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LEGAL UPDATE

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Medicare

Medicare in General Liability Settlements by Rey Alvarez, Managing Attorney

Rey Alvarez

It is widely known that Medicare's interests need to be protected when a Workers' Compensation or a Liability case is settled. There may be disagreement on how, when and why Medicare's interests need to be protected, but everyone should know that Medicare's interests need to be protected. Currently, Medicare is accepting the Medicare Set-Aside as the vehicle to ensure Medicare's interests are protected.

The Medicare Set-Aside is simply a report that projects the anticipated injury related medical treatment and prescriptions needed by the injured party over the remainder of their life expectancy. The anticipated medical care and prescription medication are priced out and the total is the amount needed to fund the Medicare Set-Aside. As you can imagine with the skyrocketing costs of medical treatment and prescription medication, the funding of a Medicare Set-Aside can be a roadblock to the settlement of a case. Even though

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Liability

Florida Statute 641.3154 and Letters of Protection by Todd T. Springer, Jacksonville Junior Partner

Todd Springer

To ensure Floridians have access to affordable health insurance, the Legislature passed the Health Maintenance Organization Act. Faced with the increasing costs of health care and the state's interest in high-quality care, the Legislature determined that there was a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services. A health maintenance organization ("HMO") is a type of managed care insurance under which the insured is limited to a closed network of doctors. The Legislature enacted several statutory provisions to protect HMO subscribers including Florida Statute 641.3154, entitled Organization Liability; provider billing prohibited.

An HMO has a duty to provide coverage for "medically necessary" services and supplies. It typically has contractual discounts with its network providers which allow for payment of services rendered to an insured at an amount that is less than what is billed by the provider. This arrangement is memorialized in a contract between the provider and the HMO. The difference between the amount billed by the provider and the amount paid by

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Medicare continued

by Rey Alvarez, WC Managing Attorney.

Medicare Set-Asides have been around for over 10 years in Workers' Compensation and have been hovering around liability settlements for a long time, the parties still approach Medicare as an afterthought. All too often, the mention of a Medicare Set-Aside does not surface until a day or two before the mediation when someone wonders out loud "is a Medicare Set-Aside needed?" Worse yet, sometimes the Medicare Set-Aside question comes up, for the first time, after the settlement. In either scenario, the Medicare Set-Aside will undoubtedly end up costing more than necessary. A little planning will go a long way in lowering the cost of funding a Medicare Set-Aside. Proper planning reduces the Medicare Set-Aside. Just by following a few basic planning options, a primary payer will end up saving thousands of dollars by greatly reducing the amount needed to fund a Medicare Set-Aside. In order to limit Medicare exposure, bring closure to cases and to minimize the cost of settlements, Medicare compliance needs to be addressed early on. The following are just a few examples of how to limit the amount needed to fund a Medicare Set-Aside.

Early Identification

The basis for lowering the cost of funding a Set-Aside is early identification. Early identification allows detection of cases that have Medicare Beneficiaries or cases that have a claimant with a reasonable expectation of Medicare enrollment within 2 years. This early detection is imperative as the cases can be handled with Medicare in mind.

Section 111 Mandatory reporting has a query application that gives the Medicare beneficiary status of the claimant. While this should prove to be a useful tool, the author recommends sending the claimant a Consent for Release of Information form (SSA-3288). This form allows the primary payer or their representative to receive Medicare information on the injured party. The form must be signed by the injured party or their representative. It usually takes two to three weeks to get the requested information after the form is submitted to Social Security.

If using interrogatories, the information requested should include the claimant's Medicare and Social Security status.

Having the Medicare beneficiary status of the injured party available early on allows for a dialogue to start with the claimant's attorney so that Medicare can be addressed as the case progresses. Going into a mediation and addressing Medicare for the first time is not going to allow for a productive mediation. Addressing Medicare after the settlement is never going to be a good idea. A completed Medicare set-Aside has a shelf life of about 6 months, after that it will more than likely need to be updated. If a Medicare Set-Aside is going to be needed, it is very important to enter a mediation or settlement negotiations with the Medicare Set-Aside and its cost and available funding options.

Rated Age

A Medicare Set-Aside is priced out based on the injured party's life expectancy. Medicare uses the Center for Disease Control's life tables to determine an individual's life expectancy. However, these tables are based on how long people are expected to live on average.

Sometimes, an individual has certain diseases or physical conditions that will reduce his life expectancy. A rated age is the tool used to determine a specific person's life expectancy. As such, it is an excellent tool to reduce the amount needed to fund a Medicare Set-Aside. A rated age is just an upward adjustment to an individual's actual age based on the claimant's related and unrelated physical condition and diseases. Simple everyday conditions, such as smoking or obesity can adversely affect an individual's life expectancy.

By identifying a case with Set-Aside implications early on, it allows time for the gathering of information. Rated age strategies may include deposition questioning, obtaining records from local hospitals and local pharmacies to ascertain the individual's prior medical history. This information is gathered and given to an annuity company that will search for a rated age. By reducing the life expectancy of an individual, a Set-Aside automatically gets reduced by the same number of years. For example, if the anticipated annual expenditure for a Medicare Set-Aside is $5,000 and the rated age takes off 5

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the HMO is referred to as the contractual adjustment. This amount should be written off by the provider.

However, in a litigation setting, some providers will attempt to collect this difference from an insured who is involved in litigation through the guise in the form of a Letter of Protection ("LOP"). These providers may even intentionally submit the charges for services rendered to an HMO patient directly to the patient and his or her attorney in an attempt to have the entire amount recovered through the use of a LOP knowing that the amount which would be payable by the HMO will be less than the amount billed. However, Florida Statute 641.3154 prevents a provider from billing the patient for services owed by the HMO.

The relevant sections of F.S. 641.3154 state as follows:

> (1) If a health maintenance organization is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider;
>
> (2) For purposes of this section, a health maintenance organization is liable for services rendered to an eligible subscriber by a provider if the provider follows the health maintenance organization's authorization procedures and receives authorization for a covered service for an eligible subscriber……..;
>
> (3) A provider or representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable.

As a result, it can be argued that a LOP should not be given effect when the provider knows that an HMO is liable. In Florida, the Circuit Court for the Eighteenth Judicial Circuit found that a LOP was a "nullity" where the patient was a subscriber to an HMO. Specifically, in Marion vs. Orlando Pain & Medical Rehabilitation Centers, Inc., 2009 W.L. 7582985 (Fla. Cir. Ct. 2009), the patient's attorney submitted a LOP to the provider promising to protect the provider's statement of services rendered from any recovery by the patient from a third party. Thereafter, the patient's HMO paid the provider's charges pursuant to the agreed upon fee schedule. After the HMO and personal injury protection final payments were made, there remained a difference of $4,454.98. The provider claimed it was entitled to rely upon the LOP to seek compensation beyond the payments it had received for services rendered to the patient. The Circuit Court disagreed citing to subsection (1) stating that the HMO was liable for fees to the provider and not the patient. The Court went on to state that the attorney's LOP could not "negate or alter the effect of the Medical Group Participation Agreement or the statutes and public policy of the State of Florida."

In Marion, the provider was part of a participation agreement with the HMO. However, even if the provider does not have a contract with the HMO, it can be argued that the HMO should be liable when one is available and therefore any LOP is void. To this end, subsection (4), states that even if the provider is not under contract with an HMO, it may not collect or attempt to collect money from a subscriber when the provider in good faith knows or should know that the HMO is liable. This would apply to non participating providers such as pathologists, anesthesiologists, and any other entity involved in procedures at a hospital that has contracted with an HMO.

Similarly, subsection 69O-191.049(2) of the Florida Administrative Code requires an HMO to "pay for medically necessary and approved physician care rendered to a non-Medicare subscriber at a contracted hospital which services are covered by the HMO subscriber contract." "Physician Care is defined as care, provided or supervised by physicians…and shall include consultant and referral services by a physician." Florida Administrative Code 69O-191.024 (13)(c).

The Fifth District Court of Appeal has ruled on this very issue finding that where an anesthesia provider was authorized to provide anesthesia services to a hospital through an exclusive contract the authorizations issued to the hospital for services to HMO subscribers extended to the services of the anesthesiologist. Therefore, the anesthesiologist was

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years from the claimant's life expectancy, then the savings are $25,000. Savings such as that are only realized by the early identification and gathering of a thorough medical history, both related and not related to the accident. This information probably would not have been gathered without the early identification that the claimant was a Medicare beneficiary.

Deposition Strategies

The information gathered about a claimant's unrelated physical condition will assist during the deposition of the injured party. Deposition questioning strategies will need to be tweaked to get more detailed information of the individual's medical past. In addition to unrelated medical conditions, there are a few other areas that should be addressed during the claimant's deposition. For example, prescription medications that are being prescribed as a result of the injured party's accident should be included in the Set-Aside. This could be the single most cost prohibitive item on the Set-Aside.

Prescription medication strategies include:

- The brand name of any medications the individual is taking;
- Whether they have taken the generic equivalent of the respective medications;
- The dosage of the medications;
- Who prescribed the medications;
- Why they are taking the medications;
- How long they have taken the respective medications;
- Are they taking the medications as prescribed;
- How long do they need to take the medications; and
- Where is the individual getting the prescription filled?

The idea behind this strategy is to limit the future prescription medication cost on the Set-Aside. If the individual was taking medications prior to the accident, there is a good chance that medication will not need to be included in the Set-Aside. Prescription medication costs on the Medicare Set-Aside can be reduced by substituting brand name medications with generics and by reducing or removing duplicative medications. If it found out at the deposition or via medical bill reviews that the injured party is not taking the medication as prescribed, the treating physician may alter or eliminate that prescription. The idea is to find ways to reduce the cost of the Set-Aside by maximizing any and all potential reductions.

Physician deposition strategies will need to include Medicare pertinent questions. The deposition questioning strategy should include a line of questions centered around the need for the individual's future medical treatment, including prescriptions, as it relates to the subject accident or injury they sustained.

- How many visits will the individual need on an annual basis;
- Will the individual require less office visits as the years progress;
- How many years does the physician anticipate that the claimant will need office visits;
- Will the individual require any surgeries/ removals/revisions in the future, why;
- What diagnostic testing will the individual need over the years and the frequency of same, why;
- What prescription medication will the individual need, why;
- How long will they need the prescription medication, if for a long period, why;
- Can they take the generic equivalent, if not, why not;
- When will the individual's dosage be lowered; if not, why not;
- Talk to the physician about the other medications the individual is taking to see if they conflict;
- Ask the physician whether the individual needs the prescription medication, if based on review of the medical records, it shows that the individual is not buying the medication or is buying the medication at intervals that would indicate they are taking it less than prescribed or if the deposition transcript shows that the individual is not taking the medication as prescribed;
- Get the cost for office visits, surgical procedures, diagnostic testing, prescription medications;

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- Find out if the prescription medication they are prescribing is being prescribed for any pre-existing condition;
- Find out how the individual's future medical treatment is related to the accident or injuries sustained in the subject case;
- Find out why the physician is recommending future medical treatment. (i.e. Is it medically necessary? Is it based on the individual's subjective complaints? Is it based on sound medical decision making? Would the recommendations stand up to peer scrutiny?)

The idea behind the physician deposition questioning strategy is to reduce future medical treatment. By reducing office visits, medications, diagnostic testing, or any other medical procedure, the Set-Aside is being reduced as well.

Structured Settlements

Probably the best and easiest way to reduce the amount needed to fund a Medicare Set-Aside is through the use of a structured settlement. With a structured settlement, the claimant gets an annual allotment (annuity) of money that should cover his or her Medicare needs for that year. The use of a structured settlement can reduce the funding of an MSA by thousands of dollars. The beauty of the annuity is that you are buying the future treatment at today's prices. The longer the life expectancy, the more of a savings that will be realized.

A structured settlement can be difficult at times, special language needs to be included in the settlement documents, the injured party has to agree with it, the laundry list of excuses go on and on. It is important to note that structured settlements cannot be used on every Set-Aside. The breakdown of the Set-Aside sometimes does not warrant the use of a structured settlement. A structured settlement is best utilized in a case with a large Set-Aside amount and a long life expectancy.

A structured settlement consists of two parts, upfront seed money and an annuity. A good rule of thumb on whether a structured settlement should be used, is to look at the first surgical procedures and/or replacements, if it makes up the bulk of the Set-Aside amount then a structured settlement may not be beneficial since the bulk of the Medicare Set-Aside will be given to the injured party in a lump sum payment (seed money).

The structured settlement also offers additional benefits as it offers protection to the primary payer, the defense attorney and the claimant's attorney. If the injured party uses the annuity funds for a purpose other than his Medicare covered medical needs as it relates to his injuries, then Medicare can deny any additional treatment for the remainder of that year. The good thing is that if the claimant uses his annuity funds for a purpose other than Medicare covered medical needs as it relates to his injuries, then he is only penalized for that one year. Once the injured party gets the next annuity payment he can use it to get Medicare covered medical needs as it relates to his injuries. A structured settlement offers certainty that the injured party will not be throwing away his settlement money.

CMS Submission

A Set-Aside that is not submitted to CMS can be priced out at a more realistic cost. For right now, Medicare for the most part, is not reviewing liability set-asides.

Settlement After MMI/Surgery

Another way to limit the cost of a Set-Aside is to settle the case after the claimant has reached Maximum Medical Improvement or after the injured party has gone through any needed surgeries. The way that the future Medicare covered medical treatment is estimated is through a review of the injured party's medical records, if the individual is undergoing active medical treatment, the Set-Aside will have to reflect the active medical treatment. If the medical care has plateaued and the injured party is being seen on a palliative nature, the Set-Aside will reflect the lessened medical treatment. As a result, it costs less to fund an MSA for an individual who is being seen on a palliative nature.

Pre-Existing Conditions

As discussed earlier, it is imperative that an injured party's prior medical history be investigated in detail during discovery. If the injured party had previously injured the body parts that were injured in the subject injury, then it will cost much less to bring the injured party back to baseline.

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Subsequent Accident

Same thing for subsequent injuries, if the individual gets into a subsequent injury, then the primary payer's responsibility is limited as well, hence reducing the cost of funding an MSA or removing it in its entirety.

The above recommendations are made to assist the reader in reducing the amount needed to fund a Medicare Set-Aside. The recommendations are not an exhaustive list, however, they are made as a result of several years of experience in this field. The best gem to take away from this article is that in the stressful and rapid environment in which we live, Medicare will be an afterthought, take that to the bank.

There will be cases that will get to the medication table and Medicare will not have been even a thought in anyone's mind. That being said, Medicare's interests still need to be addressed. Do what needs to be done to ensure the cases are identified properly, a different color folder, making notations on folders, calendaring computer files, hiring a Medicare Set-Aside Allocator early on to assist with the files or any other tool that helps identify files so that the case is approached with the mindset of reducing the amount needed to fund Medicare Set-Asides. For further information or assistance, please contact Rey Alvarez (Direct: 954.847.2957 or e-mail Ralvarez@LS-Law.com).

About Rey Alvarez

Rey Alvarez is the Managing Attorney for the Medicare Lien Negotiation, Set Aside and Workers' Compensation Department of Luks & Santaniello. He has more than ten years experience in preparing Medical Cost Projections, Medicare Set-Asides and Conditional Payment Lien negotiations with CMS. He is a member of the Florida Defense Lawyer's Association (FDLA) and recently co-authored an FDLA White Paper on Medicare Liens and Set-Asides which was presented at the 15th Annual Florida Liability Claims Conference in Orlando, Florida, on June 2, 2011.

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prevented from "balance billing" the patient. Joseph Riley Anesthesia Associates vs. Stein, 27 So.3d 140 (Fla. 5th DCA 2010). Additionally, the Third District Court of Appeal found that a "non participating provider" pathology group was prevented from billing members when it knew or should have known that an HMO was liable for payment pursuant to Florida Statute 641.3164(4). Health Options vs. Palmetto Pathology Services, P.A., (983 So.2d 608 Fla. (3rd DCA 2008), review denied, 994 So.2d 1104 (Fla. 2008). This would also arguably prevent a "non-participating provider" from entering into an LOP with the patient's attorney to recover the difference between the amounts billed by the provider and the amounts paid by the HMO.

Therefore, considering the statute and case law precedents, it would be wise to file a motion for partial summary judgment when a provider attempts to recover charges for medical services provided through the use of a LOP when the plaintiff is covered by an HMO and the provider knew or should have known that the HMO was liable. This holds true for the provider who is "balance billing" and for the provider who refuses to submit amounts billed to the available HMO in an attempt to receive greater payments through the use of a LOP. For further information or assistance, please contact Todd Springer (T: 904.791.9191 or e-mail Tspringer@LS-Law.com).

About Todd Springer

Todd Springer is a Junior Partner in the Jacksonville office located on 301 West Bay Street. Todd has over a decade of trial litigation experience and dedicates his practice to general liability, premises liability, automobile negligence, product liability, construction litigation, wrongful death, commercial litigation, labor & employment law and health, life & disability law. Todd has also worked for the United States Secret Service.

Verdicts & Summary Judgments by Office

Tallahassee Office

- **St. Johns Town Center, LLC. and Shops at St. Johns, LLC. v. Sushi House Jacksonville, Inc.** Commercial Eviction, District Court of Appeal, First District**,** James P. Waczewski**,** Tallahassee Managing Attorney. The Appellate Court affirmed a judgment in favor of our client and also awarded our client Appellate Attorney's Fees, April 15, 2011.

- **By the Sea Resorts, Inc. v. Sika Corporation and Ameritech Enterprises, Inc.** Circuit Court, Fourteenth Judicial Circuit, Bay County, James P. Waczewski**,** Tallahassee Managing Attorney. The Court granted our motion to compel arbitration in Boston, Massachusetts, as provided by the warranty at issue, and agreed with us that the Federal Arbitration Act preempts Section 47.025, Florida Statutes, a Florida statute that invalidates provisions in contracts regarding to construction that require out-of-state litigation or arbitration, June 30, 2011.

Tampa Office

- **Virginia Lowell v. Robinson Roena**, Motor Vehicle Accident, Hillsborough County, Michael Kestenbaum, Junior Partner and Anthony Petrillo, Tampa Partner, Defense Verdict, May 4, 2011.

Orlando Office

- **Chase Peysen v. Alliance and Lighting Electric,** Swimming Pool Accident (Paralysis), Orange County, Joseph Scarpa, Junior Partner and Paul Jones, Orlando Partner, Dismissed, April, 2011.

Boca Raton Office

- ***Estate Of Enrique Cortes v. Owe Enterprises***, Negligent Security – Shot to Death by Unknown Assailant, Miami-Dade County, Howard Holden, Junior Partner and Daniel Santaniello, Managing Partner, Settled, April 29, 2011.

- ***Kizzy Williams, Peterson, Baby Doe V. Owe Enterprises,*** Negligent Security- Victim Targeted Crime with 3 Innocent Shooting Victims, Miami-Dade County, Howard Holden, Junior Partner and Daniel Santaniello, Managing Partner, Settled, April 29, 2011.

Miami Office

- **Linda Klein v. Altos de Miami Condominium Association**, Charles Balli, Settled, June 1, 2011.

Fort Lauderdale Office

- **Kenia Garcia (Plaintiff/Appellee) v. Alamo Financing, LLC (Defendant/Appellant),** Automobile Negligence, U.S. Court of Appeals, Eleventh Circuit, Doreen E. Lasch, Esq. The Appellate Court affirmed the trial court's judgment in favor of our client, Alamo, July 12, 2011.

- **William Dear v. National Car Rental,** Bodily Injury – Bus Doors Shut on Plaintiff, Miami-Dade County, Daniel J. Santaniello, Managing Partner and George T. Green, Junior Partner, Defense Verdict, June 17, 2011.

Medicare White Paper

Daniel Santaniello and Reinaldo (Rey) Alvarez have co-authored a Medicare White Paper developed in collaboration with the Florida Defense Lawyer's Association. The White Paper was distributed at the 15th Annual Florida Liability Claims Conference on June 2, 2011. Visit www.LS-Law.com to read the White Paper.

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