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Navigating Mediation and Settlement in the Medicare Compliance Age

I. The Mediation Process

Why do Parties Choose to Mediate

In some jurisdictions, mediation is a mandatory process while in others the parties can voluntarily mediate a claim. Requesting a voluntary mediation usually means that all parties are interested in trying to resolve the claim in full or in part. Although some mediations are mandated by law and may not require a concessus of the parties to take place, they are still an effective tool in the resolutions process. Oftentimes, just getting the parties together in one room can be the catalyst for settlement.

Plaintiff, defense and plaintiff's counsel, adjusters, employers and settlement specialists all play a critical role in the mediation process. Because everyone is "at the table," negotiations are immediate and questions can be answered without delay. It also creates momentum in the settlement process. The parties do not have to wait days or weeks for the exchange of phone calls and correspondence to come to a reasonable settlement figure.

In addition mediators can provide an outside perspective of the case and work to manage the parties' expectations. A mediator who assesses the strengths and weaknesses of the claim; reviews realistic case values; and acts as a liaison between the parties can have a significant impact on whether or not the claim settles.

Mediation Pitfalls

Preparing for a mediation is the key to its success. Failure to review the case with clients; provide a thorough settlement assessment; review and approve settlement limits and strategies can cause a stalemate at the time of mediation. In addition, all key players must be in attendance or available by phone for progress to occur.

In a Medicare compliance age, preparation also requires knowing if the Claimant is Medicare eligible or has a reasonable e expectation of Medicare eligibility. Medicare eligibility can change the whole complexion of a claim. Pursuant to the Medicare Secondary Payer Act, failure to protect Medicare's interest can result in damages, penalties and future uncertainty for

the Claimant when it comes to his or her Medicare benefits. The mediation should not be the first time the parties address this issue. It requires careful planning and review to ensure that all parties understand how these issues will be addressed.

II. Medicare Concerns in the Mediation Process

Is the Medicare eligible?

Is simply asking if the Claimant/your client is Medicare eligible enough to protect the parties involved with a claim from potential Medicare exposure? The answer is NO! Medicare eligibility should not be confirmed by word of mouth, but through documentation including Claimant's Medicare card, Social Security Disability Information and date of birth. This information should be obtained early on in the claim and revisited throughout the claims process. Further, the type of Medicare benefits the Claimant is receiving must be clarified as well. If the Claimant is on a Medicare Advantage Plan other potential recovery rights are impacted.

If the Claimant is Medicare Eligible, What Next?

So you have hopefully determined Claimant's Medicare eligibility status prior to the mediation. What is the next step? There are three areas of Medicare compliance that should be addressed by some or all of the parties. First, Medicare Set-Asides (MSAs). Oftentimes, the parties can settle under the Medicare review thresholds, but many times it is clear that because of the type of injury or the amount of settlement, this is not an option. Get projections completed before mediation and see if there are ways to reduce an MSA by working with Claimant's counsel to limit or switch the types of prescriptions or treatments the Claimant is getting. This can be a highly successful process that can yield significant savings. Enlist a Medicare specialist to assist with these types of negotiations. They can be a tremendous resource before, during and after the mediation process.

Second, decide how and when the conditional liens will be satisfied by the parties. Liens involving traditional Medicare, parts A and B, have come a long way. Though not always the case, parties know how to obtain liens or have hired a Medicare specialist to assist with obtaining the same. Liens should also be reviewed and, when necessary disputed. This can result is significant savings. However, an inquiry into only traditional Medicare parts A and B is not enough. Because of the recovery rights that have been asserted by Medicare Advantage Organizations, knowing whether a MAO lien exists is also imperative.

Third, determine whether Section 111 Reporting is required. Although this is only completed by primary payers or their agents. Reporting impacts the entire claim. It can impact Claimant's benefits in the future, the amount of conditional liens and what needs to be included in a Medicare-Set Aside. The date of ongoing responsibility for medicals; the amount and date of the total obligation to the Claimant; and the diagnosis codes must be reviewed for accuracy.

III. Settlement Language

Settlement language should reflect why and how the parties are protecting Medicare's interest. Is the Claimant Medicare eligible; does he or she have a reasonable expectation of eligibility within the next 30 months; is an MSA needed: how will the MSA be administered; is there a Medical Cost Projection; are there conditional liens; who will satisfy the conditional lien; does the claim require a special needs or Medicare trust; what are the injuries for reporting purposes…All of these questions should be addressed in the release. Boilerplate language usually cannot address all of these issues. Each case is unique and the settlement release should be unique as well.

Medicare is not bound by the agreement of the parties and has made this clear through judicial decisions. As such, do not rely on the release to protect you from Medicare's recovery rights. That being said, the release is binding on the parties and should include protective language in the event that Claimant tries to seek a recovery under the Medicare Secondary Payer Act including a private cause of action for failure to protect Medicare's interest.