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Resolving original Medicare's lien rights

A REVIEW OF STEPS TO BE TAKEN PRIOR TO SETTLEMENT TO DETERMINE ORIGINAL MEDICARE'S ENTITLEMENT TO REIMBURSEMENT

[*Editor's note: Mr. Reifler's erudite article was edited for length. For an unedited copy and assistance in negotiating Medicare liens, contact Mr. Reifler at nreifler@medivest.com.*]

This article concerns Medicare's lien recovery rights under original (also called traditional) Medicare. The lien rights are for benefits provided by original Medicare under Medicare Part A, hospitalization, and Part B, medical provider care, to an injured Medicare beneficiary. Lien recovery for benefits provided under the Medicare Act Part C, Medicare Advantage, and Part D (prescription drugs) are discussed in a companion article in this November issue of the Advocate. Both articles should be read to fully understand lien rights under all four parts of the Medicare Act.

Medicare Secondary Payer statute, 42 U.S.C. § 1395y(b) (MSP)

Under the Medicare Secondary Payer Act, found at 42 U.S.C. § 1395y(b) (MSP), Medicare has a right to be reimbursed for payments it has made for an original Medicare beneficiary's medical treatment, when the Medicare beneficiary is compensated for the treated injury by a third-party source.

The right to reimbursement under the MSP includes both a direct statutory right and a subrogation right, with a variety of recovery remedies available to the U.S. Government. Medicare administration and its enforcement rights are delegated to the Centers for Medicare and Medicade Services (CMS).

Medicare is not the primary payer

The MSP mandates original Medicare to be a secondary payer to other forms of health insurance such as group health plans (GHPs), as well as other payment sources, such as non-group health plans (NGHPs), when these primary plans are responsible for payment.

A "primary plan" is defined in 42 U.S.C. § 1395y(b)(2)(A) to mean "a group health plan or large group health plan to the extent that clause (i) applies, and

- a workers' compensation law or plan,
- an automobile or liability insurance policy or plan (including a self-insured plan)
- or no-fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. (42 U.S.C. 1395y(b)(2)(A)(ii).")

The payment obligation that triggers the MSP arises in the tort scenario, when payment is made by original Medicare. There are no defenses listed in the MSP. When a party settles a liability case, the payment obligation is "demonstrated," and the party responsible for payment is by the primary payer.

The MSP general rule – 42 U.S.C. § 1395y(b)(2)(A) – prohibits original Medicare from making payment, when a primary plan should make the payment. Specifically, a Medicare payment may not be made "to the extent that –

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1) [pertaining to GHPs], or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance."

There is only one exception to the prohibition of Medicare making payment. The exception authorizes Medicare to make payments called "conditional payments," if a primary plan "has not made or cannot reasonably be expected to make payment with respect to such item or service promptly." (42 U.S.C. § 1395y(b)(2)(B)(i)) For definitions of "prompt payment," see 42 C.F.R. § 411.21 and 42 C.F.R. § 411.50.

Payments made by Medicare are considered "conditioned on reimbursement" to Medicare by the primary plan. These conditional payments can be made either before or after a settlement by the beneficiary with the tortfeasor.

Medicare Set Asides (MSAs)

Medicare beneficiaries should consider protecting original Medicare's *future* interests, even though, at this writing, original Medicare does not overtly require an MSA to be part of a settlement agreement. Analysis of original Medicare's potential future exposure ideally involves consultation with a lien resolution service (such as Medivest), a life care plan and consultation with an economist. MSA regulations for tort recoveries are expected to be promulgated by CMS in late 2019 or early 2020.

Original Medicare tort lien negotiations

Initial lien determination: Attorneys should early-on determine whether the injured client is eligible for and receiving original Medicare benefits. If not an original Medicare beneficiary, then Medicare could not have made any conditional payments requiring reimbursement. If the client is an original Medicare beneficiary, the client should sign an SSA Consent for Release of Information – Form SSA-3288, which allows the attorney to search for conditional payments made by original Medicare. Lien searches are crucial to identify conditional payments that need to be addressed and resolved.

Communication with CMS for plaintiffs is accomplished through CMS' Benefits Coordination and Recovery Center (BCRC) and the CMS web portal called the Medicare Secondary Payer Recovery Portal (MSPRP). Medicare beneficiaries may access the MSPRP through

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their "MyMedicare" account, via the MyMedicare.gov web site. Attorneys (and insurers) may access the MSPRP through https://www.cob.cms.hhs.gov/MSPRP/. There is a registration process that must occur before access to the MSPRP is permitted.

Claim notification: Reporting the claim to the BCRC by the beneficiary, attorney for beneficiary or other third-party representative for beneficiary starts the conditional lien "case development process." This can be accomplished by calling the BCRC or reporting the claim via the MSPRP. To prevent generation of a duplicate case, it is a best practice to confirm with the BCRC whether or not a case has been previously established, before providing notification of a claim.

The notification to the BCRC should be on the attorney's letterhead with a Proof of Representation (POR) signed by the injured plaintiff. Alternatively, an attorney could sign the POR on behalf of the injured plaintiff, naming the third-party representative as long as they also provide a copy of the underlying Attorney/Client retainer agreement to help complete the chain of custody for the lien representation. For lien resolution matters, a POR combination form may be used. Certain language is to be included, but CMS does not require that the exact "form" posted on its website be used.

The BCRC: BCRC issues a Rights and Responsibilities letter after it is initially notified of a claim from a Medicare beneficiary, the attorney for the beneficiary, or a third-party representative. BCRC then performs a conditional payment search and usually issues a Conditional Payment Letter (CPL).

A CPL does not have a specific time frame to which a beneficiary must respond. However, if the payment summary form that accompanies the CPL contains diagnosis codes belonging to pre-existing or co-morbid conditions unrelated to the claimed injury, it is a best practice to submit a dispute to the BCRC through the MSPRP to request removal of unrelated charges.

A Conditional Payment Notice (CPN) is commonly issued when a settlement over $750 has occurred. A CPN has a thirty-day time period beyond which CMS automatically generates a demand (Final Demand) for conditional payment reimbursement, unless a timely dispute is made. Settling parties are to provide additional, relevant documentation helpful to assist with conditional payment dispute.

The BCRC may issue a revised conditional payment letter within approximately 11 business days of receipt of a dispute, when the dispute is submitted via the MSPRP portal. Not all disputes are able to be submitted via the portal. When submitted by mail, the turnaround is closer to 45 days.

Pursuant to the regulation governing the dispute process, 42 C.F.R. § 411.39 (v-vi), the opportunity to dispute discrepancies is a one-time event. It does not have an appeals process; i.e. there is no administrative or judicial review of the decision of CMS regarding disputes at this stage (although there is an opportunity to appeal after the Final Demand is issued). However, each piece of conditional payment correspondence may be disputed in this fashion.

Final demand letter

A Final Demand letter is issued approximately 30 days after the initial CPN or revised CPN (if the CPN had been disputed) is served. The request for a CPL alone does not trigger the sending of a Final Demand, and the representative or beneficiary must typically provide the settlement documents to trigger the Final Demand process.

Interest accrues 60 days from service of the Final Demand letter. Notification of nonpayment can be sent by CMS to the Department of Treasury (DOT), 120 days after demand for payment is made.

The DOT has remedies including temporary diversion or suspension of federal benefits to the Medicare beneficiary such as SSI, SSDI, and Medicaid (partially federally funded), tax refunds through the Treasury Offset Program, and use of privately contracted collection agencies. Amounts over $100,000 can be referred to the Department of Justice.

Detailed information regarding the conditional payment recovery process may be obtained from the CMS website, www.cms.gov and the MSPRP, using this link: https://www.cob.cms.hhs.gov/MSPRP. The CMS website explains Medicare's Recovery Process, the reporting of pending NGHP claims to the BCRC, and defines some important terms. It also has a sample cover sheet for communication, a sample Proof of Representation form, and a sample Consent to Release form as well.

Medicare lien resolutions

Because conditional payments are to be reimbursed and there is a direct statutory right providing the U.S. Government with rights of recovery including double damages, Department of Treasury offsets, and other remedies, the industry often refers to conditional payment claims as Medicare liens. We will use this terminology although it could be said that a lien usually needs some other action (such as a filing in a court) before it may be perfected.

Because of the high interest that the U.S. may charge pursuant to 45 C.F.R. § 30.13 (currently just under 10%) for failing to pay a final conditional payment demand within 60 days, the standard in the industry is to pay the demand and then request a waiver or compromise. Under 45 C.F.R. § 30.14(a), a debtor may either pay the debt within the 60-day period from the final demand or be liable for interest during the 120-waiver determination period, while on appeal, or while any formal or informal review of the debt is pending. If a waiver or compromise is granted, a refund will be issued.

The process takes about 120 days from start to finish for a waiver determination to be made. If a conditional payment demand has been paid, a waiver or compromise request may still be made, and a refund will be considered. If the BCRC makes a determination to refund all or part of the prior payment, the refund will typically take an additional three to four weeks, depending on whether payment had been made to the

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BCRC directly or whether it was made to the Department of Treasury after a referral of the debt to Treasury by the BCRC.

While an appeal or dispute is pending, CMS will cease all collection action on the case. Interest will still accrue after the 60 days from the Final Demand time period, but the debt should not be transferred to the DOT until a determination is reached. 42 C.F.R. § 411.39 provides an overview of the entire conditional payment process, including timing for requests to obtain "final conditional payment amounts" (lien amounts) via the CMS web portal. "Once settlement, judgment, award, or other payment information is received, CMS applies a pro rata reduction to the final conditional payment amount in accordance with section 411.37 and issues a final MSP recovery demand letter." (42 U.S.C. § 411.39 (ix).) Therefore, it is important to request attorney's fees and costs in procuring settlement for CMS' consideration.

An appeal may be filed if the beneficiary disagrees that they received an overpayment, disagrees with the amount of overpayment; or disagrees with any decision by CMS to not waive the repayment of the overpayment. The beneficiary must file an appeal within 120 days from the date of their receipt of this determination.

Medicare partial lien compromise or waiver process

In their demand letters, CMS typically informs beneficiaries that they may request a waiver or compromise if paying back the money would cause financial hardship or would be unfair for some other reason. The beneficiary is asked to provide a brief statement of any reasons why paying back the money would cause the financial hardship or would be unfair. CMS will send a form asking for information about income, assets, and expenses, and requesting an explanation of why it is believed the beneficiary is entitled to waiver of the overpayment. The determination for waiver including requests from CMS for additional information typically takes up to 120 days.

Seeking a Medicare lien compromise or waiver requires CMS to evaluate the fairness of the recovery of the entire Medicare lien amount compared to the net amount to be received by injured party, after deduction for fees and costs. The goal is to get CMS to either waive the amount being requested or to reduce the amount being requested. If CMS agrees to no longer pursue the recovery claim, it is said to waive the recovery and if CMS agrees to reduce the amount it will accept as full payment, it is called a compromise of the recovery claim.

There are several federal statutes and accompanying regulations that provide authority for CMS to compromise or waive Medicare liens. The statutes and regulations discussed below outline standards and factors that may be considered for full (waiver) or partial (compromise) reductions of Medicare lien amounts. These factors often focus on the ability of the injured party to pay the lien, costs the government would incur to pursue collecting the lien, as well as the injured party's financial/physical circumstances.

Medicare lien compromise process

If there is not a significant financial or physical hardship to the Medicare beneficiary, but the dollar amount of the projected settlement is low compared with the likely settlement value and/or the Medicare lien amount, an alternative to a waiver request is a Medicare lien compromise request. To request a compromise, a third-party representative may offer to pay a specific dollar amount on behalf of the beneficiary to fully compromise the outstanding Medicare debt/lien amount.

The requester must include the settlement amount (or settlement offer), the amount they are asking CMS to accept as full payment, and the actual or projected attorney fees and costs associated with procuring the settlement. Attorney fees and costs are omitted when the beneficiary is not represented by counsel. CMS, through the BCRC, either accepts the offer or presents an alternate proposed amount. At that point, the beneficiary must pay the countered amount or, if accepted, pay the accepted amount within 60 days of the BCRC response, or else the offer is no longer valid.

Medicare lien waiver process

The Medicare lien waiver process is a more involved process than the compromise process. Waiver requests typically focus on the financial position of the injured Medicare beneficiary, who may have higher expenses and/or lower income after sustaining an injury. After settlement occurs and funds are transferred, while the MSP technically still allows the U.S. to pursue the primary payer, when a Medicare beneficiary fails to satisfy a Medicare lien, the Medicare beneficiary is most often considered the debtor and pursued by CMS initially through the BCRC. Attorneys for Medicare beneficiaries can also be caught in the MSP crosshairs.

Waiver requests for a Medicare beneficiary are sent to the BCRC. In turn, the BCRC typically asks for an SSA-632 form to be filled out with a variety of financial information about the beneficiary. Waiver determinations may be made by BCRC staff and are usually based on financial hardship.

To speed up the process and increase the likelihood of a positive outcome, it is a best practice when requesting a waiver to provide a full financial picture of the beneficiary, including either a completed SSA-632 form or as much of the information requested by that form as can be obtained, so BCRC staff will have adequate information to reach a fair determination. A waiver may be granted when continuing the collection would be against "equity and good conscience."

Out-of-pocket expenses of beneficiaries may be considered. Beneficiaries should be advised to document out-of-pocket expenses including any copies of canceled checks to correlate with bills paid. A notarized/sworn statement may be considered along with canceled checks, corresponding bills and/or receipts, etc. Examples of the type of out-of-pocket expenses and other factors that might support granting a waiver are also provided in what is known as the MSP Manual under Chapter 7.

If recovery would defeat the purpose of benefits under these titles, i.e., would

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cause financial hardship by depriving a beneficiary of income required for ordinary and necessary living expenses, examples are provided as are examples of financial hardship with analysis provided as to what CMS would recommend under the hypotheticals provided. They also provide "waiver indicators" for and against granting waivers, as well as examples of letters used to provide notice of determinations regarding same.

Statutory bases for compromise or waiver

There are three main statutory provisions allowing for compromise or waiver of a Medicare lien claim, as follows:

1) ***The Federal Claims Collection Act*** **(*FCCA*)** governs collections by the federal government and requires heads of legislative agencies to try to collect claims of the U.S. and authorizes compromise of claims up to $100,000 and waiver of claims, ". . . when it appears that no person liable on the claim has the present or prospective ability to pay a significant amount of the claim or the cost of collecting the claim is likely to be more than the amount recovered." (31 U.S.C.A. § 3711(a)(3).) The FCCA is also known as the Debt Collection Improvement Act of 1996.

2) ***The Mandatory Secondary Payer Act*** **(*MSP*)** provides that "[i]f the Secretary determines that waiver of all or part of a conditional payment is "in the best interests of the program," all or part of a conditional payment may be waived. (42 U.S.C. § 1395y(b)(2)(B)(v).) However, this general "best interests of the program" standard is rarely used as the basis for negotiating a compromise or waiver of a conditional Medicare lien. Instead, those in the lien resolution business typically request a waiver or compromise of the lien pursuant to the more detailed bases and factors listed in various regulations.

3) 42 U.S.C. § 1395gg(c) a/k/a 256 H § 1870(c) of the Social Security Act allows waivers of Medicare liens by CMS contractors when not granting the waiver would be unfair ("against equity and good conscience").

Regulatory basis for compromise or waiver of Medicare lien claims

Pursuant to 42 C.F.R. § 411.28 (Waiver of recovery and compromise of claims), CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim. It references the general rules applicable to compromise of claims in both subpart F of part 401and under 42 C.F.R. section 405.376, as well as pertinent rules in subpart C of part 405.

Falling under subpart F of part 401 is 42 C.F.R. § 401.601 et seq. Under section 401.601(c), if the claim exceeds $100,000, those claims are referred by CMS to the Department of Justice or the General Accounting Office for evaluation. Otherwise, collection of claims at or under this amount are handled initially by CMS and later referred to the Department of Treasury. 42 C.F.R. § 401.613 requires that the compromise amount "[b]ear a reasonable relation to the amount of the claim; and [b]e recoverable through enforced collection procedures." Subsection (c) of the regulation follows the general principles of the FCCA in considering waiver or compromise. For example, CMS may compromise a claim for any one or combination of the following three factors:

(1) Inability of debtor or estate of deceased debtor to pay at the time or within a reasonable period of time;

(2) Probability of success in litigation. Difficult issues of law or lack of agreement on facts may be considered. This is a "step in the shoes" evaluation whereby the amount that CMS accepts in compromise under this provision should reflect how likely it would be for CMS to win and make a recovery;

(3) If the cost of collecting the claim does not justify the enforced collection of the full amount, CMS may discount an appropriate amount for the costs of collection it would have incurred if it had not been for the compromise.

Once CMS establishes that there is a basis under subsection (c), subsection (b) of the same regulation allows CMS to also consider

- The age and health of the debtor if the debtor is an individual;
- Present and potential income of the debtor; and
- Whether assets have been concealed or improperly transferred by the debtor.

Furthermore, under subsection (d) entitled Enforcement, "CMS may compromise statutory penalties, forfeitures, or debts established as an aid to enforcement or to compel compliance, if it determines that its enforcement policy, in terms of deterrence and securing compliance both present and future, is adequately served by acceptance of the compromise amount." (42 C.F.R. § 401.613.)

Similar factors for evaluation of compromise requests are also described under 20 C.F.R. § 404.515 pertaining to recovery of overpayments from beneficiaries and under 42 C.F.R. § 405.376 pertaining to claims for overpayments against a provider or a supplier under the Medicare program.

Terms of payment may be accepted on amounts due to CMS, but a debtor must submit a request to CMS in writing along with any information required by CMS to make a decision regarding the request. (42 C.F.R. § 401.607(c)(1).) Usually, the maximum term is three years, although this regulation provides hardship circumstances under which payment terms over three years may be granted.

While the Federal Claims Collection Act grants original Medicare the right to compromise its claims, or suspend or terminate its recovery actions, only CMS claims collection officers may take this action. CMS contractors may not enter into negotiations (either pre- or post-settlement) with beneficiaries, or their attorneys or representatives, to compromise Medicare's claim.

The trend has been for CMS and its contractors to offer reductions through the compromise process. Therefore, it is more common and efficient to make a request for a reduced lien balance rather than starting with a 120 determination of whether a waiver would be acceptable

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and then moving to (and waiting for) a compromise evaluation and determination.

As of this time, a negative response to a request for a compromise is not appealable. There is currently no limit to the number of requests that may be made but after several requests, however, CMS seems to indicate it will not entertain additional requests. Waiver responses (Determinations), on the other hand, are appealable and follow the same appeals process described regarding appeals of Final Demand amounts.

Appellate rights when reduction and waiver requests fail

A first-level appeal called a Redetermination may be submitted in writing through the MSPRP, within 120 days of the issuance of the Final Demand. The Final Demand is considered an Initial Determination. Once issued, beneficiaries, providers and suppliers (and Primary Plans for commercial recovery matters) may appeal the recovery amount, as codified and described in the Code of Federal Regulations under 42 C.F.R. § 405, Subpart I.

There are five levels of appeal: Redetermination, Reconsideration, ALJ hearing, Medicare Appeals Council Review, and U.S. District Court review. A party may not obtain review by a U.S. District Court unless and until they have exhausted the four initial administrative appeal stages; a process called exhaustion of administrative remedies. There is no threshold amount in controversy for the Redetermination to be reviewed. Any evidence to support the request for Redetermination is to be reviewed by the contractor. If the Redetermination is not favorable, the parties have 180 days from the date of the Redetermination to request a Reconsideration.

Unlike the Redetermination, the Request for Reconsideration must be mailed and is reviewed by a Qualified Independent Contractor (QIC). There is no minimum amount in controversy to have a Reconsideration reviewed. Prior evidence submitted to the contractor is to be reviewed by the QIC along with any new evidence the parties include in the Request for Reconsideration.

If the Reconsideration is not favorable, the parties have 60 days after the receipt of the Reconsideration to request a Hearing in front of an Administrative Law Judge (ALJ), if it meets the amount in controversy requirements outlined in 42 C.F.R. § 405.1006. The current amount in controversy required to request an ALJ hearing is $160. The ALJ will review the evidence that is contained in the record of the previous two appeals. The ALJ will consider additional evidence if there is good reason the evidence was previously left out of the previous appeals.

If the decision by the ALJ is unfavorable, the parties have 60 days from the date of the decision to request a Medicare Appeals Council Review (Council Review). There is no current amount in controversy needed to request a Council Review. The Council is to limit its review to the evidence contained in the record of the proceedings before the ALJ, unless the ALJ's decision included a new issue that the parties did not address at an earlier stage.

If the decision by the Council is unfavorable, the parties have 60 days from the date of the decision to file an action in U.S. District Court, if the file meets the amount in controversy for the appeal. The current amount in controversy for 2019 that must be met to file an action in a U.S. District Court is $1,630. This is the final appeal a party has in the Medicare appeals process. The decision by a federal district court described above is binding on all parties.

Medicare's recovery rights for double damages

The MSP provides a statutory cause of action for double damages for failure of a primary plan to make payment or promptly reimburse a conditional payment. (42 U.S.C. § 1395y(b)(2)(B)(iii).) The MSP direct cause of action by the U.S. including double damages is distinct from any claim under a theory of subrogation, although the MSP statute provides a subrogation right to the U.S.

There is an exception to recovery from Third Party Administrators (TPA) provided the TPA would not be able to recover the amount at issue from the employer or group health plan and is not under contract with the employer or group health plan at the time the recovery action is initiated. (See *U.S. v. Travellers Ins. Co.*, 815 F. Supp. 521 (D. Conn. 1992) [holding U.S. Government had direct right of recovery against insurer under MSP apart from its rights of subrogation but determined Government did not have a claim against insurance company when the insurance company was acting as a TPA of an employer group health plan].) There is also no claim against a TPA that provides administrative services, when there is insolvency or bankruptcy of the employer's or plan.

Recovery time limits

Three Year Statute of limitations. The U.S. must file suit within three years after the date of receipt of notice of settlement, judgment, award or other payment via paragraph 8 (which is the paragraph in the MSP that describes the Section 111 Reporting requirement). (42 U.S.C. 1395y(b)(2)(B)(iii).) This was added to the MSP pursuant to the SMART Act amendments in 2012, effective in 2013.

There is also a "time limit" under the MSP for claims for reimbursement requests. Notwithstanding any other time limits applying for employer group health plans, the U.S. may seek to recover conditional payments under the MSP, where the request for payment is submitted to the "entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished." (42 U.S.C. 1395y(b)(2)(B)(vi).)

Medicare's recovery rights against beneficiaries and/or their attorneys: The U.S. may recover double damages 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 C.F.R. § 411.24 indicates Medicare has a direct right of action

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against all primary payers responsible for making payment and a direct right of action against any person or entity that received a primary payment, including the Medicare beneficiary, medical provider, physician, attorney, state agency or private insurer. Furthermore, "CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan." (42 C.F.R. § 411.24(b).)

A U.S. District Court granted summary judgment for $11,367.78 against a beneficiary's attorney holding the attorney liable when Medicare's conditional payments were not addressed and timely reimbursed from a third-party settlement. (See *U.S. v. Harris*, 2009 WL 891931 (N.D. WVa. 2009) aff'd 334 Fed. Appx 569 (4th Cir. 2009). See also, *U.S. v. Weinberg*, 2002 WL 32356399 (E.D. Pa. 2002) [Partial judgment was entered in favor of the U.S. against the Defendant attorney on the issue of liability].)

In U.S. v. Sosnowski, 822 F.Supp. 570 (W.D. Wis. 1993), the U.S. recovered MSP conditional payments from a beneficiary *and* his attorney, but it was denied an award of double damages. The *Sosnowski* court placed more weight on the MSP wording "received primary payment from a primary plan" as opposed to the wording in the next phrase "or from the proceeds of a primary plan's payment to any entity." The wording in 42 C.F.R. § 411.24 "from the proceeds of a primary plan's payment to any entity" seemingly makes it clear that attorneys and beneficiaries could be liable for double damage claims by the U.S.

Medicare's recovery rights against estates of Medicare beneficiaries: Cases in which CMS has proceeded against an estate of a Medicare beneficiary have yielded varying results. For example, CMS was successful in *Benson v. Sebelius*, 771 F.Supp. 2d 68, 75 (D.D.C. 2011) (Plaintiff claimed his mother's medical costs in pursuing his wrongful death action, and they were taken into consideration in calculating and negotiating a wrongful death settlement award (citing *Mathis v. Leavitt*, 554 F.3d 731, 733 (8th Cir.2009)) ("Because appellants claimed all damages available under the Missouri wrongful death statute, the settlement, which settled all claims brought, necessarily resolved the claim for medical expenses."); *Cox v. Shalala*, 112 F.3d 151, 154–55 (4th Cir.1997) (settlement included recovery for decedent's medical expenses); see also *Brown v. Thompson*, 374 F.3d 253, 262 (4th Cir.2004) (holding that CMS was entitled to reimbursement from the proceeds of a medical malpractice settlement pursuant to the MSP).)

However, when the underlying wrongful death claim made no claim for medical expenses, there is a stronger argument that the Medicare lien does not extend to the estate of a deceased Medicare beneficiary. (See *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir.2010) [U.S. was denied the ability to recover Medicare's conditional payments, because no medical expenses of decedent Medicare Beneficiary were claimed in wrongful death action by survivors].)

Conclusion

Prior to settlement, steps should be taken to determine original Medicare's entitlement to reimbursement for conditional payments for the claimed injury. First, obtain a copy of the front and back of each and every type of insurance the injured client had from the time of the accident, until the time retained (and beyond). Second, confirm that the reimbursement amounts requested by CMS relate to the claimed injury/body areas and are not associated with pre-existing conditions.

Obtain the final lien claim, and request a reduction for attorney's fees and costs. Follow the logic set forth in 42 C.F.R. § 411.37 for a reduction of conditional payments by the attorney fee percentage as well as the attorney's costs. While the referenced regulation is in the portion of the MSP regulations dedicated to WC cases, based on cases like the *Hinsinger v. Showboat Atl. City*, 420 N.J. Super. 15, 19, 18 A.3d 229, 232 (N.J. Super. Ct. Law. Div. 2011) case, CMS seems to now recognize this reduction formula for liability cases as well. This process of performing a pro rata reduction is mentioned in the regulations in 42 C.F.R. § 411.39 (ix) "Once settlement, judgment, award, or other payment information is received, CMS applies a pro rata reduction to the final conditional payment amount in accordance with § 411.37 and issues a final MSP recovery demand letter."

Lastly, if the amount client's net settlement is low in comparison with the amount being requested by Medicare, a request for a compromise or waiver may be appropriate.

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