

# **LITIGATING WITH MEDICARE-ELIGIBLE PERSONAL INJURY PLAINTIFFS**

**CHANDLER BAILEY**  
**Lightfoot Franklin & White**

**A NEW DECADE OF CHALLENGES FOR IN-HOUSE COUNSEL**  
**PROTECT AND DEFEND IN 2010 AND BEYOND**

Attached are the following sample materials to consider when litigating an injury case with a Medicare eligible plaintiff:

1. Medicare File Checklist
2. Sample Letter to Plaintiff's Counsel and Informal Release Forms
3. Sample Formal Discovery Requests to Plaintiff
4. Sample Settlement Agreement Language
5. Sample Medicare Set-Aside Agreement
6. Medicare File Closing Checklist

## **HOW TO COMPLY WITH NEW MEDICARE REPORTING AND SET-ASIDE REQUIREMENTS**

### **LITIGATION PHASE**

- Step 1: Send Notice Letter to Plaintiff's counsel and Information letter to Client, if necessary.
- Step 2: Serve discovery containing questions regarding Medicare if Plaintiff will not provide voluntarily, seeking Court's permission to propound additional interrogatories, if necessary.
- Step 3: Follow up on 1 and 2 as needed.
- Step 4: Forward received information to Client/RRE.

### **SETTLEMENT PHASE**

- Step 1: Remind Plaintiff's counsel by letter that the Medicare issue must be addressed during settlement.
- Step 2: Send Plaintiff's counsel a draft of the appropriate settlement agreement early on in settlement discussions:
- If your case involves a current Medicare beneficiary, use Agreement #1.
  - If your case involves a future Medicare beneficiary, use Agreement #2.

### **JUDGMENT PHASE**

- Step 1: Consider whether to add Medicare as Payee; Send 2 checks (one to Plaintiff and Plaintiff's Counsel and one to Medicare)

### **REVIEW FILE CLOSING CHECKLIST**

**NOTICE LETTER TO PLAINTIFF'S COUNSEL**

[DATE]

[TO: Plaintiff's Counsel]

**Re: Mandatory Medicare Reporting Requirements**

Dear [Plaintiff's Counsel]:

Under the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), 42 U.S.C. §1395y(b)(8), beginning January 1, 2010, **[Defendant]** is required under federal law to report to the Centers for Medicare & Medicaid Services (CMS) all claims, settlements, judgments, awards or other payments involving a Medicare beneficiaries. The new reporting requirements are designed to apprise Medicare of its rights to recoup payments made pursuant to the Medicare Secondary Payer ("MSP") Act. The regulations explaining Medicare's right to recover these amounts are set forth in 42 C.F.R. §§ 411.20, *et seq.* Information about the MSP and Medicare's recovery rights is also available at [www.medicare.gov](http://www.medicare.gov) and [www.msprc.info](http://www.msprc.info).

As I am sure you are aware, these reporting requirements are not optional and failure to comply can result in substantial fines. Moreover, Plaintiff, Plaintiff's counsel and all "primary payers," as defined by federal regulations, may be liable to Medicare for reimbursement of conditional payments made by Medicare to a Medicare beneficiary. Accordingly, please be advised that **[Defendant]** will not enter into any settlement agreement regarding this matter until it is assured that Medicare's interests will be satisfied.

Before **[Defendant]** can discuss a potential settlement of this claim, I must receive information confirming whether your client is a Medicare beneficiary and any amounts Medicare has paid related to the alleged injuries that form the basis of this lawsuit. Accordingly, please provide the following information to me within the next thirty (30) days:

- 1) **[Plaintiff's]** Social Security Number, date of birth, Medical Health Insurance Claim Number ("HICN"), and current mailing address;
- 2) Whether **[list Plaintiff(s)]** is currently a Medicare beneficiary, or is Medicare-eligible (age 65 or older; receiving Social Security Disability Insurance (SSDI) benefits; or suffering from end-stage renal disease or Lou Gehrig's disease); and
- 3) Whether Medicare has made any payments for medical treatment relating to the injuries that form the basis of this claim.

Name  
[Date]  
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Additionally, please have your client execute the enclosed release which will enable **[Defendant]** to accurately coordinate benefits with Medicare and fully comply with the MMSEA.

If **[Defendant]** makes a decision to offer a settlement, and your client accepts, **[Defendant]** will release the settlement funds to you to be held in trust until **[Defendant]** has been provided proof that Medicare has been satisfied or that any Medicare reimbursement amount has been waived.

For your convenience, I have included a Proof of Representation Form which you will need to gather information from Medicare on behalf of your client as well as a brochure which defines the rights and responsibilities of a Medicare beneficiary. Thank you for your courtesy and cooperation in this regard.

Warmest regards,

**Proof of Representation**  
**Liability Insurance (Including Self-Insurance), No-Fault Insurance,**  
**or Workers' Compensation**

**Where to find Information on “Proof of Representation” vs. “Consent to Release”**

Please refer to the PowerPoint document on this website titled: “Rules and Model Language for ‘Proof of Representation’ vs. ‘Consent to Release’ for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers’ Compensation” for detailed information on:

- **When to use a “proof of representation” document vs. a “consent to release” document,**
- Appropriate content for both documents,
- Use of attorney retainer agreements as proof of representation if certain criteria are met,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary’s guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary’s representative signs a “consent to release” document on the beneficiary’s behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers’ compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers’ or workers’ compensation.

**General**

Proof of representation is required in order for the MSPRC to communicate with and provide information to a Medicare beneficiary’s representative. Once the MSPRC has the appropriate documentation, it can communicate with the representative and act upon requests made by the representative on behalf of the beneficiary. This includes furnishing conditional payment information and/or a recovery demand letter as well as addressing questions regarding the specific claims included in the conditional payment information, appeal requests or waiver of recovery requests.

**Model Language**

See attached. Use of the model language is not required, but any documentation submitted as a “Proof of Representation” document must include the information the model language requests.

**Where to Submit Proof of Representation:**

Liability Insurance (Including Self-Insurance)  
or No-Fault Insurance:

Medicare Secondary Payer Recovery Contractor  
MSPRC Auto/Liability  
P.O. Box 33828  
Detroit, MI 48232-5828  
Fax: (734) 957-0998

Workers’ Compensation

Medicare Secondary Payer Recovery Contractor  
MSPRC Workers’ Compensation  
P.O. Box 33831  
Detroit, MI 48232-5831  
Fax: (734) 957-0998

**PROOF OF REPRESENTATION**

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

**Type of Medicare Beneficiary Representative** (Check one below and then print the requested information):

- ( ) Individual other than an Attorney: Name: \_\_\_\_\_
- ( ) Attorney\* Relationship to the Medicare Beneficiary: \_\_\_\_\_
- ( ) Guardian\* Firm or Company Name: \_\_\_\_\_
- ( ) Conservator\* Address: \_\_\_\_\_
- ( ) Power of Attorney\* \_\_\_\_\_
- Telephone: \_\_\_\_\_

\* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language. ) Please visit [www.msprc.info](http://www.msprc.info) for further instructions.

**Medicare Beneficiary Information and Signature/Date:**

Beneficiary's Name (please print exactly as shown on your Medicare card): \_\_\_\_\_

Beneficiary's Health Insurance Claim Number (number on your Medicare card): \_\_\_\_\_

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: \_\_\_\_\_

Beneficiary Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

**Representative Signature/Date:**

Representative's Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

# Tips for Managing your Rights & Responsibilities as a Medicare Beneficiary

## Managing your Liability, No-Fault or Workers' Compensation Claim

- Contacting the Coordination of Benefits Contractor (COBC) is always the first step in the process.
- Receiving this brochure, however, means that your case has already been established through COBC and with the MSPRC. Right now, the MSPRC is compiling all medical claims that Medicare paid that are related to your case.

**F.Y.I.** This process takes approximately eight weeks. The MSPRC is not able to provide conditional payment amounts until all claims are retrieved from Medicare's systems.

### The Conditional Payment Letter (CPL):

Once all claims have been retrieved from Medicare systems and filtered (determined to be related to your case), THEN the MSPRC will issue a CPL to all authorized parties on record.

- The CPL is NOT a request for payment. It lists claims that Medicare believes are related to your case.
- Within 65 days from the date of the Rights and Responsibilities Letter you will receive the CPL.

**F.Y.I.** Separate requests for Initial Conditional Payment Amounts will not make Conditional Payment information available sooner.

- Once the MSPRC has mailed your CPL, you may also review updated Conditional Payment Amounts on the MyMSP tab on [www.mymedicare.gov](http://www.mymedicare.gov) website.

### The Final Demand Letter:

- Once a settlement is reached, you or your representative must submit to the MSPRC the gross settlement amount, as well as attorney fees and additional costs you had to pay toward the resolution of your case.
- Medicare takes attorney fees and costs you paid into account before computing a final demand amount.
- A Final Demand Letter will be issued once the MSPRC receives and enters your settlement information.

## Proof of Representation:

Do you have a Representative?  
Do you have an attorney?

- Your representative may want information from Medicare in order to help you resolve your claim, BUT Medicare will not talk to anyone about you or your health related information without your permission.

## HELP US HELP YOU!

- If your representative is an attorney, the MSPRC will need a copy of the Retainer Agreement you signed when you hired your attorney. This is the easiest way to tell Medicare that your attorney represents you and is allowed to make decisions for you in his or her effort to resolve your potential Medicare recovery claim.

Please make sure the Retainer Agreement includes:

- The name of the law firm in the body of the Retainer Agreement OR is on the law firm's letterhead OR includes a coversheet on the law firm's letterhead.
- Your name, printed, so the MSPRC can read it.
- Your signature and the date of your signature.
- Your Medicare Number. This helps the MSPRC make sure YOUR information goes in YOUR file.
- Your attorney's signature and the date of the signature added to the bottom of the Retainer Agreement.

**F.Y.I.** The MSPRC will certainly accept other proof of representation documents, as long as the required information listed above is included in whatever document you choose to send.

Check out [www.msprc.info](http://www.msprc.info) for examples, downloads

AND

**SPECIAL RULES FOR ACTING ON BEHALF OF DECEASED BENEFICIARIES**

*My Health.*

*My Medicare.*

Want more info regarding your Medicare claims?  
[WWW.MYMEDICARE.GOV](http://WWW.MYMEDICARE.GOV)

If you do not already have a sign-in ID and password, register on the website!

You will have the ability to:

Once your CPL has been sent, view up-to-date Conditional Payment Summaries on the MyMSP tab of the website.

And

- View Claim Status.
- Order duplicate Medicare Summary Notices (MSN) or replacement Medicare cards.
- View enrollment information.

**F.Y.I.** Please keep your sign-in ID and password safe!

If you allow your attorney or representative to have access to your information via MyMedicare, be sure to change your pin once the necessary information has been retrieved.



[www.msprc.info](http://www.msprc.info)

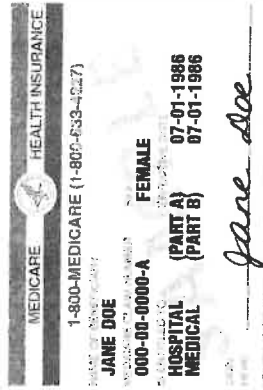


# Checklist

For any future cases, the COBC will need the information listed below in order to get the process started.

## Beneficiary Information

- ✓ Beneficiary's Name
- ✓ Beneficiary's Date of Birth
- ✓ Beneficiary's Gender
- ✓ Beneficiary's Address
- ✓ Beneficiary's Telephone Number
- ✓ Beneficiary's Medicare Number



✓ Date of Injury OR Date of First Ingestion/Exposure

- Date of First Ingestion/Exposure is required when you have taken a medication that has resulted in injury or you have been exposed to a product, like asbestos, that has resulted in injury.

✓ Description of Injury

- ✓ Type of Claim— Liability Insurance, No-Fault Insurance or Workers' Compensation
- Include both the name and address of the Insurer or Workers' Compensation Entity.

Representative/Attorney Information

- ✓ Representative/Attorney Name
- ✓ Law Firm Name, if your representative is an attorney

✓ Address

✓ Telephone Number

- ✓ Proof of Representation - send to the MSPRC immediately after contacting the COBC

## Contact the MSPRC

By Telephone



Monday- Friday,  
8:00am-8:00pm, Eastern Time  
1-866-677-7220 OR  
1-866-677-7294 (TTY/TDD)

By Mail



MSPRC Auto/Liability  
PO Box 33828  
Detroit, MI 48232-5828

Workers' Comp. MSP Recovery

MSPRC WC  
PO Box 33831  
Detroit, MI 48232-5831

By Fax



1-734-957-0998

Request a call back



Visit the MSPRC website to schedule a call back.

[www.msprc.info](http://www.msprc.info)

## Contact the COBC

By Telephone



Monday - Friday  
8:00am-8:00pm, Eastern Time  
1-800-999-1118  
1-800-318-8782 (TTY/TDD)

By Mail - General Inquiries



MEDICARE- Coordination of Benefits  
P.O. Box 33847  
Detroit, MI 48232 - 5847



[www.msprc.info](http://www.msprc.info)

Medicare Secondary Payer  
Recovery Contractor

The MSPRC is committed to serving the Medicare community by improving your knowledge of our recovery process.

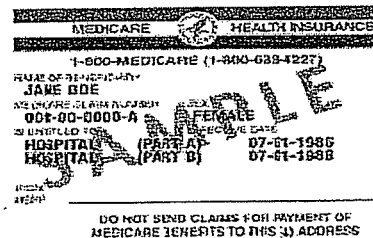
- Liability Insurance
- No-Fault Insurance
- Workers' Compensation

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



## Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?																			<input type="checkbox"/> Yes	<input type="checkbox"/> No						
<i>If yes, please complete the following. If no, proceed to Section II.</i>																										
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)																										
Medicare Claim Number:																		Date of Birth (Mo/Day/Year)				-		-		
Social Security Number: <i>(If Medicare Claim Number is Unavailable)</i>														-			-					Sex	<input type="checkbox"/> Female		<input type="checkbox"/> Male	

## Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print)

Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form

Date \_\_\_\_\_

*If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.*

Section III

\_\_\_\_\_  
Claimant Name (Please Print)

\_\_\_\_\_  
Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Completing This Form

\_\_\_\_\_  
Date

**SAMPLE INTERROGATORIES**  
**[TO BE SERVED AT THE BEGINNING OF THE CASE AND SUPPLEMENTED**  
**BEFORE SETTLEMENT]**

1. As to each named Plaintiff, please state:

- (a) Full Name:
- (b) Date of Birth:
- (c) Social Security Number:
- (d) Medicare Health Insurance Claim No. (if any):
- (e) Date in incident (date of first claimed exposure to asbestos), if applicable:
- (f) Date of last claimed exposure to asbestos, if applicable:

2. As to each named Plaintiff, please state whether you are currently on Medicare, or whether you are currently eligible to receive Medicare Benefits:

Yes \_\_\_\_\_ No \_\_\_\_\_

(a) If yes, please state the date you became, or will become, eligible to receive Medicare Benefits; and

(b) The amount of such payment to date.

3. As to each name Plaintiff, are you receiving Social Security Disability Insurance Benefits?

Yes \_\_\_\_\_ No \_\_\_\_\_

(a) If yes, please state the date you began receiving Social Security Disability Insurance Benefits.

4. As to each named Plaintiff, do you have end-stage renal disease (kidney failure), or Lou Gehrig's disease?

**SAMPLE REQUESTS FOR ADMISSION**  
**[TO BE SERVED AT THE BEGINNING OF THE CASE AND SUPPLEMENTED**  
**BEFORE SETTLEMENT]**

1. As to each named Plaintiff, Plaintiff has not received any conditional payments from Medicare for medical treatments or services..

If your response is anything other than an unqualified admission, state all facts, opinions and evidence upon which you base your failure to admit the request and identify all documents that support or establish such facts, opinions and evidence.

2. As to each named Plaintiff, all conditional payments that Plaintiff has received from Medicare for medical treatments or services have been reimbursed in full by Plaintiff.

If your response is anything other than an unqualified admission, state all facts, opinions and evidence upon which you base your failure to admit the request and identify all documents that support or establish such facts, opinions and evidence.

IN THE \_\_\_\_\_ SUPERIOR/CIRCUIT COURT OF \_\_\_\_\_

	)	CAUSE NO. _____
	)	
Plaintiff(s).	)	
	)	
v.	)	
	)	
	)	
Defendant(s).	)	
	)	

**SUPPLEMENTAL INTERROGATORIES**

These written interrogatories are being served as a result of the provisions of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. As of January 1, 2010, responsible reporting entities are required to determine the Medicare entitlement of injured claimants and report certain information to the Center for Medicare and Medicaid Services. The following interrogatories request that information.

1. Were you a Medicare beneficiary as of the accident date alleged in your complaint?

**ANSWER:**

2. Since the date of the accident, have you applied for Medicare benefits? If so, provide the application date.

**ANSWER:**

3. Since the date of the accident alleged in the complaint, have you received/become eligible for Medicare benefits? If so, please state the date on which you become eligible.

**ANSWER:**

4. If you are receiving/eligible for Medicare benefits, please state the Medicare Health Insurance Claim Number (HICN) from the Medicare Health Insurance Card (MHIC).

**ANSWER:**

5. Are you willing to sign a Social Security Administration Consent for release of information for the limited purpose of providing certain information regarding Medicare eligibility? If so, please execute the attached authorization.

**ANSWER:**

867046.1

**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
J. Chandler Bailey	Lightfoot, Franklin & White, L.L.C. 400 20th Street North Birmingham, AL 35203

I want this information released because:

Compliance with the requirements of the Medicare, Medicaid and SCHIP Extension Act of 2007, § 111.

(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
<input checked="" type="checkbox"/>	Information about benefits/payments I received from [date of alleged injury] _____ to [present] _____
<input checked="" type="checkbox"/>	Information about my Medicare claim/coverage from [date of alleged injury] _____ to [present] _____ (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 or the personal representative of the estate. 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 \_\_\_\_\_



## **Sample Release Language to Consider**

### **When Medicare has not made any past payments:**

Further, the Undersigned represent and warrant that [Plaintiff] has recently become Medicare eligible but has not received any healthcare benefits from any government or government-sponsored agency related to or arising out of the injuries alleged in the Lawsuit (including, but not limited to, any and all alleged injuries and claims released by this General Release and Confidential Settlement Agreement), including any benefit or value from Medicare, Medicaid or similar federal or state administered programs.

The Undersigned acknowledge that the accuracy of the foregoing representation is a material term of this General Release and Confidential Settlement Agreement and an essential prerequisite for [Defendant] to agree to the settlement of the Lawsuit. The Undersigned agree to HOLD HARMLESS the Released Parties from and against all actions, claims, costs, awards or other adverse consequences resulting from or arising out of any inaccuracy or incompleteness of the foregoing representation. This obligation does not provide the Undersigned with the duty or right to defend the Released Parties in such actions, but this obligation includes but is not limited to the reimbursement of all fees and costs, including attorneys' and other professionals' fees, incurred by the Released Parties in connection with any action brought by any party relating to or arising out of the inaccuracy or incomplete representations.

**When Medicare has made past, conditional payments:**

Plaintiff and his/her attorney(s) acknowledge that Plaintiff has received Medicare conditional payments related to the injuries that form the basis of Plaintiff's Complaint. Plaintiff and his/her attorney(s) understand and agree that satisfaction of all outstanding Medicare payments and obligations is a material condition of this settlement. Plaintiff and his/her attorney further acknowledge and agree that settlement payment is contingent upon satisfying outstanding Medicare payments and obligations related to the alleged injuries. **[Plaintiff's counsel's firm]** shall withhold and retain in its client trust account segregated client funds sufficient to settle and satisfy any unsettled Medicare liens and/or claims, as of the date of this Agreement, to which such monies will be applied, the terms of which are outlined below.

(i) The parties to this Agreement including their attorneys, recognize the possibility that Medicare may have made conditional payments for medical treatment and medical services for injuries sustained by **[Plaintiff]** as a result of this Incident. To comply with the Medicare Secondary Payer Statue (42 U.S.C. 1395(y)), Plaintiff has agreed to deposit the entirety of the settlement amount [\$\_\_\_\_\_] into his attorney's client trust account. This deposit will be used to reimburse Medicare for any conditional payments made for which Medicare is entitled to reimbursement pursuant to the Medicare Secondary Payer statute. If the amount deposited is not sufficient to satisfy and discharge all claims asserted by Medicare, Plaintiff will make up any shortfall from the remainder of the settlement.

(ii) Plaintiff further agrees he will provide **[Defendant]** with written proof of the satisfaction of any claim asserted by Medicare pursuant to the Medicare Secondary Payer Statute.

The Releasors and their counsel further hereby agree to indemnify the Releasees, to defend them and to hold them harmless from and against all claims addressed by this Settlement

and Full and Final Release Agreement that may be brought against Releasees as the result of payments made to the Releasors, including but not limited to, those payments for medical care made by any health provider or insurer, including but not limited to Medicare, Medicaid, wages made or paid by any insurer, any other payments by any insurer, or payments made by any lien holders.

**General Cooperation Provisions:**

The Undersigned agree to fully cooperate with [Defendant] and provide all necessary information, including but not limited to Medicare release authorizations, necessary for [Defendant] to confirm [Plaintiffs'] Medicare eligibility status, including whether any healthcare benefits have been provided by any government or government-sponsored agency, including Medicare, related to or arising out of the injuries alleged in the Lawsuit. The Undersigned shall also fully cooperate with [Defendant] and provide all information [Defendant] needs or requests to satisfy its obligation to report information required by Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

Template #2 Liability: Cases with a settlement value of more than \$250,000 and the Claimant is not a Medicare beneficiary, but is reasonably expected to become Medicare entitled within 30 months.

### MEDICARE SET-ASIDE AGREEMENT

This Agreement is intended to be, and is, a part of the settlement of (NAME OF CLAIMANT)'s ("Claimant,") claim for certain injuries against (Name of Respondent) ("Respondent), collectively referred to as the "Parties".

1. Claimant is not a Medicare Beneficiary or eligible to participate in the Medicare programs, but Claimant has applied for social security disability income benefits ("SSDI") and as such is reasonably expected to become Medicare entitled within thirty (30) months of this settlement and the total amount of the settlement exceeds the Centers for Medicare and Medicaid Services' (CMS) workload review threshold of \$250,000. Accordingly, the recommended Medicare Set-Aside allocation (MSA) requires CMS approval.
2. Without any admission of liability, the Parties have agreed to settle this case for the lump sum amount of \$\_\_\_\_\_.
4. The cost of future medical care related to the injury is in dispute. As a compromise, the Parties agree that of the total settlement amount, \$\_\_\_\_\_ (hereinafter referred to as "MSA Fund"), shall be allocated to release all liability for future Medicare covered medical expenses, pursuant to the Life Care Plan and Medicare Set-Aside Summary. In addition, the Parties reach this compromise based upon careful consideration of all of the medical reports and opinions, as well as Claimant's own knowledge of his/her condition and symptoms.
5. It is not the intention of the Parties to shift responsibility of future medical benefits to the Federal Government. The MSA Fund for future Medicare-covered expenses is intended directly for payment of these expenses. Upon receipt of tangible evidence that the Medicare-covered expenses exceed the MSA Fund, those expenses will be forwarded to Medicare for payment of covered expenses with proper documentation, provided the Claimant satisfies all of the Medicare program requirements at that time, including, but not limited to, payment of any enrollment fees, co-pays or deductibles associated with or required by the Medicare elective programs, including, but not limited to, Part B and Part D (Prescription Coverage).
6. The Parties agree that the Medicare Set-Aside Allocation shall be submitted to CMS for review and approval as part of the requirements of this settlement. Any costs and expenses associated with the process of submitting the Medicare Allocation to CMS shall be paid by the Claimant.

7. Respondent, without admitting any liability, hereby agrees to be responsible for the amount approved by CMS for the Medicare Allocation and agrees to pay any difference between the Medicare Allocation outlined herein and the amount approved by CMS pursuant to the terms for payment outlined above.

8. Approval of this settlement by the appropriate State officials may be sought prior to submission to, or approval of the proposed Medicare Set-Aside Allocation by, CMS. Claimant understands that s/he shall not receive the Medicare Allocation until CMS has approved the Medicare Allocation amount. Claimant is responsible for and shall hold Respondent harmless for payment of all medical expenses, Medicare covered or otherwise, following this settlement but prior to CMS approval. Claimant accepts responsibility for obtaining CMS approval of reimbursement for those medical expenses from the Medicare Allocation after receipt of the Medicare Allocation funds.

9. Claimant understands and agrees that s/he is administering the Medicare Allocation as a self-administered plan and that the Medicare Allocation shall be paid pursuant to the terms dictated by CMS and as follows:

- A. Claimant shall open an interest bearing bank account for the Medicare Allocation and shall disburse only payments for Medicare covered expenses which are injury related from said account.
- B. Claimant shall not pay non-Medicare covered expenses from this account, even if those expenses become Medicare covered after entering this agreement.
- C. Claimant shall not pay any Medicare covered expenses from this account which are unrelated to the claimed injury.
- D. If payments from this account are used to pay for services that are not covered by Medicare, Medicare will not pay injury-related claims until these funds are restored to the set-aside account and then properly exhausted. In this circumstance, Claimant is responsible for restoring such funds to the account.
- E. Claimant acknowledges and understands that upon complete exhaustion of the Medicare Allocation, Medicare may only be responsible for additional injury related Medicare covered expenses if the claimant is a Medicare beneficiary at the time of the complete exhaustion and has paid any enrollment fees, co-pays or deductibles associated with or required by the Medicare elective programs, including, but not limited to, Part B and Part D (Prescription Coverage).
- F. Claimant acknowledges and understands that he/she will be responsible for any and all future medical expenses, including those which would be covered by Medicare if claimant were a Medicare beneficiary, after exhausting the MSA fund, should Medicare not be responsible for, or refuses to pay, any such expenses, regardless of the reason.
- G. Even if Claimant is a Medicare Beneficiary, Claimant understands that Medicare will not pay for any expenses related to the claimed injury until, and unless, the Claimant can provide documentation indicating that the entire MSA account, including any accrued interest, was properly expended on Medicare covered treatments and expenses related to the claimed injury covered by this Settlement Agreement.

- H. Claimant must maintain accurate records of all expenses made from the Medicare Allocation and provide a final accounting when all funds have been properly exhausted or disbursed from the Medicare Allocation before Medicare will make any payments for Medicare covered expenses for the related injury.
- I. Claimant must prepare and submit annual reports to the assigned Medicare Lead Contractor to include summaries of any transactions on, and status of, the MSA account.
- J. The annual reporting summaries are to include the date of each service, procedure performed, diagnosis and paid receipt or cancelled check.

10. In reaching this Agreement, the parties have paid considerable attention to Claimant's entitlement to Social Security disability benefits pursuant to 42 U.S.C. §423, and receipt of Medicare or Medicaid benefits under 42 U.S.C. §1395y, as well as the entitlement of the Centers for Medicare and Medicaid Services to subrogation and intervention, pursuant to 42 U.S.C. §1395y(b)(2), to recover any overpayment made by Medicare. It is not the purpose of this settlement agreement to shift to Medicare or Medicaid the responsibility for payment of medical expenses for the treatment of injury related conditions. Instead, this settlement agreement is intended to provide Claimant a lump sum which will foreclose Respondent's responsibility for future payments of all injury related medical expenses.

11. In reaching this Agreement, the parties have considered that many common medical expenses are not payable or reimbursable under the Federal Medicare Program. These medical expenses, not covered by Medicare but necessary in the ongoing treatment of the Claimant's injury, and without an admission of liability on the part of the Respondent, have been taken into consideration in the settlement of Claimant's future medical expenses. Funds for these non-Medicare covered medical expenses are included in the lump sum settlement amount and shall not be paid from the Medicare Allocation.

12. Claimant acknowledges that any decision regarding entitlement to Social Security Medicare or Medicare/Medicaid benefits including the amount and duration of payments and offset reimbursement for prior payments is exclusively within the jurisdiction of the Social Security Administration, the United States Government, and the United States Federal courts and is determined by Federal Law and Regulations. As such, the United States Government is not bound by any of the terms of this Settlement Agreement.

13. Claimant has been apprised of his/her right to seek assistance from legal counsel of his/her choosing or directly from the Social Security Administration or other governmental agencies regarding the impact this Settlement Agreement may have on Claimant's current or future entitlement to Social Security or other governmental benefits.

14. Claimant understands that the receipt of these settlement funds may affect Claimant's rights to other governmental benefits, insurance benefits, disability benefits, or pension benefits. Despite this possibility, Claimant desires to enter into this Agreement to settle his/her injury claim as set forth in this settlement document.

15. Claimant further agrees to hold harmless and indemnify Respondent from any cause of action, including, but not limited to, an action to recover or recoup Medicare benefits or loss of Medicare benefits, if CMS determines that the money set aside was spent inappropriately or for any recovery sought by Medicare, including past, present, and future conditional payments.

16. Claimant shall be responsible for and hold Respondent harmless from any claim for conditional payments made by Medicare, including past, present and future. Should Medicare make a claim for conditional payments, Claimant shall not use any of the Medicare Allocation funds to pay for said conditional payments.

17. In the event of the death of Claimant prior to receipt of the Medicare Allocation funds, said funds shall revert to the estate.

18. Claimant has read and understands all terms of this agreement and enters this agreement voluntarily and without duress of any type from any party.

SO AGREED AND EXECUTED this \_\_\_\_ day of \_\_\_\_, 200\_\_.

\_\_\_\_\_  
(Claimant's Name) Claimant

\_\_\_\_\_  
(Claimant's Attorney), Esquire  
Attorney for Claimant

\_\_\_\_\_  
(Respondent's Attorney), Esquire  
Attorney for Respondent



**MEDICARE MANDATORY INSURER REPORTING  
SETTLEMENT AND FILE CLOSING CHECKLIST**

1. Is any plaintiff a Medicare beneficiary?
2. If not a beneficiary is any plaintiff Medicare eligible?
3. If yes to Question 1 or 2, is the following information for each plaintiff contained in the file:
  - a) Full name;
  - b) Date of Birth;
  - c) Social Security Number; and
  - d) Medicare Health Insurance Claim No. (if any).
4. Has CMS beneficiary status query been performed and are the results contained in the file?
5. For settlements involving Medicare eligible plaintiff(s), is there a copy of the revised settlement and release agreement that requires Plaintiff's counsel to hold settlement funds in trust and indemnify [Defendant]?
6. Does the file contain a copy of the post-settlement recovery demand letter from CMS?
7. Have we received proof of satisfaction of Medicare's claim from Plaintiff's counsel? In the alternative, have we received written confirmation (either in the settlement agreement or in a separate representation from plaintiff's counsel) that no known Medicare lien or claim exists.

**J. CHANDLER BAILEY**

Partner

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400 20th Street North  
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205-581-0700 (phone)  
205-581-0799 (facsimile)**PRACTICE AREAS**

Product Liability

Employment Law

Consumer Fraud and  
Bad Faith

Business Litigation

Chandler joined Lightfoot in 1999, after graduating with honors from Washington and Lee Law School. Chandler's practice is varied, though a great deal of his time is spent defending products liability actions. Although the national trend has been toward fewer trials of complex, high exposure cases, Chandler has tried numerous cases to jury verdict, including contract disputes, wrongful death and catastrophic injury cases. Additionally, he has tried numerous bench trials and arbitrations on a variety of issues. Chandler has also handled employment cases, warranty disputes, and general business litigation.

**EDUCATION**J.D., Washington & Lee  
University School of  
Law, 1999, cum laude.B.S., University of  
Florida, 1996, cum  
laude.

Over the years, Chandler has represented companies from a variety of industries -- from automotive to aerial lifts; agricultural equipment to heavy trucks; construction equipment to power tools. He represents several clients on a regional and national basis, and he has handled matters throughout the Southeast and beyond.

**ADMITTED**

Alabama, 1999

While in law school, Chandler was a member of the Washington & Lee Law Review. Since graduating, Chandler has been admitted to all state courts in Alabama as well as the United States court of Appeals for the Eleventh Circuit and all United States District Courts in Alabama. He also is a member of the Birmingham Bar Association, the Alabama State Bar Associate, the American Bar Association, the Alabama Defense Lawyers Association and the Defense Research Institute. He recently completed a three year run as co-chairman of the Alabama Defense Lawyers Association's Trial Academy, a program designed to teach younger attorneys valuable trial skills.

Outside of his law practice, Chandler is a proud husband and father, and he is a member of St. Mary's-on-the-Highland's Episcopal Church.

