MANAGING THE RISK OF MEDICARE SECONDARY PAYER REIMBURSEMENT CLAIMS IN TORT LIABILITY CASES

by Paul Caleo

What are Medicare Secondary Payer Reimbursement claims?

Medicare Secondary Payer ("MSP") statutes mandate that all insurance companies, self-insureds, and third-party administrators fully consider and protect Medicare's interests when they are resolving a claim with a plaintiff/claimant that is a Medicare beneficiary. Consequently, if a business or corporation is sued by a plaintiff that has had some, or all, of their medical treatment paid for by Medicare, then the Federal Government can seek reimbursement for the cost of the medical treatment provided from the defendant that paid any monies to the plaintiff by way of a settlement, judgment or award. The MSP statutes were codified with the intention of reducing federal health care costs. The threat or potential of a Medicare reimbursement claim against your business for failing to fully consider and protect Medicare's interests in a tort liability matter that may have been resolved six years before the claim is made, provides significant business uncertainty and risk that can be avoided.

Recently, the statutory mandate to protect Medicare's interests was given teeth by the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") with the addition of a new provision, Section 111, to the MSP rules requiring insurance companies, self-insureds, and third-party administrators to ***report*** tort liability claims involving Medicare beneficiary plaintiffs to the Center for Medicare Services ("CMS"). The new reporting requirement now provides a mechanism to identify the "deep pockets" from which it can seek reimbursement for the payments made by Medicare. The threat of a MSP reimbursement claim is now much more a reality, and therefore the risk cannot be ignored and must be actively managed.

Who is eligible for Medicare Benefits?

The following are the individuals who may be Medicare eligible:

1) a person 65 years old;

2) a person or their spouse who has Medicare-covered government employment;

3) a person who is under 65 years old, but has received Social Security or Railroad Retirement Board disability benefits for at least 24 months;

4) a person who is eligible to receive Social Security or Railroad benefits but has not yet filed for them; and

5) a person who has "End-Stage Renal Disease" and meets certain other requirements.

Other indicators of eligibility for Medicare are: a) claimant has not worked for 30 months or more as a result of his injury-related disability; and b) claimant has a Medicare Health Insurance Card.

With the graying of the baby boomers, the number of Medicare eligible plaintiffs will increase exponentially over the coming years. The risks presented by MSP reimbursement claims increases with the rising number of Medicare eligible plaintiffs.

Why is this a crisis for Tort Liability Cases?

Present rules require that Medicare be reimbursed 100% of the payments they have made for medical treatment, and that deductions are allowed only for economic hardship to the beneficiary, or for the procurement costs involved in obtaining reimbursement, i.e. attorney fees for the plaintiff/claimant's attorney. No deductions are allowed for the apportionment of fault or the operation of other available tort defenses. Yet, businesses and corporations manage the risk of tort liability by relying on and utilizing the principal of apportionment of fault *i.e.,* only paying for their share of legal liability.

The longstanding rules of the MSP statutes that do not allow for deductions of the cost of the medical treatment paid by Medicare have not, in the past, changed the management of the risk of tort liability cases involving Medicare eligible plaintiffs because they were not enforced and the reimbursement claims were not pursued. Now, however, all that will change as a result of the explicit stated purpose of the new MSP reporting rules in MMSEA Section 111 and the continuing fiscal crisis combined with the Medicare funding shortfall.

What is the purpose of the new MSP reporting rules in MMSEA Section 111?

The government has explicitly stated that the purpose of the new reporting requirements for insurance companies, self-insured and third party administrators in MMSEA Section 111 is to identify plans from which the government can seek reimbursement from under the MSP statutes. It is important to note that MMSEA Section 111 did not change the substantive MSP law; it merely added a reporting requirement with financial penalties for failure to comply.

All insurance companies, self-insureds and third party administrators should anticipate that the government will use the MSP statutes as a significant income stream to finance the Medicare Trust Fund into the future in anticipation of the rising costs of this program due to the graying of the "baby boomers." The 2008 annual report of the Trust Fund stated that Medicare expenditures are projected to exhaust its reserves by 2019. CMS will rely on the reporting data to ensure the future viability of the Medicare program. The intent and purpose of the new reporting rules have become even more important now given that Federal spending on the economic crisis will cause an even greater budget deficit than when the new reporting rules were passed by Congress in 2007. The new MSP reporting rules are the mechanism to allow CMS to carry out Congress' stated objective of using the reimbursement claims to help solve Medicare's future funding shortfall. We can anticipate that ambitious politicians in Washington will focus on the reimbursement claims to "save" Medicare and will target the deep pocket corporations and businesses as defendants to those claims.

What are the risks of not complying with the MSP statutes?

Failure to fully consider Medicare's interests will cause serious contingent liability and the risk of a private recovery action against you involving significant financial penalties including the

recovery of double damages and attorney fees. The statute of limitations for the private recovery actions is six years from the date the payment is made to the plaintiff/claimant.

Insurance companies, self-insureds and third party administrators cannot manage or adjust this liability by treating it as an ordinary medical lien as they do in all other tort liability cases because Medicare's interest is more than a lien, as it is a party who by statute is entitled to be reimbursed for its "conditional payments." As stated above, the present rules require that Medicare be reimbursed 100% of the payments they have made for medical treatment and that no deductions are allowed for the apportionment of fault or the operation of other available tort defenses. It is significant to note that the 9th Circuit decision in *Zinman v Shalala,* 67 F. 3d. 841 (1995) upheld the government's interpretation of the statutes, allowing it to recover the full amount paid by Medicare, even if the plaintiff only recovers a portion of the total damages in a case. Whereas this case did not involve non-compliance of the MSP statutes, it illustrates the strict interpretation the government will apply to the MSP statutes and the reimbursement claims.

To successfully manage this risk, we should anticipate that Medicare will seek reimbursement of 100% of the payments made for medical treatment.

Will the Government really file and prosecute private recovery actions seeking reimbursement of Medicare costs?

The answer is a resounding yes, as the Government already has. The recent cases of U.S. v Harris 2009 WL 891931 (N.D.W.Va.) clearly demonstrates that it will pursue the parties involved, including the attorneys, to obtain reimbursement even of a relatively small amount. In the Harris case the underlying liability case involving a fall off a ladder settled for a total of $25,000. Medicare claimed that it had made payments of $22,549.67 for plaintiff's medical treatment. Following notification of the settlement, and after reducing its demand to account for attorney's fees, Medicare demanded reimbursement of conditional payments in the amount of $10,253.59 from the plaintiff's attorney. The plaintiff's attorney failed to object to CMS's demand and the government ultimately filed suit in federal court demanding the conditional payments, plus interest. On March 26, 2009, Judge Frederick Stamp, Jr., granted the government's motion for summary judgment requiring Harris to repay more than the full amount of the demand, plus interest. A copy of the court's order is attached.

This recent decision not only demonstrates that the government will use its power to file and prosecute private recovery actions, but also the negative consequences of failing to follow the MSP statutes. It is crucial to respond to the demand from CMS and to dispute any of the conditional payments that are not related to the incident that is the subject of the claim or lawsuit.

What are the risks for not complying with the new MMSEA reporting requirements?

There are significant penalties for failing to comply with the MMSEA Section 111 mandatory reporting requirements that include fines of $1000 per day for each plaintiff/claimant. Recently, however, when asked how it would calculate the $1000 penalties under the MMSEA Section 111 reporting guidelines, CMS advised that it could not enforce the penalties until it had published a written process and, at this stage, this had not yet been done. It indicated that it was far from establishing detailed rules on the calculation or enforcement of penalties.

How can corporations and businesses manage the risks of MSP claims?

There are two distinct aspects to managing the risk of MSP claims:

1) Ensuring that you fully protect Medicare's interest while you mitigate the amount owed and guarantee that you can resolve and close the file in a timely manner, thereby avoiding any future private recovery actions; and

2) Satisfying the reporting requirements of MMSEA Section 111.

What best practices are recommended to manage the risk of MSP reimbursement claims?

The best way to manage these claims and avoid later private recovery actions against you is to ensure that all claims/lawsuits are resolved/settled with the explicit consent and written authorization of Medicare's recovery contractor. To do that you must first identify all claims/lawsuits involving Medicare beneficiaries, and then report these claims to Medicare and involve it in the negotiations to resolve them. We recommend doing the following.

Training should be conducted to ensure that all personnel that interface with Medicare eligible claimants/plaintiffs are educated on current MSP resolution protocols.

As part of the applicable MSP protocols, "MSP eligibility questions" should be developed and implemented as part of the standard investigation. Consider the development of a standard form to be given to every plaintiff/claimant so that a quick determination if he/she is Medicare eligible, or already a Medicare beneficiary may be made. At a minimum, you should obtain the Social Security numbers, and/or the health insurance claim numbers ("HICN").

If the claimant/plaintiff is Medicare eligible, immediately obtain an executed Social Security Consent to Release form (SSA-3288) a copy of which is attached. The Medicare Secondary Payer Recovery Contractor ("MSPRC") will not release any information regarding any "conditional payments" made on behalf of a beneficiary unless this form is completed. It should be done at the beginning of the claim.

Immediately report the claim to the Coordinator of Benefits Contractor ("COB"), the administrative arm of the CMS. Be sure, however, to comply with the MMSEA Section 111 mandatory reporting requirements to the COB (see below for more on this issue).

Once you have reported a claim/lawsuit involving a Medicare beneficiary to the COB, immediately request a conditional payment estimate from the MSPRC. This document will list all of the medical treatment/procedures that Medicare has paid for that it believes was related to the incident/accident that is the subject of the tort liability claim/lawsuit.

Upon receipt of this information, conduct a conditional payment claim investigation and carefully scrutinize the payment estimates and itemizations received from the MSPRC to assure that claims for treatment not related to the injury caused by the accident are identified and removed. The collective experience is that the MSPRC will make little or no effort to distinguish between medical treatments/procedures that are related to the incident/accident, and those that are unrelated.

Eliminate the unrelated charges by providing the MSPRC with full and detailed explanations so as to reduce and mitigate the amount of the reimbursement claim. This is where we can at least utilize the tort principal of medical causation to manage the risk by reducing the overall reimbursement claim.

Respond quickly to all communications from the MSPRC. This is when your persuasive negotiation skills are paramount as you will be negotiating with not only claimant/plaintiff's counsel, but also with the MSPRC. Even though the MSPRC will not formally acknowledge that they will consider issues of apportionment of liability or any other relevant tort defenses, you should still use them to try and reduce the reimbursement claim. Medicare's funding shortfall is so critical that you can expect that the contractor at the MSPRC will understand that a definite dollar recovery by a date certain is better than a continued claim and possible prosecution of a private recovery action to obtain a higher dollar amount.

Request repayment directions from the MSPRC via a recovery demand letter for the agreed reimbursement amount. This is the letter that provides you with the written authorization to resolve the MSP reimbursement claim for the negotiated amount. This is the letter you need before you can finalize your negotiations with claimant/plaintiff's counsel.

Do the above well in advance of settlement/resolution of the lawsuit/claim so that there is no delay in closing the file.

Forward a copy of the final settlement agreement to MSPRC and then make payment as directed in the revised final demand letter – CLOSE YOUR FILE!!!! You have extinguished the risk of this MSP reimbursement claim and can be satisfied that you have no contingent liability.

What do I have to do to satisfy the mandatory reporting requirements of MMSEA Section 111?

Now is the time, literally, when you must register with Medicare as a Responsible Reporting Entity ("RRE"). The registration window is between May 1, 2009 and June 30, 2009.

You can register as an RRE at www.cms.hhs.gov/MandatoryInsRep. As part of your registration; you must designate an agent as the responsible party to act on your behalf for data transmission.

You should review the record layout to verify that your system captures the necessary data elements for reporting.

To further assist you in reporting, you should obtain from the website identified above a copy of the Interim User Guide for the MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting that is identified as Version 1.0, and dated March 16, 2009.

When do the reporting requirements take effect?

CMS recently announced that it was extending implementation of the MSP reporting process by three months, until January 1, 2010, so that insurance companies, self-insureds and third party administrators are now not required to begin live production submission of data until their

assigned submission window in the January/March quarter of 2010. However, there is no delay in registering as an RRE, and this should be done now so that the testing of data transmission can be scheduled and completed. See the User Guide Supplement, dated March 20, 2009, that can be found as a PDF file at www.cms.hhs.gov/MandatoryInsRep.

Is there a threshold for reporting tort liability claims?

Yes, on March 20, 2009, CMS announced that it would impose an *interim* reporting threshold for liability claims of $5000, below which claims need **not** be reported into the system. This threshold level will continue until December 31, 2010. Between January 1, 2011 and December 31, 2011, the reporting threshold for liability claims will be $2000. From January 1, 2012 through to December 31, 2012, the reporting threshold limit will be $600. See the User Guide Supplement identified above.

What can be expected from the data exchange process?

CMS's expectations of the data exchange process after you register as an RRE are as follows:

- Submit registration data to the COB via the website;
- The COB will assign an EDI representative to the RRE;
- The EDI representative and RRE would then test the data exchange files and make necessary adjustments;
- Assuming the RRE passes the test, the RRE is ready to transmit live data;
- The RRE transmits live data to the COB;
- An acknowledgement of transmission of the data is received by the RRE;
- Response file with errors is then received; and
- The RRE is responsible to send corrections at next interval and also to send next input file. At this point, the RRE would then report quarterly to the COB.

Are there special considerations in multiple-defendant litigation?

If you are involved in a claim by a Medicare beneficiary as a co-defendant, do not cede the responsibility of reporting this claim to the COB to any other entity.

Recently, CMS stated that it is the gross amount of a joint settlement involving several defendants that must be reported by each contributing RRE.

Do the MSP statutes and the new reporting rules in MMSEA Section 111 cover payments made under the Medicaid program as well?

No. The MSP reimbursement statutes and the MMSEA Section 111 requirements do not cover payments for medical treatment made under a Medicaid program. The Medicaid program is a joint Federal and State funding of medical treatment for individuals who cannot afford to pay their own medical costs. States are not required to participate in Medicaid, but all of them do. In California, the Medicaid program is known as Medi-Cal. The program is a cooperative one; the Federal Government pays between 50% and 83% of the costs the State incurs for patient care, and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations and administering the program. One such requirement is that the State is responsible for seeking reimbursement of payments made under the plan from legally liable third parties. This is the distinguishing factor from the payments made under Medicare.

Case law has established a formula and a procedure to follow to properly calculate the amount a State should be reimbursed legally liable third party for payments made under a Medicaid plan. This formula was most recently discussed and applied in California in the recent Court of Appeal decision of *Lima v Vous,* 174 Cal. App. 4th 242 (2009) which applied the US Supreme Court case of *Arkansas DHS v Ahlborn,* 547 U.S. 268 (2006).

Are medical set asides "MSA" necessary for tort liability case settlements?

No. Generally, the parties involved in Workers' Compensation settlements need to take into account that a claimant is or could become a Medicare beneficiary with monetary "set-asides." These set-asides are a portion of the settlement proceeds that provide for future medical expenses that Medicare would otherwise have to bear. Only once the set-asides have been exhausted does Medicare become obligated to provide coverage as the primary payer of the claimants' medical costs.

It is important to note that set-asides are not statutorily required in Workers' Compensation cases but that they are common and essentially required by CMS. On its website, CMS cautions:

> Because Medicare does not pay for an individual WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in the best interest of the individual to consider Medicare at the time of settlement. For this reason, CMS recommends that parties to a WC settlement set aside funds, otherwise known as Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) for all future medical services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare.

The CMS could, in the future, decide that set-asides are similarly "required" in third-liability cases. At this point, however, the CMS has indicated that set-asides are not needed in such cases. At this stage in the "new era" of MSP reimbursement claims in tort liability cases, we have a degree of comfort in stating that you do <u>not</u> need a medical set aside "MSA".

What opportunities exist to help reform the MSP claims process?

We encourage all stakeholders, including insurance companies, self-insureds and third party administrators to become actively involved in bringing about needed reforms to the MSP statutes. We encourage all stakeholders to consider joining the Medicare Action Recovery Coalition ("MARC") at www.marccoalition.com. MARC's co-chair has described its statement of purpose as follows:

> The Medicare Secondary Payer law requires amendment so that it may provide a fair and equitable process for an insurance company, self-insured or third party administrator to reimburse its payment for services due to an alleged liability incident. Liability claims are fault-based and require proof before legal liability attaches to the responsible party. Proof is established by a trier of fact in all jurisdictions in accordance with applicable law. The majority of liability claims are never decided by a trier of fact and, instead, are compromised. Compromise requires both sides of the dispute to recognize their respective fault and make needed adjustments to avoid further litigation expense. In some cases, compromise is mostly for good will to preserve customer relations and liability is never accepted by either side. The present MSP statutes do not recognize fault concept for liability claims and treat it as another no fault program, such as Group Health Plans and Workers' Compensation. The result is an inequitable requirement to reimburse Medicare for healthcare expenses that are not in proportion to the fault of the responsible party or, in this case, the self-insured or insurance company.

MARC's purpose is to promote legislative change that advances efficiency in the recovery process and removes barriers that result in unnecessary delay and litigation. We support these goals and encourage others to do the same.

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HOnly the Westlaw citation is currently available.

United States District Court,
N.D. West Virginia.
UNITED STATES of America, Plaintiff,
v.
Paul J. HARRIS, Defendant.
Civil Action No. 5:08CV102.

March 26, 2009.

MEMORANDUM OPINION AND ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND DENYING AS MOOT PLAINTIFF'S MOTION TO STAY DISCOVERY

FREDERICK P. STAMP, JR., District Judge.

I. *Procedural History*

*1 The plaintiff, the United States of America, filed a complaint against the defendant, Paul J. Harris, for declaratory judgment and money damages owed to the Centers for Medicare and Medicaid Services by virtue of third-party payments made to a Medicare beneficiary. On November 13, 2008, this Court denied the defendant's motion to dismiss under Rule 12(b)(6) of the Federal Rules of Civil Procedure. Currently before this Court is the plaintiff's motion for summary judgment, which has been fully briefed by the parties and is ready for disposition by this Court. In addition, the plaintiff has filed a motion to stay discovery pending this Court's decision on its motion for summary judgment. The defendant did not file a response. For the reasons set forth below, this Court grants the plaintiff's motion for summary judgment, and denies as moot the plaintiff's motion to stay discovery.

II. *Facts*

On or about May 22, 2002, Mr. James Ritchea ("Mr.Ritchea"), a Medicare beneficiary, sustained injuries when he fell off a ladder purchased from a local retailer. As a result, because Mr. Ritchea was eligible for benefits through the Medicare health care benefit program, the Centers for Medicare and Medicaid Services ("CMS") paid approximately $22,549.67 in Medicare claims submitted on behalf of Mr. Ritchea for medical services.

Thereafter, Mr. Ritchea and his wife retained the defendant, Paul J. Harris ("Mr.Harris"), as their attorney to sue the ladder retailer, alleging that the retailer was liable for Mr. Ritchea's injuries. The action was settled in July 2005, and as part of this settlement, the Ritcheas and Mr. Harris received a sum of $25,000.00.

Mr. Harris admits that he forwarded to Medicare details of this settlement payment, as well as his attorney's fees and costs. Based upon this information provided by Mr. Harris, Medicare calculated that it was owed approximately $10,253.59 out of the $25,000.00 settlement, determined by Mr. Harris's share of the attorney's fees and costs subtracted from the total medical payment. CMS informed Mr. Harris of this decision by letter dated December 13, 2005. That letter also informed Mr. Harris of the applicable appeal rights, advising Mr. Harris that if his client disagreed with the amount of overpayment, an appeal must be filed within 120 days of receipt of CMS's letter. Neither Mr. Harris nor his clients filed an appeal and, to date, the debt has not been paid.

Now, because this amount has not been repaid to Medicare within the statutorily-required sixty-day time period, CMS claims that it is entitled to its calculated share of the settlement plus interest, and that it will not pay its full share of attorney's fees and costs. Accordingly, CMS is seeking total payment of $11,367.78 plus interest from Mr. Harris for the Medicare claims paid on behalf of the defendant's client, Mr. Ritchea.

III. *Applicable Law*

Under Federal Rule of Civil Procedure 56(c), summary judgment should be granted if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."The party seeking summary

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judgment bears the initial burden of showing the absence of any genuine issues of material fact. *See* Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986)."The burden then shifts to the nonmoving party to come forward with facts sufficient to create a triable issue of fact ." *Temkin v. Frederick County Comm'rs*, 945 F.2d 716, 718 (4th Cir.1991), *cert. denied*, 502 U.S. 1095 (1992) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986)).

*2 "[A] party opposing a properly supported motion for summary judgment may not rest upon the mere allegations or denials of his pleading, but ... must set forth specific facts showing that there is a genuine issue for trial." *Anderson*, 477 U.S. at 256. The Court must perform a threshold inquiry to determine whether a trial is needed-whether, in other words, "there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party." *Id.* at 250;*see also Charbonnages de France v. Smith*, 597 F.2d 406, 414 (4th Cir.1979) (Summary judgment "should be granted only in those cases where it is perfectly clear that no issue of fact is involved and inquiry into the facts is not desirable to clarify the application of the law.") (citing *Stevens v. Howard D. Johnson Co.*, 181 F.2d 390, 394 (4th Cir.1950)).

"[T]he plain language of Rule 56(c) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex*, 477 U.S. at 322. Summary judgment is not appropriate until after the non-moving party has had sufficient opportunity for discovery. *See Oksanen v. Page Mem'l Hosp.*, 912 F.2d 73, 78 (4th Cir.1990), *cert. denied*, 502 U.S. 1074 (1992). In reviewing the supported underlying facts, all inferences must be viewed in the light most favorable to the party opposing the motion. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986).

IV. *Discussion*

A. *Plaintiff's Motion for Summary Judgment*

Section 1395y(b)(2)(B)(ii) of the Social Security Act, commonly known as the Medicare Secondary Payer Statute ("MSPS"), states, in pertinent part, that when Medicare makes a conditional payment for medical services received as a result of an injury caused by another party, the government has a right of recovery for the conditional payment amount against any entity responsible for making the primary payment:

> *Repayment required.*A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the secretary under this title ... with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

42 U.S.C. § 1395y(b)(2)(B)(ii).*See also Cox v. Shalala*, 112 F.3d 151, 154 (4th Cir.1997) ("When such a conditional payment is made for medical care, the government has a direct right of recovery for the entire amount conditionally paid from any entity responsible for making primary payment.").

*3 To recover payment, the government 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 ... under a primary plan."42 U.S.C. § 1395y(b)(2)(B)(iii). Alternatively, the government "may recover under this clause from *any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.*" *Id.* (emphasis added).*See also* Cox, 112 F.3d at 154 ("In the alternative, the government's right of recovery is subrogated to the rights of an individual or entity which has received a payment from the responsible party."). The federal regulations implementing the MSPS provide the entities in which the government can recover primary payments:

> *Recovery from parties that receive primary payments.*CMS has a right of action to recover its payments from any entity, including a beneficiary provider, supplier, physician, *attorney*, State

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agency or private insurer that has received a primary payment.

42 C.F.R. § 411.24(g) (emphasis added).

A party who does not agree with CMS's determination of the amount of reimbursement has recourse through an administrative appeals process. "Any individual dissatisfied with any initial determination shall be entitled to reconsideration of the determination, and ... a hearing thereon by the Secretary [of Health and Human Services] ... and to judicial review of the Secretary's final decision after such hearing."42 U.S.C. § 1395ff (b)(1)(A).*See also*42 C.F.R. §§ 405.940, 405.960, 405.1000, 405.1100. The party has 120 days after receiving CMS's initial determination to appeal. 42 U.S.C. § 1395ff(a)(3)(C)(I).[FN1]

> FN1. A detailed description of the appeals process can be located in Chapter 29 of the Medicare Claims Processing Manual, Appeals of Claims Decisions, at http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf.

In its motion, the government contends that summary judgment is appropriate because under the applicable statute and regulations, the United States is entitled to recover the amount due from Mr. Harris. Specifically, the government argues that Mr. Harris has waived any challenge to the amount or existence of the debt at issue in this suit because the time for appealing that determination has passed. In response, Mr. Harris asserts that he must be permitted to engage in discovery on the issues of liability and damages, as well as his affirmative defenses of estoppel and consortium.

This Court finds that the government is entitled to judgment as a matter of law. In this case, the Ritcheas and the defendant received a $25,000.00 settlement and primary payment in the underlying personal injury action from the ladder retailer. Because the ladder retailer took responsibility for the payment of Mr. Ritchea's medical services, demonstrated by "a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured," the government can now receive reimbursement for the medical services paid for by Medicare. 42 U.S .C. § 1395y(b)(2)(B)(iii). Furthermore, this Court holds that Mr. Harris is individually liable for reimbursing Medicare in this case because the government can recover "from *any* entity that has received payment from a primary plan," including an attorney. 42 C .F.R. § 411.24(g) (emphasis added).

*4 Moreover, this Court agrees with the government that Mr. Harris's failure to pursue available administrative remedies precludes him from challenging CMS's reimbursement determination. As stated in *Ulman v. United States*, 558 F.2d 1, 7-8 (Ct.Cl.1977):

> Where an administrative appeal is compulsory prior to invoking the aid of a court, it does not matter that the party who failed to pursue said appeal is petitioning the Court for relief or defending an action brought against him. In either situation the failure to pursue the prescribed administrative course effectively prohibits his claim or defense which could have been entertained administratively in the first instance.

In *United States v. Savarese*, 515 F.Supp. 533 (S.D.Fla.1981), the government determined that the defendant physician had been overpaid approximately $108,720.42 under the Medicare program.[FN2]When the defendant failed to repay Medicare the alleged overpayment, a claim was filed against the defendant's estate.[FN3] *Id.* at 535.The defendant's estate did not administratively appeal the overpayment calculation. Later during suit, however, the defendant's personal representative stated that although she would not contest the amount of the alleged overpayments, she "question[ed] the allegation that Dr. Savarese ... received $108,290.82 in excess of the amount due him by the Medicare Program." *Id.* at 536.The government contended in its cross-motion for summary judgment that the decedent waived his right to judicial review of the overpayment determination because he did not utilize the administrative appeals process and that therefore, it was entitled to a judgment of a matter of law. The court agreed and held that "[d]efendant's failure to pursue administrative remedies precludes any questions regarding the amount of the overpayments received." *Id.* at 536.

> FN2. This amount was later reduced to $108,290.82 when a total of $429.60 due to the doctor was offset against the overpay-

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ment.

FN3. The defendant passed away prior to reimbursing the government.

Other courts have reached similar conclusions. *See* United States v. Home Health Agency, Inc., 862 F.Supp. 129, 134 (N.D.Tex .1994) (The defendant's "failure to exhaust the administrative appellate procedure precludes it from challenging the overpayment determination which the government seeks to recover."); United States v. Total Patient Care, Inc. of Jacksonville, Florida, 780 F.Supp. 1371, 1373 (M.D.Fla.1991) ("[T]he Court finds that defendant's failure to pursue available administrative remedies precludes judicial review of the defendant's claim concerning the propriety of the calculation of the overpayment. Exhaustion of administrative remedies is a prerequisite to any judicial review of defendant's claim under the Social Security Act.").

After careful consideration, this Court finds this authority persuasive in granting the government's motion for summary judgment. Indeed, any qualms that Mr. Harris had concerning the extent of his liability under the MSPS should have been challenged through the administrative appeals process. By letter, dated December 13, 2005, CMS advised Mr. Harris of the amount of the reimbursement, as well as the procedures to appeal the reimbursement determination. Neither Mr. Harris nor his clients filed an appeal. Therefore, because he did not avail himself of the administrative process, Mr. Harris is now precluded from contesting the reimbursement determination that the government is seeking to recover. Accordingly, this Court finds that summary judgment in favor of the government is appropriate. *See* United States v. Weinberg, 2002 WL 32356399 (E.D.Pa.2002) (granting United States partial summary judgment under MSPS and holding that United States is entitled to recover MSPS debt from beneficiary's attorney); United States v. Sosnowski, 822 F.Supp. 570 (W.D.Wis.1993) (granting, in part, the United States' motion for judgment on the pleadings under MSPS and holding that the United States is entitled to recover MSPS debt from beneficiary and his attorney).

*5 The judgment awarded to the government is $11,367.78, in accordance with 42 C.F.R. § 411.37(e)(2), which represents the total settlement amount minus the party's total procurement costs. The government is also entitled to recover interest on the total amount of reimbursement. *See*42 C.F.R. § 405.378 ("CMS will charge interest in overpayments ... to providers and suppliers of services."). That regulation also sets forth the rate of interest. *See*42 C.F.R. § 405.378(d). Since no amount of interest has previously been presented to this Court, the parties shall confer and attempt to agree upon the amount of interest to be awarded. The parties shall then present a stipulated amount to this Court within ten (10) days from the date of this memorandum opinion and order. If the parties cannot agree as to the amount of interest, then each party shall, within fifteen (15) days from the date of this memorandum opinion and order, present to this Court a written statement as to that party's detailed calculation of the amount of interest that that party contends shall be awarded.

B. *Plaintiff's Motion to Stay Discovery*

In light of this Court's holding on the plaintiff's motion for summary judgment, the plaintiff's motion to stay discovery is denied as moot.

V. *Conclusion*

For the above-stated reasons, the plaintiff's motion for summary judgment is GRANTED, and the plaintiff's motion to stay discovery is DENIED AS MOOT. The plaintiff is entitled to judgment in the amount of $11,367.78 plus the amount of interest thereon which will be calculated. This Court will defer entry of judgment pursuant to Federal Rule of Civil Procedure 58 until the interest has been calculated as provided above.

IT IS SO ORDERED.

The Clerk is directed to transmit a copy of this memorandum opinion and order to counsel of record herein.

N.D.W.Va.,2009.
U.S. v. Harris
Slip Copy, 2009 WL 891931 (N.D.W.Va.)

END OF DOCUMENT

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This document may be used to request information and records from the federal government including those pertaining to medical care and treatment as well as Medicare eligibility and payments.

Form Approved
OMB No. 0960-0566

Social Security Administration
Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE: The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.*

This document may be used to request information and records from the federal government including those pertaining to medical care and treatment as well as Medicare eligibility and payments.

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parents' names)
____ Monthly Social Security benefit amount
____ Monthly Supplemental Security Income payment amount
____ Information about benefits/payments I received from_____ to_____
____ Information about my Medicare claim/coverage from_____ to_____
(specify)
____ Medical records
____ Record(s) from my file (specify)
____ Other (specify)

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature:
(Show signatures, names, and addresses of two people if signed by mark.)
Date: Relationship:

Form SSA-3288 (5-2007) EF (5-2007)