

SETTLING WC CASES – HOW MEDICARE IS INVOLVED IN THE PROCESS

I. Introduction

A WCMSA (or MSA) is the acronym for a Workers' Compensation Medicare Set-aside Arrangement.¹ Up until a few years ago these did not exist. They came into being to satisfy a mandate from Congress that it was no longer permissible to shift the responsibility of medical expenses to Medicare.

The origin of the mandate stems from a collection of statutory provisions known as the Medicare Secondary Payer (MSP) statute which was enacted in 1980 to reduce Medicare costs.² The MSP states that Medicare should be a secondary insurance provider when another source of primary coverage exists.

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 Medicare's enforcement powers. The Centers for Medicare and Medicaid Services (CMS), the entity that enforces the MSP, was provided with 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' comp carrier.³ CMS would be entitled to double damages if it brought an action to enforce its right.⁴ It was this expansion of powers that 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.

CMS is currently focusing on workers' compensation claims because it is not an uncommon practice 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 Medicare benefits to pick up the tab for any remaining medical treatment related to his on-the-job injury. The aim of the MSP was to curtail this practice of intentionally (or negligently) shifting medical expenses to Medicare.

II. How to satisfy the provisions of the MSP

As is discussed in further detail below, there are two issues that need to be addressed: (1) past medical expenses (conditional payments) and (2) future medical expenses (Medicare set-asides).

1. 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’ comp case the employer is already paying for the treatment associated with the job related injury. But in some cases the employee, for a variety of reasons, seeks treatment from another provider and uses his Medicare benefits to pay for the treatment. Medicare will pay the physician, but the payment is *conditioned* upon Medicare being reimbursed in the future by the primary insurer.

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 Medicare charges.

This system frustrates the settlement process because the parties cannot determine the total conditional payment amount until after the case settles. Make sure this issue is 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.

2. The Medicare Set-aside

CMS' website 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 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, it is the parties that must determine how much Medicare could be expected to *reasonably* pay out in benefits to the employee for his 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. It is hard to tell.

Obtaining an accurate projection is essential because CMS has retained a third-party company comprised of physicians and nurses (“reviewers”) to analyze all WCMSAs that are 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 even 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 in getting a WCMSA approved by CMS.

III. The CMS Review Process

The CMS review process usually takes from two to five months. The process begins in New York City at the Coordination of Benefits Contractor (COBC).⁹ This is where all WCMSAs and related correspondence are submitted. The COBC transfers all of the material into an electronic file for further handling.¹⁰ Once this is completed, the file is transferred to a third-party contractor located in Baltimore that does 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 as well. Following which, the third-party contractor makes a recommendation concerning the total amount of the WCMSA.

The recommended MSA amount is then forwarded to a regional CMS office¹¹ for final processing. All parties to the WCMSA will 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. Submission directly to any entity other than the COBC is prohibited. Therefore, not submitting a complete WCMSA can severely delay the process (by 60 days or more) because the information has to go through the COBC for distribution to the entity that requested the information.

IV. Should the WCMSA be submitted to CMS?

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

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, then CMS will not review the WCMSA. While it is easy to confuse 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 complete 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.

VI. 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, then consider establishing an unapproved Medicare set-aside trust.

VII. Conclusion

Dealing with Medicare issues and the CMS can be a time consuming and thorny process. Taking Medicare's interests into account early will pay dividends at the time of settlement because the parties will know all (or most) of the 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.

¹ For a general overview *see* Workers' Compensation Agency Services at <http://www.cms.hhs.gov/WorkersCompAgencyServices/>

² 42 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 <http://www.cms.hhs.gov/MedicareSecondPayerandYou>

³ CMS 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 http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp

⁴ 42 USC 1395y(b)(2)(B)(iii)

⁵ Go to http://www.cms.hhs.gov/WorkersCompAgencyServices/03_reportingwc.asp to learn more about obtaining this information

⁶ http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp

⁷ Keep in mind that as of January 1, 2006 Medicare currently covers prescription drugs, so those must be added to any WCMSA.

⁸ As CMS' website states: "[t]he amount of the set aside is determined on a case-by-case basis."

⁹ http://www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp

¹⁰ You may be able to speed up this process if the WCMSA is submitted electronically. See http://www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp for further information regarding electronic submissions.

¹¹ For a list of regional offices go to <http://www.cms.hhs.gov/RegionalOffices>

¹² http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp

¹³ CMS Memorandum dated April 25, 2006. Available at http://www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp