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What's Inside:

Three Keys to Medicare Compliance in Workers' Compensation

By Daniel Anders, Esq.

Since the enactment of Medicare in 1965 it has been secondary to workers compensation coverage. In other words, medical expenses stemming from a work-related injury are to be paid by the workers compensation plan, such as insurance or self-insurance, not the Medicare program. However, for most of Medicare's existence, the federal government did not enforce its right to be secondary. This has changed. With increasing healthcare costs, huge federal deficits, and the baby boomer generation soon entering the Medicare program, the government is looking to place the bill for medical treatment on any entity but itself.

The government first addressed the Medicare solvency issue in 1980 when Congress passed the Medicare Secondary Payer (MSP) Act (42 USC 1395y(b)(2)) which added liability insurance and group health plans as entities which are primary to Medicare. The MSP Act also gave Medicare a formal right to seek reimbursement against workers' compensation plans and those who receive payments from these plans such as plaintiffs and plaintiffs' counsel.

Nonetheless, even with the enactment of the MSP Act, it was another two decades before Medicare began to aggressively enforce its right to be secondary to a workers' compensation plan. This was primarily signaled by the release of a memo in July 2001 from the Centers for Medicare and Medicaid Services (CMS), the agency overseeing Medicare, stating that parties to a workers' compensation settlement must consider Medicare's interests in the need for future injury related medical treatment. CMS advised that failure to do so would result in CMS considering the whole settlement as available for future medical pursuant to Medicare regulations (42 CFR 411.46). Besides issuing these warnings, CMS also set up formal submission and approval process for what has become known as Medicare Set-Asides (MSAs). An MSA is CMS's recommended method for appropriately considering future medical upon settlement of a case.

Medicare's efforts at ensuring its interests were protected in future medical was followed by stepped up efforts to collect on payments made by Medicare prior to settlement of a case. These so-called conditional payments are for injury related medical treatment and result in a lien which arises after settlement of a case.

In an effort to further identify responsible primary plans other than Medicare, the Medicare, Medicaid and SCHIP Extension Act of 2007 provided a mandatory reporting requirement for workers' compensation as well as liability, no-fault and group healthcare plans for claims involving Medicare beneficiaries. The goal of the reporting requirement is to stop Medicare from paying when there is a primary plan to which Medicare is secondary or to identify entities responsible for reimbursement to Medicare.

As a result of these three compliance requirements, every workers' compensation claim must at least identify whether Medicare concerns are raised. If a claimant is Medicare eligible or has a reasonable expectation of Medicare eligibility under Medicare guidelines, then consideration of future medical, resolution of past medical paid by Medicare and reporting Medicare eligible claimants, must be addressed. This article will discuss each of these three key compliance requirements.

Consideration of Future Medical and the Medicare Set-Aside

The government wants to ensure Medicare's solvency. Consequently, Medicare regulations provide that if a settlement appears to represent an attempt to shift to Medicare "the responsibility for payment of medical expenses . . . the settlement will not be recognized." 42 CFR 411.46. In other words, the burden of future medical may not be shifted to Medicare for injury-related treatment, otherwise the settlement funds will be considered available to pay for this future treatment. Does this mean Medicare will never pay injury-related medical treatment? No; if they did, it would be

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difficult to close out medical in settlement of a case as it is impossible to predict every future medical expense. Medicare regulations as well as memorandum from Medicare require parties to reasonably consider Medicare's interest in settlement of a case. The expectation then by Medicare is if the medical records reveal the claimant will have future medical treatment and prescription medication, then the settlement funds must include a reasonable allocation for that future medical treatment and prescription medication.

The question then becomes what is considered reasonable by Medicare's standards? CMS responded to that question in 2001 with the establishment of a formal program in which proposed allocations for future medical treatment, now known as Medicare Set-Asides, would be reviewed and approved. If CMS believes the MSA is too low it increases the amount and advises that this amount reasonably protects Medicare's interests. It is important to note that this is a voluntary process. However, the review and approval process provides certain guarantees. First, to the claimant CMS approval means that once the MSA amount is exhausted, assuming it was used appropriately, then Medicare will step in and begin to pay bills related to the injury. Second, for the workers' compensation plan the approval means CMS will not attempt to make any future claim against the primary plan as a result of Medicare making payments for injury related medical treatment.

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Medicare review and approval of a Medicare Set-Aside is limited to cases meeting CMS workload review thresholds. If a settlement involves a Medicare beneficiary and the total settlement amount is more than $25,000, then Medicare will review and approve the MSA. Or, if the claimant has a reasonable expectation of Medicare eligibility and the total settlement amount is $250,000 then Medicare will review and approve it.

If the case meets one of these workload review thresholds, submission is not required, but is recommended by CMS as the approval provides certain benefits. To the claimant it means when the MSA monies run out, assuming it was used appropriately, CMS will step in and pay for injury related medical treatment. To the insurance carrier or self-insured company it provides them with the assurance that CMS will not make a claim for additional monies following settlement of a case.

Medicare Set-Aside Allocation

A Medicare Set-Aside can be broken out into three components: the allocation, the funding and the administration.

The first component is the allocation. This consists of a reasonable determination of a person's future medical treatment and prescription medications for the claimed injury based upon a review of the past medical history, usually the latest two years of medical records. Pursuant to CMS guidelines the MSA must be calculated over the person's life expectancy; however a rated age is allowed.

Once the allocation is calculated it must be determined how it will be funded, which is the second component to an MSA. The arrangement can be funded via lump sum or structured settlement, usually with an annuity.

And the third component is the method of administering the MSA account, either professionally or self-administered by the claimant. Most MSAs are self-administered given the additional costs involved with professional administration.

MSAs in Disputed or Denied Claims

A question that comes up often is whether an MSA must be placed on a disputed settlement. CMS is not obligated to abide by causation determinations unless it is as a result of a judicial decision. Consequently, Medicare's interests must still be considered and an MSA potentially placed on the settlement of a case if it is disputed. However, CMS does grant an exception for cases that are fully denied from the outset with no medical or indemnity having been paid. In that situation CMS will approve a $0 MSA as CMS recognizes the settlement as a "true compromise" settlement under its guidelines.

Prescription Drug MSAs

With the initiation of Medicare Set-Aside reviews and approvals in 2001, CMS only required monies set-aside for medical treatment. However, upon the Medicare Part D program going into effect in January 2006, CMS advised that an MSA allocation for prescription drugs would need to be included if indicated by the treatment records. CMS stated at the time that it would only review the necessity of a prescription drug MSA, not the appropriateness of the MSA itself. What this meant was CMS would identify medical records that indicated future prescription drugs and advise the submitter of the MSA of the need for additional funds for prescription drugs. CMS would then accept any amount submitted to it for the prescription drug MSA as they had no procedures in place to review the amount submitted.

As of June 1, 2009, CMS began to independently review and price prescription medications for not only the necessity, but also the amount placed in the MSA. Medications are priced at the average wholesale price. CMS is now pricing prescription medications just like they have been doing with treatment, over the claimant's lifetime. This means if CMS believes the MSA is too low they will increase it and if there is no prescription drug MSA placed in the submission, CMS will place one on it if indicated by the records. The initial approval letters from CMS under this new policy have yielded significant increases in MSA amounts. This is primarily a result of CMS pricing every medication listed in the medical reports over a person's lifetime unless there is a specific report from the treating physician documenting the termination of a prescription medication or that limits the future medication needs of the claimant.

For more on MSAs: http://www.cms.hhs.gov/WorkersCompAgencyServices/

Conditional Payments and the Medicare Lien

The consideration of future medical and increasing cost of MSAs as a result of prescription drugs is only one of the three concerns for Medicare compliance. The second key to Medicare compliance is resolution of the Medicare lien. A Medicare lien arises as a result of conditional payments. Conditional payments are payments which Medicare makes for treatment that should be covered by a primary plan, such as a workers' compensation plan. These payments allow a Medicare beneficiary to receive timely medical treatment while awaiting resolution of a dispute with a primary plan. Medicare has a right to recover these monies once a settlement is completed as such the actual lien arises following settlement. Consequently, these conditional payments must be identified prior to settlement and terms to resolve those payments must be included in the settlement agreement.

Investigation of conditional payments begins by reporting the workers' compensation case to the Medicare Coordination of Benefits Contractor (COBC). COBC opens a file after which the Medicare Secondary Payer Recovery Contractor (MSPRC) must be contacted to obtain an itemization of conditional payments. Once obtained, the itemization must be reviewed to identity any items unrelated to the injury. If unrelated, then MSPRC must be advised and a revised itemization requested. The parties to a settlement may negotiate the conditional payment amount with Medicare or the claimant may ask for a waiver. It is advisable to enter these negotiations prior to settlement as after settlement is completed Medicare will issue a final lien which must be paid within 60 days. While negotiation and waiver requests are still possible after settlement, Medicare must be paid first with a refund depending on Medicare's determination of the negotiation or waiver request.

For more on Medicare liens: http://www.msprc.info/

Medicare Mandatory Reporting

CMS efforts at identifying primary plans responsible for reimbursement led to the third key to Medicare compliance, reporting Medicare eligible claimants. This requirement stems from the Medicare, Medicaid and SCHIP Extension Act of 2007. Called Section 111 of the Medicare Secondary Payer Act, it requires all claims involving a claimant who is Medicare eligible be reported to Medicare. And this applies to all liability, workers comp and no-fault cases. The purpose of this is to one, stop Medicare from making payments for treatment that should be paid by a primary plan and two, identify who is responsible for repayment of Medicare liens.

The responsibility for ensuring compliance with Section 111 is assigned to what CMS calls responsible reporting entities (RREs). An RRE is the self-insured company or an insurance company associated with a claim involving a Medicare beneficiary. Note, it is not a third party administrator. The RRE has ultimate responsibility for ensuring the reporting task is completed, although the actual reporting can be done in-house, by a TPA or through a vendor. If reporting is not done or is improperly done, Medicare may enforce a penalty of $1,000 per day, per claimant on the RRE.

Since the enactment of Section 111 at the end of 2007, CMS has been developing an electronic reporting system for workers' compensation and liability plans. This system will allow for queries in determining which claimants are Medicare eligible. Once identified and a trigger for reporting occurs, there are more than 100 information fields which will need to be completed as part of each report submitted. According to CMS's timeline all RREs should have been registered by Sept. 30, 2009, however there is no penalty for late registration. During the first quarter of 2010, January through March, there is a mandatory testing period to ensure the RREs' reporting method is working appropriately. Finally, CMS's plan is to fully implement reporting in the second quarter of 2010, April through June.

Based upon announcements from CMS, it is expected that once the reporting system is fully implemented, parties to a settlement will begin to see stepped up enforcement of Medicare liens in the form of letters advising of the amount of reimbursement claimed by Medicare. It remains to be seen whether CMS will also use the information reported to confirm its future interests were appropriately protected.

For more on mandatory reporting: http://www.cms.hhs.gov/mandatoryinsrep/

Conclusion

Medicare eligible claimants or those with a reasonable expectation of Medicare eligibility must be identified in all workers' compensation claims so that Medicare interests are properly considered. However, once identified, except for the reporting of ongoing responsibility for medical, the three compliance requirements come into play only when a case is settled, or close to being settled.

If future medical is closed upon settlement, then the parties must consider Medicare's interest. If an MSA is placed on settlement then it may be submitted and approved by CMS if it meets the workload review thresholds. Besides an MSA, settling parties also must ensure that any Medicare conditional payments are identified and that settlement terms indicate which party resolves the lien following settlement. Finally, workers compensation plans, whether it is insurance or self-insurance plans, must ensure that the claim is properly reported to Medicare. Compliance with these three Medicare requirements is the key to fulfilling the settling parties' obligations to protect Medicare's interests in the settlement of a workers' compensation claim and provide assurance to the parties that there will be no unexpected demands by Medicare post-settlement.

Daniel Anders, Esq., *is an attorney licensed to practice in the state of Illinois and the United States District Court for the Northern District of Illinois. As MedAllocators', Inc. Compliance Director, Anders is responsible for ensuring the integrity and quality of MedAllocators' Medicare Set-Asides (MSAs) and related products. His primary focus is developing guidelines and practices in addressing Medicare issues in the context of the MSA process and lien investigations. He also has extensive litigation experience, including the handling of workers' compensation cases in his prior position with a Chicago law firm, where he developed and coordinated the firms' policies for handling of Medicare requirements in workers' compensation cases, including an in-house MSA submission program.*

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Events & Holiday Calendar

The Advisory Council on Workers' Compensation and Occupational Disease Disablement will meet at 9 a.m., Thursday, Jan. 28, at Hotel Santa Fe, 1501 Paseo de Peralta, Santa Fe

The Workers' Compensation Offices in Albuquerque and all Field Offices will be closed on the following mandatory furlough days:

Friday, March 5
Friday, April 2