

# Contrast

a publication of Endurance Specialty Insurance Ltd.

winter | 2009

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## About Us

The Endurance Healthcare Liability practice focuses on excess medical professional liability for multiple hospital systems, integrated delivery networks, university teaching hospitals and large specialty hospitals. Our clients are typically sophisticated purchasers who practice strong clinical risk and claims management.

## Contact Us

We welcome your comments and suggestions. Our editor, Ms. Judy Hart, may be reached at [jhart@endurance.bm](mailto:jhart@endurance.bm) or +1 441-278-0441. Ms. Hart is an Executive Vice President of Endurance Specialty Insurance Ltd. and is the head of the healthcare practice.

For electronic copies of previous issues please visit [www.endurance.bm](http://www.endurance.bm)

## Letter from the Editor

Dear Friends:

As we close out a turbulent year for our economy, we approach the New Year with sustained dedication to meeting the needs of our customers and partners. In that spirit we are pleased to offer this installment of *Contrast*, the purpose of which continues to be discussion of current issues with respect to medical malpractice and other healthcare related litigation.



This issue includes two timely and important articles. The first, entitled "Pearls in a Sea of Uncertainty: A Primer on Potential Liabilities in Electronic Medical Records" provides insights on electronic discovery, metadata, data ownership, privacy and security with respect to electronic medical records ("EMR"). The author shares practical tips that will help you analyze how electronic medical records may affect your organization, and how you can get the most from EMR while minimizing potential liability.

The second article is entitled "One More Thing to Worry About in Your Settlements: The Medicare, Medicaid and SCHIP Extension Act of 2007." This article provides an overview of the new Medicare reporting requirements for personal injury cases, which will affect personal injury defendants, insurers, and plaintiffs when they become effective in July 2009.

I also want to again take the opportunity to thank you, our valued customers, partners and friends. Your support and confidence in us has allowed our Healthcare Practice to remain a significant part of the Endurance success story. We welcome your comments about this publication and wish you a joyful and successful New Year.

Yours truly,

A handwritten signature in black ink that reads "Judy Hart".

Judy Hart



## Pearls in a Sea of Uncertainty: A Primer on Potential Liabilities in Electronic Medical Records

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Originally published in the June 2008 edition of *Teaching Hospitals & Academic Medical Centers* (Volume 6, Issue 1).  
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***In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purpose of comparison. If they could be obtained . . . they would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was not doing mischief rather than good . . . .***<sup>1</sup>

If you think the above quote was made by some healthcare provider dramatically lamenting the inefficiencies and inadequacies in the modern day medical record, think again. Although she was certainly a visionary in her time, Florence Nightingale would not likely have imagined that her words would still be ringing true more than 100 years after complaining about the then “modern” system of documenting a patient’s medical care.<sup>2</sup> Today, more than seven years after the Institute of Medicine first identified health information technology as one of the “single most significant tools” that could help improve the quality of healthcare, the question is no longer if medical records will be maintained solely through electronic means, but rather a question of *when*.<sup>3</sup>

Seen as a vehicle to improve quality of care and reduce medical errors,

the Electronic Medical Record (EMR) is included in every presidential candidate’s healthcare briefing book. The rhetoric and momentum in implementing electronic medical records within a secure infrastructure is escalating in both private and public sectors, and healthcare providers are following suit by implementing EMRs at record rates. Yet, despite their obvious significance, the unseen liabilities ingrained in EMRs have received little attention to date. The following article is designed to help readers recognize some of the potential liabilities that exist throughout the lifecycle of an electronic records system, and to offer some pearls of wisdom in providing counsel on the issues identified.

### **e-IATROGENESIS**

***iatrogenic: a Greek work defined as “induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures.”***<sup>4</sup>

You do not have to search long for the source of the term “e-iatrogenesis,” a term recently coined by health information technology (HIT) professionals to describe the unintended patient harms caused by health information systems.<sup>5</sup> Paper and electronic-based medical records share in many of the same types

of risks (e.g., harms resulting from data loss/destruction, inappropriate corrections, inaccurate entries, and unauthorized access). Over time, the EMR becomes a repository for voluminous amounts of data, plausibly resulting in a greater impact when the aforementioned risks are realized.

While hospitals are understandably reluctant to make public any unintended patient harms resulting from their own internal technology, some are willing. One hospital reported an increase in medication errors when implementing a computerized physician-order entry (CPOE) system.<sup>6</sup> Still another reported that it had actually seen an *increase* in mortality in its pediatric intensive care unit after implementing a CPOE system.<sup>7</sup>

As providers become more transparent in sharing their hardearned lessons in implementing EMRs, e-iatrogenic harms should decrease. Counsel are encouraged to share their learned experience by actively participating in EMR listserves.

### **ELECTRONIC DISCOVERY**

I am just saying, there’s nothing worse than a federal judge who thinks the discovery process is being screwed around with.<sup>8</sup>

If the admonition Judge Joseph M. Hood, U.S. District Court for the Eastern District of Kentucky, gave to defendants when ruling against them in an electronic discovery matter does not grab your attention, not much will. When the Federal Rules of Civil Procedure (Rules) were revised in 2006, new challenges to the discovery process were created. Under the revisions, electronically stored information (ESI) was specifically recognized as a distinct category of discoverable information.

The revisions laid out specific ground rules for what ESI is discoverable (mostly everything) and when it is discoverable (responsive party must be readied to identify all potentially relevant data within ninety-nine days of the filing),<sup>9</sup> and attempted to provide clarification of the parties' preservation and production obligations (duty to preserve ESI attaches when litigation can be "reasonably anticipated"). During the initial scheduling conference, the responsive party must also identify any ESI it plans on using in cross-claims or defense and/or what ESI it considers as unduly burdensome to produce. The implications are huge, as hospitals must now not only determine the potential relevance of its ESI, but must also be able to determine the cost implications in producing it in the beginning stages of litigation.

No matter where they practice, lawyers are ethically obligated to represent their clients competently, diligently, and



zealously. In the words of one court, "[F]ailure to understand what is required by the discovery rules demonstrates incompetence."<sup>10</sup> Yet, according to a recent study by one of the industry's largest providers of electronic document discovery services, 75% of in-house counsel are unaware of or inattentive to case law, legal developments, and regulations relating to electronically stored information—a critical shortcoming when the entity is faced with an electronic document discovery (EDD) matter.<sup>11</sup> Failure to comply with the Rules carries significant risks not only for the hospital but also for its counsel. Significant sanctions may be imposed if the court determines that an abuse of discovery

occurred or relevant ESI was destroyed in bad faith. Sanctions include adverse jury inferences, dismissal of claims/defenses, award of attorney's fees and costs, and stiff monetary penalties. Under the Rules, the hospital's counsel is equally responsible for compliance; hence, if discovery rules are violated, the lawyer may find himself/herself sitting on the other side of the table—as the defendant in a legal malpractice case.

Some hospitals are under the belief that because medical malpractice cases are brought in state courts and hence not subject to the Rules (representing the majority of hospital cases), little, if any, resources need to be spent now

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**PEARL:**

**Ask the hospital's Chief Information Officer (CIO) to designate two or more individuals who will be primarily responsible for responding to EDD requests. Then, make sure they understand your "legal speak" and that you understand their "geek speak" before asking them to implement a litigation hold on ESI.**

in preparing for EDD, at least until their respective states adopt similar rules.<sup>12</sup> While such an approach may seem reasonable, it ignores the fact that the hospital is already subject to the Rules when before the federal court in at least two circumstances: (1) when a case is brought by the Equal Employment Opportunity Commission, and (2) where complete diversity of jurisdiction exists in a medical malpractice claim, if initially filed in or removed to federal court<sup>13</sup> (e.g., or where medical care has been provided in multiple jurisdictions).<sup>14</sup>

To appreciate the significance of metadata in the hospital setting, one need only read the account of the anesthesiology group that experienced it first-hand.<sup>15</sup> After a seven-hour neurosurgical procedure, the unnamed patient woke up as a quadriplegic. A claim of medical negligence against the surgeon was brought, and the patient's electronic anesthesiology records were produced in discovery. In a surprise to the anesthesiologist, a review of the audit trail revealed a ninety-three-minute gap in the patient's electronically recorded vital signs. In addition, a hidden time stamp in the audit trail revealed that the anesthesiologist's last entry at the end of the surgery had actually been made just shortly after surgery had begun. As can be expected, the plaintiff's complaint was amended to bring in the anesthesiologist, who settled the case during trial. Had the discovery been limited to the paper record, the flawed documentation would never have been discovered.

The importance of preparing the hospital for EDD cannot be overemphasized. Consider the enormity of just being able to identify the location of relevant ESI in a "typical" medical malpractice case: database files, word-processing files, PCs, laptops, desktops, PDAs, imaging systems, spreadsheets, disks, and backup tapes, to name a few—all of which are generated in multiple departments, are stored on different network servers, and must be preserved from the moment litigation is reasonably anticipated. If the EMR supports a "mail box" function that permits users to email data from the EMR, the hospital also must determine what information was sent and to whom. Add that to the need to identify potentially relevant ESI existing in biomedical equipment such as fetal heart monitors, blood pressure monitors, etc., and you begin to get a real sense of the complexity of e-discovery in the healthcare setting. Moreover, that does not even take into consideration the need to actually access, preserve, and produce it within the Rules' strict deadlines.

- PEARL: Download and read a copy of the revised Rules with Committee Notes, available at [www.uscourts.gov/rules/EDiscovery\\_w\\_Notes.pdf](http://www.uscourts.gov/rules/EDiscovery_w_Notes.pdf).
- PEARL: Read *The Sedona Principles Addressing Electronic Document Production*, Second Edition (June, 2007); *The Sedona Conference® Commentary on Legal Holds*, August 2007 Public Comment Version; and *The Sedona Conference® Commentary on ESI Evidence & Admissibility*, available at

www.thesedonaconference.org/publications\_html?grp=wgs110.<sup>16</sup>

- PEARL: Visit the following websites for publicly available e-discovery case databases, searchable by keyword:
  - www.krollontrack.com.
  - https://extranet1.klgates.com/ediscovery/.
- PEARL: Multidisciplinary response teams should be formed with representatives from Legal, Corporate Compliance, Information Technology (IT), Health Information Records Management (HIMS), Human Resources, Bio-Engineering, Finance, and Clinical Services. Each of the departments will play a critical role in the hospital's ability to respond to a request for ESI in a consistent and efficient manner. When suitable, bring outside counsel to the table, as well as members of the executive team, who can assist the team in implementing its directives.
- PEARL: Designate two or more individuals who will serve as the hospital's 30(b)(6) witnesses.<sup>17</sup> The individuals should have institutional knowledge of what ESI exists, where it originates, where it is stored, and what its retention properties are. It will be counsel's responsibility to make sure they also understand the legalities of collection, preservation, and production of the ESI.
- PEARL: Ask the hospital's Chief Information Officer (CIO) to designate two or more individuals who will be primarily responsible for responding to EDD

requests. Then, make sure they understand your “legal speak” and that you understand their “geek speak” *before* asking them to implement a litigation hold on ESI.

## METADATA

By its very nature, the medical record serves as a valuable tool in proving—or defending against—an assertion of medical malpractice. Whether the paper record will best serve the plaintiff or defendant largely depends on two factors: (1) if the record accurately reflects the care that was provided to the patient, and (2) if it provides sufficient detail for the trier of fact to determine whether or not the standard of care was met in delivering the care. With electronic medical records, a third factor comes into play: that of metadata.

The easiest way to think about metadata is simply “data about data.” It is a sort of electronic “fingerprint” the computer generates whenever it manipulates an electronic document. For example, metadata will reveal what algorithms the system used in generating clinical alerts and warnings, and what their triggers were. In most instances it also will reveal what the user did in response to the warnings. For instance, if a provider overrides one of the system's clinical alerts, metadata will not only reveal that the provider viewed the information, but also that he/she disregarded it.

Metadata also will reveal the who, the what, and the when of data creation,

access, or modification. This is true even after the record has been “locked” from further data entry, so any later changes to the record must be clearly identified as an addendum. Failure to do so may be viewed as an inappropriate alteration of the record, and can compromise its usefulness as a defense mechanism in litigation.

Metadata also serves a critical role in establishing the record's reliability as admissible evidence, and it will be up to the attorney to convince the judge accordingly. As one judge so eloquently stated:

***I don't care how much I try to understand meta-data, and residual data, and legacy data, and up data, and down data, and whatever . . . it is the lawyer's responsibility not only to understand that and to know it, but also to be able to communicate it to me, so that I can make a decision if there is a dispute among the parties.***<sup>18</sup>

Metadata can be particularly important in a medical malpractice case, especially when the substantive issue is if and when the defendant had access to some critical piece of information. The courts have not yet grappled with the question of whether or not the EMR creates a new standard of care; e.g., given the (presumed) ease in accessing all of the information available in the EMR, will a provider's failure to review it constitute medical negligence? What about reliance on flawed clinical decision support mechanisms? Or a pattern of overriding clinically appropriate alerts?

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**PEARL:**

**It is important to fully test the system's interoperability prior to going live. Failure to do so may result in inaccurate financial and/or clinical data, both of which can have significant negative impact on the hospital.**

Members of the plaintiff's bar are becoming increasingly savvy about the usefulness of metadata, and are now being advised to seek metadata whenever requesting medical records in discovery.<sup>19</sup> Hospital counsel must be equally well versed and knowledgeable about what metadata exists in the EMR, what its functionality is, and what should be preserved in anticipation of litigation.

- PEARL: For a summary of the rules of evidence, review the practice brief *Maintaining a Legally Sound Health Record*, available at [www.ahima.org](http://www.ahima.org).
- PEARL: In order to provide adequate counsel, health lawyers need to be knowledgeable about metadata and its relationship to liability risks. For an excellent and easy to understand explanation about metadata, see *Beyond Data about Data: The Litigator's Guide to Metadata*, available at [www.craigball.com/metadata.pdf](http://www.craigball.com/metadata.pdf).

### INTEROPERABILITY

While a patient's electronic health information may appear visually as a single record set when displayed on the screen, much of the data in the record may, in actuality, be generated by separate computer applications located throughout the hospital. Similar to building a paper record with documents generated from various departments within the hospital, an electronic record is built with data that is either pushed or pulled from other operating systems, oftentimes numbering in the hundreds. Each speaks their own

computer language and may not be able to understand the meaning or context of data generated from another. By analogy, think about trying to run Windows-based software on a Mac system—it just does not compute. In order to build the EMR, there must be an “interface” solution that permits movement of the data between two or more operating systems with two or more databases.

Arguably, building an effective interface solution is the most critical factor in successfully implementing an EMR. Without reliable data exchange, the data in the EMR simply cannot be trusted. Unfortunately, it can take months, even years, for the software interface to be fully refined. Hence, it is crucial that the system be tested, tested, and retested. Premature or inadequate deployment of the EMR may give rise to allegations of corporate negligence.

- PEARL: It is important to fully test the system's interoperability prior to going live. Failure to do so may result in inaccurate financial and/or clinical data, both of which can have significant negative impact on the hospital.

### DATA OWNERSHIP

As with any contract, limitations to the scope of potential liability may be addressed during contract negotiations; in fact, there are several good legal resources available that are specific to negotiating EMR agreements.<sup>20</sup> Nevertheless, the issue of data ownership deserves mention.

The information gathered in an EMR system is a veritable goldmine for data miners. Oftentimes, the purchaser of the EMR does not consider the commercial value of the data as a negotiating tool when sitting at the table with the vendor. The right to disclose, sell, assign, and lease the data should remain with the hospital, and should be clearly stated in its license agreement. Should the hospital choose to permit vendor use of the data in any manner, it should be well compensated.

Unlike the hospital party in the agreement, the vendor is not considered a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and thus has little, if any, constraints in using the data.<sup>21</sup> If the hospital is agreeable to designating the vendor as the owner of the data, it should have some say in how the vendor can or cannot use the data. At least one vendor has contracted to provide patient data detailing patients' genetic information to a genetics research company for purposes of identifying genetic markers.<sup>22</sup> Given the well-recognized concerns of discrimination by insurers and employers based on a person's genetic predisposition, the sensitive nature of the data is of particular concern.<sup>23</sup> Although the data will be disclosed in a "de-identified" format,<sup>24</sup> it may nevertheless be possible to re-identify patients with relatively little effort.<sup>25</sup>

Readers are cautioned to check applicable state laws before considering an agreement to grant the vendor any

ownership rights, as even de-identified disclosures are actionable under some state laws.<sup>26</sup>

## PRIVACY AND SECURITY

The healthcare community's commitment to patient confidentiality long precedes the myriad of federal and state laws that now govern the protection of patient confidentiality. This is not an easy feat, considering that an estimated 150 people will have access to a patient's record in a typical hospital stay, and that is in addition to the roughly 600 thousand payors, providers, and outside entities that have access for purposes of billing, utilization review, etc.<sup>27</sup> Moreover, consider this: other than information technology, the only mechanisms available to the hospital in fulfilling its legal obligations are limited to policies, procedures, and protocols. Add the sheer volume of information collected in the EMR and the implications of a security breach become staggering, and far exceed that which would result from breaching the confidentiality of a single paper record.

The hospital's most prominent privacy obligations arise from HIPAA's Privacy Rule, which require the hospital, inter alia, to protect against reasonably anticipated threats to the security of electronic health information protected under the Act (ePHI); protect against reasonably anticipated inappropriate use or disclosure of ePHI; and assure its workforce complies with the Act's Security Rule. There is no private cause of action under the regulations. Nevertheless, at least

one appellate court has determined that a plaintiff may assert a violation of the Rules as the basis for a claim of negligence. In *Acosta v. Byrum*, plaintiff asserted that her electronic medical records had been inappropriately accessed by an employee of a medical clinic, who then shared the information with a third party without her consent.<sup>28</sup> Asserting that the clinic's owner had breached his duty owed under HIPAA and hospital policies, plaintiff named him, alleging that he was negligent in sharing his password with the employee. The trial court dismissed for failure to state a claim upon which relief could be granted. The North Carolina Court of Appeals reversed, holding that while HIPAA does not create a private right of action, citing HIPAA may help establish breach of appropriate standards of care.

Electronic security breaches can be grouped into six categories, each of which present their own compliance challenges: (1) lost or misplaced records or hardware; (2) stolen records or hardware; (3) improper disposal; (4) unauthorized access; (5) unencrypted emails; and (6) unintended disclosure/release. Failure to implement adequate protections in any one category will result in vulnerabilities to potential data tampering, disruption of hospital operations, and inappropriate disclosure of sensitive information. However, the degree of protection that can/should be afforded to each category is limited, primarily by the security functions of the EMR itself, the proficiency of the IT staff, the commitment of hospital executives, and budgetary restrictions.

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The impact of a security breach is multifaceted. Not only could the hospital be subject to a criminal penalty under federal and/or state law, but to civil damages, loss of community confidence (loss of revenue), and negative impact on employee morale as well (staff turnover shortage of care providers decreased patient satisfaction loss of revenue). Additionally, the monetary expenditures necessary to offer credit monitoring services to affected individuals can reach upwards of multi-millions of dollars. Such was the experience of the Department of Veterans Affairs (VA) last year when it reserved more than \$20 million after discovering an external hard drive was missing from its Birmingham, AL, research facility.<sup>29</sup> The hard drive contained sensitive information on an estimated 650,000 physicians and 254,000 veterans who were provided with credit monitoring services. What was the total cost per person? A mere \$22.22 per person, on average.

Security breaches also may result in class actions as was brought against Providence Health Systems, when computer back-up tapes and disks containing patient information were stolen from the car of an employee who had taken them home to make back-ups.<sup>30</sup> When Providence refused the patients' request to offer credit monitoring services, they filed suit under theories of negligence, negligence per se, and unlawful trade. Providence eventually offered the credit services and the case was dismissed,

just in time to reach a settlement agreement with the Oregon Department of Justice, which investigated the hospital following the theft.<sup>31</sup>

A similar breach just unfolding at the University of Miami (UM) also bears watching. There, computer back-up tapes containing patient health information and other sensitive information were stolen from a vehicle belonging to its off-site storage company.<sup>32</sup> The scope of the breach was huge: anyone who had been a patient of a UM physician or visited a UM facility at any time since January 1, 1999, was affected. UM anticipates it will provide notice to the approximate 47,000 patients whose financial information may have been compromised, but no public mention of offering credit monitoring services has been made.

- PEARL: Review the Government Accountability Office's report to Congress *Lessons Learned About Data Breach Notification* (GAO-07-657 Privacy) for suggested best practices in responding to a security breach, available at [www.gao.gov/new.items/d07657.pdf](http://www.gao.gov/new.items/d07657.pdf).
- PEARL: Stay abreast of your state's breach notification laws. Under sweeping revisions to California's data breach notification laws (effective January 2, 2008), any compromise to a resident's medical or health information is now subject to the state's data breach notification laws. Further, the law now ap-

plies to any business holding covered information, which would include any business with computerized employee health benefit information or health data (no mention of how the state plans to address jurisdictional issues raised). Whether other states will follow suit remains to be seen.

- PEARL: Educate, educate, educate. Make it painfully clear to users that even a seemingly simple thing like sharing log-on information could result in an erroneous audit trail that may someday be used against them. Give examples, such as leaving an active record open and failing to log out. In the event of someone else continuing the session without logging on themselves, the audit would appear as though the entire session was that of the original user, and this is problematic if the person who follows behind inappropriately peruses through other patient records.

## CONCLUSION

What the ultimate liabilities in electronic medical records will be is unknown at this early stage of development. To assist the hospital in navigating its way through the uncertainties, counsel must become comfortable with multiple aspects of information technology. If adequately prepared, perhaps we will all have a hand in achieving Florence Nightingale's vision of a medical record that "shows what amount of good it can really do." ◀

- 1 Florence Nightingale, *Notes on Hospitals*, LONGMAN, GREEN AND COMPANY 176 (1863).
- 2 Judy Ozbolt, et al., *Much Ado About Terminology*, *J Perianesthesia Nursing*, 280-284 (Aug. 2007).
- 3 INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (National Academy Press 2001).
- 4 Merriam-Webster Online Dictionary, available at [www.merriam-webster.com/dictionary/iatrogenic](http://www.merriam-webster.com/dictionary/iatrogenic) (last accessed Apr. 25, 2008).
- 5 Jonathan P. Wiener, et al., "e-Iatrogenesis": *The Most Critical Unintended Consequence of CPOE and other HIT*, 14 *J. AM. MED. INFORM. ASSOC.*, 387-388 (2007).
- 6 Amy L. Potts, et al., *Computerized Physician Order Entry and Medication Errors in a Pediatric Critical Care Unit*, 113 *PEDIATRICS*, 59-63 (Jan, 2004).
- 7 Yong Y. Han, et al., *Unexpected Increased Mortality After Implementation of a Commercially Sold Computerized Physician Order System*, 116 *PEDIATRICS*, 1506-1512 (2005). See also Dean F. Sittig, et al., *Lessons From "Unexpected Increased Mortality After Implementation of a Commercially Sold Computerized Physician Order System"*, 118 *PEDIATRICS*, 797-801 (2006).
- 8 *Grange Mut. Casualty Co. v. Mack*, Nos. 07-5097/07-5387, 2008 WL 744723 (6th Cir. Mar. 17, 2008).
- 9 Rule 16(b) requires that that the parties engage in a "meet and confer" conference within ninety-nine days of the case filing.
- 10 *In the Matter of Michele Estrada*, 143 P.3d 731, 740 (N.M. 2006).
- 11 Kroll Ontrack, *ESI Trends Report (2008)*, available at [http://commonscolld.typepad.com/eddupdate/files/2008\\_esi\\_trends\\_report.pdf](http://commonscolld.typepad.com/eddupdate/files/2008_esi_trends_report.pdf) (last accessed Apr. 25, 2008).
- 12 Some states have already revised their rules of civil procedure to mirror the Federal Rules. See Arizona 16 A.R.S. Rules of Civil Procedure, Rules 16(b), 16(c), 16.3, 26(b), 26.1, 26.2, 33(c), 34, 37(g), and 45 (Supp. 2008).
- 13 See *Thornburg v. Stryker Corp.*, No. 1:05-CV-1378 -RLY, 2006 WL 211952 (S.D. Ind. July 3, 2007) (denying plaintiff's motion to remand to state court and defendants had removed to federal court).
- 14 See *Daigle v. Maine Med. Ctr. Inc.*, 14 F.3d 684, (1st Cir. 1994) (medical malpractice case brought with complete diversity).
- 15 See Michael M. Vigoda and David A. Lubarsky, *Failure to Recognize Loss of Incoming Data in an Anesthesia Record-Keeping System May Have Increased Medical Liability*, 102 *Anesthesia & Analgesia* 1798-1802 (2006).
- 16 The Sedona Conference is a nonprofit, 501(c)(3) research and educational institute dedicated to the advanced study of law and policy in the areas of antitrust law, complex litigation, and intellectual property rights. Judges will often rely on deliverables created by its Working Groups (comprised of leading jurists, lawyers, experts, and consultants) when addressing issues involving electronic discovery. *United States v. O'Keefe*, 537 F.Supp.2d 14 (D.D.C. 2008) (requiring defendant to preserve electronically stored information in its native form with metadata).
- 17 In litigation, public and private corporations, associations and government entities speak through their designated representatives. Rule 30(b)(6) in both federal and state court Rules of Civil Procedure allow a party to request the deposition of a single individual representing an entity, whether a party or a non-party to the litigation. A 30(b)(6) witness is the individual designated by the responsive party as the person most knowledgeable about the subject of the deposition testimony.
- 18 National Center for State Courts, *Electronic Discovery: Questions and Answers*, Civil 3(2);2-3,2 (2004), available at [www.ncsconline.org/WC/Publications/KIS\\_EIDiscCivilActionSummer04.pdf](http://www.ncsconline.org/WC/Publications/KIS_EIDiscCivilActionSummer04.pdf) (last accessed Apr. 25, 2008).
- 19 Kathleen F. Peterson, American Trial Lawyer's Association, *Litigating Tort Cases*, § 61:3.1 (2007).
- 20 See Leon Altman and Steve Phillips, *What Providers Should Know Before Negotiating Their Next Software Purchase*, *HIT News* Spring 2007, at 10-14. See also Daniel F. Shay, *A Primer on Electronic Health Record License Agreements*, *HEALTH L. HANDBOOK*, § 9 (2006).
- 21 45 C.F.R. §§ 160, 164.
- 22 Richard Pizzi, *EMR Vendor to Share Patient Data with Genetics Research Firm*, *HEALTHCARE IT NEWS*, (Mar. 20, 2008), available at [www.healthcareitnews.com/printStory.cms?id=8922](http://www.healthcareitnews.com/printStory.cms?id=8922) (last accessed Apr. 25, 2008).
- 23 On May 21, 2008, President George Bush signed into law the Genetic Information Nondiscrimination Act, Pub. L. No. 110-233, which prohibits insurers from seeking or using genetic information in a discriminatory manner.
- 24 See 45 C.F.R. § 164.514(b)(2)(i), setting forth specific identifiers that, if removed, "de-identify" health information protected under the Privacy Rule.
- 25 See *People ex rel Dep't of Prof. Reg. v. Manos*, 782 N.E.2d 237, 246-47 (Ill. 2002), distinguished by *Doe v. Ill. Dep't of Prof. Reg.*, 793 N.E.2d 119, (Ill. App. Ct 2003).
- 26 *Parkson v. Central DuPage Hosp.*, 435 N.E.2d 140, 143-44 (Ill. App. Ct. 1982).
- 27 *HIMMS Analytics Report: Security of Patient Data*, commissioned by Kroll Fraud Solutions (2008).
- 28 *Acosta v. Byron*, 638 S.E.2d 246 (N.C. Ct. App. 2006).
- 29 Daniel Pullian, VA Sets Aside \$20 Million to Handle Latest Breach, *GOVERNMENT EXECUTIVE* (June 14, 2007), available at [www.govexec.com/dailyfed/0607/061407p1.htm](http://www.govexec.com/dailyfed/0607/061407p1.htm) (last accessed Apr. 25, 2008). See also Government Accountability Office, *Sustained Management Commitment and Oversight are Vital to Resolving Longstanding Weaknesses at the Department of Veterans Affairs* (GAO-07-1019 Sept. 2007), available at [www.gao.gov/new.items/d071019.pdf](http://www.gao.gov/new.items/d071019.pdf) (last accessed Apr. 25, 2008).
- 30 *Gibson v. Providence Health Sys.-Or.*, No. 0601-01059 (Multnomah County, Or. 2005).
- 31 *Providence Settles with State Over Loss of Records*, *PORTLAND BUS. J.* (Sept. 26, 2006), available at [www.bizjournals.com/portland/stories/2006/0/25/daily13.html?t=printable](http://www.bizjournals.com/portland/stories/2006/0/25/daily13.html?t=printable) (last accessed Apr. 25, 2008).
- 32 *Announcement from the University of Miami*, available at [www.dataincident.miami.edu](http://www.dataincident.miami.edu) (last accessed Apr. 25, 2008).

## One More Thing to Worry About in Your Settlements: The Medicare, Medicaid and SCHIP Extension Act of 2007

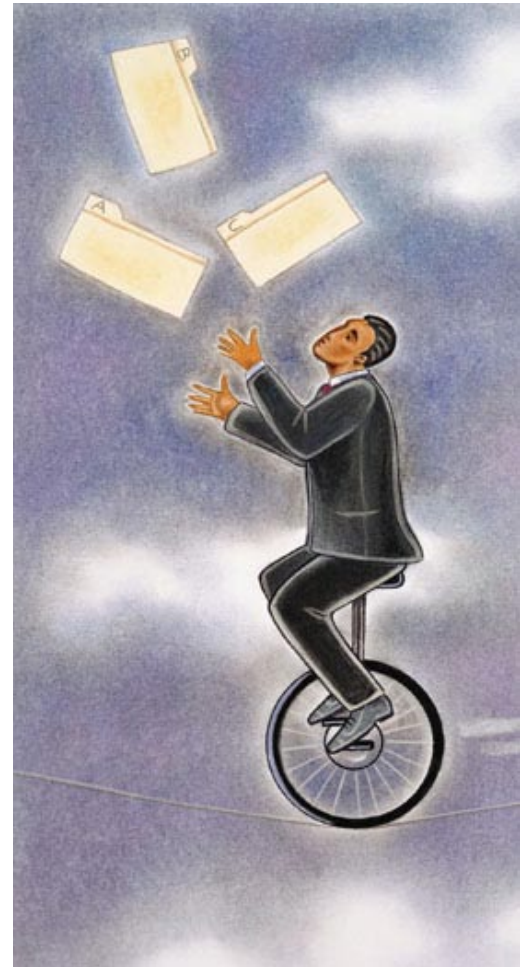
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*Abstract: A new Medicare law could make it more difficult for plaintiffs and defendants to settle single event and mass tort personal injury claims after July 1, 2009. Now more than ever, practitioners must embrace new procedures on the front end of cases in order to minimize disruption on the back end.*

On December 29, 2007, President Bush signed into law the “Medicare, Medicaid and SCHIP Extension Act of 2007”<sup>2</sup> (MMSEA) adding yet more teeth to the Medicare Secondary Payer Statute.<sup>3</sup> Section 111 of the MMSEA will require the providers of liability insurance (including self-insurance), no fault insurance and workers’ compensation insurance (hereinafter “insurers”) to determine the Medicare-entitlement of all claimants and report certain information about those claims to the Secretary of Health and Human Services.<sup>4</sup> With the objective of assisting the Secretary with coordinating benefits and uncovering potential reimbursement claims, this recent legislation reinforces that the federal government is intent on ensuring Medicare always is treated as the payer of last resort. The penalty for non-compliance has teeth indeed - \$1,000 per day for each day the insurer is out of compliance. This penalty is in addition to the often-feared, rarely-levied “Double Damages Plus Interest” that defendants can be fined if Medicare’s reimbursement claim is ignored in any settlement.<sup>5</sup> The new rules will apply to settlements on or after July 1, 2009.

MMSEA represents the next turbulent adjustment in the long continuum of change since President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act in December 2003 (“MMA”).<sup>6</sup> The MMA further defined Medicare’s recovery rights, clarified its enforcement powers<sup>7</sup>, and erased all doubt regarding a plaintiff’s lawyer’s affirmative duty to verify and resolve conditional Medicare payments made from the date of injury through the date of settlement.<sup>8</sup> Whereas the teeth added to the Medicare Secondary Payer framework by MMA in 2003 were targeted at the plaintiff community, those just added by MMSEA are directed at insurers.<sup>9</sup> In this regard, the ongoing transformation of Medicare reimbursement policy and practice creates continual challenges for lawyers and their clients in personal injury and workers’ compensation cases. Simply put, the days of either treating Medicare as the proverbial sleeping dog or punting the issue until the end of the case are long gone.



### SEEKING CLARITY – WHAT WILL BE REQUIRED?

On or after July 1, 2009, insurers must engage in a two-step process:

**Step 1:** Determine whether a claimant (including an individual whose claim is unresolved) is **entitled** to Medicare benefits.

**Step 2:** If the claimant is determined to be entitled, submit certain **information** about the claimant to the Secretary of Health and Human Services in a form and manner (including frequency) that has yet to be specified by the Secretary.

While seemingly straightforward, practitioners need clarification regarding the intended scope of the words *entitled* and *information*.

**Entitlement:** The Secretary should clarify exactly what is meant by “entitled” for purposes of MMSEA so that no one gets lost in the semantics. For instance, will the insurer only be required to verify whether or not the claimant is actually enrolled in Medicare Parts A and B only or will the insurer need to determine if the claimant is eligible to be enrolled? In other words, will “entitlement” include someone who is eligible to enroll in Medicare but has not yet done so, such as a person over age 65 who is still employed with group health benefits?<sup>10</sup>

Also, what, if anything, will an insurer need to do for a claimant who receives Medicare supplements like Part C (Medicare HMO) and Part D (Prescription Drugs)? While these are healthcare plans created under the statutory rubric of Medicare, they are, nonetheless, supplemental or replacement plans offered through a variety of uncoordinated, private health insurance companies, each with their own policies. While Medicare HMO’s may have a right of recovery from a settlement, they do not follow the same procedures for identifying and resolving potential reimbursement claims/liens.<sup>11</sup>

Depending on how broadly “entitled” is defined, it may be difficult and costly for

insurers to obtain the necessary information to determine that a claimant is “entitled” in a reasonable amount of time, therefore holding up the processing of claims and adding additional transactional costs.

**Information:** According to the MMSEA language, the information that insurers will be required to submit will include the identity of the claimant, as well as any other information necessary to make a determination regarding coordination of benefits, including any applicable reimbursement claim Medicare might have arising out of a settlement. Like the term “entitled”, the scope of what is meant by “other additional information” has yet to be defined by the Secretary of Health and Human Services.

One should not be alarmed by the fact that the scope of information that defendants are required to submit has yet to be specified. The Secretary has more than a year to set these standards. In fact, in a recent news article, it was reported that the Secretary intends to seek the dialogue of insurers and attorneys prior to releasing the standards.<sup>12</sup>

This article is intended to help spark the necessary dialogue (internally and collectively) among plaintiffs, defendants and insurers to help make sure MMSEA does not add yet another level of disruption to the already complex and time-consuming settlement process. Indeed, if we fail to

work through the issues discussed in this article over the next year, come July 1, 2009, constituents in the settlement process will be scrambling to deal with the issue and likely only be left with one possible solution... the tactic of trying to make this the other side’s problem.

## HOW WILL MEDICARE USE THIS INFORMATION?

Prior to diving further into the issues that need to be clarified, a moment should be spent contemplating how Medicare will utilize this claimant/settlement information. As stated above, by July 1, 2009, the Secretary shall specify the information that insurers must submit that will enable the Secretary to make “an appropriate determination concerning coordination of benefits, including any applicable recovery claim.”

The phrases “coordination of benefits” and “applicable recovery claim” address two separate and distinct timeframes. The former speaks to who should be paying for medical care *presently* and/or in the *future*, and the latter speaks to who should have been paying in the past.

More specifically, in the personal injury and workers’ compensation context, *coordination of benefits* is Medicare-speak for ensuring that if there is another source of coverage that is available for someone’s injury-related care, he or she should use it. If no other source

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of coverage is available (and the person is eligible for Medicare), Medicare will begin paying for injury-related care. Further, in the same context, *recovery claim* refers to situations where some other source of funding is later found that should have been paying all along. In that instance, Medicare gets reimbursed for past injury-related expenses.

*Don't Succumb to Paranoia!* In recent years, the timeframe that is subject to Medicare's interest in personal injury matters has been the subject of tremendous scholarly as well as practical debate. Specifically, the focus of the debate is whether Medicare's interest is only related to the past (i.e., for injury-related care from the date of injury through the date of settlement) or, whether Medicare has an interest in settlement proceeds related to the future cost of care. In previous articles<sup>13</sup>, this author explored the issue of whether Medicare requires parties who settle liability claims to calculate a "set aside" amount that the injured client must spend on injury-related care before Medicare picks up the tab again. The roots of the set aside obligation are similar to the coordination of benefits concept, which, in effect stands for the proposition that *if another source of coverage (i.e., settlement dollars earmarked as payment for medicals) exists for a claimant, he or she should use it first.*

In the workers' compensation arena, this question has been squarely, yet controversially, answered. If a workers' comp carrier is settling its future obligation to pay for injury-related care, the settlement

must properly recognize the shift of this future burden to Medicare by allocating a portion of the settlement proceeds to cover those costs of care.<sup>14</sup> Medicare does not pay for care—before or after a settlement—until the beneficiary has exhausted his or her remedies under workers' compensation.<sup>15</sup> This includes spending the portion of any settlement earmarked for future medical expenses.<sup>16</sup>

For liability settlements, this *set aside* question has never been addressed to the satisfaction of most personal injury practitioners. Certainly, the fundamental statutory principle requiring settling parties to protect Medicare's interests in workers' compensation settlements already exists and appears to apply to liability settlements as well.<sup>17</sup> Yet, while perhaps no new laws or regulations need be promulgated before Medicare could extend the reach of set asides to the liability context, obstacles currently exist which have made it, in this author's opinion, very difficult to fairly, efficiently and uniformly apply the set aside requirement to liability settlements.

Specifically, unlike workers' comp, liability insurance policies generally have caps, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to offset the damages to an amount less than full value. Currently, CMS' "set aside" calculation methodologies are geared toward the full-value, "no fault" nature of workers' comp statutes. The types of damages in workers' compensation cases, such as "indemnity" and "medical"

payments, are readily delineated, but in personal injury settlements, an array of damages can be categorized as "general" and "special." Absent a court finding on the merits of the case, presently there is not an efficient mechanism to determine what the intention of the parties was in making payment to the claimant (i.e., allocation between medical and non-medical damages).

The point of this article is to spark dialogue, not anxiety. When MMSEA was announced, some in the settlement consulting community prematurely sent out missives stating that Medicare will begin requiring liability set asides as of July 1, 2009, and/or that guidance on the issue is expected shortly from CMS. Such an interpretation of MMSEA is wide of the mark. CMS currently offers no formal guidance (nor do they have formal procedures in place) on the issue of liability set asides and this author believes it will not be coming in the near future.<sup>18</sup> Additionally, Medicare's contractor offers guidance on their website that "set aside *agreements* only apply to workers' compensation cases"<sup>19</sup> (emphasis added). It is important to note that the website does not state that an obligation to consider Medicare's future interest does not exist in all cases, but rather that obtaining CMS's *agreement* or approval of a set aside amount is limited to the workers' compensation cases.<sup>20</sup> [For more information about the factors involved in conducting a good-faith, case-by-case analysis of whether steps must be taken to protect Medicare's future interest in liability settlements see page 15 of the

article entitled, "Medicare's Reimbursement Claim - The Only Constant is Change" available at <http://www.garretsonfirm.com/library.php> ]. The point, however, is that all conspiracy theories should be cast aside for the time being; nothing in MMSEA is designed as a "Trojan horse" for liability set asides.<sup>21</sup>

A rationale interpretation of Section 111 of MMSEA is that the new requirement for defendants to report information about resolved or unresolved claims is a sign that CMS is not yet content with the entire regulatory framework utilized to enforce its secondary payer status. It is a work in progress so to speak.

Regardless of what other changes may be down the road, several issues need clarification prior to the July 1, 2009, effective date for MMSEA:

- **Triggering Event** - This author believes the Secretary should clearly describe the types of insurance claims that trigger this requirement to provide information. For instance, what if the claim against the insurer does not involve a claim for payment of medical expenses related to personal or workrelated injury? Further, what about the approval requirements for workers' compensation cases? In workers' compensation, settlements frequently do not become final until approved by the state workers' compensation agency. Is the *trigger* the date the settlement is agreed upon or is it the date it is approved by the appropriate state agency? Also, what about matters that are being

appealed? Is it the triggering date for reporting the date the judgment is initially made or when it becomes final?

- **Thresholds** - Insurers regularly pay personal injury and workers' compensation claims which involve small amounts of medicals (i.e. less than \$500). In many instance, it is conceivable that it could cost insurers more to investigate whether the claimant is Medicare-entitled than for Medicare to process and act upon the information.

- **Accessibility** - Will new technology be introduced to assist insurers in verifying whether a claimant is entitled to Medicare? Or, would insurers simply rely on the response from the claimant or his attorney regarding the claimant's entitlement? With existing technology, injury claimants can sign up and access "Explanation of Benefit" or "EOB" through MyMedicare.gov which tracks medical treatment history. Will defendants be given such access? If so, what HIPAA concerns are raised?

- **Multiple Defendants** - In situations involving multiple defendants, such as asbestos cases involving multiple insurers on the coverage during the exposure period, will each defendant's insurer have the obligation?

- **Redundancy** - What if the claimant's counsel already has made contact with Medicare? According to 42 U.S.C. §1395y(b), when a Medicare beneficiary retains an attorney to represent him/her in a liability case, it is the attorney's

responsibility to notify the Medicare Coordination of Benefits Contractor (COBC). Therefore, if the claimant is entitled, regardless of the extent to which he/she has informed counsel that he/she has utilized his/her Medicare coverage, counsel should contact the COBC and follow the process with the MSP Recovery Contractor (MSPRC) to identify, audit and resolve any conditional payments.<sup>22</sup>

## CHANGING HABITS

From the start of every new case, plaintiff's counsel is familiar with worrying about possible liens on the claim. These concerns, however, are in large part new for defendants and insurers. Accordingly, insurers will need to institute internal procedures for compliance with the MMSEA. Such procedures will depend, of course, on what information is eventually required by the Secretary. While dialogue likely will take place and lead to clarity, below are some initial practice considerations for insurers:

- **Consent to Release Information** - Since insurers will need to determine the Medicare eligibility status of every claimant, regardless of whether the claim has been resolved, they may need to require each claimant to sign a Social Security form SSA-3288 (Consent to Release Information). This form can be submitted to the Social Security office closest to the claimant's residence with a request for complete benefit eligibility information. Ideally, this should be done at the time the claim is opened and *again* at the time the

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**Medicare wants its interest satisfied in any settlement prior to distribution to the claimant or attorney.**

claim is resolved through judgment, settlement or award. A claimant who is not eligible for Medicare at the time the claim is initiated may have become eligible by the time the claim is finally resolved. Be sure consent to release information includes the claimant's counsel so he/she is included on any resulting correspondence.

- **Data Collection and Storage** - Further, insurers must take the required steps to ensure they are set up to collect, manage and transmit (in a HIPAA-complaint manner) such

data as the claimant's Social Security or Medicare HIC number and any other claims information the Secretary may require. In other contexts, like resolving Medicare reimbursement claims after settlement or seeking the approval of Medicare set asides, the data transmitted includes a copy of the judgment or settlement; medical records, applicable ICD-9 codes, life care plans or cost projections; life expectancy information; the insurer's payment history on the claim and any other documentation that Medicare deems helpful in determining whether its interests were reasonably considered.

One also may question whether the new requirements ultimately will lead to a change in the process by which claims are paid by defendants. In recent years, many in the plaintiff bar have seen insurers place both the claimant's name and Medicare on a settlement check, leaving the attorney and claimant with the obligation of getting Medicare to endorse the check. The assumption by the carrier is that this process, while a terrific burden on the claimant and his or her attorney, ensures that any obligation to Medicare is addressed since the check cannot be cashed by the claimant unless Medicare first signs off.<sup>23</sup> Those insurers who like to wear a "belt with suspenders" are going even farther and agreeing on settlement in principle, but requiring some written verification by Medicare (provided by claimant or his/her attorney) demonstrating that no reimbursement obligation exists, or that it has been satisfied. Is it too far of a stretch to now envision an

end-game wherein Medicare will expect (and/or the insurer will want to make) payment directly to Medicare from the insurer and not to the trust account of the attorney? Indeed, on this point Medicare's intent is clear – Medicare wants its interest satisfied in any settlement prior to distribution to the claimant or attorney. Medicare states that no disbursement of settlement should be made until Medicare's interest is satisfied in full.<sup>24</sup>

## ISSUES FOR PLAINTIFFS' COUNSEL

Medicare's role in settlements is undeniably evolving. As most plaintiff attorneys already understand, formal procedures must be implemented in their practice, and they cannot wait to receive a notice of a potential claim from CMS before taking action. The agency is not required to give notice, so lawyers must proactively identify, verify, and satisfy Medicare's interests before distributing any settlement proceeds.<sup>25</sup>

For those practitioners who have not yet created solid internal protocols, this new law will place greater importance on making sure that an appropriate Medicare *verification* and *resolution* strategy is fully integrated into their practice. The tenets to such a successful strategy would include protocols for getting started early, enhanced client intake information, client education modules<sup>26</sup> and, for complex cases, perhaps changes in retainer agreements that allow the attorney to seek outside assistance to handle lien verification and resolution.

## NEUTRAL ASSISTANCE FOR THE PARTIES

This notion of seeking outside assistance with lien resolution is a relatively new development, yet it is not without good purpose. Plaintiffs' attorneys are keenly aware that they struggle to keep up with the changing regulations, protocols and contractors associated with the liens competing for a "share" of the client's recovery. Many believe their clients' interests are best served if the attorney's time and efforts are spent on addressing damages and liability.<sup>27</sup> With MMSEA, defense attorneys now share these same concerns.

This author's firm, The Garretson Firm, has a practice area exclusively focused on evaluating and resolving healthcare liens and reimbursement claims with federal (Medicare), state (Medicaid) and private health insurance (ERISA) providers in single event and mass tort settlements. In this respect, while the attorney focuses on litigation (his or her expertise), our firm's attorneys, billing/coding specialists and experienced lien resolution analysts focus on ensuring reimbursement claims and liens are handled in a compliant manner; affirmative duties are properly executed; defendants receive the benefit of the bargain and injured individuals receive the maximum benefit from their settlement.

## CONCLUSION

As discussed above, this new legislation puts new reporting burdens on insurers

and plaintiffs' counsel alike. In turn, it may have a chilling effect on the insurer's willingness to disburse settlement proceeds until the plaintiff's attorney proves Medicare's interests have been resolved.

Undeniably, lien resolution is no longer an administrative function that can be addressed by the claimant's attorney on the back end. Nor is it any longer a subject that defendants address simply by requiring only an indemnification clause. Rather, it has evolved over the last several years into one of the most demanding *condition precedent* in any settlement agreement, often requiring counsel affirmatively to notify the governmental healthcare agencies (i.e., Medicare and Medicaid) of plaintiffs who are settling and then proactively satisfying those agencies' interests prior to disbursement of settlement proceeds to any plaintiffs.

In light of MMSEA, claimants, defendants and insurers must communicate and cooperate to make sure MMSEA does not add yet another level of disruption to the already complex and time-consuming settlement process. With all settlement-related Medicare issues, a proactive rather than reactive approach will yield a better result. Simply put, if you know you are going to have to deal with it in the end, why not start addressing it in the beginning? ◀

To learn how the **Garretson Firm** is taking proactive measures to implement MMSEA requirements into its lien resolution practice for settling parties, please contact **Matt Garretson** at 513-794-0400.

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- 2 Public Law No: 110-173.
- 3 MMSEA amended Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) by adding at the end these new requirements as paragraph 8.
- 4 Section 111 of the MMSEA also addresses new amendments to the Medicare Secondary Payer statute regarding reporting requirements for Group Health Plans. This article, however, only addresses the amendments related to providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance.
- 5 Many things would need to go terribly wrong before a Medicare reimbursement claim gets to the point of a Defendant being liable for double damages plus interest. For instance, Medicare's final demand for reimbursement from the claimant after a settlement must be paid 60 days from the date the final demand was issued by the Medicare Secondary Payer ("MSP") department of The Centers for Medicaid and Medicare Services ("CMS"). The MSP department allows 180 days for payment. After these 180 days transpire, the department will send an "intent to refer" letter (i.e., refer to Treasury for collection) and provide an additional 60 days to respond. So, in effect, settling parties are allowed 240 days to address the final demand. (Certain exclusions apply to a referral involving a case pending on appeal). When a case ultimately is referred to Treasury, their first step is to send a letter to the beneficiary seeking collection of the debt. If unsuccessful, the second step is to seek the remedy available through the Tax Refund Offset Program ("TROP") whereby Treasury seeks satisfaction of the lien by being "constructively paid" through offsetting the plaintiff's government checks (benefits) and/or refunds (tax). The government will pursue this exhaustive solution to secure reimbursement from the beneficiary. Plaintiff counsel and the defendant/carrier typically is not a target for reimbursement until the second step of Treasury recovery is fully explored. But see *United States of America v. Henry L. Sosnowski, D.J. Weis, and Home Mutual Insurance Company, Defendants* (822 F.Supp. 570, 41 Soc. Sec.Rep.Serv. 312, [Feb. 5, 1993]). When payment was received, Sosnowski and his attorney neglected to reimburse Medicare from the settlement, as required under federal law (42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 411.24). The federal government therefore commenced an action against both Sosnowski and his attorney, jointly and severally, for recovery of the amount due. Consistent with the MSP provisions, the court ruled that the government did have a cause of action for recovery against not only the Medicare recipient, but also his attorney for the entire reimbursement.
- 6 Medicare Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 42 U.S.C. §1395). Section 301 further clarifies the government's right to reimbursement that it had been seeking in *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003) and *Baxter*, 345 F.3d 866. See also *Brown v. Thompson*, 374 F.3d 253 (4th Cir. 2004) (further clarifying congressional intent to modify the MSP statutes using §301).
- 7 The Centers for Medicare and Medicaid Services ("CMS") has a right to seek 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" if those third-party funds—rather than Medicare—should have covered injury-related medical expenses. The right of reimbursement exists regardless of whether the settlement acknowledges liability and how the settlement agreement stipulates disbursement should be made. This includes situations in which the settlement does not expressly include damages for medical expenses. The plaintiff attorney and defendant can be held responsible for twice the amount owed to the agency. See 42 U.S.C. §1395y(b)(2)(B)(iii) (2000 & Supp. 2004). Until the 2003 amendments, there was little statutory support for this position, but 42 U.S.C. §1395y(b)(2)(B)(ii) now provides recovery from an entity that receives payment from a primary insurer.
- 8 As a result, no matter how a particular settlement agreement is worded and no matter whether the tortfeasor is covered by a commercial insurance insurer or a self-insured insurer, or is just paying the claim out of its general assets, any payments Medicare makes are considered conditional.
- 9 One could argue, however, that the indirect target of MMSEA is the plaintiff community since MMSEA would be superfluous if the federal government felt its interests were being protected by plaintiffs' bar after MMA.
- 10 For purposes of defining a claimant's and claimant attorney's obligation to protect Medicare's interest at the time of settlement, the notion of "entitlement" is clear. If the claimant is entitled, regardless of the extent to which he/she has informed counsel that he/she has utilized his/her Medicare coverage, counsel should contact the Medicare Coordination of Benefits Contractor (COBC) and follow the process with the MSP Recovery Contractor (MSPRC) to identify, audit and resolve any conditional payments.
- 11 In various states, anti-subrogation laws may come into play in this analysis as well.
- 12 "CMS to Issue Guidance Later This Year On Medicare Secondary Payer Reporting", BNA Health Plan and Provider Report, Volume 14, Number 5 (January 30, 2008). Peter Ashkenaz, spokesman for the Centers for Medicare & Medicaid Services, told BNA on Jan. 22 the department intends to issue guidance on the MSP requirements "later this year," but not before talking with interested stakeholders, such as insurance groups and lawyers' groups.
- 13 "Making Sense of Medicare Set Asides," Trial, May 2006. See also "The Only Constant is Change" available in the library at [www.garretsonfirm.com](http://www.garretsonfirm.com), which contains further analysis regarding set aside issues in the liability settlement context.
- 14 42 C.F.R. §411.46 (2005).
- 15 42 C.F.R. §411.45 (2005) specifies two exceptions.
- 16 42 C.F.R. §411.46 (2005).
- 17 The MSP provisions say Medicare is always secondary to workers' comp and other insurance, including no-fault and liability insurance. Under the Social Security Act, payment "may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan." 42 U.S.C. §1395y(b)(1), amended by Pub. L. No. 109-171, 120 Stat. 4 (2006). Also, Medicare's authority to review liability settlements arises under the same statute as its authority to review workers' comp settlements does. Social Security Act §1862, as amended, 42 U.S.C. §§1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), amended by Pub. L. No. 109-171, 120 Stat. 4 (2006).
- 18 The only statement this author envisions Medicare making on the issue will be designed to clarify any misinformation about whether or not MMSEA is intended to lead to formal protocols/procedures for addressing the liability set aside issue.
- 19 MSPRC FAQs, available at: <http://www.msprc.info/index.cfm?content=includes/faq/faq&vFlag=display&ID=69&cID=7> (accessed Jan. 25, 2008.)
- 20 Allowing CMS to review and agree upon a workers' compensation MSA is the only way to ensure that Medicare will deem its interests adequately protected. Although CMS' approval of the set aside calculation may not be required, it helps avoid problems with future Medicare coverage. It also ensures that only a predefined portion of the settlement—rather than the entire settlement—must be spent before Medicare takes over payment again. If CMS approves the set aside, claimants can be certain Medicare will resume primary coverage after the claimant demonstrates that the set aside proceeds were properly depleted. While such certainty gives some peace of mind, obtaining it often comes at a price of additional time and money.
- 21 When CMS announced the "review and approval" protocols for Workers Compensation MSA, it did so with a series of memoranda. See for instance, Memorandum from Parashar B. Patel, Deputy Director, CMS Purchasing Policy Group, Center for Medicare Management, to All Associate Regional Administrators, "Workers' Compensation: Commutation of Future Benefits" (July 23, 2001), available at [www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo.rtf](http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo.rtf) (last visited Mar. 4, 2006). At this point, there is no objective evidence that such policy memoranda could be coming soon for set asides in liability settlements.
- 22 After the claimant's attorney has contacted the Medicare Coordination of Benefits Contractor regarding the representation of a Medicare beneficiary in a liability case, the COBC will assign the case to the MSP Recovery Contractor (MSPRC) and forward the attorney and beneficiary notification providing all contact information for the MSPRC.
- 23 If the insurer makes the check out to more than one party including Medicare, Medicare's policy is as follows: All parties must endorse the check. The check is then sent to Medicare for deposit. Medicare will issue a separate check for the award amount less Medicare's claim amount to the attorney after a five-day waiting period. Alternatively, if Medicare is sent separate a check for Medicare's claim amount, Medicare will deposit the check made out to Medicare and endorse the multi-party check. The multi-party check will be immediately returned to the attorney.
- 24 50.4.1 Medicare Secondary Payer Manual, "Existence of Overpayment", stating that settlement proceeds should not be disbursed until Medicare's claim has been satisfied.
- 25 Medicare's right to reimbursement is superior to almost all other claims, including those of the injured individual. 42 C.F.R. §411.26, amended by 71 Fed. Reg. 9466-01 (Feb. 24, 2006). See also footnote 5 for discussion of *United States of America v. Henry L. Sosnowski*.
- 26 Visit [www.garretsonfirm.com](http://www.garretsonfirm.com) or [www.lienresolution.com](http://www.lienresolution.com) for copies of client education materials.
- 27 Certainly seeking the assistance of experienced and knowledgeable resources is the accepted practice in personal injury matters when the client's case requires attention related to probate, bankruptcy, the calculation of Medicare Set Aside accounts and disability planning (e.g., special needs trusts).