# Rubber Meets the Road: *Future Medicals in Injury Cases*

Prepared by:
Aaron Frederickson
*MSP Compliance Solutions, LLC*

LORMAN®
Published on www.lorman.com - January 2020

INTRODUCING

Lorman's New Approach to Continuing Education

# ALL-ACCESS PASS

## The All-Access Pass grants you UNLIMITED access to Lorman's ever-growing library of training resources:

- ☑ **Unlimited Live Webinars** - 110+ live webinars added every month
- ☑ **Unlimited OnDemand and MP3 Downloads** - Over 3,800 courses available
- ☑ **Videos** - More than 1,900 available
- ☑ **Slide Decks** - More than 3,000 available
- ☑ **White Papers** - More than 1,900 available
- ☑ **Reports**
- ☑ **Articles**
- ☑ **... and much more!**

## Join the thousands of other pass-holders that have already trusted us for their professional development by choosing the All-Access Pass.

## Get Your All-Access Pass Today!

# SAVE 20%

Learn more: **www.lorman.com/pass/?s=special20**

Use Discount Code Q7014393 and Priority Code 18536 to receive the 20% AAP discount.

*Discount cannot be combined with any other discounts.

BY AARON FREDERICKSON

# Rubber Meets the Road: Future Medicals in Injury Cases

**If you represent plaintiffs with personal injury claims, make sure to evaluate each case for Medicare Secondary Payer considerations. Failure to do so could leave clients with large financial obligations to the government and you with potential malpractice exposure.**

The concept of "future medicals" continues to challenge lawyers, claim management professionals, and other interested stakeholders who concentrate their practices in personal injury cases. This problem creates friction as the Centers for Medicare and Medicaid Services (CMS) ramps up its recovery and enforcement efforts. This includes the rollout of a voluntary review process for non-worker's compensation Medicare set-aside arrangements.

All interested stakeholders can protect their clients and consider Medicare's interests by taking simple steps that include understanding the relevant legislation and evaluating cases early and often for Medicare considerations. Failure to do so will only result in a proverbial car-wreck of epic proportions. (See Sidebar, Brief History of Medicare.)

## Law versus Policy: Future Medicals under the Act

The lack of legislative history of the Medicare Secondary Payer (MSP) Act and of consistent enforcement have confused even the most experienced lawyers. The complex statutory framework, cumbersome regulations, and inconsistent CMS policy concerning the treatment of personal injury and worker's compensation claims have only compounded this problem.[1] Central to this issue is whether the law itself supports future medical considerations in all injury-related cases, or if CMS policy is contrary to both the letter and spirit of the MSP Act.

Some legal scholars and lawyers question whether an MSA should be a consideration as part of a non-worker's compensation personal injury settlement. This is partly because "set-asides" are a legal fiction and not designated specifically by name in the MSP Act or regulations. Proponents also assert that regulations interpreting Medicare's rights of future recovery only affect worker's compensation plans.[2] Unfortunately, misinformed individuals are making what might be costly mistakes as the CMS attempts to point interested stakeholders in the right direction via procedures designed to prompt better compliance practices.

## CMS Advances Future Medicals in All Injury Cases

Lawyers handling worker's compensation cases started to take note of the Act in the late 1990s. This gave rise to the use of Medicare set-aside arrangements, which are now commonly referred to as MSAs. It is unclear why the practice took hold, but the CMS eventually noticed it and issued the Patel memorandum on July 23, 2001.[3] Highlights of this policy memorandum include the following:

- The CMS can refuse to make payment in instances when a settlement shifts the future burden onto Medicare – thus Medicare becoming the primary payer.
- The use of an MSA allows Medicare to identify cases in which future medicals have been closed out, which prevents it from making mistaken payments.
- The MSP and supporting regulations do not mandate a specific mechanism to "adequately consider" Medicare's interests. A "set-aside" is the agency's preferred arrangement.

In the late 1990s and early 2000s, lawyers and other interested stakeholders resisted using MSAs in injury-related settlements, including worker's compensation claims. This was driven by not only ignorance of this highly unpublicized law, but also the lack of guidance by the CMS. Further confusing matters was vague policy. This bred contempt, resulting in resistance to the adoption of effective compliance practices industry-wide.

While the solvency of the Medicare Trust Fund and avoidance of future legal complications will benefit from compliance

SUMMARY

Before enactment of the Medicare Secondary Payer Act, there was no efficient mechanism to identify or evaluate situations in which Medicare's liability should be secondary to that of the "responsible" party, such as a personal injury claim defendant or an employer in a worker's compensation case. The Act has a complex statutory framework, cumbersome regulations, and inconsistent agency policy concerning how personal injury and worker's compensation claims are treated. These have made it difficult for lawyers to know whether they are adequately accounting for Medicare's interests when structuring payments for injured plaintiffs and workers.

This article highlights the continuing issues and encourages lawyers to educate themselves promptly in light of increased federal government enforcement regarding set-aside arrangements.

with the MSP Act in many worker's compensation claims, it has given rise to two persistent urban legal legends that permeate the compliance landscape in non-worker's compensation personal injury claims:

• The MSP Act applies to only worker's compensation cases; and

• An MSA is "required" only in worker's compensation cases, but not other personal-injury related cases.[4]

The origin of Medicare compliance myths remains unclear. What is certain is that they are the equivalent to a poorly marked traffic sign that only leads the unsuspecting down the proverbial legal dead end. For the lawyer, it is an avenue that leads to legal malpractice and ethical dilemmas. Now is the time to take notice and change direction.

## Debunking MSP Myths and False Legends

To determine the application of the MSP Act, one should turn to the opening sentences of the Act. In sum, the Act clearly states it applies evenly to all worker's compensation and personal injury claims.[5] It should also be noted that Medicare is specifically precluded from making payment when "payment has been made, or can reasonably be expected to be made, with respect to the item or service ..., or payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an *automobile* or *liability insurance policy or plan* (including a self-insured plan) or under *no fault insurance*."[6]

**Aaron Frederickson,** William Mitchell College of Law 2002, of MSP Compliance Solutions LLC, concentrates his practice in Medicare and Medicaid coordination-of-benefits compliance issues.

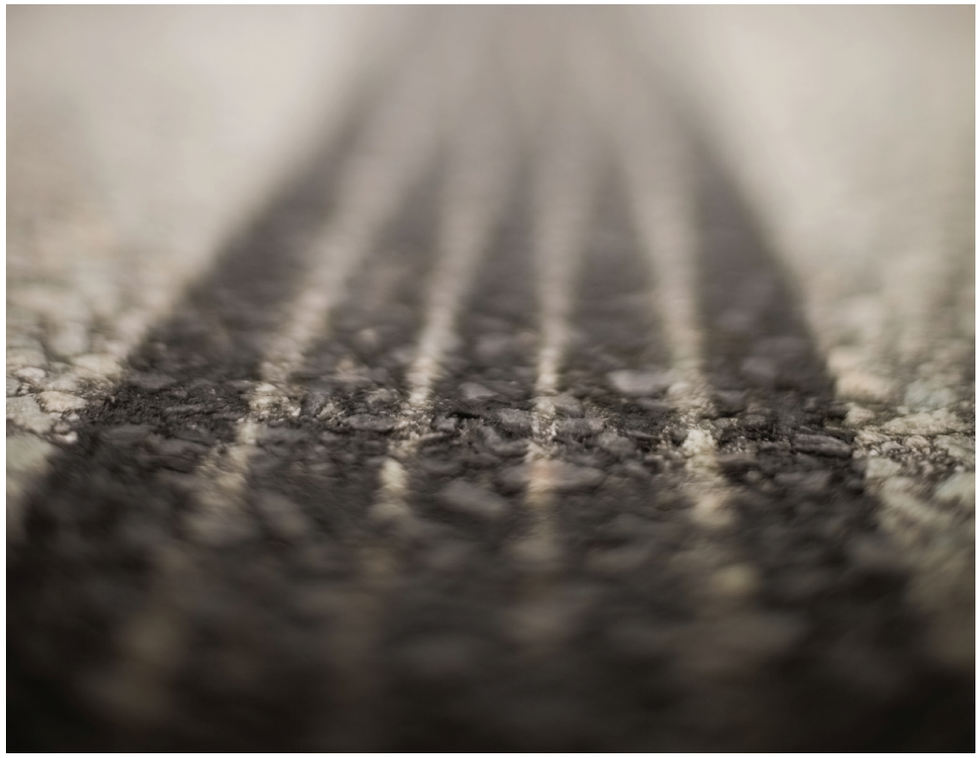
**aaron@mspComplianceSolutions.com**

Notwithstanding the statutory authority to enforce the Act, the CMS has been relatively quiet in terms of guidance or enforcement related to future medicals other than in worker's compensation cases. In May 2011, Sally Stalcup, with the CMS-Dallas Regional Office, issued a general memorandum regarding Medicare's interests in non-worker's compensation personal injury cases, otherwise known as liability Medicare set-aside arrangements (LMSAs).

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

Arguments asserting that Stalcup's position are not based in law, but policy, ignore the letter of the law. Again, those who assert otherwise must read the opening paragraphs of the MSP Act.[7] The statutory definition of "conditional payment" also supports the argument that this issue is not limited to payments by Medicare before settlement but also could apply to similar payments after settlement, judgment, award, or *other payment*.[8] In sum, the MSP is not merely a reimbursement statute, but also is a coordination-of-benefits law covering both past and future medicals.

The MSP Act applies to all injury-related cases. The absence of a voluntary review and approval process



**The CMS can refuse to make payment in instances when a settlement shifts the future burden onto Medicare – thus Medicare becoming the primary payer.**

of future medicals in non-worker's compensation injury cases does not give plaintiffs and their legal counsel a free pass when it comes to considering Medicare's interests. The same caution holds true for those representing the insurance carrier or self-insured interests.

## Warning: Danger Ahead – Use Caution

Recent pronouncements by the CMS have signaled caution to those skirting their responsibilities by avoiding effective MSP compliance efforts. Effective Oct. 1, 2017, Medicare administrative contractors (MACs) will deny payment for items or services that should be paid from an LMSA or a no-fault Medicare set-aside arrangement (NFSA).[9] This policy shift is similar to enforcement mechanisms in place for worker's compensation claims.

While on its face the memorandum is directed to physicians and suppliers, everyone who practices in personal injury or worker's compensation litigation, and other involved parties, should take note. Following the effective date, MACs have permission to pay for injury-related care and treatment *only* in instances when "benefits are exhausted/terminated" or when not related to the injury claim. This means plaintiffs in injury-related cases will be required to demonstrate the following criteria:

- The settlement agreement did not shift the burden onto Medicare for future injury-related medical care and treatment (for example, an MSA or some other tool to demonstrate consideration of Medicare's interests).[10]
- The amount set aside is reasonable.
- Those settlement funds designated for future Medicare-reimbursable care and treatment were properly exhausted.

Notice of these changes is unwelcome news for lawyers representing injured parties. Continued practices of overlooking future medical issues will likely render injured Medicare beneficiaries' ineligible for injury-related care and result in unpaid medical bills. These bills will then ultimately be the plaintiff's responsibility.

Lawyers representing parties in personal injury cases will now be at greater risk. This includes the increasing potential for legal malpractice claims by former and existing clients. There will also likely be an uptick in professional responsibility complaints made against lawyers representing persons in all personal injury claims who fail to take notice of this CMS notice.

Insurance defense lawyers and claims management professionals should also take greater care when settling injury cases involving claimants who have a reasonable expectation of Medicare entitlement or who are currently receiving benefits under Medicare and Medicare Advantage Plan programs. The bottom line is clear – this new CMS directive will affect all interested parties in personal injury cases. Enforcement is expanding beyond worker's compensation matters in Wisconsin and nationwide. (See Sidebar, Working with U.S. Attorneys on Medicare Claims.)

## Best Practices to Consider in Injury Cases

While review of future medicals in any personal injury (and worker's compensation) case is never a requirement, it is important for parties to consider and evaluate this issue as part of a final

## Brief History of Medicare

Although much has been written about the Medicare Secondary Payer (MSP) Act and its effect on worker's compensation and personal injury claims, many questions remain. Consider the following timeline:

**1965:** President Lyndon Johnson created the Medicare program as part of the "War on Poverty." Medicare was the primary payer for all beneficiaries – even if other forms of insurance were available, such as worker's compensation, no-fault/automobile, or liability.

**1980:** In an effort to contain costs and keep the Medicare Trust Fund solvent, President Jimmy Carter signed into law the MSP Act. Medicare was now a "secondary payer." In practice, Medicare would only pay for injury-related care if a worker's compensation, no-fault/automobile, or liability plan did not have responsibility to pay.

**2001:** The Centers for Medicare and Medicaid Services (CMS) started to issue a series of policy memoranda regarding a primary payer's responsibilities under the MSP Act. Interested stakeholders were once again warned that forcing Medicare to assume primary-payer status could result in adverse action. This included a direct cause of action against parties who benefit from an injury-related settlement or a claim in subrogation. Medicare beneficiaries could also lose entitlement if the CMS determined its interests were not taken into consideration.

**2018:** The CMS continues to struggle with enforcement of the MSP Act. This has resulted in confusion over effective compliance. Lawyers representing parties in injury-related cases, interested stakeholders in the insurance industry, Medicare beneficiaries, and courts continue to struggle with this complex issue.

Now is the time to understand the MSP Act and implement it in your law practice, before enforcement efforts are ramped up. Failure to comply with the MSP Act can result in the CMS taking adverse actions against Medicare beneficiaries and their lawyers. Others could be at risk as well. The result is many are spinning their wheels when it comes to effective compliance. **WL**

settlement. Lawyers can be better advocates for their clients by at least asking if such a review is "recommended" given the case-specific factors. There is the opportunity to take note of existing guidance from well-informed members of the bar and judiciary on how to adapt with a much-needed change in prevalent mindsets.[11] Based on the natural trajectory of future medicals in CMS policy and treatment by the courts, it is important to evaluate this issue in all personal injury cases.

Consideration of an LMSA in personal injury matters does not mean an LMSA is appropriate in every case. It is especially important to set client expectations at not only the beginning of each case, but throughout the life of the claim – including during settlement discussions and when drafting the settlement release. Cooperation and communication between the adverse parties can prevent problems before they arise and thus help diminish client anxiety.

Case law also emphasizes that issues concerning future medicals and necessary settlement-release language are an integral part of all discussions. These issues should always be material terms of the final settlement document.[12] Sloppy and imprecise drafting can result in protracted post-settlement legal wrangling. Parties should also avoid using boilerplate or form language when settling their claims. Consultation with an experienced lawyer who understands these issues is essential.[13]

## Working with U.S. Attorneys on Medicare Claims

Lawyers and members of the claims management team practicing in the area of Wisconsin worker's compensation law have held a number of advantages over their counterparts in other states when dealing with Medicare secondary payer compliance issues. This is based primarily on the involvement of the respective U.S. Attorney's Offices in the conditional-payment recovery and resolution process. Time will tell if this assistance will expand.

Under the current system, lawyers in the Wisconsin worker's compensation system can bypass the CMS recovery contractors. By contacting the appropriate U.S. Attorney's Office, interested stakeholders can communicate on conditional-payment matters. This includes receiving updates and resolving matters, which may involve compromise or waiver. The current process does not extend to future medicals and the voluntary review or approval of MSAs.

Based on the current process, it goes without saying lawyers who practice in worker's compensation matters would favor an expansion of the U.S. Attorneys' role. With anticipated changes in the CMS formalizing a review process for non-worker's compensation personal injury cases, significant pressure from various bar associations could lead to change in the process. Given the demands of litigation and anticipated delays the rollout of new policy changes will bring, plaintiffs' and defense attorneys should try to effectuate such modifications. **WL**

## Conclusion

Now is the time to become educated on the MSP Act. It is an essential process and challenge that all lawyers and interested stakeholders must think about to protect clients' interests and avoid an ethical complaint or malpractice action. Steer clear of danger by taking reasonable steps to comply, even within the context of non-worker's compensation injury cases where policy limits create issues. One way to accomplish these objectives is to understand how to implement effective best practices in your company or law firm when considering Medicare's interests and protecting your clients. **WL**

### ENDNOTES

[1]The Medicare Secondary Payer Act is complex and has been described in the courts as "the most completely impenetrable text within human experience." *Cooper Univ. Hosp. v. Sebelius*, 636 F.3d 44, 45 (3d Cir. 2010).

[2]*See* 42 C.F.R. §§ 411.20-.39.

[3]While this policy memorandum focused on worker's compensation matters, it is difficult to deny the CMS would have reached a similar legal conclusion had it also chosen this as an opportunity to address other injury-related cases. As of July 10, 2017, the CMS has cautioned interested parties from relying on previous guidance outside the *Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide*, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2_6.pdf.

[4]*Aranki v. Burwell*, 151 F. Supp. 3d 1038 (D. Ariz. 2015). This case presents the classic misuse of the word "required" when it applies to the MSP Act. Although the court reached the correct decision, the dicta from the case completely misstate the MSP Act and CMS policy.

[5]42 U.S.C. §1395y(b)(2)(A).

[6]*Id.* (emphasis added).

[7]*Id.*

[8]*See* 42 U.S.C. §1395y(b)(2)(B) (emphasis added).

[9]CMS MLN Matters Number: MM9893 (Feb. 17, 2017). Under this CMS guidance, MACs are instructed to deny claims when an MSA may be appropriate in liability and no-fault situations. Several technical revisions of the memorandum occurred since its original publication. Its contents are supported by MLN Matters Number: SE17018 - Billing in Medicare Secondary Payer (MSP) Liability Insurance Situations.

[10]*See* 42 C.F.R. § 411.46.

[11]*See Benoit v. Neustrom*, No. 10-CV-1110, 2013 WL 1702120 (E.D. La. April 17, 2013) (unpublished); *Alvarenga v. Scope Industries*, 2016 Cal. Wrk. Comp. P.D. LEXIS ___ (2016).

[12]*Paluch v. United Parcel Serv. Inc.*, 8 N.E.3d 506 (Ill. App. 2014); *see also Bruton v. Carnival Corp.*, No. 11-21697-CIV, 2012 WL 1627729 (S.D. Fla. May 2, 2012).

[13]*Iowa Supreme Court Atty. Disciplinary Bd. v. Silich*, 872 N.W.2d 181 (Iowa 2015).**WL**