Medicare Conditional Payments

Assessing Exposure, Protecting Interests

by Patty Meifert and Robert T. Lewis

Congress established the Medicare program in 1965 to pay medical expenses for the elderly, disabled, and people suffering from end-stage renal disease. Initially, Medicare paid essentially all expenses for eligible participants (beneficiaries).[1] However, in 1980, Congress created the Medicare Secondary Payer Statute (MSP) to reduce spending and preserve the fiscal integrity of the Medicare program.[2]

Under the MSP as it exists today, medical benefits are available for qualified individuals. However, if a Medicare beneficiary's injury or illness is the responsibility of a third party, Medicare is no longer required to pay for treatment. The theory is to shift the cost back to the responsible party. The MSP specifically provides that Medicare may not make payment on behalf of a beneficiary if, "payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan ... or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault

insurance."[3] As a result, Medicare will look to one of these designated plans or policies as the "primary" payer for all injury– or illness-related medical expenses.

What happens if one of these primary plans doesn't pay? How will the beneficiary receive medical care if there is no other coverage? The MSP provides that Medicare has the authority to make payment if one of the previously described plans "...has not made or cannot reasonably be expected to make payment with respect to such item or service promptly...[a]ny such payment ... shall be conditioned on reimbursement..."[4] If the primary plan does not pay for treatment, the beneficiary could still receive care through Medicare, but such payments, called conditional payments, are subject to reimbursement.

Conditional payments may arise in both liability and workers' compensation claims. It is common to see conditional payments in the following types of litigation:

- automobile and motorcycle accidents
- work-related accidents
- slips & falls
- asbestos exposure claims
- nursing home injuries
- medical malpractice claims

Conditional payments typically arise when one or more of the following factors are present:

- The claim is denied by the carrier or self-insured
- The carrier or self-insured does not pay promptly
- The beneficiary elects to pursue unauthorized treatment
- The beneficiary fails to document the fact that other insurance exists
- The provider mistakenly bills Medicare
- The beneficiary fails to file, or improperly files, a claim
- There is a long delay between the occurrence of an injury or illness and the decision by the Court.[5]

During claim litigation, the carrier may have a justifiable basis for denying medical benefits pursuant to state law. Liability and workers' compensation claims often involve genuine disputes over liability, causal relationship, and/or the need for treatment. Cases may be further complicated by pre-existing conditions, degenerative changes, or unrelated exposure. As such, it is not always clear who is legally responsible for providing treatment, and certainly not uncommon for a conditional payment claim to arise during litigation. It is essential to properly investigate this issue **prior** to resolving any liability or workers' compensation claim involving a Medicare beneficiary. Otherwise, as described below, all parties involved in the litigation may face significant future exposure.

Right of Reimbursement

Medicare's right of reimbursement for conditional payments is sometimes referred to as a "Super Lien."[6] The name might be derived from the broad authority granted to the Centers for Medicare and Medicaid Services (CMS) to enforce recovery.

CMS has the right to initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, liability, no-fault insurance, or an employer group health plan.[7] CMS also has a direct right of action to recover from any entity responsible for making primary payment, including an employer, insurance carrier, plan, or program, and a third-party administrator.[8] Additionally, CMS has a right of action to recover its payments from any entity (including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer) that received a third party payment.[9] The bottom line is that everyone involved in the claim has potential exposure for reimbursement.

The extent of potential exposure is clarified in the Code of Federal Regulations. If it becomes necessary for CMS to take legal action to recover any conditional payment from the primary payer, CMS is entitled to recover **twice** the amount of the Medicare primary payment.[10] If it is not necessary to take legal action to recover a conditional payment, CMS may recover the lesser of two amounts: the Medicare primary payment, or full primary payment that the primary payer is obligated to pay.[11]

It is imperative, therefore, to properly investigate any conditional payment claim prior to resolution of the underlying claim. The amount of the claim must be determined in advance and factored into settlement discussions in order to reach a full and final resolution. It is also important to understand a technicality regarding the timing and demand for reimbursement. Before a settlement is reached between the beneficiary and the responsible party, there can be no overpayment or claim for reimbursement.[12] Medicare's claim arises pursuant to 42 U.S.C. 1395y(b)(2)(B)(ii) *only when payment is received from a primary plan.*

Medicare will notify the parties prior to resolution of the "current lien amount," but a formal demand for recovery can only be made post settlement. Reimbursement must then be made within sixty (60) days.[13] After that time, Medicare may charge interest that will continue to accrue until reimbursement is made.[14]

Estimating and Negotiating Conditional Payment Claims Prior to Demand

A formal demand for recovery of Medicare conditional payment claims can only be made once the third party payer makes a payment, but the following procedures allow the parties to obtain an estimate of Medicare's claim to date, and to negotiate for removal of inappropriate claims.

1. Establish a Record

The Coordination of Benefits Contractor (COBC) was established in 2001 to collect data on cases involving a Medicare beneficiary and another payer primary. Once the details of a case are called in to the COBC, a record is established and the case is assigned to a Medicare Fiscal Intermediary for investigation. The beneficiary's record will be flagged to prevent further Medicare payments related to the illness or injury specified. The following information is required when reporting a case to the COBC:

- Beneficiary's Medicare number
- Date of accident or injury
- Description of injury or ICD 9 code(s)
- Name & address of the insurance carrier or payer
- Name & address of beneficiary's legal representative

2. Contact the Fiscal Intermediary Assigned to the Case

Submit to the assigned Fiscal Intermediary a written request for an estimate of conditional payments. A Medicare Consent to Release form, signed by the beneficiary, is required in order to receive a response. The Fiscal Intermediary will furnish a Claim Payment Summary detailing payments made by Medicare for treatment of diagnoses matching those reported to the COBC.

3. Review the Claim Payment Summary

The Claim Payment Summary provides details of Medicare's payment, including the name of the provider, the date of service and the amount paid by Medicare. The Claim Payment Summary should be compared to the primary payer's medical payment history to identify duplicate billing involving the provider. If it is determined that the provider billed both the primary payer and Medicare for the same service, Medicare will seek reimbursement from the provider.

4. Negotiate Removal of Inappropriate Claims

Negotiations to remove inappropriate claims must be made in writing to the assigned Fiscal Intermediary and must include adequate medical documentation to support the basis for negotiation, which may include:

- the claim paid by Medicare was not related to the injury being settled;
- Medicare made a duplicate payment to a provider and to the primary payer for the same DOS;
- an unauthorized provider was used while the primary payer provided appropriate care.

5. Case Study

Parties reached a $125,000 settlement agreement in a workers' compensation case involving diagnoses of chronic back pain and anxiety. Prior to settlement, Medicare estimated it made conditional payments in the amount of $87,025.51. A review of Medicare's Claim Payment Summary revealed duplicate claims by Medicare, and the claim was reduced from $87,025.51 to $43,777.78. Medical records from the listed providers indicated that while the physician listed anxiety as one of the diagnoses on the Medicare claim form, the reason for the majority of the medical treatment was due to a cardiac condition unrelated to the work injury. Medicare accepted the argument and the final demand for reimbursement at settlement was $41.80.

Additional Statutory Reductions

Medicare's lien may be further reduced from a legal basis. In *Estate of Washington v. U.S. Secretary of Health and Human Services*[15], the court held that the reimbursement of the Medicare obligation was

subject to a reduction for procurement costs. In other words, Medicare reduces its recovery to take into account the cost of procuring the judgment or settlement.[16] The costs include attorney's fees, expert witness fees and court costs. In order to properly calculate this reduction, the claimant's attorney must provide a copy of the fee agreement along with documentation of costs incurred during litigation. These procurement costs are ultimately submitted to CMS for adjustment.

In addition to a lien reduction for procurement costs, in some instances a waiver, or compromise of Medicare's right of reimbursement, may also be obtained. Such a request must be made in writing, and not until settlement has been reached and the amount of Medicare's final claim has been received.[17] The procedure for obtaining a waiver or compromise is beyond the scope of this article, but there are three statutory authorities under which Medicare may accept less than the full amount of its claim. §1870 (c) of the Social Security Act; §1862(b) of the Social Security Act; and the Federal Claims Collection Act (FCCA).[18] Each statute contains different criteria upon which decisions to compromise, waive, suspend, or terminate Medicare's claim may be made.[19]

The following indicators may support a full or partial waiver under these provisions:

- Medicare's recovery exceeds the settlement amount
- the beneficiary sustained permanent injuries, or has documented lost wages, or became unemployed
- there are non-covered out-of-pocket accident-related expenses
- the beneficiary's living expenses are equal to or higher than his/her income.[20]

In contrast, the following indicators may support denying a waiver:

- Medicare asserted its right to recover before the settlement proceeds were disbursed
- the beneficiary received a large settlement
- the beneficiary's income exceeds his/her ordinary living expenses
- after repaying Medicare and allowing for out-of-pocket medical costs, the beneficiary will still be left with a substantial amount of the settlement proceeds
- the beneficiary has other substantial assets.[21]

Once Medicare agrees to a final claim amount the case will be closed by the lead contractor and the parties may go forward knowing that the case is properly resolved. Following this procedure is the only way to ensure that a claim for reimbursement will not be made in the future for payments made prior to the date of settlement. ❖

1 See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862(b), 79 Stat. 286
2 *See Health Ins. Ass'n of America, Inc. v. Shalala*, 306 U.S. App. D.C. 104, 23 F.3d 412, 414 (D.C. Cir. 1994)
3 42 U.S.C. § 1395y(b)(2)(A)(ii)
4 42 U.S.C. § 1395y(b)(2)(B)(i)
5 42 C.F.R. 411.45; 411.52; 411.53
6 *Should Attorneys be Reimbursing Medicare Out of Tort Settlements?* Benjamin W. Glass, III, The Advocate November 2003.
7 42 C.F.R. 411.24 (b)
8 42 C.F.R. 411.24(e)
9 42 C.F.R. 411.24(g)
10 42 C.F.R. 411.24 (c)(2)
11 42 C.F.R. 411.24 (c)(i)(ii)
12 CMS: Information Package, Medicare Secondary Payer
13 42 C.F.R. 411.24 (h)
14 42 C.F.R. 411.24 (m)(ii)
15 53 F. 3d 1173 (1995)
16 42 C.F.R. 411.37
17 CMS: Information Package, Medicare Secondary Payer
18 §3418.11 Intermediary Manual Part 3
19 Id.
20 Id.
21 Id.

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