MEDICARE REPORTING REQUIREMENTS
AND THE MSPS (MEDICARE SECONDARY PAYER STATUTE)
WHERE DO WE GO FROM HERE?

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INTRODUCTION

The nightmare: Defense counsel settles a case with a plaintiff who is a Medicare beneficiary with the typical release language stating that the plaintiff will satisfy and be responsible for all liens. The plaintiff and plaintiff counsel ignore the lien. Medicare comes calling for a $20,000.00 check to satisfy the lien. Defense counsel sends the Release to Medicare and tells them the plaintiff agreed to be responsible for the lien. Medicare advises that the plaintiff has no money and the insurer, the insured and perhaps defense counsel are responsible despite the fact that the money has been paid and the Release is signed.

On December 29, 2007, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) became law. Section 111 of this Act, codified at 42 U.S.C. § 1395y(b)(8), requires liability insurers to report certain information to Medicare when making indemnity payments to Medicare beneficiaries. The purpose of the law is to allow Medicare to identify beneficiaries who receive payment by way of settlement or judgment. Under the MSPS (Medicare Secondary Payer Statute) Medicare is entitled to recover any medical expenses it paid on behalf of a beneficiary to the extent that a third party ultimately becomes responsible to pay their expenses. Under the new reporting requirements they will have the data to pursue collection of these payments like never before. The following is an overview of the new law and suggestions on dealing with Medicare claimants to avoid the above nightmare.
REPORTING

Section III of the MMSEA adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlement judgments, awards or other payment from liability insurance (including self-insurance), no fault insurance, or workers compensation. See 42 U.S.C. 1395y(b)(7)&(8). These reports are mandatory and must be done electronically. RREs have an obligation to report payments they make beginning October 1, 2010. The first reports are due in a designated reporting window each quarter beginning January 1, 2011. Failing to file a mandatory report can carry with it a $1,000 a day fine for insurers or any entity that meets the definition of an RRE (Responsible Reporting Entity). Significantly, this could include a physician in a medical malpractice case who decides to settle a claim out of pocket or any insured for that matter. Many insurance companies will not agree to be responsible for filing the reports under these circumstances. Thus, the insured will have to register and submit the information. There are certain TPAs who can do this for the insured for a fee, but the insured must register. Registration can be accomplished online at cms.hhs.gov/MandatoryInsRep or see www.section111.cms.hhs.gov. One TPA doing these filings is Western Litigation, Inc. Corvel is also submitting the reports for insurance companies. Additionally, Medicare recently implemented a “Small Reporters” option in which RREs with less than 500 claim reports per year may utilize a Direct Data Entry system to submit the required reports. Thus a physician who settles a case out of his pocket (which is considered self-insurance
for Medicare purposes) may now complete his own reporting rather than designating an agent or hiring a company to meet the reporting obligations for him.

There are minimum thresholds for reporting that are slowly phased out. For liability insurers, the initial threshold is $5,000.00. Information about these thresholds is in the CMS, MMSEA Section 111, Medicare Secondary Payer Mandatory Reporting User Guide (Section 11.4). This is found at cms.hhs.gov/MandatoryInsRep. This is a helpful guidebook as it relates to all of the requirements for reporting. It is updated periodically so be certain you review the most updated version.

Significantly, the duty to determine if a plaintiff is a Medicare claimant is on the RRE. As a result, RREs are in need of certain basic information from all plaintiffs so they can query Medicare on the status of the plaintiff. This includes: name, date of birth, gender, social security number or their HICN (health insurance claim number). Discovery should focus on these items. This information is easily found in the medical record. If a payment is made to a beneficiary, the RRE must file a timely report that requires more specific information. The report is due at an assigned time at the end of each quarter.

The additional information that must be provided by insurers if a payment is made to a Medicare beneficiary includes:

- The identity and contact information for the patient;
- The identity and contact information for the actual claimant if the Medicare beneficiary is deceased;
- The identity and contact information for the patient’s representative (attorney);
• The date of the incident giving rise to the injury;
• The patient’s diagnosis or body part injured (utilizing the ICD-9 Codes);
• A description of the incident giving rise to the injury;
• Information regarding the payment and insurance company’s contact information and TIN.

According to the guidebook, the duty to report is triggered when a payment obligation is established arising out of a claim by a Medicare beneficiary for medical expenses or when a claim for medical expenses is released by a settlement agreement. Thus, in cases where there is no claim for medical expenses or by law medical expenses are not recoverable such as wrongful death cases in the State of Alabama, the prudent lawyer must draft the release accordingly. Otherwise, the lawyer could unknowingly trigger a reporting responsibility for a client in a case where medicals could never be claimed and there is no lien.

Other interesting aspects of the duty to report are set out in the guidebook. In section 11.10.2, for example, it is noted that RREs must report settlements, judgments, awards or other payments regardless of whether there is an admission or determination of liability. Reports are required with either partial or full resolution of a claim. The RRE does not make a determination of what portion of any settlement, judgment, award or other payment is for medicals and what portion is not. If medicals are claimed in a release, the settlement, judgment, award or other payment must be reported regardless of any allocation made by the parties or determination by the Court. CMS says they will not be bound by any allocation made by the parties even where a court has approved such an
allocation. CMS does normally defer to an allocation made through a jury verdict or after
a hearing on the merits. However, this issue is relevant as to whether or not CMS has a
recovery claim with respect to a particular settlement, judgment, award, or other payment,
and does not affect the RRE’s obligation to report. As noted above, RREs are not required
to report liability insurance settlements, judgments, awards or other payments for
“property damage only” claims which did not claim and/or release medicals or have the
effect of releasing medicals.

Obviously, with the significant fines of a $1,000.00 a day insurers should have
already implemented a program to report. At the time of this writing, CMS has had
significant difficulties in handling the enormous amount of data in the testing phase. It is
anticipated that significant administrative problems will only continue.

**THE MSPS**

Broadly speaking, “Congress established the Medicare program in 1965 as Title
XVIII of the Social Security Act in order to provide hospital and medical coverage to most
persons over sixty-five years of age and to certain disabled persons.” *Henry Ford Health
Services administers the program through the Center for Medicare Services (‘CMS’).”
generally paid for medical services, even when a recipient was also covered by another
health plan or insurer.” *Id.* (citation omitted). However, in 1980, “Congress began
enacting a series of cost-cutting amendments to the Medicare program, collectively known
as the Medicare Secondary Payer, MSP, provisions.” *Id. See also United States v. Baxter
Int'l, Inc., 345 F.3d 866, 874 (11th Cir. 2003) ("The MSP is actually a collection of statutory provisions codified during the 1980s with the intention of reducing federal health care costs.").

The MSP provisions codify the regulations regarding Medicare reimbursement. See 42 U.S.C. § 1395y(b)(2); 42 C.F.R. §§ 411.20-.37 (2008). These regulations “[make] Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another primary payer.” Cochran v. U.S. Health Care Fin. Admin., 291 F.3d 775, 777 (11th Cir. 2002). More precisely, “if payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay.” Id. However, “[i]n order to accommodate its beneficiaries, . . . Medicare does make conditional payments for covered services, even when another source may be obligated to pay.” Id. (citing § 1395y(b)(2)(A)(ii)). Because the payment is conditional, Medicare has a right to reimbursement:

The way the system is set up the beneficiary gets the health care she needs, but Medicare is entitled to reimbursement if and when the primary payer pays her. Among other avenues of reimbursement, Medicare is subrogated\(^1\) to the beneficiary's right to recover from the primary payer. 42 U.S.C. § 1395y(b)(2)(B)(iii). Medicare regulations extend that subrogation right to any judgments or settlements “related to” injuries for which Medicare paid medical costs, thereby casting the tortfeasor as the primary payer. 42 C.F.R. § 411.37 (2002). Those same regulations also provide that, when Medicare is reimbursed out of a judgment or settlement, the amount of money it takes is reduced by a pro-rata share of the “procurement costs,” which include attorney's fees of the

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\(^1\) “The United States shall be subrogated . . . to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.” 42 U.S.C. § 1395y(b)(2)(B)(iv).
That is why Medicare asks attorneys handling any related tort suits for its beneficiaries to supply the agency with a copy of the agreement setting out the share of the recovery they are to receive.

*Id.* It should also be noted that in addition to its subrogation rights, “CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.” 42 C.F.R. § 411.26(b).

To illustrate Medicare’s right to recover what they pay for medical bills in liability cases consider this example. Mary, a 75 year-old female, went to see Dr. Smith for minor hip surgery. Due to complications arising from the surgery, she was hospitalized for an additional three week period. The additional medical treatment she received during her three week hospitalization was paid for by Medicare. She filed suit against the physician. Through her lawyers she entered into settlement negotiations with the professional liability insurer. Subsequently, Medicare informed the insurer and Mary that Medicare was entitled to reimbursement from any compromise, waiver, release, settlement, award, or judgment that Mary received as a result of her suit against Dr. Smith. See 42 C.F.R. § 411.22(b)(1)-(3) (2008). In our example, we assume that all parties agree the medical bills associated with Medicare’s reimbursement were the result of the hip surgery.

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2 See 42 C.F.R. § 411.37 (2008) (establishes the formulas for computing the “[a]mount of Medicare recovery when a primary payment is made as a result of a judgment or settlement”).

3 “A primary payer’s responsibility for payment may be demonstrated by: (1) A judgment; (2) A payment conditioned upon the recipient’s compromise, waiver, release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer.” 42 C.F.R. § 411.22 (b)(1)-(2).
Under these facts “CMS may initiate recovery as soon as it learns that payment has been made or could be made under” Dr. Smith’s liability insurance coverage. 42 C.F.R. § 411.24(b). 4 “If it is not necessary for CMS to take legal action to recover,” CMS may recover “[t]he amount of the Medicare primary payment.” § 411.24(c)(1)(i). Alternatively, “[i]f it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount” of the Medicare primary payment. § 411.24(c)(2) (emphasis added). Making matters more complicated, “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 has received a primary payment.” § 411.24(g) (emphasis added). See United States v. Weinberg, No. Civ. A. 01-CV-0679, 2002 WL 32356399, at *3 (E.D. Pa. July 1, 2002) (“Attorneys who have received settlement funds on behalf of clients who have received Medicare benefits may be subject to a direct claim by the Government.”).

In the above scenario, if Mary and the liability insurance company settle her claim, Mary will have 60 days to reimburse Medicare for conditional payments made on Mary’s behalf. § 411.24(h). If Mary does not reimburse Medicare within the 60 day time frame provided by the MSP provisions, the other entities identified in § 411.24(i) must reimburse Medicare including the liability insurer or the attorney who has received the primary payment. This is true even though the insurance company already paid Mary for that amount pursuant to the settlement agreement. § 411.24(i). See also Manning v. Utils.

4 “A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any payment if it is demonstrated that the primary payer has or had responsibility to make payment.” 42 C.F.R. § 411.22(a).
Mut. Ins. Co., No. 98 Civ. 4790, 2004 WL 235256, at *7 (S.D.N.Y. Feb. 9, 2004) (stating that “Medicare’s right of recovery against [an] insurer is not precluded by the insurer’s settlement payment to the beneficiary”). Furthermore, if reimbursement is not made before the expiration of the 60 day time frame, “the Secretary may charge interest . . . on the amount of the reimbursement until reimbursement is made.” 42 U.S.C. § 1395y(b)(2)(B)(ii).

The case of United States v. Harris, 2009 WL 891931 (N. D. W.Va.) is a recent example of the government aggressively pursing their lien under these regulations. In the case, the United States successfully sued the plaintiff lawyer for the lien amount plus interest. The case involved a fall from a ladder and a $25,000.00 settlement. Another case in which the government aggressively pursued their lien was United States v. Stricker, et al., filed in the United States District Court for the Northern District of Alabama (CV-09-PT-2423-E). In Stricker, the United States sued the defendants in a PCB-contamination class action, along with the plaintiffs’ attorneys and the defendants’ insurers, for failing to reimburse Medicare after reaching a $300 million settlement in the class action. The United States alleged there were 907 Medicare beneficiaries who settled their claims, including claims for medical expenses that were paid by Medicare. The government sought double damages and interest. As evidenced by the Stricker case, the government will enforce its right to pursue its claims against those who receive claim proceeds (plaintiff attorneys) and those responsible for making the payments (defendants and their insurers).
The new reporting requirements of Section III and the provisions of the MSPS create complex and difficult issues for plaintiff and defense counsel regarding settlement or trial with a Medicare beneficiary. As recognized in the recent DRI article “Mission Impossible: Resolution of a Case with a Medicare Claimant?”: “Tort cases that involve a Medicare beneficiary need to be handled differently than all other personal injury claims.”\(^5\) How do you avoid the *Harris* and *Stricker* situation or the nightmare of having to go to a client and advise them they owe more money on a case they thought had been closed?

**OPTIONS TO CONSIDER IN RESOLVING A CASE WITH A MEDICARE CLAIMANT**

The issue of how to resolve a case with a Medicare claimant has already been the matter of much debate. According to the DRI article:

> “Change is needed to avert disastrous unintentional consequences and a coalition of trade associations, insurers, self-insureds, third-party administrators, MSAs and attorneys has come together to lead to reform. The Medicare Advocacy Recovery Coalition (MARC) has already made a positive impact to change the law and will continue to raise awareness about its present consequences. For more information about MARC see [http://www.marccoalition.com](http://www.marccoalition.com).”\(^6\)

There are a number of options to consider in trying or settling cases with Medicare beneficiaries that are outlined below. These options are not exhaustive. Some options may not work in certain jurisdictions. However, under the MSPS, Medicare wants their interest protected in litigation involving Medicare beneficiaries no matter where the case is pending. At the same time, one real concern is that getting Medicare to respond can be

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\(^6\) Franco at p. 13.
difficult and slow. Trial judges do not like to wait and counsel are often under the pressure of time. Thus, one of the most important things to do in any litigation involving a Medicare Beneficiary is to put Medicare on notice of the claim as early as possible.

One way to involve Medicare early is to use the contact information for the Medicare-COB (Coordinator Benefits Office in Detroit) and put them on notice of the claim so that a file can be created and the matter can be assigned to the MSPRC (Medicare Secondary Payer Recovery Contractor). The Medicare COB has a fax 734.957.9598 or a toll free hot line at 1.800.999.1118. The MSPRC is the party who will ultimately determine the amount Medicare will accept to settle the lien. However, traditionally, this amount has not been provided until after the case is settled by what is known as the final demand letter. Most defense lawyers have seen a copy of the letter Medicare sends that is called the Conditional Payment Summary which is often an inflated amount that is not realistic and requires negotiation with the MSPRC. In order to obtain a copy of the Conditional Payment Summary, counsel should use the Medicare Consent Form that can be obtained directly from Medicare. This process should be instituted whether counsel decides on formally bringing Medicare in the case as a real party or not.

Involving Medicare in cases early may be done by adding them as a real party in interest and serving the United States Government with a copy of the Complaint. Rule 17 of the Federal Rules of Civil Procedure dictates “Every action shall be prosecuted in the name of the real party in interest.” Where both insurer and insured seek recovery against the defendant, both insured and insurer are real parties in interest under Rule 17. See United States v. Aetna Cas. & Surety Co., 338 U.S. 366, 381, 70 S. Ct. 2207, 215 (1949)
(stating that if an insurer “has paid only part of the loss, both insurer and insured . . . have substantive rights against the tortfeasor which qualify them as real parties in interest.”). 

*Underwriters at Interest v. Nautronix, Lt., 79 F. 3d 480, 484 (5th Cir. 1996)* (where an insurer paid only part of loss, both insurer and insured are real parties in interest); *HIP Industrial, Inc. v. Permalert, ESP, 178 F.R.D. 483* (S.D. Miss. 1997) (contractor’s insurer was real party in interest in contractor’s suit against pipe supplier based on subrogation agreement, even though contractor retained pecuniary interest in any recovery by insurer). Interestingly, Medicare has taken the position that these motions are not proper because their right of recovery is not triggered until after a judgment or settlement is reached.

The following are some options in dealing with cases involving Medicare claimants for both settlement and trial.

**GENERAL OPTIONS**

A. Add Medicare as a real party in interest (are you and your client okay with removal to federal court?). This is the safest way to assure they are bound and that the lien amount is settled one way or the other.

B. Involve Medicare early as outlined above by giving notice of the claim to the COB.

C. Secure a copy of a signed consent and obtain the conditional payment summary from the Contractor or ask for it in discovery and get it from plaintiff’s counsel.

D. Negotiate the amount so that it properly reflects those bills related to the alleged tort before settlement or trial.
SETTLEMENT OPTIONS

A. Get the Medicare Contractor to participate in the mediation even if they are not a real party in interest. Have them agree to the amount of the past and future lien amounts and cut them a check directly. Have them sign off on the agreement. Obviously, this option is conditioned upon Medicare’s responsiveness. In Pollo Operations, Inc. v. Tripp, 906 So. 2d 1101 (Fla. Dist. Ct. App. 2005) the Florida Court of Appeals for the Third District addressed this scenario. In response to the lower court’s “order directing an insured tortfeasor to write a settlement agreement check directly to the Plaintiff without receiving a release of Medicare’s lien,” the court of appeals stated:

Because [the insurer] and its insured . . . are clearly aware that Medicare paid the medical bills that Plaintiff associates with her alleged slip and fall, the decision of the lower court places [the insurer] in a catch-22 and exposes the company to additional liability. If it follows the directives of the lower court and has its insured . . . deliver to Plaintiff a check in hopes that Plaintiff will turn around and pay Medicare, [the insurer] exposes itself to paying off [plaintiff’s] Medicare lien in the event [plaintiff] herself does not. Leaving [the insurer] to then try to enforce the Settlement Agreement’s indemnity clause to get justice is likely a vain hope with the normal plaintiff, who by then will probably have spent the proceeds. This is one of the reasons that most settling counsel almost always involve Medicare in the settlement of these claims, and demand a concurrent release from Medicare and other similarly situated subrogee, so that all interested parties are “in the know” and can receive their fair share in the settlement.
Pollo, 906 So. 2d at 1106 (emphasis added). In reaching this conclusion the court of appeals acknowledged that if “a third-party payer is aware that Medicare has advanced payment, and the third party and beneficiary negotiate a settlement whereby the subrogated interests of Medicare are circumvented, the third party has been held liable to reimburse Medicare, even though the third party has already paid monies to the beneficiary.” Id. at 1105 (citing Health Ins. Ass’n of Am. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994)). See 42 C.F.R. § 411.24(i)(2). Thus, during the settlement negotiations, defense counsel should explain to the plaintiff’s attorney that any settlement is conditioned on a concurrent release from Medicare regarding any reimbursement interest Medicare might have in the settlement proceeds.

B. If Medicare is not a real party and you cannot wait on them or get them to the negotiations, settle your case with strong indemnity language and a stipulation that all funds will not be distributed until the final demand letter is submitted. In other words, wait to distribute any money until you get the final number and then cut a check to Medicare directly. This scenario identifies the real problem with all of this: technically Medicare cannot give the final number until after the case is settled or there is a verdict! Also, what about future medicals and Medicare’s interest? Under this scenario Medicare is not bound by the release and may look to recoup futures long
after your file is closed. This is discussed further below and is also the subject of much debate.

C. Under the above assumptions, you could consider retaining the full amount of the conditional payment and distribute the rest to the plaintiff and plaintiff counsel. Once the final demand is sent then you can release those funds to Medicare directly with the remainder going to the plaintiff and their lawyer. Again, what about futures?

D. Under the above assumptions, you could settle the case and use strong indemnity language and state that the plaintiff and the plaintiff lawyer will resolve all liens and the Medicare lien will be satisfied before the plaintiff is paid. Then, you could cut a check payable to the plaintiff lawyer, the plaintiff and Medicare. Note this will take a long time and most plaintiff lawyers will not agree to it. Most will agree to take care of the lien, but if they go broke and the plaintiff fails to satisfy the lien, you and/or your client may be the target. See, Wall v Leavitt, Civ. ND 5-05-2553, 2008 WL 4737164 (E.D. Cal. Oct. 29, 2008) where the court held that:

“For all practical purposes… where it is not possible to make an initial determination prior to issuance of the settlement check…any insurance company.. would understand that it should, as a practical necessity, name Medicare as a payee on a third party settlement check in order to stave off significant penalties and interest in the event the beneficiary refused to reimburse Medicare in whole or part.”

Id. At 6.
E. Another option suggested by a plaintiff’s lawyer is to cut a check to Medicare and the plaintiff’s lawyer that covers the estimated lien amount and a separate check to the plaintiff and plaintiff lawyer for the remaining amount. Use the indemnity language and set all this out in the release. What about futures?

**FUTURE MEDICALS**

In terms of protecting future medicals in the settlement area, the safest way is to directly involve Medicare as a party on the release documents and release both past and future medicals. If this is not an option, the answer is less than clear. In the workers compensation arena, Set Aside arrangements are used where future medicals are kept in trust using the life expectancy of the claimant. Medicare does not require this in liability cases and they offer little guidance on how to proceed. One suggested way to handle it is to set out a reasonable amount of the future medicals in the release with an explanation for the amount (life expectancy and the expert testimony connecting the damages) and then set that amount aside in trust or pay it into court. Forward the agreement to Medicare and have them declare what amount they will accept in full satisfaction of past and future payments. Distribute the lien amount at that time.

**TRIAL OPTIONS**

A. Going to trial will be less stressful if Medicare is a real party who will be bound by the adjudication with regard to the amount of the damages and their lien. You can pay the verdict into court for distribution according to the instructions of Medicare.
B. If they are not a party and you go to trial what is a reasonable plan? The options are less than clear. Some have suggested the parties reach a stipulation that involves the Medicare Contractor and the plaintiff lawyer as to what amount Medicare’s claims for the past medicals. This stipulation could be read to the jury. A verdict form will need to be used that separates past and future damages. Reach an agreement with the Medicare contractor and the plaintiff lawyer as to how the future medicals will be handled in terms of the lien amount in the event of a plaintiff verdict.

CONCLUSION

One of the biggest concerns about all of this is that settlements with Medicare beneficiaries will be delayed. Nominal settlements will be difficult, if not impossible. Getting Medicare to respond to lawyers from both sides seems to be the biggest sticking point. Medicare needs to be educated on the realities of the litigation with regard to the strengths and/or weaknesses of any claim so they can evaluate what amount they will accept in full satisfaction of their lien. This takes time and requires someone with authority to make the decision for Medicare. Until Medicare creates a system that is geared toward doing this timely and efficiently, resolving these cases appropriately will be frustrating and difficult. Hopefully, with the help of the MARC coalition, Medicare can find a way to remedy “the disastrous unintended consequences” of these laws and regulations.