The Medicare Secondary Payer Statute: Medicare's Recovery Rights in Relation to Liability and No-Fault Insurance

by Robert G. Trusiak

The Medicare program is administered by the Centers for Medicare and Medicaid Services ("CMS"), a component of the United States Department of Health and Human Services. Medicare claims on behalf of beneficiaries who have received medical items or services are reviewed and paid by CMS contractors, traditionally known as Part A "fiscal intermediaries" and Part B "carriers." However, Medicare Secondary Payer (MSP) claims for reimbursement of conditional payments made by the Medicare program, as discussed here, are handled by a single national contractor known as the Medicare Secondary Payer Recovery Contractor ("MSPRC").

The MSP Statute

Congress created the MSP statute, section 1862(b) of the Social Security Act, to stem the skyrocketing costs of the Medicare program. These provisions require that certain "primary plans," as relevant here, liability insurance (including self insurance) and no-fault insurance plans, be the primary payer for items and services furnished to Medicare beneficiaries, leaving the Medicare program to provide benefits only as a "secondary" payer. Currently, the liability and no-fault insurance MSP provisions operate to save in excess of $6 billion per year.

The MSP provisions employ two mechanisms to protect Medicare funds and to ensure that Medicare is the secondary payer. First, these provisions prohibit Medicare from making payments for medical items and services that are otherwise reimbursable by Medicare if payment has already been made or can reasonably be expected to be made by another source that has primary payer responsibility. Second, these provisions authorize Medicare, as an accommodation to minimize beneficiary concerns over continuity of care issues that might arise from delays in the payment of medical bills, to make payments if a primary plan has not made or cannot reasonably be expected to make payment promptly. However, any such payments are conditioned upon reimbursement to the Medicare Trust Funds.

The MSP statute and implementing regulations make it explicitly clear that a primary plan, entities that make payment on behalf of a primary plan, and an entity that receives payment from a primary payer, shall reimburse Medicare for any payment made with respect to an item or service if it is demonstrated that such primary payer has or had a responsibility to make payment with respect to such item or service. Responsibility to make such a payment can be demonstrated by the existence of a judgment or a payment conditioned on a recipient's compromise or release (whether or not there is a determination or admission of liability) with respect to what is claimed or released for the claim against the primary plan. Further, Medicare is to be reimbursed within 60 days of payment by the primary plan or interest may be imposed. Moreover, if a primary plan learns that Medicare has made a payment for services for which the primary payer should have made the primary payment, it must give notice to and repay Medicare.

In the event that the Medicare program is not reimbursed for its conditional payments made on behalf of its beneficiary, the MSP statute and regulations set forth numerous avenues of recovery available to the United States. First, the Medicare program may recover its conditional payments "by direct collection or by offset against any monies [it] owes the entity responsible for refunding the conditional payment." Second, the United States "may bring an action against any or all entities that are or were required or responsible ... to make payment with respect to the same item or service ... under a primary plan." Significantly, under this provision, the United States may actually sue the primary payer for double damages. Additionally, the regulations require that in such circumstances, a "beneficiary must cooperate in the

action." Third, the United States may bring a direct action against "any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity," including "a beneficiary, provider, supplier, physician, attorney, state agency or private insurer." Congress also provided that "[t]he United States shall be subrogated ... to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan."

Medicare Right to Reimbursement Superior to any Lien

Private attorneys regularly refer to Medicare's interest as a "lien." However, the U.S. District Court for the Northern District of California in *Zinman v. Shalala* noted that, "The MSP statute does not state that Medicare has a lien ... Medicare's right is superior to a lien." The statute creates a statutory claim for reimbursement which may be pursued by a direct action or through the right of subrogation. Significantly, the courts have recognized that the United States' right of reimbursement "is paramount to any other claim."

Statute of Limitations is Six Years to Pursue MSP Recovery Action

The proper statute of limitations applicable in cases involving liability insurance (including self-insurance) or no fault insurance with primary payer responsibility is six years. The courts have held that this limitations period is applicable to MSP claims through the application of 28 U.S.C. § 2415(a), which states that actions for money damages brought by the United States are barred unless filed within six years after the right of action accrues. In liability and no-fault cases, the right of action accrues from the later of the date of payment or the date that Medicare learns of the payment.

Medicare May Share Costs of Tort Action

Under Medicare's regulations, Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement if procurement costs are incurred because the claim is disputed and those costs are borne by the party against which CMS seeks to recover. This provision is based on the recognition that the beneficiary may have incurred certain fees and costs and obtaining his or her recovery. However, when CMS recovers directly from an insurer, there is no such pro rata reduction.

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MSP Statute Requires Reimbursement of Conditional Medicare Payments

The Medicare program certainly possesses the legal authority to bring a direct action against any primary plan responsible to make payment as a primary payer under the MSP statute. However, it is far more consistent with the intent of Congress, to work together cooperatively to maximize MSP collections. Such cooperation fosters the laudable national goal of sustaining the long term fiscal viability of the Medicare program and avoids overburdening the federal court system with expensive and unnecessary litigation.

On occasion, a personal injury attorney suggests that beneficiaries should attempt to avoid the obligations set forth in the MSP statute by filing an artfully worded complaint that seeks to exclude a claim for medical damages from its four corners. However, most releases issued in the context of personal injury settlements tend to be very broad in scope, releasing all causes of actions, sums of money, damages, claims, and demands of any kind, in law or equity, that a plaintiff ever had and further declare that the settlement constitutes payment for all damages and injuries arising from the incident. Medicare reads such a release as including damages for medical expenses and, if not reimbursed for its conditional payments, could seek double damages from the primary plan or could look to the beneficiary or the beneficiary's attorney as an entity that received payment from the settlement, judgment, or award for repayment of the Medicare conditional payment amount, if appropriate. Thus, in settling a personal injury claim, a primary payer would assume the risk that it indeed was not settling any claim for medical damages.

No Ethical Concern with Satisfying MSP Claim from Tort Settlement

A personal injury attorney representing a client who is a Medicare beneficiary does not by virtue of that fact enter into a fiduciary relationship with the Medicare program. Medicare is not the attorney's client. Rather, the attorney is representing a client who has a legal obligation to ensure that Medicare is reimbursed for conditional payments that are the subject of a recovery against the tortfeasor.

In Conclusion

The United States, on behalf of the Medicare program, appreciates the opportunity to address issues of

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interest and concern regarding the operation of the MSP statute and the proper procedures to follow in complying with the statute. At the outset of a case involving representation of a Medicare beneficiary in a personal injury/malpractice action, the attorney should immediately contact CMS' Coordination of Benefits Contractor (the "COBC") to initiate the opening of an MSP potential recovery case. The COBC can be reached at 1-800-999-1118 or by mail at: MEDICARE-COB, MSP Claims Investigation Project, P.O. Box 33847, Detroit, Michigan 48232. The COBC will need the Medicare beneficiary's full name, sex, date of birth, Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN), date of incident, and a description of the incident. The COBC updates CMS' Common Working File, which then transmits information to a system used by CMS' MSPRC to establish a potential recovery case.

After information on claims paid by Medicare starting with the date of incident has been collected and reviewed to determine if the claims are related to what is being claimed or released by the beneficiary, the MSPRC sends interim conditional payment amount information to www.mymedicare.gov where the beneficiary may access and print this information or authorize his/her representative to use the beneficiary's PIN number to do so. Once there is a settlement, judgment, or award, the MSPRC must be notified in writing of the date of the settlement, the amount of the settlement, and any attorney fees or other procurement costs borne by the beneficiary and associated with the settlement, judgment, or award. The MSPRC searches for additional Medicare reimbursed claims and updates the conditional payment amount, as appropriate.

The MSPRC then uses the settlement, judgment or award information, including fees/costs borne by the beneficiary, as appropriate, to calculate the recovery claim amount and issue a recovery demand letter. The recovery demand letter includes information on the beneficiary's administrative appeal rights under 42 U.S.C. § 1395ff if there is a disagreement concerning the amount or existence of the recovery claim as well as information on the right to request a waiver of recovery under 42 U.S.C. § 1395gg if the beneficiary believes he/she meets the criteria for such a waiver of recovery. Ultimately, no legal action to contest Medicare's reimbursement of conditional payments can be filed in federal court until all applicable administrative remedies have been exhausted. If the attorney believes that the client's case warrants a compromise under the criteria set forth in 42 C.F.R. § 405.376, he or she can request that the appropriate CMS Regional Office compromise Medicare's recovery claim.

From Medicare's perspective, a cooperative approach involving the Medicare beneficiary, his or her attorney, and the primary plan/payer limits the necessity of time-consuming, expensive federal court litigation, limits the primary payer's risk of paying double damages and preserves judicial resourees. Such an approach constitutes good public policy by effectuating Congress' intent to keep the Medicare program financially viable for present and future beneficiaries who depend upon this vital program. [B]

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Trusiak: State courts not an out on MSP

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Editor's note: *Assistant U.S. Attorney Robert Trusiak submitted the following as an open letter to the Western New York bar. We are running his letter in its entirety, as submitted.*

The position of the United States concerning the statutory, regulatory and judicial basis for reimbursement of a conditional payment upon the negotiated resolution of a tort claim involving a Medicare beneficiary was set forth in plenary detail in the July 27, 2009 edition of the Buffalo Law Journal. The purpose of this article is not to set forth yet another detailed iteration of the authority for the self-intuitive concept the federal taxpayer, in the words of the statute, "shall be" reimbursed for medical expenses upon a tort settlement involving a Medicare beneficiary. The purpose of this article is to set forth the consequences associated with the failure to secure through the federal administrative process an allocation of the conditional payment amount owed under the Medicare Secondary Payor (MSP) absent an adjudicated result in state court. The following discussion summarily sets forth fundamental MSP principles, the roles of the state and federal parties in adjudicating the MSP interest, the consequences associated with subversion of the MSP process, and the continued desire of the United States to work in partnership with the bar to secure MSP compliance.

MSP basics

Congress created the MSP statute, section 1862(b) of the Social Security Act, to stem the skyrocketing costs of the Medicare program. These provisions require that certain "primary plans," as relevant here, liability insurance (including self insurance) and no-fault insurance plans, be the primary payer for items and services furnished to Medicare beneficiaries, leaving the Medicare program to provide benefits only as a "secondary" payer. Currently, the liability and no-fault insurance MSP provisions operate to save the Medicare Trust Funds approximately $500 million in known savings per year with overall MSP savings in excess of $6 billion per year.

The MSP provisions employ two mechanisms to protect Medicare funds and to ensure that Medicare is the secondary payer. First, these provisions prohibit Medicare from making payments for medical items and services that are otherwise reimbursable by Medicare if payment has already been made or can reasonably be expected to be made by another source that has primary payer responsibility. Second, these provisions authorize Medicare, as an accommodation to minimize beneficiary concerns over continuity of care issues that might arise from delays in the payment of medical bills, to make payments if a primary plan has not made or cannot reasonably be expected to make payment promptly. However, any such payments are conditioned upon reimbursement to the Medicare Trust Fund.

The MSP statute and implementing regulations make it explicitly clear that a primary plan, entities that make payment on behalf of a primary plan, and an entity that receives

payment from a primary payer, shall reimburse Medicare for any payment made with respect to an item or service if it is demonstrated that such primary payer has or had a responsibility to make payment with respect to such item or service. Responsibility to make such a payment can be demonstrated in a number of ways, including the existence of a judgment or a payment conditioned on a recipient's compromise or release (whether or not there is a determination or admission of liability) with respect to what is claimed or released for the claim against the primary plan. Further, Medicare is to be reimbursed within 60 days from the date of notice to the primary plan and interest may be imposed if the payment is not made within that time frame. Moreover, if a primary plan learns that Medicare has made a payment for services for which the primary payer should have made the primary payment, it must provide notice to Medicare, about primary payment responsibility and information about the underlying MSP situation. On December 29, 2007, President Bush signed the "Medicare, Medicaid, and SCHIP Extension Act of 2007." The Act's reporting requirement requires electronic reporting of settlements involving Medicare beneficiaries. The Act provides transparency to the United States of tort settlements involving Medicare beneficiaries and an outstanding MSP interest. MSP compliance, therefore, may be verified and appropriate action taken against culpable parties due to the absence of MSP compliance. The electronic reporting requirement of the Act is unrelated to the underlying substantive obligation to reimburse Medicare for the conditional payment.

In the event the Medicare program is not reimbursed for its conditional payments made on behalf of its beneficiary, the MSP statute and regulations set forth numerous avenues of recovery available to the United States. First, the Medicare program may recover its conditional payments "by direct collection or by offset against any monies [it] owes the entity responsible for refunding the conditional payment." Second, the United States "may bring an action against any or all entities that are or were required or responsible ... to make payment with respect to the same item or service ... under a primary plan." This right is characterized as a "direct right of action." Significantly, under this provision, the United States may actually sue the primary payer for double damages. Additionally, the regulations require that in such circumstances, a "beneficiary must cooperate in the action." Third, the United States may bring a direct action against "any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." The Medicare regulations provide that CMS has a right of action to recover its payments from any entity that has received a primary payment and explicitly define the term "entity" as including "a beneficiary, provider, supplier, physician, attorney, State agency or private insurer." In addition to these direct rights of action, Congress also provided the United States with a separate subrogation right. "The United States shall be subrogated ... to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan."

Please be mindful of the double payment" provisions of 42 C.F.R. §411.24(i). In the case of a liability (including self-insurance) or no-fault settlement, judgment, or award, if a primary payer makes its payment to the beneficiary and Medicare is not reimbursed, or if it makes payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment, the primary payer must nonetheless reimburse Medicare.

Medicare has established a website to expedite the processing of MSP claims. Please reference http://msprc.info/index.cfm?content=includes/toolkits/attorney_nghp. The website contains model letters, links and contact information for the practitioner, primary plan, self-insured and all relevant entities for the MSP repayment obligation.

Pay now or pay more later

The Upstate New York tort bar has generally worked in partnership with the United States to effect MSP compliance. The United States Attorney's Office is grateful for the general response of the tort bar to MSP compliance. There are continued MSP compliance concerns based on three incorrect presumptions: first, the incorrect presumption a prayer for only pain and suffering in the complaint and/or a similarly narrow release avoids the mandatory statutory obligation to repay Medicare; second, the incorrect presumption a state court possesses authority to adjudicate Medicare's interest despite the state court's absence of subject-matter jurisdiction over the Medicare claim and personal jurisdiction over the United States; and third, the incorrect presumption concerning the perceived obligation of CMS to appear in a state court proceeding to defend its interests despite the distinctly federal nature of the process which requires the parties to affirmatively contact CMS and secure an administrative adjudication rather than require the federal government to waive sovereign immunity in derogation of the distinctly federal scheme and appear in state court. The cessation of conduct based on these incorrect presumptions will promote compliance with the law, repay the federal taxpayer for the conditional Medicare payment, and avoid the significant financial consequences visited on the practitioner, primary plan, or others that fail to reimburse CMS for the conditional MSP payment.

A careful review of the MSP statute, case law and implementing regulations demonstrates the repayment obligation is mandatory and unrelated to any perceived pleading or release limitation to pain and suffering. The MSP law since 1980 has required repayment of the conditional payment upon the tort settlement: " [a] primary plan, and an entity that receives payment from a primary plan shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service...." 42 U.S.C. §1395y(b)(2). The statute proceeds to plainly demonstrate through its simple language the reimbursement obligation is based on payment, settlement, judgment or other award. Id. The Court in United States v. Baxter Int'l, Inc., 345 F.3d 866, 899 n.27 (11th Cir. 2003), stated that "[c]ourts have uniformly concluded that a settlement agreement that includes a non-itemized element of compensation for a plaintiff's medical care is 'for' medical expenses, even if the exact share or amount is indeterminate." See also Mathis v. Leavitt, 554 F.3d 731, 733 (8th Cir. 2009)(Medicare is entitled to reimbursement so long as "the settlement, which settled all claims brought, necessarily resolved the claims for medical expenses"). The MSP manual (CMS Pub. 100-05, Chapter 7, §50.4.4) partly states as follows: "The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case." The manual also states that "...regardless of how amounts may be designated in a ... settlement, e.g. loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed ... from the proceeds of the ... settlement." Chapter 7, Section 50.1 (CMS Pub.100-5).

Stated otherwise, the conditional reimbursement obligation exists without regard to the limited nature of the complaint or settlement release.

The CMS manual position concerning the mandatory reimbursement obligation for the conditional payment without regard to characterization of the settlement absent a merits-based adjudication is entitled to Chevron deference. Chevron deference holds that an "[a] gency interpretation is reasonable and controlling unless it is 'arbitrary, capricious, or manifestly contrary to the statute.'" Dawson v. Scott, 50 F.3d 884, 887 (11th Cir. 1995) quoting Chevron USA, Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984). The view by a personal injury practitioner that a pleading or release limitation avoids the repayment obligation is an argument subordinate to the agency view absent capriciousness. Stated otherwise, these excuses do not stand on equal footing to the CMS manual position which requires repayment without regard to a pleading or settlement limitation due to Chevron deference.

The Court in Bradley v. Leavitt, 2009 WL 2216580 (M.D.Fla. 2009) adopted the conclusion of law concerning the reasonableness of the Secretary's interpretation that a non-adjudicated apportionment of settlement money was irrelevant to the obligation to reimburse CMS for the conditional payment. The Court stated "[t]he MSP provides Medicare with an independent right of reimbursement for conditional medical expense payment from any and all entities who receive such payments. 42 U.S.C. § 1395y(b)(2)(B)(iii). The undersigned recommends that the Court find that the Secretary's interpretation of the MSP, as set forth in the Medicare Secondary Payer Manual (CMS Pub. 100-05), Chapter 7, § 50.4.4, providing Medicare will recognize allocations of liability payments for nonmedical damages only where there is a court order on the merits of the case is reasonable and consistent with the statute and Congressional intent for the MSP program. Without a court order on the merits of the case, after a full adversarial proceeding, Medicare would be 'at the mercy of a victim's or personal injury attorney's estimate of damages.' Zinman, 67 F.3d at 846. Any other conclusion would subvert Medicare's statutory right of reimbursement, independent of its subrogation rights, and thwart the Congressional intent for the MSP program."(emphasis added)(footnotes omitted). Id.

The merit of the suggestion that Merrifield v. United States, 2008 WL 906263 (D.N.J. 2008), supports the notion that a pleading limitation defines the reimbursement obligation is belied by a more careful analysis of the case. The initial footnote by the Merrifield Court dispels any reasonable argument the Court holding permits evasion of the MSP repayment obligation based on a pleading limitation to pain and suffering. The Court stated "[t]he only issue presently before the Court is whether it has jurisdiction to hear plaintiff's statutory and constitutional claims regarding the MSP actions taken in this case. The Court need not, at this stage, analyze whether CMS properly sought recovery from Plaintiffs under this statute." Merrifield, 2008 WL 906263 at n.1. The value of the Merrifield case to the practitioner is its complete recitation of the administrative adjudication process to appeal an MSP decision or seek an equitable waiver.

Deterrence and punishment

The initiation of affirmative litigation by the United States generally contains two

litigation goals: deterrence and punishment. The commencement of suit for the failure to secure an administrative adjudication from CMS concerning the existence and/or amount of the repayment obligation shares these two important litigation goals. It may be necessary for the United States to pursue its double damage remedy in federal court to vindicate these litigation goals of deterring MSP misconduct by others and punishing MSP violations for the continued recklessness in failing to pursue an administrative adjudication. It is important to recognize any federal double damages suit will address the panoply of MSP misconduct by the practitioner rather than address only a single case. To that end, the United States Attorney's Office will compel the following documentation from tort counsel who either fail to seek waiver or compromise through the administrative process created by Congress or improvidently use the state court to allocate the MSP interest through New York State Civil Practice Law and Rules §5003-a or otherwise: any and all documentation concerning any and all personal injury settlements involving Medicare beneficiaries for settlements executed from January 1, 2000 to present. The federal government will initiate the MSP quantification process with the Medicare Coordination of Benefits Contractor (COBC) for all MSP claims implicated in the document production. If there is not payment of the MSP value upon the conclusion of the administrative process for all of the relevant claims settled from January 1, 2000 to present, then the United States will give every consideration to commencement of a double damage suit against the plaintiff, plaintiff's counsel and/or the liability insurer.

The role of the state court

The adjudication of MSP matters is a distinctly federal process. The existence of the MSP value, the amount of the MSP value, and the compromise or waiver of the MSP interest are federal questions determined by CMS, a federal agency. The MSP appeals process involves a federal administrative process with an appeal to federal district court upon exhaustion of administrative remedies. 42 U.S.C. §1395ff(b)(1)(A). See also 42 C.F.R. §§ 405.940, 405.960, 405.1000 and 405.1100. There is no subject-matter jurisdiction for a state court to adjudicate an MSP interest. There is also no personal jurisdiction of a state court over the United States due to the bar of sovereign immunity absent an entry of appearance. A state court possesses no jurisdiction to allocate the MSP interest. See, e.g., Warren v. Secretary of Health and Human Services, 868 F.2d 1444, 1446-47 (5th Cir.1989), (The Secretary "is under no constitutional compulsion to give full faith and credit to the Judgment [of a state probate court], nor is [the Secretary] bound by the Judgment under principles of res judicata since he was not a party to the probate court proceeding.").

The absence of jurisdiction by a state court over MSP, however, does not mean the state court does not enjoy an important role in the adjudication of MSP matters. A state court can promote the timely adjudication of the MSP interest by ensuring through scheduling orders or discovery the litigants contact the COBC upon the commencement of suit to initiate the MSP process. The early and continued involvement of the state court in this way promotes MSP compliance and ensures the MSP issue does not result in congestion of state court dockets.

The role of the liability insurer or self insured

The United States Attorney's Office recognizes through its experience with the tort bar on MSP that certain counsel seek to unnecessarily and improvidently invoke state court involvement in MSP matters. For example, some plaintiff's counsel have invoked New York State Civil Practice Law and Rules §5003-a, which requires payment of settlement proceeds within 21 days of the delivery of the release documents, to secure a state court judgment entry that purports to require payment and dissolve the MSP interest-- despite defense counsel's express stipulation to satisfy the MSP amount as part of the settlement and notwithstanding the absence of state court jurisdiction over the MSP interest. The Court in Liss v. Brigham Park Cooperative Apartments Sec. No. 3, Inc., 694 N.Y.S. 2d 742 (1999), reversed a Supreme Court judgment that granted plaintiff's §5003-a motion for disbursement. The Court stated "the general release and stipulation of settlement sent by the plaintiff to the defendants were defective as they did not provide for release of the plaintiff's Medicare lien. Since the Federal government has a right of subrogation and may collect the amount of the lien directly from the defendant (see 42 CFR 411.24), it was incumbent upon the plaintiff to provide for the release of the lien in the general release and stipulation of settlement." Liss, 694 N.Y.S. 2d at 742-743. See also White v. New York City Housing Authority, 842 N.Y.S. 2d 685, 686-687 (2007)("CPLR §5003-a (e) provides that 'in the event that a settling defendant fails to pay all sums as required by subdivisions (a), (b), and (c), any unpaid plaintiff may enter judgment, without further notice, against such settling defendant who has not paid.' However, where there is a lien with a right of subrogation to collect the amount of the lien directly from the defendant, the general release and stipulation of settlement must provide for release of said lien or the release is defective."). The preceding state decisions recognize the incorrect utilization of §5003-a to effect payment of a settlement amount with an outstanding MSP value.

The exercise of state court action requiring payment of the settlement amount is neither a legal defense nor excuse to a double damages suit by the federal government against the liability insurer. The above referenced subpoena will include documentation that also identifies the liability insurer. The notification by the insurer to this Office of plaintiff's counsel acting in the above-described manner and seeking a state court judgment despite the reservation to satisfy the MSP value, and notwithstanding the absence of state court jurisdiction over the MSP interest, will be a factor utilized by the United States in assessing culpable parties for any double damages suit. So too, the act of notifying this Office of those practitioners that fail to seek adjudication of the MSP interest through the federal administrative process also will be a factor in assessing culpable parties for any double damages suit. This Office wants to be notified of those practitioners subverting the administrative process by improvidently seeking state court action that includes allocation of the MSP interest or practitioners that fail to pursue the required federal administrative process. The notification to this Office by the liability insurer of the offending practitioner will be a factor in determining the inclusion or exclusion of the insurance company from any ensuing double damages litigation.

The role of CMS

The distinctly federal process for adjudication and allocation of the MSP interest, coupled with the absence of state court jurisdiction over an MSP claim, demonstrates two

principles clear beyond cavil. First, CMS does not waive sovereign immunity by routinely appearing in state court personal injury cases involving Medicare beneficiaries. Second, the affirmative obligation to adjudicate the MSP interest lies with the Medicare beneficiary or practitioner. CMS, not a state court, is the singular entity that possesses the authority to make the initial determination as to the existence and/or amount of the MSP interest. The Medicare beneficiary or practitioner possesses the affirmative obligation to adjudicate the MSP interest through the federal administrative process established by Congress. There is no authority that entitles the practitioner to a privately held belief that a pleading limitation, a narrow release or a perceived ethical concern relieves the Medicare beneficiary of the obligation to seek an administrative adjudication concerning the statutory obligation to reimburse Medicare for the conditional payment. CMS may choose to waive or compromise the MSP value based on legal or equitable considerations. CMS, however, must be given that opportunity to decide through the commencement and completion of the administrative process. The role of CMS, therefore, is to adjudicate through the administrative process the existence and/or amount of the MSP value, and further, to adjudicate any appeals concerning the existence or amount of the MSP value.

The role of the U.S. Attorney's Office for the Western District Of New York

The United States Attorney's Office for the Western District of New York defers to CMS on MSP waiver and compromise as such decisions are solely within the province of the administrative agency. The Department of Justice involvement is based on punishing through a double damage suit either the avoidance of the administrative process or the failure to comply with the CMS payment demand after exhaustion of the administrative process. It is essential for the practitioner to appreciate the uniquely administrative nature of the process to adjudicate the MSP claim as outlined above. The administrative process means that no amount of correspondence by the tort bar to CMS or this Office concerning the invitation to appear in a state personal injury case, or the claimed absence of an MSP interest asserted in the absence of an administrative adjudication, will estop the federal government from pursuing its remedies. Estoppel has never been found to lie against the United States.

The role of plaintiff's counsel

There is no regulatory, statutory or judicial support for the notion a tort practitioner representing a Medicare beneficiary may unilaterally determine without resort to the federal administrative process the absence of a conditional repayment obligation and forego administrative adjudication of the claimed defense, waiver or excuse. The role of plaintiff's counsel regarding the MSP interest is twofold: first, commence the COBC process upon initiation of the tort matter to promote timely adjudication of the MSP interest and avoid docket congestion due to dilatory notification to CMS; and second, pursue legal defenses and/or equitable claims for waiver concerning the conditional repayment obligation within the federal administrative process established by Congress for adjudication of the MSP interest; or not, and the United States will avail itself of its remedies without further notice.

And now the bad news

The double damages exposure pursuant to the MSP statute as set forth in the preceding discussion constitutes a constrained litigation approach compared to the primary law used by the United States since 1863 to civilly redress fraud in federal programs: the False Claims Act, 31 U.S.C. §3729 et seq. The False Claims Act (FCA) provides for treble damages and a mandatory penalty of $5,000 to $10,000 per false claim. Id. The aggregate value of FCA settlements since the 1986 amendments to the Act totals approximately $23 billion dollars. If the casual reader is unfamiliar with the power of the FCA as a fraud enforcement tool, then one recent resolution involving the pharmaceutical company Pfizer sufficiently demonstrates its power to redress fraud. The United States recently resolved allegations of civil and criminal wrongdoing against Pfizer. The total value of the resolution was $2.3 billion based, in large part, on the FCA.

FCA liability is partly based on the concealment or avoidance of an obligation to pay the federal government. The FCA at 31 U.S.C. §3729(a)(1)(G) partly defines a false claim as follows: "any person who .... knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 ... plus three times the amount of damages which the Government sustains because of the act of that person."

The use of the FCA to redress MSP misconduct is obvious: the knowing avoidance by the practitioner of the obligation to repay CMS for its conditional payment constitutes a false claim. The broad scienter element under the FCA provides no defense. The FCA defines knowledge to include reckless disregard or deliberate ignorance. 31 U.S.C. §3729(b). The FCA expressly excludes "specific intent" to defraud as an element in the scienter analysis. Id. The breadth of the FCA identification of culpable persons is as expansive as the breadth of actionable mens rea. The FCA partly defines culpable persons as those who avoid or cause the avoidance of the obligation to pay money to the Government. 31 U.S.C. §3729(a). Again, the use of the FCA to redress MSP misconduct is obvious: a liability insurer that recklessly facilitates the avoidance of the MSP obligation by plaintiff's counsel may also bear FCA liability.

The characterization of FCA exposure as significant in MSP litigation involving any amount of historical conduct is an understatement. A doctor, hospital, skilled nursing facility, therapist or durable medical equipment (DME) provider submit Medicare claims for reimbursement through a claim form; either a UB 92 for institutional providers or a HCFA 1500 claim form for individual providers. Each claim form - UB 92 or HCFA 1500 - constitutes a claim within the meaning of the FCA. See 31 U.S.C. §3729(b)(2). See also, United States v. Krizek, 111 F.3d 934, 940 (D.C. Cir. 1997). If the government similarly advocated in an MSP case, then each provider claim submission for medical treatment of the beneficiary/plaintiff could constitute a false claim subject to the mandatory penalty of $5,000 to $10,000 per false claim, in addition to treble damages. For example, assume the Medicare beneficiary treated for one year after the tort event and such treatment involved hospitals, doctors, DME and therapists for a total of 50 claim submissions. Please also assume the total value of the MSP conditional payment is only $10,000. The total FCA exposure could be $500,000 in penalties (50 x $10,000) and $30,000 in treble damages ($10,000 x 3) for total FCA exposure of $530,000 for one

case. If the liability insurer facilitated the avoidance of the MSP obligation through deliberate ignorance of the plaintiff's conditional repayment obligation, then it would be jointly liable for such damages for one case.

The FCA also contains a whistleblower provision. See 31 U.S.C. §3730(b). A whistleblower files the FCA lawsuit under seal and participates in any monetary recovery. See §§31 U.S.C. 3730 (b)-(d). The conduct of counsel in advocating MSP avoidance on a website, blog or other forum may serve to only invite an FCA action by a whistleblower who reasonably construes such avoidance advocacy as reckless disregard of the MSP repayment obligation actionable under 31 U.S.C. §3729(a)(1)(G).

Please understand the preceding FCA discussion is intended to only make the tort community aware that any MSP liability analysis by this Office will be plenary and involves an assessment of several laws. The singular intent of the United States through the above analysis is to increase the awareness of the parties to the tort settlement of the benefits and consequences associated with MSP compliance or its absence. The specific action undertaken by the United States for any continued MSP misconduct will be based on a complete and deliberative assessment of the evidence for each case or cases.

Conclusion

The United States Attorney's Office looks forward to continued partnership with the tort bar as we collectively seek to timely and cooperatively advance MSP compliance. This Office prefers to coordinate with the bar in an educational manner that seeks to advance MSP compliance. This Office remains willing to meet with the bar or state judiciary to promote timely adjudication of the MSP interest consistent with regulatory, statutory and judicial authority. Mr. Trusiak is an Assistant United States Attorney for the Western District of New York. Mr. Trusiak is neither a spokesperson for CMS nor the Department of Justice.

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http://www.lawjournalbuffalo.com/news/article/current/2010/03/25/102185/trusiak-state-courts-not-an-out-on-msp

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The U.S. Attorney's Office for the Western District of New York Releases MSP Protocol for Liability Cases

Workers' Compensation Law Center Blog
May 10, 2011 Tuesday 12:26 PM EST

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Byline: mpopolizio@nqbp.com (Mark Popolizio)

Body

May 10, 2011 (LexisNexis delivered by Newstex) --

Protocol Establishes "Application for MSP Compromise" Regarding Liability MSA Proposals

On May 6, 2011, the United States Attorney's Office for the Western District of New York released a one page document entitled Western District of New York **Medicare Secondary Payor** Protocol (WDNY MSP Protocol) regarding the issue of future medicals in relation to liability settlements (excluding mass torts).

A copy of this document can be obtained here, Western District of New York **Medicare Secondary Payor** Protocol.

The WDNY MSP Protocol establishes a voluntary "Application for MSP Compromise" process through which the U.S. Attorney's Office (WDNY) will review certain Liability Medicare Set-Aside (L-MSA) proposals.

The Application for MSP Compromise is available regarding liability settlements (excluding mass torts) where the plaintiff is a Medicare beneficiary and "the value of the agreed settlement" equals or exceeds $350,000. In addition, the parties must satisfy several other prerequisites and requirements, including the submission of a statement warranting that they had previously requested approval of the proposed L-MSA from the Centers for Medicare and Medicaid Services (CMS) but had not received a "substantive response" from the agency "for at least 60 days from the date of the letter to CMS." As part of this process, the U.S. Attorney's Office will issue a "Release" as more specifically referenced in the protocol document.

The WDNY MSP Protocol is described as "a voluntary process and not the policy of CMS." The released statement further indicates that the protocol "confers no substantive rights and may be used or withdrawn at the unilateral discretion of the United States Attorney's Office of the Western District of New York."

The WDNY MSP Protocol document does not contain a jurisdictional statement or any other information regarding exactly which cases the U.S. Attorney's Office (WDNY) considers (or may consider) as falling within its jurisdiction in regard to the WDNY MSP Protocol.

The specifics of the Application for MSP Compromise process as contained in the WDNY MSP Protocol can be outlined as follows:

WDNY MSP Protocol

Application for MSP Compromise

Prerequisite Filing Requirements -

Before the parties can submit an Application for MSP Compromise, they must undertake certain prerequisite measures stated in the WDNY MSP Protocol as follows:

Prior to any application filed with the U.S. Attorney's Office for the Western District of New York (WDNY), Medicare must have been notified of the pending liability claim, the settlement of same and the letter from the **Medicare Secondary Payor** Regional Contractor (MSPRC) that the conditional payment obligation concerning repayment for historical medical items and services related to the tort was resolved or provide adequate assurance to that effect.

It remains unknown at this time exactly how the U.S. Attorney's Office (WDNY) intends to interpret and apply the prerequisite factors regarding the conditional payment aspect of the claim as referenced in the above statement.

Information Required to be Submitted -

The Application for MSP Compromise must be made "jointly by the Medicare beneficiary, or his representative, and the primary plan."

In terms of documentary evidence, the following items must be included as part of the parties' Application for MSP Compromise:

1. A copy of the MSPRC letter stating the matter concerning repayment for historical medical items and services related to the tort was reviewed and resolved or provide adequate assurance to that effect.

2. Proposed Liability Medicare Set-aside Arrangement concerning payment for the future medical items and services related to the tort (LMSA).[Fn1]

3. An agreed copy of the settlement agreement subject to completion of the MSP obligations.

4. A joint statement from the applicants that warrants the following:

a. The value of the agreed settlement equals or exceeds $350,000.00.

b. The plaintiff is a Medicare beneficiary as that term is defined under 42 C.F.R. §400.202.[Fn2]

c. The Centers for Medicare and Medicaid Services (CMS) was requested to approve the LMSA, but no substantive response has been received for at least 60 days from the date of the letter to CMS; and

d. An affidavit from the preparer of the LMSA that it is true and correct based on the Medicare beneficiary's medical records and the injuries being released as well as in conformance with the WCMSA submission checklist as published by CMS. See Sample Submission/Checklist for a Workers' Compensation Medicare Set-aside Arrangement ("WCMSA") Proposal.

Upon submission of the above information, the WDNY MSP Protocol states as follows:

Subsequent to the application by the U.S. Attorney's Office for the WDNY, the U.S. Attorney may request additional information from the parties, including, but not limited to, a request for an additional LMSA(s), and upon receipt of all required information, issue a Release. The release issued by the U.S. Attorney's Office for the WDNY will compromise the LMSA obligations related to the settlement, judgment, award or other payment.

The nature, scope and extent of the "Release" to be issued by the U.S. Attorney's Office (WDNY) are unknown at this time.

U.S Attorney's Office (WDNY) Contact Information

The statement directs any requests for information or questions regarding the WDNY MSP protocol to: **Robert G. Trusiak**, Esquire (716) 843-5847, **Robert.G.Trusiak**@usdoj.gov or Jessica Rogers, Esquire (716) 843-5700, Ext. 634, Jessica.Rogers2@usdoj.gov.

For More Information...

For more information regarding NuQuest/Bridge Pointe's MSP compliance products, including our WC-MSA, L-MSA and Non-Threshold MSA services, please contact us at info@nqbp.com, or via phone at 866-858-7161, option 2.

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1. In the WDNY MSP Protocol statement, this sentence includes a footnote defining the term "Set-Aside Arrangement" as follows:

Set-Aside Arrangement - An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set-aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).

2. 42 C.F.R. § 400.202 (Title: Definitions Specific to Medicare) states that "[e]ntitled means that an individual meets all the requirements for Medicare benefits."

Mark Popolizio, J.D. is the Vice President of Customer Relations for NuQuest/Bridge Pointe. Mark also served as Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) from 2006-2008 and remains active with NAMSAP concentrating on educational and legislative matters.

Prior to joining NuQuest, Mark practiced workers' compensation and liability legal defense for 10 years. During this time, he developed a national Medicare practice which included Medicare Set-Asides and Medicare Compliance. Mark is very active on the national MSA/Medicare educational and training circuit. He is a regularly featured speaker on MSA/Medicare issues before carriers/TPAs, state bar associations and industry specific organizations.

Mark has also published several articles on MSA/ Medicare issues. Mark can be reached at 786-457-4393 or via e-mail at mpopolizio@nqbp.com.

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Western District of New York
Medicare Secondary Payor Protocol

Application for Medicare Secondary Payor (MSP) compromise with regard to Medicare concerning future medical treatment must be made jointly by the Medicare beneficiary, or his representative, and the primary plan. Prior to any application filed with the U.S. Attorney's office for the Western District of New York (WDNY), Medicare must have been notified of the pending liability claim, the settlement of same and the letter from the Medicare Secondary Payor Regional Contractor (MSPRC) that the conditional payment obligation concerning repayment for historical medical items and services related to the tort was resolved or provide adequate assurance to that effect.

The application for MSP compromise concerning payment for the future medical items and services related to the tort shall include:

1. A copy of the MSPRC letter stating the matter concerning repayment for historical medical items and services related to the tort was reviewed and resolved or provide adequate assurance to that effect.
2. Proposed Liability Medicare Set-aside Arrangement concerning payment for the future medical items and services related to the tort (LMSA)[1].
3. An agreed copy of the settlement agreement subject to completion of the MSP obligations.
4. A joint statement from the applicants that warrants the following:
    a. The value of the agreed settlement equals or exceeds $350,000.00.
    b. The plaintiff is a Medicare beneficiary as that term is defined under 42 C.F.R. §400.202.
    c. The Centers for Medicare and Medicaid Services (CMS) was requested to approve the LMSA, but no substantive response has been received for at least 60 days from the date of the letter to CMS; and
    d. An affidavit from the preparer of the LMSA that it is true and correct based on the Medicare beneficiary's medical records and the injuries being released as well as in conformance with the WCMSA submission checklist as published by CMS. See https://www.cms.gov/WorkersCompAgencyServices/Downloads/samplesubmission.pdf.

Subsequent to the application by the U.S. Attorney's Office for the WDNY, the U.S. Attorney may request additional information from the parties, including, but not limited to, a request for an additional LMSA(s), and upon receipt of all required information, issue a Release. The release issued by the U.S. Attorney's Office for the WDNY will compromise the LMSA obligations related to the settlement, judgment, award or other payment.

Exclusions: The WDNY MSP Protocol is not available for liability cases involving mass torts. This protocol confers no substantive rights and may be used or withdrawn at the unilateral discretion of the United States Attorney's Office of the Western District of New York. This is a voluntary process and not policy of the CMS.

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[1] *Set-Aside Arrangement – An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set-aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).*

For more information or questions regarding the Western District of New York, Medicare Secondary Payor Protocol, please contact:

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Digitally signed by Assistant U.S. Attorney Robert G. Trusiak, WDNY
Date: 2011.05.06 15:58:57 -04'00'