Medicare Issues in Workers’ Compensation Settlements

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MEDICARE ISSUES IN WORKERS’ COMPENSATION SETTLEMENTS

1. INTRODUCTION

Medicare is a federal medical insurance program which is funded by Congress through the Centers for Medicare and Medicaid Services (CMS).\(^1\) It is divided into two parts. Medicare Part A provides for in-patient hospital care, skilled nursing home care, hospice care and home health services. Medicare Part B helps pay for physicians services, some in-patient care, durable medical equipment, supplies, outpatient services and other health services. Part A is administered by fiscal intermediaries and Part B is administered by Medicare carriers.

For the past several years, Medicare\(^2\) has been mistakenly paying medical expenses for injured employees even when those expenses stemmed from work-related accidents or occupational diseases. Pursuant to the Medicare Secondary Payer (MSP) statute,\(^3\) CMS, the federal agency that administers Medicare, has recently undertaken a comprehensive effort to collect money owed to Medicare for the payment of these expenses.

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\(^1\) CMS was previously known as the Health Care Financing Administration.

\(^2\) Medicare differs substantially from Medicaid. Eligibility for Medicaid is based upon an applicant’s assets and income whereas eligibility for Medicare is not based upon an individual’s financial condition.

II. THE STATUTORY AND REGULATORY FRAMEWORK SUPPORTING MEDICARE SET-ASEIDES

A. Medicare Secondary Payer Statute and the Code of Federal Regulations

The MSP statute was created by the Omnibus Reconciliation Act of 1980. The purpose of the statute was to ensure that Medicare was only secondarily responsible for paying for medical expenses for individuals covered by Medicare who were also covered by another type of private insurance. The belief was that private insurers could more easily absorb the burden of paying such medical expenses. The Deficit Reduction Act of 1984 amended the MSP statute to provide the government with a statutory right of recovery for Medicare overpayments against those designated as primary payers. Again, in 1986, the MSP statute was amended by the Omnibus Budget Reconciliation Act to add a private right of action against primary payers for the recovery of funds paid by Medicare.

B. Primary Versus Secondary Payers

The MSP statute provides, in part, that Medicare may not pay for an individual’s medical treatment if payment can reasonably be expected to be made promptly under a workers’ compensation law or under an automobile or liability insurance policy or plan. In such instances, Medicare is the secondary payer while the insurance company or other responsible party remains the primary payer. Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare. That is the rule even if a state law provides otherwise. Specifically,


5 42 C.F.R. ' 411.21.
the Code of Federal Regulations, (42 C.F.R. @), which provides additional guidance for MSP claims, states as follows:

Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer6 states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.7

The MSP statute itself provides, in pertinent part, as follows:

(2) Medicare secondary payer.

(A) payment under this sub-chapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that-

(ii) payment has been made, or can be reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen=s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

(B) conditional payment

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6 A third party payer means an insurance policy, plan, or program that is primary to Medicare. @ 42 C.F.R. '411.21.

7 42 C.F.R. '411.20.
(i) repayment required. Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).8

A conditional Medicare payment is a payment made by Medicare when another party is responsible and may be made in either of the following circumstances:

(a) The beneficiary has filed a proper claim for workers' compensation benefits, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.

(b) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.9

The MSP statute specifically provides that, in the event Medicare does pay for an individual's medical expenses in secondary payer circumstances, those expenses shall be paid subject to reimbursement. If such reimbursement is not made within the established time period, interest may be charged on the amount of reimbursement until Medicare receives the same from the primary payer.

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9 42 C.F.R. '411.45.
The duty of a primary payer to reimburse Medicare arises from the portion of the MSP statute which provides that Medicare shall be subrogated to any right of an individual or any other entity for any payment made by Medicare which should have been made by a primary payer. In addition, Medicare may intervene in any lawsuit related to workers’ compensation benefits if Medicare has paid any medical expenses for an injured worker. The C.F.R. provides as follows:

Subrogation and right to intervene.

(a) Subrogation. With respect to services for which Medicare paid, HCFA is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) Right to intervene. HCFA may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

C. Medicare Intermediary Manual

Medicare fiscal intermediary manuals and Medicare carrier’s manuals are valuable sources of information to assist in understanding how the government monitors, in part, workers’ compensation settlements. These manuals were prepared by CMS. They were written to assist Part A fiscal intermediaries and Part B carriers with recognizing and

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12 Fiscal intermediary are the insurance companies that contract with Medicare to administer Part A Medicare benefits in different regions.
13 Carriers are those providers, including doctors, labs, etc., who have contracted with an insurance company to provide Part B Medicare benefits in a specific region.
rejecting claims for services covered by Medicare when a workers’ compensation claim is involved.

III. MEDICARE CLAIM TO SETTLEMENT PROCEEDS FOR PAST MEDICAL EXPENSES PAID

Medicare regulations distinguish between lump sum settlements in workers’ compensation cases that are either 1) compromised for past medical expenses paid and 2) commutations of future medical benefits due. In many workers’ compensation cases, the parties reach a compromise with regard to which medical expenses should be paid by the employer and how much money is due the employee for his or her work-related injury. Compromises related to past medical expenses are often the result of disputes over issues such as preexisting conditions, causation, whether an employer/employee relationship in fact existed and whether the employee was acting within the line and scope of his or her employment at the time the alleged work-related injury occurred. In cases wherein the employee is already entitled to Medicare, a possibility exists that Medicare may have paid for some of the injured employee’s medical expenses, particularly when the employer disputes liability. These type of cases give rise to a Medicare claim for the expenses paid on behalf of the injured employee. It is important to note that, even though the workers’ compensation carrier may dispute liability, the existence of a dispute alone does not extinguish Medicare’s claim for past medical expenses paid for the alleged injury.

The C.F.R. specifically provides as follows with regard to recovering conditional payments made by Medicare:

If a Medicare conditional payment is made, the following rules apply:

If a Medicare conditional payment is made, the following rules apply:
(a) Release of information. The filing of a Medicare claim by or on behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers’ compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to HCFA. This information will be used only for Medicare claims processing and for cooperation of benefits purposes.

(b) Right to initiate recovery. HCFA may initiate recovery as soon as it learns that payment has been made or could be made under workers’ compensation, any liability or no-fault insurance, or any employer group health plan.

(c) Amount of recovery.

(1) If it is not necessary for HCFA to take legal action to recover, HCFA recovers the lesser of the following:

   (i) The amount of the Medicare primary payment.

   (ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a third party payment recipient, the amount of the third party payment.

(2) If it is necessary for HCFA to take legal action to recover from the primary payer, HCFA may recover twice the amount specified in paragraph (c) (1) (i) of this section.

(d) Methods of recovery. HCFA may recover by direct collection or by offset against any monies HCFA owes the entity responsible for refunding the conditional payment.

(e) Recovery from third parties. HCFA has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

(f) Claims filing requirements.

(1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan
imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, HCFA will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) Recovery from parties that receive third party payments. HCFA 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 third party payment.

(h) Reimbursement to Medicare. If the beneficiary or other party receives a third party payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) Special rules.

(1) In the case of liability insurance settlements and disputed claims under employer health group plans and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i) (1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(l) Recovery when there is failure to file a proper claim.

(1) Basic rule. If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a third party payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) Exceptions:
(i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) HCFA will not recover from providers or suppliers that are in compliance with the requirements of Sec. 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) Interest charges.

(1) With respect to recovery of payments for items and services furnished before October 31, 1994, HCFA charges interest, exercising common law authority in accordance with 45 C.F.R. 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, HCFA charges interest in accordance with section 1862 (b)(2) (B) (i) of the Act. Under that provision

(i) HCFA may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by HCFA that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by HCFA and is charged until reimbursement is made; and
(iii) The rate of interest is that provided at 42 C.F.R. 405.376 (d).\textsuperscript{14}

The amount which Medicare may recover is determined as follows:

(a) Recovery against the party that received payment

   (1) General rule. Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if

      (i) Procurement costs are incurred because the claim is disputed and

      (ii) Those costs are borne by the party against which HCFA seeks to recover.

   (2) Special rule. If HCFA must file suit because the party that received payment opposes HCFA=s recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) Recovery against the third party payer. If HCFA seeks recovery from the third party payer, in accordance with Sec. 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

   (1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

   (2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

   (3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

\textsuperscript{14} 42 C.F.R. \textsuperscript{1} 411.24.
If HCFA must bring suit against the party that received payment because that party opposes HCFA=s recovery, the recovery amount is the lower of the following:

1. Medicare payment.
2. The total judgment or settlement amount, minus the party=s total procurement cost.\footnote{42 C.F.R. ' 411.37.}

The Medicare Intermediary Manual provides the following guidance to MSP claims handlers regarding the procedures for recovering conditional payments:

\textbf{3417 Overpayment Due to WC Coverage}

You may have paid for services and subsequently learned that they were work-related. However, the information indicating that a particular injury or illness occurred on the job does not necessarily mean that Medicare payments made for that injury were incorrect... For example, the particular services may have been for a condition not related to the work injury.

If you determine that payment has been made for services covered by WC, initiate recovery of the overpayment. Sections 3417.1 and 3417.2 provide guidelines for recovery of Medicare payments in some of the more common situations. However, since the circumstances in which work-related issues arise vary greatly, it is impossible to provide definitive rules to cover every situation. Use judgment and discretion in applying the guidelines.
3417.2 Medicare Paid for Services Which Should Have Been Paid For by WC. --

When it is clear that Medicare paid for services that should have been paid by the WC carrier, request the carrier to reimburse the Medicare program. Include in your request, the reason(s) you feel that the services should be paid under WC, and the amount that Medicare paid. In addition, explain that the Medicare law excludes payments for services covered under WC, and requires WC carriers to make direct refund to the Government where Medicare has paid for services that are reimbursable under WC.

If arrangements to refund the amount due are not made by the WC carrier within 30 days after notification, ask the carrier for an explanation for the delay, whether it intends to refund the overpayment and, if not, why. If the WC carrier’s response is negative, and you still feel that the services are covered under WC, refer the case to the RO. Include copies of all correspondence. If the beneficiary is represented by an attorney, address any correspondence on the WC issue to the attorney. Send copies of all correspondence with the WC carrier and with the beneficiary concerning the WC issue to the State WC agency when the WC carrier does not cooperate.

If the WC carrier either declines to refund the overpayment or indicates a long delay will be necessary, refer the file to:

Health Care Financing Administration
Overpayment Section
P.O. Box 120
Baltimore, MD 21203

Fully explain the WC issue and your recommendations for disposition of the case. Include copies of all pertinent documents, including the WC award and your correspondence and reports of contact with the WC carrier, the State WC carrier, the State WC agency, and the beneficiary. HCFA reviews the case and determines what further action to take.

A. The Duty to Inquire with Medicare Regarding Potential Claims for Past Medical Expense Paid

The C.F.R. makes it clear that the third party payer has an affirmative duty to notify Medicare if the third party payer learns that Medicare has made a payment for an injured worker’s medical expenses which would be covered under the MSP statute. Specifically, the C.F.R. provides as follows:

Third party payer=s notice of mistaken Medicare primary payment.
(a) If a third party payer learns that HCFA has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances... and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to HCFA. Otherwise, the insurer, underwriter, or third party administrator must give the notice.16

The third party payer should not rely on someone else to ascertain the existence of a Medicare claim. Medicare regulations provide that CMS has a direct right of action to recover from any entity responsible for making primary payment.17 If the primary payer fails to reimburse Medicare for such claim, then the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.18

16 42 C.F.R. '411.25.
18 42 C.F.R. '411.24(i)(1).
Plaintiff=s attorneys must keep in mind that the burden of notifying Medicare regarding potential MSP claims does not rest entirely with the employer or insurance carrier. The C.F.R. states that Medicare is Asubrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.\(^{19}\) Further, Section 411.24(g) of the C.F.R. provides that Medicare Ahas 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 third party payment.\(^{20}\)

The Medicare Intermediary Manual provides as follows regarding notification to CMS of potential secondary payer claims and identification and investigation of the same:

3408.4 Responsibility of Provider to Document Cases in Which There Is a Possibility of WC Coverage.--

Information supplied by the provider is one of the means of alerting you to actual or potential WC coverage. A condition is work-related if it resulted from an accident that occurred on the job or from an occupational disease. The billing form is completed in accordance with '3679 when any of the following apply:

- The physician or the patient states that the condition is work-related;

- The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual=s employment, e.g., the patient fell from a scaffold while at work;

- The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis, and Ablack lung@ disease in the case of a coal miner); radiation sickness, anthrax, undulant fever; dermatitis

\(^{19}\) 42 C.F.R. '411.26.

\(^{20}\) 42 C.F.R. '411.24(g).
due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;

- The beneficiary previously received WC for the same condition;
- There is indication that a WC claim is pending; or
- There is other indication that the condition arose on the job.

Providers are expected to inquire of the beneficiary or representative at the time hospitalization is ordered or at admission, whether the condition is work-related. When the patient or his physician indicates that the condition is work-related or there is other indication that it is work-related, the provider is required to ask the patient or his physician, wherever possible, whether WC is expected to pay. (Generally, where hospital services are covered under a WC program, the services will be authorized in advance by the WC carrier or the employer.)

If the patient denies that WC benefits are payable for a condition which the provider believes may be covered by WC, a supplementary statement is attached to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

3409. Contractor Identification of Claims with Possible WC Coverage.

3409.1 General.--

Identify potential WC cases as well as initiate any investigation promptly since a delayed determination that WC payment can reasonably be expected, coupled with failure by the patient to file under that system, may result in delay or even loss of benefits under both WC and Medicare. Where the supplementary information submitted by the provider in accordance with '3408.4 clearly indicates, under the guidelines in '3409.3, that the services are not covered under WC, pay Medicare benefits without further investigation. However, where it appears that the services may be compensable, ascertain the extent to which payment under WC can reasonably be expected.

3409.2 Sources of Information--

The primary sources indicating that WC coverage may be involved are the beneficiary, the provider, the physician, or the employer. When information from these initial sources indicates that further information is needed, contact the employer= compensation carrier or the State WC agency. (Although in most jurisdictions the WC program is administered by a State Commission or
board, there often is no central record of WC cases until a hearing is requested or some action taken to docket a proceeding.) It may be necessary to obtain copies of decisions made by the WC agency, or settlements it approved.

B. Data Exchange from WC Agencies.--Transfers of information on claimants for WC benefits, who also may be Medicare beneficiaries, have been negotiated with many State WC agencies. Information from such data transfers provide a valuable source for identifying beneficiaries who may be entitled to WC benefits. If you are not receiving information either directly from the State agency or from the lead contractor contact your RO to determine the possibility of such a data transfer in your State.

3409.3 Investigation and Evaluation Guides.--

The following are general guidelines for investigating and evaluating the likelihood of WC coverage when the condition appears to be work- related, but the beneficiary has not filed a claim for WC benefits. If the investigation indicates that WC benefits could be paid for the services, deny benefits and notify the beneficiary that Medicare benefits are not payable for services covered under WC. Advise the beneficiary to file for WC if he has not, and that in the event a WC claim is filed and denied, the Medicare claim may be reopened. Further advise the beneficiary that if the reason for denial of WC benefits is due to the beneficiary=s failure to timely file a claim, Medicare payment will not be made. Document your determination.

B. Compromise and Waiver of Medicare=s Claim for Past Medical Expense Paid

A Medicare claim for past medical expenses paid on behalf of an injured worker may be either compromised or waived under 1) the Federal Claims Collection Act, 2) the MSP Statute or 3) 42 U.S.C. ' 1395gg(c). Under the FCCA, the basis for compromising a claim are as follows: 1) the worker does not have sufficient money to repay Medicare=s claim within a reasonable period of time; 2) CMS believes it would be difficult for it to prevail on its claim in court; or 3) the costs which CMS would incur in collecting the claim exceed the value of such. Under the MSP statute, claims may be waived if such waiver is deemed to be in the best interest of the MSP program. Pursuant to 42 U.S.C. ' 1395gg, a claim may be compromised for economic hardship, for equitable reasons, and for reasons that are beyond
the fault/control of the worker, such that the worker was not responsible for Medicare=s overpayment. Specifically, the C.F.R. provides for compromise and waiver of a MSP claim as follows:

Waiver of recovery and compromise of claims.

(a) HCFA may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

The Medicare Intermediary Manual provides the following guidance to claims handlers regarding compromising and waiving MSP claims:

3407.12 Authorities for Agreeing to Compromise or Waive Medicare=s Claim.--

HCFA may agree to compromise a claim for reimbursement from WC settlements under the FCCA, if:

- The individual does not have the present or prospective ability to pay the full amount of the claim within a reasonable period;

- It would be difficult to prevail in the case before a court of law; or

- The cost of collecting the claim is likely to be more than the amount collected. All claims in excess of $20,000 must be referred to the Department of Justice.

- Send these cases to the RO.

Waiver Authority Under ’1870(c) of the Social Security Act.--Medicare claims that do not involve the FCCA could be considered for waiver based on economic hardship or equity and good conscience.

Send cases that could qualify on this basis to:

Health Care Financing Administration
Overpayment Section
P.O. Box 120
Baltimore, MD 21203
3410. Requests That Medicare Accept Less than its Claim.

If there is a request that Medicare accept less than the full amount of its claim and less than the full amount of the WC settlement for the party that legally Medicare has the right to recover its full claim up to the full amount of the settlement. However, a request for such a reduction will be reviewed if it is in writing and specifies the reason(s) why, and to what extent, the Medicare claim should be reduced.

C. The Consequences of Failing to Consider Medicare's Claim for Past Medical Expenses Paid

The MSP statute provides fairly harsh penalties for failing to adequately consider Medicare's interests when settling workers' compensation cases for Medicare beneficiaries. The statute states as follows:

(ii) Action by the United States. In order to recover payment under this sub-chapter for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(a) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and they join or intervene in any action related to the events which gave rise to the need for the item or service. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(3) Enforcement
   (A) Private cause of action. There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for
primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A). 21

IV. CLOSING FUTURE MEDICAL BENEFITS IN WORKERS’ COMPENSATION SETTLEMENTS

A. What is a Medicare Set-aside Custodial Agreement?

Medicare Set-aside Custodial Agreements have been recognized as a way of balancing Medicare’s interests in a workers’ compensation settlement that purports to close future medical benefits and an injured employee’s entitlement to Medicare benefits after receiving a workers’ compensation settlement. The Medicare Set-aside Custodial Fund is established with a sum of money designated to cover future medical expenses which Medicare would ordinarily cover. The beneficiary of the fund may either submit the bills for medical treatment related to his or her work-related injury to the custodian of the fund or the bills may be sent directly to the custodian by the medical treatment provider. After the fund is exhausted, the beneficiary becomes eligible for Medicare to pay any and all future medical expenses which Medicare would normally cover.

In many cases, prior approval of the amount of the Custodial Fund must be obtained from CMS. If CMS approves the amount that will be deposited into the Custodial Fund, Medicare will waive any claims against the employer or insurer for the employee’s medical treatment expenses and will agree to pay such expenses after the fund is exhausted. It is important to remember that only the medical expenses that Medicare would normally cover need to be set aside.

In order to approve a settlement agreement incorporating a Medicare Set-aside Custodial Fund, CMS must be provided with all of the relevant facts concerning an

employee=s injury and his or her medical treatment. The factors that CMS uses to determine whether a Medicare Set-aside Custodial Fund amount will be approved include, but are not limited to, the following:

1) The date of entitlement to Medicare;
2) The basis for Medicare entitlement (disability or age);
3) The type and severity of the injury or illness;
4) The age of the beneficiary (including an evaluation of whether the beneficiary=s condition would shorten his or her life span);
5) The classification of the beneficiary=s disability, such as permanent, total;
6) Prior and future medical needs and expenses of the beneficiary due to the injury or illness;
7) Whether the commutation is for the beneficiary=s lifetime or for a lesser period of time;
8) The State law governing how long workers= compensation is obligated to cover the services related to the injury or illness;
9) Whether the beneficiary=s condition is stable or if medical deterioration is possible; and
10) The living arrangement of the beneficiary and the level of continued care required.

In addition to submitting the above information, a copy of relevant documentation, including a copy of the proposed Set-aside Agreement, should be provided to CMS to assist it in evaluating the settlement. It is important to remember that no form agreement should be used as several factors must be considered and appropriately addressed in each agreement.
B. What is a Medicare Set-aside Agreement?

This type of agreement is very similar to the Medicare Set-aside Custodial Agreement. Instead of a trust or custodial fund, however, the employer or insurer may purchase an annuity or structured settlement from which a designated amount each month will go toward the injured employee’s medical care. Under a Medicare Set-aside Agreement, Medicare will agree to pay for the cost of the employee’s medical care above that monthly amount, but CMS must approve the amount of the settlement, the payment plan, and the settlement documents. When this is done, Medicare will sign off to pay any additional medical costs above the amount provided by the structured settlement. It should be noted, however, that, because the expenses for most injured employees’ medical treatment vary from month to month, CMS may prefer that a Medicare Set-aside Custodial Agreement be used as opposed to an agreement funded through an annuity.
V. WHEN SHOULD A MEDICARE SET-ASIDE BE UTILIZED?

Medicare Set-asides should be used if future medical benefits are being closed and either of the following applies:

1) The employee is a current Medicare beneficiary, regardless of the settlement amount.

2) The employee will be a Medicare beneficiary within thirty (30) months of the date of the settlement and the anticipated amount of the settlement, including indemnity, is expected to be greater than $250,000.22

If an individual is currently receiving social security disability benefits, he or she has a reasonable expectation of qualifying for Medicare enrollment within thirty (30) months. Individuals become eligible for Medicare after they have been receiving social security disability benefits for twenty-four (24) months. Social security disability benefits do not begin until five (5) months after the date of the accident, injury or other disabling event.

In order to qualify for social security disability, an individual must be unable to perform any kind of substantial, gainful work because of a physical or mental impairment, or a combination of both, which is expected to either 1) last at least twelve (12) months or 2) end in death. There are additional ways to qualify for social security disability benefits including, but not limited to:

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22 Medicare has reserved the right to revise this number should it become necessary.
1) The claimant is fifty (50) years old or older and unable to perform past work (his own occupation) due to a physical or mental impairment;  

2) The claimant has any physical or mental impairment and a long history of heavy, unskilled work;  

3) The claimant has a physical or mental condition that appears to satisfy the medical listings in the Code; or  

4) The claimant is illiterate with any physical or mental impairment.

If an employee meets these criteria at the time of the settlement, a Medicare Set-aside should be utilized.

The Medicare Intermediary Manual provides the following guidance regarding the settlement of future benefits in workers' compensation cases:

3416. Effect Of Lump-Sum Compromise Settlement

Negotiated compromise settlements of WC claims, by their very nature, provide less than full benefits for both income replacement and medical expenses...

In general, medical expenses incurred after the date of the final release of a lump sum compromise settlement are reimbursed under Medicare; however, if the settlement agreement allocates certain amounts for future medical expenses, Medicare does not pay for those services until the beneficiary presents medical bills related to the injury totaling the amount of the lump sum settlement allocated to medical treatment. If the lump-sum settlement includes payment for future services, to prevent erroneous payments, retain a copy of the lump-sum agreement and flag any new claims for the condition for which the beneficiary received the lump-sum payment. Whenever you are informed of any lump-sum agreement, notify other contractors that process  

claims in your area. The Regional Data Exchange System lends itself to notification within the region. Contractors from other regions can obtain this data upon request.

If it appears that a settlement represents an attempt to shift to Medicare the responsibility for the payment of medical expenses for the treatment of a work-related condition, it will not be recognized. Settlements of this type may occur, for example, when the parties attempt to maximize the amount of disability benefits paid an injured employee under WC by releasing the WC carrier from liability for a particular course of treatment, despite facts showing a relationship between the work injury and the condition which necessitated the treatment. In such cases, determine that the services could have been paid for under WC and are, therefore, not payable under Medicare.

EXAMPLE 1:
BORA Medicare beneficiary was operated on for a hip fracture received in the course of his employment. Following surgery, the individual went into post-operative shock and suffered a cerebrovascular accident which required hospitalization for an additional 3 months. The total hospital bill was $12,000. Despite the fact that, under these circumstances, the State WC plan would have covered the individual's entire hospital bill, his attorney instructed the hospital to bill the WC carrier only for the expenses incurred through the date of the hip surgery, pending the outcome of the disability settlement which was being negotiated.

The State WC agency subsequently approved a compromise settlement, under the terms of which the WC carrier admitted liability for the hip fracture but not for the stroke. The settlement provided payment to the beneficiary of $18,000 plus payment to the hospital of $1,200 for his stay through the date of the surgery. Following the settlement, the beneficiary requested the intermediary to pay for the 3 months of hospitalization following the surgery, since the settlement did not stipulate that treatment of the stroke was work-related. The intermediary determined that payment under WC for treatment of the stroke could reasonably have been expected if the beneficiary had not agreed to give up his right to such compensation. It, therefore denied the claim. The provider has the right to bill the beneficiary since these services would have been covered by WC and, therefore, are not payable by Medicare.

EXAMPLE 2:
A Medicare beneficiary settled a WC claim which stipulated, among other things, that the WC carrier would: (1) pay the individual a lump-sum of $50,000 as compensation for permanent and total disability, (2) pay all of the individual's medical expenses related to his work injury until he became entitled to benefits under Medicare or any other government medical benefit program, and (3) continue to pay, without any time limitation, any portion of
his medical expenses for the work injury which was not reimbursable under a
government program. It further stipulated that the employee would seek
payment for the medical care related to the work injury from State and
Federal Government programs to reduce the obligation of the employer and
carrier as much as possible. Although the compensation order was designed
to reduce the obligation of the employer and carrier to pay for medical care
by shifting medical expenses to Medicare and other government programs
where possible, the agreement recognized the WC carrier=s continuing
responsibility for the individual=s medical care. Since Medicare is not bound
by such covenants, benefits were denied for all expenses subsequently
incurred for treatment of the work injury. As in Example 1, the Medicare
beneficiary may be billed for these services.

EXAMPLE 3:
In July, 1980 Mr. Y, age 30, was involved in an accident at work sustaining
injury to his neck, back, right arm and legs. Beginning with the date of the
accident, the WC carrier paid Mr. Y weekly benefits of $182 for temporary
disability and also paid all of his medical expenses. In 1982, Mr. Y became
entitled to Medicare based on disability. In July, 1984, the WC insurer
decided to terminate Mr. Y=s medical and disability payments based on
medical advice that his continuing impairments were not attributable to the
work injury. By this time, the insurer has paid a total of $90,000 for Mr. Y=s
medical care.

Mr. Y contested the termination of his WC benefits, and the case was settled
by compromise. A lump sum of $46,000 ($6,000 of which was designated as
attorneys= fees) was paid to Mr. Y. As part of the settlement agreement, Mr.
Y signed a final release which stipulated that future medical expenses were
in dispute and that they were to be assumed by Mr. Y as his sole
responsibility. The fact that Mr. Y accepted, and the State WC agency
approved, a relatively small lump sum payment, compared with what Mr. Y
would have received had his WC claim been approved in full, indicates that
there was doubt as to the compensability of the injury. There was no
indication that the lump sum was intended to be payment for future medical
expenses, nor do these facts indicate that the settlement represented an
attempt to shift the responsibility for future medical expenses from WC to
Medicare.

Therefore, Mr. Y=s signing of the final release of all rights under WC makes
it possible for medical expenses incurred after the date of settlement to be
reimbursed under Medicare.

3416.1 Lump-Sum Payment Which Represents Commutation of Future Benefits.--
If an individual is paid a lump sum WC benefit which is intended to compensate the individual for all future medical expenses and disability benefits, and the amount is reasonable considering the future medical services that can be anticipated for the medical condition, Medicare benefits are not payable for any future expenses directly related to the work injury for which the lump-sum was paid until the beneficiary presents medical bills related to the injury in excess of the amount of the lump sum settlement allocated to medical treatment.
VI. DETERMINING THE AMOUNT TO PLACE IN A MEDICARE SET-ASIDE

Essentially, the amount of money to be placed in a Medicare Set-aside is not negotiable between the parties. To determine the amount of the fund, the medical records of the employee are evaluated in depth, usually by a Medicare Set-aside allocation company. Inquiries are then made to medical providers to determine the future medical treatment anticipated for the employee. Next, a review is made of Medicare regulations to determine what part of that treatment would normally be covered by Medicare. A projection is then made of the likely expenses for the covered treatment based upon the appropriate Medicare or State fee schedule. This is the amount that should be placed in the Medicare Set-aside.

A. Releases

In order to communicate with Medicare regarding a potential claim for past and/or future medical benefits, the employee must sign a release. Oftentimes, however, employees and/or their attorneys are reluctant to sign the release for various reasons. They should be wary of refusing to do so, however, as the MSP regulations state specifically that the beneficiary must cooperate with efforts to recover money due Medicare.\footnote{42 C.F.R. \textsection 411.23.} If the worker does not cooperate, Medicare may recover directly from the beneficiary for Medicare's expenditures.

B. Life Care Plans and Medicare Set-aside Allocations

When an allocation company is utilized to assist with the amount to be placed into a Medicare Set-aside Fund, the following information must be provided to them:

- Claimant name, date of birth, Social Security number, address
- Date of injury
• Date Social Security payments started
• Whether the employee is a Medicare beneficiary
• If the employee is a Medicare beneficiary, provide Medicare number and a copy of his or her Medicare card
• Social Security release
• Release authorizing communication with Medicare
• Life Care Plan (if one has been performed)
• Medical records describing the injury and treatment and confirming MMI
• Claim payment history (five year payout records, if available)
• Description of the type and severity of the illness or injury
• List of any injuries or conditions that were not the responsibility of workers' compensation
• Workers’ compensation classification, such as permanent partial, permanent total, etc.
• Life expectancy of the employee
• Rated age

In addition to the allocation documents, a draft of the settlement documents, including the Medicare Set-aside Agreement (which should distinguish between the amount of money dedicated to past medical expenses, indemnity, vocational disability benefits, and future medical benefits), must be provided to CMS for approval.
C. Securing Medicare Approval of a Set-aside Amount

After an allocation is made, in appropriate cases, Medicare approval of the Set-aside amount must be obtained. Medicare is administered on a nationwide basis through ten regional offices. Each of the regional offices administers the MSP program including collecting, enforcing and compromising Medicare’s claims. Additionally, each of the regional offices has the authority to approve a workers’ compensation settlement incorporating a Medicare Set-aside agreement.
VII. ADMINISTRATION OF MEDICARE SET-ASIDE FUNDS

A. The Custodians Role

Medical providers for injured workers covered by a Medicare Set-aside typically send bills for their services directly to the custodian of the Medicare Set-aside Fund. The custodian pays the medical bills in accordance with either the applicable state workers’ compensation fee schedule or the Medicare fee schedule, depending upon which fee schedule the allocation was based.

The custodian is limited, however, in the amount which may be paid for medical treatment. First, the custodian may not pay for any treatment that Medicare would not cover. In addition, the fund must not be used to pay bills not connected with the work-related injury. Furthermore, no bills may be paid from the Medicare Set-aside Fund until the worker is actually a Medicare beneficiary.

At least on an annual basis, the custodian must send reports to the appropriate regional office of Medicare. This report must indicate all of the expenditures from and deposits made into the fund over that period of time. Once the fund is exhausted, the custodian must then forward a report to the appropriate Medicare regional office detailing all expenses paid from the Fund and all deposits made thereto for the life of the Fund. Upon approval of the report, the custodian’s duty ends.

Should the employee die before the custodian fund is exhausted, the money will usually revert to the employee’s estate. In such case, the custodian must insure that the appropriate transfers are made before he is released from his obligations in connection with the Medicare Set-aside.

B. Beneficiary Administered Fund
Medicare Set-asides may be beneficiary administered. Several stringent guidelines, however, must be followed if this option is utilized. A copy of these guidelines is attached hereto.

C. Annuities

Annuities are also an option which may be used to close future medical benefits in cases covered by the MSP statute. In such cases, an annuity may either be used to pay the beneficiary a certain amount of money over a fixed period of time or the annuity may be used to fund the Medicare Set-aside.
VIII. ELEMENTS OF MEDICARE SET-ASIDE AGREEMENTS

Medicare Set-aside Agreements contain numerous elements including, but not limited to, the following:

Definitions
Qualified Medical Expenses
Supplemental Medical Services
Custodial Fund
Investments

Duties and Obligations of Payor

Duties and Obligations of Custodian
Custodial Fund
Distributions of Principal and Income
Reliance Upon Presentation
Investment Supervision
No Obligations for Disbursements in Excess of Custodial Fund
Reporting and Record Keeping
Taxes and Accounting

Resignation of Custodian

Compensation of Custodian

Termination of Custodial Fund and Agreement
Exhaustion of the Custodial Fund
Death of Beneficiary

Indemnification
By Custodian
By Payor

General Provisions
Governing Law
Medicare Coverage for Other Conditions
Binding Effect

Effective Date of Agreement
IX. THE CONSEQUENCES OF CLOSING FUTURE MEDICAL BENEFITS WITHOUT USING A MEDICARE SET-ASIDE OR SIMILAR AGREEMENT

A. Reimbursement Actions by Attorney General

In order to recover payments described in the MSP statute, the United States is authorized to bring an action against the primary payer directly, as a third-party administrator, or otherwise. In addition, the statute provides that double damages plus interest may be collected from the primary payer. It is important to remember that regulations specifically provide that, if a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for treatment of a work-related condition, the settlement will not be recognized.

B. Medicare Refusal to Pay Injured Workers' Medical Bills

In addition to paying and seeking reimbursement for an injured employee's medical expenses, Medicare also has the option under the MSP statute to simply refuse to pay such expenses in the first place. This could occur if the injured employee has previously reached a lump sum settlement with the primary payer regarding future medical benefits. Medicare regulations specifically provide as follows:

29 Id.
If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.32

Similarly, the Medicare Intermediary Manual states as follows:

3407.8 Lump Sum - Commutation of Future Benefits.--

When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump sum settlement allocated to medical treatment.

In the event that no part of a lump sum settlement is specifically allocated for future medical expenses, Medicare has a formula for apportioning an amount of the settlement itself. Apportionment of a lump-sum compromise settlement of a workers’ compensation claim.

(a) Determining amount of compromise settlement considered as a payment for medical expenses.

(1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

(2) If the settlement does not give reasonable recognition to both elements of a workers’ compensation award or does not apportion the sum granted, the portion to

32 42 C.F.R. ' 411.46(a).
be considered as payment for medical expenses is computed as follows:

(i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.

(ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.

Example: As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers' compensation payment would have been $24,000 if the case had not been compromised. The medical expenses amounted to $18,000. The workers' compensation carrier made a settlement with the beneficiary under which it paid $8,000 in total. A separate award was made for legal fees. Since the workers' compensation compromise settlement was for one-third of the amount which would have been payable under workers' compensation had the case not been compromised ($8,000/$24,000=\(1/3\)) , the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (\((1/3)\times $18,000=$6,000\)).

(b) Determining the amount of the Medicare overpayment. When conditional Medicare payments have been made, and the beneficiary receives a compromise settlement payment, the Medicare overpayment is determined as set forth in this paragraph (b). The amount of the workers' compensation payment that is considered to be for
medical expenses (as determined under paragraph (a) of this section) is applied, at the workers’ compensation rate of payment prevailing in the particular jurisdiction, in the following order:

(1) First to any beneficiary payments for services payable under workers’ compensation but not covered under Medicare.

(2) Then to any beneficiary payments for services payable under workers’ compensation and also covered under Medicare Part B. (These include deductible and coinsurance amounts and, in unassigned cases, the charge in excess of the reasonable charge.)

(3) Last to any beneficiary payments for services payable under workers’ compensation and also covered under Medicare Part A. (These include Part A deductible and coinsurance amounts and charges for services furnished after benefits are exhausted.)

The difference between the amount of the workers’ compensation payment for medical expenses and any beneficiary payments constitutes the Medicare overpayment. The beneficiary is liable for that amount.

Example: In the example in paragraph (a) of this section, it was determined that the workers’ compensation settlement paid for $6,000 of the total medical expenses. The $18,000 in medical expenses included $15,000 in charges for services not covered under Medicare, $7,500 in charges for services covered under Medicare Part B, and $9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers’ compensation payment rate, that is, in amounts the provider or supplier must accept as payment in full.
The Medicare reasonable charge for physicians' services was $7,000 and Medicare paid $5,600 (80 percent of the reasonable charges). The Part B deductible had been met. The Medicare payment rate for the hospital services was $8,000. Medicare paid the hospital $7,480 ($8,000 - the Part A deductible of $520).

In this situation, the beneficiary's payments totaled $3,920:

- Services not covered under Medicare: $1,500
- Excess of physicians' charges over reasonable charge: $500
- Medicare Part B coinsurance: $1,400
- Part A deductible: $520

Total: $3,920

The Medicare overpayment, for which the beneficiary is liable, would be $2,080 ($6,000 - $3,920).  

The Medicare Intermediary Manual also provides the following guidance regarding apportionment:

3416.2 Apportionment of a Lump-Sum Compromise Settlement of Contested WC Claim.--

If the settlement covers both medical care and disability benefits but does not apportion the sum granted between them and income replacement, or does not give reasonable recognition to both medical care and disability, calculate the amount of the award deemed to be payment of medical and hospital expenses as follows:

- Determine the ratio which the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) bears to the total amount which would have been payable under WC for both medical and hospital expenses (including expenses not covered under Medicare) and income replacement, if the claim had not been settled by compromise.

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33 42 C.F.R. '411.47
Multiply this ratio by the total medical and hospital expenses incurred as a result of the injury or disease up to the date of the settlement. The product is deemed to be the amount of WC settlement intended as payment for medical and hospital expenses. Apply the latter amount to the medical and hospital expenses incurred due to the work-related injury.

Generally, base the determination of the total amount that would have been payable under WC had the claim not been settled by compromise on information furnished by the beneficiary=s attorney. If you have reason to question the attorney=s estimate, base the determination on information from other sources such as the State WC agency.

First request the attorney to furnish you a statement of the amounts that would have been payable for disability and medical care if the beneficiary were awarded full benefits under the WC law. The attorney=s estimate should include an amount for disability based on the anticipated number of months of total disability and an amount for partial disability. Each amount should be based on the specific amounts which the law states are payable for each type of disability. The estimate should include an amount for medical care based on actual and anticipated medical expenses related to the work injury. The information provided by the attorney should be consistent with the beneficiary=s medical condition and the provisions of the applicable WC law. (WC laws require that employers pay all work-related medical expenses, and designate amounts for temporary and permanent disability.)

If you believe there is a discrepancy between the attorney=s estimate and what you consider to be the beneficiary=s medical situation and the provisions of the law, ask the attorney for additional information and/or an explanation of how the amount was determined. It may be helpful to consult with the State WC agency to obtain confirmation that the attorney=s estimate is consistent with the medical facts and with the law.

Contact this agency for the above information if the attorney does not cooperate.

If you are convinced that the attorney has overstated the amount that would have been paid if the claim were not settled by compromise, base your determination of overpayment on a lower amount that you feel is reasonably based on all the facts. Send the attorney a full explanation of how you determined your estimate with particular attention to the aspects which differ from the attorney=s.

EXAMPLE 4:
Mr. A suffered a work injury resulting in loss of income and expenses for hospital and medical services for which the total WC payment would have been $24,000 had the case not been compromised. The expenses totaled $18,000 and included $10,200 in hospital services, which in the absence of WC, would be paid for under Part A; $6,300 in expenses for medical and other health services for which payment would be made under Part B on a reasonable charge basis, and $1,500 in expenses for services not reimbursable under Part A or Part B but reimbursable under WC. The WC carrier made a settlement with the beneficiary under which it paid a total of $8,000. A separate award was made for legal fees.

Since the settlement was for one-third of the amount which would have been payable under WC had the case not been compromised ($8,000/$24,000 = 1/3) the settlement is deemed to have paid for one-third of the total medical and hospital expenses (1/3 x $18,000 = $6,000).

To determine the amount of Medicare benefits payable, apply the $6,000 of the compromise WC settlement considered as payment for hospital and medical expenses, first to the $1,500 in non-covered expenses. Apply the remaining $4,500 to the $6,300 in Part B covered expenses (without deducting the deductible and coinsurance). The remaining $1,800 of Part B expenses and all of the $10,200 in expenses for services covered under Part A would be reimbursable under Medicare, subject to the regular deductible and coinsurance requirements. It is assumed, in this example, that the expenses specified above as incurred by Mr. A are the amounts which would have been paid by the WC. If this is not the case, charge the services against the lump-sum payment at the usual WC rate.

EXAMPLE 5:
Mr. B worked for a florist. On May 18, 1986, while making a delivery, he fell and broke his hip. He was admitted to the hospital, where it was discovered that, in addition to his fracture, he had a severe infection. He was hospitalized until August 20, 1986. Medicare paid a total of $60,000 toward the medical and hospital expenses.

Mr. B settled his WC claim by accepting a lump sum compromise payment of $50,000, $10,000 of which represented attorney=s fees. Medicare submitted a claim to Mr. B=s attorney requesting reimbursement for the amount it had paid. The WC lump sum represented a compromise settlement of Mr. B=s present and future disability benefits, estimated at $35,000, and past medical expenses (including $48,000 paid under Part A, $12,000 covered under Part B, and $5,000 for expenses not covered under Medicare). Thus, had Mr. B not compromised, the total amount that would have been payable for disability and medical expenses would have been $100,000 ($35,000 for disability and $65,000 for medical). There did not appear to be an attempt to shift the WC liability to Medicare.
The award ($50,000), less attorney fees ($10,000), is 40% of what would have been paid if Mr. B had been awarded full benefits ($100,000). Under the lump sum apportionment formula, 40% of $65,000 in total medical expenses, or $26,000, is deemed to have been paid by the WC compromise settlement.

As Mr. B had $5,000 medical expenses for non-covered Medicare services, that amount is deducted from the $26,000, leaving $21,000 to be applied to Mr. B’s Medicare covered expenses. The entire $12,000 of Mr. B’s Part B expenses (including the deductible and coinsurance) is considered to have been paid by the WC award and $9,000 of the $48,000 in Part A expenses are considered paid by the WC award. Medicare’s claim is the amount it paid toward the $12,000 in Part B services and $9,000 of the Part A payment. These payments were duplicated by the WC payment.

C. Private Causes of Action

In 1986, Congress amended the MSP statute to add a private cause of action. Under this provision, appropriate individuals may recover damages in an amount double the amount otherwise provided when a primary payer fails to provide for payment or reimbursement under the MSP statute.34

X. THE BENEFITS OF UTILIZING A MEDICARE SET-ASIDE

There are numerous benefits to using Medicare Set-asides to close future medical benefits.

Benefits for insurers/employers:

1) Cost savings to insurer/employers.
   - Medicare allows a A-rated age@ to be used to determine the amount of money required to be set aside. Essentially, although an individual may be 40 years old, if he has heart disease and cancer, the chances of him living out a full life expectancy are slim. A A-rated age@ is based upon the totality of an individual=s medical condition and reduces the number of years for which medical treatment must be rendered. Consequently, the amount of money necessary to be set aside is reduced.
   - Claims administration savings

2) Obtaining court approval of workers= compensation settlements is significantly easier.

Benefits for the employee

1) Professional administration of medical claims
2) Ownership of their medical treatment
3) Obtaining court approval of workers= compensation settlements is significantly easier.
XI. UPDATE FROM WASHINGTON, D.C.

On February 25, 2002, Melisa George, along with ten other leaders in the workers' compensation industry, met with officials from CMS regarding the MSP statute and Medicare Set-asides. Three CMS officials were present at the meeting. Although some questions were answered by the CMS officials, many remain unanswered. In a few months, however, another guidance memorandum will be published by CMS which should answer more questions and address some of the concerns outlined below. Following are some of the issues discussed at the meeting:

A. Must Medicare be involved with the settlement of disputed claims?

Medicare officials made it clear that, if an individual is on Medicare at the time of the settlement, Medicare must be involved in the process and steps must be taken to protect Medicare's interest regardless of the fact that a settlement claim is disputed. This rule applies even if the plaintiff acknowledges that causation is an issue and a judge signs an order specifically finding that the causation element has not been met. This position is supported by the C.F.R. which basically provides that Medicare does not have the burden of proof with regard to liability in workers' compensation cases. If a payment of any amount of money is made by the insurer/employer to an injured worker in a case wherein an allegation was made that the insurer/employer is liable to the injured worker for benefits in connection with a work-related accident, Medicare may have a claim with regard to the settlement proceeds. Obviously, if the claimant has a congenital malformation in his back for which Medicare has paid a substantial amount of money and the work-related injury is to the employee's leg, for example, Medicare will only make a claim for the amounts of money which it has paid in connection with the leg injury. Once an allegation is made that a
particular injury was caused by a work accident, Medicare may make a claim for past medical expenses even if liability is strongly contested and causation cannot be proven.

The meeting attendees challenged Medicare=s position with regard to disputed claims on numerous grounds, including res judicata and that it violates the due process clause of the U.S. Constitution. Medicare=s response was, basically, that the current law entitles Medicare to such a claim. Specifically, the C.F.R. provides as follows:

Lump-sum payments.

(a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(b) Lump-sum comprise settlement.

(1) A lump-sum compromise settlement is deemed to be a workers= compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers= compensation law or plan.

(2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers= compensation by releasing the workers= compensation carrier from liability for medial expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

(c) Lump-sum compromise settlement: Effect on services furnished before the date of settlement. Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in Sec. 411.47.
(d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of the settlement--

(1) Basic rule. Except as specified in paragraph (d) (2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.

(2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.\(^\text{35}\)

Similarly, the Medicare Intermediary Manual provides:

3407.7 Lump Sum Compromise Settlement.--

If a WC agency approves a lump sum settlement of a case where compensability is contested, the settlement is deemed to be a WC payment, even if the agreement stipulates that there is no WC liability.

3407.6 Contested WC Claims.--

A. General.--An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits by the WC agency. Appeals are generally heard by a hearing officer or judge of the agency, with further appeal to the WC agency or appeals board and to the courts. Sometimes contested claims are settled by compromise with the approval of the WC agency.

In general, accept a decision by a State WC agency on a contested claim, or a compromise settlement which has been approved by a WC agency, as a basis for applying the WC limitation, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, allow claims for treatment of that condition, unless the decision or settlement is clearly inconsistent with the medical facts and applicable State law and has the effect of shifting to Medicare, liability for medical expenses which are the responsibility of the State WC program. Where it is clear that an attempt was made to shift responsibility, deny the

\(^{35}\) 42 C.F.R. \textsection 411.46

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Medicare claim. In your denial notice explain your conclusions in detail and state that the beneficiary may wish to request a reopening under the WC law.

B. Which fee schedule should be used for Medicare Set-aside allocations?

If a Medicare Set-aside allocation is based upon the Medicare fee schedule, the custodian or administrator of the Medicare Set-aside Funds must ensure that expenses are paid only in accordance with the Medicare fee schedule. For example, assume that an allocation is based upon the Medicare fee schedule and that it allows $45.00 for doctors visits. Also assume that, after a set-aside is established, the claimant goes to the doctor. Although the doctor might charge $100.00 for the visit, only $45.00 may be expended from the Set-aside Fund to cover that visit. If the doctor refuses to reduce his or her fee for such, the beneficiary must pay the additional amount out of his or her pocket. If the fund is beneficiary administered, the beneficiary will be responsible for making sure he is aware of the Medicare fee schedule and only paying expenses in accordance with the same.

Alternatively, if a state workers’ compensation fee schedule is used to determine the allocation for the Medicare Set-aside, future medical expenses may be paid in accordance with that workers’ compensation fee schedule. Again, if medical expenses are paid in excess of the fee schedule, Medicare will not allow a credit for the extra amount expended.

C. Must future changes in Medicare services be anticipated in Medicare Set-aside agreements?

Currently, Medicare requires that Medicare Set-aside Agreements be drafted to allow for future changes in the law regarding what may or may not be covered by Medicare. Obviously, it is very difficult, if not impossible, to predict what may or may not be covered by Medicare in six weeks, let alone five or ten years. The issue regarding the duty to
speculate about future Medicare coverage in Medicare Set-aside Agreements will be addressed in the forthcoming guidance memo.
XII. CONCLUSION

When Medicare Set-aside Custodial Agreements and Medicare Set-aside Agreements are properly utilized, employees, employers and workers’ compensation insurance carriers may settle a workers’ compensation claim closing future medical benefits without fear of Medicare either 1) attempting to make a claim for reimbursement of medical expenses resulting from a work-related injury, or 2) refusing to pay an injured employee’s medical expenses. Utilization of a Medicare Set-aside Custodial Agreement or a Medicare Set-aside Agreement should allow parties to settle future medicals with greater ease, since the employee will have insurance, through Medicare, for future treatment. Additionally, trial courts are more likely to approve settlements that include this safeguard.

These agreements can also provide a substantial cost savings to employers and workers’ compensation carriers. While Medicare recognizes that the employer or workers’ compensation carrier will put less money into the custodial account or the annuity than it would likely expend over the remainder of the injured employee’s life, this type of compromise with an injured employee is accepted by Medicare as an incentive to the employer or insurer to settle claims for future medical expenses. Moreover, because any amount remaining in the Medicare Set-aside at an employee’s death will usually go to the employee’s heirs, Medicare Set-asides provide an added benefit for injured employees.