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Expedite a Medicare lien appeal for independent review

Know what information is needed to obtain an independent review of Medicare's reimbursement decisions, and how to shortcut this process

By JACK BOLLIER

We can expect Medicare to reduce its lien to account for its fair share of attorneys' fees and procurement expenses. But, we should only rarely expect Medicare to go beyond this base preliminary reduction, even when the circumstances obviously warrant it, such as when the liability insurance policy limits are inadequate. Fortunately, there is a very simple and predictable mechanism to obtain an independent review of Medicare's preliminary lien determinations by an outside Qualified Independent Contractor ("QIC").

Unlike other government collections arms, Medicare and its contractors are surprisingly timely and transparent in their responses, provided you play by their rules and produce the information and evidence they want. Since we already know what information is needed to obtain an independent review of Medicare's reimbursement decisions, why not, when appropriate, shortcut this process and work up the record at the outset of negotiations, rather than wait for Medicare to request additional information? This article provides a road map on this process, so that you can maximize your client's recovery by accelerating an independent review determination and getting those additional funds to your client faster.

Hurry up and wait

The diligent lawyer, having just mediated their case and knowing the agreed settlement number, may attempt to start negotiating with Medicare, while still waiting on opposing counsel to

provide the "general release" that was a condition of settlement. But be wary of *when* you attempt to begin negotiating Medicare's lien. We know that Medicare requires the amount of the settlement before it will calculate a reduction, but if you communicate the settlement amount, there is a strong chance that Medicare will interpret this to mean that *the case has settled* and the settlement funds are therefore in your client trust account, or very nearly there. As such, in conjunction with its preliminary lien reduction, Medicare will also give you a deadline to make payment, usually 60 days. Interest will begin to accrue on the outstanding balance and the matter referred to the U.S. Treasury Department for collections if payment is not made by that deadline.

So, resist the urge to communicate the settlement until it is finalized. Since our lawyer is still waiting for the "general release" and the settlement funds may not be delivered for many weeks, this additional time should be used to begin preparing the record for independent review of Medicare's reimbursement decision.

On the record

As Medicare will tell you in its correspondence: "A beneficiary's overpayment may be waived if the beneficiary is without fault in causing the overpayment and if recovery would either defeat the purpose of the Social Security Act (including the Medicare Program) or would be *against equity and good conscience*." Medicare will cite to 42 U.S.C., § 1395gg(c) and these regulations: 42 C.F.R. 405.355-356, 405.358; 20 C.F.R. 404.507-509, 404.510a, 404.512.

"Equity and good conscience" are such broad and indefinite concepts that you are free to craft your own theories for reduction. This article suggests that there are two concepts that should be readily considered to satisfy this standard: (1) inadequacy of settlement, and/or (2) plaintiff's significant out-of-pocket expenses.

Settlement amounts are most typically inadequate when the liability insurance policy limits are insufficient to fully compensate the plaintiff for their injuries. We can establish inadequacy just as we would otherwise prove case value, by marshalling evidence of the following, much of which may have already been developed in the underlying case:

- A representative sampling of your client's medical records that highlights the salient injuries and medical procedures. Evidence of invasive, risky, or otherwise painful anticipated future treatment should also be emphasized when available.
- Photographs demonstrating your client's pre-injury quality of life, including time spent with family and friends and time spent traveling or being physically active. Post-injury photographs, including the injuries when available, will emphasize the loss.
- Plaintiff deposition testimony (or declaration) concerning post-injury pain and limitations, which is not otherwise adequately covered in the medical record.
- Jury verdicts or settlement reports substantiating case value in your jurisdiction.

Medicare's coverage is broad, but it is not unlimited. Moreover, Medicare clients may have unique needs compared to younger members of the population. You



JANUARY 2023

have probably had an elderly client whose injury transformed what was once a largely independent lifestyle into one that required some level of assistance. Medicare often does not pay for that assistance. Include evidence of these costs, past and future, plus any other costs to compare your client's out-of-pocket expenses to Medicare's outlay. There is a strong argument for waiver if your client's expenses come anywhere near Medicare's conditional payment total. Include this information on Form SSA-632-BK.

Form SSA-632-BK

Medicare will also require that you complete Social Security form SSA-632-BK, Request for Waiver of Overpayment Recovery (<https://www.ssa.gov/forms/ssa-632-bk.pdf>) is the most current version of the form; request from Medicare that they provide a copy of their preferred version).

At first glance, this form is confusing because it requires you to explain why the government should "waive" its right to make an "overpayment recovery." Keep in mind that from Medicare's perspective as a "Secondary Payor," any of its conditional payments *are* "overpayments" which it has a right to "recover," either from your client or the at-fault third party. You are requesting that it waive that right.

At the outset, you must complete this form to reflect that the overpayment occurred on behalf of your client, that the overpayment was not your client's fault, and that equity and good conscience require a waiver. Since the form is obviously not primarily intended for Medicare lien negotiations, complete the form as best you can and provide information that gives context to your overall objective: obtaining a waiver of a Medicare lien which you may have already satisfied out of the settlement funds.

The form is primarily intended to convey financial information to Medicare and is similar to an asset declaration that a plaintiff's attorney might require as a condition of settlement. Proper completion of the form provides a comprehensive overview of your client's assets, income, and recurring expenses. Consider consulting

with your client's CPA if available. Your client or a person with durable power of attorney must sign the form.

All of the above evidence and documentation should come under a cover letter that weaves a persuasive narrative of why equity and good conscience mandates a waiver in your client's case.

Do the Medicare dance

This article assumes that you have already opened a claim with Medicare, have been provided itemized listings of Medicare's conditional payments, and there is no dispute as to those payments (i.e., all payments relate to charges for treatment for the injuries at issue).

Notice of settlement

The first step is to notify Medicare of the settlement. Use their form (<https://www.medicareappeal.com/>) to set forth the settlement amount, attorneys' fees and procurement expenses, and other miscellaneous information; include an itemized accounting of litigation expenses. Medicare will respond with its demand for payment after making its preliminary reductions for attorneys' fees and costs.

You will have 60 days to remit payment to Medicare. Medicare states that it will cease collection action while pursuing a waiver, but the more risk-averse could still choose to pay Medicare while also pursuing a waiver. If the waiver is successful, Medicare will refund the balance that is not in dispute. You could also hold Medicare's portion in trust within the 60-day window while pursuing the waiver with the aim to obtain a satisfactory result before the close of the payment window.

Request for waiver

This is what you have been waiting for. You have Medicare's preliminary lien determination with its demand for payment after reducing for fees and costs. Now transmit the record that you have developed. Send your cover letter and supporting evidence, including a completed and signed SSA-632-BK. You should also include Medicare's preliminary lien reduction notice. Continue to compile Medicare's responses and include

them in your transmittals. Medicare will respond with its *determination* concerning your request for waiver, which you can appeal through a Request for *redetermination*.

Appeal waiver determination (Request for redetermination)

You will have 120 days to appeal and request a redetermination of Medicare's waiver determination, but you have already done all the work. There is no need to wait; prepare a simple cover letter which clearly sets forth your demand for a redetermination decision on your waiver request. Enclose all of your original waiver request documents, including the original cover letter. Your compilation of Medicare correspondence should now include their preliminary lien determination and waiver determination. Include any additional helpful evidence not previously included. Medicare will respond with its *redetermination* decision, which you can appeal through a request for *reconsideration* by one of Medicare's Qualified Independent Contractors.

Appeal redetermination decision (Request for reconsideration of redetermination decision)

You will have 180 days to appeal and request reconsideration of Medicare's redetermination decision. You will again draft another cover letter that clearly demands a request for reconsideration. Medicare will provide a "Reconsideration Request Information Sheet" for you to complete. Enclose your prior cover letters and evidence, compilation of Medicare correspondence which now includes the redetermination decision, and any additional evidence not previously submitted. The package will be delivered to Medicare's QIC, which, at the time of drafting this article is Maximus Federal Services; Medicare will provide you with their contact information.

Hopefully, Medicare's QIC will be receptive to your argument and the record that you have developed, and issue a determination that a partial waiver, at least, is appropriate, if not a complete waiver. Review of the QIC decision



JANUARY 2023

requires an appeal to an Administrative Law Judge within 60 days, which is beyond the scope of this article, but be aware that the record before the ALJ would likely be limited to the evidence that you submitted to the QIC.

Conclusion

Armed with knowledge of Medicare's process for evaluating lien reductions, an understanding of its cryptic jargon, the applicable legal standard, and relevant evidence, the plaintiff's lawyer can play offense and put Medicare on its back foot when pursuing a lien reduction. The rules in this game are predictable and there is no reason to wait for Medicare to tell you how to

play. With a little luck, you will get a favorable result faster and earlier in the process than you expected.

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