MEDICARE & BWC SETTLEMENTS

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SOCIAL SECURITY AND THE SETTLEMENT OF WORKERS' COMPENSATION CLAIMS

Shaun Omen – Staff Counsel, Ohio Bureau of Workers' Compensation

CAUTIONARY NOTE

The Medicare Act has been referred to as "remarkably abstruse" *MSP Recovery LLC v. Allstate Ins. Co.* 835 F.3d 1351, 1358 (11 Cir. 2016); a "complex maze" *MSPA Claims 1, LLC v. Bayfront HMA Medical Center* No. 17CV21733, 2018 WL 1400465 (S.D. Florida March 20, 2018); and "the most completely impenetrable texts within human experience" *Avandia* 685 F.3d at 365. The Court gives no credence to the whispered tales of courts that wandered innocently into the tangled forest of the Medicare Act never to be heard from again. Yet, in an abundance of caution, should some tragedy befall us, we want our mothers to know we loved them and ask that the same inscription be given this Court, with slight modification, as was given the Spartan dead at Thermopylae: "Go tell Congress, stranger passing by. That here, because of their convoluted laws, we lie."

CAUTIONARY NOTE

As the court observed, the law surrounding Medicare Secondary Payer is confusing and evolving. It is our intention to provide this group with helpful and useful information. However, we all are forced to continue to monitor the law and its evolution.

The origin of Medicare Secondary Payer

HOW WE GOT HERE

HOW WE GOT HERE

- In July 1965, President Lyndon Johnson signed the Medicare amendment to the Social Security Act into law.
- Medicare is a federal health insurance program that provides health insurance benefits to people 65 years of age or older, disabled people, and people with end-stage renal disease. *Stalley v. Methodist Healthcare*, 517 F.3d 911, 915 (6th Cir.2008).

HOW WE GOT HERE

- CMS is the federal agency responsible for administration of the Medicare program. *BP Care, Inc. v. Thompson*, 337 F.Supp.2d 1021, 1023 (S.D.Ohio 2003).
- Prior to 1980, Medicare paid for medical services regardless of whether another health plan also covered the Medicare beneficiary. *Fanning v. United States*, 346 F.3d 386, 388 (3d Cir.2003).

HOW WE GOT HERE

- Rising Medicare costs eventually led Congress to enact a series of amendments in the 1980s which became known as the Medicare Secondary Payer Act ("MSPA").
- Codified as 42 U.S.C. § 1395y, the Act makes Medicare the secondary payer in cases where a primary plan (e.g. a state workers' compensation plan) exists. It is administered by CMS.
- Chiquita Brooks-LaSure is the current Administrator of CMS
- The regional CMS office for Ohio is in Chicago and the Depuity Associate Regional Manager is Gregg Brandush

- 312-353-1567: Gregg.Brandush@cms.hhs.gov

Primary Plans and Secondary Plans

THE RULES OF MEDICARE SECONDARY PAYER

THE RULES OF MSP

- In 1980, Congress prohibited Medicare from paying for health services covered by other "primary" insurers though its creation of the Medicare Secondary Payer (MSP) program.
- This means that if payment for covered services has been or is reasonably expected to be made by somebody else, Medicare does not have to pay.
- The prohibition includes past and future health services. 42 C.F.R. §411.46: " (a) Lump-sum commutation of future benefits. 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."

THE RULES OF MSP

- The MSP defines a "primary plan" as "a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no-fault insurance." 42 U.S.C.A. 1395y.
- If the primary payer has not paid and will not promptly pay, Medicare can conditionally pay the cost of treatment. 42 U.S.C. § 1395y(b)(2)(B).

THE RULES OF MSP

- The MSP empowers Medicare to seek reimbursement for any conditional medical payments from the primary payer – or from the recipient of the payment – if it is demonstrated that the primary payer has a responsibility to pay.
- The responsibility of a primary payer may be demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver or release, of payment for items/services included in a claim against the primary plan, or the primary plan's insured; or other means. 42 U.S.C. 1395y(b)(2)(B)(ii).

THE RULES OF MSP

The federal regulation on settlement of workers' compensation claims, 42 C.F.R. 411.46, provides: (a) Lump-sum commutation of future benefits. 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. (b) Lump-sum compromise settlement. (1) **A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan.** (2) If a settlement *appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized*. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition. (Emphasis added).

THE RULES OF MSP

Under the regulation, an agreement which allocates a portion of a lump sum to medical expenses will be "disregarded" only where the parties have attempted to unlawfully shift medical expenses covered under the workers' compensation statutes to Medicare. *The regulations do not require a formal set aside or trust be created. Frazer v. CNA Ins. Co., 374 F.Supp.2d 1067, 1075 (N.D.Ala.2005)*. An individual claimant receiving a lump-sum settlement which includes future medical care is only bound to exhaust funds reasonably allocated to the cost of future medical treatment.

SETTLEMENT OF A WORKERS' COMPENSATION CLAIM

Settlements under Ohio Revised Code (ORC) 4123.65 and Court Settlements

SETTLEMENT OF A CLAIM

The Ohio Supreme Court has recognized that claimants and employers in the workers' compensation system keep rights to settle claims or causes of action after they have accrued. *State ex rel. Weinberger v. Indus. Comm.*, 139 Ohio St. 92, 96 (1941). These rights are incidental to and necessarily included in the right of the claimant and employer to assert their claim or prosecute a cause of action on such claim in a court or other tribunal. (*Id*). [See also, *State ex rel. Johnston v. Ohio Bur. of Workers' Comp.*, also: 92 Ohio St.3d 463, 466 (2001)].

SETTLEMENT OF A CLAIM

Recognizing that "settlement of workers' compensation cases necessarily affects the interests of the workers' compensation system itself," the Ohio General Assembly created specific mandatory guidelines for the administrative settlement of workers compensation claims and all self-insured claims in ORC 4123.65. *Gibson v. Meadow Gold Dairy*, 88 Ohio St.3d 201, 203 (2000). [See also, *State ex rel. Wise v. Ryan*, 118 Ohio St.3d 68, 70 (2008)].

SETTLEMENT OF A CLAIM

- Under ORC 4123.65(D), "the administrator, for state fund settlements, and the self-insuring employer, for self-insuring settlements, immediately shall send a copy of the agreement [SI-42/C-240] to the industrial commission who shall assign the matter to a staff hearing officer."
- The staff hearing officer shall determine, within the time limitations specified in division (C) of this section, [30 days] *whether the settlement agreement is or is not a gross miscarriage of justice*. *If the staff hearing officer determines within that time period that the settlement agreement is clearly unfair, the staff hearing officer shall issue an order disapproving the settlement agreement.* If the staff hearing officer determines that the settlement agreement is not clearly unfair or fails to act within those time limits, the settlement agreement is approved.

SETTLEMENT OF A CLAIM

When a self-insuring employer and claimant agree to a settlement, or when a state fund claim is settled administratively, review by the Commission is mandatory for the protection of the parties to the agreement. *John Burke, Jr., Plaintiff-Appellant, v. Wal-Mart Stores, Inc., et al.*, 11th Dist. Lake No. 2016-L-024, 2017 WL 1136183, *3.

Not subject to ORC 4123.65

STATE FUND COURT SETTLEMENTS

SETTLEMENT OF A CLAIM

- ORC 4123.65 does not apply to state-fund workers' compensation claims on appeal to a common pleas court under ORC 4123.512. *Jones v. Action Coupling & Equip., Inc.*, 98 Ohio St.3d 330, 332 (2003).
- In state-funded court appeals under ORC 4123.512, the court of common pleas possesses the authority to enforce a settlement agreement voluntarily entered into by the parties since such agreement constitutes a binding contract.

Reliance on the judgment of a court or The Ohio Industrial Commission on the merits

HOW DO I CRAFT A WORKERS' COMPENSATION SETTLEMENT FOR A MEDICARE BENEFICIARY?

SETTLEMENTS WITH AN MSA

Under the MSP Manual. "[t]he only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case." (quoting MSP Manual, Ch. 7, § 50.4.4). If the "adjudicator of the merits specifically designate[s] amounts … not related to medical services, Medicare will accept the Court's designation." Id. "In deference to the court's substantive decision, 'Medicare does not seek recovery from portions of the court awards that are designated as payment for losses other than medical services.'" Id.

SETTLEMENTS WITH AN MSA

A court order is "on the merits" when it is "delivered after the court has heard and evaluated the evidence and the parties' substantive arguments." Black's Law Dictionary 1199 (9th ed.2009)… [S]tate proceedings occur "on the merits" "when a state court has made a decision that 1) finally resolves the claim, and 2) resolves the claim on the basis of its substance". *Taransky v. Secy. of U.S. Dept. of Health & Human Services*, 760 F.3d 307, 318 (3d Cir.2014)

SETTLEMENTS WITH AN MSA

The scope of a primary plan's obligation to reimburse Medicare and thus the claimant's own obligation upon receipt of a settlement; is defined by the scope of an approved workers settlement backed by the Commission under ORC 4123.65 or court order "on the merits." See, *Hadden v. United States*, 661 F.3d 298, 302 (6th Cir.2011).

SETTLEMENTS WITH AN MSA

CMS will respect allocations of liability amounts to non-medical losses when the allocation is based on a court or administrative judgment. See, *Bio-Med. Applications of Tennessee, Inc. v. Cent. States Southeast & Southwest Areas Health & Welfare Fund*, 656 F.3d 277, 279 (6th Cir. 2011).

SETTLEMENT WITH AN MSA

CMS's Workers' Compensation Medicare Set-Aside Arrangement ("WCMSA") Reference Guide re-affirms this position and notes: Because the CMS prices based upon what is claimed, released, or released in effect, the CMS must have documentation as to why disputed cases settle future medical costs for less than the recommended pricing. **As a result, when a state WC judge or other binding party approves a WC settlement after a hearing on the merits, Medicare generally will accept the terms of the settlement,** unless the settlement does not adequately address Medicare's interests. This shall include all denied liability cases, whether in part or in full. If Medicare's interests were not reasonably considered, 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. Medicare may also assert a recovery claim, if appropriate. *If a court or other adjudicator of the merits (e.g., a state WC board or commission) specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.* (WSMA reference guide page 5-6, emphasis added).

SETTLEMENTS WITH AN MSA

Therefore, for administrative settlements and self-insured settlements, Under 42 U.S.C. §1395y(b)(2)(B)(ii), demonstrated responsibility for medical expenses, past and future, may be settled by a judgment of the Commission under ORC 4123.65 that the proposed settlement allocation is not a "miscarriage of justice" or "clearly unfair" where the commission has reviewed the proposed apportionment of indemnity and medical benefits and the Commission's determination is the result of a hearing on the merits.

SETTLEMENTS WITH AN MSA

For state-funded court settlements a proposed MSA is binding when a court issues a decision "on the merits" That allocates the settlement proceeds between medical and indemnity benefits.

SETTLEMENTS WITH AN MSA

- If the Commission or the court merely rubber stamps an un-contested and pre-prepared submission to approve settlement, it is not on the merits. *Paraskevas v. Price*, 2017 WL 5957101, *6 (Nov. 27, 2017).
- There must be a substantive hearing, evidence presented, the particulars of the Medicare lien should be discussed, and the order should be the result of an adversarial process. See *Weiss v. Azar*, 2018 WL 6478025, (Dec. 7, 2018).

WHAT TO DO IF CMS PROPOSES AN UNREASONABLE MSA OR IF A MEDICARE BENEFICIARY IS DENIED COVERAGE BASED UPON A SETTLEMENT?

The appellate process of 42 C.F.R. §§ 405.900

MEDICARE'S ADMINISTRATIVE APPEAL

Once a Medicare beneficiary requests and receives a demand letter indicating the amount owed as reimbursement to Medicare under the MSP Act, the beneficiary may challenge the determination administratively. 42 C.F.R. § 411.37, *et seq. Wetterman v. Secy., Dept. of Health & Human Services*, S.D.Ohio No. 2:18-CV-85, 2019 WL 3208130, *4.

MEDICARE'S ADMINISTRATIVE APPEAL

Similarly, if Medicare denies benefits under Part A or Part B of the act, based upon a failure to spend down money associated to the medical portion of a settlement, the beneficiary may challenge Medicare's denial of coverage administratively. 42 C.F.R. § 405.900.

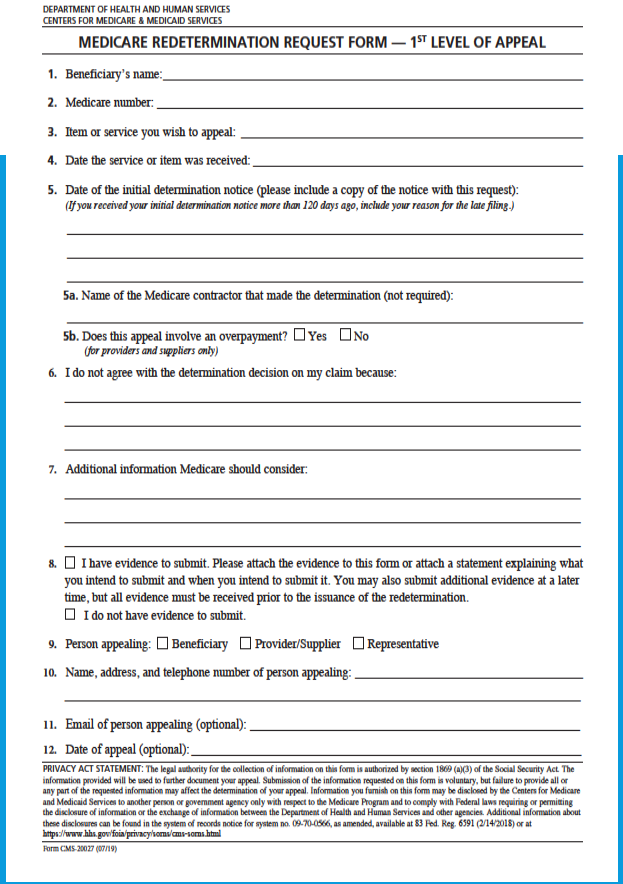
MEDICARE'S ADMINISTRATIVE APPEAL

The administrative review process includes: 1) redetermination; 2) reconsideration; 3) ALJ hearing; 4) Medicare Appeals Council review; and 5) judicial review in a federal district court. 42 U.S.C. § 1395ff; 42 C.F.R. §§ 405.900–405.1140. *Wetterman v. Secy., Dept. of Health & Human Services*, S.D.Ohio No. 2:18-CV-85, 2019 WL 3208130, *4.

MEDICARE'S ADMINISTRATIVE APPEAL

Redetermination 1st level of appeal

- 120 days to file from a CMS demand letter or denial of benefits. 42 C.F.R. 405.942. You can request an extension for good cause (serious illness, language barrier, destroyed records etc.). (id).
- Must attach supporting documentation (Commission / court order, transcript, settlement documents etc.). "When filing the request for redetermination, a party must explain why it disagrees with the contractor's determination and should include any evidence that the party believes should be considered by the contractor in making its redetermination." 42 C.F.R. 405.946.
- Filed on form CMS-20027
- Medicare contractor has 60 days to decide.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: _____
2. Medicare number: _____
3. Item or service you wish to appeal: _____
4. Date the service or item was received: _____
5. Date of the initial determination notice (please include a copy of the notice with this request):
   (If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

   _____

   _____

   _____

   5a. Name of the Medicare contractor that made the determination (not required):

   _____

   5b. Does this appeal involve an overpayment? ☐ Yes ☐ No
   (for providers and suppliers only)
6. I do not agree with the determination decision on my claim because:

   _____

   _____

   _____
7. Additional information Medicare should consider:

   _____

   _____

   _____
8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
   ☐ I do not have evidence to submit.
9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative
10. Name, address, and telephone number of person appealing: _____

    _____
11. Email of person appealing (optional): _____
12. Date of appeal (optional): _____

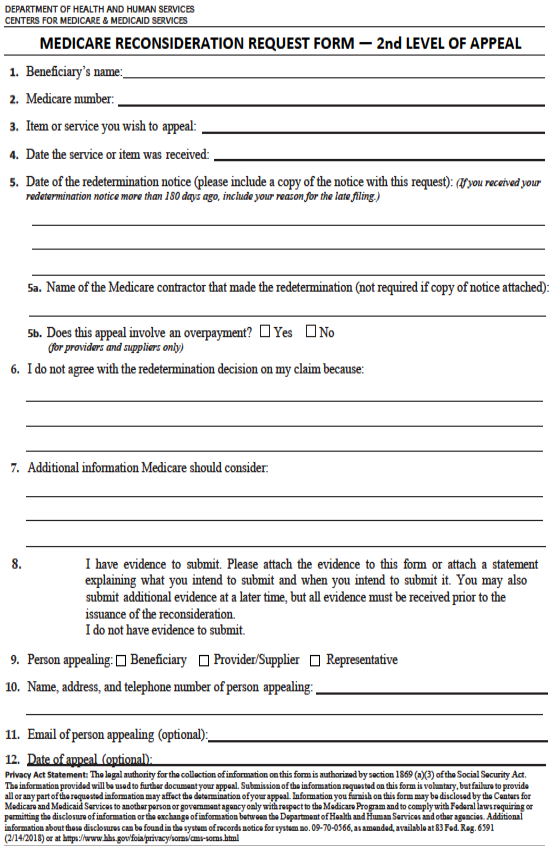
PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html

Form CMS-20027 (07/19)

MEDICARE'S ADMINISTRATIVE APPEAL

Reconsideration 2nd level appeal

- Any request for a reconsideration must be filed within 180 calendar days from the date the party receives the notice of the redetermination. 42 C.F.R. 405.962. Again extensions will be given for good cause. (Id).
- You should present evidence and allegations of fact or law related to the issue in dispute and explain why you disagree with the initial determination, including the redetermination. 42 C.F.R. 405.966.
- Absent good cause, failure to submit all evidence, including documentation requested in the notice of redetermination prior to the issuance of the notice of reconsideration, precludes subsequent consideration of that evidence. 42 C.F.R. 405.966.
- Filed on Form CMS-20033
- Decision should be made in 60 days. 42 C.F.R. 405.970.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE RECONSIDERATION REQUEST FORM — 2nd LEVEL OF APPEAL

1. Beneficiary's name: _____
2. Medicare number: _____
3. Item or service you wish to appeal: _____
4. Date the service or item was received: _____
5. Date of the redetermination notice (please include a copy of the notice with this request): *(If you received your redetermination notice more than 180 days ago, include your reason for the late filing.)*

   _____

   _____

   _____

   5a. Name of the Medicare contractor that made the redetermination (not required if copy of notice attached):

   _____

   5b. Does this appeal involve an overpayment? ☐ Yes ☐ No
   (for providers and suppliers only)
6. I do not agree with the redetermination decision on my claim because:

   _____

   _____

   _____
7. Additional information Medicare should consider:

   _____

   _____

   _____
8. I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the reconsideration.
   I do not have evidence to submit.
9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative
10. Name, address, and telephone number of person appealing: _____

    _____
11. Email of person appealing (optional): _____
12. Date of appeal (optional): _____

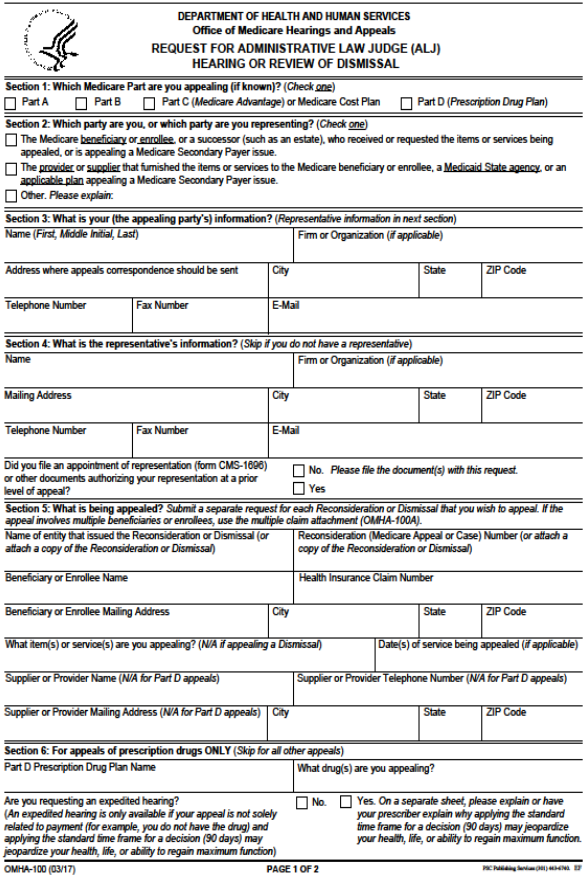
Privacy Act Statement: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html

Form CMS-20033 (07/19)

MEDICARE'S ADMINISTRATIVE APPEAL

ALJ Hearing 3rd level appeal

- Any request must be filed within 60 calendar days from the date the party receives notice of the reconsideration or dismissal. 42 C.F.R. 405.1014.
- Any evidence submitted that was not submitted prior to the issuance of the reconsideration determination must be accompanied by a statement explaining why the evidence was not previously submitted to the prior decision-maker. 42 C.F.R. 405.1018.
- You may request discovery. 42 C.F.R. 405.1037.
- Filed on form OMHA-100.
- No timeframe for decision.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

REQUEST FOR ADMINISTRATIVE LAW JUDGE (ALJ) HEARING OR REVIEW OF DISMISSAL

Section 1: Which Medicare Part are you appealing (if known)? (*Check one*)

☐ Part A ☐ Part B ☐ Part C (*Medicare Advantage*) or Medicare Cost Plan ☐ Part D (*Prescription Drug Plan*)

Section 2: Which party are you, or which party are you representing? (*Check one*)

☐ The Medicare beneficiary or enrollee, or a successor (such as an estate), who received or requested the items or services being appealed, or is appealing a Medicare Secondary Payer issue.

☐ The provider or supplier that furnished the items or services to the Medicare beneficiary or enrollee, a Medicaid State agency, or an applicable plan appealing a Medicare Secondary Payer issue.

☐ Other. *Please explain:*

Section 3: What is your (the appealing party's) information? (*Representative information in next section*)

Name (*First, Middle Initial, Last*)		Firm or Organization (*if applicable*)		
Address where appeals correspondence should be sent		City	State	ZIP Code
Telephone Number	Fax Number	E-Mail		

Section 4: What is the representative's information? (*Skip if you do not have a representative*)

Name		Firm or Organization (*if applicable*)		
Mailing Address		City	State	ZIP Code
Telephone Number	Fax Number	E-Mail		

Did you file an appointment of representation (form CMS-1696) or other documents authorizing your representation at a prior level of appeal? ☐ No. *Please file the document(s) with this request.* ☐ Yes

Section 5: What is being appealed? *Submit a separate request for each Reconsideration or Dismissal that you wish to appeal. If the appeal involves multiple beneficiaries or enrollees, use the multiple claim attachment (OMHA-100A).*

Name of entity that issued the Reconsideration or Dismissal (*or attach a copy of the Reconsideration or Dismissal*)		Reconsideration (Medicare Appeal or Case) Number (*or attach a copy of the Reconsideration or Dismissal*)		
Beneficiary or Enrollee Name		Health Insurance Claim Number		
Beneficiary or Enrollee Mailing Address		City	State	ZIP Code
What item(s) or service(s) are you appealing? (*N/A if appealing a Dismissal*)			Date(s) of service being appealed (*if applicable*)	
Supplier or Provider Name (*N/A for Part D appeals*)		Supplier or Provider Telephone Number (*N/A for Part D appeals*)		
Supplier or Provider Mailing Address (*N/A for Part D appeals*)		City	State	ZIP Code

Section 6: For appeals of prescription drugs ONLY (*Skip for all other appeals*)

Part D Prescription Drug Plan Name	What drug(s) are you appealing?

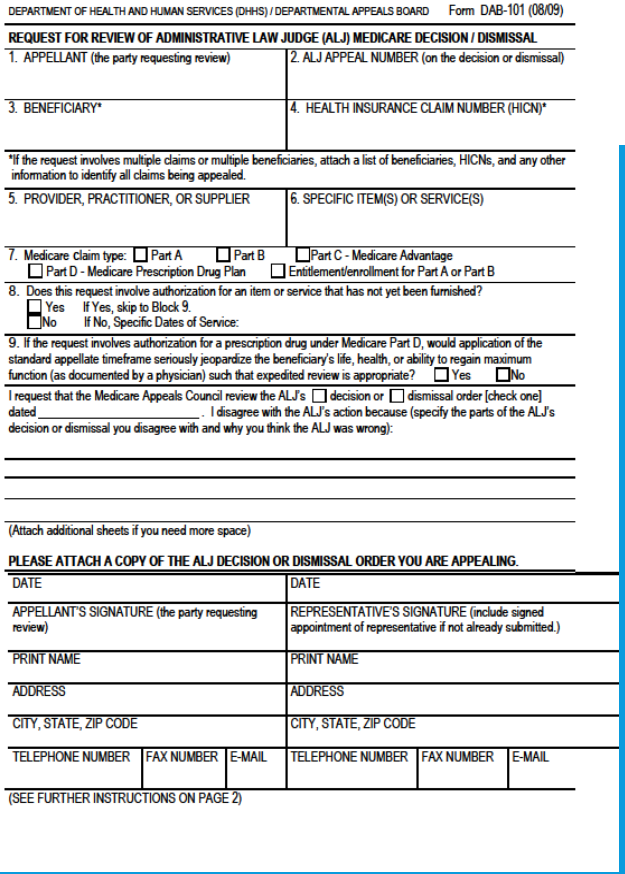
Are you requesting an expedited hearing? ☐ No. ☐ Yes. *On a separate sheet, please explain or have your prescriber explain why applying the standard time frame for a decision (90 days) may jeopardize your health, life, or ability to regain maximum function.*
(*An expedited hearing is only available if your appeal is not solely related to payment (for example, you do not have the drug) and applying the standard time frame for a decision (90 days) may jeopardize your health, life, or ability to regain maximum function*)

OMHA-100 (03/17) PAGE 1 OF 2

MEDICARE'S ADMINISTRATIVE APPEAL

Medicare appeals counsel 4th level

- A party to a decision or dismissal issued by an ALJ or attorney adjudicator may request a Council review if the party files a written request for a Council review within 60 calendar days after receipt of the ALJ's or attorney adjudicator's decision or dismissal. 42 C.F.R. 405.1102.
- The request for review must identify the parts of the ALJ's or attorney adjudicator's action with which the party requesting review disagrees and explain why he or she disagrees with the ALJ's or attorney adjudicator's decision, dismissal, or other determination being appealed. 42 C.F.R. 405.1112.
- A party may request to appear before the Council to present oral argument. 42 C.F.R. 405.1124. a party may additionally brief the matter. 42 C.F.R. 405.1120.
- The Council's decision is final and binding on all parties unless a Federal district court issues a decision modifying the Council's decision or the decision is revised as the result of a reopening in accordance with § 405.980. A party may file an action in a Federal district court within 60 calendar days after the date it receives notice of the Council's decision. 42 C.F.R. 405.1130.
- Filed on form DAB-101.



DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) / DEPARTMENTAL APPEALS BOARD Form DAB-101 (08/09)

REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL

1. APPELLANT (the party requesting review) | 2. ALJ APPEAL NUMBER (on the decision or dismissal)

3. BENEFICIARY* | 4. HEALTH INSURANCE CLAIM NUMBER (HICN)*

*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, HICNs, and any other information to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER | 6. SPECIFIC ITEM(S) OR SERVICE(S)

7. Medicare claim type: ☐ Part A ☐ Part B ☐ Part C - Medicare Advantage ☐ Part D - Medicare Prescription Drug Plan ☐ Entitlement/enrollment for Part A or Part B

8. Does this request involve authorization for an item or service that has not yet been furnished?
☐ Yes If Yes, skip to Block 9.
☐ No If No, Specific Dates of Service:

9. If the request involves authorization for a prescription drug under Medicare Part D, would application of the standard appellate timeframe seriously jeopardize the beneficiary's life, health, or ability to regain maximum function (as documented by a physician) such that expedited review is appropriate? ☐ Yes ☐ No

I request that the Medicare Appeals Council review the ALJ's ☐ decision or ☐ dismissal order [check one] dated _____. I disagree with the ALJ's action because (specify the parts of the ALJ's decision or dismissal you disagree with and why you think the ALJ was wrong):

(Attach additional sheets if you need more space)

PLEASE ATTACH A COPY OF THE ALJ DECISION OR DISMISSAL ORDER YOU ARE APPEALING.

DATE			DATE		
APPELLANT'S SIGNATURE (the party requesting review)			REPRESENTATIVE'S SIGNATURE (include signed appointment of representative if not already submitted.)		
PRINT NAME			PRINT NAME		
ADDRESS			ADDRESS		
CITY, STATE, ZIP CODE			CITY, STATE, ZIP CODE		
TELEPHONE NUMBER	FAX NUMBER	E-MAIL	TELEPHONE NUMBER	FAX NUMBER	E-MAIL

(SEE FURTHER INSTRUCTIONS ON PAGE 2)

Medicare's administrative Appeal

ALTERNATIVELY, OR ADDITIONALLY REQUEST A WAIVER

WAIVER

- CMS has the right to compromise claims for less than the full amount arises under the Federal Claims Collection Act of 1966 (31 USC § 3711) §§ 1870(c) and 1862(b) of the Social Security Act.
- Each section sets forth different criteria to compromise, waive, suspend, or terminate Medicare's claim.
- Medicare contractors have authority to consider requests for waivers under § 1870(c) of the Act.

WAIVER

To grant a waiver, CMS must determine whether the beneficiary meets the criteria for waiver determinations under § 1870(c) of the Social Security Act (42 CFR § 405.355 and 20 CFR 404.506-512). Medicare may waive all or any part of its recovery where an overpayment has been made with respect to a beneficiary: (1) who is without fault and (2) recovery would be against equity and good conscience or defeat the purpose of the social security act.

WAIVER

- "Defeat the purposes" of the Social Security Act means that recovery would cause financial hardship by depriving a beneficiary of income required for ordinary and necessary living expenses. MSP Manual, §§ 50.6.2 and 50.6.5.
- Ordinary and necessary living expenses include: (1) fixed living expenses, such as food, clothing, rent, mortgage payments, utilities, insurances, taxes, installment payments, etc.; (2) medical, hospitalizations and similar expenses not covered by Medicare or other insurer; (3) other miscellaneous expenses which may reasonably be considered necessary to maintain the beneficiary's current standard of living.

WAIVER

To "be against equity and good conscience" CMS must consider: (1) the degree to which the beneficiary contributed to causing the overpayment; (2) the degree to which Medicare contributed to causing the overpayment; (3) the degree to which recovery would cause undue hardship for the beneficiary; (4) whether the beneficiary would be unjustly enriched by a waiver; and (5) whether the beneficiary changed their positions to their material detriment as a result of receiving the overpayment or as a result of relying on erroneous information supplied by Medicare. See MSP Manual § 50.6.5.2.

WAIVER

- The request is filed on Form SSA-632.
- You must file a request within 30 days of receiving CMS's demand letter to prevent denial of Medicare benefits. 20 C.F.R. 404.506.
- CMS will review the application and determine if a waiver can be approved. If waiver cannot be approved after this review, the individual is notified in writing and given the dates, times, and place of the file review and personal conference; the procedure for reviewing the claims file prior to the personal conference. 20 C.F.R. 404.506

WAIVER

- At the personal conference beneficiaries may: Appear personally, testify, cross-examine any witnesses, and make arguments; and submit documents for consideration by the decisionmaker. 20 C.F.R. 404.506
- Medicare will issue a written decision. 20 C.F.R. 404.506.
- Beneficiaries may request a hearing before an ALJ after personal conference. 20 C.F.R. 404.930(a)(6).

WAIVER

After ALJ hearing, waiver request may be appealed to appeals counsel. 20 C.F.R. 404.967.

CONDITIONAL PAYMENTS

WHAT DO I DO IF MEDICARE ASSERTS CONDITIONAL PAYMENTS FOR DATES OF SERVICE PRIOR TO THE SETTLEMENT?

CONDITIONAL PAYMENTS PRIOR TO SETTLEMENT DATE

- Both Court settlements and settlements subject to R.C. 4123.65 include language to help.
- In administrative settlements the following language is included: The persons involved with filing this settlement agree that if any claim(s) or part of any claim(s) being settled has been recognized or allowed, *the cost of all medical services, hospital bills, drugs and medicines with date(s) of service or filling of related prescriptions (not to exceed a 30-day supply) provided to the claimant before the effective settlement date, shall be the responsibility of the state insurance fund, provided such costs result from the allowed conditions of the claims and are properly payable under current medical payment guidelines.* Unless this agreement settles indemnity benefits only, the costs of medical services, hospital bills, drugs and medicines provided to the claimant on or after the effective date of the settlement is the responsibility of the claimant.

CONDITIONAL PAYMENTS PRIOR TO THE SETTLEMENT DATE

- Court Settlements provide: . *Except for the terms, if any, listed in paragraphs six (6) and seven (7) which follow, the parties involved with this settlement agree that if any claim(s) or part of any claim(s) being settled has been recognized or allowed, then the cost of all medical services, hospital bills, drugs and medicines with date(s) of service or filling of related prescriptions (not to exceed a 30-day supply) provided to the injured worker before the effective settlement date, shall be the responsibility of The State Insurance Fund, provided such costs result from the allowed conditions of the claims and are properly payable under current medical payment guidelines established by the Bureau or Industrial Commission.* The costs of medical services hospital bills, drugs and medicines (not to exceed a 30-day supply) provided to the injured worker on or after the effective date of the settlement date are the responsibility of the injured worker.

CONDITIONAL PAYMENTS PRIOR TO THE SETTLEMENT DATE

- BWC's guideline for payment is found in O.A.C. 4123-3-23:
- (A) Except as otherwise provided in this rule, fee bills for medical or vocational rehabilitation services rendered in a claim *shall be submitted to the bureau or commission for payment within one year of the date on which the service was rendered or one year after the date the services became payable under division (I) of section 4123.511of the Revised Code, whichever is later, or shall be forever barred.*

CONDITIONAL PAYMENTS PRIOR TO THE SETTLEMENT DATE

- (C) Paragraph (A) of this rule shall not apply to the following : Requests made by the centers for Medicare and Medicaid services in the United States department of health and human services for reimbursement of conditional payments made pursuant to section1395y(b)(2) of title 42, United States Code (commonly known as the "Medicare Secondary Payer Act") as in effect on the date of the request;

CONDITIONAL PAYMENTS PRIOR TO THE SETTLEMENT DATE

- Also be aware of 42 U.S.C. §1395y(b)(2)(B)(vi): Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, *the United States may seek to recover conditional payments in accordance with this subparagraph 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.*

CONDITIONAL PAYMENTS PRIOR TO THE SETTLEMENT DATE

- Contact us or:

Tunishia Coleman

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ERISA AND SETTLEMENT

Ohio Workers' Compensation is not Subject to ERISA Preemption

ERISA AND SETTLEMENT

- ERISA protects the interests of employee benefit plan participants and their beneficiaries. It requires plan sponsors to provide plan information to participants. It establishes standards of conduct for plan managers and other fiduciaries. It establishes enforcement provisions to ensure that plan funds are protected and that qualifying participants receive their benefits, even if a company goes bankrupt.
- ERISA covers retirement plans and welfare benefit plans. ERISA encompasses roughly 684,000 retirement plans, 2.4 million health plans and 2.4 million additional welfare benefit plans. These plans cover about 141 million workers and beneficiaries and include more than $7.6 trillion in assets. About 54 percent of America's workers earn retirement benefits on the job, and 59 percent earn health benefits.
- ERISA policies have greater rights to subrogation because they are "self-funded." ERISA policies are exclusively offered by employers and are funded entirely by the premiums of the members (employees) paying into it. ERISA policy holders generally ague they pre-empt state law on subrogation such as "made whole" doctrines.

ERISA AND SETTLEMENT

29 U.S. Code § 1003 specifically exempts Workers' Compensation from ERISA. Additionally, In *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), the sixth federal circuit isolated three factors to consider in making the determination whether state law is pre-empted by ERISA: (1) "whether the state law represents a traditional exercise of state authority," id. at 555; (2) whether the "'state law . . . affects relations among the principal ERISA entities--the employer, the plan, the plan fiduciaries, and the beneficiaries,'" which would be troublesome, or if, rather, the law affects "'relations between one of these entities and an outside party, or between two outside parties with only an incidental effect on the plan," id. at 556; or (3) whether the effect of the state law on the ERISA plan is merely incidental in nature, id. at 556.

First, workers' compensation is clearly one of the state's traditional areas of authority. Second, although Ohio workers' compensation may be seen as having an effect, generally, upon Plan beneficiaries, it affects them "in their capacity as employees, without regard to their status as participants in an ERISA plan." *Firestone*, 810 F.2d at 556. Third, effects of Ohio workers' compensation are incidental to effects on ERISA disability plans.

ERISA AND SETTLEMENT

Regarding a denied claim where an ERISA plan is asserting a right of subrogation:

Even if the insurance contract has a "reimbursement clause." R.C. 4123.66(C) would bar collection in a disallowed claim:

If an employer or a welfare plan has provided to or on behalf of an employee any benefits or compensation for an injury or occupational disease *and that injury or occupational disease is determined compensable under this chapter*, the employer or a welfare plan may request that the administrator reimburse the employer or welfare plan for the amount the employer or welfare plan paid to or on behalf of the employee in compensation or benefits.

A welfare plan only maintains a right of reimbursement for allowed workers' compensation claims. The statute does not give the insurance company a right of reimbursement in settlement.

ERISA AND SETTLEMENT

Further, if the claim is properly denied the claimant has no personal responsibility for the medical bills. The last sentence of OAC 4123-6-25(D)provides:

(D) Prior to services being delivered, the provider must make reasonable effort to notify the claimant, bureau, MCO, QHP or self-insuring employer when the provider has knowledge that the services may not be related to the claimed or allowed condition(s) related to the industrial injury or illness, or that a service is non-covered. The provider may not knowingly bill or seek payment from the bureau, MCO, QHP or self-insured employer for services that are not related to the claimed or allowed condition(s) related to the industrial injury or illness. The provider may not knowingly mislead or direct providers of ancillary services to bill or seek payment for services that are not related to the claimed or allowed condition.

The provider may not bill or seek payment from the claimant for services determined as medically unnecessary through the use of bona fide peer review based on accepted treatment guidelines.

YOUR FUTURE IN SAFETY.
WE'VE GOT YOU COVERED.

MEDICAID AND SETTLEMENT

MEDICAID'S RIGHT TO RECOVERY

- Ohio Department of Medicaid's right of recovery is covered under R.C. 5160.37, which requires disclosure, by the Medicaid recipient or the recipient's attorney, of any settlement to the appropriate county department of Medicaid.
- "No settlement, compromise, judgment, or award or any recovery in any action or claim by a medical assistance recipient where the department or county department has a right of recovery shall be made final without first giving the department or county department written notice as described in division (C) of this section and a reasonable opportunity to perfect its rights of recovery. *If the department or county department is not given the appropriate written notice, the medical assistance recipient and, if there is one, the recipient's attorney, are liable to reimburse the department or county department for the recovery received to the extent of medical assistance payments made by the department or county department.*"

MEDICAID'S RIGHT TO RECOVERY

- R.C. 5160.37 additionally provides for joint and several liability:
- (H) A right of recovery created by this section may be enforced separately or jointly by the department of Medicaid or county department. To enforce its recovery rights, the department or county department may do any of the following:
- (1) Intervene or join in any action or proceeding brought by the medical assistance recipient or on the recipient's behalf against any third party who may be liable for the cost of medical assistance paid;
- (2) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical assistance paid;
- (3) Initiate legal proceedings in conjunction with any injured, diseased, or disabled medical assistance recipient or the recipient's attorney or representative.
- (I) A medical assistance recipient shall not assess attorney fees, costs, or other expenses against the department of Medicaid or a county department when the department or county department enforces its right of recovery created by this section.
- (J) The right of recovery given to the department under this section includes payments made by a third party under contract with a person having a duty to support.
- (K) The department of Medicaid may assign to a medical assistance provider the right of recovery given to the department under this section with respect to any claim for which the department has notified the provider that the department intends to recoup the department's prior payment for the claim.

QUESTIONS?