SPECIAL NEEDS TRUSTS
Medicare Liens

presented by:

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Nothing in this paper is to be construed as the rendering of legal advice for specific cases, and readers are responsible for obtaining such advice from their own legal counsel. This publication is intended for educational and informational purposes only.

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I .WHEN TO WORRY ABOUT A SUBROGATION CLAIM.

In most cases the attorney experienced in dealing with public benefits will be brought into a case by a personal injury attorney that is on the verge of settling a case for a client that the PI attorney knows or suspects has been receiving some type of government assistance but is not sure what program provided the benefits and what possible rights of subrogation the government may possess. In these cases the PI attorney is seeking assistance in dealing with these subrogation issues. Upon being contacted by the PI attorney's office, the safest course of action is to not seek to find out from the parties what benefits they have been receiving, as many times they are not sure, but to assume the client received benefits from both Medicare and Medicaid and request confirmation from the governmental entities directly. You should only rely upon the programs to tell you what benefits, if any, the person may have received. In every case the rule is, to assume that we have received benefits and get a written statement from the program telling you the amount of their claim, if any. [1]

II. DEALING WITH MEDICARE'S SUBROGATION CLAIM

Medicare Secondary Payer Statute

" \l 2 The enabling legislation for the Medicare program prohibits Medicare from paying for services to the extent that payment has been made or reasonably can be expected to be made from worker's compensation, liability or no-fault insurance, or employer group health plans. Title 42 Chapter 7 Subchapter XVIII § 1395y(b), 42 CFR 411.20, 42 CFR 411.50 ©). The statute is commonly referred to as the Medicare Secondary Payer Statute (MSP). If payment is made by Medicare because a bill was submitted to Medicare and the existence of the alternate insurer was not know at the time the bill was submitted, the payment is called a Medicare Conditional Payment.[2] Medicare is entitled to seek repayment of the amount paid, less a proportionate share

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[1] Randal Kauffman, The War of the Cockatrice, 60 Texas Bar Journal No.4 p. 311 April 1997.

[2] Medicare Explained 1996, CCH, March 1996 at p. 131. Title 42 Chapter 7 Subchapter XVIII § 1395y(b) (A).

of procurement cost even if the case is settled and the defendant does not admit to any liability. [3] If the claimant receives any payment from the defendant, then Medicare is entitled to repayment. [4] Medicare has both a subrogation claim [5] as well as statutorily created cause of action to collect directly against the "entity" that is required to pay for any such medical care.[6]

[3] 42 C.F.R. §411.37.

[4] Medicare Explained 1996, CCH, March 1996 at p.at 134.

[5] Title 42 Chapter 7 Subchapter XVIII § 1395y(b)(B) (iii).

[6] *Id. at* § 1395y(b)(B)(ii).

Medicare is only entitled to recover from payments made for medical services. There is no right of recovery for any monies received by the claimant for any damages other than medical bills. If the case is settled without an adjudication by a court or jury, Medicare will disregard any apportionment in the settlement that allocates the monies between pain and suffering or future medical and seek recovery of the full amount of the conditional payment less the procurement costs.[7] It is not possible to escape Medicare recovery by characterizing the settlement as recovery for other than medical bills in the settlement documents.[8]

A. **Attorney Responsibility For Payment Of Medicare Claim**

In a recent publication The Medicare Handbook (2002) from the Center for Medicare Advocacy at page 9-13 the position is taken that an attorney in a personal injury case has no duty to protect Medicare's property interest in a client's personal injury award. The authors note that Medicare takes the position that personal injury attorneys have a statutory obligation to "affirmatively assist Medicare" in recovering conditional payments. In fact, the authors make the case that an attorney is obligated to give the client the proceeds from the settlement if the client so chooses and the Medicare Secondary Payor (MSP) statutes and regulations impose no penalty on the attorney for doing so. (9-14.)

The Medicare Handbook (2002) at page 9-13 and 14 authors explain their position based on a careful reading of the statute and subsequent federal district court rulings. Basically the position is that CMS has wrongfully claimed that the MSP statute gives Medicare claims the status of liens. Second, the case is made that CMS incorrectly asserts that certain punitive powers that exist to punish insurance companies for noncompliance with the MSP claims extend to attorneys as well. The following is the author's attempt to explain the position but this entire section is based on the idea set forth by the authors of aforementioned Handbook.

To evaluate the position taken in the Handbook the statute itself must be carefully viewed. But the premise of the position is not subject to dispute. In a nationwide class action suit *Zinman v. Shalala* [9] the district court ordered Medicare to stop using the term "lien" to describe its reimbursement claim in its collection efforts. The lack of lien status means that an attorney does not owe Medicare any duty to protect its right of recovery. The argument is bolstered by the following facts. The regulations impose a duty on the beneficiary to cooperate with Medicare and if the CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.[10] The regulations impose a duty on 3rd party payers to notify Medicare when a payment is made or should have been made by the 3rd party and the 3rd party learns that Medicare has made a payment. The notice must describe the specific situation

[7] *Medicare Intermediary Manual §* 3418.7.

[8] Kauffman, *supra*, at 311.

[9] 835 F. Supp. 1163, 1171 (N.D. Cal. 1993), aff'd, 67 F.3rd 841 (9th Cir. 1995).

[10] 42 C.F.R. § 411.23.

and the circumstances including the particular type of insurance coverage and, if appropriate, the time period during which the insurer is primary to Medicare.[11] Further evidence is found in the attempt by CMS to promulgate a regulation that would have imposed a duty on the beneficiary *or his representative* to notify Medicare if an insurance claim was pending but the regulation was never finalized.[12] Since an attorney has no duty to contact or notify or cooperate with CMS it would be difficult to understand how any duty to protect CMS's claim position would supercede the duty that an attorney owes to his or her client. Based on their position the Handbook offers the following advice at page 9-13:

> ....if the client chooses to receive his portion of the insurance proceeds from his attorney and deal with Medicare directly, the MSP statute and regulations impose no penalty on the attorney. Under ethical rules of practice, the attorney should advise his client of MSP recovery program, but the client should then be allowed to decide whether she wants her attorney to pay Medicare directly or disburse the proceeds so that she can handle the MSP claim herself. The client should be advised of the possibility of collection action or termination of future benefits if the MSP recovery claim is not paid. She should also be advised of the possibility of qualifying for a waiver of MSP recovery pursuant to the provisions described above if she received the proceeds from her attorney and used them for necessary items.

The Handbook continues its rationale for its position with an examination and comparison of the specific language of several sections of the regulations dealing with this matter. The regulations impose a duty to reimburse Medicare on the beneficiary or *other party* within 60 days of receiving a third party payment.[13] Other party is described as including physicians and attorneys.[14] Therefore, if the attorney is in possession of liability proceeds then CMS has a right of recovery against the attorney to obtain those proceeds. This section most likely refers to a doctor or hospital that has already been paid by Medicare for a claim and later receives a payment from a third party medical insurance plan. It is difficult to envision a situation where an attorney would receive proceeds from a third party payer and take possession of the monies directly. The only time a attorney is likely to hold such proceeds is in a trust account for the benefit of a client.

Evidence for the position set forth in the Handbook is offered in the statutes and regulations that give Medicare the right to recover against an insurer that has already paid a claim and the ability to collect only the proceeds in the hands of an attorney. The federal statute authorizing a private cause of action against a primary plan empowers Medicare to recover an amount double the

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[11] 42 C.F.R. § 411.25.

[12] 63 Fed. Reg. 14,506 (March 25, 1998).

[13] 42 C.F.R. § 411.24(h).

[14] *Id. at* § 411.25(g) .

amount they are otherwise allowed to collect.[15] A primary plan is defined as a group health plan or large group health plan, a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance. [16] The regulations authorize CMS to recover its payment amount from a "third party payer" even if the payer has already reimbursed the beneficiary or other party.[17] However, as set forth above the regulations only require that an entity reimburse Medicare for any third party payment the entity receives. [18] The same section that requires an entity to reimburse Medicare is subject to the provision in the regulations that reduces Medicare's claim to the amount of the total judgement or settlement minus the party's total procurement costs.[19] This means that even if Medicare seeks to recover the third party payment from an attorney they will still allow the deduction of attorney fees if the claim is disputed. In the past CMS has advanced the position that they could recover the amount of their claim plus additional amounts from a entity such as an attorney. Currently, the Medicare website (see below) warns attorneys of "responsibilities and obligations" they have to report under the MSP that appear to be lacking in the statute and regulations. The website further cautions that Medicare must be paid prior to any disbursements of funds to a client. CMS tells its contractors in the Medicare Intermediary Manual (MIM) at §3418.6 (B)(1) to notify the beneficiary and his or her attorney of his or her responsibility to notify Medicare of both his or her intent to file a claim and of the settlement amount, if a settlement is awarded.

In summary, the position set forth in the Handbook is that because the statues and regulations empower CMS to collect amounts in excess of the conditional payments from third party payers (insurance companies) and does not allow such punitive recoveries from other entities (attorneys) that if an attorney has received a recovery (such as in a trust account) and then disbursed the proceeds to a client minus allowable procurement fees (attorney fees) then the attorney would have no further obligation to Medicare. .

III. PROCEDURE FOR PAYING A CLAIM

B. Contacting Medicare

Once you realize that Medicare may have a claim then the problem becomes how do we find out how much they are claiming we owe and can we negotiate the amount. Because of some fairly recent changes in how Medicare handles the reimbursement process the act of just finding out how much you owe has become complicated.

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[15] Title 42 Chapter 7 Subchapter XVIII § 1395y(b)(3) (A).

[16] Title 42 Chapter 7 Subchapter XVIII § 1395y(b)(2 (A)(ii)

[17] 42 C.F.R. § 411.24(i).

[18] 42 C.F.R. § 411.24(h).

[19] 42 C.F.R. § 411.37

The Centers for Medicare & Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA) has a new initiative to centralize the collection of data for dealing with Medicare Secondary Payment (MSP) issues. The initiative is called Medicare Coordination of Benefits (COB)

The Medicare website at http://cms.hhs.gov/medicare/cob/factsheets/fs_attorneys_msplaws.asp explains the COB program as:

> The purposes of the Medicare Coordination of Benefits (COB) program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor (COBC) collects, manages, and reports other insurance coverage. The COBC must be notified of situations where medical services rendered to a beneficiary are related to a workers' compensation injury, automobile accident, or other liability because in these instances, another payer has the primary responsibility for payment of medical claims related to the injury. **Both you and your client have significant responsibilities and obligations under the Medicare Secondary Payer (MSP) laws to report these situations**, and your participation is vital in ensuring the integrity of the Medicare Trust Funds. (emphasis added)

On this same website Medicare makes the assertion:

> Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party. If Medicare is not repaid in a timely manner, interest may be assessed.

The idea behind COB is to simplify the process for attorneys. The attorney will call a toll-free number and the COB office will direct the attorney to the lead contractor on the case. You are required to give the lead contractor the “adequate lead time” to gather the information but “adequate lead time” is not defined. The lead contractor will gather all of the information for the claim but the contractor will not be able to compromise or waive the claim.

If you are starting a new auto/no-fault, liability, or workers' compensation case or have a general liability question, you can contact the COB office by phone or mail. They have customer service representatives available to provide you with service from 8:00 a.m. to 8:00 p.m., Eastern Standard Time, Monday through Friday. The toll free number is 1-800-999-1118 and the mailing address for written inquiries is: Medicare-COB, MSP Claims Investigation Project, P.O. Box 5041, New York, New York 10274-5041.

When contacting the COB contractor, you should have the following information:

Your client's name
Your client's Medicare Health Insurance Claim Number (HICN) or Social Security number (SSN)

Date of accident/incident
Description of illness/injury
Name and address of the other insurance (e.g., workers' compensation carrier, auto/no-fault insurance carrier, etc.)
Name and address of legal representative

Upon receipt of this information, the COBC will apply it to your client's Medicare record, assign the case to a Medicare contractor, and inform you and your client of the applicability of the MSP program and Medicare's recovery rights. You will receive a notice advising you of the Medicare contractor assigned to handle the specifics of the case to recovery (i.e., the lead contractor), Medicare's right of recovery, and a beneficiary consent to release form. Once this process is complete, all further inquiries are made through the lead contractor.

The COB contractor (COBC) has another duty as well. Providers of services to Medicare beneficiaries are required to gather information on the specifics of a claim for which they are seeking payment from Medicare. One of the questions that providers are required to ask of a beneficiary is:

> Is the patient receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

If a claim from a provider contains a Trauma/injury diagnosis code it will alert the COBC that an accident or traumatic injury may have occurred and the possibility of an MSP situation warrants development. This process is known as Trauma Code Development (TCD). If information is missing from the claim the COBC will initiate an MSP investigation. This process is intended to alert Medicare to a potential third party liability situation.

As a practical matter although you should go through the process with the COB if you know who your lead contractor is copy them with the letter to COB and it will jump start the claim. Otherwise there will be a needless delay while you deal with the COB that you can eliminate if you have the correct lead contractor.

In Texas, the lead contractor is is Trailblazer Health Enterprises. In years past Trailblazer was behind the requirements set by CMS for handling and responding to claims. Currently they are suppose to be in compliance with CMS guidelines by addressing 7200 separate pieces of correspondence within a 45 day timeframe. The letter should be mailed to:

Trailblazer Health Enterprises
Liability Unit
Box 9020 Denison, Texas 75021
Fax 903-463-0642
Voice: 903-463-0641

The letter must include the following information or it will be returned and further delay

your case: [20]

1. The name of the Medicare Beneficiary (the Plaintiff)
2. The beneficiary's HIC number (usually their Social Security Number and can be found on the beneficiary's red, white and blue Medicare Health Insurance Card)
3. Date of the accident or onset of illness involved
4. A description of the accident or illness causing the claim
5. A description of the injuries or medical problems
6. A medical authorization signed by the beneficiary giving Medicare permission to release medical information

Once this letter is received by the lead contractor, a "Notice of Medicare's Potential Recovery" will be sent to the requesting party. In most cases Medicare will take at least 2 months to determine the conditional payment amount. Usually, the PI attorney will be in a hurry to settle the case and get the funds from the defendant. Any action taken in reliance upon the amount that is owed to Medicare without waiting for an official reply from Medicare is apt to be fraught with problems. Medicare will then send a "Notice of Conditional Payment" that will include a list of each claim Medicare has paid to date and a total amount of the conditional payment. The notice states that they will continue to check their records and will keep you informed of any updates. If the timeframe between receiving the Notice of Conditional Payment and payment of the funds is very long, it is important to request a revised conditional payment notice. [21] Until the check is paid to Medicare and a release is obtained, it is possible that the amount of the conditional payment will increase.

In the above discussion, mention was made of the amount of the conditional payment being reduced by the "procurement costs".[22] The procurement costs are attorney's fees and expenses incurred in pursing the case. The case must be such that the payments received by the claimant are disputed. Recovery made under PIP or no-fault insurance coverage will not be eligible for a reduction of the Medicare claim unless such payments are in dispute. [23] The calculations concerning how much reduction in the Medicare claim is possible can be very valuable in terms of knowledge for use in planning case strategy or settlement positions; however, the final result will not be known until the actual amount of the settlement is sent to Medicare. Only after receiving the numbers on the final settlement, will Medicare send an "Initial Determination Letter or Demand Letter" which will include their calculations of the

[20] Miller, *Handling Liability Cases Involving Medicare*, Elder Law Institute, State Bar of Texas 1996.

[21] *Id.* at B-2.

[22] *Medicare Intermediary Manual §* 3418.8.

[23] Miller at B-3.

reduction allowed for procurement costs. This letter will detail the claims paid by Medicare and the amount they will expect to be paid. Upon settlement of the case, the payment to Medicare should be made within 60 days. If payment is not made within 60 days after the receipt of the funds, then Medicare can charge interest on the amount they deem they are owed. [24] After receipt of payment, if requested Medicare will send a release. If a reason exists that you need to seek a waiver or compromise of the Medicare lien for an amount greater than the procurement costs, it will be impossible to settle the claim at this point with the Contractor. There are three statutory authorities under which Medicare may accept less than the full amount of its claim: Section 1870©) of the Social Security Act, §1862(b) of the Social Security Act, and the Federal Claims Collection Act (FCCA). Each statute contains different criteria upon which decisions to compromise, waive, suspend, or terminate Medicare's claim may be made. [25] Medicare contractors have authority to consider beneficiary requests for waivers under §1870©) of the Social Security Act. Authority to waive Medicare claims under §1862(b) and to compromise claims, or to suspend or terminate recovery action under FCCA, is reserved exclusively to CMS and/or Regional Office staffs.

The process of seeking a further waiver of the claim is a familiar one to those attorneys that have sought a waiver of overpayment in regular Social Security or Social Security Disability cases. [26]

After the amount of the claim has been determined, the settlement of all claims that do not exceed $100,000.00 must be handled by the regional CMS office. Claims in excess of $100,000.00 will be sent to the regional office but will be forwarded to the central office in Baltimore for compromise or waiver.

In order to speed up the process it is important to know the procedure the lead contractor will follow. The process has changed since October of 2002. Prior to October of 2002 the lead contractor had access to a list or summary of all of the claims paid on a specific Medicare beneficiary. The computer record was current up to 18 months after the date of the inquiry. If there was a question raised about the bills Medicare was trying to collect as part of the reimbursement claim and the questions were raised more than 18 months after the date of notice to Medicare then the lead contractor would have had to write each of the other contractors handling the claims for an update or summary and request that each individual contractor update the pending claims. The lead contractor is now responsible for handling the claim and is suppose to have a computer record of all of the claims filed by any contractor in the country.

Even though your clients healthcare was delivered in Texas that does not mean that all of the claims filed by providers for the care they received in Texas will be filed with the financial

[24] 42 C.F.R. § 411.24 (m) (2) (i).

[25] *Medicare Intermediary Manual §* 3418.13.

[26] Kaufffman, *supra*, at 313.

intermediary in Texas. The average case handled by a contractor will involve 2 to 3 different contractors.

IV. MEDICARE DOESN'T HAVE A CLAIM FOR REIMBURSEMENT

Subsequent to the original draft of this paper a case was decided by the 5th Circuit Court of Appeals that has the potential to negate everything set forth above. At the time this article is published the ultimate impact of the case is unknown. The government may appeal the case in which case the ability of CMS to collect on claims will be in limbo until a final ruling on the matter. Currently, because of the ruling in this case it is impossible to settle a claim with CMS. The parties that would normally discuss the settlement of a case have been instructed not to discuss any claim for reimbursement for fear that they will be in contempt of the order by the 5th Circuit Court.

The case is *Thompson v. Goetzman*, No. 02-10198, 315 F.3rd 457, December 17th 2002. The impact and breath of the ruling is being discussed and debated by attorneys throughout the United States at this time. You author will attempt to determine if a consensus exist on the impact of the case pending a final action by the government. The case appears to hold that Medicare does not have a claim for reimbursement against beneficiaries or attorneys that settle with a tortfeasor. Further discussion of the case will be made at the presentation of this paper.

***Medicare Intermediary Manual* § 3418.8**.

3418.8 Calculation of Medicare's Claim and Procurement Expenses (When Liability Insurer Paid Beneficiary).--

1. A. Allegation of Pre-existing Conditions.--In some cases, the amount of the overpayment is questioned on the grounds that services included in the calculation were for pre-existing conditions and should be omitted from the overpayment calculation.

When a beneficiary has filed suit for accident-related services, including services relating to exacerbation of an underlying condition as the basis for the complaint, the total amount of Medicare's payments should be used to calculate the amount of Medicare's recovery. The fact that the settlement or other documentation provides that all parties considered such services to be unrelated to the accident or injuries, does not justify omitting them from Medicare's recovery.

B. Calculating Medicare's Share of Procurement Costs.--42 CFR 411.37©) stipulates that Medicare will recognize a proportionate share of the necessary procurement costs incurred in obtaining the settlement. Procurement costs are those costs incurred in obtaining a judgment or settlement (e.g. court costs, attorney fees). If a beneficiary is paid by a liability insurer, recover Medicare's payment from the beneficiary, reduced by a proportionate share of the beneficiary's procurement costs, if any.

If, under the Prospective Payment System (PPS), Medicare pays a provider more than its charges, do not recover more than the charges from a beneficiary's liability settlement. (Under Medicare regulations, a beneficiary who must refund a Medicare payment made to a provider is liable only to the extent that he or she benefitted from the payment. Since the beneficiary would have had to pay only the provider's charges in the absence of Medicare, the beneficiary is not liable for refunding more than the charges.) The provider is not required to refund the excess of the Medicare payment rate over the provider's charges.

To determine procurement costs, ask the attorney to furnish (in writing) the costs, including attorney fees, incurred by the individual to procure the settlement/judgment. If these costs appear in excess of the prevailing costs in the area for similar claims, ask for an itemized statement of costs or copy of a contingency agreement, if applicable, or other appropriate documentation. If the procurement costs are documented, allow them. Should you need advice on what constitutes procurement costs in a particular case, consult your legal counsel or the RO. (Also, see definition of procurement costs in §3418.2.M.)
Use the following formula to determine the amount of Medicare's claim when there are procurement costs:

1. Determine the ratio which the procurement costs bear to the amount of the liability payment or settlement.

2. Apply this ratio to the Medicare payments; and

3. Subtract the amount determined from b) above from the lesser of the total conditional payments or the providers' charges. The remainder is the amount to be refunded to the Medicare program. (You may round this amount to the nearest dollar.)

Exhibit 1- Medicare Liability Settlement Claim Reimbursement Summary, provides a worksheet for use in calculating procurement costs, Medicare's share of procurement costs, and Medicare's claim to be recovered.

NOTE: If Medicare payments equal or exceed the amount of the liability insurance payment, recover the entire liability insurance payment up to the providers' charges, less total procurement costs.

***Medicare Intermediary Manual* § 3418.10**

C. Release Agreement Form.--Once the beneficiary agrees to pay Medicare the amount that Medicare will accept in satisfaction of its claim (full amount, or amount remaining after an appeal or waiver determination), it is your responsibility to obtain the appropriate signatures on a general release after the settlement. A general release as applied to Medicare is an agreement which waives Medicare's right to change the amount of money it is accepting in satisfaction of its claim, and precludes Medicare from later asserting a claim against any outstanding amount not included in the satisfaction, e.g., monies remaining in the case of a partial waiver (See Exhibit 7 - Release Agreement Form.) The beneficiary agrees to the amount in question and is released from further obligation to repay. Medicare has no obligation to pay for any services related to the injury furnished before the date of the settlement which were not brought to Medicare's attention in writing before the settlement was reached.

1. This form should be signed either a) when the beneficiary agrees to remit in full, or b) after final disposition of a waiver/appeal request. The RO is responsible for securing a release for claims compromised under FCCA.

1. **MEDICARE LIABILITY SETTLEMENT CLAIM REIMBURSEMENT SUMMARY**

Beneficiary: _____ HICN: _____

1. Amount of settlement $_____

2. Medicare payments
(contractor) $_____

(contractor) $_____

(contractor) $_____

3. Total Medicare payments $_____

4. Attorney fees (___% of line
1, if applicable) $_____

5. Other procurement costs incurred
(per attorney) $_____

6. Total procurement costs
(lines 4 + 5) $_____

7. Ratio of procurement costs to
settlement (line 6 / line 1) _____%

8. Medicare's share of procurement
costs (line 3 x 7) $_____

9. Total Providers' Charges $_____

10. Medicare's claim to be recovered
(the lesser of line 3 or line 9
minus line 8) $_____

PLEASE PREPARE THE CHECK EXACTLY AS SPECIFIED BELOW

NAME OF CONTRACTOR $ AMOUNT

If any questions arise, please call -- (Name and telephone number of appropriate contractor staff person.)

EXHIBIT 1

1. STANDARD RECOVERY/INITIAL DETERMINATION LETTER TO BENEFICIARY/ATTORNEY

Dear Mr./Ms. _____

This letter follows our (date of initial letter to beneficiary/attorney) letter in which we advised you that you would have to pay Medicare back if you received money from a third party due to your (date of accident) accident which caused medical expenses for which Medicare conditionally paid. We have now been advised that you have received such proceeds. This means that Medicare now has a claim against these proceeds in the amount of $_____, which represents Medicare's claim after reduction for procurement costs, in accordance with 42 CFR 411.37.

The Medicare Secondary payer provisions of the statute, 42 CFR 1395y(b)(2), preclude Medicare from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made promptly... under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance." However, Medicare will pay for a beneficiary's covered medical expenses when the third party payer does not pay promptly, conditioned on reimbursement to contract room proceeds received from a third party liability settlement, award, judgment or recovery. In your case, Medicare made a conditional payment in the amount of $_____. A list of the claims used to arrive at this total is enclosed.

Medicare's regulations require that you pay Medicare back within 60 days of your receipt of settlement or insurance proceeds. It is our understanding that 60 days have passed since you received the insurance proceeds. Therefore, please send a check or money order in the amount of $_____, made payable to (name of contactor) in the enclosed envelope.

Exercising common law authority and consistent with the Federal Claims Collection Act and 45 CFR 30.13, interest will be assessed if this debt is not repaid in full within 30 days of the date of this letter. Additionally, 45 CFR 30.14(a) provides that a debtor may either pay the debt, or be liable for interest on the uncorrectable debt while a waiver determination, appeal, or a formal or informal review of the debt is pending. Therefore, assessment of interest may not be suspended solely because further review may be requested. Interest will be assessed at the rate of _____. It should be noted, however, that you may repay the debt to avoid accruing charges, but retain your right to dispute, appeal, or request waiver of the debt. If you succeed in your appeal or waiver request, Medicare will refund your money.

If you do not repay this overpayment, Medicare has the authority to refer it to the Social Security Administration or Railroad Retirement Board for further recovery action, which may result in the overpayment being deducted from any monthly Social Security or Railroad Retirement benefits to which you may be entitled.

EXHIBIT 2

If you are unable to refund this amount in one payment, you may ask us to consider whether to allow you to pay in regular installments.

The law requires that you must repay an overpayment to Medicare unless both of the following conditions are met:

(1) This overpayment was not your fault, because the information you gave us with your claim was correct and complete as far as you knew, and, when the Medicare payment was made, you thought that it was the right payment for your claim,

AND

1. (2) Paying back this money would cause financial hardship **OR** would be unfair for some other reason.

If you believe that **BOTH** of the conditions above apply in your case, please let us know, giving a brief statement of your reasons. You will be sent a form asking for information about your income, assets, and expenses, and requesting that you explain why you believe you are entitled to waiver of the overpayment. We will notify you if recovery of this overpayment can be waived.

You may appeal our decision if: you disagree that you received an overpayment; or you disagree with the amount of overpayment; or you disagree with our decision not to waive your repayment of the overpayment.

For Part A services, you must appeal within 60 days from the date of your receipt of this determination. For Part B services, you must file an appeal within 6 months of the date of this determination. However, we recommend that you file appeals of Part A and Part B claims within 60 days of receiving this notice so that both appeals may be resolved efficiently. Appeals should be requested in writing to _____.

If you decide to appeal this determination further, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

If you have any questions about this letter, you may contact either this office or any Social Security office.

Sincerely,

ABC Contractor

Attachments: List of claims

Pre-ad

STANDARD LETTER GRANTING PARTIAL WAIVER

1. Re: Name of Beneficiary HIC #

Dear Beneficiary/Attorney:

We have completed our review of your/your client's request to waive monies owed to Medicare. It is our decision to partially waive Medicare's claim.

The authority to waive recovery of a Medicare overpayment is found in Section 1870©) of the Social Security Act (42 U.S.C. 1395gg©)). Under this provision, and the regulations found at 42 CFR 405.355-405.356, if a beneficiary is without fault in causing the overpayment and recovery would either defeat the purpose of the Social Security Act or Medicare program, or would be against equity and good conscience, recovery may be waived. In making these decisions, Medicare applies the rules found in Social Security regulations at 20 CFR 404.506-404.509, 404.510a, and 404.512.

In applying these rules, we found the following:

Enter reasons for partial deductions:

Example: This partial waiver is granted because it would be against equity and good conscience to recover the full amount of the claim. The settlement proceeds in this particular case were very small considering the injuries suffered; therefore, it would be against equity and good conscience for Medicare to take the entire settlement.

OR

Example: You have documented financial hardship and we have determined that it would defeat the purpose of the Social Security Act to request repayment of the entire claim. Therefore, we are granting a partial waiver in the amount of _____, and _____must be repaid to Medicare.

Medicare's conditional payment in this case was _____. You (your client) received a settlement of $_____. The procurement costs in this case, including attorney fees were $_____. After allowing $_____ as Medicare's share of procurement costs per 42 CFR 411.37, Medicare's net conditional claim was $_____.

However, in accordance with this determination, we are granting a partial waiver in the amount of _____. The total amount now due to Medicare is $(principle and interest). In accordance with this determination, a check in the amount of $_____, made payable to Medicare, should be sent to:

Medicare contractor
Address

Your/the beneficiary's name and health insurance claim number should be included on the check made payable to Medicare.

On (date that exhibit 2 was sent)_____, we notified you that interest would be assessed on any debt not repaid in full within 30 days of that date, regardless of whether you chose to appeal or to seek waiver of the debt. We advised you that repaying the debt would not affect your right to dispute, appeal, or request waiver of the debt. Because you did not repay the debt within 30 days of (the date that exhibit 2 was sent), you owe Medicare $_____, in interest charges.

1. Please sign the enclosed release agreement form within 10 days and return it to this office.

If you disagree with the decision not to grant a full waiver of recovery of this overpayment, you have 60 days from the date you receive this letter to request a reconsideration. The request can be submitted directly to the address above.

If you decide to exercise your appeal rights, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. There are groups, such as lawyer referral services and public interest advocacy groups, that can help you find a lawyer. There are also groups, such as legal aide services, who provide free legal services if you meet eligibility requirements. Should you/your client have any questions concerning this letter, please contact _____ on _____.

Medicare Contractor

Enclosure(s): Release Agreement Form
Pre-addressed envelope

RELEASE AGREEMENT FORM

1. (Name, title and name of contractor) , as a Medicare intermediary or carrier authorized to make the following statements and assurances on behalf of Medicare. The undersigned beneficiary, (name of beneficiary) , is the claimant in an action resulting from an accident which occurred on or about (Date of accident) .

Medicare has been advised of a (proposed) settlement in the above action in the amount of $_____. In accordance with Federal Regulations at 42 CFR 411.37, the amount of funds to be recovered by Medicare pursuant to Section 1862(b)(2) of the Social Security Act (42 U.S.C. 1395y(b)(2)) has been determined to be $_____. Medicare and the undersigned beneficiary have agreed that Medicare will accept $_____ in full satisfaction of its claim.

(Name, title and name of contractor) , on behalf of Medicare, does forever discharge (name of beneficiary) , his/her agents, successors, executors, administrators and assigns from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses, and compensation whatsoever, which Medicare now has or which may hereafter accrue related to the incident above.

(Name of beneficiary) does forever discharge Medicare, its agents, successors and assigns from any liability for payment for claims related to the incident above and does specifically waive any and all rights to appeal, waiver or [further] compromise of Medicare's interest in claims for items or services related to the incident above.

Medicare has no liability or obligation to pay for any services related to the injury that were furnished before the date of the settlement and that the beneficiary did not specifically identify to Medicare in writing before the release was executed.

Each of the undersigned has read the foregoing release and fully understands it and its terms.

Date: _____

_____ _____
(Witness) (Name & Title)
_____ Medicare
(Witness)

Date: _____

_____ _____
(Witness) (Name of Beneficiary)
_____ Beneficiary/Claimant
(Witness)

EXHIBIT 7

1. NOTICE TO BENEFICIARY OF MEDICARE'S POTENTIAL RECOVERY

Dear Beneficiary:

Our records indicate that the medical services you received on [date(s)] were the kind that are often the result of an accident or injury. If this is the case, Medicare recognizes that you might file a claim against the persons you believe should be financially responsible for your accident/injury. If you file such a liability claim, they may pay you a sum of money as a remedy for your injuries and associated costs. Also, your own automobile insurance or homeowner's policy, or other type of insurance, may pay for your medical expenses.

The purpose of this notice is to tell you that Medicare will pay for the medical expenses arising from this accident/injury only on the condition that you pay Medicare back out of any money that you receive from the person or insurance company that compensates you for your damages and losses, including your own insurance company.

This conditional payment that Medicare makes for your accident-related expenses and Medicare's right to reimbursement from your settlement proceeds is the law. It is known as the Medicare Secondary Payer provisions, and can be found at 42 U.S.C. 1395y(b)(2). The rules that govern how this statute operates can be found beginning at 42 CFR 411.20.

This notice is applicable to you only if you receive monies in the future OR have already received monies from a third party or insurance company, or your own insurance company, as a settlement or recovery of a claim you filed (or should have filed) for your injuries, damages, and losses arising from this accident/injury.

Please remember that you are required by law to pay us back as soon as you receive any monies as settlement or recovery of the claim. It is your obligation to let us know when you have settled your claim, no matter how long a time has passed between the original accident/injury and when you receive money.

It is important that you keep in mind the fact that you must pay Medicare back when you, your representative, or attorney negotiates and finally accepts a dollar amount in settlement. This reimbursement should be considered a cost that must be paid up front out of the settlement proceeds before any distribution occurs. Under no circumstances should you spend settlement proceeds which should be used to satisfy Medicare's claim.

If you have engaged an attorney to pursue your liability claim, or are planning to, the amount Medicare may recover will be reduced by a proportional share of attorney fees and/or other procurement costs. If you have a representative or attorney in this matter, give him or her a copy of this notice immediately. If applicable, please advise us of the name and address of your attorney, insurance companies involved, and a description of your injuries on the enclosed HCFA-L365 form, and return it to this office.

EXHIBIT 10

1. NOTICE TO ATTORNEY OF MEDICARE'S POTENTIAL RECOVERY

RE: Mary Smith, HIC# 000-00-0000A
Date of Injury: January 7, 1990

Dear Mr. Adams:

The above Medicare beneficiary has advised us that you have been retained to represent him/her in matters arising out of the above-referenced accident. Medicare acknowledges that you may file a claim and/or a civil action against a third party on [name of beneficiary]'s behalf, seeking damages for injuries he/she received and medical expenses he/she incurred as a result of the accident.

The purpose of this letter is to advise you of the applicability of the Medicare Secondary Payer Program in this circumstance. See 42 U.S.C. 1395y(b)(2). Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made . . . under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." However, Medicare may pay for a beneficiary's covered medical expenses conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement, award, judgment or recovery. This conditional payment gives Medicare the right to recover its payments when the beneficiary receives proceeds from a third party arising out of an accident which generated the medical expenses for which Medicare conditionally paid.

In these instances, Medicare's reimbursement is reduced by a pro rata share of procurement costs. It is in your, and your client's, best interests to keep Medicare's payment and the obligation to satisfy Medicare's claim in mind when negotiating and accepting a final dollar amount in settlement of the claim with the third party. Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days of receipt of proceeds from the third party. If Medicare is not repaid timely, interest may be assesses. You may not disburse proceeds up to the amount of Medicare's claim prior to satisfaction or alternative resolution of the matter.

We are coordinating with other Medicare claim offices to obtain a summary of conditional payments made to date. A Medicare contractor will contact you regarding the total amount that Medicare paid for the above-referenced accident-related medical expenses.

If a settlement has already been reached, please provide the following information:

1. An authorization from your client to permit us to release specific claims data to you. If you do not have a release on file, please have your client sign the enclosed release form and return it to our office.

2. A copy of the settlement agreement showing the settlement date and total amount of the award.

3. An itemized statement of attorney fees and procurement costs.

4. The name, address and telephone number of the automobile or liability insurer involved, and if available, the policy number, claim number, and adjustor's name.

Please acknowledge receipt of this letter in writing at your earliest convenience. Should you have any questions regarding this matter, please contact this office at (XXX) XXX-XXXX.

Sincerely,

MSP Coordinator
ABC Contractor

Enclosure: Release of Claims Data Form

EXHIBIT 12