PMLS

THE PLAINTIFF'S MSA & LIEN SOLUTION LLC
AVOID. REDUCE. SAVE.

DEACTIVATE THE MEDICARE LANDMINES

When you settle a case, do you deactivate ***ALL*** the Medicare landmines?

One of those *multiple* landmines is case-related, *future* Medicare-allowable medical costs.

When a case is settled, your client assumes that everything has been taken care of, including future Medicare.

Don't be that lawyer who gets a call from a distraught client whose medical bills were just denied by Medicare and doesn't have the money to pay them.

A legally and medically minimized MSA is the *best* way to protect you and your clients.

CORRECT — MSAs are **not** required by law, but that fact **completely** *misses* the point. Since 1980, Medicare is secondary, and when they discover that your client has a settlement, even years later, by **law** they are precluded from paying.

We Know The Secrets. We can help you **deactivate** the Medicare landmines.

Plaintiff's MSA & Lien Solution, LLC

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The Truth About MSAs…

How the Medicare Landmines Get Set, and What You Can Do About Them

By Jack L. Meligan, RSP, BCFE, MSCC, CMSP

The label of being ***"Medicare eligible"*** can lead to a lot of ***untruths*** about Medicare Set-Aside arrangements ("MSAs").

For example, defendants may claim that your client is required to create an MSA. ***Not true.***

Defendants may also claim that they can't settle your case until they have proof that Centers for Medicare and Medicaid Services (CMS) has approved your client's MSA. ***Also not true***.

Or, that you must obtain a CMS letter stating that an MSA is not required in your client's case. ***Not true and not even possible.***

If any of this sounds familiar, it's because defendants have been spreading these untruths about MSAs for years.

The Truth?

The truth is that CMS will *not* provide a letter stating that an MSA is not required in a specific case.

Further, CMS is *not* approving liability MSAs.

And finally, there is *no law* requiring an MSA arrangement or account in liability cases.

In fact, there is no law requiring MSAs in Workers Compensation cases either.

Hearing that, you may never even consider one. That, however, misses the larger point and could be a huge mistake, and here's why.

The law since the 1980s, specifically Section 1862(b)(2)(A) of the Social Security Act, requires that Medicare is a ***secondary payer*** behind all forms of insurance and insurance settlements.

This means that if your Medicare-eligible client's settlement includes compensation for future medical, and their future treatment costs could be shifted to Medicare, then that part of your client's settlement representing your client's future medical compensation should be used to pay those costs first.

Now, you may be wondering ***two*** things:

- **First**, how will Medicare find out that my client is Medicare-eligible?
- **Second**, how will Medicare find out about my Medicare-eligible client's settlement?

The answer is that Medicare has a few ways of discovering this information.

One of these is the reporting requirement outlined in Section 111 of the Medicare Secondary Payer law.

Since 2007, Section 111 of the Medicare law has created a reporting requirement for defendants and self-insureds (also known as "responsible reporting entities" or "RREs") which tasks them with determining whether your client is Medicare-eligible.

Medicare-eligible means *"has Medicare card in hand"* at time of settlement. If your client is determined to be Medicare-eligible, then the RREs are required to report your client's settlement to Medicare on the date of settlement. They are subject to a $1,000-per-day fine for being late, so they are not likely to forget to do this.

That report goes into your client's common working file ("CWF") and includes several important data points. Most critical are the date of settlement, the TOTAL amount of the settlement (also known as the "TPOC" or "Total Payment Obligation to Claimant") and the specific ICD-9 or 10 codes that identify body parts, injuries and conditions that are covered by your client's settlement.

From that report date forward, Medicare is supposed to compare bills received from your client's treating physicians with ICD-9 or 10 codes in the CWF, and DENY payment when they have a match.

So, this can all be avoided if your client is not Medicare-eligible at the time of settlement, right?

Wrong.

When your client is not Medicare-eligible at the time of settlement, but *later* becomes eligible due to applying for either Social Security Disability or retirement, Medicare can STILL discover your client's settlement through "self-reporting."

That's right. Clients with settlements who qualify for Medicare post-settlement can still be discovered by Medicare years later when they receive the "RED LETTER" or some similar type of communication from Medicare.

There is NO STATUTE OF LIMITATIONS on Medicare discovering your client's settlement, NONE, which means that communication could come at any time. If it's the RED LETTER, then there's a lot of information your client will feel compelled to disclose.

The RED LETTER asks, *"Are you receiving treatment for an injury or illness which another party could be held liable . . . ?"* When your client checks the box next to "yes," they are directed to page two where more information is required. That information includes the casualty insurance carrier's name, your client's attorney's name and address (*that's you*) and a description of your client's injuries. Again, all of this information goes into your client's CWF to be compared with future bills received from their doctors and then denied payment when there is a match.

If payment is denied by Medicare, then you can bet the doctors will be billing your client directly for payment. And then your client may be calling you, asking, "What happened?" and "Where am I supposed to get the money to pay all of these bills?"

If your client becomes Medicare-eligible post-settlement, and their settlement gets discovered, and they also have done nothing to consider and protect the Medicare Trust Fund from becoming a primary payer on their case, ***then things may get even worse***.

Medicare can take the position that your client must PROVE that they have exhausted their entire settlement paying for Medicare-allowable medical bills, before Medicare will come back in and start paying.

Depending on the size of your client's settlement, that could take a while. Perhaps your client might not even reach that lofty mountaintop in their lifetime.

It's a thought that raises two questions *you need to ask yourself*:

- The ***first*** is "Do I feel lucky?" ala Clint Eastwood's "Dirty Harry."
- The ***second***, is "Can I trust that my client will have any money left from their settlement (not just the portion representing future medical) with which to pay these denied Medicare bills, when that day eventually arrives?"

If the answer to either or both of these is "No," then it's time to consider whether an MSA may be right for your client.

This brings us to another set of questions to help determine that.

The very first question is: does your client

The Truth About MSAs… *(continued)*

have their Medicare card now, or will they have it when the case settles? If they don't have the card now, and they won't by the date when the case settles, then do they have the required 40 quarters of payroll-deducted contributions into the Social Security and Medicare programs to eventually get their Medicare card at retirement? Even if they don't have it now, if they have their "40 quarters" in, they WILL get Medicare at retirement. This is important because, as I mentioned earlier, there is NO STATUTE OF LIMITATIONS on Medicare's discovery of your client's settlement. Here's what that means.

If your client will someday be eligible for Medicare, even if that day is way off, there is nothing that says Medicare can't discover your client's settlement, years later, even years and years later, and enforce their secondary payer position. It is already happening, with Medicare enforcing their position by denying payment for services related to injuries covered by a settlement from years earlier. When this happens it's best to have protection, unless your client doesn't need it. That can be determined by the second question.

The second question is, has your client completed ALL treatments for the injuries and conditions that are or will be the subject of their settlement for this claim? If treatment has been totally completed, will their treating doctors certify in writing that your client has been released, and NO further treatment is necessary, warranted or prescribed?

If so, and their treating doctor will certify it in writing, then "glory, glory, Hallelujah." Your client has reached the exalted status of "NO MSA NECESSARY."

This status was first glimpsed within the 2011 CMS Director Charlotte Benson memo. The 2011 Benson memo details "certified completed treatment" as the way to avoid *even having to consider* using an MSA to protect the Medicare Trust Fund.

If, however, Medicare CANNOT be avoided because your client will be continuing treatment, or is now on Medicare or will be in their lifetime, then they may want to consider voluntarily creating an MSA.

There are at least two reasons why a plaintiff receiving a personal injury liability settlement might want to voluntarily consider creating an MSA.

The **first** reason is to segregate an amount of money that approximates the portion of their settlement that represents compensation for future medical expenses THAT ARE MEDICARE-ALLOWABLE. In doing so, they can use these funds FIRST for paying for Medicare services and protect the Medicare trust funds from being first payer.

The **second** reason is that the very creation of the voluntary MSA is, in and of itself, evidence of your client's consideration of Medicare's interests and protection of the Trust Fund.

This should avoid Medicare requiring that your client spend their entire settlement on medical bills before Medicare will cover their settlement-related medical expenses. Furthermore, this means that your client's potential exposure to Medicare bills SHOULD BE CAPPED at the much lower number that has been identified as the proper amount to fund their MSA account.

If this amount has been **minimized to the absolute lowest dollar amount that is reasonable and defensible**, then that's even better. It means more money is left for your client from their settlement to meet other needs.

Said another way, which would you prefer:

- That your client has to **spend the equivalent of their ENTIRE gross settlement** (including the portion that went to your fee, the costs and the liens) on future Medicare-allowable expenses before Medicare pays one thin dime?

OR,

- That your client has *voluntarily* funded an MSA with the absolute lowest dollar amount that is reasonable and defensible and **effectively capped their exposure to Medicare** at that much lower amount? And that when their MSA account is exhausted, Medicare, by law, must cover ALL of their Medicare expenses, even those related to their injury settlement, FOREVER?

Creating an MSA should effectively "cap" your client's exposure to Medicare, and gets your client into Medicare's pocket a whole lot faster than potentially having to spend their entire settlement before that happens.

That being said, determining the proper amount to fund their MSA with is essential. And in order to determine the proper amount to fund their MSA, the first step is to obtain an MSA Allocation Study.

But BEWARE!

In order to attract your business and fulfill your need for these Allocation Services, some companies may offer to administer their "over-allocated" MSAs for your client for free. These defense-oriented companies will try to bait you with the come-on of "free" (or "almost free) professional administration.

Don't be fooled. **There is no free lunch**. Their allocation methodology, honed from years of servicing the Worker's Comp and Casualty Insurance companies, almost GUARANTEES that your client will receive a grossly-inflated allocation amount.

By grossly inflated we're talking tens of thousands, and in some cases, hundreds of thousands of dollars. What good is "free administration" if your client ends up spending tens of thousands more to fund their MSA account? No good.

That's why it's so important to identify the **proper amount to fund your client's MSA account** and minimize your client's MSA to the lowest dollar amount that is reasonable and defensible.

This is done in a couple of ways, and starts with the Medicare-mandated review of the past two years of your client's medical records, which is mandatory in creating an Allocation recommendation.

Challenging unrelated past medical, overstated amounts and doubtful future treatments is the first step.

Challenging unrelated past medical means getting rid of anything that doesn't match up with the injuries or conditions that are the subject of the settlement. In other words, preexisting conditions that don't match the ICD-9 or ICD-10 codes associated with your client's case.

Overstated cost amounts then need to be adjusted down and doubtful future treatments removed. This process alone can significantly reduce the amount needed to fund your client's MSA.

The **final** step involves utilizing innovative reduction strategies we have helped develop for reducing MSA funding requirements even more for certain eligible clients.

This involves, at the sole discretion of the plaintiff attorney, using the settlement's procurement costs to further minimize the funding, as well as what we call, the "ratio of recovery" (call to discuss).

It all begins with figuring out what the right move is for you and your client.

Can they avoid an MSA? If so, then that's great.

Trust yourself and don't accept any of the defendant's untruths.

If not, then voluntarily creating and funding a minimized MSA may be your client's best protection from Medicare, as well as preserving more of their settlement, quality of life, and peace of mind.

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