August 2016

NuQuest

Settlement News

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Providing Education to the MSA

Industry

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Meet NuQuest's Legal and Settlement Consultant Team

NuQuest's expanded services now include access to a Medicare Secondary Payer (MSP) compliance legal team. Headed by Robert Sagrillo, President of NuQuest and Chief Legal Officer, the team assists our customers in evaluating their MSP obligations in settlements and works with them to facilitate optimal outcomes.

Robert Sagrillo, JD, Chief Legal Officer and President of NuQuest, is a highly respected professional in the Medicare set-aside arena and was one of the first Medicare set-aside advisors in the country. Mr. Sagrillo draws on his expertise in public benefits, trust and estate planning, and tax to advise his clients on the best and most cost-effective way to maximize benefits for claimants, while minimizing the overall cost and liability for insurance companies and employers. Many of the nation's largest self-insured employers and workers' compensation insurance carriers turn to Mr. Sagrillo regularly for consultation.

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.

Patrick Czuprynski is an Illinois licensed attorney and Medicare Set-Aside Consultant Certified with substantial experience in the areas of workers' compensation litigation and Medicare Secondary Payer compliance. Patrick has handled hundreds of claims in various jurisdictions dealing with Medicare Secondary Payer Compliance issues including, but not limited to: conditional payment negotiations, Medicare Set-Aside submissions and redetermination requests, settlement contract and release negotiation, and Section 111 compliance.

The NuQuest Settlement Consultant team has extensive experience analyzing and strategizing to assist in the settlement of medical-legal claims and have the longest tenure in the Medicare Secondary Payer Compliance (MSP) industry. The NuQuest Settlement Consultants work to assist you with the cost containment and settlement of workers' compensation and liability claims, from the initial medical cost projections to the final set-aside allocation and administration.

The NuQuest Settlement Consultant Team members are:

Becky Coombs – Becky has over 30 years of experience handling workers' compensation claims with a focus on high-exposure claims. Becky is also well versed in Federal claims, including US Longshore and Harbor claims, Defense Base Act claims, and Jones Act claims.

Jennifer Shymanski, JD, CMSP – Jennifer has over ten years of experience in claims with a focus on structured settlement annuities. She works with clients to establish and implement their Medicare Secondary Payer (MSP) compliance programs and directs the Triage process before the MSA is completed.

PJ Smith – In his over 30 year insurance career, PJ handled both Workers' Compensation and Liability claims. PJ worked at both the adjuster level and management levels handling complex and catastrophic claims. He was also a home office examiner responsible for supervision of several states.

Thomas Spratt, CMSP – With more than 30 years of management experience in the insurance industry in both Workers' Compensation and Liability, Tom is NuQuest's Director of Settlement Services. Tom oversees assessment of client's MSP compliance programs, training of claims staff and client settlement strategies. His main focus is on exposure assessment, mitigation opportunities and identification / implementation of settlement options.

Join Us on August 3rd! MSP Compliance & Liability Settlements. Patrick Czuprynski, JD, MSCC

Join Patrick Czuprinski, J.D., MSCC August 3rd at 1:00 pm CST for our webinar **Register here** presentation on Medicare Secondary Payer compliance issues in liability cases. He will address Section 111 reporting obligations as well as the numerous conditional payment reimbursement options in liability claims. The presentation will also examine the various factors that impact a decision to include a future medical allocation in a liability settlement.

Federal versus State Law: Which one wins? Patrick Czuprynski, JD, MSCC

In the United States there are two types of laws: state laws and federal laws. A state court generally interprets and applies state law to the facts of a claim and a federal court generally interprets and applies federal law. However, there are circumstances where a state court must use federal law in determining the outcome of the claim and a federal court must use state law in determining the outcome of the claim. If there is a conflict between a state's law and federal law, federal law wins or "preempts" state law. This is because the Supremacy Clause of United States Constitution establishes that federal law is the supreme law of the United States over a state law or constitution.

If a federal law does not expressly state it preempts state law, preemption may still occur where the federal law provides a regulatory scheme that overtakes a state's regulation over the same issue. Another circumstance where a federal law does not express preemption, but preemption occurs is where the state law as applied conflicts with the federal law.

The MSP Act provides that Medicare may not make payment where payment has been made or can reasonably be expected to be made under a Non Group Health Plan (NGHP) or workers' compensation law. If payment is made by Medicare, reimbursement is required if there is a demonstration of responsibility for a primary payer (NGHP or recipient of settlement funds) to pay for the particular item service. A demonstration of liability may be determined by a settlement, judgment, award or other payment.

If there is a settlement, judgment, award or other payment made related to a NGHP claim, the analysis requiring reimbursement to Medicare does not end. What must also be determined is whether a state law precludes payment of the medical item or service and establishes that the payment by the primary plan is not reasonably expected. In other words, federal law does not define what is compensable under a state's liability or workers' compensation law.

Examples of state laws that the courts have wrestled with federal preemption are: the Illinois Health Care Services Lien Act requiring 40% reduction for medical services (MSP Act preempts and Medicare is entitled to full reimbursement in accordance with federal law and rules), Pennsylvania's statute regarding requiring settlement proceeds paid within 20 days (MSP Act does not preempt state law requiring payment of proceeds), and Texas law requiring pre-authorization of surgical procedures (MSP Act does not preempt state law requirement for payment of services).

Other state statutes in workers' compensation may preclude CMS from denying payment or seeking reimbursement. Georgia's catastrophic injury cases workers' compensation statute precludes the requirement of payment of medical items and services after 400 weeks where the injury meets the definition of non-catastrophic injury. Hence, if the facts of the claim demonstrate that the injury is not a catastrophic injury, there is no reasonable expectation of payment by the workers' compensation carrier after 400 weeks. Further, in North Carolina, a workers' compensation statute terminates medical compensation two years after the employer's last payment of medical or indemnity benefits unless the employee or the commission files a motion and an order is obtained for additional medical benefits. Similarly, California's Independent Medical Review (IMR) decisions that are final, are binding on the parties in terms of treatment that should be authorized.

The courts have yet to determine whether the Georgia or North Carolina statute is preempted by the MSP Act. However, if litigated, we anticipate CMS to argue there is a direct conflict as the state statute shifts the cost of medical services related to the NGHP claim. We are hopeful that at that time the court will see the light and CMS will lose this argument as reimbursement to Medicare is limited to payments that are reasonably expected under state law. Parties should also continue to raise state law defenses in connection with CMS review of Medicare Set-Asides and in conditional payment recovery actions.

Opioid Abuse and Workers' Compensation. Rasa Fumagalli, JD, MSCC

Opioid projections frequently make up a significant portion of a Medicare Set Aside (MSA). CMS projects the future drug component of the MSA by looking at the claimant's current pharmacy usage and treatment records. The existing usage patterns generally account for CMS' monthly drug projections for life. Given the growing body of evidence-based medicine studies that show the dangers of opioid use for chronic non-cancer pain and national attention to the opioid epidemic, a shift in opioid prescribing patterns is likely to occur over the next few years.

According to the Centers for Disease Control and Prevention, opioid overdoses from prescription painkillers and heroin were responsible for approximately 47,000 deaths in 2014. The U. S. Surgeon General Vivek Murthy's office recently launched a public health campaign to "Turn the Tide RX" in an effort to halt the opioid abuse epidemic. The campaign is focused on changing the opioid prescribing patterns of physicians through meetings with physician groups. In addition, the campaign calls for expanded use of naloxone and Medication-Assisted Treatment (MAT) in the treatment of those with opioid addictions. Naloxone counters the effects of an opioid or heroin overdose.

The opioid issue was also addressed by Congress when it passed the Comprehensive Addiction and Recovery Act of 2016 on July 13, 2016. The Act, expected to be signed by President Obama, calls for expanded availability of naloxone for police and health officials to prevent overdoses. Nurse practitioners and physician assistants would also be allowed to prescribe buprenorphine for opioid addiction, while improved prescription drug monitoring programs (PDMP) would help states monitor drug diversion. Although the final bill does not come with funding, it is expected to be authorized by the end of the year.

States have similarly addressed the opioid epidemic through a variety of policy changes. Recent studies put out by the Workers' Compensation Research Institute (WCRI) examined the impact of opioid policies on opioid use. In the "Interstate Variation in Use of Opioids" report, (Vennela Thumula, Dongchun Want, Te-Chun Liu) the authors concluded that states that had adopted opioid policies including, in part, enhanced state PDMPs, drug formularies, and chronic pain treatment guidelines with provider education, showed reductions in opioid utilization. The "Longer-Term use of Opioids" report by Dongchun Wang looked at the impact of evidence-based medicine opioid treatment guidelines on opioid use trends. In examining data from 25 states, the author observed that although current opioid treatment guidelines call for random urine drug testing, psychological and psychiatric evaluation, as well as physical therapy, few injured workers actually received these services. In order for the revised opioid treatment guidelines to have an impact, they must be implemented.

As with all national campaigns, only time will determine its success rate. The drug industry's active marketing of opioids coupled with patients' expectation of complete pain relief, and physician prescribing patterns have taken years to develop and will likely take several to undo. In the meantime, consideration should be given to weaning programs for opioid addicted workers prior to preparation of an MSA. Non-opioid alternatives should also be explored as viable options for pain relief.

NuQuest In and Around Town

August 7th: Alabama Self-Insured, Destin, FL

August 11th: Indiana Worker's Compensation Institute, Indianapolis, IN

August 11th: Workers Compensation Medical and Disability, San Diego, CA

August 18th: Louisiana Business Industry, Baton Rouge, LA

August 21st: Workers' Compensation Institute Annual Conference, Orlando, FL

August 25th: State Board Workers' Compensation of Georgia, Atlanta, GA

August 26th: KORT Annual WC Seminar, Louisville, KY

August 28th: Maine Compensation Summit, Rockport, ME

August 29th: Georgia Employers' WC Association, Atlanta, GA

September 7th: Tennessee Self-Insurer's Association, Nashville, TN

September 18th, Missouri Self-Insurers Association, St. Charles, MO

September 14th, NAMSAP, San Antonio, TX

September 28th: Mississippi Association of Self-Insurers, Biloxi, MS

NuQuest Speaking Engagements Past and Future:

June 20 and 21, 2016, Rasa Fumagalli accompanied fellow NAMSAP members to meetings with representatives from the Office of National Drug Control Policy, CMS, and Senator Bill Cassiday's senior health policy advisor to discuss opioids.

June 28, 2016, Robert Sagrillo and Rasa Fumagalli presented our "BluePrint for Reducing the MSA" during the Louisiana Claims Association Educational Conference.

Rasa Fumagalli's article "Global Settlements and Medicare" was published in the South Carolina Workers' Compensation Educational Association Summer Chronicles 2016 magazine.

Stay up to date! Check out blog updates http://mynuquest.com/news/cases-points-blog/

Global Settlements and Medicare, Rasa Fumagalli Featured in SCWCEA Summer Chronicles

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. 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.