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Tales from the MSP Compliance Crypt
NuQuest Settlement News

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(P) 866.858.7161 • (F) 407.389.0299 www.mynuquest.com P.O. Box 915619 • Longwood, FL 32791

Join Us on November 7th – Highlights of WCMSA Reference Guide Updates
Rasa Fumagalli, JD, MSCC

Join us on November 7th, 2017 at 1:00 CST Register here for a webinar that discusses the changes that were made to the updated WCMSA Reference Guide (Version 2.6, July 10, 2017). We will look at the new Amended Review process as well as the expanded state-specific Statute section. CMS' implementation of the updated Guide will also be discussed.

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.

WCRC's Application of Updates to the WCMSA Reference Guide

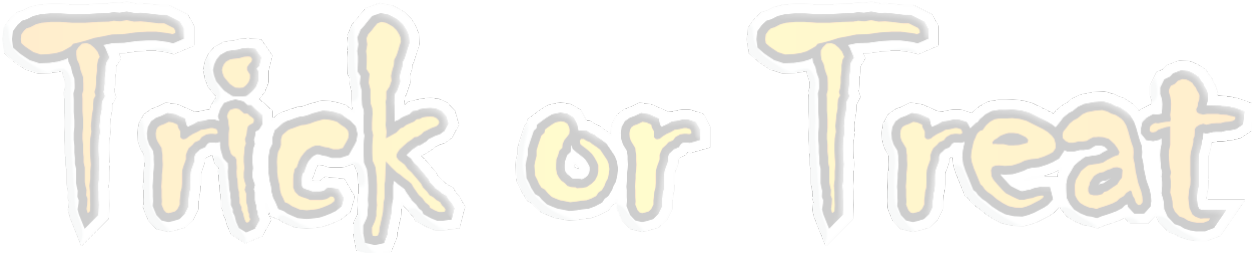
Nancy Heidrich, BSN, RN, CDMS, MSCC

With the release of the WCMSA Reference Guide, Version 2.6 dated July 10, 2017; how is the WCRC actually applying these guidelines when reviewing a WCMSA? CMS noted 13 changes to Version 2.6 of the Guide. Three of these changes are addressed below.

The expanded state-specific statute guidelines (Section 9.4.5) have changed the way CMS is reviewing the Independent Medical Review (IMR) in California. Since the Guide was released, we have seen CMS including provision for treatment that the IMR found not medically necessary and appropriate. In one case, the IMR Final Determination found gabapentin 800mg #90 per month not medically necessary and appropriate. WCRC included this medication in the Part D drug costs which over a 33-year life expectancy, added $102,287 to the MSA amount. In another case, the IMR final determination found lumbar transforaminal epidural steroid injections (ESI) not medically necessary and appropriate. WCRC included provision for three lumbar transforaminal ESIs noting these were included "per the treatment recommendations" in the medical records. Unless alternative treatment is provided specifically to the IMR reviewed treatment and would be acceptable through the IMR process, CMS is not considering the IMR and is including provision for the recommended treatment.

Based on another change to the Guide; the updated defined requirements for Spinal Cord Stimulator (SCS) pricing (Section 9.4.5); WCRC is now pricing the SCS per the state fee schedule or usual and customary charges depending on the state of jurisdiction. Previous versions of the Guide did not specifically address SCS pricing and the WCRC priced all SCS trials, replacements and reprogramming at a set amount. Regardless of the jurisdiction, an SCS trial was priced at $9,328, the SCS placement/replacement was priced at $30,274, and SCS reprogramming was priced at $222. A CMS determination letter provided in August 2017 priced the SCS replacement at $28,397 and the reprogramming at $76 which resulted in a counter-lower. Another CMS determination letter provided in the same time period priced the SCS replacement at $59,368 and the SCS reprogramming at $86 which resulted in a counter-higher. It is apparent that WCRC has implemented this update and continues to do so.

The updated off-label medication requirement (Section 9.4.6.2) introduces "Unlabeled Use of Drug" according to Medicare IOM (Internet-Only Manuals) 100-02 Chapter 15 section 50.4.2 in addressing the off-label use of drugs. This version of the Guide states "Off-label use is when a drug is prescribed in a manner that is different from the FDA-approved product labeling… There are many off-label indications that are listed in recognized compendia and peer- reviewed sources; thus, they would be covered under the Part D Benefit, and should also be included in a WCMSA." The previous version of the Guide stated "Off-label use is when a drug is prescribed in a manner that is different from the FDA-approved product labeling. There are many off-label indications that are listed in recognized compendia, and thus would be covered under the Part D Benefit, and so should be included in a WCMSA." Now, CMS is taking peer- reviewed sources as well as an unlabeled use of a drug into consideration. "An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier (emphasis added) determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice." We have yet to see a change in CMS determination letters specific to this update; however, this is something to watch. Will CMS include provision for a drug prescribed for an off-label use that previously was considered an off-label use not supported by compendia but was paid for by the workers' compensation carrier? This will be interesting to see.



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Escaping CMS' "Haunted" Submission Maze
Rasa Fumagalli, JD, MSCC

Under the Medicare Secondary Payer Act, Medicare is not allowed to make payment where payment has been made or can reasonably be expected to be made under a workers' compensation law or plan, automobile or liability insurance policy or plan. 42 U.S.C. 1395 y(b)(2)(A)(ii). A Medicare Set-Aside ("MSA") allocation is a settlement tool that allows parties to fund future injury related care in connection with their settlement, essentially preventing a future conditional payment by Medicare. There is nothing in the MSP Act or Code of Federal Regulations that requires the parties to fund an MSA; the MSA is a legal fiction.

In order to protect Medicare's Secondary Payer status, the Centers for Medicare and Medicaid Services ("CMS") has indicated a willingness to review MSAs in workers compensation settlements when CMS' workload review thresholds are met. The current thresholds allow CMS review when: the claimant is a current Medicare beneficiary and the projected settlement exceeds $25,000.00 or when the claimant has a reasonable expectation of Medicare entitlement within 30 months of settlement and the projected settlement exceeds $250,000.00. CMS has clearly stated that its review process is purely voluntary. If however the parties choose to use the CMS WCMSA review process, CMS' guidelines and procedures will apply to the review.

CMS' updated Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide ("Guide") (Version 2.6, July 10, 2017) sets forth the documents that must be submitted to CMS for review. The projection "formula" for diagnostic studies, Spinal Cord Stimulators, pain pump implants and drugs is also outlined in the Guide. In the event that CMS determines additional information is needed, development letters may be sent seeking additional records or payout information. Once CMS issues a determination letter that notes the amount of the WCMSA that adequately considers Medicare's interests, the parties may elect to fund the figure. CMS requires a copy of the final settlement documents reflecting the funding of the amount of the CMS determination in order to finalize the figure. Once the determination is finalized, Medicare agrees to become primary upon proper exhaustion of the WCMSA fund. The updated Guide recommends professional administration of the WCMSA funds. CMS' submission process often results in overfunded WCMSAs, delays and unnecessary document gathering.

Given the voluntary nature of the CMS review process, parties to a settlement should also be aware of alternative approaches for avoiding a cost shift of injury related expenses to Medicare. These approaches may include a non-submitted MSA, a compromise MSA, a zero dollar MSA or the NuShield certified MSA. The NuShield certified MSA projects future injury related Medicare covered treatment based on the last two years of medical treatment and Evidence Based Medicine standards. It provides an assist with the proper administration of the funds in order to extend the life of the funds and assure proper expenditures. The certification that Medicare will become primary upon proper exhaustion and the corresponding hold harmless and indemnification agreement associated with the NuShield certified MSA program, provide the parties with additional peace of mind. Get out of the CMS haunted submission maze by contacting our settlement consultant team for more information.

NuQuest's Spine Tingling Result with the New Amended Review Process

Rasa Fumagalli, JD, MSCC

CMS announced the new Amended Review process in the July 2017 updated WCMSAP guide and in the updated WCMSA Reference Guide. Within days of the releases, NuQuest submitted an amended review seeking a significant reduction in CMS 2014 WCMSA determination of $2.3 million. As expected, the amount of the CMS determination had thwarted the settlement. The basis of the request for an amended review was claimant's successful completion of an opioid weaning program in 2016. Although CMS initially declined the amended review, NuQuest's team continued to push for the review finally securing a revised determination in the area of $628,000. Review your open cases too and see if the amended review process may work for you.