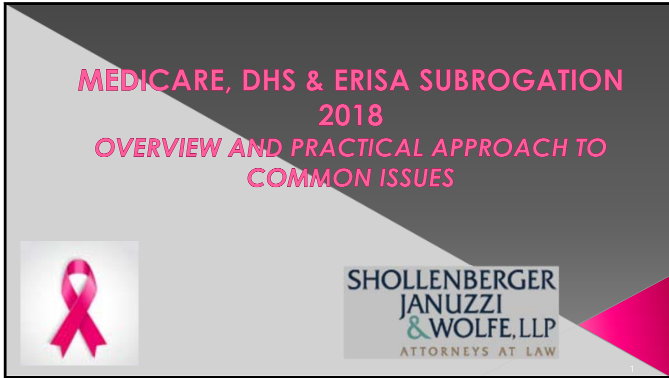

AN OVERVIEW OF THE MEDICARE PROCESS

what once was lost …

…is now kind of found

- Still report by phone
  - Way more efficient – Not calling more than once to report/less wait time/call back option
- BCRC reports to MSPRC within 7-10 days on average
- Fax or upload Proof of Representation Form – 2 to 3 days for Medicare to verify then access to portal or paper copies of CPL/CPN/FDL
- RAR letter issued first
- Within 65 days Initial CPL will be sent – usually sooner
  - Portal provide CP amount even sooner but no itemization
- Final Demand Amounts are issued within 30 days of notification of settlement
- Challenging Charges – Done by Portal (be aware of deadlines)

ISSUE: UNREASONABLE RELEASE LANGUAGE/MEDICARE ADDENDUMS

- Giving Medicare more rights than they should have
- Misinterpreting the language of the regulations
- Asking our clients to state something that is not true

4

Example from Medicare Addendum:

"Anytime a Medicare beneficiary receives funds from a liability insurance policy due to a settlement, judgment or award arising out of an accident that requires the beneficiary to receive medical treatment, Medicare expects that those funds will be used to pay for services already rendered and services provided in the future related to that medical treatment. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers that would otherwise be covered by Medicare"

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"By receiving this settlement, I and my counsel, if represented, understand that I/we may have continuing obligations to CMS and/or the MAO, as the Released Parties have included in their payment to me any obligations they have as a PRIMARY PAYER to CMS and/or the MAO. In the event that I do not fulfill my obligations to CMS and/or the MAO, I understand that I or my counsel, if represented, may be subject to a direct suit by CMS and/or the MAO:

1.) For recovery of attorneys fees collected through a settlement or release (42 CFR 411.24(g) and 42CFR 422.108(f)).

2.) For recovery of medical expenses that should have been paid from the settlement (42 CFR 411.24(g)and 42 CFR 422.108(f) and Subrogation 42 CFR 411.26(a))." *[411.24 applies to conditional payments only]*

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FUTURE MEDICAL EXPENSES

CONSIDERING AND PROTECTING MEDICARE'S INTEREST VS. CONTRACTUALLY ACKNOWLEDGING/CONFERRING ADDITIONAL RIGHTS TO MEDICARE

- Fall of 2014 – CMS withdraws proposed rule to address future medicals in tort actions ("Medicare Secondary Payer and Future Medicals")… No instruction in tort cases
  - Show you considered it and took some step(s)- To be considered especially in larger cases with lifecare plan or other future medicals that are made part of the demand. Dept. of Health and Human Services has stated that Set Aside, if approved, is a sufficient means of protecting Medicare's future interest
- Set Asides for settlements over $250k in Work Comp Cases
  - Usually requires hiring of consultant to determine the amount and submit to Medicare – Costs between $3k-$6k on average
- Medicare Secondary Payer Manual still directs staff not to attempt to recover payments made after date of settlement

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Medicare Website:

June 8, 2016 - Consideration for Expansion of Medicare Set-Aside Arrangements (MSA)

The Centers for Medicare and Medicaid Services (CMS) is considering expanding its voluntary Medicare Set-Aside Arrangements (MSA) amount review process to include the review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS plans to work closely with the stakeholder community to identify how best to implement this potential expansion. CMS will provide future announcements of the proposal and expects to schedule town hall meetings later this year. Please continue to monitor this website for additional updates.

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If they want something, Insurers need to make it part of the negotiations

- If nothing is paid by Medicare yet (i.e.… recoverable medicals are future and/or Medicare eligible or expected to be in 30 months) – Insurer has no right to require confirmation from Medicare that they will not assert a lien and/or that a portion of the settlement monies be set-aside or paid into a separate fund. *Sipler v. Trans AM Trucking, Inc., et al*, No. 10-3550(DRD)(D.N.J. July 24, 2012 DeBevoise, S.J.); *Villare v. GEICO Casualty Company*, NO. 14-2288 (E.D. Pa. March 24, 2015 Baylson, J.).
- Insurer cannot require production of Medicare FDL if not requested and made part of original settlement terms. *Zaleppa v. Seiwell*, 2010 Pa.Super. 208 (Pa.Super. Nov. 17, 2010, Allen, Mundy, and Colville, JJ.). *Carty v. Clark*, Civil Action No. 11-6083 (E.D.Pa. June 14, 2012 Rueter, Mag. Judge)(Order by Robreno, J.); ***Furman v. Wildermuth*, No. C-0048-CV-2008-3556 (C.P. Northampton Co. July 12, 2011 Dally, J.);** *Villare v. GEICO Casualty Company*, NO. 14-2288 (E.D. Pa. March 24, 2015 Baylson, J.), *Dailey-Console v. Barnwell*, PICS Case No. 11-1115 (Monroe Co. May 18, 2011, Zulick, J.).
- Insurer cannot insist that they can hold the check or pay into escrow, or that Medicare be named on the settlement check or a separate draft be sent to Medicare unless agreed to as part of settlement. *Carty v. Clark*, Civil Action No. 11-6083 (E.D.Pa. June 14, 2012 Rueter, Mag. Judge)(Order by Robreno, J.) *Dailey-Console v. Barnwell*, PICS Case No. 11-1115 (Monroe Co. May 18, 2011, Zulick, J.), *Vincent v. Buck*, No. 2011-CV-456 (Cambria Co., April 4, 2011, Swope, S.J.).
- *If the insurer wants it, they need to ask for it as part of the settlement. See e.g., Wimberly v. Katruska*, PICS Case No. 12-1060 (C.P. Allegheny Co. May 23, 2012 Wettick, J.) – Likely will not be granted though if Plaintiff objects to initial request and there is no proof of receipt of any benefits to date.

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EXAMPLE CONTINUED: (MAO: MAPs vs. MEDIGAP PLANS)

"I further understand that 42 USC 1395w-21 through 42 USC 1395w-28 authorizes CMS to contract with private insurance companies to administer Medicare Advantage Plans (MAP). These private insurance companies, operating as Medicare Advantage Organizations (MAO), cover Medicate benefits under what is known as Medicate Part C coverage. For the purposes of this addendum, the term "Medicare" also includes and encompasses MAPs and MAOs."

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Do They Want the Client to "Warranty" Something not True?

"II. Warranties

Therefore, in consideration of the parties' willingness to settle the claim referenced in the RELEASE OF ALL CLAIMS, and to induce said settlement, Claimant makes the following warranties:

- I am a Medicare beneficiary
- My Medicare Health Insurance Claim Number is
- Medicare has made NO CONDITIONAL PAYMENTS for any medical expense or prescription drug expense related to the Accident.
- No medical expense or prescription drug expense related to the Accident has been or will be submitted to Medicare for payment.
- I have disclosed to the Carrier the names of all medical providers which provided treatment for the injuries I sustained in the Accident.
- All treating physicians have provided written reports which release me from medical care as a result of the injuries I sustained in the Accident which I have provided to the Carrier. The reports indicate that I will need no further treatment as a result of these injuries.
- Should future medical treatment related to the Accident be required, the expense associated with that treatment will be paid from the proceeds of this settlement.
- No further medical expense or prescription drug expense related to the treatment I have received or will receive in the future related to the Accident will be submitted to Medicare for payment, and I will instruct all medical providers rendering such treatment that the expense associated therewith should not be submitted to Medicate.
- No liens, including but not limited to liens for medical treatment by hospitals, physicians, or medical providers of any kind have been filed for the treatment of injuries sustained in the Accident."

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EXAMPLE OF OTHER INCORRECT PROVISIONS

"hold free and harmless from and against any and all losses, claims, demands, cause or causes of action or judgments of every kind and character, which may or could be brought for attorneys' fees, contribution or indemnity, any and all statutory contractual or common law subrogation claims or liens, including, but not limited to, all hospital liens, workers' compensation subrogation liens, Medicare or Medicaid liens, Medicare Advantage Organization liens, Social Security disability liens, health insurance liens, federal, state or local governmental liens."

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ERISA SUBROGATION

"The Case Driver"

US Department of Labor Study from 2013 (of people receiving employer provided healthcare benefits):

- 30 Million people were insured through employer fully self-funded ERISA plans
- 26 Million people were insured through mixed insurance/self-funded plans (likely to still have reimbursement rights)
- 12 Million insured through fully insured plans

Add in HMOs = Large % of our clients who have non-government medical insurance

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ERISA SUBROGATION

- THE *MINIMUM* REQUEST FROM PLAN ADMINISTRATOR:

1. 5500 Form with all Schedule A;
2. Summary Plan Description; and
3. Master Plan Document

McCutchen Catch All (add to specific requests & ask to identify):

"IN ACCORDANCE WITH US AIRWAYS V. MCCUTCHEN, PLEASE PROVIDE ALL DOCUMENTS THAT THE PLAN CONSIDERS TO GOVERN THE ISSUE OF SUBROGATION/REIMBURSEMENT, WHICH COULD INCLUDE BUT IS NOT LIMITED TO THE PLAN DOCUMENT ITSELF, THE SUMMARY PLAN DESCRIPTION OR ANY DOCUMENTS REFERRED TO AS GOVERNING OR DISPOSITIVE AS TO THE PLAN'S RIGHT OF SUBROGATION/REIMBURSEMENT."

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Checklist When Reviewing Plan Documents
[Don't take these for granted]

- Conflicts between documents or within the same document (*General Rule: MPD prevails if conflict with SPD so long as meets requirements of 29 USC 1022 and 29 CFR 2520.102-1)*
  - *Language indicating what controls if conflict exists or if one has provisions that other does not (incorporation language)*
- *Nature and Existence of Rights – Language regarding Source of Recovery is very important*
- *Language regarding coverage tragedy/cost and fee sharing/other repayments*
- *Specific abrogation of Made-Whole and Common-Fund Doctrines*
- *Does it extend to plan participants dependents and their medical benefit payments*
- *Requirement of Subrogation/Reimbursement Agreement (what does the agreement say)*
- *Ability to collect fees and costs of enforcing/recovering the benefits from the beneficiary*
- *Funding Mechanism (may need other documents i.e. Annual Reports/proof of benefits payments/administration agreement etc…)*

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EXAMPLE FROM THE PLAN DOCUMENT (only one in this case) OF LARGE NATIONAL COMPANY:

"As used in this booklet, 'subrogation' refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with an injury.

The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or insurance company in connection with an injury caused or alleged to be caused by the person or organization."

Language does go on to address some of the other issues on the checklist

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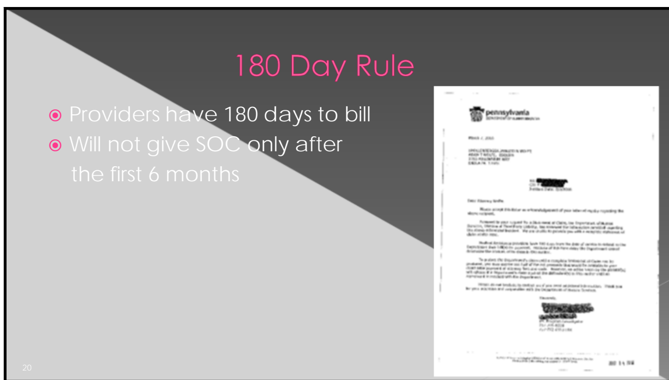
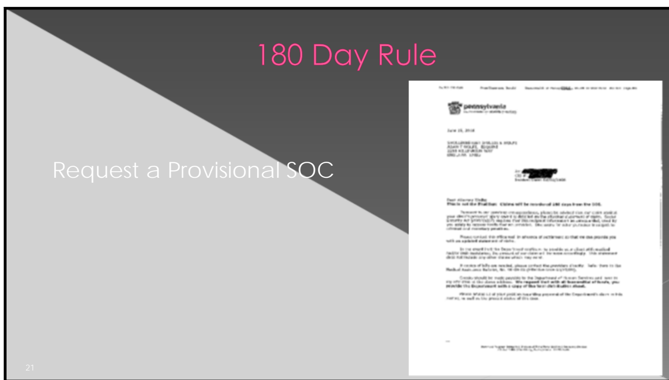
THE DHS PROBLEM

- DELAYS: 2012 budget Cuts; 2014-2015 turnaround time hit its worst – 6 months behind in opening the mail (meaning your reports of claims)
- Gotten Better – New portal/increased budget – more staff
  - Mail being opened in 2 days
  - 20-40 days for SOC (was more than 120 days) (still depends on rep assigned)
  - Clean up efforts/Caseload assessments – 3 months – July to October, 2016
  - Phase II of Portal Rollout – Still can only give information, Not get it
- However, really enforcing 6 month time frame for SOC
- ½ of the net rule even more important when delays (after fees, costs and other recoverable medicals- 62 P.S. 1409(b)(11))….At least for now





CASH ASSISTANCE: BE VERY CAREFUL

- Will not always be on the initial SOC(s) but becoming more aggressive in recovering
- According to DHS, lien can be asserted even if receipt of cash assistance has nothing to due with the incident
- Problem – some carriers will not pay cash assistance unless can prove off work due to injury
- Application:
  - Talk to clients to make sure no cash during time from incident to settlement
  - Request updated SOC before finalizing settlement – specifically requesting inclusion of any cash

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LETTER FROM OGC

Attorney Wolfe,

This email is in response to your March 16th Letter (attached) in which you asserted that DHS lacks authority to claim reimbursement of cash assistance benefits. While you may disagree with the Department's position, 23 Pa.C.S. § 4604(d) does give the Department legal authority to compel reimbursement from the proceeds *"of any cause of action that existed during the time an individual . . . received cash assistance."* This long-standing requirement was originally borne out of case law involving the state's support of the indigent (See Com. v. Schuylkill County, 62 A.2d 922, 361 Pa. 126, Sup.1949; Shearer v. Moore, 277 Pa. Super. 70, 74, 419 A.2d 665, 667 (1980) and many others), but was later codified into statute at 62 P.S. § 1974 (since repealed). The current iteration of the statute, in place since 2005, reads *"(d) Lien against proceeds.--In order to carry out the purposes of this section, the department shall have a first lien against the proceeds of any cause of action that existed during the time an individual, his spouse or his unemancipated children received cash assistance. Unless otherwise directed by the department, no payment or distribution shall be made to a claimant or claimant's designee of the proceeds of any action, claim or settlement where the department has an interest without first satisfying or assuring the satisfaction of the interest of the Commonwealth. Any person who, after receiving notice of the department's interest, knowingly fails to comply with this subsection shall be liable to the department, and the department may sue and recover from the person.* 23 Pa.C.S.A. § 4604(d). See also 55 Pa Code §§ 257.21-24. ("The obligation of reimbursement has always been inherent in the receiving of public assistance in the Commonwealth").

The reimbursement requirement is also explicitly mentioned on the Department's website…

http://www.dhs.pa.gov/citizens/casualtyrecoverydivisionthirdpartyliability/

As you can see, this requirement is, and has been, an important part of the cash assistance program.

Your client's injury gave rise to a cause of action. She received cash assistance benefits after she was injured and before her case settled. The duration of treatment is irrelevant, what matters is when the case was settled and if assistance was received.

Accordingly, please remit payment of the agreed $1,178.06 as requested in TPL's March 8th letter.

If you have any questions, please contact me at the below number or via email.

Thank you.
Governor's Office of General Counsel
Department of Human Services
Piatt Place, 301 5th Avenue | Suite 430
Pittsburgh, PA 15219

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FIGHTING BACK/APPEALING = FAVORABLE RESOLUTION TO CLIENT

- The Department's position puts injured persons in a dubious position, - caught in the middle - requiring them to "pay back" something they can't recover in the first place.
- A main tenant of tort law is causation: the negligent party is responsible for compensating the injured Plaintiff for the damages that were *caused* as a result of their negligence. In particular, the Superior Court has held "that the right to recover income loss benefits…depends [ ] upon whether there has been an 'actual loss of gross income.' To prove an actual loss of income it is necessary to show that income would have been earned but for the injury caused by the accident." Persik v. Nationwide Mut. Ins. Co., 382 Pa. Super. 29, 34, 554 A.2d 930, 933 (1989). This is specified in the Pennsylvania State Civil Jury Instruction pertaining to income loss: "The plaintiff is entitled to be compensated for the amount of earnings that [he] [she] has lost up to the time of the trial as a result of [his] [her] injuries…" *See* PAST LOST EARNINGS AND LOST EARNINGS CAPACITY, Pa. SSJI (Civ), § 7.110 (2013).

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- The Department's use of 23 Pa.C.S. 4604(d) in every scenario where it's believed they are due reimbursement is not only misplaced but violative of the Federal Medicaid statute and the fundamentals set forth in the Untied State Supreme Court's decision in Arkansas Department of Health and Human Services et al., v. Ahlborn, 547 U.S. 268, 126 S.Ct. 1752 (2006). As noted by the Supreme Court in Ahlborn, 42 USCS 1396a(a)(25)(A) –(H) allows states to "seek reimbursement for assistance to the extent of such legal liability" and, relating to medical assistance, to enact legislation that facilitates reimbursement of those expenses from payments for medical expenses made by other parties.
- The case law is clear in that the Department is only entitled to be reimbursed from the portion of the settlement attributable to past medical expenses – obviously the same logic would hold true for past income loss or cash assistance. *See* Ahlborn and Wos v. E.M.A. ex rel. Johnson, 568 U.S. ___, 133 S.Ct. 1391 (2013). Moreover, there has been no authority provided whatsoever that would even allow for reimbursement of cash assistance and a strong argument can be made that the Medicaid anti-lien provision applies to cash assistance benefits from a general standpoint. *See* 42 U.S.C.A. 1396p(a)–(b).

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- It's doubtful that the Pennsylvania legislature's passage of this statute was based on intent to obtain monies from the injured that those people can't collect from the person or entity who injured them. This is evident in the legislature's exclusion of cash assistance benefits from 62 Pa.C.S. 1409, which deals primarily with third party liability recovery of medical expenses in light of the Ahlborn decision.
- 55 Pa Code 257.21-24 was cited as providing the general policy or explanation of DHS' right to reimbursement. A close reading of those sections of the code only strengthens the argument of the injured person in these circumstances. In particular it states: "[r]equiring reimbursement from persons who receive assistance in lieu of the utilization of certain resources will insure that they are treated equitably with other persons who have the same kind of resources but who use their resources instead of seeking public assistance."

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