DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicare Management

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer -- Workers' Compensation (WC) Frequently Asked Questions

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1) **What statutory law, regulations, or Federal case law supports/allows CMS to review proposed settlements of injured workers who are not Medicare beneficiaries?**

Answer: Section 1862(b)(2) of the Social Security Act (the Act) (42 USC 1395y(b)(2)) requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation (WC) law or plan. Medicare does not pay for an individual's WC related medical services when that individual received a WC settlement, judgment, or award that includes funds for future medical expenses, until all such funds are properly expended.

Because Medicare does not pay for an individual's WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in that individual's interests to consider Medicare at the time of settlement. Once CMS agrees to a Medicare set-aside amount, the individual can be certain that Medicare's interests have been appropriately considered.

2) **When dealing with a WC case, what is "a reasonable expectation" of Medicare enrollment within 30 months?**

Answer: Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are not limited to:

a) The individual has applied for Social Security Disability Benefits;
b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

3) How does Medicare determine its interests in WC cases when the parties to the settlement do not explicitly state how much of the settlement is for past medical expenses and how much is for future medical expenses?

Answer: A settlement that does not specifically account for past versus future medical expenses will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.

Example: A beneficiary is paid $50,000 by a WC carrier, and the parties to the settlement do not specify what the $50,000 is intended to pay for. If there is no CMS approved Medicare set-aside arrangement, Medicare will consider any amount remaining after recovery of its conditional payments as compensation for future medical expenses.

Additionally, please note that any allocations made for lost wages, pre-settlement medical expenses, future medical expenses, or any other settlement designations that do not consider Medicare's interests, will not be approved by Medicare.

4) What's the difference between commutation and compromise cases? And can a single WC case possess both?

Answer: When a settlement includes compensation for future medical expenses, it is referred to as a " WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.

5) When a state WC judge approves a WC settlement, will Medicare accept the terms of that settlement?

Answer: Medicare will generally honor judicial decisions issued after a hearing on the merits of a WC case by a court of competent jurisdiction. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

However, a distinction must be made where a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. Medicare cannot accept the terms of the settlement as to an allocation of funds of any type if the settlement does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire WC settlement. Medicare will also assert a recovery claim, if appropriate.

6) What is the expected time frame for the regional offices (ROs) to review and make their decisions regarding proposed WC settlements?

Answer: ROs seek to review and make a decision regarding proposed WC settlements within 45 to 60 days, from the time that all necessary/required documentation has been submitted.

7) May administrative fees/expenses for administration of the Medicare set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement be charged to the set-aside arrangement?

Answer: Yes, such fees and costs may be charged to the arrangement if all the following are true:

a) They are related to the Medicare set-aside itself;
b) They are reasonable in amount; and

c) They are included in the proposed Medicare set-aside arrangement submitted to CMS and incorporated into the Medicare set-aside approved by CMS.

It is important to note that all administrative fees and other costs and expenses associated with the disability/lost wages portion of the settlement and/or the portion of the settlement that provides for medical services that are not covered by Medicare cannot be charged to the Medicare set-aside arrangement.

Note: This question and answer does not address attorney fees and costs in connection with procurement of the WC settlement from the WC carrier.

8) May a beneficiary self-administer his or her own Medicare set-aside arrangement?

Answer: Yes, if this is permitted under state law. It should be noted though, that a self-administered arrangement is subject to the same rules/requirements as any other set-aside arrangement.

9) In WC cases that use structured Medicare set-aside arrangements (i.e., settlement monies are apportioned over fixed or defined periods of time), will Medicare agree to cover the beneficiary when it has not been verified whether the funds as apportioned in the arrangement have been exhausted?

Answer: No, Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the Medicare set-aside arrangement.

Additionally, please note that any structured set-aside arrangement agreed to by the parties will not be approved by Medicare if the settlement has not adequately considered Medicare's interests.

10) In a structured Medicare set-aside arrangement where payments are made at regular intervals to cover expenses incurred during those periods, how should an administrator account for unspent funds during a given period?

Answer: If funds are not exhausted during a given period then the excess funds must be carried forward to the next period. The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.

Example: A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2003 the injured

individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2004. Therefore, in 2004 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2004. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

11) If a beneficiary or injured individual's physical condition substantially improves, may the administrator of the Medicare set-aside arrangement release or reduce the amounts of the set-aside?

Answer: The administrator of the CMS approved Medicare set-aside arrangement cannot release or reduce the set-aside amounts without approval from CMS. If the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary (or his/her representative) may submit a written request to the appropriate CMS RO asking for a reduction of the Medicare set-aside arrangement. This request must include supporting documentation from the treating physician(s). Once the RO receives all pertinent documentation, the RO will then evaluate the request and make a decision. The RO decision is final and not subject to administrative appeal.

12) What are an attorney's ethical and legal obligations when his or her client effectively ignores Medicare's interests in a WC case?

Answer: Attorneys should consult their national, state, and local bar associations for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26.

13) From where can CMS recover funds if Medicare's interests are ignored in a WC case?

Answer: The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly. The CMS also has a subrogation right with respect to any such third party payment. See, for example, 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26.

14) If Medicare rejects a proposed Medicare set-aside arrangement, how can the parties to a WC settlement appeal this rejection?

Answer: The CMS has no formal appeals process for rejection of a Medicare set-aside arrangement. However, when CMS does not believe that a proposed set-aside adequately protects Medicare's interests, the parties may provide the RO with additional information/documentation in order to justify their proposal. If the additional information does not convince the RO to approve the set-aside arrangement, and the parties proceed to settle the case despite the ROs objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as WC settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. At this point, when Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. Information on applicable appeal rights is provided at the time of each claim denial.

15) When the parties to a WC settlement present CMS with documentation that is intended to support and justify their proposed Medicare set-aside amounts, will Medicare accept a "life care plan" or similar evaluation prepared by a non-treating physician?

Answer: Yes, Medicare will consider accepting a life care plan or similar evaluation from a non-treating physician, if the physician does <u>all</u> of the following:

a) Examines the WC claimant;
b) Reviews the claimant's medical records;
c) Contacts any of the claimant's treating physicians (if applicable);
d) Is available to answer CMS' questions;
e) Prepares a report that summarizes the above; and
f) Offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury.

Please note that such a life care plan or evaluation is not automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question for some reason, such as contrary evidence, internal conflicts, or if the plan is not credible on its face.

16) If a current Medicare beneficiary has outstanding WC related claims that were not paid prior to the settlement and are not covered in that settlement, will Medicare or the Medicare set-aside arrangement pay those claims?

Answer: No, Medicare cannot pay because it is secondary to the WC settlement and the Medicare set-aside arrangement cannot pay because it is created solely for future medical expenses related to the WC case. Medical expenses incurred prior to the

settlement need to be accounted for in the compromise portion of the settlement. These services should be known to the parties. The provider/supplier will typically have billed

Medicare and/or the WC carrier for these services and the beneficiary's representative will have made inquiries about outstanding related claims.

In addition, to the extent Medicare has made any conditional payments, Medicare will recover those payments pursuant to 42 CFR 411.47.

17) When an annuity is included in a settlement for an injured individual (who is not yet a Medicare beneficiary), how does Medicare determine whether the value of the annuity meets the $250,000 monetary threshold?

Answer: Medicare determines the value of an annuity based on how much the annuity is expected to pay over the life of the settlement, not on the Present Day Value (PDV) or cost of funding that annuity.

Example: A settlement is to pay $15,000 per year for the next 20 years to an individual who has a "reasonable expectation" of Medicare enrollment within 30 months. This settlement is to be funded with an annuity that will cost $175,000. The RO will review this settlement because the total settlement to be paid is greater than $250,000 ($15,000 per year x 20 years = $300,000). It is immaterial for Medicare's purposes that the PDV or cost ($175,000) to fund this settlement is less than $250,000.

18) Is there a means by which an injured individual can permanently waive his or her right to certain specific services related to a WC case, and thereby reduce the amount of a Medicare set-aside arrangement?

Answer: No, the ROs cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement.

19) Does CMS require that a Medicare set-aside arrangement be established in situations that involve both a WC claim and a third party liability claim?

Answer: Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further WC claim related medical services. A Medicare set-aside arrangement is also

unnecessary if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.

20) If the settling parties of a WC case contend that a WC settlement is not intended to compensate an injured individual for future medical expenses, does CMS still require that a Medicare set-aside arrangement be established?

Answer: It is unnecessary for the individual to establish a set-aside arrangement for Medicare if all of the following are true:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);
b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and
c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

However, if Medicare made any conditional payments for work-related services furnished prior to settlement, then Medicare would require recovery of those payments. In addition, Medicare will not pay for any services furnished prior to the date of the settlement for which it has not already paid.

21) If a beneficiary or injured individual dies before the Medicare set-aside arrangement is completely exhausted, what happens to the remaining money?

Answer: Once the RO and the contractor responsible for monitoring the beneficiary's case ensure that all of the beneficiary's claims have been paid, then any amount left over in the beneficiary's Medicare set-aside arrangement may be disbursed pursuant to state law, once Medicare's interests have been protected. This may involve holding the Medicare set-aside arrangement open for some period after the date of death, as providers, physicians, and other suppliers are permitted to submit their initial bill to Medicare for a period ranging from 15-27 months after the date of service.

22) What happens if one of the parties settling a WC case refuses to involve CMS, even though Medicare has an interest in the case?

Answer: In these situations, the "cooperative" settling party should notify the appropriate CMS RO. Where the RO believes it is appropriate, the RO will then send the "uncooperative" party a letter (via certified mail) conveying that Medicare's interests must be considered in the WC settlement.

The ROs should inform the "uncooperative" settling party that: "Pursuant to 42 CFR 411.24(g), 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 third party payment. Moreover, pursuant to 42 CFR 411.26, CMS 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. Therefore, pursuant to 42 CFR 411.24(b), CMS may initiate recovery against the parties listed under 42 CFR 411.26 as soon as it learns that payment has been made or could be made under workers' compensation."

Additionally, if Medicare's interests are not adequately considered in any settlement, then Medicare may refuse to pay for services related to the WC injury until such time as expenses for such services have exhausted the amount of the entire WC settlement.

23) Who should the parties settling a WC case contact in the RO?

Answer: The first report of attorney representation of a Medicare beneficiary for a WC claim should be made to the CMS Coordination of Benefits (COB) Contractor. Attorneys can call the COB Contractor from 8am-8pm, Monday - Friday, Eastern Time; the toll-free number is 1-800-999-1118.

Settling parties should also contact the CMS RO responsible for a particular state (contact information is provided in an attachment to these questions and answers) for approval of a Medicare set-aside arrangement. The inquiry should be directed to the attention of the Regional Office Medicare Secondary Payer Coordinator, who will forward the inquiry to the appropriate RO if a transfer is necessary. (WC set-aside responsibilities are generally, but not always, assigned based upon RO responsibility for contractor oversight over the lead fiscal intermediary for WC recoveries for a particular state. This may or may not be the same RO as the one with general responsibilities for a particular state.)

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

Thomas L. Grissom

Attachment

cc: All ARA's for Financial Management
ARA for DHPP RO VII
All RO MSP Coordinators

bcc: Paul Olenick
Martha Kuespert
Fred Grabau
Eve Fisher
Tina Merritt
Barbara Wright
Betty Noble
Hugh Hill
Joan Fowler
Harry Gamble
Donna Kettish

MEDICARE SECONDARY PAYER REGIONAL OFFICE COORDINATORS
(WORKERS' COMPENSATION CONTACTS)

NAME	REGIONAL OFFICE	PHONE
James Bryant	I--Boston	617-565-1331
Thomas Hatchfield		617-565-1254
Sedric Goutier		617-565-1228
Jerry Kerr	II--New York	212-264-3760
	III--Philadelphia	
Catherine McCoy		215-861-4250
Maria Kuehn		215-861-4306
Juanita Dixon	IV--Atlanta	404-562-7313
Geraldine Taylor		404-562-7311
	V--Chicago	
Janice Edwards		312-886-3256
Barry Thomas	VI--Dallas	214-767-6455
Doug Rundle	VII--Kansas City	816-426-5783
Cindy Christensen	VIII--Denver	303-844-7095
Rosie Sagum	IX--San Francisco	415-744-3655
Tom Bosserman		415-744-4907
Jean Tsutakawa	X--Seattle	206-615-2382
Jonella Windell		206-615-2385

Note: If the caller is simply contacting Medicare for the first time in order to report workers' compensation coverage (as opposed to seeking out RO approval of a proposed Medicare set-aside arrangement), then the caller should contact the Coordination of Benefits Contractor at 1-800-999-1118.

STATES IN EACH REGION

Region	Office	States
I.	BOSTON	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
II.	NEW YORK	New Jersey New York Puerto Rico Virgin Islands
III.	PHILA.	Delaware Dist. Of Columbia Maryland Pennsylvania Virginia West Virginia
IV.	ATLANTA	Alabama North Carolina South Carolina Florida Georgia Kentucky Mississippi Tennessee
V.	CHICAGO	Illinois Indiana Michigan Minnesota Ohio Wisconsin
VI.	DALLAS	Arkansas Louisiana New Mexico Oklahoma Texas
VII	KANSAS CITY	Iowa Kansas Missouri Nebraska
VIII	DENVER	Colorado Montana North Dakota South Dakota Wyoming
XI.	SAN FRAN	American Samoa Arizona California Guam Hawaii Nevada
X.	SEATTLE	Alaska Idaho Oregon Washington Utah