DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Financial Management and Fee for Service Operations, Region VI

1301 Young Street, Room 833
Dallas, Texas 75202
Phone (214) 767-6441
Fax (214) 767-4440

May 25, 2011

This specific handout was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain certain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. It is intended to provide consolidated guidance to those attorneys, insurers, etc., working liability, no-fault and general third party liability cases for any Medicare beneficiary residing in Oklahoma, Texas, New Mexico, Louisiana and Arkansas and is not to be considered a CMS official statement of policy.

If the Medicare beneficiary involved in your case is not a resident of one of these states, please contact the appropriate Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer Regional Office (MSP RO). If you do not have that information please contact Sally Stalcup (contact information below) for that information.

Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law requires that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law.

Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

Section 1862(b)(2)(A)(ii) of the Social Security, Act [42 USC 1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines the term "liability insurance". Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment, award .y are not funded there is no reasonable expectation that third party funds are available to pay for those services.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8) add reporting rules and do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment. The new provisions do NOT require a set-aside when there is a recovery for future medicals, in fact this legislation does not address that subject. This legislation is unofficially known as "Mandatory Insurer

Reporting" because it does just and only that. It specifies the entity mandated to report a settlement/judgment/award/recovery to Medicare and addresses specifics of that issue.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation. **However,** CMS does expect the funds to be exhausted on otherwise Medicare covered and otherwise reimbursable services related to what was claimed and/or released before Medicare is ever billed. CMS review is decided on a case by case basis.

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review on the merits of the case. A review of the merits of the case is a review of the facts of the case to determine whether there are future medicals - not to determine the proper allocation of funds. If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the Court's designation.

While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc, we are frequently asked how one would 'know'. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any Medicare covered otherwise reimbursable, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is by no means all inclusive.

We use the phrase "case related" because we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare's right of recovery, and the prohibition from billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) of the Social Security Act.

"Otherwise covered" means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust funds. For example, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate. We include the designation of "otherwise reimbursable" because Medicare does not pay for services that are not medically necessary even if the specific service is designated as a covered service and Medicare does not pay primary when Group Health Plan insurance has been determined to be the primary payer.

At this time, the CMS is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fund in most cases. We do however urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.

CMS does not review or sign off on counsel's determination of whether or not there is recovery for future medical services and thus the need to protect the Medicare Trust Funds and only in limited cases do they review or sign off on counsel's determination of the amount to be held to protect the Trust Funds.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation, however Regional Offices do review a number of submitted set-aside proposals. On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the "set-aside" aspect of that request we only need to state that IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Funds must be protected. If there was/is no such funding, there is no expectation of 3rd party funds with which to protect the Trust Funds. Each attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should to see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them to protect the Medicare Trust Funds. It will also be part of their report to Medicare in compliance with Section 111, Mandatory Insurer Reporting requirements.

Medicare educates about laws/statutes/policies so that individuals can make the best decision possible based on their situation. This is not new or isolated to the MSP provisions. Probably the best example I can give is the 2008 final rule adopting payment and policy changes for inpatient hospital services paid under the Inpatient Prospective Payment System. That final rule also adopted a number of important changes and clarifications to the physician self-referral rules sometimes known as the Stark provisions. The physician self-referral law prohibits physicians from referring Medicare and Medicaid patients to certain entities with which the physician or a member of their immediate family has a financial relationship. Exceptions apply. Requests for determinations as to whether or not the physician met the exception criteria, or whether or not their situation was covered by this prohibition poured in. CMS/Medicare did not and continues to make no such determinations. It is the responsibility of the provider to know the specifics of their situation and determine their appropriate course of action.

Sally Stalcup
MSP Regional Coordinator
CMS
Medicare Fee for Service Branch
Division of Financial Management
and Fee for Service Operations
1301 Young Street, Room 833
Dallas, Texas 75202
(214) 767-6415
(214) 767-4440 fax