QUICK REFERENCE FOR MEDICARE COMPLIANCE

Determining Medicare Eligibility:

1. The claimant is 65 years of age;
2. The claimant has received Social Security Disability Insurance (SSDI) benefits for 24 months or longer, with a 5 month waiting period; or
3. The claimant is suffering from disabling End State Renal Disease or Amyotrophic Lateral Sclerosis.

REIMBURSEMENT OF MEDICARE CONDITIONAL PAYMENTS

The Medicare Secondary Payer Act (MSP) prohibits Medicare from making medical payments on behalf of a Medicare beneficiary if a primary plan (liability, workers' compensation or no-fault insurance policy) has the responsibility to pay for such treatment. The MSP specifically requires primary plans to reimburse the appropriate trust fund for any payment made by Medicare if it is demonstrated that the primary plan has or had a responsibility to make the payment. Payments made by Medicare which are the responsibility of a primary plan are conditioned on reimbursement, and are referred to as "conditional payments." A primary plan's responsibility to reimburse Medicare for these payments may be demonstrated by a judgment in favor of a beneficiary, a settlement with a beneficiary, a contractual obligation to pay a beneficiary, or by other means.

Obtaining Conditional Payment Information

Notice to CMS of a claim can be provided by electronic reporting pursuant to the MMSEA Section 111 mandatory reporting requirements, or given to Medicare Benefits Coordination and Recovery Center (BCRC) at 1-855-798-2627. Information regarding the beneficiary, the case, and the representative contacting CMS should be included in any correspondence or accessible for any telephone calls.

Conditional payments can be monitored on the Medicare Secondary Payer Recovery Portal (MSPRP), or conditional payment letters may be requested by phone, fax (4058693309) or through the portal. For information about claims where there is an ongoing responsibility for medical treatment (ORM), the Commercial Repayment Center (CRC) should be contacted (fax: 8443154313). For liability or other claims with no ORM, the BCRC should be contacted. To reach either contractor, the 1-855-798-2627 should be used.

Payment of Conditional Payments After Settlement

Upon settlement, either a demand or a case closure letter will be issued by Medicare. Medicare is supposed to send the demand/case closure letter upon notification of settlement. Notification of settlement may be provided through the Section 111 reporting, and/or through notice to Medicare on a "Final Settlement Detail Document."

- Payment is due within 60 days of the demand letter;
- Interest accrues from the date of the demand letter and will be assessed on the balance on day 61 if it is not paid;
- Before paying, the demand letter should be reviewed to confirm that only case related claims are included;
- If the party that received the primary payment fails to reimburse Medicare within 60 days, the primary payer must reimburse Medicare even though it has reimbursed the beneficiary (or other party);
- If CMS has to take legal action, Medicare may recover double the amount of the Medicare primary payment.

Liability Settlements

Medicare permits a beneficiary to elect to resolve his/her conditional payment claims in liability settlements via the "Fixed Percentage Option." This option is available when all of the following requirements are met:

- The underlying injuries are physical injuries (do not relate to ingestion, exposure, or medical implant);
- The total settlement is $5,000.00 or less;
- The option is elected before or at the same time of the submission of Notice of Settlement documentation, or by the date specified in the conditional payment notice; and
- The beneficiary is in a position where he/she has not received and does not expect to receive any settlements, judgments, awards, or other payments related to the incident.

Note: Medicare will not assert a right of recovery for conditional payments and MMSEA reporting is not required in certain liability exposure, ingestion and implementation claims as long as all exposure or ingestion ended, or the implant was removed before 12/15/1980. As of 1-1-2017, CMS will not pursue recovery for conditional payments in physical trauma based liability settlements totaling $750 or less. Similarly, CMS will not pursue recovery for conditional payments in cases involving no-fault insurers or workers' compensation entities where settlement is $750 or less so long as there is not an ongoing responsibility for medical expenses on the part of the insurer/entity.

FUTURE INTEREST OF MEDICARE

Workers' Compensation

Parties have an obligation to consider and protect Medicare's future interests when resolving workers' compensation cases which may involve future medical expenses. CMS recommends that parties utilize Workers' Compensation Medicare Set Aside Arrangements (WCMSAs) to protect its interest in workers' compensation settlements. The WCMSAs are reviewed and approved by CMS only when the cases meet the threshold for review. Medicare will only pay for future Medicare covered expenses related to a worker's compensation injury when the WCMSA amount is exhausted and the money spent is accounted for to CMS.

CMS will review an MSA under the following criteria:

- The claimant is Medicare eligible and the value of settlement is more than $25,000 (total settlement value includes reimbursement of medical expenses and liens, attorneys fees, prior money paid out in a partial settlement, and the total value of an annuity pay out); and
- The claimant is reasonably expected to become Medicare eligible within 30 months of a WC settlement with a total value of more than $250,000. A Claimant is "reasonably expected" to become Medicare eligible if the claimant has applied for SSDI; has been denied SSDI, but intends to appeal or has appealed the denial; is 62.5 years of age; or has End Stage Renal Disease.

Liability Cases

There are no published memoranda expressly mandating use of Medicare Set Asides (MSAs) in liability cases. However, Medicare has emphasized that parties in liability cases should consider and protect its interest in any settlement, including liability cases. Parties may decide an MSA is an efficient way to ensure money is set aside to protect Medicare's future interests. CMS' regional offices may review liability MSAs at their discretion.

MANDATORY REPORTING REQUIREMENTS

Who reports? The "applicable plan" is responsible for reporting, and is known as the "RRE." An "applicable plan" by statute includes liability insurance (including self-insurance), no fault insurance, and workers' compensation plans.

What triggers RREs to report? Reporting occurs when there has been a settlement, judgment, award or other payment to a Medicare beneficiary (hereinafter referred to as "total payment obligation to the claimant" or "TPOC"), or a responsibility for the payment of ongoing medicals (hereinafter referred to as "an ongoing responsibility for medical expenses" or "ORM") on behalf of a Medicare beneficiary has been assumed or terminated.

When do RREs report? NO-FAULT/WORKERS' COMPENSATION: Any TPOC on or after October 1, 2016, that is greater than $750 must be reported. LIABILITY: Any TPOC on or after January 1, 2017, that is greater than $750 must be reported.

What is reported? The total amount of the TPOC or the assumption or termination of the ORM is reported. If a Workers' Compensation claim is a medical only claim; the worker's lost time is no more than the number of days permitted by the applicable law in "medical only" claims (or seven days if no such limit applies); all payments have been made directly to the medical provider; and the total payment does not exceed $750, then the ORM is excluded from reporting indefinitely.

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This quick reference guide was last edited on January 25, 2019, and the guidelines set forth herein are subject to change. It is recommended that updated rules, regulations and guidelines at www.cms.gov be examined to confirm the information contained herein is up to date.