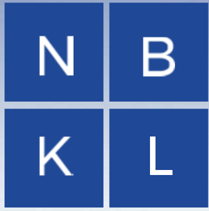
Nyhan Bambrick Kinzie & Lowry

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SUMMER 2018

Welcome to NBKL's "Medicare Secondary Payer Compliance Corner"

CROSSING THE THRESHOLD: What's Included in the Total Settlement Amount?

CMS will consider a proposed Medicare Set-Aside (MSA) when the Total Settlement Amount (TSA) exceeds the one of two review thresholds. The CMS review thresholds are well-known and, for Medicare beneficiaries, is only $25,000. For claimants who have a reasonable expectation of Medicare enrollment within 30 months of the settlement date, the threshold jumps to $250,000.

However, less is understood about what is included in the TSA. Most often, the TSA will include 1) the anticipated indemnity (permanency and unpaid lost time and past medical expenses); 2) the proposed MSA; and 3) any pending conditional payments by Medicare for past medical expenses. However, CMS has provided more specific information in its Workers' Compensation MSA Reference Guide.

What's Included?

First, the TSA is the gross total indemnity settlement and includes attorney fees and expenses. Note that exact amounts, not rounding up or down, should be used. Settlement payments from a state second injury being made at the same time are included.

Next, the TSA includes the MSA (whether proposed or approved by CMS) itself. The MSA is comprised of Medicare-covered medical items and services and future prescription medications normally covered by Medicare. If applicable, non-Medicare-covered medical costs that are paid in the settlement are also included.

If the MSA is to be funded by an annuity, the full annuity payout expected over the life of the settlement is included in the TSA. The actual cost or present value of an annuity is not relevant to calculating the TSA.

In addition, prior settlements of the same claim and settlement advances are included in the TSA. A common example is where the indemnity or permanency portion of a settlement is reached, but future medical rights are kept open. Later, the parties agree to settlement those medical rights. In that situation, both the prior settlement amount and the amount of the projected future medical costs are included in the TSA calculation.

Amounts forgiven by the carrier or primary payer are included in the TSA. This provision includes amounts waived against third party recovery as part of settlement of a workers' compensation claim. In Illinois, such right of recovery or lien is found in Section 5 of the Workers' Compensation Act. The amount of prior third party liability settlement of the same workers' compensation injury is also included in the TSA, though such amount may be reduced if apportioned by a court on the merits.

Prior lien payments to be repaid - including Medicare conditional payment claims – are also considered in the TSA. Regarding conditional payments, CMS has not clarified what constitutes amounts to be repaid. Generally, a final conditional payment amount is not determined until after a settlement is approved. In the interim, CMS will assert conditional payment claims which may be disputed (usually for relatedness) and reduced or even removed. Considering these interim amounts in the calculation may cause the TSA to exceed the review threshold, particularly if the lower $25,000 figure for Medicare beneficiaries applies.

What's Excluded?

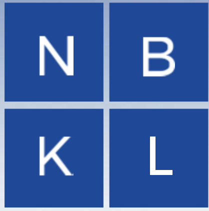
The Reference Guide also specifically excludes certain items from the TSA. The most relevant exclusions are past payments of indemnity or medical expenses that are not part of settlement and payment of prior contested awards by a court on the merits. Liens that the claimant will pay from the settlement funds are also excluded. In addition, medical malpractice settlements based on alleged mishandling of the workers' compensation injury are not considered part of the settlement.

Thoughts to Takeaway and Compliance Strategies

Settlement refers to "new" amounts being offered to resolve existing claims. While prior settlements of workers' compensation claims are included in the TSA calculation, CMS has drawn a distinction for past payments of voluntary benefits and even for prior contested awards. Consider the following scenario: a claim went to a full hearing on contested matters and a final award was paid for lost time, medical expenses, and/or permanency benefits, but the claimant's future medical rights remained open. Later, the parties wish to settle the remaining future medical portion. There is a strong argument to exclude payment of the prior contested award in the TSA and it may be beneficial to remain under the threshold where CMS review is not available. In fact, it is likely that CMS would not review a proposed MSA under those circumstances. It is important to note, however, CMS' internal workload review threshold are not "safe harbors" when it comes to Medicare Secondary Payer obligations.

In the calculating conditional payments to be included in the TSA, the TSA may fluctuate and present a timing component. If interim conditional payments would put an otherwise under-the-threshold settlement over the threshold, consider whether the conditional payments are unrelated and may be disputed. The dispute process can take a few months, but once removed the planned settlement may go forward without submission of the MSA proposal to CMS for approval. Conversely, the certainty of CMS approval may be desirable where certain body parts/conditions are accepted while others are denied and waiver of future medical costs is sought, the inclusion of interim conditional payments might allow CMS review.

While the TSA calculation is fact-specific and sometimes complex, our MSA team of attorneys is available to assist with strategies and recommendations. Let us help navigate CMS policy and Medicare Secondary Payer compliance.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SUMMER 2018

Dispelling Medicare Secondary Payer (MSP) Compliance Myths

By now, most claims adjusters and attorneys involved in workers' compensation and liability settlements are aware of the Medicare Secondary Payer Act (MSP Act) and the potential impact that it may have in certain settlements. An incomplete understanding of the actual obligations however may result in a less than ideal approach for claims handling and settlement. This article reviews the core provisions of the MSP Act and supporting Regulations in order to dispel some of the more common MSP compliance misconceptions and assist you in determining the best MSP compliance approach for your claim.

Core provisions of the MSP Act and Regulations

MSP compliance involves three main components: the resolution of Medicare's conditional payments; the avoidance of a cost shift of injury related expenses to Medicare in a settlement; and mandatory reporting under Section 111. All of these components are addressed in the MSP Act and supporting Regulations. In addition to the above laws, the Centers for Medicare and Medicaid Services (CMS) has issued Guidance Memos on the MSP Act that have been summarized in Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guides. These Guidance Memos do not carry the weight of law but simply provide CMS' view of the MSP Act.

Conditional Payments / Section 111

The MSP Act provisions begin at 42 U.S.C. Sections 1395y(b) and focus on Medicare's status as a Secondary Payer in certain situations. 42 U.S.C. Section 1395y(b)(2)(A) specifically prohibits Medicare from making a payment for any item or service "*to the extent that …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.*" The exception to this prohibition is found in subparagraph (B) which states that Medicare may make payment if the primary plan described above "has not made or cannot reasonably be expected to make payment with respect to such item or service promptly…" Medicare's payment is conditioned on reimbursement to the appropriate Medicare Trust Fund.

The obligation to reimburse the Medicare Trust Fund for conditional payments falls on the primary plan and "an entity that receives payment from a primary plan …. if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." Responsibility to make payment may be demonstrated "by a judgment, 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 by other means."

Chapter 42 of the Code of Federal Regulation Sections 411.20 through 411.54 provide additional details regarding the recovery process for conditional payments in workers' compensation, liability and no fault claims. Section 111 mandatory reporting obligations, found at 42 U.S.C. 1395y(b)(8), enhance Medicare's ability to identify Medicare

beneficiaries that have received settlements, judgments, awards or other payments from workers' compensation, no fault insurance or liability insurance plans. By virtue of this reporting, Medicare is then able to seek recovery of conditional payments from a primary plan and avoid making additional payments when a primary plan is available.

Closure of Future Medical in a Settlement

Although the MSP Act and supporting Regulations never mention a Medicare Set-Aside, 42 C.F.R Section 411.46 discusses workers' compensation commutation and compromise settlements that close out future medical rights. It states that "if a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment." This type of settlement is a commutation settlement.

Disputed workers' compensation settlements are considered to be lump-sum compromise settlements. Medicare views these settlements as workers' compensation payments under the MSP Act regardless of their disputed nature. Medicare will not recognize the settlement, if the settlement "appears to represent an attempt to cost shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition."[1] If the lump-sum compromise settlement does not attempt to shift injury related expenses to Medicare, and the settlement agreement allocates for specific future medical services, "Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses."[1]

Dispelling MSP Compliance Myths

Many cases involve soft tissue types of injuries or injuries that are unlikely to require future care with claimants that return to work. In light of this, parties may not encounter MSP compliance issues on a regular basis. Below are a few of the more common MSP compliance misconceptions, followed by factual clarifications.

Myth 1: A Workers' Compensation Medicare Set Aside (WCMSA) must be reviewed by CMS when the projected settlement meets CMS' internal workload review threshold.

Fact: There is no requirement to submit a WCMSA to CMS for review. Medicare review is purely voluntary. Section 1.0 of CMS' WCMSA Reference Guide (Version 2.7, March 19, 2018) states: "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures." Section 4.1.4 further states: "If Medicare's interests were not 'reasonably considered' in the settlement, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the entire dollar amount of the entire WC settlement." Although CMS notes the benefits of obtaining

[1] See 42 C.F.R. Section 411.46 (b)(2)

[1] See 42 C.F.R. Section 411.46 (d)(2)

the "certainty" associated with CMS reviewing and approving the proposed WCMSA amount, the value of this benefit should be examined on a case by case basis.

As long as the settlement does not appear to cost shift injury-related expenses to Medicare and includes a reasonable allocation for future medical services, Medicare should become primary after the amount of the lump-sum settlement allocated to future medical expenses is properly exhausted (42 C.F.R Section 411.46 (d)(2)). An appropriate allocation within the settlement will show Medicare's interests were "reasonably considered."

Myth 2: Medicare has no interest in a settlement when the projected settlement is below CMS' internal workload review threshold.

Fact: The CMS internal workload review thresholds do not provide parties with a "safe harbor" when it comes to MSP compliance. The settlement should still avoid a cost shift of injury related expenses to Medicare, whether it is done by fully funding the future injury related care or by apportioning the net settlement funds in an objective manner that supports the future medical allocation. Conditional payments must also be investigated and Section 111 reporting may also apply.

Myth 3: All MSAs have to be projected consistently with CMS' methodology as outlined in the WCMSA Reference Guide.

Fact: CMS' projection methodology is appropriate when the parties are electing to use the voluntary CMS review process. The traditional CMS projection methodology however may result in over funded future allocations: most people do not undergo diagnostic studies in the "cookie-cutter" frequency used by CMS nor do they maintain the same drug regimen for life.

Alternatives to the traditionally projected CMS reviewed MSA include the non-submitted Evidence-Based Medicine allocation that projects care based on ODG guidelines and the recommendations of the treating physicians, the compromise MSA allocation that is carved out of the net settlement in a disputed claim and allocations that are limited based upon the underlying State law. These alternatives to the traditionally projected CMS reviewed MSA are both legally and medically defensible ways to give Medicare's interests "reasonable consideration" in the settlement.

Myth 4: Medicare has no interest in a liability settlement.

Fact: The MSP Act and supporting Regulations identify liability plans as plans that are primary to Medicare in certain situations. (42 U.S.C. Section 1395y(b)(2)(A)). In light of this, Medicare has the right to seek recovery of conditional payments made in connection with liability settlements. Liability settlements are also subject to mandatory Section 111 reporting.

Although 42 C.F.R Section 411.46 discusses the closure of future medical rights in lump-sum commutation or compromise settlement in the context of workers' compensation settlements, the same analysis may be considered in determining the approach for a liability settlement. Liability settlements would generally fall into the compromise settlement category. Given the language of the MSP Act and Regulations, it would be prudent for parties in a liability

settlement to avoid the appearance of an attempt to cost shift to Medicare the responsibility for payment of medical expenses for the treatment of the injury related condition. An apportionment of the negotiated settlement funds in an objectively reasonable manner would reduce the risk that Medicare may deny future injury related care.

A review of CMS' statements and Guidance Memos further supports the conclusion that Medicare views itself as having an interest in liability settlements. This view goes back to the May of 2011 memo issued by Sally Stalcup, the MSP Regional Coordinator for CMS Region 6. She wrote that "Medicare's interests must be protected; however CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law requires that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law."

On September 29, 2011, CMS issued a Guidance Memo on liability MSAs. It states that the agency will consider Medicare's interests regarding future medical in the liability settlement to be satisfied upon procurement of a certification from the beneficiary's treating physician that the beneficiary's treatment has concluded and no future care will be required. Other actions taken by CMS, such as the Advance Notice of Proposed Rulemaking for liability MSAs put out in June of 2012, the requirement that the new Workers' Compensation Review Contractor be able to review liability MSAs, and CMS' notice of system updates to allow for the identification of liability MSAs and no fault MSAs in MSP records all suggest that at some point, CMS may be willing to provide a voluntary review of a liability MSA. Despite speculation that the new voluntary liability MSA review process would be in place by July of 2018, this has not occurred.

To date, MSP compliance caselaw generally address issues pertaining to the reimbursement of conditional payments, as well as standing to bring a Private Cause of Action. The issue of a liability MSA was however discussed in the *Silva v Burwell* case, 2017 U S Dist LEXIS 195032 (D.N.M. November 28, 2017). This case arose in connection with a medical malpractice settlement agreement between Mr. Silva and the hospital Defendants. The Hospital Defendants wanted Mr. Silva to establish an MSA in connection with his settlement or in the alternative secure a federal court order finding that one was not needed. Since CMS declined to state its position on this, Mr. Silva brought an action under the Declaratory Judgement Act against Defendants Burwell, the Secretary of the US Department of Health and Human Services, CMS and the US Department of Health and Human Services requesting a finding that no liability MSA is needed in the case.

The Court reviewed the MSP Act and noted that although CMS had promulgated regulations addressing MSA arrangements in the context of workers' compensation cases and established a review process, it had not done so in liability claims. It further stated that there is no federal law or regulation that requires CMS to provide its position on the liability MSA, although the uncertainty associated with this was detrimental to the settlement process. The Court dismissed the claim pursuant to Defendant Burwell's Motion, finding a lack of subject matter jurisdiction.

Although CMS has not provided the same degree of "guidance" in the area of liability MSAs as in the area of workers' compensation MSAs, MSP compliance obligations are determined by the MSP Act. The MSP Act clearly identifies liability plans as primary plans in certain situations in which Medicare is a secondary payer.

Conclusion

Parties should consider Medicare's interests when settling workers' compensation and liability claims. As noted earlier, the three main components of MSP compliance involve the resolution of conditional payments, the avoidance of a cost shift of future injury related care to Medicare, and Section 111 reporting.

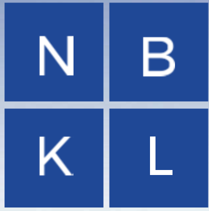
In settlements involving a Medicare beneficiary, it is prudent to investigate and address conditional payments made under traditional Medicare Part A and B plans as well as any potential payments made by Medicare Advantage Plans under Medicare Parts C and D. Section 111 mandatory reporting obligations also have to be met.

When it comes to avoiding a cost shift of future injury-related Medicare covered expenses, there are alternatives to the traditional WCMSA that is reviewed by CMS. Although the traditional CMS reviewed WCMSA has its benefits, non-submitted MSAs that avoid the appearance of a cost shift of injury related expenses to Medicare may also play a role in your MSP compliance strategy. The non-submitted MSA may be one that is projected based on evidence based medicine guidelines, one that is apportioned from the net settlement funds in a disputed claim, or one that is based on the limitations imposed by the underlying State law.

Parties reaching liability settlement agreements may also benefit from apportioning some of the net settlement funds for future injury related Medicare covered treatment. As long as the apportionment is done in a reasonable manner without the appearance of a cost shift of injury related Medicare covered expenses, Medicare should become primary upon proper exhaustion of the allocated funds.

It is important to recognize that your MSP compliance obligations are determined by a combination of the underlying state law, MSP Act and Regulations, and not by CMS' Guidance Memos. There is also more than one way to give Medicare's interests reasonable consideration in a settlement. Our team of experienced MSP compliance attorneys is available to assist in determining the best MSP compliance option for you in any given case. We also partner with you to develop and implement internal MSP compliance programs. Additional information is available upon request.

*1 See 42 C.F.R. Section 411.46 (b)(2)
*2 See 42 C.F.R. Section 411.46 (d)(2)



The Private Cause of Action under the Medicare Secondary Payer Act

The Medicare Secondary Payer (MSP) Act provides that Medicare will make conditional payments for medical services when a primary plan has not made, or cannot reasonably be expected to make, payments for those services. 42 USC §1395(y)(b)(2)(B)(i). If it turns out that the "primary payer" had a responsibility to make those payments, Medicare is permitted to seek reimbursement from that payer. In the event that Medicare is not timely reimbursed, the private cause of action mechanism allows actions for ***double*** the amount initially paid by Medicare against the primary payer. 42 USC §1395(y)(b)(3)(A).

It is well established that Medicare is not the only party that may compel a reimbursement of conditional payments. The private cause of action mechanism of the MSP Act is an enforcement provision that allows Medicare Beneficiaries, and others, to bring an action against a party for double the amount owed to Medicare. In order to bring the private cause of action however, a party must have "standing."

The legal concept of "standing" in an action based on federal law is found in Article III of the U.S. Constitution. Article III standing has three requirements: (1) the plaintiff must have suffered an injury in fact; (2) the injury must be fairly traceable to the conduct of the defendant; and (3) the injury must be likely to be redressed by a favorable decision. Below is a discussion of caselaw relating to various groups that may have standing to bring an MSP private cause of action.

Physicians and Medical Groups

The Sixth Circuit in *Bio-Medical Applications of Tennessee Inc. v. Central States Southeast & Southwest Areas Health & Welfare Fund* limited the private cause of action's applicability to only group health plans that differentiated coverage based on Medicare eligibility. 656 F.3d 277 (2011).

Subsequently, the Sixth Circuit in *Michigan Spine & Brain Surgeons v. State Farm Mutual Automobile Insurance Co.* held a health care provider can bring the private cause of action against a non-group health plan. 2014 U.S. App. LEXIS 13499 (2014). In *Michigan Spine & Brain,* State Farm Insurance Company was a no-fault carrier that denied coverage of an injured claimant's medical treatment based on an alleged pre-existing condition. Instead, Michigan Spine & Brain Surgeons provided treatment to the injured claimant. Michigan Spine and Brain submitted its bills to Medicare and then sought reimbursement from State Farm based on the private cause of action of the MSP Act.

On appeal, the Sixth Circuit reversed the lower court's decision and held that the health care provider may bring an action for double damages regardless of any demonstration that a non-group health plan denied coverage based on a claimant's Medicare eligibility, thus expanding the ability of clinicians to bring such actions.

The holding in *Michigan Spine & Brain* appeared to expand the interpretation in *Bio-Medical* by allowing a private cause of action without a showing of denied coverage based on a claimant's Medicare eligibility.

Medicare Advantage Organizations

The right of Medicare Advantage Organizations to bring a private cause of action under the MSP Act has been extensively litigated due to ambiguousness within the Act. This was demonstrated in *Parra v. PacifiCare of Arizona, Inc.* wherein the U.S. District Court for the District of Arizona dismissed a private cause of action suit for lack of subject matter jurisdiction. 2011 WL 1119736 (2011). In *Parra*, the Court held the MSP Act gave no private cause of action to Medicare Advantage Organizations and further held that there was no congressional intent to do so. Instead, the Court held that reimbursement claims by Medicare Advantage Organizations should be brought under state law contract theories.

In affirming this notion, the U.S. District Court in the Eastern District of Pennsylvania in *In re Avandia Marketing* shut down Humana's argument that the MSP Act unambiguously allowed Medicare Advantage Organizations to bring a private cause of action. 2011 U.S. Dist. LEXIS 63544 (2011). The Court focused on the lack of a congressional grant in the statute of such remedy. Then, in 2012, the Third Circuit in *In re Avandia Marketing* overturned that decision and held that Medicare Advantage Plans may bring a private right of action to recover conditional payments. No. 15-2145 (2016). The Third Circuit instead held that any private plaintiff with standing may bring an action for recovery under the MSP Act.

Later, the 11th Circuit held in *Humana Medical Plan Inc. v. Western Heritage Insurance Co.* that Medicare Advantage Organizations have standing to bring actions against primary payers for reimbursement of conditional payments as well. 2016 WL 4169120 (11th Cir. Aug. 8, 2016). These cases demonstrate that if primary payers are not proactive in identifying and resolving conditional payments, they are open to potential surprises at, or even after, settlement.

More recently, a Southern Florida District Court in *MSP Recovery Claims Series LLC v. Travelers Cas. & Sur. Co.* addressed a Medicare Advantage Organization's standing to bring a private cause of action. 1:17-cv-23628 (2018). In *Travelers,* MSP Recovery sought reimbursement from Travelers Insurance on behalf of Health First Administrative Plans, a Medicare Advantage Organization. Travelers argued MSP Recovery did not have adequate standing to bring the action because it did not suffer an injury in fact. The Court noted for MSP Recovery to have suffered an injury, it must show that it suffered some personal harm, pled facts showing that HFAP itself suffered an injury in fact, and that HFAP validly assigned its rights of recovery to MSP Recovery.

The Court determined that MSP Recovery had not established that HFAP was an MAO, as established in *MSP Recover Claims v. Auto-Owners Ins. Co.* 2018 U.S. Dist. LEXIS 69723. In *Auto-Owners*, The Court noted that HFAP was not listed on the CMS website list of Medicare Advantage Organizations and thus, the Court took judicial notice of same. The Court differentiated between *any* party and a *specific* party that may bring an action under the MSP for recovery. The Court explained that a party must have suffered an injury under the statute. Again, the Court relied on the reasoning in *Auto-Owners* and reasoned that because HFAP was not considered a valid Medicare Advantage Organization, it was not able to assign its rights to pursue a private cause of action to MSP Recovery Claims, and thus, MSP Recovery would not have suffered any injury. Next, the Court ruled not only that MSP Recovery failed to establish HFAP had standing and by extension, MSP Recovery did not possess standing.

Individuals/Beneficiaries

Beneficiaries and personal representatives of a beneficiary's estate have also been determined to have standing under the MSP Act. The 8th Circuit in *Stalley v. Catholic Health Initiatives* outlined the policy goals of giving Beneficiaries this authority:

- First, the Beneficiary is more aware than the government to determine whether and what other entities may be responsible to pay for his or her expenses.
- Second, without the incentive of double damages, the Beneficiary would have no motivation to sue the insurer, because they have likely already been paid.
- Finally, a Beneficiary could potentially reimburse Medicare and have funds remaining to go towards the cost of litigation. 509 F.3d 517, 2007 U.S. App. LEXIS 27331.

The issue of a personal representative of an estate was very recently addressed in *Netro v. Greater Baltimore Medical Center,* 2018 WL 2472789 (4th Cir. June 4, 2018). In *Netro*, the Plaintiff, on behalf of her deceased mother, brought a civil action against the hospital for post-surgical complications leading to her mother's death. At trial, the Defendant was found liable and the Plaintiff was awarded $451,956.00 in damages, which included around $157,000.00 in Medicare conditional payments. Shortly after, the Defendant asked the court to reduce the amount of damages to reflect medical expenses actually paid, which the court agreed to. A short three weeks later, the Plaintiff filed a Private Cause of Action under the Medicare Secondary Payer statute alleging the Defendant failed to reimburse Medicare for the conditional payments.

The court addressed two issues: (1) Standing and, (2) Whether the Defendant's delay in payment warranted the double damage remedy under the PCA of the MSP.

First, the Court determined the Plaintiff had standing under the Medicare Secondary Payer statute. The Defendant argued the Plaintiff could not have standing to bring the PCA because the money was owed to Medicare, not her, and therefore, she could not have suffered an "injury" needed in order to establish standing under Federal law. The Court reasoned the damages owed to Plaintiff included the amount owed to Medicare, and that the MSP assigned reimbursement efforts to Beneficiaries within the statute, as outlined above.

In explaining the standing issue in context of the MSP, Judge Wilkinson noted, "Step back for a moment from the complex world of Medicare payments, and imagine more mundane litigation: If Plaintiff Pam borrows something from Lender Lisa, and Defendant Dan steals it, Pam obviously has standing to recover from Dan. Her injury is not erased by the fact that the recovery will ultimately end up in Lisa's hands. The same logic applies here".

Second, the Court determined the Defendant's delay in payment did not warrant double damages. Ultimately, the Plaintiff received the funds 37 days after the judgement. The Court reasoned this delay was not how the statute contemplated "failure to pay," and that much of the delay was brought on due to the need to determine the amount of the judgement, rather than any bad faith avoidance.

This case demonstrates the one interpretation in a wide range of rulings on what constitutes standing and a "failure to pay" in the MSP context. Though the Defendant ultimately did not pay double damages, the litigation illustrates the importance of who has standing in these cases, and determining the amount of conditional payments as soon as practical and any disputes available.

The Medicare Secondary Payer's private cause of action mechanism opens parties to post-settlement litigation, though preliminary hurdles of constitutional standing must be crossed prior to making a case for double damages. This potential exposure further underscores the need for parties to be pro-active in the identification, negotiation and resolution of conditional payments as a part of any settlement. Our team of experienced MSP compliance attorneys is here to assist you in all stages of this process. Additional information is available upon request.

About our MSP Compliance Services

The Medicare Secondary Payer Act and supporting Regulations are complex. Our team of thought leading experienced MSP compliance attorneys, all with workers' compensation defense backgrounds, is here to help you navigate the MSP compliance path. Our full range of MSP compliance services includes the following:

1. Medicare Set-Asides
2. CMS submissions and review
3. Amended Re-review to CMS
4. Future Medical Allocations
5. Conditional Payment Negotiation
    a. Parts A & B,
    b. Parts C & D
    c. Recovery of overpayments to CMS
6. Liability Payment Compliance
7. Medicaid Lien Resolution
8. Assistance with the Development and Implementation of internal MSP Compliance programs

Contact us for information regarding the above services. Additional services may also be available upon request.