NAMSAP

National Alliance of Medicare Set-Aside Professionals

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Special Edition

The MSP Debate Heats Up in New York:

A Look at the Opposing Sides of the Issue

Inside this Issue:

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Trusiak: State courts not an out on MSP

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

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

MSP basics

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

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

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

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

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

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

Pay now or pay more later

The Upstate New York tort bar has generally worked in partnership with the United States to effect MSP compliance. The United States Attorney's Office is grateful for the general response of the tort bar to MSP compliance. There are continued MSP compliance concerns based on three incorrect presumptions: first, the incorrect presumption a prayer for only pain and suffering in the complaint and/or a similarly narrow release avoids the mandatory statutory obligation to repay Medicare; second, the incorrect presumption a state court possesses authority to adjudicate Medicare's interest despite the state court's absence of subject-matter jurisdiction over the Medicare claim and personal jurisdiction over the United States; and

third, the incorrect presumption concerning the perceived obligation of CMS to appear in a state court proceeding to defend its interests despite the distinctly federal nature of the process which requires the parties to affirmatively contact CMS and secure an administrative adjudication rather than require the federal government to waive sovereign immunity in derogation of the distinctly federal scheme and appear in state court. The cessation of conduct based on these incorrect presumptions will promote compliance with the law, repay the federal taxpayer for the conditional Medicare payment, and avoid the significant financial consequences visited on the practitioner, primary plan, or others that fail to reimburse CMS for the conditional MSP payment.

A careful review of the MSP statute, case law and implementing regulations demonstrates the repayment obligation is mandatory and unrelated to any perceived pleading or release limitation to pain and suffering. The MSP law since 1980 has required repayment of the conditional payment upon the tort settlement: " [a] primary plan, and an entity that receives payment from a primary plan shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service...." 42 U.S.C. §1395y(b)(2). The statute proceeds to plainly demonstrate through its simple language the reimbursement obligation is based on payment, settlement, judgment or other award. Id. The Court in United States v. Baxter Int'l, Inc., 345 F.3d 866, 899 n.27 (11th Cir. 2003), stated that "[c]ourts have uniformly concluded that a settlement agreement that includes a non-itemized element of compensation for a plaintiff's medical care is 'for' medical expenses, even if the exact share or amount is indeterminate." See also Mathis v. Leavitt, 554 F.3d 731, 733 (8th Cir. 2009)(Medicare is entitled to reimbursement so long as "the settlement, which settled all claims brought, necessarily resolved the claims for medical expenses"). The MSP manual (CMS Pub. 100-05, Chapter 7, §50.4.4) partly states as follows: "The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case." The manual also states that "...regardless of how amounts may be designated in a ... settlement, e.g. loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed ... from the proceeds of the ... settlement." Chapter 7, Section 50.1 (CMS Pub.100-5). Stated otherwise, the conditional reimbursement obligation exists without regard to the limited nature of the complaint or settlement release.

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

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

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

Deterrence and punishment

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

The role of the state court

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

proceeding.").

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

The role of the liability insurer or self insured

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

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

The role of CMS

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

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

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

The role of the plaintiff's counsel

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

And now the bad news

The double damages exposure pursuant to the MSP statute as set forth in the preceding discussion constitutes a constrained litigation approach compared to the primary law used by the United States since 1863 to civilly redress fraud in federal programs: the False Claims Act, 31 U.S.C. §3729 et seq. The False Claims Act (FCA) provides for treble damages and a mandatory penalty of $5,000 to $10,000 per false claim. Id. The aggregate value of FCA settlements since the 1986 amendments to the Act totals approximately $23 billion dollars. If the casual reader is

unfamiliar with the power of the FCA as a fraud enforcement tool, then one recent resolution involving the pharmaceutical company Pfizer sufficiently demonstrates its power to redress fraud. The United States recently resolved allegations of civil and criminal wrongdoing against Pfizer. The total value of the resolution was $2.3 billion based, in large part, on the FCA.

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

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

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

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

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

Conclusion

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

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By: J. Michael Hayes, Esq.

The standard approach to Medicare reimbursement, upon which there is no significant disagreement, recognizes that as Medicare is a Federal statute, it preempts State law. The Medicare statute requires that, upon any settlement involving a Medicare recipient or one who will be eligible within 30 months, CMS must be notified, 42 USC 1395y(b)(8)(E)(i). There is a $1,000 per day penalty for a failure to comply with this requirement. Upon resolution of such a personal injury claim, a consent must be executed permitting CMS to communicate with the attorney (Plaintiff or Defense), an itemization must be provided setting forth the amount of the settlement, the disbursements, attorney fees and net amount allocated to the plaintiff.

Upon receipt and consideration of all this information, CMS will issue a "conditional demand" for repayment. The present standard is that the government's claim of reimbursement is limited to the amount it paid minus the costs of litigation including attorney fees. Any disbursal of funds to the Plaintiff prior to satisfying the "conditional demand" may result in double damages, 42 USC 1395y(b)(2)(B)(iii), 42 USC 1395y(b)(3)(A). These deficiencies may be enforced against any of the parties, their attorneys or the liability carrier. Recently, CMS sued and was granted a judgment from the Plaintiff's attorney personally as opposed it to levying upon the Plaintiff. That was in United States of America v Harris, N.D. W. Va. (2008), where the District Court found that "because the [tortfeasor] took responsibility for the payment of [Plaintiff's] medical services…demonstrated by a release for items or services included in a claim, the government can now seek reimbursement."

If there is any disagreement with the amount of the "conditional demand", the attorney may pay it, may negotiate with CMS in an attempt to make it more equitable or may follow CMS' Administrative Appeal process, provided that the amount demanded has been paid while the appeal is pending.

There may be an alternative approach to this entire issue. It may not be in the best interests of the client in every instance but it is one the attorney should be aware of and consider during prosecution of the case. The Medicare enabling legislation accords the government a right of "subrogation" in order that it may recoup its medical expenditures. 42 USC 1395y(b)(2)(B)(iv). The Federal Government's statute of limitations on this subrogation recovery claims is three (3) years from the date of payment for the medical benefit. 42 USC 1395y(b)(2)(B)(vi). By definition, therefore, CMS is only entitled to reimbursement for medical expenditures it made that are actually recovered by the Plaintiff. This includes anticipated future expenses that are included as damages recovered in the personal injury action. Often these are protected in the form of a "Supplemental Needs Trust" which is where the "Medicare Set Aside Professional" becomes involved. For an analogous analysis of the impact and principles of subrogation, see: Arkansas Dept. of Health and Human Services v. Ahlborn, 126 S.Ct 1752 (2006); Sprint v APPC Services, Inc. 544 U.S. ____, (2008).

There is one very important question/issue that does not seem to be a part of the equation: What if the recovery does not include reimbursement for medical expenses? What if a jury were not to award full or even any medical expense reimbursement? What if there was a state statute that precluded medical expense recovery as part of a personal injury claim and an order or judgment confirming same? This may be a "grey" area but, beyond the definitional constraints of subrogation principles, there is support for the proposition that if there is no recovery of medical expenses, then Medicare/CMS is not entitled to any reimbursement.

The only case to address this issue is Merrifield v. United States, et al., Civil No. 07-987 (JBS), U.S.D.C.N.J. 2008 U.S. Dist. LEXIS 25877, March 31, 2008. In that case, there was no recovery of medical expenses by any of the seven Plaintiffs. Two of the actions are instructive. One involved an administrative appeal wherein an Administrative Law Judge confirmed that there had been no medical expense recovery such that Medicare was not entitled to claim any part of the Plaintiff Burke's settlement. The other, Frick, had her lack of medical expense recovery confirmed in an Order by a New Jersey State Court Judge. In both those cases, CMS withdrew its appeal that had been taken to the Federal District Court. That tactic by CMS permitted the determinations favorable to the Plaintiffs to stand. CMS made no recovery and was not reimbursed. However, perhaps more importantly to CMS, an adverse ruling by a Federal District Court was avoided. The absence of a Federal Court decision permits CMS to continue to claim a "lien" on every personal injury recovery regardless the nuances of the settlement and whether it was a "global" release and resolution or one limited to "pain and suffering only".

There are issues beyond the simple application of subrogation principles. The statute establishes that Medicare's recovery is pursuant to its "subrogation" rights. The Medicare mandate does not dictate that a Plaintiff's counsel is required to pursue Medicare's subrogation claim as a part of the personal injury claim. This is an important nuance as The *ABA Model Code of Professional Responsibility*, Rule 1.8(g) provides that:

> A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients … unless each client gives informed consent, in writing signed by the client.

It is debatable as to whether the retained client can knowingly make an informed concession in this situation where the Federal Government does not even retain the attorney and takes no risks of litigation. The Federal Government and CMS agree to partake only of the benefits of a successful resolution.

It clearly is an ethical violation for an attorney to represent competing claimants on a single lump sum recovery, take a fee on the total and then allocate the funds between the two. Is this such a situation? That a Federal Attorney General might not be concerned about potential ethical violations by Plaintiffs practitioners so long as the Federal government recoups its expenditures is recognized. The strength of the arguments aside, a Plaintiff's attorney is ethically bound to maximize his client's recovery and is certainly prohibited from paying any "claimed" creditors or co-claimants until and unless their rights are fully proven.

For the practitioner and the Medicare professionals, the obvious course is to follow the prescribed administrative procedures. Whether the ultimate decision is to pay any or all demands made by CMS or to seek to distinguish the personal injury claim from the medical reimbursement claim and contest such demands is between the practitioner, his client, the

Continuation: An Alternative Perspective Regarding Medicare Reimbursement

By: J. Michael Hayes, Esq.

Grievance Committee, CMS and Administrative processes. If the claims are severed or the Plaintiff's attorney chooses or is able to only pursue his injured client's personal injury claim, the Medicare right of action remains open to a subrogation claim against the tortfeasor. The statute of limitations is three (3) years from date of payment which appears to mean that this is a "rolling" statute.

If the plaintiff's attorney does not pursue the Medicare recovery claim, an independent party, group or association of attorneys could subcontract those claims and even specialize in these type of recovery actions. If billions of dollars are at stake, as they are, then the fees could be proportionately large for enterprising individuals or groups. There may be opportunity for other groups to specialize in contesting and pursuing the "Administrative" remedies that are available to Medicare recipients.

While there may be no statutory obligation to notify either CMS of a suit or of the claims or lack thereof, given the three (3) year statute of limitations on subrogation claims under the statute, it would seem a courtesy, as well as good faith, to advise CMS of the suit. This would be especially important if there are bona fide ethical concerns that compel the practitioner to restrict the scope of the suit to "pain and suffering". Whether the claims for pain and suffering and those for medical expense can be severed will be determined by "the administrative process" and/or the Federal Courts. However, that determination is not made until the suit is resolved and, often, the statute of limitations has expired. In order to avoid any appearance of opportunism or subterfuge claimed by CMS, informing CMS of the lack of a medical recovery claim could be prudent. There are cases in the "pipeline" that should help clarify all these issues and apparent distinctions.

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J. Michael Hayes has been in private practice in Buffalo since his admission to the Bar in 1977. He was born in St. Louis, Missouri in 1946 and attended the University of Notre Dame and SUNY at Brockport graduating Summa Cum Laude in 1973. He attended the University of Buffalo Law School graduating in 1976 after achieving an award for excellence in the Senior Trial Technique Course. He is presently an adjunct professor at the University of Buffalo Law School where he teaches a course on Motor Vehicle Accidents.

Mr. Hayes is Board Certified by the National Board of Trial Advocates. Mr. Hayes He is President of the Inns of Court, Buffalo Chapter. He is President of the Western Regional Affiliate of the New York State Trial Lawyers Association. He is a former Director and a member of the New York State Trial Academy. He is a member of the Association of Trial Lawyers of America, is listed in The Bar Register of Preeminent Lawyers, Best Lawyers in America, Who's Who in America, Who's Who in American Law and New York Super Lawyers. He was a Charter Member of the Buffalo Chapter of the American Board of Trial Advocates.

Mr. Hayes is a frequent lecturer and has presented seminars for the New York State Bar Association and the National Institute for Trial Advocacy on trial technique, punitive damages, the Labor Law, assumption of risk, depositions and discovery. Additionally, he is the author of New York Motor Vehicle Accidents, a text published by James Publishing Company, 1999, two chapters in the text New York Plaintiff's Personal Injury Actions published in March, 2008 by the New York State Bar Association, a recent text on Subrogation vs. Liens as well as articles in Statewide publications including the New York State Bar Journal, the New York State Trial Lawyers Association's "Bill of Particulars", the New York Law Journal and the Buffalo Law Journal.

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MSP debate still heating up

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By Annie Deck-Miller
Buffalo Law Journal

It’s a law that's been on the books just shy of 30 years, but is still being hotly discussed and interpreted in jurisdictions across the country.

“This is not a new law, but it is a law that's been honored in the breach, largely, since 12/5/80," says the federal prosecutor in Buffalo who oversees enforcement of this one provision of the Social Security Act.

But the Medicare Secondary Payer (MSP) statute has caught the attention - and the tongues and the pens - of the Western New York bar to an unusual extent.

This area of federal recovery has become "radioactive" over the last decade, says one plaintiffs' personal-injury lawyer. A cadre of Buffalo lawyers has been debating fine points of the MSP statute and case law - and what they mean for plaintiffs, insurers, physicians and the U.S. government - in seminar presentations, white papers, blog postings and published articles and letters (some of which have appeared in the Buffalo Law Journal).

The conversation has not yet become a legal showdown, but it's heating up into something approaching an Old-West duel. And the two lawyers with their hands moving toward their holsters are Assistant U.S. Attorney Robert Trusiak and trial lawyer J. Michael Hayes.

Opposing counsel

Trusiak and Hayes are both intellectually gifted, skilled persuaders.

Trusiak, who favors pin stripes, pocket squares and cufflinks, says his mission is one of education, alerting lawyers and their clients as to how they should be handling these claims, and what the penalties will be for not following that prescribed course.

And Hayes, a fearless, steely-eyed challenger, is willing to suggest that the legal system overhaul itself before it asks him to compromise his advocacy for his clients.

Hayes has no illusions about how far out he's sticking his neck out.

What they say

Trusiak, who's chief of the Affirmative Civil Enforcement Unit of the U.S. Attorney's Office for the Western District of New York, says the issue is as simple as this: If your client received Medicare benefits and if Medicare paid for those medical expenses, you need to pay the agency back following a tort resolution.

And he's quick to note that a state court cannot declare Medicare's interest invalid.

There are steps prescribed by the MSP statute for how insurers and plaintiffs have to communicate with the Centers for Medicare & Medicaid Services (CMS) and meet the agency's demands for repayment following a settlement.

The penalties for not following those steps are stiff: $1,000 a day for each claim, and the possibility that the government will be awarded double damages - in Trusiak's words, a potential for "ruinous financial exposure" for attorneys and clients alike.

Not so fast, says Hayes. He says that approach forces the plaintiff's attorney to represent not only the interests of a client, but also of the federal government.

Rule 1.8(g) of the New York Rules of Professional Conduct, he says, states that it would be "unethical for an attorney to represent competing claimants for a single pool of money, collect that pool, divide and allocate it between those two claimants, and then take a fee on the whole thing.

"You can't do it," Hayes says. "It's unethical."

He has suggested that plaintiffs' attorneys avoid this conflict by suing only for pain and suffering in tort cases, leaving Medicare or other entities to pursue recovery for medical expenses if they wish.

The point is moot, Trusiak says. The law says CMS must be given the opportunity to decide what share, if any, it's entitled to from a tort settlement, he says. The agency's MSP manual indicates, he says, "that any perceived limitation based on pain and suffering or otherwise is not (necessarily) an impediment to MSP recovery."

Defense attorney Michael Perley says he's not convinced by Hayes' argument.

"I don't think it's a conflict of interest, I think it's just a fact of life," says the Hurwitz & Fine lawyer.

The idea of limiting exposure by suing only for pain and suffering in a tort action, he said, doesn't apply in the Medicare arena.

"I don't think the law is going to be on his side of this argument," he says of Hayes.

Even if Hayes is right about the conflict issue, says a partner in a new Buffalo Medicare-claims consultancy, Franco Signor LLC, defendants won't sign on to that approach.

"The defendant is going to want to make sure that the entire process is resolved so that they don't have to have two cases related to this one transaction of events," says Roy Franco, who is admitted to the bar in California and Hawaii. "They want to make one payment and receive a settlement for it."

An appealing option

Hayes recognizes that it would take legislative or judicial intervention to address the perceived conflict of interest.

But he says he'll go the distance to get his argument heard. He's appealing a CMS decision on behalf of a client who won a medical-malpractice

settlement. He declined to name the plaintiff or reveal the settlement amount.

“It’ll go up to the district court and it will go up as high as necessary until they say that I must violate the disciplinary rules in the State of New York," he says.

He has also appealed rulings on severance motions - they seek to isolate pain-and-suffering allotments from medical and wage recovery - in two Workers' Compensation cases: Traska vs. Allied Storage and Robinson v. National Vacuum. Both cases will be argued before the state Appellate Division in Rochester in September.

In the meantime, Hayes says as far as he is aware, Western New York plaintiffs' lawyers are following the administrative processes they're supposed to in responding to MSP recovery claims - and that his clients are paying what's required "in accordance with the regulations."

What’s at stake

Trusiak cites a CMS document that says these provisions save Medicare half a billion dollars every year.

"We're also talking about the continued integrity of the Medicare trust fund," he says, noting a reality that underpins the whole debate.

Franco believes no one's being shortchanged more than Medicare beneficiaries.

"They're getting caught in the middle of the plaintiffs' bar, the defense bar, insurance carriers, self-insureds - some pretty powerful groups," he says.

Medicare issues have to be considered in every single personal-injury case, says Perley. He estimates that recovery issues come up in 30-40 percent of all personal-injury cases.

"You can either pretend it's not there," he said, "freak out or take the time to figure it out."

Bill proposes changes to MSP statute

Rep. Patrick Murphy, D-Pa., and Rep. Tim Murphy, R-Pa., introduced the Medicare Secondary Payer Enhancement Act of 2010 (HR 4796) March 9. The bill is now in committee.

Roy Franco, a principal of a new Medicare-claims consultancy in Buffalo, Franco Signor LLC, says the proposals include key provisions that would:

- Clarify legislation to establish a limitations period of three years
- Protect the privacy of plaintiffs' Social Security numbers, which insurance carriers and self-insureds are now required to report when they report payments electronically
- Establish a clear administrative appeal process
- Expedite submission of conditional payments to the government - “putting the power back in the hands of the parties to do it as opposed to waiting on the government for information,” says Franco.
- Add flexibility to penalty regulations so that parties may not be assessed the full penalty when they make a “good faith” error

Franco, who used to work in risk management for Safeway Inc. and is co-chair of the Medicare Advocacy Recovery Coalition, says the legislation has legs, largely because it takes into consideration concerns from a broad base of stakeholders, including the U.S. Chamber of Commerce, the American Association for Justice, DRI (formerly the Defense Research Institute), the National Structured Settlement Trade Association and the Medicare Rights Center.

"I believe we have quite a bit of support mounting," he says.

A law that takes effect Oct. 1, Franco notes, will require defendants to report payments made to plaintiffs to the government.

"You're under a constant obligation to know whether you're dealing with a Medicare beneficiary," he says. "Either from a plaintiff's or the defense side, you really need to start sorting out what your liabilities are with regard to the Medicare beneficiary and Medicare itself."

MSP watchers are also closely watching U.S. v. Stricker et al., a case filed in the Northern District of Alabama December 2009 that seeks to recover MSP payments from 907 Medicare beneficiaries who settled in 2003 for $300 million.

- Annie Deck-Miller

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NAMSAP is the only non-profit association exclusively addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. Through the voluntary efforts of our members, NAMSAP is a forum for the exchange of ideas and is a leading resource for information and news in this constantly evolving area of practice. The collective knowledge of our members and NAMSAP's resources will provide you with the ingredients essential to your success!

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- A Conditional Payment Letter will be generated automatically within 65 days of the issuance of the "Rights and Responsibilities Letter";
- Conditional Payment Letters will go to all authorized parties;
- Requests for an updated CPL can only be processed every 90 days after the last CPL was issued. Rush updated letters can be requested but are not guaranteed;
- All parties should update the CPL thoroughly to make sure that only case related items are included;
- Up-to-date CPL amounts can be accessed on the MyMedicare.gov website (attorneys will need to gain access through the claimant);
- If authorization is not on record, the beneficiary will receive the letter and their attorney and/or representative must obtain a copy through the beneficiary;
- Once the case has settled, the settlement documentation must be sent to the MSPRC;
- The MSPRC will generate the final demand letter after receiving the settlement documentation;
- Payment is due within 60 days of the date of the demand letter;
- If payment is not received within 60 days of the date if the demand letter, interest will be charged from the date of the demand letter.

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