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MEDICARE AND THE EFFECT ON WORKERS' COMPENSATION SETTLEMENTS

The issue of reimbursement to Medicare for medical expenses paid pursuant to workers' compensation injuries has quickly become an important issue in the process of resolving claims. Medicare has indicated a desire to more actively protect its own interests when called upon to make payments for medical treatment that arguably should have been paid for by an individual's employer. The area of law pertaining to this issue is evolving, and we have prepared ourselves to meet the requirements imposed by the current laws and to adapt to potential changes in the future.

1. Medicare's Right of Action

The Code of Federal Regulations (42 CFR §411) provides Medicare with a cause of action to "initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation" (42 CFR § 411.24(b)). The Center for Medicare/Medicaid Services has a "direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator" (42 CFR §411.24(e)). If legal action is necessary to recover mistaken payments, the code affords Medicare the right to

recover twice the amount specified for recovery (42 CFR § 411.24 (2)).

II. The Threshold Test

The statutory requirement to protect the interests of Medicare applies in all cases in respect to future medical expenses. Every case presents a different factual analysis depending on the likelihood of future medical expenses and the compensability of the workers' compensation claim. For the purposes of efficiency, the Center for Medicare/Medicaid Services has provided a "threshold test" in determining whether or not review of workers' compensation agreements by CMS is necessary.

WARNING: Even if a specific case does not meet the threshold test, there is still a legal duty to protect the interests of Medicare in workers' compensation agreements. The "test" is merely a guide by which CMS is utilizing to concentrate their attention on those cases that are likely to involve Medicare's interests.

To determine whether or not a case meets the threshold test, two questions need to be addressed:

1. Is the petitioner a Medicare Beneficiary at the time of the Agreement?
2. Is there a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date?

If the answer to question (1) is YES, then the agreement must be sent to Medicare for approval, regardless of whether or not there is a perception of future medical expenses. If the answer to question (1) is NO, but the answer to question (2) is YES, then an examination into the amount of the settlement must take place. If the total amount of the settlement for future medical expenses and disability/lost wages over the life or duration of the agreement is expected to be greater than \$250,000.00, then the agreement must be sent to Medicare. If the amount is less than \$250,000.00 or the answers to (1) and (2) are NO, then CMS is not requiring review of the agreement before processing. However, please pay special attention to the “warning” discussed above.

III. Conclusion

If review of a case is warranted by meeting the threshold test or is necessary based on a review of all of the facts pertaining to a claim, we are qualified to gather all of the necessary information for presentation to CMS for the purposes of review and approval before processing at the Industrial Commission. This is a process that, in all likelihood, will continue to change as CMS begins handling increasing numbers of these claims. We will continue to provide updates regarding changes in this evolving area of law.

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