medicare liability. *See* CMS, www.cms.gov/Medicare/Medicare.html.
11. *See* 42 U.S.C. §1395y(b). The MSP also makes Medicare the secondary payer in workers' compensation cases. However, this article focuses on Medicare's role in liability cases.
12. Pub. L. No. 110-173, 121 Stat. 2492 (2007).
13. 42 U.S.C. §1395y(b).
14. For example, in claims involving liability insurance and self-insurance, CMS recently issued a memo that, as of Jan. 1, 2015, a threshold amount of $1,000, as opposed to $300, would be required to trigger any reporting obligations. *See* CMS, *Change in Reporting Threshold for Certain Liability (including Self-Insurance) Settlements, Judgments Awards, or Other Payments* (Feb. 28, 2014), www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/New-Downloads/Alert-Change-in-Reporting-Threshold-for-Certain-Liability-Insurance-including-Self-Insurance-Settlements-Judgments-Awards-or-Other-Payments.pdf.
15. 42 U.S.C. §1395y(b)(8). This recovery claim often is referred to as a Medicare lien or a super lien. CMS insists it is erroneous to refer to Medicare's recovery claim as a lien.
16. Medicare Program; Medicare Secondary Payer and Certain Civil Money Penalties, 78 Fed. Reg. 75304, 75305 (Dec. 11, 2013).
17. *See* 42 C.F.R. §411.24(e), (g) (2012).
18. *See* 42 C.F.R. §411.24(h) (2012).
19. *United States v. Harris*, 2009 WL 891931 at *5 (N.D. W. Va. Mar. 26, 2009) *aff'd*, 334 Fed. App'x 569 (4th Cir. 2009).
20. CMS, *ALERT: Change in Reporting of Medicare Health Insurance Claim Numbers and Social Security Numbers for Non-Group Health Plan Responsible Reporting Entities* (Sept. 10, 2014), www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/Change-in-Reporting-of-Medicare-Health-Insurance-Claim-Numbers-HICNs-and-Social-Security-Numbers-SSNs-for-Non-Group-Health-Plan-NGHPResponsible-Reporting-Entities-RREs-.pdf.
21. *Tomlinson v. Landers*, 2009 WL 1117399 at *6 (M.D. Fla. Apr. 24, 2009).