

# Compliance with Medicare Laws: What Every Litigator Should Know

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## I. Medicare Laws and the Litigator

Like it or not, Medicare laws applicable in the context of personal-injury litigation are here to stay. Compliance is mandatory; noncompliance costly. Litigators who handle personal-injury cases or workers' compensation claims, among others, must face the reality that a basic understanding of these laws is no longer enough to protect ourselves and our client. We must also advise and assist our client to ensure compliance with these laws that are constantly changing or evolving. Indeed, keeping up with and understanding the changes are arguably a full-time job. We can't seem to get enough information on the subject which remains a hot topic of discussion in law seminars, CLEs, and a variety of periodicals—and rightly so.

The purpose of this article is to provide a “refresher” or overview on Medicare laws, including a highlight of recent changes that should be of interest to the personal-injury litigator. Further information and a

means to “keeping up” with the constant changes in these laws may be found on the website of the Centers for Medicare and Medicaid Services, or “CMS” (<http://www.cms.hhs.gov/default.asp>), or the website of the Medicare Secondary Payer Recovery Contractor, or “MSPRC” (<http://www.msprc.info/>).

## II. An Overview of Medicare Laws (or What Every Litigator Should Know)

We all know that Medicare is a costly, tax-subsidized health insurance program administered and managed by the federal agency known as the CMS for the benefit of “the aged and the disabled.”<sup>1</sup> Specifically, the costs of this program cover healthcare for: (1) Persons who are 65 years of age or older and are entitled to receive either Social Security, Railroad Retirement, or widow's benefits; (2) Qualified disabled persons of any age who receive Social Security, widows or Railroad disability benefits for 25 months; (3) Persons with end-stage

renal disease, or permanent kidney failure, who require dialysis treatment or a kidney transplant; or (4) Persons over age 65 who are not eligible for either Social Security or Railroad Retirement Benefits who purchase Medicare coverage by payment of a monthly premium.<sup>2</sup> The number of persons who qualify for Medicare benefits has grown exponentially since its enactment. Indeed, the program covered 19.1 million people on its effective date of July 1, 1966.<sup>3</sup> By 2004, the number of persons enrolled in the program rose to 42.3 million.<sup>4</sup> And the number of beneficiaries is expected to climb to 77 million by 2030.<sup>5</sup> These extraordinary numbers reflect the high likelihood that a plaintiff in a personal-injury or workers' compensation case may be a Medicare recipient or at least eligible for its benefits. As a consequence of these numbers, some experts predict that the program's annual cost will rise to a staggering \$600 billion within the next several years.<sup>6</sup>

The costs of the Medicare program led to enactment of a series of amendments to the Social Security Act<sup>7</sup> which provided that healthcare coverage would be secondary<sup>8</sup> to any coverage under a primary healthcare plan or policy.<sup>9</sup> A “primary” plan or policy is defined as “a workmens' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no fault insurance . . . .”<sup>10</sup>

The early amendments to the Social Security Act became the “template” upon which current Medicare laws evolved<sup>11</sup> in response to “skyrocketing Medicare costs” and the desperate need to preserve the

<sup>1</sup> See *Stalley v. Catholic Health Initiatives*, 2006 WL 3091324, at \*1 (E.D.Ark Oct. 20, 2006), quoted in *Stalley v. Sumner Regional Health Systems, Inc.*, 2007 WL 173686, at \*3 (M.D. Tenn. Jan. 18, 2007).

<sup>2</sup> See *Medicare & You 2008 Handbook*, Dep't of Health & Human Servs., at 5 (2008). The “working aged” are those Medicare beneficiaries who are also active employees working for an employer of 20 or more employees. See 42 C.F.R. §§ 405.340-341; *Cooper v. Blue Cross and Blue Shield*, 19 F.3d 562 (11<sup>th</sup> Cir.1994).

<sup>3</sup> Social Security Online, “History of Social Security During the Johnson Administration 1963-1968,” at <http://www.ssa.gov/history/ssa/lbjmedicare3.html>.

<sup>4</sup> See Center for Medicare Advocacy, Inc., website at [http://www.medicareadvocacy.org/FAQ\\_QuickStats.htm](http://www.medicareadvocacy.org/FAQ_QuickStats.htm) (citing Mathematica Policy Research analysis – Medicare Health Plan tracker).

<sup>5</sup> Kaiser, Medicare Chart Book, at 3 (2001).

<sup>6</sup> See, e.g., H. Gleckman, “This Medicare Reform Is No Cure,” *Businessweek* (July 14, 2003) ([http://www.businessweek.com/magazine/content/03\\_28/b3841055.htm](http://www.businessweek.com/magazine/content/03_28/b3841055.htm)).

<sup>7</sup> See Social Security Amendments of 1965, Pub.L. No. 89-97, § 1862(b), 79 Stat. 286.

<sup>8</sup> See *Fanning v. United States*, 346 F.3d 386, 388 (3<sup>rd</sup> Cir. 2003) (citing Social Security Amendments of 1965, Pub.L. No. 89-97, § 1862(b), 79 Stat. 286); accord *Zinman v. Shalala*, 67 F.3d 841, 843 (9<sup>th</sup> Cir.1995); *Stalley*, 2007 WL 173686, at \*3 (“From 1965 until 1980, Medicare was the primary payer of health care costs for Medicare-eligible individuals.”) (citing *Mason v. American Tobacco Co.*, 212 F.Supp.2d 88, 91 (E.D.N.Y. 2002)).

<sup>9</sup> See *United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1<sup>st</sup> Cir. 1996) (citing H.R. Rep. No. 96-1167, at 389 (1980), reprinted in 1980 U.S.C.C.A.N. 5526, 5752; see also S. Rep. No. 404 § 1862, 89<sup>th</sup> Cong., 1<sup>st</sup> Sess. (1965), reprinted in 1965 U.S.C.C.A.N. 1965, 2127-28 (“no payment may be made ... for any item or service for which payment has been made, or can reasonably be expected to be made, under a workman's compensation law or plan of the United States or a State. Any payment ... with respect to any [such] item or service must be conditioned on reimbursement being made to the appropriate trust fund for such payment if any when notice or other information is received that payment for such item or service has been made under such a law or plan.”); *Glover v. Liggett Group, Inc.*, 459 F.3d 1304, 1306-07 (11<sup>th</sup> Cir. 2006); *Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 388 (Ind.Ct.App 2001) (providing a good discussion on MSPS history and development).

<sup>10</sup> 42 U.S.C. § 1395y(b)(2)(A)(ii).

<sup>11</sup> *U.S. v. Baxter Int'l, Inc.*, 345 F.3d 866, 875 (11<sup>th</sup> Cir. 2003).

fiscal integrity of the Medicare system.<sup>12</sup> Beginning in 1980, for example, Congress enacted various cost-cutting amendments to the program which are now collectively referred to as the Medicare Secondary Payer laws, or MSP.<sup>13</sup>

The bottom line of these amendments, which have been codified at 42 U.S.C. §1395y(b), is that Medicare serves as the secondary payer when a beneficiary (e.g., personal-injury plaintiff or workers' compensation claimant) has a primary insurance policy or healthcare plan that can cover the costs of medical treatment and expense.<sup>14</sup> Thus, MSP laws place primary responsibility for payment of a beneficiary's medical treatment and related expenses (e.g., Medicare covers costs related to physician evaluations, hospitalization, therapy, diagnostics, durable medical equipment, prosthetics, assistive devices, implant hardware including battery replacement, supplies, medical procedures, and pharmacotherapy—but not home health or group home care, nursing home, attended

care, housing, or the so-called “donut hole” in pharmaceutical drugs),<sup>15</sup> and requires exhaustion of, coverage available under any private insurance plan or policy before Medicare coverage is triggered.<sup>16</sup> In other words, when triggered, Medicare acts as the secondary payer responsible only for those eligible amounts not covered by the primary payer.<sup>17</sup> Few if any will argue that that the statute is anything but structurally complex—so complex that it has generated considerable confusion and inconsistency among the courts which have attempted to interpret and apply its provisions.<sup>18</sup> Nonetheless, the purpose and function of MSP laws are simple, straightforward, and rational:

[I]f payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay. In order to accommodate its beneficiaries, however, Medicare does make conditional payments for covered services, even when another source may

be obligated to pay, if that other source is not expected to pay promptly.<sup>19</sup>

“Congress established two principal directives to achieve this objective”:<sup>20</sup> (1) by prohibiting Medicare coverage where “payment has already been made or can reasonably be expected to be made” by a private healthcare plan or insurance policy,<sup>21</sup> and (2) by providing that, when Medicare does cover or pay for medical services which should have been covered or paid for by a primary payer, the payment shall be deemed “conditional” and Medicare shall be “entitled” to reimbursement.<sup>22</sup>

In the absence of a voluntary reimbursement, the government may institute an action against “any entity [e.g., insurer] which is required or responsible ... to make payment ... under a primary plan” and against “any other entity (including a physician or provider) that has received payment from that entity.”<sup>23</sup> MSP laws also

<sup>12</sup> *Zinman v. Shalala*, 67 F.3d 841, 845 (9<sup>th</sup> Cir.1995) (“The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs.”); *Blue Cross & Blue Shield of Texas v. Shalada*, 995 F.2d 70, 73 (5<sup>th</sup> Cir. 1993).

<sup>13</sup> See *New York Life Ins. Co. v. United States*, 190 F.3d 1372, 1374 (Fed.Cir.1999); *Blue Cross and Blue Shield Ass’n v. Sullivan*, 794 F.Supp. 1166, 1168-70 & n. 4 (D.D.C. 1992); *Colonial Penn Ins. v. Heckler*, 721 F.2d 431, 440 & n. 4 (3<sup>rd</sup> Cir. 1983) (referencing legislative history); H.R. Rep. No 96-1167, at 352 (1980).

<sup>14</sup> See *Zinman*, 67 F.3d at 843.

<sup>15</sup> See, e.g., <http://www.healthcare.gov/blog/2010/09/donuthole-50percentdiscount.html> (a website managed by the U.S. Department of Health & Human Services).

<sup>16</sup> See 42 U.S.C. §1395y(b)(2); see also *Provident Life & Accident Ins. Co. v. United States*, 740 F.Supp. 492, 498 (E.D.Tenn.1990) (“The intent of Congress in shifting the burden of primary coverage from Medicare to private insurance carriers was to place the burden where it could best be absorbed.”); *Rhode Island Insurers’ Insolvency Fund*, 80 F.3d at 618; *In re Silicone Gel Breast Implants Products Liability Litigation*, 174 F.Supp. 2d 1242, 1250 (N.D. Ala.2001).

<sup>17</sup> See *Blue Cross & Blue Shield of Texas*, 995 F.2d at 73.

<sup>18</sup> *Compare Baxter Int’l, Inc.*, 345 F.3d at 866 (in reversing district court’s dismissal of government’s motion to intervene for purpose of asserting of asserting MSPS claim relative to breast implant settlement funds, the Circuit Court held that, pursuant to the MSPS, “any payment that Medicare does make is secondary and is subject to reimbursement from sources of primary coverage under the statute” and that it is irrelevant whether those sources can be expected to pay promptly), and *Estate of Urso v. Thompson*, 309 F.Supp.2d 253, 256-59 (D.Conn.2004) (concurring in the *Baxter* reasoning), with *Thompson v. Goetzmann*, 337 F.3d 489, 492 (5<sup>th</sup> Cir. 2003) (concluding that “reasonable expectation” of prompt payment by primary payer is a requirement of MSPS “plain language” for reimbursement—while admitting that this is an “absurd result”), and *In re Orthopedic Bone Screw Prod. Liab. Litigation.*, 202 F.R.D. 154, 167-69 (E.D.Pa.2001) (holding that the “plain language” of the MSPS restricts the government’s right to seek reimbursement “to situations in which prompt payment has been made or can reasonably be expected by a ‘primary plan’”).

Such inconsistencies in judicial interpretation of the MSPS was addressed on December 8, 2003, when the President George Bush signed into law amendments which deleted the language at issue. *Compare* 42 U.S.C. §1395y(b)(2)(A)(ii), (B) (i) (2000) (old version), with 42 U.S.C. §1395y(b)(2)(A)(ii), (B) (i)-(ii) (2004) (current version). For further information on this subject, see Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, §301, 117 Stat.2066, 2221 (2003) (hereinafter “MMA”). The amendments to MSP enacted in MMA removed the two elements that had resulted in these conflicting interpretations, i.e., the word “promptly” in subparagraph (A)(ii) and the cross-reference to subparagraph (A) in subparagraph (B)(i).

<sup>19</sup> *Cochran v. HCFA*, 291 F.3d 775, 777 (11<sup>th</sup> Cir. 2002). In view of the amendments signed into law by President Bush (see *supra* n.18), courts may now conclude without equivocation that “[a] primary plan, and an entity that receives payment from a primary plan, shall reimburse” Medicare for any payment made by Medicare “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.” *Brown v. Thompson*, 374 F.3d 253, 258 (4<sup>th</sup> Cir. 2004) (citing §1395y(b)(2)(B)(ii)). “It further states that “[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.” *Id.* (citing §1395y(b)(2)(B)(ii)).

<sup>20</sup> *Fanning v. U.S.*, 346 F.3d 386, 389 (3<sup>rd</sup> Cir. 2003) (citing 42 U.S.C. §1395y(b)(2)(A)).

<sup>21</sup> “This provision ‘is intended to keep the government from paying a medical bill where it is clear an insurance company will and can pay instead.’” *Id.* (quoting *Evanston Hosp. v. Hauck*, 1 F.3d 540, 544 (7<sup>th</sup> Cir.1993) (citation omitted)); see also 42 U.S.C. §1395y(b)(2)(A) and 42 C.F.R. §§411.21 & 411.50.

<sup>22</sup> *Fanning*, 346 F.3d at 389; see 42 U.S.C. §1395y(b)(2)(B); *Zinman*, 67 F.3d at 845 (“The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs.”); *Blue Cross & Blue Shield of Texas*, 995 F.2d at 73.

<sup>23</sup> *Fanning*, 346 F.3d at 389 n.4 (citing 42 U.S.C. §1395y(b)(2)(B)(ii)). The Eleventh Circuit in *Baxter* explained that:

The Deficit Reduction Act (“DERFA”) of 1984 conferred on the Government a direct right of action to recover its payments from any entity “which would be responsible for payment” under a “law, policy, plan or insurance,” and provided that the Government would be subrogated to the right of any individual or entity to receive payment. DERFA also modified the original wording of the secondary payment provision by adding the modifier “promptly,” so that the pivotal phrase dictated that a Medicare payment “may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made promptly ... with respect to such item or service, under a workmans’ compensation plan or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or no-fault insurance[.]”

345 F.3d at 877-78 (quoting H. Res. 4170, 98<sup>th</sup> Cong., 2d Sess., 98 Stat. 494 (1984) §2344).

give the government a separate right of subrogation.<sup>24</sup>

MSP laws further provide for a private right of action, with double damages available, if a primary plan “fails to provide for primary payment (or appropriate reimbursement) in accordance with” the MSP laws.<sup>25</sup>

Since its enactment, the scope or “reach” of MSP laws has been “expanded” on several occasions—“making Medicare secondary to a wider array of primary coverage sources and creating a larger spectrum of beneficiaries who no longer may look to Medicare as their primary source of coverage.”<sup>26</sup> Of significance, the Eleventh Circuit Court of Appeals opined that the government’s right to enforce coverage by primary payers and to seek reimbursement from primary sources for conditional payments made by Medicare has been clarified, enlarged, and reinforced.<sup>27</sup>

The bottom line of MSP laws that every litigator should know and understand is

that they (MSP laws) were created: (1) to prohibit Medicare coverage where payment has already been made or can reasonably be expected to be made by a private healthcare plan or insurance policy, and (2) to provide that, when Medicare does cover or pay for medical care and treatment which should have been covered or paid for by a designated primary payer, the payment shall be deemed conditional and Medicare shall be entitled to reimbursement. Despite the fact that laws requiring reimbursement have been around for well over a quarter-century, they have been largely ignored by primary payers (now referred to as “RREs” or “Responsible Reporting Entities”) such as insurers and businesses with a deductible or self-insured retention, attorneys, and others while being selectively enforced by the governmental entity charged with its enforcement (the CMS).

In response to this apathy and neglect as well as the rising costs of health care and the Medicare program, President George

W. Bush signed into law the “Medicare, Medicaid, and SCHIP Extension Act of 2007” (“MMSEA”),<sup>28</sup> which mandates that RREs register with the CMS Coordination of Benefits Contractor (“COBC”) and electronically file specified information (as outlined below), also referred to as the “Claim Input File,”<sup>29</sup> on all claims that involve or may involve Medicare or Medicare-eligible recipients.<sup>30</sup> The information must be reported “after the claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability).”<sup>31</sup> Failure to comply with Medicare laws could lead to imposition under the MMSEA of severe, financially debilitating penalties.<sup>32</sup>

In an effort to protect themselves from imposition of such penalties, attorneys may be called upon by their clients who are designated as RREs to assist in the collection of the following information which must be filed with CMS:

<sup>24</sup> 42 U.S.C. §1395y(b)(2)(iii); *accord Baxter*, 345 F.3d at 875 (“Consequently, Medicare is empowered to recoup from the rightful primary payer (or from the recipient of such payment) if Medicare pays for a service that was, or should have been, covered by the primary insurer.”).

<sup>25</sup> [1] See 42 U.S.C. §1395y(b)(3)(A). This provision of MSP laws states in full: “[t]here is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).” *Bio-Medical Applications of Tennessee, Inc. v. Central States*, 656 F.3d 277, 284 (6th Cir. 2011) (quoting 42 U.S.C. §1395y(b)(3)(A)). In view of this available private right of action, a settlement release agreement should contain a provision which holds that the plaintiff or claimant, as releasor, agrees to waive or refrain from any attempt to enforce or assign a private right of action, if available, against the releasees. See also *Baxter*, 345 F.3d at 878 (“It also added the cross-reference to that section in §1395(b)(2)(B)(ii), which enables the Government to collect double damages ‘in accordance with’ the new private right of action.”) (quoting H. Res. 5300, 99th Cong., 2d Sess., 100 Stat. 1874 (1986) §9319).

<sup>26</sup> *Baxter*, 345 F.3d at 877; see, e.g., Omnibus Budget Reconciliation Act of 1981, H. Res. 3982, 97th Cong., 1st Sess., 95 Stat. 357 (1981) §2146 (providing that Medicare shall be deemed secondary to group health coverage for end-stage renal patients); Tax Equity and Fiscal Responsibility Act of 1982, H. Res. 4961, 97th Cong., 2d Sess., 96 Stat. 324 (1982) §116 (providing that Medicare shall be deemed secondary payer for “working” employees and their spouses between the 65 and 69 years of age and “belonging to large employer group health plans covering twenty or more workers”); Omnibus Budget Reconciliation Act of 1986, H. Res. 5300, 99th Cong., 2d Sess., 100 Stat. 1874 (1986) §9319 (providing that Medicare shall be deemed secondary payer for disabled individuals enrolled in large employer group health plans).

<sup>27</sup> *Baxter*, 345 F.3d at 877.

<sup>28</sup> The purpose of this legislation, specifically Section 111, was expressed by its sponsor Chuck Grassley (R – IA):

[To] continue to improve accountability in the Medicare Program. There are situations when Medicare is not the primary payer for a beneficiary’s health care, but it is currently difficult to identify these situations. This legislation will improve the Secretary’s ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary.

See Congressional Record, U.S. Senate, December 18, 2007, S15835, para. 9.

<sup>29</sup> “The “Claim Input File” is the data transmitted from a MMSEA Section 111 RRE to the COBC that is used to report liability insurance (including self-insurance), no-fault insurance, and workers’ compensation claim information **where the injured party is a Medicare beneficiary** and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals. See MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation User Guide Version 3.2, at §11 (Aug. 17, 2011).

<sup>30</sup> The evolution of the MMSEA of 2007 is an interesting one. In December 18, 2007, the bill passed in the Senate by unanimous consent. Curiously, a record of each senator’s position was not kept. One day later, on December 19, 2007, the bill passed the House of Representatives by a roll-call vote that was held under a suspension of the rules to cut debate short and pass the bill, needing a two-thirds majority. This usually occurs for non-controversial legislation. The vote totals were 411 Ayes, 3 Nays, 18 Present/Not Voting. See <http://www.govtrack.us/congress/bills/110-2499>.

<sup>31</sup> Claim information is reported after ORM has been assumed by the RRE or after a TPOC settlement, judgment, award or other payment has occurred. Claim information is to be submitted for no-fault insurance and workers’ compensation claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment that meet the reporting thresholds described in Section 11.4 of the MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation User Guide (version 3.2). Claim information is to be submitted for liability insurance (including self-insurance) claims that are addressed/resolved (or partially addressed/resolved) through a TPOC settlement, judgment, award or other payment that meet the reporting thresholds described in Section 11.4. A TPOC single payment obligation is reported in total regardless of whether it is funded through a single payment, an annuity or a structured settlement. RREs must also report claim information where ongoing responsibility for medical services (ORM) related to a no-fault, workers’ compensation or liability claim was assumed by the RRE. For further information, see MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation User Guide Version 3.2, at §5 (“MSP Overview”), §11.10.2 (“What Claims Are Reportable/When Are Such Claims Reportable?”), & Appendix H (“Definitions and Reporting Responsibilities”).

<sup>32</sup> “The penalty for noncompliance has teeth indeed—\$1,000 per day, per beneficiary, for each day an insurer is out of compliance.” M. Garretson & S. von Saucker, *Medicare Insurer Reporting*, at 28 (Sept. 2010) (published in Defense Research Institute’s “For the Defense” publication). In addition to the \$1,000-per-day penalty, the “often feared” penalty of “double damages plus interest” may also be imposed on RREs “if Medicare’s reimbursement claim is ignored in a settlement.” *Id.* (citing 42 U.S.C. §1395y(b)(2), and 42 C.F.R. §411.24).



## **Reporting Information Requirements**

### **Injured Medicare beneficiary:**

First name  
Middle initial  
Last name  
Social security number (SSN)  
Medicare health insurance claim number (HICN)  
(SSN or HICN required but not both)  
Gender  
Date of birth

### **Client/RRE:**

Medicare reporter identification number\*  
Taxpayer identification number ("TIN")  
Office code/site identification number  
Street address  
City  
State  
Zip

### **Litigation:**

(required if injured party is represented)

Attorney/representative  
Name  
Name & TIN  
Address  
City  
State  
Zip  
Telephone number

### **Ongoing responsibility for medical payments ("ORM"):**

ORM "flag"  
Initial date of payment obligation/revised date if funding is delayed  
Amount of payment obligation  
Termination date of ORM

### **Injury/Incident/Illness:**

Date of incident  
Venue  
External cause of injury  
Medical diagnosis code(s)

*Note: New fields for mass torts and other special claim situations will be applied in upcoming CMS alerts or releases.*

### **Insurer:**

Insurance type  
Policy number  
Claim number  
Plan contract name  
Plan contract telephone number  
No-fault insurance policy limit  
Exhaust date for no-fault insurance

### **Additional claimant information:\***

Claimant/claimant representative:  
Relationship (claimant only)  
TIN (claimant only)  
First name  
Last name  
Middle initial  
Firm name (claimant representative only)  
Address  
City  
State  
Zip Code  
Telephone number

*(\*This information is required in cases of wrongful death or death of an injury party while litigation is in progress. Information on as many as additional claimants and their representatives may be provided. Information required for each additional claimant and claimant representative is required if the claimant is a representative/attorney.)*

The MMSEA was crafted with the goal of ensuring compliance with MSP laws. "Teeth," in the form of severe penalties, were built into the MMSEA to assist the CMS with its responsibility to enforce MSP laws.<sup>33</sup> And the CMS apparently means business and intends to fulfill its responsibility as reflected in its statements, or warnings, that it expects to collect billions of dollars in penalties and reimbursements over the next few years.<sup>34</sup>

## **III. Recent "Alerts" and "Memorandum" Advising of Changes in Medicare Laws**

CMS regularly issues so-called "alerts" or "memorandum" on its website (<http://www.cms.hhs.gov/default.asp>) which advise of changes or clarifications of existing policies which are created for the implementation of the mandates of Medicare laws. One important recent alert involves new "trigger" dates for reporting under the MMSEA's Mandatory Insurer Reporting ("MIR").

### **A. New Timeline for Reporting Under the MMSEA**

Specifically, CMS provided a revised timeline of dates based on the total amount of a settlement, judgment, or other payment—also referred to as the total payment obligation to claimant ("TPOC"):<sup>35</sup>

- For TPOCs between \$5,000 and \$25,000 – the trigger date is Oct. 1, **2012** (with MIR starting the First Quarter, **2013**)
- For TPOCs between \$25,001 and \$50,000 – the trigger date is July 1, **2012** (with MIR starting the Fourth Quarter, **2012**)
- For TPOCs between \$50,001 and \$100,000 – the trigger date is April 1, **2012** (with MIR starting the Third Quarter, **2012**)
- For TPOCs of \$100,001 and above – the trigger date remains the same – Oct 1, **2011** (with MIR starting the First Quarter, **2012**)

For example, severe penalties could be imposed if the RRE settles a claim having a TPOC in excess of \$100,000 on or after October 1, 2011, but fails to comply with Section 111's MIR during the reporting period in the first quarter of 2012. (Note that the threshold for reporting remains unchanged. Therefore, any TPOC of \$5,000 or less need not be reported and will

<sup>33</sup> See generally Brent M. Timberlake & Monica A. Stahly, *Fool Me Once, Shame on Me; Fool Me Again and You're Gonna Pay for It: An Analysis of Medicare's New Reporting Requirements for Primary Payers and the Stiff Penalties Associated with Noncompliance*, 45 U. Rich. L.Rev. 119 (2010).

<sup>34</sup> "The genesis for this law is that Medicare (as secondary payer) has lost over \$43 billion\* (in an 8 year window) by failing to be reimbursed when they should have been reimbursed by the liable party." See <http://counsel.cua.edu/fedlaw/medicare.cfm> (report by the Office of General Counsel for Catholic University of America).

<sup>35</sup> A copy of this alert may be downloaded via the following link:

<http://www.google.com/url?sa=t&rct=j&q=medicare%20revised%20timeline%20tpoc%20september%202011&source=web&cd=2&ved=0CDUQFjAB&url=https%3A%F%Fwww.cms.gov%2FMandatoryInsRep%2FDownloads%2FRevNGHPTimelineTPOC.pdf&ei=na2uTtbYJaqosQLi7MDpDg&usg=AFQjCNEgkpJe15xNeBNSvUTtHEQp3q1DvA>

be rejected by CMS if reported by an RRE or the RRE's agent.).

### ***B. Fixed Percentage Option Offered by CMS***

Another alert advised that CMS will be implementing a new and simple fixed percentage option that became available to certain beneficiaries in November 2011.<sup>36</sup> This option is available to beneficiaries who receive certain types of liability insurance (including self-insurance) settlements of \$5,000 or less.

A beneficiary who elects this option will be able to resolve Medicare's recovery claim by paying Medicare 25% of his/her total liability insurance settlement instead of using the traditional recovery process. This means that a beneficiary will know what he or she owes and will be able to immediately pay Medicare. In order to elect this option, the following criteria must be met:

1. The liability insurance (including self-insurance) settlement is for a physical trauma based injury. (This means that it does **not** relate to ingestion, exposure, or medical implant), and
2. The total liability settlement, judgment, award, or other payment is \$5,000 or less, and
3. The beneficiary elects the option within the required timeframe and Medicare has not issued a demand letter or other request

for reimbursement related to the incident, and

4. The beneficiary has not received and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident.

When a beneficiary elects this option, he or she will give up the right to appeal the fixed payment amount or request a waiver of recovery for the fixed payment amount.

### ***C. Liability Set-Asides<sup>37</sup> and a Physician's Certification***

In September 2011, CMS published a "memorandum" whose "purpose" was to provide "information regarding proposed Liability Medicare Set-Aside Arrangement ('LMSA')<sup>38</sup> amounts related to liability insurance (including self-insurance) settlements, judgments, awards, or other payments ('settlements')."<sup>39</sup> Specifically,

[w]here the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) "settlement" has been completed as of the date of the "settlement," and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement", satisfied. If the beneficiary receives additional "settlements" related to the

underlying injury or illness, he/she must obtain a separate physician certification for those additional "settlements."

When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that Medicare's interest with respect to future medicals for that "settlement" has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician's certification.

### ***D. Liability Insurance and Exposure, Ingestion and Implantation Issues***

Another recent memorandum, issued in September 2011 which was subsequently revised in October 2011, involves cases of continued exposure to an environmental hazard, or continued ingestion of a particular substance.<sup>40</sup> This memorandum commenced with a policy statement:

The Centers for Medicare & Medicaid Services has consistently applied the Medicare Secondary Payer (MSP) provision for liability insurance (including self-insurance) effective 12/5/1980. As a matter of policy, Medicare does not assert a MSP liability insurance based recovery claim against settlements, judgments, awards, or other payments, where the date of incident (DOI) occurred before 12/5/1980.

<sup>36</sup> See <http://www.msprc.info/>.

<sup>37</sup> Countless websites and "experts" on MSP and MMSEA laws have declared that LMSAs are required under these laws. This is absolutely wrong. CMS has definitively clarified on repeated, during "Town Hall" telephonic conference calls for example, that LMSAs are not required. During once such call, on March 16, 2010, regarding MMSEA MIR implementation, Barbara Wright (then Acting Director of the Medicare Debt Management division at CMS), explained in response to a question on the subject of LMSAs that Section 111 of the MMSEA "does not mandate or specify anything about liability set asides." Interestingly, Sally Stalcup, representative of CMS' Dallas regional office, stated "unofficially" that "although the law does not require a 'set-aside' in any situation," a "[s]et-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary." A copy of Stalcup's "unofficial" paper entitled, "Medicare Set-Aside: The View From CMC," presented to the University of Texas in January 2011, may be downloaded via the following link:

[http://www.google.com/url?sa=t&rct=j&q=sally%20stalcup%20dallas&source=web&cd=5&ved=0CEcQFjAE&url=http%3A%2F%2Fwww.utcle.org%2Flibrary%2Fpreview.php%3Fasset\\_file\\_id%3D28559&ei=3cuuTvK2H\\_KksQKn7emGDw&usg=AFQjCNERMT6krj3IGHHW\\_20\\_3Oq3M5IOjA](http://www.google.com/url?sa=t&rct=j&q=sally%20stalcup%20dallas&source=web&cd=5&ved=0CEcQFjAE&url=http%3A%2F%2Fwww.utcle.org%2Flibrary%2Fpreview.php%3Fasset_file_id%3D28559&ei=3cuuTvK2H_KksQKn7emGDw&usg=AFQjCNERMT6krj3IGHHW_20_3Oq3M5IOjA)

<sup>38</sup> "There is no formal CMS review process in the liability arena as there is for Workers' Compensation." *Id.* (statement of Sally Stalcup, representative of CMS' regional office in Dallas). Bottomline—each of the ten regional offices promulgates its own discretionary policy on whether to review LMSAs and will generally decline a request for a review of an LMSA based on lack of sufficient resources. See <http://www.cms.gov/regionaloffices/> (Mississippi falls within the jurisdiction of CMS' regional office in Atlanta, designated as "Region 4," which may be contacted at Office of Regional Administrator, Atlanta Federal Center, 61 Forsyth Street, SW, Suite 4T20, Atlanta, GA, 30303-8909, telephone (404) 562-7347). Currently, CMS has no plan for a formal process for review and approval of LMSAs.

<sup>39</sup> A copy of this memorandum may be downloaded via the following link:

[http://www.google.com/url?sa=t&rct=j&q=medicare%20benson%20charlotte%20physician%20certification&source=web&cd=1&ved=0CEIQFjAA&url=https%3A%2F%2Fwww.cms.gov%2FCOBGeneralInformation%2FDownloads%2FFutureMedicals.pdf&ei=hq6uTq\\_-Co3hsQLoQ4X\\_Dg&usg=AFQjCNHlXpRhMEMdfvg-LfGH-BnDT8aabw](http://www.google.com/url?sa=t&rct=j&q=medicare%20benson%20charlotte%20physician%20certification&source=web&cd=1&ved=0CEIQFjAA&url=https%3A%2F%2Fwww.cms.gov%2FCOBGeneralInformation%2FDownloads%2FFutureMedicals.pdf&ei=hq6uTq_-Co3hsQLoQ4X_Dg&usg=AFQjCNHlXpRhMEMdfvg-LfGH-BnDT8aabw)

<sup>40</sup> A copy of this revised policy, including "some illustrative examples of how the policy related to December 5, 1980, should be applied to situations involving exposure, ingestion, and implantation," may be downloaded via the following link:

<http://www.google.com/url?sa=t&rct=j&q=medicare%20ingestion%20exposure%20implantation&source=web&cd=1&ved=0CFQqFjAA&url=https%3A%2F%2Fwww.cms.gov%2FCOBGeneralInformation%2FDownloads%2FNGHPExpInglmplant.pdf&ei=Ra-uTrajHoT3sQLJvfz6Dg&usg=AFQjCNF5X-JuF2zhGOel6DOJS89t855zw>

CMS then proceeded to clarify this policy relative to cases involving continued exposure to an environmental hazard, or continued ingestion of a particular substance. In such cases, CMS will focus on the date of last exposure or ingestion for purposes of determining whether the exposure or ingestion occurred on or after 12/5/1980. Similarly, in cases involving ruptured implants that allegedly led to a toxic exposure, the exposure guidance or date of last exposure is used.<sup>41</sup>

For non-ruptured implanted medical devices, CMS will focus on the date the implant was removed. Under the following scenarios situations, CMS will assert a recovery claim against settlements, judgments, awards, or other payments (and RREs must comply with MMSEA's MIR):

- Exposure, ingestion, or the alleged effects of an implant on or after 12/5/1980 is claimed, released, or effectively released.
- A specified length of exposure or ingestion is required in order for the claimant to obtain the settlement, judgment, award, or other payment, and the claimant's date of first exposure plus the specified length of time in the settlement, judgment, award or other payment equals a date on or after 12/5/1980. This also applies to implanted medical devices.
- A requirement of the settlement, judgment, award, or other payment is that the claimant was exposed to, or ingested, a substance on or after 12/5/1980. This rule also applies if the settlement, judgment, award, or other payment depends on an implant that was never removed or was removed on or after 12/5/1980.

Conversely, when all of the following criteria are met, Medicare *will not* assert a recovery claim against a liability insurance (including self-insurance) settlement, judgment, award, or other payment (and MMSEA's MIR will have no application):<sup>42</sup>

All exposure or ingestion ended, or the implant was removed before 12/5/1980; and

- Exposure, ingestion, or an implant on or after 12/5/1980 has not been claimed and/or specifically released; and,
- There is either no release for the exposure, ingestion, or an implant on or after 12/5/1980; or where there is such a release, it is a broad general release (rather than a specific release), which effectively releases exposure or ingestion on or after 12/5/1980. The rule also applies if the broad general release involves an implant.

#### ***E. \$300 Threshold in Cases Involving Liability Insurance***

CMS also recently implemented a \$300 threshold applicable in cases involving liability insurance coverage.<sup>43</sup> If all of the following criteria are met, application of this threshold is triggered and the MSPRC will not seek recovery against the beneficiary's settlement, judgment, award or other payment.

1. As of September 6, 2011, the beneficiary received a lump sum settlement of \$300 or less;
2. The settlement is related to an alleged physical trauma-based incident but not an alleged exposure, ingestion, or implantation; and
3. The beneficiary did not receive any additional settlements related to the same alleged incident.

This threshold specifically excludes settlements where an insurer is paying the beneficiary's medicals bills directly or on an ongoing basis ("ORM"). This threshold will also not apply if a demand letter was already issued on behalf of CMS in the case.

## **IV. Selected Significant Cases Involving Interpretation of MSP Laws<sup>44</sup>**

### ***A. Bradley v. Sebelius, 2010 WL 3769132 (11<sup>th</sup> Cir. Sept. 29, 2010).***

In *Bradley*, the Eleventh Circuit Court of Appeals held, in part, that CMS' reliance on its own MSP directives and manuals was misplaced because these materials are not authoritative like statutes and case law. The court further found that, in the absence of authoritative support, CMS is not entitled to proceeds (from a wrongful-death settlement) allocated by a probate court to a beneficiary's surviving children.

The beneficiary, Charles Burke, died from injuries allegedly sustained while in a nursing home. Medicare paid \$38,875.08 for Burke's medical treatment. Burke's estate then filed a negligence action against the nursing home and settled the dispute for \$52,500. CMS, which was notified of the settlement, demanded reimbursement of the \$38,875.08 payment pursuant to MSP laws.

Burke's estate then filed an application with the state probate court to adjudicate the rights of Burke's children with regard to the settlement (\$52,500). CMS (through the Secretary of the Department of Health and Human Services) was invited to participate in the proceedings in probate court, but CMS declined the invitation. In the end, the probate court awarded CMS only \$787.50.

CMS rejected the probate court's award and took the position that the court's decision was merely advisory in nature and did not preempt MSP laws. CMS appealed the court's decision to the local federal district court which agreed with CMS' position and awarded it \$22,480.89 in reimbursement of benefits paid.

On appeal, the Eleventh Circuit acknowledged that Medicare is a secondary payer under MSP laws and has a right to reimbursement if a primary payer exists. The court, however, found that CMS' position was untenable because CMS failed to cite any statutory authority or case law but instead relied on an interpretation of its own directives and an MSP "field manual." The court opined that CMS erred in failing to participate in the probate proceedings and

<sup>41</sup> The term "exposure" refers to the claimant's actual physical exposure to the alleged environmental toxin, not the defendant's legal exposure to liability.

<sup>42</sup> Where multiple defendants are involved, the claimant must meet all of these criteria for each individual defendant in order for a settlement, judgment, award, or other payment from that defendant to be exempt from a potential MSP recovery claim and MMSEA Section 111 reporting.

<sup>43</sup> See <http://www.msprc.info/>.

<sup>44</sup> Highlights of a court's holdings are underlined for convenience.

in subsequently rejecting the probate court's findings. The court found that a rejection of the probate court's findings could result in a chilling effect on settlements because it would mean that allocations of funds were only authorized following a court order on the merits of the case. The district court concluded the CMS was entitled to only \$787.50.

**B. Haro v. Sebelius**, 789 F.Supp.2d 1179 (D. Ariz. 2011)

On May 9, 2011, the United States District Court (Arizona) enjoined CMS from demanding that personal-injury plaintiffs (who were Medicare beneficiaries) to reimburse CMS pursuant to MSP laws while threatening to commence "collection actions before there is a resolution of an appeal or waiver request." The district court further enjoined the CMS from "demanding that attorneys withhold proceeds from their clients pending payment of disputed MSP reimbursement claims." The court found that the CMS' actions exceeded its authority under MSP laws.

**C. United States v. Stricker**, 2010 WL 6599489 (N.D. Ala. Sept. 30, 2010)

In this case involving a \$300 million toxic tort settlement reached in 2003, the United States District Court (Alabama) applied different statutes of limitations to bar CMS's (United States') lawsuit against plaintiffs, insurers, and attorneys through which CMS was seeking reimbursement of conditional payments made to various plaintiffs. The district court found that MSP laws did not provide a deadline by which CMS had to file a claim for reimbursement or recovery of conditional payments. The court, therefore, relied on the Federal Claims Collection Act in determining the applicable statute of limitations and held that the claim against corporate defendants was based in tort and, as such, a three-year statute of limitations applied. Under a three-year statute of limitations, the court concluded that CMS' claims were barred because the statute began to run on the date of the court's approval of the settlement (in 2003) but CMS did not seek recovery until 2009.

The court then dismissed the claims against the attorneys after determining that those claims were based on contract law because they arose from counsels' fee

agreements. As such, the court applied a six-year statute of limitations which began to run when payment of the settlement was made.

**D. Smith v. Marine Terminals of Ark.**, 2011 WL 3489806 (E.D. Ark. Aug. 9, 2011)

In this personal-injury action, the parties agreed to settle and decided to establish an LMSA (Liability Medicare Set-Aside) to cover future injury-related medical expenses because the plaintiff was Medicare-eligible. The proposed LMSA was submitted to CMS for approval, but CMS refused to review it due to "workload issues." The parties then filed a motion with the United States District Court (Arkansas) for review and approval of the proposed LMSA. The district court approved the proposed LMSA--finding that the parties had sufficiently considered and protected Medicare's interests and that the LMSA amount was fair and reasonable. The court, thus, took the initiative to review and approve a Medicare set-aside in the absence of CMS' refusal to do so.

**E. Big R Towing v. David Wayne Benoit**, 2011 WL 43219 (W.D. La. Jan. 15, 2011).

This is another case in which a federal district court (Louisiana) agreed to review a proposed LMSA because CMS "does not currently have a policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of the future medical aspect of a liability settlement or recovery of future medical expenses incurred in liability cases." In so doing, the court found that: (1) Medicare is a secondary payer under MSP laws and is entitled to protection of its interests; (2) The findings of fact support the conclusion that the plaintiff may become a Medicare beneficiary in the future; and (3) The sum of \$52,500 being proposed as a LMSA set-aside for future injury-related medical expenses fairly protects Medicare's interests.

**F. Tomlinson v. Landers**, 2009 WL 1117399 (M.D. Fla. April 24, 2009)

In this personal-injury case, the defendant was concerned about whether the plaintiff would reimburse Medicare after receiving

settlement funds. The defendant's concern was based on MSP laws that dictate: "If Medicare is not reimbursed as required . . . , the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party." Plaintiffs' attorney's offer to sign an agreement that would hold the defendant harmless for any future Medicare claims liens did not alleviate the defendant's concerns, so the defendant included CMS as a payee on the settlement check. The plaintiff challenged the defendant's decision, and the district court (Florida) court held:

[Defendant's] decision [to] list Medicare as a payee on the settlement check may have been in [defendant's] best interest; however, [defendant] was not required by federal law to include Medicare on the settlement check. The fact the parties were in dispute over this issue supports plaintiffs' argument that there was never a meeting of the minds regarding the manner in which payment was to be tendered to plaintiffs.

See also *Zaleppa v. Seiwel*, 210 Pa. Super. 208 (Nov. 17, 2010) (The court in this case held that CMS cannot be included as a payee on a settlement check unless CMS is a party to the lawsuit.)

**G. United States v. Harris**, 2009 WL 891931 (N.D. W.Va., March 26, 2009)

The United States District Court (West Virginia) held a plaintiff's attorney responsible liable for failure to comply with MSP laws and ordered the attorney to reimburse CMS for conditional payments made on behalf of his client (the beneficiary) in the amount of "\$11,367.78 plus the amount of interest thereon which will be calculated."

**H. Hadden v. United States**, 2011 WL 5828931 (6<sup>th</sup> Cir. Nov. 21, 12011)

In this recent decision, Medicare demanded from a plaintiff (Hadden) \$62,338.07 in reimbursement (plus interest) for benefits paid on his behalf for treatment of injuries sustained as a result of an accident. Hadden paid Medicare under protest which he based on the theory that the amount of the settlement in his personal-injury case represented only 10% of his total damages and that he should



therefore be required to pay Medicare only \$8,000 (or 10% of the benefits paid by Medicare).

Hadden appealed Medicare's decision, but an administrative law judge (ALJ) "took a dim view of this theory, finding that the plain language of the Medicare statute required Hadden to reimburse Medicare the full amount that Medicare had demanded." The ALJ also disagreed with Hadden's opinion that the reimbursement was against "equity and good conscience." The Medicare Appeals Council (MAC) subsequently agreed with the ALJ's findings, so Hadden appealed--once again--to the district court which ultimately concurred in the decisions of the ALJ and the MAC.

The Sixth Circuit affirmed the district court's decision. The Court reasoned, in part, that Hadden did not demand that the Defendant pay him for only 10% of his medical expenses that he incurred as a result of the accident. Rather, he demanded that the Defendant pay for *all* of his expenses. "That choice has consequences--one of which is that Hadden must reimburse Medicare for those same expenses" based on the Court's strict interpretation of federal statutory law. The Court further declined to accept Hadden's argument that Medicare's decision to demand full reimbursement in light of the settlement amount was against "equity and good conscience." The Court explained that "Hadden's basic problem was that he presented little or no evidence

of hardship as a result of the reimbursement, and that he otherwise retained almost \$44,000 of the settlement proceeds after reimbursing Medicare."

## V. Conclusion

Updates on issues pertaining to compliance with Medicare laws are readily found in periodicals such as the MDLA Quarterly and on websites such as those of the CMS<sup>45</sup> and MSPRC.<sup>46</sup> A litigator's knowledge of these updates, not to mention the laws that underlie them, is a critical component of one's effort to ensure protection of Medicare's interests and a client's compliance with applicable laws. ■

<sup>45</sup> CMS' website has an overabundance of information --too much information, in fact, for the casual researcher to easily comprehend. Nonetheless, a link to a useful publication found on CMS' website--known as the "MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide"--may be found via the following web address:

[http://www.cms.gov/MandatoryInsRep/03\\_Liability\\_Self\\_No\\_Fault\\_Insurance\\_and\\_Workers\\_Compensation.asp#TopOfPage](http://www.cms.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage)

Alternatively, the actual publication may be downloaded via the following link:

[http://www.google.com/url?sa=t&rct=j&q=medicare%20user%20guide%20mmsea%20111%20august%2017&source=web&cd=1&ved=0CE0QFjAA&url=https%3A%2F%2Fwww.cms.gov%2FMandatoryInsRep%2FDownloads%2FNGHPUserGuideV3.2.pdf&ei=jbSuTtaULoTosQLb15z\\_Dg&usg=AFQjCNF4rvEc8EVkK6RimwXIFABQyBWpg](http://www.google.com/url?sa=t&rct=j&q=medicare%20user%20guide%20mmsea%20111%20august%2017&source=web&cd=1&ved=0CE0QFjAA&url=https%3A%2F%2Fwww.cms.gov%2FMandatoryInsRep%2FDownloads%2FNGHPUserGuideV3.2.pdf&ei=jbSuTtaULoTosQLb15z_Dg&usg=AFQjCNF4rvEc8EVkK6RimwXIFABQyBWpg)

<sup>46</sup> One of the most useful sections of the MSPRC is referred to an "Attorney's Tool Kit," which provides an easy-to-understand "recovery flowchart" (see [www.msprc.info](http://www.msprc.info) for flowchart of recovery process and other helpful information and documentation.), model language and forms that can be used when communicating with CMS, and plain-English information on such topics as "reporting a case" and "interest calculation."

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