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Making Sense of Medicare Set-Asides By Matthew L. Garretson

*As Medicare's role in workers' compensation and liability settlements evolves,
a lack of clear guidance has left many lawyers perplexed.
Know how to protect the interests of both your client and Medicare.*

Political and popular pressure to preserve the Medicare Trust Fund is mounting. The population of beneficiaries that Medicare is intended to cover--older people and the severely disabled¹--is on the rise. Statistics about the growing number of retiring baby boomers are now cliché. At least 54 million Americans are disabled and more than 41 million receive Medicare.²

To reduce Medicare costs, Congress enacted a collection of statutory provisions in the 1980s called the Medicare Secondary Payer, or MSP, statute, largely in recognition that workers' compensation carriers should be the primary source of medical insurance coverage for people injured on the job.³ The statute says the government serves as a secondary insurance provider when another source of primary coverage exists.

Interpreting the statute's requirements, however, can be difficult, and critics say the system is inefficient and the law has not succeeded in substantially lowering Medicare costs. As early as 1990, one U.S. senator commented, "Failure to follow the MSP law is costing the taxpayer billions of dollars," and as recently as 2003, a court was still citing the senator's statement as relevant.⁴

Medicare's role undeniably is evolving. In December 2003, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act,⁵ which further defined Medicare's recovery rights and clarified its enforcement powers. As a result, no matter how a particular settlement agreement is worded and no matter whether the tortfeasor is covered by a commercial insurance plan or a self-insured plan, or is just paying the claim out of its general assets, any payments Medicare makes are considered conditional. 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.⁶ The plaintiff attorney and defendant can be held responsible for twice the amount owed to the agency.⁷ Complicating matters, a plaintiff lawyer 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. Medicare's right to reimbursement is superior to almost all other claims, including those of the injured individual.⁸

While the Medicare Prescription Drug Improvement and Modernization Act erased all doubt regarding a lawyer's affirmative duty to verify and resolve conditional Medicare payments made from the date of injury through the date of settlement, some issues remain unclear. Do Medicare's interests extend beyond settlement? Does Medicare require 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?

Personal injury lawyers, frustrated with growing Medicare-related requirements, also legitimately may be asking, How did I get left holding the bag? After all, isn't protecting Medicare's interests a statutory obligation shared equally among attorneys, defendants, beneficiaries, and insurance companies?

Some fundamental principles of §301 of the Medicare Prescription Drug Improvement and Modernization Act are important to comprehend. First, Medicare does not pay for any medical services for which payments have been made, or can reasonably be expected to be made promptly, under a workers' compensation law or insurance plan.⁹ Second, §301 makes clear: "A primary plan, and an entity that receives payment from a primary plan, shall



reimburse [Medicare] . . . if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.”¹⁰

Basically, if another source of coverage is immediately available for someone's injury-related care, he or she should use it. If no other source of coverage is available (and the person is eligible for Medicare), Medicare will begin paying for injury-related care. But if some other source of funding is later found that should have been paying all along, Medicare gets repaid for past expenses--and perhaps is let off the hook for future expenses while such funding continues.

In the workers' compensation arena, this means that 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.¹¹ Medicare does not pay for care--before or after a settlement--until the beneficiary has exhausted his or her remedies under workers' compensation.¹² This includes spending the portion of any settlement earmarked for future medical expenses.¹³

If a settlement does not specifically account for separate past and future injury-related medical expenses, CMS will consider the balance remaining after addressing the Medicare reimbursement claim for past payments to be entirely for future medical expenses.¹⁴ If no allocation is made for future expenses, Medicare will not pay until the entire settlement is exhausted.

With a Medicare set-aside, however, the claimant does not have to spend the whole settlement before Medicare resumes payment.¹⁵ The set-aside acts as the primary coverage for post-settlement treatment--an amount the beneficiary must spend before Medicare picks up the tab.

A properly administered Medicare set-aside should pay for reasonable injury-related medical expenses, including doctor bills, hospital care, skilled and intermediate care, skilled rehabilitation, home health care, hospice care, durable medical equipment, and any other items or services that would otherwise be covered by Medicare. Set-aside proceeds should not be used for items that are not ordinarily covered by Medicare, such as some prescription medications and attendant care costs.¹⁶

Medicare Part D

Medicare's recently expanded coverage directly translates into expanded reimbursement obligations for plaintiff attorneys and their Medicare-entitled clients, creating a "bigger bite" of the proverbial apple for Medicare and further eroding the clients' net proceeds. Before December 31, 2005, Medicare's interest was focused only on the reimbursement of injury-related care in the form of primary physician care and hospital treatment. Effective January 1, 2006, Medicare expanded its reimbursement interest to include prescription drugs under its Part D program. Unquestionably, this change further complicates Medicare's role in all settlements.

As the scope of Medicare's recovery rights evolves, the form of the recovery process also will become more complicated. Via the Medicare Secondary Payer Division of CMS, Medicare recovers its past "conditional" payments for Part A and B injury-related care by outsourcing the recovery effort to the Coordination of Benefits office--which, in turn, appoints one of the approximately two dozen lead contractors (fiscal intermediaries) to work the file.

However, Part D is covered by a different entity: Prescription Drug Plans (PDP). PDP is similar to Medicare-managed plans (supplemental and replacement plans) and has a similar yet separate right of recovery. Based on recent discussions with CMS officials, this author understands that reimbursement for Part D coverage (prescription drugs) will be addressed through an additional, separate recovery effort.

In other words, PDP will share the same recovery right as Medicare-managed plans but will need to seek recovery on its own, rather than working in concert with the traditional Medicare recovery effort.

Consequently, future personal injury settlements involving Medicare beneficiaries will require consideration of two reimbursement obligations: diagnosis codes related to the primary injury and prescription drugs associated with the management of the injury (such as drugs for disease treatment and pain management).



The impact of Part D doesn't end there. In addition to Medicare's recovery of injury-related prescription drug treatment from the date of injury to the date of settlement, CMS is also adding the future costs of injury-related prescription drug coverage to allocations crafted for Medicare set-asides. In a December 30, 2005, memorandum, CMS commented that all workers' compensation settlements that occur on or after January 1, 2006, must consider and protect Medicare's interests when future treatment includes prescription drugs and future medical services that would otherwise be reimbursable by Medicare.¹⁷ CMS noted in the memorandum that its review process of Medicare set-aside proposals will not change until it begins to independently price prescription drug treatments for the set-asides it receives on or after January 1, 2007. Until that review of future prescription drug treatment begins, CMS will continue to review and independently price future Medicare-covered medical expenses in set-asides by following its published policy memoranda.

Calculating the set-aside amounts

The general standard for calculating a set-aside is a "reasonable allocation."¹⁸ Set-aside calculations are determined by evaluating the client's past course of medical treatment, current condition, future medical needs, life expectancy, and other factors. Some practitioners, however, are concerned that CMS holds all the cards when measuring reasonableness--no future procedure is discounted, and any future expense that is "reasonably probable" will be included, regardless of the chance that the procedure will be needed. This process does not provide an objectively reasonable way to consider the present value of the cost of future procedures.

CMS review

To ensure that claimants and carriers meet their obligation to exhaust workers' comp remedies for the costs of future care, CMS has a right to review settlements involving current Medicare beneficiaries whose total settlement exceeds \$10,000¹⁹ and people whose total settlement exceeds \$250,000 and who have a reasonable expectation²⁰ of becoming a Medicare beneficiary within 30 months²¹ of the date of the settlement. (These thresholds are only CMS workload-review thresholds, not substantive dollar or "safe harbor" thresholds under the MSP law.)

In 2001, CMS released a memorandum (often referred to as the Patel memorandum) to its regional offices, suggesting that workers' comp claims should not be settled until CMS can review the settlement and approve the set-aside allocation.²² Then, in a July 2005 "frequently asked questions" memo, Medicare asserted its authority to disregard any settlement that does not protect Medicare's past and future interests²³ -- an unsettling prospect for workers and workers' compensation carriers alike. Having thought they settled the case, the worker, attorney, and carrier may find Medicare with its hand still outstretched, looking for a portion of the settlement proceeds even though the parties thought the past and future obligations were adequately spelled out in their settlement agreement.

The review and approval process, which is fraught with unreasonable delays and additional costs, has been implemented without bona fide standards or regulations. CMS has instead relied on the Patel memorandum, which suggests that consequences for failing to submit the set-aside allocation for CMS review and approval may be severe for all settling parties, including injured workers.

However, CMS's review authority has been questioned. Edward Welch of Michigan State University noted,

There is nothing in the law or the published regulations that requires the parties to seek preapproval of settlements or that requires a set-aside. . . . CMS has indicated that it will impose penalties or at least treat people differently if they do not obtain preapproval. It has not pointed to anything in the law that gives it authority to do that.²⁴

Why the recent fuss? Without question, the workers' compensation industry does not have clean hands. For years, the carriers (with the collaboration of claimants, their lawyers, and workers' comp judges) were settling the "future medical" component of the injured worker's claim, with the net proceeds going into the worker's pocket and Medicare immediately picking up the tab for the ongoing cost of injury-related care. This shifted an immense financial burden--surely in the billions of dollars--to the taxpayers who finance the Medicare Trust Fund. Many practitioners, frustrated by the "damned if you do, damned if you don't" options, say the present punishment--a complicated and cumbersome review process--does not fit past crimes.



Requirement or recommendation?

Apparently, allowing CMS to review and approve a workers' compensation settlement is the only way to ensure that Medicare will deem its interests adequately protected. But, as Welch noted, beyond the Patel memorandum, nothing in the case law or the published regulations requires parties to seek approval of set-aside calculations before settlement.

In any case, a Medicare beneficiary (whether setting aside settlement proceeds or not) must document the use of settlement proceeds for appropriate medical expenses before Medicare will resume payment. 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, you 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. Parties are forced to accept CMS's methodologies for calculating the set-aside without any right of appeal, and the agency may take six months or longer to review and approve the calculations submitted.

Common-sense solutions could include new legislation requiring CMS to publish regulations and example-based guidelines and occasional audits to ensure compliance--as the IRS does with the tax code. CMS also could consider giving injured people the option to reimburse Medicare in one lump sum--the present value of the Medicare set-aside--at the time of settlement. Certainly, this would ameliorate much of the present problem associated with forcing injured parties to deal with the ongoing responsibilities, costs, and reporting requirements associated with set-aside accounts.

Not everyone is crediting CMS memoranda with the force and effect of regulations. For example, in a recent complaint against the Department of Health & Human Services/CMS in Colorado, a Colorado law firm and a settlement consulting firm argued that CMS approval of a set-aside is not required and that the approval process, as currently implemented, may be unconstitutional.²⁵ In general, parties who have argued against the approval process note that the Medicare regulations have been vetted through a standard process, but the CMS memoranda have not. Parties have argued that certain assertions made in the July 2005 memo appear to contradict the plain language of the MSP statute.

Other parties have challenged the lack of due process. For example, the July 2005 memo states that no appeal process exists for a Medicare-entitled beneficiary who disagrees with CMS's determination. Also, parties have argued that the agency unconstitutionally shifted to the claimant the burden of proving that the set-aside was funded in the amount CMS specified. This challenge is based on the proposition that CMS does not have the authority to determine one "appropriate" amount and then require the parties to a settlement to either pay that exact amount or have the settlement disregarded.

To date, none of these common-sense solutions have been considered, and none of the challenges has succeeded. Like so many government agencies that operate in a vacuum, CMS may be trapped in its own depths and not unaware of its limited perspective.

Liability claims

The fundamental statutory principle requiring settling parties to protect Medicare's interests in workers' compensation settlements appears to apply to liability settlements as well.

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."²⁶ Also, Medicare's authority to review liability settlements arises under the same statute as its authority to review workers' comp settlements does.²⁷

Perhaps no new laws or regulations need be promulgated before Medicare extends the reach of set-asides to the liability context. But there may be obstacles to fairly applying the set-aside requirement to liability settlements.



The math may prove to be the challenge in liability settlements. Unlike workers' comp, which covers a worker's lifetime injury-related care, 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's 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."

The MSP Recovery Division has limited resources. While CMS does not formally release statistics on how many set-asides are being submitted and approved each year, based on this author's experience and conversations with industry professionals, the agency already appears to be reviewing an overwhelming number of workers' compensation set-asides.

Even though no formal set-aside process exists for liability settlements, it would be difficult to argue that settling parties have no obligation to protect Medicare's interests when they consider future medical expenses. Medicare's concern that the payment burden could be shifted from a liable third-party payer to the government is the same in workers' comp and liability settlements. As noted earlier, the regulations appear to give CMS the power to disregard a settlement and assess penalties to any party that attempts to shift payment responsibility inappropriately to Medicare.²⁸

Clearly, lawyers must recognize and protect Medicare's interests. But should you tell clients across the board that they need to set aside a portion of every liability settlement? Should you seek to withhold client funds when Medicare has yet to issue bright-line requirements? How do you balance your responsibility to zealously represent a client's interests with this gray area of set-asides in liability matters? In the absence of clear answers from Medicare, lawyers must look to their own professional responsibility guidelines.

Until CMS provides further guidance, the following tips may be useful.

- Employ the "reasonable person" evaluation and make a good-faith determination of whether the settlement amount was based on some specific recognition of the cost of future medical treatment.
- If applicable, articulate this calculation in the settlement documentation.
- Set aside the settlement funds (if any) consistent with this calculation.
- To be cautious, submit this set-aside calculation to CMS for approval.
- To minimize the possibility of a disruption in the client's benefits, properly inform the client about the need to exhaust these funds for injury-related care as well as the obligation to track and report such expenditures before submitting any expense to Medicare.
- Keep accurate records and receipts for injury-related care in case CMS ever inquires.

But is this approach too conservative, since CMS does not yet have a formalized process for acquiring future medical costs associated with third-party injury? The agency may never formally release standards for liability set-asides. In a typical legal malpractice case, the question is whether the attorney breached a duty to the client and failed to conform to the appropriate standard of care. Where does this leave you?

I believe CMS will release a position statement on this issue in the near future. But until then, when settling a liability case in which you have not specifically negotiated payments for future medical expenses, draft a general release using broad language--referring, for example, to "all claims past and future"--to avoid the assumption that the settlement covers lifetime medical costs. Be prepared to prove that the settlement did not contemplate a specific future medical component--that the parties, acting in good faith, came up with one indivisible sum of money for release of all claims. Make sure your assessment is consistent with key documents such as the complaint, the subsequent procedural aspects of the litigation, and the ultimate settlement agreement.

Conversely, if you are settling a liability case that does specify future medical costs and the settlement is of significant value, you should consider addressing both past (conditional) and future interests of Medicare. Furthermore, keep in mind that some liability settlements involving critically injured plaintiffs are so large that CMS may presume the plaintiff is being compensated for future medical expenses.



If you are settling a third-party liability case and at the same time indefinitely settling the workers' compensation plan's obligation to cover future medical expenses, you may need a Medicare set-aside. A 2003 CMS memo states, "To the extent that a liability settlement is made that relieves a [workers' compensation] carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted."²⁹

Medicare's separate claim

In workers' comp cases, carriers generally have taken the lead in preparing set-aside calculations and submitting them to CMS for approval. But personal injury settlements have a quite different tradition. Typically, the defense forces the plaintiff attorney to handle the issue for all parties (and hold them harmless) as a condition of the settlement.

This practice is troubling. A personal injury settlement involving a Medicare beneficiary includes two distinct causes of action: the injured person's claim and Medicare's right to reimbursement from the liable party.³⁰ Generally, a personal injury attorney's fee agreement obligates him or her only to handle the personal injury matter, not to represent Medicare in pursuing reimbursement.

Compare Medicare to an ERISA-qualified health insurance plan--one provided by employer to employee and self-funded by the employer--that has a contractual and/or common law right to subrogation and is entitled to an equitable lien against any proceeds a client receives from a third-party tortfeasor. With private health insurance claims, the lien is attached to the settlement and cannot be separated from it, but Medicare's reimbursement claim can be separated.

Because of this, attorneys may want to revise their fee agreements to include new language that further defines the scope of representation, such as:

We understand that current Medicare regulations may require all parties involved in this matter (client, law firm, defendant, and any insurance companies) to compromise, settle, or execute a release of Medicare's separate claim for reimbursement for past and future payments prior to distributing any verdict or settlement proceeds. We agree that the law firm may take all steps in this matter deemed by us to be advisable for the handling of our claim, including hiring separate attorneys/experts who assist with resolving any Medicare reimbursement claim for past and/or future injury-related medical care. The expense of any such Medicare claim-handling counsel or service shall be treated as a case expense and deducted from our net recovery and shall not be paid out of the law firm's contingent fee in this matter.³¹

If the fee for separate Medicare-related counsel is reasonable, the personal injury attorney's contingent fee still would comply with ABA Model Rule 1.5(a), which states that a lawyer "shall not make an agreement for, charge, or collect an unreasonable fee or an unreasonable amount for expenses." Working to preserve a client's ongoing Medicare eligibility (either through resolving past conditional payments or considering set-aside issues) is akin to bringing in a disability lawyer to draft a special-needs trust to preserve Medicaid benefits.

The client should have no reasonable expectation that his or her tort attorney is an expert in Medicare preservation. CMS recognizes the enormous complexity of its own rules and regulations and has outsourced reimbursement issues to private firms. Similarly, workers' comp carriers outsource the calculation and approval of the Medicare set-aside to third-party firms with special expertise.

Thus, providing services in this area need not be included in the tort attorney's contingent fee.³² Given the growing complexity of Medicare benefits preservation, personal injury attorneys may be doing their clients a disservice if they find themselves left holding the bag.

Recommendations

Don't forget that all settlements must address reimbursement of Medicare's past conditional payments. Since there is no question about this point, lawyers should implement a formal process to ensure the verification and resolution of Medicare's reimbursement interests for payments made from the date of injury to the date of settlement.³³



Don't make the mistake of believing that the uncertainty about future injury-related payments is a sleeping dog to leave lying. Consider the following points.

- Medicare's improved radar. In 2001, the U.S. government hired an outside vendor to help hunt down, largely through the use of trauma-related diagnosis codes, future medical payments made by Medicare that a workers' compensation carrier or other primary payer should have paid.
- Double damages. CMS is entitled to double damages if it resorts to litigation to recover payments that another entity should have made.
- Retroactivity. By their terms, the 2003 amendments are retroactive to 1980.

Lawyers must explore and better understand their duty to protect Medicare's interests while balancing the call to zealously represent clients. They need to improve client-lawyer dialogue about the impact of settlement on a client's government benefits. Given the risks, it makes sense for lawyers to reexamine their approach to these benefits-related issues.

Matthew L. Garretson is founding partner of the Garretson Firm Resolution Group in Cincinnati.

¹ Cornell University, Disability Statistics, Frequently Asked Questions, at www.ilr.cornell.edu/ped/disabilitystatistics/faq.cfm?n=7#Q7 (last visited Mar. 8, 2006) (based on data from the U.S. Census Bureau, Survey of Income and Program Participation).

² Centers for Medicare & Medicaid Services, Medicare Coverage Center, at www.cms.hhs.gov/center/coverage.asp (last visited Mar. 8, 2006). See generally SOC. SEC. ADMIN., UNDERSTANDING THE BENEFITS, No. 05-10024 (2006), available at www.ssa.gov/pubs/10024.pdf (last visited Mar. 21, 2006).

³ 42 U.S.C. §§1302, 1395w-101 through 1395w-152, 1395hh (2000 & Supp. 2004); see 42 C.F.R. §411.40 (2005).

⁴ *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 891 n.16 (11th Cir. 2003) (quoting 136 CONG. REC. S13419-01 (daily ed. Sept. 19, 1990) (statement of Sen. Roth)), cert. denied, 542 U.S. 946 (2004).

⁵ 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 clarified 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).

⁶ Memorandum from Thomas L. Grissom, Director, CMS Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer--Workers' Compensation (WC) Frequently Asked Questions" (Apr. 22, 2003), question & answer No. 13, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf (last visited Mar. 2, 2006). 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.

⁷ 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 plan.

⁸ 42 C.F.R. §411.26, amended by 71 Fed. Reg. 9466-01 (Feb. 24, 2006).

⁹ 42 C.F.R. §411.21, amended by 71 Fed. Reg. 9466-01 (Feb. 24, 2006)

¹⁰ 42 U.S.C. §1395y(b)(2)(B)(ii)(2000 & Supp. 2004).

¹¹ 42 C.F.R. §411.46 (2005).

¹² Section 411.45 specifies two exceptions.

¹³ 42 C.F.R. §411.46 (2005).

¹⁴ Medicare generally will honor judicial decisions issued after a hearing on the merits of a workers' compensation case. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (such as lost wages), Medicare will accept that designation.

¹⁵ In this regard, a set-aside acts as a waiver or compromise of Medicare's rights in the settlement. 42 C.F.R. §§411.46, 411.28 (2005).

¹⁶ CMS's booklet *Medicare & You 2006* lists services that are and are not covered by Medicare. It is available at www.medicare.gov/publications/pubs/pdf/10050.pdf (last visited Mar. 21, 2006).

¹⁷ Memorandum from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management, to All Regional Administrators, "Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) Questions and Answers," question & answer Nos. 2-3 & 6 (Dec. 30, 2005), available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/123005PartDMemo.pdf (last visited Mar. 21, 2006).

¹⁸ 42 C.F.R. §411.46(d)(2) (2006).

¹⁹ 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); see also Memorandum from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management, to All Regional Administrators, "Medicare Secondary Payer (MSP)--Workers' Compensation (WC), Additional Frequently Asked Questions," question & answer No. 2 (July 11, 2005), available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf (last visited Mar. 4, 2006).

²⁰ This includes someone who has applied for Social Security disability benefits, has been denied them and anticipates appealing that decision, or is in the process of appealing and/or refiling for them.



²¹ Claimants must wait six months after applying for Social Security before they can receive their first check, and they are eligible for Medicare 24 months after their entitlement date. You should evaluate whether a claimant is likely to become a beneficiary in all cases where the claimant has been off work for two years or more or is 62.5 years or older.

²² 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 (last visited Mar. 4, 2006).

²³ See Memorandum of Walters, *supra* note 19.

²⁴ Edward M. Welch, Medicare and Workers' Compensation after the 2003 Amendments §7.14, at 23 (2004), available at www.lir.msu.edu/wcc/Medicare/Medicare%20Web%202004.pdf (last visited Mar. 4, 2006).

²⁵ Protocols, LLC v. Leavitt, No. 05-CV-1492 (D. Colo. filed Aug. 5, 2005).

²⁶ 42 U.S.C. §1395y(b)(1), amended by Pub. L. No. 109-171, 120 Stat. 4 (2006).

²⁷ 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).

²⁸ 42 C.F.R. §411.46(b)(2) (2005).

²⁹ Memorandum of Grissom, *supra* note 6, at question & answer No. 19.

³⁰ "The United States may bring an action against any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan." *Id.* at question & answer No. 13.

³¹ However, such an approach may not be advisable for handling private health insurance claims or state Medicaid claims. One state bar has repeatedly held in its ethics opinions that resolving liens and subrogation claims is a service to be included in the contingent fee charged by the client's original personal injury attorney: "Negotiating with health care providers and insurers [regarding client bills] is a necessary part of the legal services for which the [personal injury] lawyer has been retained, and [charging the client for this service] would amount to collecting two fees for the same subject matter. In addition, charging an additional fee for reducing medical bills is not a customary practice in personal injury representation and therefore may not be reasonable on this basis." Md. Ethics Op. 2001-01.

³² Ethics opinions issued in several states go so far as to declare that a lawyer has a duty to refer a client to other appropriate resources when the need is apparent. See, e.g., Bd. of Comm'rs on Grievances and Discipline of the Sup. Ct. of Ohio, Op. 2000-1 (Feb. 11, 2000); see also Conn. Informal Ethics Op. 89-10 (1989); Utah Ethics Op. 135 (1993). . Although some of these opinions dealt with financial and tax professionals, they support the proposition that clients expect certain referrals as part of the service for which they pay the attorney. See generally A.B.A., ETHICAL GUIDELINES FOR SETTLEMENT NEGOTIATIONS (2002); MODEL RULES OF PROF'L CONDUCT R. 2.1 (2004).

³³ The author may be contacted by e-mail at mlg@garretsonfirm.com for a copy of his firm's practice guide and standard operating procedures.