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# IN BRIEF

MALPRACTICE AVOIDANCE NEWSLETTER FOR OREGON LAWYERS

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## WORKERS' COMPENSATION AND SOCIAL SECURITY DISABILITY

For many years, workers' compensation (WC) attorneys have recognized the need to take steps to prevent the direct offset of social security disability insurance (SSDI) benefits when settling WC claims of injured workers who are or will become eligible for social security disability benefits. Recently, the Centers for Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration or HCFA), announced that it would step up its efforts to recover Medicare benefits and to disqualify Medicare beneficiaries from future benefits when a settlement agreement inappropriately shifts responsibility for medical benefits from a WC carrier to Medicare. This article helps attorneys identify and address social security disability issues that arise when settling WC claims.

### TYPES OF BENEFITS

Medicare benefits are available to individuals who have reached age 65, as well as individuals who are disabled (eligible for SSDI) according to the Social Security Administration and whose entitlement to SSDI continues for 24 months. Generally, Medicare benefits do not cover services for which WC benefits are available.[1]

Medical benefits paid by Medicare on a denied WC claim need to be repaid when the WC claim is later settled. Federal law also requires that Medicare's interests be protected when a WC claim involving the need for future medical treatment is settled. The obligation to repay Medicare for benefits received and to protect Medicare's rights to avoid future medical expenses for work-related conditions varies, depending on the nature of the settlement and the type of benefits (past or future) involved.

Medicare will make "conditional payment" for medical services for a condition that is the subject of a WC claim if Medicare determines that the carrier will not pay promptly or has denied the claim.[2] In this situation, WC carriers are considered primary insurers, with Medicare providing secondary coverage. If – after Medicare makes conditional payments – a WC claim is either accepted or settled, Medicare expects reimbursement of those payments.[3] Federal law allows CMS to pursue recovery of conditional payments by direct action against the beneficiary or the WC carrier.[4]

### DISPUTED CLAIM SETTLEMENTS

In the context of a WC claim, CMS has the right to reimbursement from the WC carrier or self-insured employer when it has made conditional payments in a denied claim and the claim is settled with a disputed claim settlement.[5] CMS, if contacted in advance of settlement, has the authority to reduce its demand for reimbursement of conditional payments where the circumstances of the settlement support it (for example, if the risk of losing a claim results in diminished settlement value). Under Oregon law, if a WC claim is settled pursuant to a disputed claim settlement, or if a denied claim is later accepted, the WC carrier must "notify each affected service provider and health insurance provider of the results of the disposition or settlement."[6] Given the WC carrier's obligation to notify Medicare of claim settlement and Medicare's rights to recover from either the WC carrier or the injured worker, there is good reason to approach Medicare early regarding a proposed settlement.

## CURRENT MEDICAL BENEFITS

An injured worker who is eligible for Medicare and enters into a disputed claim settlement on a WC claim that will give rise to a need for future medical treatment faces a problem. That individual can be disqualified from Medicare benefits for the same condition until the medical expenses for the claimed condition equal the amount of the WC settlement.[7] Once the medical expenses equal (and essentially exhaust) the settlement proceeds, the beneficiary is again eligible for Medicare benefits for the medical condition at issue.

Attorneys who wish to ensure that an injured worker is not unexpectedly disqualified from future Medicare benefits may do so in one of two ways. First, Medicare may approve a settlement agreement that allocates the settlement proceeds between the portion intended to cover future covered medical costs and the portion intended to cover income replacement.[8] Such an agreement, if approved, would result in disqualification from Medicare benefits for the condition at issue *only* until such time as the funds allocated for future medical expenses are exhausted. Another option is a "Medicare Set Aside Trust," a trust agreement that allows the injured worker to set aside a portion of the settlement proceeds in a trust to cover future medical costs related to the disputed condition. A third-party trustee administers the trust agreement, paying the medical bills from the trust until such time as it is exhausted. Either process ensures that an injured worker is guaranteed that Medicare benefits will be available after the WC settlement. A settlement that apportions the proceeds to cover future medical costs, or that includes a Medicare Set-Aside Trust Agreement, may be submitted to CMS for approval prior to finalization of the settlement.

## FUTURE MEDICAL EXPENSES

If the injured worker is not eligible for Medicare, the parties have no legal obligation to notify Medicare or to request approval of a settlement agreement. Medicare does, however, have the authority to disqualify a beneficiary from benefits based on the earlier receipt of settlement money for the condition giving rise to the need for future treatment. For that reason, Medicare will, upon request of the injured worker, review and approve a settlement agreement that settles issues related to future rights to medical benefits. Pursuant to a July 25, 2001 guidance letter, HCFA (now known as CMS) instructed its regional offices to provide, upon request, written opinions regarding the sufficiency of a settlement arrangement in those cases in which there is a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and lost wages is expected to exceed $250,000. Regional offices may be willing to review smaller settlement agreements, depending on the demand and on the resources available within those offices to conduct such reviews.

While CMS has stepped up its efforts to recoup conditional benefits and to protect itself from responsibility for claims that should be covered by WC, it is too early to tell how aggressively CMS will pursue recovery of benefits or declare Medicare beneficiaries ineligible on the basis of the receipt of settlement proceeds. However, the following guidelines may be of some assistance to attorneys faced with assessing whether an obligation exists to inform CMS of a settlement or whether to secure CMS approval in advance of entering into a settlement:

1. Any time a denied WC claim involves a worker who has been found eligible for Medicare, confirm whether Medicare has made conditional payments for medical services arising from the denied condition. You can do this by calling the CMS Coordinator of Benefits (COB) contractor at 1-800-999-1118. The COB will contact a Medicare contractor, who will determine the existence and amount of any repayment owing to Medicare. This process generally takes four to six weeks.

2. If the worker is Medicare eligible, consider obtaining Medicare approval of any lump-sum settlement that could reasonably be construed to compensate the worker for the cost of future medical benefits that would otherwise be covered under Medicare. Obtaining review of a proposed settlement by Medicare can take a significant amount of time. To avoid unnecessary delays, start the process as early as possible once a tentative settlement has been reached. If a settlement agreement involves a request that Medicare reduce its lien, be prepared to provide Medicare with the total settlement amount before requesting approval. Requests for approval of settlements involving injured workers residing in

Oregon should be directed to the Medicare Secondary Payer Program, Division of Financial Management, Department of Health and Human Services, Region 10, M/S 46, 2201 Sixth Avenue, Seattle Washington 98121.

3. If the amount of a settlement is substantial, consider the use of a Set-Aside Trust Agreement. Most Set-Aside Trusts are drafted by attorneys retained by either the worker or the WC carrier specifically for that purpose. Set-Aside Trust Agreements should be submitted to the Medicare Secondary Payer Office in the same manner as a settlement that encompasses future medical costs and apportions the settlement proceeds. Proposed Medicare Set-Aside Trust Agreements may be submitted for approval as

[1] *42 CFR 411.40(1)(i)*
[2] *42 CFR 411.45*
[3] *42 CFR 411.24*
[4] *42 CFR 411.24*
[5] *ORS 656.289(4)*
[6] *ORS 656.313(4)*
[7] *42 CFR 411.46(a)*
[8] *42 CFR 411.47*