State of New Jersey
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
PO BOX 381
TRENTON, NEW JERSEY 08625-0381

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

HAROLD J WIRTHS
Commissioner

MEMORANDUM

July 11, 2012

TO: All Judges and Attorneys

FROM: Peter J. Calderone, Director & Chief Judge

SUBJECT: Medicare Conditional Payment and Set-Aside Issues

The federal Medicare Secondary Payer Statute as administered by the Center for Medicare & Medicaid Services (CMS) has set various policies, procedures and regulations affecting workers' compensation petitioners who are Medicare entitled or have reasonable expectation of eligibility. We have attempted to understand and implement the CMS process and have issued policy memoranda concerning Medicare issues.

Based on recent CMS announcements and the position of the United States Justice Department in litigation in the New Jersey Federal District Court, this Division is revising our involvement in the application of the Medicare Secondary Payer Statute.

With respect to conditional payments, we have required that parties initiate the conditional payment process for Medicare entitled petitioners with judicial oversight. Where the process is not completed prior to N.J.S.A. 34:15-22 settlements or judgments, we have provided our own Medicare Attachments A or B. While judges and parties should continue to ensure that the CMS process is initiated in all New Jersey workers' compensation cases where the petitioner is Medicare entitled, we will no longer require that Attachments A or B be the only acceptable language. The parties may reach an agreement that is suitable for their particular situation such as naming one of the parties responsible for finalizing the CMS conditional payment process and/or allocating responsibility for any payments to CMS. While it is important that settlements or judgments reference the status of the CMS process, it is best left to the parties on how they want to resolve remaining issues with CMS.

With respect to Medicare Set-Aside arrangements, CMS and the Justice Department have now taken the position that CMS offers an opportunity for parties to submit proposed Workers' Compensation Medicare Set-Aside Arrangements (WCMSA) to CMS for approval but that there is no legal requirement that the CMS WCMSA process be utilized. They maintain that it is an optional process. As such, this Division will no longer require the parties to obtain an approved CMS WCMSA on N.J.S.A. 34:15-20 settlements of any amount. Please note the advantage of a CMS approved WCMSA is finality and assurance from CMS that the Set-Aside meets CMS standards and will not be challenged later. A non-approved Set-Aside could create uncertainty and the possibility of a later denial of Medicare benefits to a petitioner. Whether to seek or not seek a CMS approved Set-Aside is best left to the case parties.

Clearly to avoid later misunderstandings and potential client claims against counsel or others, it is recommended that the parties fully inform their clients of CMS requirements and their CMS compliance options. While parties may want to include these matters on the workers' compensation record, clear written information to clients would be beneficial.

In summary:

1. Workers' compensation judges and the parties should ensure that the CMS conditional payment process is initiated whenever a petitioner is Medicare entitled. However, the parties may utilize the Division's Attachment A or agree on other language that best meets the needs and understanding of the parties with respect to CMS issues. On judgments, Attachment B will no longer be included.

2. Set-Aside issues are best left to the parties in their dealings with CMS and the Division will not require approved CMS WCMSAs in finalizing N.J.S.A. 34:15-20 settlements.

Attached is an excerpt of the position of CMS and United States Justice Department as presented to the United States District Court for your consideration and guidance.

Attachment

I. INTRODUCTION

The Secretary of the United States Department of Health and Human Services (the "Secretary")[1] respectfully submits this motion to dismiss for lack of subject matter jurisdiction and failure to state a claim upon which relief can be granted pursuant to Federal Rules of Civil Procedure 12(b)(1) and (6).

Plaintiff has asserted in his complaint that he is on the verge of settling a longstanding workers' compensation case wherein he hopes to collect a lump payment of approximately $[redacted] from his employer's carriers. Plaintiff seeks a declaration from this Court as to his liability pursuant to the Medicare Secondary Payer provisions of the Medicare statute, which

[1] Though plaintiff has named the United States as defendant, the appropriate defendant is the Secretary of the United States Department of Health and Human Services. See 42 C.F.R. § 405.1136(d).

designates Medicare the secondary payer to payment made by a primary payer, such as a workers' compensation settlement or plan. Specifically, he requests a declaration that he has reimbursed Medicare for all conditional payments made for past medical treatment and that he is not required to set aside any portion of his settlement to cover any future Medicare liability.

The Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services ("CMS") is charged with administration of the Medicare program. Though not required to do so by the Medicare statute nor applicable regulations, CMS provides beneficiaries like plaintiff, who obtain an award or settlement proceeds from a Workers' Compensation suit, to avail themselves of an opportunity to seek CMS's approval of an amount to be set aside out of such award or settlement to account for any liability to the Medicare program for future medical expenses. Because this process is an entirely voluntary process on the part of CMS and beneficiaries, plaintiff's Complaint that requests an order from this Court to require CMS to process its request for a future set-aside fails to state a claim upon which relief can be granted.

Plaintiff's Complaint further fails to state a claim upon which relief can be granted in that it asserts that CMS has acted in "bad faith" in failing to "respond" to its proposal for a future set-aside. Plaintiff's allegation of "bad faith" is directly contradicted by the facts of this case, which demonstrate CMS's extensive efforts to assist plaintiff by repeatedly identifying, in writing and by telephone, the documentation needed to CMS to review its proposal. It is plaintiff's failure to properly avail himself of CMS's voluntary process and submit the documentation necessary for CMS's review that is impeding resolution of plaintiff's Workers' Compensation settlement, not any actions or inactions by CMS or its contractor.

Plaintiff's attempt to insulate his $[redacted] from Medicare liability at this time is moreover entirely premature. Plaintiff's complaint rests upon a series of potentialities that may

never be realized. He is assuming that, at some time in the future, Medicare will either demand reimbursement for conditional payments, or deny a claim for payment for future medical expenses, due to the workers' compensation settlement proceeds. However, there is no current Medicare overpayment demand nor claims denial at issue. Even if plaintiff is faced, at some point, with a Medicare demand for payment or a claims denial that relates to his workers' compensation settlement, as the United States Supreme Court made clear in Shalala v. Illinois Council, 529 U.S. 1 (2000), the Medicare statute requires the channeling of virtually all legal attacks through the agency, even at the occasional price of individual delay-related hardship.

II. STATUTORY AND REGULATORY BACKGROUND

In 1965, Congress created the Medicare program, which pays for medical care for the aged, disabled, and those suffering from end stage renal failure. 42 U.S.C. §§ 1395 et seq. The Secretary of the United States Department of Health and Human Services (the "Secretary") administers the program through the Centers for Medicare & Medicaid Services ("CMS").

A. MEDICARE SECONDARY PAYER

For the first fifteen years of the Medicare program, Medicare was the primary payer for covered medical items and services (except for items and services covered by workers' compensation, which has always been primary to Medicare). In 1980, Congress enacted a series of amendments designed to curb skyrocketing Medicare costs. See e.g., Health In. Ass'n of Am. v. Shalala, 23 F.3d 412, 414 (D.C. Cir. 1994), cert. denied, 513 U.S. 1147 (1995); United States v. Baxter Int'l, 345 F.3d 866, 874-75, 888-89 (11th Cir. 2003), cert. denied, 125 S. Ct. 2907

(2004). These amendments are referred to as the Medicare Secondary Payer ("MSP") provisions and are codified at 42 U.S.C. § 1395y(b).[2]

The MSP statutory provisions state that the Medicare program will not pay for medical items and services if "payment has been made or can reasonably be expected to be made" under the following primary plans: (i) workmen's compensation; (ii) liability insurance policy; or (iii) no fault insurance. 42 U.S.C. § 1395y(b)(2)(A)(ii); 42 C.F.R. § 411.20(a)(2). However, the MSP provisions permit the Medicare program to pay for covered items and services if a plan described in subsection (A)(ii) "cannot reasonably be expected to make payment . . . promptly."

The MSP provisions make clear that any such payment is "conditioned on reimbursement to the appropriate Trust Fund." 42 U.S.C. § 1395y(b)(2)(B)(i); 42 C.F.R. § 411.21. The statute specifies that primary plans, and entities receiving payment from a primary plan, are required to reimburse the Trust Fund "for any payment made by the Secretary" if it is determined that such primary plan has or had a responsibility to make payment. 42 U.S.C. § 1395y(b)(2)(B)(ii).

A primary payer's responsibility for payment may be demonstrated by: (1) a judgment; (2) a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured; or (3) by other means, including but not limited to, a settlement, award, or contractual obligation. 42 U.S.C. § 1395y(b)(2)(B)(ii) (Repayment Required); 42 C.F.R. § 411.22(b) (Reimbursement obligations of primary payers and entities that received payment from primary payers).

---

[2] On December 8, 2003, Congress enacted technical and clarifying amendments to the MSP provisions. See Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"), Pub. L. 108-173, § 301.

If the Medicare program is not reimbursed for conditional payments made on a beneficiary's behalf, the MSP provisions afford the United States several avenues of recovery. First, the United States "may bring an action against any or all entities that are or were required or responsible . . . to make payment" and is authorized to collect "double damages against any such entity." 42 U.S.C. § 1395y(b)(2)(B)(iii); see also 42 C.F.R. § 411.24(e); 42 C.F.R. § 411.24(c)(2). Second, the United States may recover from "any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." 42 U.S.C. § 1395y(b)(2)(B)(iii); see also 42 C.F.R. § 411.24(g).[3] Finally, in addition to these direct rights of action, Congress provided the United States with a separate subrogation right, subrogating CMS to the rights of any individual or any entity entitled to payment by a third-party payer. 42 U.S.C. § 1395y(b)(2)(B)(ii); see also 42 C.F.R. § 411.26(a).

As applied to worker's compensation, CMS's regulations specify that Medicare does not pay for any services for which payment has been made, or can reasonably be expected to be made under, a workers' compensation law, or plan of the United States or a state. 42 U.S.C. § 411.40. If CMS is notified that a proper workers' compensation claim has been made by an injured worker who also happens to be a Medicare beneficiary, CMS may pay conditionally for any disputed medical items and services at issue in the claim. 42 C.F.R. § 411.45. However, those payments are then subject to recovery once the workers' compensation case is settled, or a judgment or award has been rendered. 42 C.F.R. § 411.45. Once CMS determines the conditional payment amount that must be reimbursed, CMS sends a demand letter, which affords

---

[3] Parties that receive primary payments may include a beneficiary, provider, supplier, physician, attorney, private insurer, State agency, or any other entity entitled to payment by a primary payer. 42 C.F.R. §§ 411.24(g), 411.26(a).

the individual or entity the opportunity to file an administrative appeal to review such overpayment determination, as discussed in more detail below. 42 C.F.R. 405 Subpart I.

Many workers' compensation settlements, judgments or awards also include payment for anticipated future medical expenses, and release the workers' compensation carrier from continuing payment for such medical expenses. Because the Medicare program is prohibited from paying for those future medical expenses covered by a settlement, judgment or award, CMS recommends to workers' compensation claimants and carriers that sufficient settlement funds be set aside by the claimant to cover those future medical expenses that would otherwise be reimbursable by Medicare. 42 U.S.C. § 1395y(b)(2)(A)(ii); 42 C.F.R. § 411.46.

CMS's recommended method to protect a claimant's future Medicare benefits is for a claimant to establish a Workers' Compensation Medicare Set-Aside Arrangement ("WCMSA"). Though CMS is not required to do so by either the MSP provisions, or applicable regulations, CMS offers an opportunity for claimants like plaintiff to submit their proposed WCMSA to CMS for approval. This is an entirely discretionary function on the part of CMS. See 42 U.S.C. § 1395y(b)(2); 42 C.F.R. Part 411. Beginning in July of 2001, CMS issued the first in a series of "Frequently Asked Questions" memoranda to explain and respond to questions regarding the WCMSA process. CMS's website also contains detailed information concerning the submission of WCMSAs, as well as links to CMS's MSP manual and CMS's memoranda. See, e.g., http://www.cms.gov/WorkersCompAgencyServices; http://www.cms.gov/manuals; http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/wcsetaside.html.

Though the WCMSA is recommended by CMS, there is no legal requirement that the WCMSA process be utilized by a claimant, and a claimant can decline to do so. See e.g., Coryell v. Liberty Mut. Ins. Co., 329 Fed. Appx. 657, 659 (7th Cir. 2009) (CMS's regulations "do not require that parties obtain preapproval from HHS before agreeing on the amount of the set-

aside"); 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411. 21 et seq. If a claimant does not engage in the process and fails to set aside sufficient funds to protect Medicare's interests, the Medicare program can only refuse to pay for future medical expenses related to the workers' compensation injury when, and if, a claim is submitted for payment. http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/wcsetaside.html.

The party submitting a proposed WCMSA (the "submitter") will typically determine the WCMSA amount based on the claimant's medical records or a life care plan which has been prepared by a professional and details the claimant's future medical expenses. Id. The proposed WCMSA is submitted to CMS for review of the amount of funds to be set aside. The process of submitting a WCMSA for approval is entirely voluntary and has been developed so as to protect both the claimant's and Medicare's interests. Id.

In reviewing a proposed WCMSA amount, CMS considers whether the proposed amount allocated for future medical expenses is reasonable and protects the Medicare program's interests. The submitter and the claimant are informed of CMS's results of the WCMSA review. Id. If a submitter or claimant believes that a CMS determination contains obvious mistakes, or believes that there is additional evidence not previously considered by CMS, that would warrant a change in the determination, either party may bring the mistake to CMS's attention or resubmit the proposed WCMSA with the additional information and request a re-evaluation of the WCMSA amount. Id.

There is no formal appeals process for rejection of a Medicare set-aside arrangement. If a claimant does not engage in the voluntary WCMSA process and/or fails to set aside sufficient funds to protect Medicare's interests, the Medicare program may refuse to pay for future medical expenses related to the workers' compensation injury. Id. At this point, when Medicare denies a

particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process, as discussed below.

B. THE ADMINISTRATIVE AND JUDICIAL REVIEW PROCESS

Any claim by a beneficiary related to whether individual claims should be paid by the WCMSA or the Medicare program, or any issue that the monies put into the WCMSA are no longer needed for future medical expenses, can be effectively raised by beneficiaries through the Medicare administrative review and appeals process. See 42 U.S.C. § 1395ff(b)(1); see also Fanning v. United States, 346 F.3d 386, 400-01 (3d Cir. 2003), cert. denied, 124 S.Ct. 2872 (2004) (noting that administrative review of MSP overpayments and waiver determinations is clearly provided for by statutory scheme).

A beneficiary's right to challenge the existence or amount of a Medicare overpayment or a denial of a Medicare claim includes an extensive administrative appeals process. 42 U.S.C. § 1395ff(b); 42 C.F.R. Part 405 Subpart I; 42 C.F.R. § 405.904(a)(2); 42 C.F.R. § 405.920 et seq. The Medicare contractor makes an initial determination when a claim for benefits is submitted and a beneficiary who is dissatisfied with the initial determination may request that the contractor perform a redetermination. 42 C.F.R. § 405.940 et seq. Following the redetermination, the beneficiary can request reconsideration by a Qualified Independent Contractor ("QIC"). 42 C.F.R. § 405.960 et seq. If still dissatisfied, the beneficiary can seek a hearing before an ALJ, if the amount remaining in controversy and other requirements are met. 42 C.F.R. § 405.1000 et seq. Finally, the beneficiary can seek review of the ALJ's decision by the Medicare Appeals Council of the Departmental Appeals Board. 42 C.F.R. § 405.1100 et seq.

Ultimately, a beneficiary who has obtained a "final decision of the [Secretary] made after a hearing "may obtain judicial review of the decision by filing an action in federal district court.