Global Settlements & Medicare

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Although work related injuries are generally pursued under the exclusive remedy offered through state workers' compensation laws, certain injuries may also give rise to a common law action against a third party. These scenarios frequently involve injuries from motor vehicle accidents during work related travel or from defective machinery used in the workplace. In recognition of this, workers' compensation laws provide certain offsets against an employee's benefits in order to prevent a double recovery from the employer and the third party. Given the interplay between the workers' compensation law offsets and the third party claim, parties will often find a global settlement of both claims to be an effective method of resolution. The global settlement will typically involve a full or partial release of the workers' compensation lien on the third party settlement proceeds in exchange for a one dollar settlement of the workers' compensation claim.

Global settlement negotiations should include discussion of Medicare Secondary Payer compliance issues. Since Medicare is a secondary payer when a primary payer is available, conditional payments made by Medicare, should be reimbursed to the Medicare Trust Fund. The reimbursement obligations should be clearly outlined and cross referenced in the settlement documents for both claims.

Similarly, discussions of the likelihood of future injury related Medicare covered treatment should focus on avoiding a cost shift of these expenses to Medicare. The Centers for Medicare and Medicaid Services' (CMS) April 22, 2003 Policy Memo explains that a Medicare Set Aside (MSA) is appropriate when the liability settlement relieves a workers' compensation carrier from any future medical expenses. Since the injuries being settled stem from one specific accident, only one MSA is appropriate. Funding of the MSA generally comes from the liability settlement.

Parties desiring voluntary CMS review of the MSA, are able to submit it in connection with the workers' compensation settlement provided that the CMS workload review thresholds are met in the claim. CMS has traditionally provided only sporadic review of liability MSAs or declined their review altogether.

Currently CMS' workload review thresholds in workers' compensation claims allow for review of a total settlement that exceeds $25,000.00 when the claimant is a Medicare beneficiary. When a claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement, CMS is willing to review a total settlement that exceeds $250,000.00. Reasonable expectation of Medicare enrollment within 30 months occurs when any of the following apply: the claimant has applied for or is in

the process of applying for Social Security Disability Benefits (SSDB), the claimant anticipates appealing a denial of SSDB, the claimant is 62 years and 6 months old or has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based on this condition. In determining the "total settlement" amount, Medicare will factor in the following: the value of the MSA and non-Medicare covered future treatment included in the settlement, the indemnity, attorney fees, payout totals for all annuities rather than cost or present values, settlement advances, lien payments, amounts forgiven by the carrier, prior settlement of the same claim and liability settlement amounts on the same WC claim. (WCMSA Reference Guide, Version 2.5, April 2016)

CMS recently issued a notice of a proposed expansion of its voluntary MSA review to include the review of liability settlements and no fault insurance MSA amounts. Since liability settlements involve different types of disputes than workers' compensation disputes, CMS' voluntary review process would need to be modified to take these factors into consideration. Failure to do so, would remove any incentive for parties to partake of the voluntary liability MSA review process.

When CMS review of the MSA is requested, it is imperative that the parties discuss their options should CMS return an MSA determination that differs from that submitted. If a counter higher determination is issued by CMS, will the claimant agree to set the larger amount aside from the settlement proceeds? Similar discussions should occur in the context of the conditional payment reimbursement obligations. Taking the time to discuss Medicare's potential interests in the settlement during the settlement negotiation phase is time well spent and will minimize any unforeseen Medicare complications down the road.

Short and Sweet Case Law Review January-June 2016

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Hartzell v. Palmetto Collision, LLC, 415 S.C. 617, 785 S.E.2d 194 (2016)

The defendants raised the notice defense. The claimant testified that the day after his injury, the claimant told his employer that he was "pretty sore" and he "must have hurt [himself.]" He further testified the employer suggested he go to the ER if he was having problems. The employer had no recollection of the back injury. He did not deny the conversation occurred, only that it did not "ring a bell." The Commission found the claimant's testimony more credible. The court held the finding of the Commission that the claimant gave proper notice was supported by substantial evidence.

Russell v. Wal-Mart Stores, 415 S.C. 395, 782 S.E.2d 753 (Ct. App. 2016)

Based on the findings, it was evident the Commission denied a change of condition solely because there were no objective changes on the MRI. The court reversed and found "[t]here is no requirement in the Act that a claimant prove a change of condition by objective evidence."

McMahan v. South Carolina Department of Education-Transportation, ___S.C.___, ___S.E.2d___, 2016 WL 3342240 (Ct. App. 2016)

It is not necessary for a claimant to reach MMI for a work injury to recover permanent benefits for the work injury after a death from an unrelated cause. Furthermore, § 42-9-280 allows for a posthumous adjudication of a claimant's permanent disability.