Challenging Medicare's Claim

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There is a very defined process available to Medicare beneficiaries who want to challenge a claim asserted by Medicare. Unfortunately, the current process is **not** as clear and easy for insurers and self-insurers. There is finally relief on the horizon with the recent passage of the SMART Act, which will be discussed below.

In accordance with the Medicare Secondary Payer Act, liability insurers (including self-insurers), no-fault, and workers' compensation plans must ensure that Medicare is appropriately reimbursed as a result of settlements, judgments, awards, or other payments made to Medicare beneficiaries. If Medicare asserts a claim for treatment that is not related to the injury at issue, it is necessary to challenge that claim.

Administrative Process

As a first step in challenging a claim asserted by Medicare, a party may not automatically sue Medicare for any reason connected with the Medicare Act nor can Medicare be forced to be a party to any state court action. To assert a claim against Medicare, including disputing a conditional payment claim, an individual must exhaust administrative remedies prior to seeking judicial review.[1] This requirement is mandatory and non-waivable, and until such remedies are exhausted, a federal district court does not have subject matter jurisdiction over any claim arising out of the Medicare Act.[2]

The administrative process begins when the Secretary issues an initial determination "with respect to a claim for benefits."[3] If an individual is unhappy with the initial determination, the first step is to file for a redetermination within 120 days of receiving notice of the initial determination.[4] An individual may then move to the second step and request reconsideration of the redetermination within 180 days of receiving notice of the same.[5] Medicare contracts with "qualified independent contractors" to conduct these reconsiderations.[6] During the pendency of

the dispute process, *interest and penalties will still accrue*. If the appeal or dispute is successful, the interest and penalties will not be charged to the debtor. If the debtor has already paid the amount initially demanded by Medicare and the redetermination or reconsideration is favorable, a refund should be given to the debtor.[7]

At the third level of appeal, if dissatisfied with the result of the reconsideration, an individual may obtain a hearing with an Administrative Law Judge (ALJ), if such request is filed within sixty (60) days of receiving notice of the reconsideration decision.[8] The fourth and final step in the administrative process is to file an appeal with the Appeals Council.[9] Such appeal must be filed within sixty (60) days of receiving notice of the ALJ's decision following the hearing. If the Appeals Council grants the request for review, it may either issue a decision or remand the case to an ALJ.[10]

Judicial Review

After exhausting all of the aforementioned administrative remedies, an individual may seek judicial review.[11] This review may be obtained by filing a civil action in the appropriate United States District Court within sixty (60) days after the notice of the final decision of the Appeals Council has been mailed. Subject to the general appellate process of the district court, the judgment of the court is final.[12]

The law expressly provides for judicial review in federal district court but only after obtaining a final decision from the Secretary of the Department of Health and Human Services (i.e., exhausting the available administrative remedies).[13] Section 405(h) provides:

> The findings and decision of the [Administrator of CMS] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Administrator of CMS] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, [the Administrator of CMS], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code [28 U.S.C § 1331 or 1346], to recover on any claim arising under this title [42 U.S.C §§ 401 et seq.].[14]

Accordingly, no state court may ever properly exercise subject matter jurisdiction over an action arising under the Medicare Act,[15] and Medicare may never be properly interpleaded in any state court action. The same provisions prevent an individual from bypassing the administrative process to obtain relief through a declaratory judgment action in federal court. Subject matter jurisdiction is exclusive to the procedures set out in the Medicare Act, which include exhaustion of the agency's administrative remedial process and, upon exhaustion, judicial review in the appropriate federal district court.[16] Failure to exhaust the administrative process "is fatal to [a] Plaintiff's request for judicial review[.]"[17]

There have been several cases in the past few years that addressed the administrative appeals process and judicial review provisions discussed above. One case that provides a detailed analysis of the administrative process is Gray v. Doe.[18] In Gray, the plaintiff filed an action naming the Secretary of the Department of Health and Human Services (hereafter, "Secretary of HHS") as a defendant.[19] The plaintiff had sustained injuries in a slip and fall accident, and Medicare paid for treatment related to those injuries.[20] The plaintiff sought to compel the Secretary of HHS to intervene in the action to assert its claim for reimbursement of the conditional payments made.[21] The Secretary of HHS filed a motion to dismiss arguing that the plaintiff failed to exhaust his administrative remedies before filing suit.[22] The court held that the Secretary of HHS "may not be compelled to intervene in a common law tort action to assert a subrogation interest . . . [and] the plaintiff's only remedy is to follow the appropriate administrative procedures[.]"[23]

Haro v. Sebelius was an important case decided in 2011 and resulted in the revision of Medicare's publications and correspondence.[24] Although it was not one of the key issues in the case, there is a short, but noteworthy, discussion of who can challenge a claim arising under the Medicare Act through the administrative appeals process.[25] In analyzing the U.S. v. Weinberg[26] case, the court explained that the administrative appeals process that is available to a Medicare beneficiary does not apply to the beneficiary's attorney.[27] Therefore, had the attorney in

Weinberg not been sued by the Secretary of HHS, he could not have challenged the amount of the reimbursement claim.[28] The court noted the individuals who may request administrative review, which include the Medicare beneficiary, spouses, divorced spouses, surviving spouses, surviving divorced spouses, parents, surviving divorced parents, and children.[29]

Practical Considerations

The Medicare Secondary Payer Recovery Contractor (MSPRC) is the primary entity responsible for recovering payments Medicare made when another entity had primary payment responsibility. CMS has established guidelines for the MSPRC to follow regarding who can challenge a claim asserted by Medicare and the documentation necessary to pursue such a challenge. The two types of authorization forms required by the MSPRC are Consent to Release forms and Proof of Representation forms.[30] A Proof of Representation may be signed by the Medicare beneficiary or by a no-fault or workers' compensation insurance carrier, if the beneficiary or carrier has retained a third party to assist with the conditional payment claim research process.[31] It indicates that the authorized individual or entity may obtain information and act on the beneficiary's or carrier's behalf in order to resolve Medicare's claim.[32] The authorized individual or entity may submit information, request information, respond to requests from the MSPRC, receive a copy of the demand letter, and file an appeal.[33] A Consent to Release signed by the Medicare beneficiary allows the authorized individual or entity to receive information from the MSPRC but does not provide authority to act on behalf of the beneficiary.[34] The MSPRC will provide conditional payment information to no-fault insurers or workers' compensation carriers without a Consent to Release form.[35] The MSPRC will not, however, provide conditional payment information to a liability insurer without a Consent to Release form.[36] In addition, a Proof of Representation form may only be signed by the Medicare beneficiary in a liability case, which prevents a liability insurance carrier from challenging a claim asserted by Medicare. The reason is that the beneficiary is almost always listed as the debtor in

liability cases and the insurer does not have appeal rights.

Although the administrative review process set out above is statutorily only available to Medicare beneficiaries, CMS and the MSPRC currently allow workers' compensation carriers a single appeal once the formal demand letter has been issued. Because of this limitation, it is wise to obtain any information and documentation needed to support an appeal in advance so that you have the best chance of success on that *one and only* level of appeal. As discussed below, the process will change for workers' compensation carriers due to the SMART Act.

Aside from a post-settlement appeal, there are two other options available in workers' compensation and no-fault cases to combat the conditional payment claim issues. The first is to dispute any claims asserted prior to settlement. This type of dispute can be accomplished by insurers or self-insureds for workers' compensation and no-fault claims without limitation. The second is to request a pre-settlement compromise, which would only be granted in certain situations. Fortunately, workers' compensation and no-fault insurance carriers presently have options for disputing/appealing claims asserted by Medicare both prior to and after settlement. Liability insurance carriers, including self-insurers, however, are left with their hands tied. At this point, they must depend on the Medicare beneficiary and/or the beneficiary's attorney to assist with challenging a claim. The SMART Act that was enacted on January 10, 2013, will correct this problem. There is now hope that liability insurance carriers will be able to appeal conditional payment claims in the near future.

The SMART Act

On January 10, 2013, President Obama signed HR 1845, otherwise known as the SMART Act, into law. As part of this legislation, insurance companies and self-insureds are provided with a right to appeal conditional payment claims asserted by Medicare.[37] Although it is not necessary to have consent from the Medicare beneficiary to appeal, the beneficiary must be notified of the intent to appeal.[38] According to the legislation, regulations will be promulgated

to establish the right of appeal and the appeals process; however, no deadline is provided for when CMS must complete that task.[39]

Endnotes

1. 42 U.S.C. §§ 405(g), (h) (2000).
2. See Cochran v. U.S. Health Care Fin. Admin., 291 F.3d 775, 779 (11th Cir. 2002).
3. 42 U.S.C. § 1395ff(a)(1)(A)(c) (2000); 42 C.F.R. § 405.900, et seq.
4. 42 U.S.C. §§ 1395ff(a)(3)(A), (C)(i) (2000).
5. 42 U.S.C. §§ 1395ff(b)(1)(A), (D)(i) (2000).
6. 42 U.S.C. § 1395ff(c)(1) (2000).
7. Centers for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Medicare-Secondary-Payer-Recovery/MSPRecovClaimPro/index.html (last visited October 8, 2012).
8. 42 U.S.C. § 1395ff(d)(1)(A) (2000).
9. 42 U.S.C. § 1395ff(d)(2)(A) (2000).
10. 42 U.S.C. § 1395ff(d)(2)(A) (2000).
11. 42 U.S.C. § 405(g) (2000).
12. 42 U.S.C. § 405(g) (2000).
13. 42 U.S.C. § 405(g) (2000).
14. 42 U.S.C. § 405(h) (2000).
15. See Stanton v. State Farm Mut. Auto. Ins. Co., 2011 U.S. Dist. LEXIS 93599, 2011 WL 3678912 (S.D. Ill. Aug. 22, 2011) (holding that the court does not have subject matter jurisdiction to hear Stanton's claim because he has not completed the administrative review process).
16. Wilson v. United States, 405 F.3d 1002, 1013 (Fed. Cir. 2005).
17. Hicks v. Chamberlain, 2010 U.S. Dist. LEXIS 112969, 2010 WL 4226698 (E.D. Ky. Oct. 21, 2010) page 5
18. 2010 U.S. Dist. LEXIS 83067, 2010 WL 3199347 (E.D. Ky. Aug. 12, 2010).
19. Id. at 2.
20. Id. at 3.
21. Id.
22. Id.
23. Id. at 10.
24. Haro v. Sebelius, 789 F. Supp. 2d 1179 (D. Ariz. 2011).
25. Id. at 1193.
26. 2002 U.S. Dist. LEXIS 12289, 2002 WL 32356399 (E.D. Pa. July 1, 2002).
27. Haro, 789 F. Supp. 2d at 1193.
28. Id.
29. Id. (citing 42 U.S.C. § 405(b)(1)).
30. "Proof of Representation" vs. "Consent to Release", http://www.msprc.info/forms/POR%20Powerpoint.pdf at 3 (last visited October 8, 2012).
31. Id. at 4.
32. Id.
33. Id.

34. Id. at 5.
35. Id. at 12.
36. Id.
37. 42 U.S.C. § 1395(b)(2)(B)(viii).
38. Id.
39. Id.