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Join Us on July 10th! Proper Administration Webinar

Rasa Fumagalli, JD, MSCC

Join us on July 10th, 2017 at 1:00 (CST) **Register here** for a webinar that addresses the proper administration of an MSA. We will review CMS' specific guidelines on this issue and address common mistakes that may be made in self-administration. We will also go over tools that may assist in the administration process.

Rasa Fumagalli, JD, MSCC, NuQuest's Director of Compliance, holds a law degree from IIT's Chicago Kent College of Law with an undergraduate business degree from the University of Illinois. Prior to joining NuQuest, she spent over twenty years specializing in workers' compensation defense work in the Chicago area. Rasa utilizes her extensive experience in handling workers' compensation cases when consulting with clients about Medicare Secondary Payer (MSP) compliance issues. She is admitted to practice law in the State of Illinois and is an active member of the National Alliance for Medicare Set- Aside Professionals (NAMSAP) organization, serving on the Evidence-Based Medicine, Communications and Liability Committees.

Examining CMS Submission and Appeals

Patrick Czuprynski, JD, MSCC

Medicare has established workload review thresholds in determining whether the Medicare Workers' Compensation Review Contractor (WCRC) will review proposed future medical allocations and provide a recommended Medicare Set-Aside (MSA) amount. If a workers' compensation settlement involves a Medicare beneficiary and exceeds $25,000.00, the WCRC will review the parties' settlement and proposed future medical allocation. The WCRC will then advise if the proposed future medical allocation adequately prevents a cost shift of injury-related medical expenses to Medicare.

The WCRC will also review a workers' compensation settlement if the claimant has a reasonable expectation of Medicare enrollment within 30 months and the settlement exceeds $250,000.00.

With respect to workers' compensation claims, the workload review threshold is not a safe harbor. This means that if a claim falls outside of these categories, the parties to settlement must still consider Medicare's interests when settling a claim and prevent a cost shift of injury-related medical expenses. This is also true if the claim surpasses a workload review threshold, but is not submitted to Medicare for review.

Currently, the WCRC will generally only review workers' compensation claims and will not review liability or no-fault settlements. However, the Medicare Secondary Payer Act and supporting regulations also require parties to no-fault and liability claims (including self-insured) to consider Medicare's interests and prevent a cost shift of injury-related expenses to Medicare. In the near future, Medicare may begin to review proposed liability future medical allocations and provide recommended liability MSA amounts.

The above information does not mean parties to a workers' compensation settlement must submit a WCMSA proposal to Medicare if a claim surpasses a review threshold. In fact, as noted by Medicare in its most recent reference guide, 2.5, "[t]here are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review." If the parties choose to submit a proposed MSA to Medicare, compliance with the CMS' established policies and procedures is expected.

If Medicare has reviewed a MSA proposal and the parties do not like the recommended amount provided by Medicare, can the parties appeal the decision?

If the parties disagree with Medicare's recommended MSA amount, the claimant can provide the Medicare regional office that made the recommendation with additional documentation to justify the original proposed amount. The regional office will then decide if the additional information justifies the proposed MSA amount.

Another option is for the parties to request Medicare to re-review its recommended MSA amount. Currently, the reference guide provides two circumstances where a re-review request will be examined by Medicare:

(1) the parties believe CMS' determination contains obvious mistakes (e.g., a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, that has already occurred); or

(2) the parties have additional evidence, not previously considered by CMS, which was dated prior to the submission date of the original proposal and which warrants a change in CMS' determination.

Re-review policies are expected to change in the near future to provide additional circumstances where a re-review request is appropriate. Additionally, we have had limited successes in reducing recommended MSA amounts with documents and evidence that is dated after submission of the original proposal. We will keep you advised as we receive updated information on re-review procedures.

Dispelling MSP Compliance Misconceptions

Rasa Fumagalli, JD, MSCC

"Fake News", "alternative facts" and rumors have been in the forefront of the news cycle over the past year. The discussions all highlight the need to scrutinize the source of the information that is being shared and assess its credibility. Although Medicare Secondary Payer compliance issues may not be as exciting as some of the news stories that have come out, there are certain misconceptions that should be examined in greater detail. This article will review and dispel some of the more common misconceptions in the area.

Fact or Fiction

Fiction: If you meet CMS' review thresholds, the parties must seek CMS review of the Medicare Set-Aside (MSA).

Fact: Since CMS review of an MSA is voluntary, CMS review of a Medicare Set-Aside proposal is never required. Should the parties elect to seek CMS review, CMS has indicated a willingness to review settlements when the "projected settlement" meets specific workload review thresholds. For a current Medicare beneficiary, the projected settlement should exceed $25,000.00. For a claimant with a "reasonable expectation of Medicare entitlement within 30 months of settlement", the projected settlement should exceed $250,000.00. Failure to meet CMS' review thresholds, however, does not mean that an MSA is inappropriate or that this failure provides a "safe harbor" from CMS.

Fiction: The CMS workload review thresholds have changed.

Fact: The Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, Version 2.5 (April 4, 2016) provides information about CMS' workload review thresholds. The current Guide notes that these thresholds may be adjusted by CMS. Changes to the review threshold would be posted on CMS' website. As of today's date, CMS' workload review thresholds are unchanged.

Fiction: Only workers' compensation settlements need to consider Medicare's interests.

Fact: Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance and Workers' Compensation under certain circumstances. This is based on 42 U.S.C. §1395y(b)(2)(A)(ii) that states that Medicare may not make a payment for medical services where "payment has been made or can reasonably be expected to be made under a workers compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." Id. In light of these provisions, it is clear that Medicare's secondary payer status is not limited to workers' compensation insurance.

CMS' guidance, albeit limited, further clarifies Medicare's secondary payer status in liability claims. CMS' September 30, 2011 memo states "where a beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) "settlement" has been completed as of the date of the "settlement", and that future medical items and /or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement" satisfied." This memo, coupled with CMS' search for a new Workers' Compensation Review Contractor that has the ability to review liability and Non-Group Health Plan MSAs, suggests that CMS will be establishing a voluntary review process for these types of settlements as well.

Fiction: MSA funds may be used to reimburse Medicare's conditional payments involving pre-settlement treatment.

Fact: Parties should not use MSA funds to reimburse Medicare's conditional payment claims for injury-related Medicare covered treatment incurred prior to a final settlement. The MSA is intended to prevent a cost shift of future injury-related expenses to Medicare and should be funded at time of final settlement. See *McCarroll v Livingston Parish Council and Louisiana Workers' Compensation Corporation (LWCC), 2014 La. App.LEXIS* 2570.

Fiction: MSA funds may not be used for injury-related treatment before the claimant is a Medicare beneficiary.

Fact: Since the MSA funds are based on the claimant's life expectancy at time of settlement, the funds in the MSA cover the claimant's care prior to Medicare entitlement. This is confirmed in CMS' July 11, 2005 Memorandum.

Fiction: The MSA treatment projections should be based on the Medicare reimbursement rate.

Fact: Since Medicare's secondary payer status is based on the primary payer's responsibility to make payment under "a workers compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance," the MSA treatment projections are priced consistently with the State's Workers' Compensation law.

If the state does not have a fee schedule, the projections are based on actual charges. Liability MSA projections would generally be based on the "usual and customary" charges for treatment in the particular jurisdiction.

Fiction: Present Cash Value of the future treatment plays a role in the amount of the MSA.

Fact: CMS indicated in its October 15, 2004 Memorandum that WCMSAs may not be discounted to present-day value. The funds also do not need to be adjusted for inflation. This position remains consistent with information contained in the WCMSA Reference Guide Version 2.5. (April 4, 2016).

Conclusion:

The MSP Act, corresponding Federal Regulations, CMS Memorandums, the WCMSA Reference Guides and the WCRC's internal practices all play a role in determining the best MSP compliance option for your particular case. Given the highly specialized nature of MSP compliance, it is especially important to remember that "a little knowledge is a dangerous thing."

Simplifying MSA Account Administration with BP's MSP Card

Rasa Fumagalli, JD, MSCC

CMS has issued specific guidelines that address the proper administration of a Medicare Set Aside (MSA) account. The guidelines require that the MSA funds only be used for injury-related Medicare-covered treatment and Medicare-covered pharmacy expenses. Certain costs such as document copying charges, mailing fees/postage, banking fees related to the account and income tax on interest income from the MSA may be paid from the MSA account. In addition, the funds must be kept in a separate interest bearing account with annual attestation through the depletion of the MSA account.

Funding for the MSA may be made by a lump-sum payment or through a structured settlement annuity. If a structured settlement is proposed, the initial deposit or "seed" amount must include the cost of the first surgical procedure and first replacement, if any (e.g., pain pump or spinal cord stimulator). The first two years of annual payments are also added to the seed. If the MSA was funded by a structure, excess funds must be carried forward in the account. Should the structured MSA account be exhausted prematurely in any given year, CMS should pay for additional injury-related medical expenses during the year, provided that the claimant is on Medicare. The MSA account may be self-administered, self-administered with support services or professionally administered by a custodian.

Bridge Pointe's MSP debit card, available through the self-administration with support program, simplifies the proper administration of the MSA account. This free pharmacy and medical debit card provides discounts for injury-related Medicare covered drugs and tracks medical expenses for greater ease in the annual attestation reporting required by CMS. The MSP debit card may be used like any traditional debit card to pay for injury-related Medicare covered treatment from the MSA account at the time of service. Additional details about the MSP debit card are available upon request.