

AVOIDING DOUBLE DAMAGES OF THE PRIVATE CAUSE OF ACTION IN THE MEDICARE SECONDARY PAYER ACT

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A recent article circulating among the civil plaintiff's attorney community suggests that a provision in the Medicare Secondary Payer Act (MSP) can be used as a tool to bolster the value of tort cases. The MSP provides a private cause of action against a primary payer (i.e. a WC carrier) for damages if a primary payer fails to provide primary payment, **or appropriate reimbursement**, for payments made by Medicare. A "private cause of action" is a civil claim, outside of the workers' compensation arena, which allows applicants to sue their workers' compensation carrier for double damages in Federal Court if Medicare is not reimbursed for industrially-related medical treatment once liability is established (i.e., at the time of settlement).

This "tool" is not much of a weapon at all, and is easily disarmed, because **appropriate reimbursement** can be made at the time liability is admitted, i.e. at the time of settlement or Findings & Award. Even the author concedes this significant caveat to their so-called "diamond in the rough": the alleged primary payer's responsibility to pay must be established before a private cause of action can be brought.

To illustrate this point, *Glover v. Liggett Group, Inc.* (2006) 459 F.3d 1304, involved a plaintiff who filed a Medicare secondary payer private cause of action against a cigarette manufacturer for medical expenses paid by Medicare. The case was denied, however, because the primary payer (cigarette manufacturer) had not been held liable for the medical treatment. Thus, it could not be said that the primary payer had failed to provide appropriate reimbursement. The court held that **a private cause of action could be brought only against proven tortfeasors, not against alleged tortfeasors.**

Furthermore, the private cause of action can only be brought against proven tortfeasors who **refuse** to reimburse Medicare after liability for primary payment is established. The cases cited by these plaintiffs' attorneys that support their argument all deal with primary payers who refused to reimburse Medicare post settlement; i.e., carriers that made payment to the injured party and refused to reimburse Medicare for one reason or another. (Generally, the primary payers believed they were exempt from reimbursing Medicare pursuant to their (mis)interpretation of the MSP statute, and recent amendments to the statute which increased a primary payers' duties to reimburse Medicare.)

This is the one area where carriers should be on notice; if Medicare made payment where the primary payer (after liability is established) should have made payment, Medicare must be reimbursed and cannot be ignored. However, if Medicare is properly reimbursed, the private cause of action is gone.

The Private Cause of Action Applied to Workers' Compensation Cases

The private cause of action was applied to a workers' compensation case in *O'Connor v. Mayor of Baltimore* (2007) 494 F. Supp. 2d 372. In that case, a firefighter diagnosed with mesothelioma had his treatment paid for by Medicare. Injury was eventually accepted, but the City refused to reimburse Medicare. **The court allowed the private cause of action to proceed**, noting that the Medicare Secondary Payer (MSP) statute permits Medicare to render conditional payments for medical expenses, with the expectation that the primary payer will later reimburse Medicare if found responsible for the cost.ⁱ Two causes of action contained in the MSP statute aid in the enforcement of this repayment provision. First, the government itself may sue primary payers to obtain money belonging to Medicare.ⁱⁱ **Second**, private citizens may collect double damages by bringing claims against primary payers to recover money owed.ⁱⁱⁱ **Once liability is established for the primary payer, Medicare must be reimbursed.**

A carrier found itself in a similar predicament when it refused to reimburse Medicare after a settlement in a medical malpractice case. In *Brown v. Thompson* (2004) 374 F.3d 253, a plaintiff in a medical malpractice case received a settlement and refused to reimburse Medicare, arguing that she was not required to because Medicare's payments were not made on the condition that they would be reimbursed (a weak argument based on former language in statute). The Court held that the MSP as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, clearly provides that the reasonable expectation of a prompt payment **is not** a requirement for reimbursement. MSP now states unequivocally that a primary plan, and an entity that receives payment from a primary plan, shall reimburse Medicare for any payment made by Medicare with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.^{iv}

It further states that a primary plan's responsibility for such 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. This case also highlighted what entities could be liable to reimburse Medicare; including self-insured employers as primary payers.

Although the MSP statute does not provide its own statute of limitations, the courts have interpreted it to have the same limitations period found in similar causes of action, and opined that 6 years was timely.^v

Conclusion

Recent congressional legislation has strengthened the MSP private cause of action in that it is now more difficult for a primary payer to avoid reimbursement to Medicare. The arguments made by primary payers in the past, such as "payment was not made upon the **condition** that Medicare would promptly be reimbursed," no longer exist, and primary payers are required to reimburse Medicare across the board.

However, the threat of any private cause of action can be disarmed by taking care of Medicare liens at the time of settlement. WC carriers must implement a formal process to ensure the resolution of Medicare's reimbursement interests. If the injured worker is a Medicare beneficiary at the time of settlement, Medicare must be contacted to determine if any medical treatment was provided for the WC injury, and Medicare must be reimbursed.^{vi} If Medicare has not already filed a lien, a claims adjuster can contact the Coordination of Benefits (COB) Contractor to report workers' compensation coverage at (800) 999-1118.^{vii}

If Medicare's interests are ignored in a WC case, the CMS has a **direct priority right of recovery** against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly. The CMS also has a **subrogation** right with respect to any such third party payment.^{viii}

Therefore, medical expenses incurred prior to the settlement need to be accounted for in the compromise portion of the settlement. A simple telephone call to the COB Contractor at (800) 999-1118 can determine whether the injured worker is a current Medicare beneficiary. Additionally, claims adjusters can also inquire of the medical providers whether they billed Medicare for any services.

To protect oneself from unknown pre-settlement medical expenses covered by Medicare, WC carriers should include a clause in all Compromise & Releases stating that the settlement amount includes any and all past medical expenses up to the time of settlement, for example:

CMS has advised that no claims have been paid by Medicare related to this workers' compensation claim. If any claims are later asserted by Medicare, subsequent to the date of this settlement, it will be the Claimant's responsibility to satisfy said claims out of these settlement proceeds.

Thus, in the unlikely event that medical expenses turn up for which Medicare should have been reimbursed, the CMS will assert Medicare's right of recovery against the applicant.

The private cause of action is also a threat in cases settled by Stipulations. Medicare's right to reimbursement vests at the moment liability is accepted by the carrier. Of course, the medical treatment must be reasonable and necessary, and within ACOEM guidelines to be subject to reimbursement by a WC carrier. Nevertheless, Stipulations alone will not avoid the section 1395 private cause of action.

As we know, MSA's are required where an individual has a "reasonable expectation" of Medicare enrollment for any reason, including a) The individual has applied for Social Security Disability Benefits; b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision; c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits; d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months).

However, the MSA's ensure protection from the section 1395 private cause of action for medical expenses **post**-settlement. The only real threat of the private cause of action will stem from the denial of reimbursement to Medicare for an admitted industrial injury. However, if Medicare's reimbursement rights are dealt with at the time of settlement, and/or a provision for unknown Medicare expenses is made for in the settlement agreement, the private cause of action is not available to the injured worker.

ⁱ 42 U.S.C.S. § 1395y(b)(2)(B).

ⁱⁱ 42 U.S.C.S. § 1395y(b)(2)(B)(iii).

ⁱⁱⁱ 42 U.S.C.S. § 1395y(b)(3)(A).

^{iv} 42 U.S.C.S. § 1395y(b)(2)(B)(ii).

^v *Manning v. Utils. Mut. Ins. Co.*, (2001) 254 F.3d 387, Plaintiff, injured worker, permitted to proceed with MSA Private COA to recoup double of \$875,000 of meds paid over 6 years by Medicare. Def's motion to dismiss on SOL denied. "To encourage compliance with [reimbursement to Medicare], Congress has authorized a private cause of action and double damages against entities designated as primary payers that fail to pay for medical costs for which they were responsible, which are borne in fact by Medicare."

^{vi} 42 U.S.C. § 1395y(b)(2)(B) (2000); 42 C.F.R. § § 411.20, 411.24 (2001).

^{vii} In fact, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added new mandatory reporting requirements of Workers' Compensation insurance. 42. U.S.C. 1395y(b)(7) and (8)

^{viii} See e.g. 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26.