

How to Comply with the Medicare Secondary Payer Act

BY CHRISTINE HUMMEL

This article explores the Medicare Secondary Payer Act and provides practical tips for compliance with the statute's main requirements.

The Medicare Secondary Payer Act (MSPA),¹ in its broadest reading, requires that (1) the defendant or its insurance provider must report qualified settlements to the Centers for Medicare and Medicaid Services (CMS);² (2) Medicare conditional payments must be reimbursed at settlement;³ and (3) Medicare must remain in a secondary payer position when a primary payer or primary plan issues a payment for a medical condition (also called a primary payment).⁴

This article offers practical tips for identifying when the MSPA applies to a case and ensuring compliance with all relevant sections of the statute as the case progresses toward settlement. The tips generally apply equally to plaintiff and defense attorneys, unless otherwise noted. The article also highlights recent changes to MSPA

enforcement by CMS, notably changes to the Common Working File (effective October 1, 2017) and an anticipated expansion of the formal Medicare set-aside (MSA) review process (expected in 2018).

Payment Priorities

The MSPA requires that Medicare remain secondary to any source of primary payment⁵ for medical expenses. The reporting requirements embedded within the MSPA ensure that Medicare remains secondary by identifying when an insurance company or self-insured entity has assumed responsibility for a specific body part, injury, or disease process. Should Medicare make a medical payment for an injury or disease process that it later receives notice is the primary responsibility of an insurance

company or self-insured entity, Medicare can seek reimbursement for this payment via the conditional payment recovery system. Therefore, it is critical for practitioners to understand the MSPA reporting requirements and report accurately.

The Compliance Threshold

The Strengthening Medicare and Repaying Taxpayers Act (SMART Act) of 2012⁶ requires the Department of Health and Human Services to determine an annual threshold amount for MSPA recovery actions. If the case settles below the threshold, CMS will waive all interest in the settlement. For 2018, the MSPA threshold is \$750;⁷ thus, if the case settles for an amount equal to or below \$750, CMS will not assert a conditional payment against the settlement

proceeds, and no future medical allocation will be required to ensure that Medicare remains secondary to settlement proceeds. Further, the defendant/insurance provider in the case would not be required to submit a Section 111 report (discussed below), which notifies Medicare of payments to a Medicare beneficiary.

Section 111 Reporting

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 mandated reporting requirements for settlements, judgments, awards, or other payments from liability insurance, no-fault insurance, or workers' compensation to Medicare beneficiaries. Insurance providers or self-insured entities must report to CMS any settlement or other award of monetary damages that includes a payment for a claim of past, present, or future medical damages payable to a Medicare beneficiary.⁸ The settlement report must be timely; failure to timely report may result in a financial penalty assessed against the responsible reporting entity.⁹

It is important to accurately report to CMS the date of injury or loss, date of settlement or TPOC date,¹⁰ plaintiff's identifying information, and applicable ICD-9 or ICD-10 codes. ICD codes are medical billing codes used to classify procedures, treatments, diagnoses, and other health-related conditions. Medicare uses these codes to identify the body parts or illnesses that are the subject of the underlying settlement payment to the Medicare beneficiary.

While the reporting requirement is a defense-only requirement, plaintiffs should not ignore it. Plaintiffs should ask defendants which specific ICD-9 or -10 codes they will report as part of the Section 111 report to ensure that the codes reported are accurate and do not overstate or understate the body parts or injuries involved in the case. Failure to accurately report the ICD codes can have serious repercussions, which are discussed below in the Future Medical Allocations section.

Conditional Payments

Medicare conditional payments are Medicare payments made from the date of injury to the date of settlement. Medicare will make a payment for a medical bill when it appears

that the party or entity responsible for the injury is refusing to make timely payment.¹¹ However, this payment is "conditioned" on the requirement that Medicare must be reimbursed if the primary payer or primary plan eventually makes a payment for the injury in question.¹² For purposes of compliance with

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the conditional payment statute and Code of Federal Regulations, the settlement payment meets the definition of a primary payment from a primary plan or payer.¹³

General Information

Medicare's actions are date-of-injury specific. Medicare does not define or determine the

date of injury; the agency must rely on the data provided to it by the parties to the case. For example, in a medical malpractice case, is the date of injury the date the malpractice occurred or the date the patient discovered the malpractice? Depending on the nature of the claimed malpractice, the date of occurrence and the date of discovery could be weeks, months, or even years apart. It is easy to see how reporting to Medicare the date of discovery versus the date of occurrence will result in a very different conditional payment amount, particularly because Medicare compares Section 111 data to data in the conditional payment database.¹⁴ Therefore, if a plaintiff requests a conditional payment search and reports the date of discovery as the date of injury, but the defendant's Section 111 report states the date of occurrence as the date of injury, the two dates of injury will not match. The failure of the reported dates of injury to match may result in CMS opening a second conditional payment file for the same settlement, which may result in administrative delays.

Parties must also take care to report to Medicare an accurate date of settlement. CMS defines "date of settlement" as the date the settlement becomes legally binding and obligates the defendant to make a payment.¹⁵ This means the date of an arbitration agreement, mediation agreement, or high-low agreement. The date the parties agreed to settle "in principle" is not the proper date of settlement for conditional payment purposes unless this agreement is legally binding and compels the defendant to issue a settlement check. If the parties are required to finalize the terms and conditions of settlement in another document or writing, the date this subsequently drafted document is signed should be provided to CMS as the date of settlement. Reporting any other date as the date of settlement prematurely cuts off the date range CMS uses to calculate a conditional payment amount. Purposefully and knowingly reporting a false date of settlement could be Medicare fraud and may result in the assessment of fines or penalties against all parties to the settlement.¹⁶

CMS contracts with private companies to manage payments. Correspondence that CMS issues through its contractor outlining a conditional payment before the date of settlement is

not final. The parties can dispute this “tentative”¹⁷ conditional payment amount at any time before settlement. A tentative conditional payment amount should not be paid. Further, payment of a Medicare conditional payment amount before a final demand request does not close Medicare’s lien file, and payments made to a tentative lien may be misapplied by Medicare.

To obtain the final demand amount from Medicare, a notice of settlement must be provided to the conditional payment contractor. Once a notice of settlement has been provided, a final demand letter will be generated. The final demand amount must be paid within 60 days of the date on the “final demand notice.” Failure to pay within 60 days will result in interest accruing on the final demand amount. The parties have the right to appeal, or request a redetermination review, of any final demand amount; however, if it takes more than 60 days for the appeal to be reviewed, interest will begin accruing even though the appeal is still pending. Interest accruals may be avoided by paying the final demand amount within the required 60-day time period. Note that payment of the final demand amount does not minimize the ability to appeal the final demand amount, nor does payment lessen the likelihood of obtaining a successful appeal result.

Failure to pay the final demand amount within the 60-day timeframe will result in the file being turned over to the Department of the Treasury (DOT) for formal collections proceedings. Once the file is transferred to DOT, it may use a variety of recovery tools, such as freezing bank accounts, garnishing wages, and seizing federal government benefit checks (including federal income tax refunds). It can be very challenging to work within the DOT system; therefore, respond timely to all CMS correspondence. Regardless of settlement language that may attempt to shift the burden of MSPA compliance to one party or the other, all parties must timely and accurately comply with the MSPA to avoid unintended consequences.

BCRC versus CRC

Since October 5, 2015, two national contractors have handled Medicare Parts A and B conditional payment searches: the Benefits Coordination

and Recovery Center (BCRC) and the Commercial Repayment Center (CRC). The contractors handle payments according to the type of claim and which party is designated as the “debtor of record or primary debtor.”

The BCRC handles all liability cases and any other case where the Medicare beneficiary is designated as the debtor of record. The CRC handles all workers’ compensation and no-fault cases or any other case where the primary payer/plan (the defendant or its insurance provider) is designated as the debtor of record. In liability cases, the Medicare beneficiary (or an agent acting on his or her behalf) has the right to contact Medicare for conditional payment data and to decide whether to dispute or appeal charges. For workers’ compensation or no-fault cases, the defendant or its insurance provider (or designated agent) has these rights.

For automobile cases where both a personal injury protection/medical payment (no-fault) claim and a bodily injury/underinsured motorist (liability) claim are filed, the bifurcation of the conditional payment process can complicate the settlement process. It will also necessitate communication between the no-fault carrier and the plaintiff to ensure that all conditional payment letters (from the CRC for the no-fault claim and from the BCRC for the liability claim) have been received.

Notably, CMS does not waive recovery rights against defendants simply because the Medicare beneficiary is the designated debtor of record for liability cases. Federal law specifically allows CMS to seek recovery for conditional payments from the workers’ compensation insurer, liability insurer, or no-fault insurer if the Medicare beneficiary fails to reimburse the required conditional payment amount.¹⁸ Therefore, to avoid future recovery actions from CMS, it is important for the defendant to ensure that the Medicare conditional payment amount is reimbursed in all liability cases.

Final Conditional Payment Process

The tentative conditional payment amount may change or even increase dramatically before settlement, which can make finalizing a settlement number difficult.¹⁹ Parties to a settlement cannot properly assess the adequacy

of a proposed settlement without knowing all of the liens and other expenses that must be reimbursed from that settlement, and plaintiffs want to know how much of the gross settlement amount they will receive after all fees, costs, and liens are paid. It can be almost impossible to determine the plaintiff’s net settlement recovery when the final demand amount from Medicare cannot be obtained until after settlement. Congress addressed the numerous complaints on this issue from the bar and lobbying groups by promulgating the “Final CP Process,” effective January 1, 2016. The Final CP Process allows parties to receive the final demand amount before finalizing a settlement, but only if certain strict rules and deadlines are met.

The key elements of the Final CP Process are:

1. the Final CP Process can only be used via the MSPRP Web Portal, an online Medicare conditional payment management service;²⁰
2. a legally binding settlement agreement must be signed within 120 days of requesting the Final CP Process;²¹ and
3. a legally binding settlement agreement must be signed within three days of requesting from the MSPRP Web Portal the final demand determination.²²

If any deadline is missed, Medicare automatically terminates the Final CP Process. The Final CP Process can only be requested one time per individual conditional payment lien account,²³ so if the process is voided, it cannot be restarted. If the Final CP Process is voided, CMS has the right to recalculate the final demand amount and the final demand amount cannot be requested until after the settlement has been finalized. Therefore, keep track of all deadlines to ensure that the Final CP process is not inadvertently voided.

In addition to completing the process within 120 days and signing the settlement agreement, within three days after requesting the final demand amount, the Final CP process allows the parties to dispute the tentative conditional payment amount. Each claim on the tentative conditional payment amount can be disputed one time only, and the BCRC must process the dispute request within 11 days.²⁴ All dispute requests must be completed and resolved before

requesting the final demand amount.²⁵ Once all filed disputes have been reviewed, and if 120 days have not yet elapsed from initiating the process, the final demand determination may be requested. Once the final demand determination has been made, the parties to settlement must sign the legally binding settlement agreement within three days. If the settlement agreement is signed before requesting the final demand or is signed on the same day as requesting the final demand amount, the process is voided. Therefore, ensuring that all parties are ready and able to sign the release agreement within the timeframe permitted is extremely important.

Parties electing to participate in the Final CP Process must pay particular attention to 42 CFR § 411.39(d), which states:

Obligations with respect to future medical items and services. Final conditional payment amounts obtained via the Web portal represent Medicare covered and otherwise reimbursable items and services that are related to the beneficiary's settlement, judgment, award, or other payment furnished before the time and date stamped on the final conditional payment summary form.

Given subsection (d), it is very important that all non-accident related ICD codes are formally disputed when included in any tentative conditional payment amount or final demand amount received through the Final CP Process. Failure to do so may be an admission by the parties to settlement that the undisputed code(s) is related to the settlement and therefore no future Medicare payments should be made for the undisputed codes.

This CFR section is somewhat vague because it is unclear whether subsection (d) applies only to final demand amounts requested as part of the Final CP Process, or if it applies to all final demand amounts requested through the Web portal. To date, there has been no case law further explaining this section or guidance on how aggressively CMS may use this section to avoid payment of future medical expenses. Further, the section indicates it applies to any final demand requested "via the Web portal." This is important because parties can use the Web portal to request a final demand amount

MSPA COMPLIANCE TIPS

- 1 Assess the compliance threshold.
- 2 Report case details and settlements timely and accurately.
- 3 Use the Final CP Process when appropriate.
- 4 Meet all Final CP Process deadlines to not void the process.
- 5 Use an MSA for future medical payments
- 6 Consider using the MSA review process once available.
- 7 Reimburse Medicare conditional payments promptly.

even if they are not formally using the Final CP Process.

Medicare Parts C and D

Medicare beneficiaries²⁶ can add a Medicare Part D²⁷ drug plan to their Medicare Parts A and B coverage, or they can elect to opt into a Medicare Part C²⁸ plan (also known as Medicare HMO and Medicare Advantage Plans).²⁹ These Part C and Part D plans are administered by private health insurance companies, and all payments made under these plans are contained on the billing systems for the administering plans. The national contractors for Medicare Parts A and B payments cannot access any Parts C and D payments. Therefore, letters and notices issued by the Parts A and B contractors will not contain Parts C and D payments. If a Medicare beneficiary has opted into one of these plans, additional Medicare conditional payment searches are required to determine any additional Medicare conditional payments

that must be reimbursed from the settlement proceeds. While there have been arguments in many cases that the Parts C and D plans do not have a right to reimbursement, the most recent case law on this issue has found in favor of the plans.³⁰ Therefore, it is important to complete a conditional payment search with the Part C or D plan administrator when necessary.

Future Medical Allocations

The MSPA states clearly that the Medicare program is prohibited from making any payment for which a primary payer is responsible and primary payment has been made.³¹ A settlement payment qualifies as a "primary payment" from a "primary payer" for purposes of the MSPA.³² CMS looks to the damages claimed by the plaintiff and released by the settlement agreement to determine whether a settlement amount includes compensation for future medical damages. CMS is not bound by the terms, conditions, or allocation of settlement dollars in the release agreement.³³ Accordingly, if the plaintiff claims during the case that the injury, illness, or accident in question caused "permanent," "lifetime," "foreseeable," "ongoing," or other similar long-term medical needs or treatment, and such claim was released as part of the settlement agreement, CMS has a valid argument that at least some portion of the settlement was provided to compensate the plaintiff for this claim of future medical damages. Therefore, the settlement is primary to Medicare and must be exhausted before Medicare will resume post-settlement payment for the injury or illness allegedly caused by the accident.

CMS requires that settlement proceeds be used to pay for all reasonably foreseeable future medical care or treatment required for the injury in question that the Medicare program would otherwise cover.³⁴ This treatment includes, but is not limited to, ongoing care such as office visits, medications, diagnostic imaging studies, physical therapy, and treatment that has been recommended but has not yet occurred, such as pain management injections, surgeries, and the purchase of durable medical equipment. Treatment that is "reasonably foreseeable" at the time of settlement can include medical

care discussed in any document that outlines the plaintiff's medical condition arising from the alleged accident-related injury, such as clinic notes, independent medical evaluations, answers to interrogatories, and deposition testimony.³⁵ Where conflicting or competing medical evidence exists for such issues as whether an injured person requires surgery, CMS, in practice, tends to default to the opinion of the plaintiff's primary treating physician for the alleged injury. For example, where the primary treating physician believes the plaintiff requires surgery and the surgery is causally related to the accident, but an independent evaluator determines that no surgery is required, CMS tends to put more value on the opinion of the primary treating physician, and consequently requires that settlement dollars be used for surgery expenses.

In addition to reviewing claims or statements from the plaintiff regarding alleged medical damages, CMS also reviews the ICD codes the defendant provides in the Section 111 report to determine what medical conditions or treatment relate to the alleged injury. The importance of accurate Section 111 reporting cannot be stressed enough. Over-reporting of codes may result in Medicare refusing payment for medical conditions truly not related to an accident, but under-reporting of codes will shift the burden of payment to Medicare and result in Medicare making payments for treatment related to the accident. Shifting the burden of payment to Medicare is a violation of the MSPA and could result in Medicare seeking recovery for any resulting payment from the parties to the settlement.³⁶

If the plaintiff makes a claim for medical damages that is released as part of the settlement agreement, the parties to the settlement should ensure that Medicare remains in a secondary payer position relative to the settlement proceeds. This can be accomplished by use of a future medical allocation such as a Medicare set-aside.

Medicare Set-Asides

The biggest confusion regarding future medical payments and compliance with the MSPA stems from the term "Medicare set-aside" or "MSA."

This term does not appear in the text of the MSPA nor in the Code of Federal Regulations.

An MSA (or other future medical arrangement) is an allocation of settlement dollars placed in a separate, interest bearing account that is used to pay for future accident-related

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medical expenses that would otherwise be covered by the Medicare program. The MSA must be reasonably calculated and supported by the medical evidence available at the time of settlement. Once MSA funds are fully exhausted,

including any earned interest, on appropriate medical expenses, Medicare should resume its primary payer status for accident related treatment.

CMS has made it clear that the MSPA does not mandate an MSA. However, the MSA is the agency's preferred method for full compliance with the MSPA.³⁷ CMS has acknowledged that other financial tools may equally comply with MSPA requirements;³⁸ however, to date CMS has never approved any method other than the MSA for MSPA compliance. Therefore, attorneys should view the MSA as a tool for MSPA compliance rather than a statutory mandate.

The MSA allocation must be supported by the medical and legal evidence of the case. Medicare uses a reasonableness standard when determining the sufficiency of an MSA allocation in workers' compensation cases;³⁹ nothing suggests a change of standard for liability or no-fault cases. There is no minimum threshold amount, percentage of settlement amount, or other arbitrary allocation amount that will guaranty compliance with the requirement to keep Medicare as a secondary payer.

To avoid a future medical or MSA allocation from settlement proceeds, the injured person should obtain a "certification of no treatment" statement.⁴⁰ This statement must come from the injured person's primary treating physician and must clearly state that the patient has been discharged from all accident-related treatment and that no future treatment related to the alleged injury is anticipated, and the statement must be specific to the settlement. If a plaintiff has filed claims against multiple defendants and settles with each defendant separately over time, the plaintiff must obtain a statement for each settlement. If the treating physician refuses to provide a clear discharge statement or certification of no treatment statement, a future medical allocation must be considered.

Recent Changes

In 2017, CMS made amendments to the "common working file" and released additional guidance to facilitate MSPA compliance.

The common working file is an internal system by which Medicare determines whether a medical bill submitted to Medicare should be

paid. In February 2017, CMS issued a notice requesting a change to the common working file. Specifically, the common working file was to be modified to include internal coding information to notify the Medicare billing department about the existence of liability and no-fault settlements. The February 2017 notice⁴¹ specifically stated that CMS was creating two new MSA processes: one for Medicare liability set-asides and one for no-fault set-asides. The modifications to the common working file became effective October 1, 2017.

On November 8, 2017, CMS issued a Medicare Learning Bulletin specifically targeting physicians and medical providers to educate them on when to accept payment from a patient's settlement proceeds or Medicare set-aside arrangement.⁴²

The changes were implemented to ensure compliance with the statutory requirement to maintain Medicare as secondary to liability and no-fault settlements. The November bulletin specifically states that physicians and other medical providers should be paid from a patient's settlement proceeds or MSA if

1. the treatment or prescription is related to what was claimed or what the settlement, judgment, award, or other payment had the effect of releasing; and
2. the treatment or prescription is something Medicare would cover.⁴³

CMS is consistent in its instruction that settlement proceeds are primary to Medicare for treatment of all medical care for damages and medical conditions claimed and/or released as part of the settlement. The November 2017 bulletin further states that the obligation to protect the Medicare Trust Fund exists regardless of whether there is a formal CMS-approved MSA account.

The changes to the common working file and the CMS educational outreach to the medical community send a strong signal that CMS is stepping up its enforcement of the statutory requirement to keep Medicare in a secondary payer position. Due to changes to CMS enforcement of the MSPA in late 2017, the practitioner's office policy or procedures for dealing with Medicare, specifically the statutory requirement to maintain Medicare as secondary

to settlement proceeds post-settlement, should be re-evaluated to ensure that they fully comply with the MSPA. There is no settlement language strong enough to estop or prohibit CMS from seeking recovery from the defendant if the plaintiff fails to fully comply with the MSPA. Similarly, there is no settlement language strong enough to estop or prohibit CMS from stopping all Medicare payments and leaving the plaintiff without access to accident related healthcare should the parties to settlement fail to adequately comply with the MSPA.

Anticipated Expansion of MSA Review

CMS reviews future medical allocations for reasonableness. Although a formal review process by CMS of future medical allocations exists for workers' compensation cases, at present no formal CMS review process exists for liability or no-fault cases. Parties to the settlement may submit a liability or no-fault MSA proposal to the appropriate CMS regional office; however, each regional office may determine whether it will or will not review the proposal. Industry practice suggests that at present very few liability or no-fault MSA proposals are actually being reviewed. In most cases, the various CMS regional offices are issuing a "No Review Letter." These letters are neutral statements that indicate CMS does not have the resources necessary to review the proposed MSA; however, the parties to settlement are still obligated to fully comply with the MSPA.


On June 9, 2016, CMS issued a technical alert notifying the public that CMS is considering expansion of the formal MSA review process that is presently available only in workers' compensation cases.⁴⁴ In 2017, the MSA review contractor contract was up for bid. In the scope of work section of the notice soliciting bids for the new contract, CMS notified companies submitting bids that their bids should take into account a possible expansion of the MSA review system.⁴⁵ Further, in October 2017, the email technical alert regarding expansion of the formal MSA review system that was originally issued on June 9, 2016 was reissued by CMS.⁴⁶

Given the changes made to the common working file, the scope of work expansion in the notice soliciting bids for the MSA review

contractor, and the re-issuing of the email technical alert regarding possible expansion of the formal MSA review system, it seems logical to conclude that CMS is moving toward expanding the formal MSA review system to include liability and no-fault cases. This expansion is anticipated to be implemented in 2018. The formal MSA review process will be voluntary once available to liability and no fault cases; there will be no mandate for the parties to submit an MSA allocation to CMS for review. However, obtaining CMS approval of an MSA allocation will help parties document their full compliance with the MSPA. There will be cases where formal review of the MSA will be in all parties' best interests. Therefore, review by CMS of a liability or no-fault MSA should be given due consideration after CMS expands the formal MSA review process.

Conclusion

The MSPA is a complex piece of legislation that should be carefully considered in all liability, no-fault, and workers' compensation settlements. This article does not address every possible element in a case that can impact the applicability of the MSPA; each case must be examined on its own merits.

Both plaintiffs and defendants are responsible for identifying Medicare's potential interest in any settlement and for statutory compliance. Parties should work together to accurately report case details and settlements, and use the Final CP Process and MSA review process when appropriate. Finally, practitioners should be alert to further guidance on MSPA compliance and anticipate changes to the formal MSA review process. 



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NOTES

1. 42 USC § 1395y.
2. 42 USC § 1395y(b)(2) and (8).
3. 42 USC § 1395y(b)(2)(B) and 42 CFR § 411.24.
4. 42 USC § 1395y(b)(2)(A)(ii).
5. Primary payment can consist of private health insurance, workers' compensation medical benefits, or settlement proceeds from a tort, liability, or workers' compensation settlement. See 42 USC § 1395(y)(b)(2)(A)(i) and (ii).
6. 42 USC § 1395y(b)(2)(B)(9)(A) and (B).
7. This compliance threshold applies only to physical-trauma based claims. It specifically does not apply to settlements for alleged ingestion, implantation, or exposure cases. 42 USC § 1395y(b)(2)(B)(9)(B)(i).
8. 42 USC § 1395y(b)(2)(B)(8)(F).
9. The penalty is a sliding scale. The maximum penalty is \$1,000 per day/per claim. 42 USC § 1395y(b)(2)(B)(8)(E)(i).
10. See instructions for Field 80 in the Section 111 NGHP User Guide (www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html) regarding determination of the appropriate TPOC (Total Payment Obligation to Claimant) reporting date. The TPOC date is not necessarily the payment date or check issue date. The TPOC date is the date the payment obligation was established. This is the date the obligation is signed if there is a written agreement, unless court approval is required. If court approval is required, it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement, the TPOC date is the date of payment or the check issue date.
11. For example, an injured person's only source of medical insurance for a slip and fall injury may be Medicare. Medicare will pay for the injury related expenses; however, if a settlement is reached with a liability insurance provider or self-insured entity to compensate the beneficiary for their injuries, the Medicare payments made before settlement must be reimbursed.
12. 42 CFR §§ 411.24 and 411.26.
13. 42 USC § 1395y(b)(2)(B)(ii).
14. Settlement information for conditional payment purposes can be provided to Medicare via fax, mail, or uploaded via the web portal at www.cob.cms.hhs.gov/MSPRP/login.
15. 42 USC § 1395y(b)(2)(A)(ii) and (B)(ii) and (iii).
16. To date there are no Medicare fraud cases against attorneys specifically for misstating or misreporting a date of settlement for the purpose of avoiding or prematurely cutting off Medicare's conditional payment amount. However, in an educational bulletin aimed at physicians, Medicare makes it clear that knowingly reporting false information or misstating facts that negatively impact Medicare could be deemed fraud. MLN Booklet, "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" (Sept. 2017) (available online only), www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fraud_and_abuse.pdf.
17. It is important to note that the word "tentative" does not appear in correspondence issued by the Medicare contractors, nor is it used in their verbal communications. This article uses the word "tentative" to highlight the difference from a final determination.
18. 42 CFR § 411.24(i).
19. See 42 CFR § 411.39.
20. 42 CFR § 411.39(c).
21. 42 CFR § 411.39(c)(1)(iv).
22. 42 CFR § 411.39(c)(1)(vii)(A).
23. 42 CFR § 411.39(c)(1)(iv). Medicare assigns individual case identification numbers for individual lien files in Medicare's system. Medicare may have multiple lien files for the same claimant, the same claim type, and same date of injury.
24. The 11-day review time for disputes is valid in most cases. There are a few instances where CMS will allow for an extension of time to review a Final CP dispute. Those instances include, but are not limited to, times when the federal government is experiencing a national crisis or a computer system failure making it impossible for the contractor to review the dispute request. See 42 CFR § 411.29(c)(1)(B).
25. 42 CFR § 411.39(c)(1)(vii).
26. See 42 CFR §§ 411.108 (Part C) and 423.462 (Part D).
27. 42 USC § 1395w-101 to -154.
28. 42 USC § 1395w-21 to -29.
29. 42 USC § 1395w-21(a)(1).
30. *In re Avandia Mktg., Sales Practices and Prods. Liab. Litig.*, 685 F.3d 353, 367 (3d Cir. 2012); *Humana Medical Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229 (11th Cir. 2016).
31. 42 USC § 1395y(b)(2)(A)(ii).
32. 42 USC § 1395y(b)(2)(B)(ii).
33. May 25, 2011 Memorandum issued by the Centers for Medicare and Medicaid Services Dallas Regional Office. A copy of this memo can be obtained by contacting the author.
34. 42 USC § 1395y(b)(2).
35. *Id.*
36. See *supra* notes 1, 12, and 15.
37. May 25, 2011 Memorandum, *supra* note 33.
38. *Id.*
39. Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide v2.7 section 3.0 (Mar. 19, 2018), www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2_7.pdf.
40. CMS Memorandum, Medicare Secondary Payer—Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals—INFORMATION (Sept. 29, 2011), www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Future-Medicals.pdf.
41. CMS Manual System Pub. 100-20 One-Time Notification (Feb. 3, 2017), www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1787OTN.pdf.
42. MLN Matters Number SE17019 Reissued, Accepting Payment from Patients with a Medicare Set-Aside Arrangement (Nov. 8, 2017), www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17019.pdf.
43. *Id.* at 2.
44. Medicare Secondary Payer electronic listserv mailing list. A copy of the listserv update can be obtained by contacting the author. To subscribe to CMS electronic mailing lists, go to www.cms.gov/Outreach-and-Education/Outreach/FFSPProvPartProg/Electronic-Mailing-Lists.html.
45. The request for bids can be reviewed at www.fbo.gov/index?s=opportunity&mode=form&id=f1ae2d5eb785ac35d331eccc4d001ebb&tab=core&_cview=1.
46. The technical alert can still be viewed at the CMS workers' compensation website, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Whats-New/Whats-New.html.