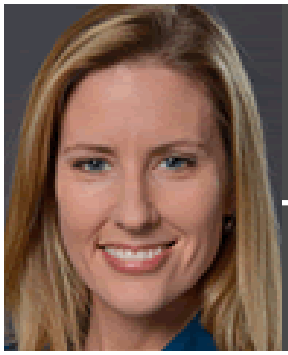


TOOLS FOR INVESTIGATING MEDICARE CLAIMS

Nikki Nesbitt
Goodell DeVries Leech & Dann (Baltimore, MD)
410.783.4026 | knn@gdldlaw.com

Tools for Investigating Medicare Claims
K. Nichole Nesbitt

Medicare, Medicaid, Medicare Advantage Organizations, and other government-sponsored payors have statutory rights to recover for conditional payments already made on behalf of an injured beneficiary following a final settlement with or judgment from a third-party insurer (including self-insurers). In some instances, the government-sponsored payor may also have the right to recover for future care costs.

Due to these statutory rights of Medicare and other government-sponsored payors, it is critical for everyone involved in a settlement -- including the defendant -- to investigate whether a Medicare or other form of "super lien" exists and ensure that the interests of the government-sponsored plan are protected. In addition, if a patient was a Medicare beneficiary, settlements above a reporting threshold must be reported to the Centers for Medicaid and Medicare Services (CMS). Penalties for noncompliance can be severe, including double damages for failing to reimburse Medicare or fines for non-reporting of settlements.

Fortunately, several tools can assist defense counsel and risk management professionals in investigating Medicare liens and other super liens. This paper discusses how practitioners can identify Medicare and other types of super liens and how to analyze those liens and prepare to address them at mediation or settlement.

I. Medicare and Other Super Liens

Medicare

Per 42 U.S.C. § 1395y(b), Medicare is considered a "secondary payer" when a third-party "primary payer" may ultimately be held liable for payment. Medicare can make "conditional" payments for services for an injured beneficiary for which a primary payer may ultimately be responsible. The Medicare Benefits Coordination & Recovery Center (BCRC) is responsible for recovering conditional payments for Medicare.

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, all settlements, judgments, awards, or other payments from liability insurance (including self-insurance) must be reported to BCRC. A claimant can face fines of up to $1,000/day for failure to report.

If the injured party fails to reimburse Medicare within 60 days of receipt of the settlement funds, Medicare may pursue recovery directly from the insurer. See 42 C.F.R. § 411.24. Federal law also permits plaintiffs to seek double damages in a private cause of action if Medicare is not reimbursed. See 42 U.S.C. § 1395y(b)(3)(A).

Medicare Advantage Organizations (MAOs)

A Medicare Advantage Plan, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. Approximately 25% of all Medicare beneficiaries (roughly 12,000,000 people), are enrolled in an MA plan. By statute, 42 U.S.C. § 1395w-22(a)(4), MAOs may charge a primary plan for medical expenses paid on behalf of a participant.

Medicaid

Federal law requires states to "take all reasonable

measures to ascertain the legal liability of third parties ... to pay for care and services available under [Medicaid]," and, "in any case where such liability is found to exist after medical assistance has been made available[,] ... seek reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. § 1396a (a)(25). Many states have enacted statutes pursuant to this requirement to effectuate reimbursement from third-parties in the event of a judgment or settlement in a personal injury case. See, e.g., Md. Code Ann., Health-Gen. § 15-120 and D.C. Code Ann. § 4-602.

Tricare/VA

Military families covered under Tricare also have super lien considerations. 42 U.S.C. § 2651 provides the government with the statutory right to recovery "under circumstances creating a tort liability upon some third person."

II. Identifying Medicare and Other Super Liens in Your Claim or Case

Internal Investigation

It is usually straightforward to identify whether Medicare, Medicaid, or a similar payer was billed for allegedly negligent care provided by your defendant/institution. But it is more challenging to determine whether care received at other institutions was caused by the alleged negligence of your client. Still, a defendant is responsible for ensuring Medicare's and Medicaid's lien interests are covered for all care related to the injury, not just the defendant's own care. Accordingly, defendants need to request and obtain billing records from any later-in-time care claimed as damages so that this can be investigated. Another challenge is identifying whether an insurer listed on medical or billing records is an MAO as opposed to an ordinary private insurer. Many MAO plans have "Medicare" or "Advantage" in the plan name, but some do not. Look out for HumanaChoice (in Maryland) and Cigna-Health Spring (in D.C.), which offer MAO plans without "Medicare" or "Advantage" in the plan name.

Discovery/Requests to Claimant

For cases already in litigation, formal written discovery to the plaintiff should request key paperwork for Medicare or other super liens, such as:

- Conditional Payment Letter ("CPL")
- All correspondence received from Medicaid, Medicare, CMS, the Coordination of Benefits Contractor (COBC) or any Medicare or Medicaid third party administrator
- A print-out or print screen shot from the claimant's account on www.mymedicare.gov if any exists, showing the amount of any conditional payments made by Medicare.

Some vendors can help obtain data. One of the Network's sponsors, Berkeley Research Group, LLC, has one of the largest and broadest healthcare practice groups in the world and warehouses years of Medicare claims data on their servers.

MSP Recovery Portal - for use by the defense

In the event a defendant faces a pro se claimant or a plaintiff's attorney who is non-cooperative or not diligent, there is another option to investigate whether Medicare has made conditional payments. Any lawyer or law firm or institution can create an account on the Medicare Secondary Payment Recovery Portal. This is a lengthy process due to federal government IT security protocols, but once it is set up (using the claimant name, address, and SSN), defense counsel can search for whether Medicare has a recovery case for that claimant. If a match is found, the attorney can request a copy of a Conditional Payment Letter or an updated Conditional Payment Letter directly instead of waiting on the plaintiff's attorney.

Note that this portal only covers traditional Medicare liens in the BCRC process. It does not apply to Medicaid or MAO liens.

III. Analyzing Medicare and Other Super Liens with an Eye Towards Settlement

Step One: Request an Updated CPL

Even if defense counsel has received a Medicare CPL earlier in discovery, they should request an updated CPL prior to mediation or settlement talks, as CPL amounts are updated by Medicare contractors over time.

Step Two: Review the Lien and Consider Disputing It

Defense counsel should carefully review the CPL/lien information. The information should include a "Payment Summary Form" listing DRG/ICD codes for the care that Medicare, Medicaid, or other protected payer is claiming was caused or necessitated by the alleged negligence. Frequently, the lien will include costs for care that is NOT causally associated with the claim or injury. Liens may also reflect prices for services that are greater than what was actually paid.

Medicare and all other super liens have a lien dispute process. Typically, this process can only be used by

the beneficiary or his/her counsel, and they have every interest in doing so. For cases with large liens where the care at issue in the case is mixed in with other care such that the lien needs to be "scrubbed," consider proposing to the plaintiff's counsel that a Medicare claims specialist review the lien, identify care not causally associated with the claim, and negotiate reduction of the lien.[1]

Step Three: Use the MSP Recovery Portal to Confirm the Final Conditional Payment Process

The MSP Recovery Portal has some functions available only to plaintiffs' firms who have validated that they are representing the beneficiary (or vendors acting on a plaintiff's counsel's behalf). The portal allows plaintiffs to: (1) submit notification of potential settlement within 120 days in advance of the anticipated date of settlement; (2) dispute lien amounts (and if the Medicare contractor does not respond within 11 business days, the dispute is automatically granted in their favor); and (3) within 120 days, make a one-time request for a Final Conditional Payment Letter, which constitutes the Final Conditional Payment amount.

Going through this process avoids the danger of reaching a settlement based on an earlier CPL amount to the extent the Medicare Final Demand Letter is substantially higher. See Mayo v NYU Langone Medical Center, No. 805036/12, 2018 WL 1335262, at *1 (N.Y. Sup. Ct. Mar. 15, 2018) (in which the case settled based on CPL of $2,824.50, but Final Demand was $145,764.08; the plaintiff ultimately succeeded in vacating the settlement as based on an incorrect assumption).

Step Four: Have Points Ready on Liens at Mediation/ Settlement

For Medicare liens, a Medicare Final Demand Letter typically will reflect a reduction in the lien to reflect the plaintiff's attorneys' costs and fees. If the cost of the Medicare lien is less than the settlement amount, Medicare will reduce the amount of the lien by the ratio of the plaintiff's procurement costs (attorney's fees and case expenses) to the total amount of settlement. 42 CFR 411.37(c). If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs. 42 CFR 411.37(d). Some states also include automatic reductions for fees. In Maryland, for instance, Medicaid liens are automatically reduced by one-third for attorneys' fees in any settlement in which a plaintiff is represented by counsel. COMAR 10.09.83.02. For Medicaid liens, there are several additional points that may impact settlement and should be considered prior to mediation. For instance, defense counsel should consider whether a Medicaid Special Needs Trust may be appropriate. Federal Supreme Court cases[2] have limited the right of state Medicaid agencies to recover solely the portion of settlement reflecting past medical expenses, so future care needs are important to consider. It is also important to note that states do not have a right to recover against the parts of a settlement representing pain and suffering, lost wages, and other economic, non-medical damages.

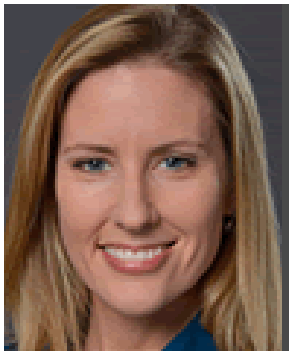
The upshot of these cases is that there is an option of including language in the settlement agreement explicitly breaking down the settlement amount into categories (i.e. past medicals, future medicals, non-economic damages). Medicaid's recovery would be limited under law to the past medical category. This may be a good option in cases where the plaintiff has received significant medical care for a variety of illnesses, and there is a large Medicaid lien, but the parties agree that the negligence at issue caused only a small fraction of that care.

IV. Conclusion

Tools are available that take some of the mystery out of protecting Medicare's interests, and defense counsel should take advantage of these tools before determining the settlement value of a case.

1 Our firm has had success with Verisk ISO Claims Partners. In one instance, they were able to reduce substantial Medicare and DHMH liens in the six figures by more than 90%. This company's fees are reasonable: as of 2018, it cost $500/individual lien for claim dispute services. Another specialist is Synergy Settlement Services.

2 The relevant cases are Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. 268 (2006) and Wos v. E.M.A., 568 U.S., 133 S.Ct. 1391 (2013). In 2013, a federal Budget Resolution Act reversed these cases and allowed state Medicaid agencies to recover up to the entire settlement amount, mirroring Medicare's full recovery rights. But, more recently, the holdings in Ahlborn and Wos were restored in Section 53102 of the 2018 Budget Act, which repealed Medicaid's expanded rights provided by subsection 202 the 2013 Bipartisan Budget Act



K. NICHOLE NESBITT

Partner

GOODELL DEVRIES LEECH & DANN (Baltimore, MD)

410.783.4026 | knn@gdldlaw.com

Nikki Nesbitt is a partner with Goodell DeVries. Her current practice concentrates on medical malpractice defense and complex commercial litigation, as well as cases that combine the two fields. She represents several health systems in Maryland and the District of Columbia, handling complicated malpractice cases as well as credentialing, employment, and compliance-related matters. Ms. Nesbitt also handles employment matters outside of the healthcare context for employers in this region and beyond. Ms. Nesbitt's experience as a litigator provides her with insight to counsel her employment clients on drafting guidelines, policies, and agreements, in addition to defending matters that have already proceeded to litigation. For the entirety of her 18 years at the bar, Ms. Nesbitt has worked for Goodell DeVries and has moved through the ranks from summer associate to partner. Likewise, she has enjoyed positions of leadership in the Maryland Defense Counsel, the Defense Research Institute, and in non-legal organizations such as JDRF.

Practice Areas

- Commercial and Business Tort Litigation
- Employment Litigation
- Medical Malpractice
- Medical Institutions Law
- Professional Liability
- Hospitality Law

Representative Matters

- Wilds v. MedStar Washington Hospital Center (2018), Superior Court for the District of Columbia. Obtained defense verdict for hospital and its special police officers in connection with an excessive force claim brought by a visitor. The plaintiff claimed she was wrongfully taken to the ground and handcuffed following an altercation with two special police officers, resulting in injury to her shoulders. The jury returned a verdict in favor of the hospital and the officers after a four-day trial.
- Wood v. MedStar Harbor Hospital (2017), Circuit Court for Baltimore City. Obtained defense verdict for physician accused of injuring another physician in the course of performing surgery on a patient. The plaintiff, an orthopedic surgeon, accused the defendant, also an orthopedic surgeon, of negligently striking him in the elbow with a drill while both surgeons were performing a knee replacement. The plaintiff claimed the injury was career-ending. After an eight-day trial, the jury returned with a verdict in favor of Ms. Nesbitt's client.
- Al-Ameri v. The Johns Hopkins Health System (2017), United States District Court for the District of Maryland. Obtained summary judgment on claims for more than $1M in medical expenses on the grounds that all expenses were paid by the government of the plaintiff's home country, the United Arab Emirates.

Honors and Awards

- Best Lawyers in America, Commerical Litigation (2016 - Present)
- Chambers- Healthcare, Maryland (2017)
- Leading Women Award from The Daily Record (2011)
- Super Lawyers Rising Stars (2009-2014)

Education

- University of Maryland (B.A., cum laude, 1996)
- University of Maryland, School of Law (J.D., 1999) - Order of the Coif