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Medicare's role in workers' compensation cases



Medicare has become a necessary party in workers' compensation settlements. Taking Medicare's interests into account early will pay off at the time of settlement.

by Michael R. Merlino II

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In recent years, Medicare has become a necessary party in workers' compensation settlements. In 1980, a collection of statutory provisions known as the Medicare Secondary Payer (MSP) statute was enacted to reduce Medicare costs.¹ The MSP states that Medicare should be a secondary insurance provider when another source of primary coverage exists. As a result, Congress mandated that it was no longer permissible to shift the responsibility for medical expenses to Medicare. A few years ago, Workers' Compensation Medicare Set-aside Arrangement (WCMSA or MSA) was created to satisfy the mandate.²

In 2003, the federal government enacted the Medicare Prescription Drug Improvement and Modernization Act that furthered the objectives of the MSP by clarifying and expanding



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Medicare enforcement powers. The Centers for Medicare and Medicaid Services (CMS), the entity that enforces the MSP, was given the right to seek recovery "against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third-party payment directly or indirectly" if those funds were part of a settlement involving a primary insurer such as a workers' compensation carrier.³ CMS would be entitled to double damages if it brought an action to enforce its right.⁴ This expansion of powers lead insurers, employers and attorneys to seriously consider Medicare's interests because they did

not want to be exposed to future claims (and double damages) by CMS.

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CMS is currently focusing on workers' compensation claims because it is common for an employer to settle a workers' compensation case and leave it up to the employee to deal with any future medical expenses. In many instances the employee would pocket the money and then rely on his or her Medicare benefits to pick up the tab for any remaining medical treatment related to his or her on-the-job injury. The aim of the MSP was to curtail this practice of intentionally (or negligently) shifting medical expenses to Medicare.

The following advises attorneys how to address Medicare issues in settlement documents and satisfy the provisions of the MSP. Discussed in further detail are two issues that need to be addressed: past medical expenses (conditional payments) and future medical expenses (Medicare set-asides).

Conditional payments

The first issue involves making sure that Medicare has not already made payments on behalf of the employee/claimant before the case settles. CMS refers to these as "conditional payments."⁵ Usually in a workers' compensation case the employer is already paying for the treatment associated with the job-related injury. In some cases, though, the employee, for a variety of reasons, seeks treatment from another provider and uses his or her Medicare benefits to pay for the treatment. Medicare will pay the physician, but the payment is *conditioned* on the primary insurer reimbursing Medicare in the future.

Conditional payment information can be obtained by sending a basic request to CMS. Once CMS processes the request (six to eight weeks), it will provide a list of the conditional payments that Medicare has made on behalf of the employee/Medicare recipient. This correspondence should be scrutinized to make sure it is accurate. If it is not, a letter to CMS should be sent advising it of the errors.

CMS will only provide an *estimated* conditional payment amount *before* the case settles. CMS will not provide a *final* amount until *after* it receives a copy of the board-approved settlement documents from the parties. In some instances, the final amount can be significantly higher than the estimated amount due to Medicare's system of reporting and tracking its charges.

This system frustrates the settlement process because the parties cannot determine the total conditional payment amount until after the case settles. This issue should be addressed at the time of settlement. The settlement document should contain language that indicates which party is responsible for paying the *final* conditional payment amount, regardless of the estimated amount provided by CMS prior to settlement.

The Medicare set-aside

The CMS Web site provides the following explanation of the MSA:

All parties in a Workers' Compensation (WC) case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses. The recommended method to protect Medicare's interests is a Workers' Compensation Medicare

The Centers for Medicare and Medicaid Services would be entitled to double damages if it brought an action to enforce its right.

Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate. Once the CMS approved set aside amount is exhausted and accurately accounted for to CMS, Medicare will agree to pay primary for future Medicare covered expenses related to the WC injury.⁶

In other words, the parties must determine how much Medicare could be expected to *reasonably* pay out in benefits to the employee for his or her work-related injury (based on the employee's current medical condition).⁷ The ambiguous process of projecting health care costs for the duration of someone's life based on current medical records is a little like predicting the weather for next month by looking out the window today.

Obtaining an accurate projection is essential because CMS retains a third-party company comprised of physicians and nurses (reviewers) to analyze all WCMSAs submitted to CMS. These reviewers have unfettered authority to increase the WCMSA amount if they deem the medical records support their position. Unfortunately, the parties are left with very limited recourse if they do not agree with the reviewers' assessment.

To complicate matters further, CMS has provided very little guidance as to what it considers a "reasonable" WCMSA.⁸ Accordingly, one with little experience in evaluating medical records or knowledge of CMS' interpretation of what is reasonable could have a difficult time getting a WCMSA approved by CMS.

The CMS review process

The CMS review process usually takes between two to five months. The process begins in New York city at the Coordination of Benefits Contractor (COBC), where all WCMSAs and related correspondence are submitted.⁹ The COBC transfers materials into an electronic file for further handling.¹⁰ Once this is completed, the file is transferred to a third-party contractor in Baltimore to do the "heavy lifting" by reviewing the medical records and analyzing the MSA projection. At this stage, the WCMSA goes through a five-step review process that includes a quality control component. Then the third-party contractor makes a recommendation concerning the total amount of the WCMSA.

The recommended MSA amount is forwarded to a regional CMS office for final processing.¹¹ All parties to the WCMSA

receive a formal letter from the CMS regional office indicating the final WCMSA amount.

If, at any stage of the process, more information is requested (e.g. additional medical information), the supplemental information must be sent to the COBC in New York; direct submission to any entity other than the COBC is prohibited. Therefore, submitting an incomplete WCMSA can severely delay the process (by 60 days or more) because the information has to go through the COBC for distribution to the requesting entity.

Should the WCMSA be submitted to CMS?

The only sure way to protect all parties of a workers' compensation claim is to obtain CMS approval of the WCMSA amount. Once approval is acquired, all parties are absolved from further liability. However, CMS will not review all WCMSA proposals:

Legislation to watch

The Medicare Secondary Provider statute (MSP) applies to all workers' compensation settlements in Ohio, whether the employer is state-funded or self-insured. Because the MSP permits direct action against any entity that is responsible for making payments or any entity or person that has received a payment, all parties to a workers' compensation settlement must ensure that the interests of Medicare and Medicaid are protected.

In May 2006, the Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act (MSPWCSA) was introduced in the U.S. House of Representatives. This act would, among other things, exempt certain workers' compensation settlements; allow the parties to a settlement to pay the Medicare Set-Aside

(MSA) amount directly to the Centers for Medicare and Medicaid Services (CMS) for administration; and provide deadlines for CMS to provide information on conditional payments made prior to settlement and issue initial decisions on MSA's submitted for approval.

MSPWCSA was immediately referred to a House subcommittee but it appears that activity on this bill may be resurfacing. This bill could result in making many workers' compensation settlements less complicated and more timely. Clearly, however, there are competing interests in ensuring that the Medicare Trust Fund Reserves are not depleted. ■

—Mary Beth Reynolds
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It is not in Medicare's best interest to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. (Ref: 7/23/01 Memo QI (c)). A WCMSA is not necessary when resolution of the WC claim leaves the medical aspects of the claim open.

A WCMSA may be submitted to CMS for review in the following situations:

- (1) The claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000; OR
- (2) The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000.¹²

This is commonly referred to as the "review threshold." If the case does not meet one of the two listed criteria, CMS will not review the WCMSA. While it is easy to confuse the CMS refusal to review to mean that a WCMSA is not necessary, that is not the case:

The CMS wishes to stress that this is a CMS **workload** review threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases.¹³

In other words, just because CMS is trying to reduce its workload does not mean that the parties do not need to com-

plete a WCMSA. Therefore, if the case does not meet the review threshold requirement it still may be advisable to establish an unapproved WCMSA at the time of settlement.

Practice considerations

- Here are a few recommendations for those handling WC cases:
- Find out early in the process if the claimant/employee is a Medicare recipient;
 - Make a request for conditional payment information as soon as possible;
 - Take Medicare's interests into account and make sure that there is language in the settlement agreement that reflects that;
 - The settlement document should also address which party is responsible for the *final* conditional payment amount; and
 - If the case meets CMS review threshold requirements, obtain CMS approval. If not, consider establishing an unapproved Medicare set-aside trust.

Conclusion

Dealing with Medicare issues and the CMS can be a time-consuming, thorny process. Taking Medicare's interests into account early will pay off because the parties will know all (or most) Medicare issues that must be addressed in the settlement documents. The end result should be a settlement that leaves all parties knowing where they stand regarding Medicare and as comfortable as possible that CMS will not be making any future claims. ■

If you have questions about Medicare's role in workers' compensation cases or would like more information, contact Michael Merlino at (770) 374-3697 or mmerlino@gmail.com.

Endnotes

- ¹42 U.S.C. 8 1595y(b)(5); applicable regulations are found at 42 C.F.R. Part 41 1; *see also* Medicare Secondary Payer and You at www.cms.hhs.gov/MedicareSecondPayerandYou.
- ²For a general overview *see* Workers' Compensation Agency Services at www.cms.hhs.gov/WorkersCompAgencyServices/.
- ³CMS Memorandum dated April 22, 2003 (Answer to Question 13) *citing*, for example, 42 C.F.R. 411.24(b), (e), and (g) and 42 C.F.R. 411.26. Available at www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp.
- ⁴42 USC 1395y(b)(2)(B)(iii).
- ⁵Go to www.cms.hhs.gov/WorkersCompAgencyServices/03_reportingwc.asp to learn more about obtaining this information.
- ⁶www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp.
- ⁷Keep in mind that as of Jan. 1, 2006, Medicare covers prescription drugs, so those must be added to any WCMSA.
- ⁸As the CMS Web site states, "[T]he amount of the set aside is determined on a case-by-case basis."
- ⁹www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp.
- ¹⁰You may be able to speed up this process if the WCMSA is submitted electronically. *See* www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp for further information regarding electronic submissions.
- ¹¹For a list of regional offices go to www.cms.hhs.gov/RegionalOffices.
- ¹²www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp.
- ¹³CMS Memorandum dated April 25, 2006. Available at www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp.

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