Understanding CMS' WCMSA Review Thresholds & Addressing Non-threshold Cases

It has been over ten years since the Centers for Medicare and Medicaid Services (CMS) released its policy memorandum in July, 2001 (known as the "Patel Memo")[1] formally introducing the Medicare Set-Aside (MSA) arrangement regarding workers' compensation (WC) settlements. The WCMSA is CMS' recommended compliance mechanism to protect Medicare's "future interests" under the Medicare Secondary Payer Statute (MSP).[2]

The Patel Memo, in part, established two "review thresholds" outlining when review and approval of a WCMSA by CMS is deemed appropriate.[3] While not every component of CMS' WCMSA review thresholds may necessarily be clear, they have at least provided some practical guidance for the industry in determining WCMSA applicability.

However, the issue quickly plunges into murky waters when the focus shifts to determining WCMSA applicability in "non-threshold" cases – that is, those WC settlements which do not meet CMS' formal WCMSA review thresholds.

On this front, several perplexing questions remain regarding what obligations the parties may have in considering Medicare's interests in non-threshold cases, and exactly how this should (or could) be accomplished. This unusual and troubling state of affairs is largely the result of incomplete and unclear guidance from CMS.

When the dust settles, the question that continues to haunt the claims industry almost a decade into the WCMSA process is: "What should I do if my case does not meet CMS' WCMSA review thresholds?"

This question is currently receiving a fresh new look as primary payers and practitioners re-examine their MSP best practices and compliance protocols. At least one jurisdiction, Maryland, has even recently proposed formal regulations that would require parties to take affirmative measures to ensure that Medicare's interests are considered in non-threshold WC settlements.

In this article, we aim to place the convoluted issue of MSP compliance in non-threshold WC cases into proper and practical perspective. In analyzing this issue, it is important to understand up front that we cannot simply and blindly dive straight into the topic. Rather, the issue first requires an understanding of the WCMSA review thresholds, as determining whether your case first meets the review threshold dictates— or whether or not you will find yourself in the unusual world of non-threshold cases.

Accordingly, to lay the groundwork, we must first examine CMS' WCMSA review thresholds and highlight potential review threshold "pitfalls," such as the popular $24,999 settlement. From this pivot point, the spotlight

then turns to the thorny issue of MSP compliance in non-threshold WC cases.

This analysis is broken down as follows:

PART I

Does My Case Meet CMS' WC-MSA Review Thresholds?

Understanding the Review Thresholds & Avoiding the Pitfalls

Under CMS' WCMSA framework, the initial screening test in determining WCMSA applicability requires an assessment of the type of settlement at issue. CMS classifies WC settlements as commutation or compromise settlements.[4]

A detailed examination of CMS' commutation/compromise distinction is beyond the scope of this article. However, in general, CMS views a commutation settlement as a settlement that compensates claimants for future medical expenses related to the work injury[5], while a compromise settlement is viewed as a settlement that compensates only current or past medical expenses.[6] CMS also notes that it is possible for a single settlement to possess both a commutation and compromise component.[7] Per CMS, a MSA is appropriate only in relation to settlements that possess a commutation aspect.[8]

Along these lines, CMS indicates that admission of lia bility is not the sole determining factor of whether or not a settlement is considered a commutation or com promise.[9] Furthermore, and importantly, CMS states that a settlement which does not provide for future medicals could still be viewed as possessing a commutation aspect if the facts indicate a need for future medical care in relation to the WC injury.[10]

Once it is determined that a particular settlement is a commutation, contains a commutation component, or could possibly be viewed by CMS as possessing a commutation aspect, the focus shifts to determining whether or not the case meets CMS' WCMSA review thresholds.

CMS' Current WCMSA Review Thresholds

CMS' current WCMSA review thresholds are as follows:

Threshold 1 ➔ Medicare Beneficiaries

The claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is greater than $25,000.

Threshold 2 ➔ Non-Medicare Beneficiaries

The claimant is not a Medicare beneficiary at the time of the settlement but has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the total settlement amount is greater than $250,000.[11]

If a WC settlement meets either one of the above thresholds, CMS deems submission of a WCMSA proposal for its review and approval appropriate.

In determining whether a WC settlement meets the review thresholds, it is important to understand how CMS defines the terms total settlement amount (Thresholds 1 and 2), and reasonable expectation of Medicare enrollment (Threshold 2).

How Does CMS' Define Total Settlement Amount?

CMS defines the total settlement amount as follows:

Total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement.[12]

To determine if the monetary component of the review thresholds is met (that is, whether the total settlement amount is greater than $25,000 or $250,000) every settlement should be filtered through each of the above definitional criterion as a matter of standard practice. In doing so, we shall highlight the following three definitional components warranting specific consideration:

Payout Totals For All Annuities:

Structure/annuity MSA funding is commonly used as part of claim settlement. When using these arrangements, it is important to remember that, per CMS policy, it is the total payout to the claimant— not the cost or present day value of the annuity— which should be used to calculate the total settlement amount.[13]

Any Previously Settled Portion of the WC Claim:

Unfortunately, CMS has not provided any further guidance as to exactly what may be considered to fall within this concept. This could create uncertainty in particular situations given the host of payment arrangements (formal, informal and administrative) that are typically used in WC practice.[14]

While it is unclear how CMS could interpret this factor in light of the various payment arrangements commonly used in typical WC claims administration, this definitional component would at least appear to have direct applicability to those situations where there is a settlement closing out indemnity benefits (but leaving medicals open) at one point, followed by a settlement of medicals (including future medicals) at some subsequent point in time. In this situation, the amount of the prior indemnity settlement would seemingly need to be added to the amount of the subsequent medical settlement to determine if the combined sum exceeds the applicable monetary threshold amount.[15]

Repayment of Any Medicare Conditional Payments:

Perhaps the most overlooked (and troubling) component of CMS' total settlement amount definition is repayment of any Medicare conditional payments.[16]

This definitional factor comes into play in settlements involving claimants who are Medicare beneficiaries at the time of settlement (Threshold 1).

Unfortunately, CMS has not provided any guidance regarding exactly how conditional payments should be factored for total settlement amount calculation purposes. A key and interpretational point is how CMS intends

the concept of “repayment” to be applied. In particular, a strict technical interpretation of this concept could result in significant practical complications, as pursuant to current CMS policy, the parties generally cannot obtain the “final” conditional payment amount that would technically need to be “repaid” until after the case is actually settled, and the executed settlement agreement is sent to the appropriate CMS contractor.

Along these lines, this factor could cause considerable problems (or even doom) for the popular $24,999 settlement or a settlement for some other amount that is close to, but does not exceed, CMS’ $25,000 monetary threshold. These settlements are considered sometimes by the parties to keep the claim below the review thresholds. However, by factoring conditional payments (in some manner or form) into the total settlement amount calculation, it is possible that the case could end up tipping over and into the review thresholds— despite the parties’ intentions to keep the settlement under the $25,000 threshold.[17]

Accordingly, absent clarification from CMS, primary payers and practitioners are left to wrestle with how best to address the repayment of any Medicare conditional payment component of CMS’ total settlement amount definition.

In doing so, it is important to recognize the larger issues: (1) Per CMS policy, repayment of any Medicare conditional payments is an includable factor in calculating the total settlement amount for WCMSA review threshold purposes; and (2) Accordingly, a settlement seemingly below the $25,000 monetary threshold could actually end up meeting the WCMSA review thresholds when the repayment of any Medicare conditional payments factor is considered.

How Does CMS Define Reasonable Expectation of Medicare Enrollment?

The next definitional component needing dissection relates to how CMS defines the term “reasonable expectation of Medicare enrollment.” This concept deals with those claimants who are not Medicare beneficiaries at the time of settlement (Threshold 2).

CMS defines reasonable expectation of Medicare enrollment in its April 22, 2003 memo as follows:

Question: *When dealing with a WC case, what is “a reasonable expectation” of Medicare enrollment within 30 months?*

Answer: Situations where an individual has a “reasonable expectation” of Medicare enrollment for any reason include but are not limited to:

a) The individual has applied for Social Security Disability Benefits;

b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;

c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;

d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or

e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

As will be noted, three of the factors (a-c) revolve around the claimant’s social security disability (SSD) status. To determine whether (a-c) could be applicable, direct measures need to be taken to determine the claimant’s SSD status. Best practices dictate that this determination be made via direct inquiry to the social security administration (SSA) for a variety of reasons.

Importantly, it should be noted that CMS' Query Function process, which has been established to determine a claimant's Medicare status in relation to Medicare's new notice and reporting law (Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007)[18], will not provide any information relat ed to the claimant's social security status.

Special attention to factors (b) and (c) is in order. As will be noted, applicability of these factors could, in some situations, ultimately hinge on the claimant's intentions and representations. For example, assume the SSA provides confirmation that the claimant's application for SSD was denied, and that he/she has not appealed or re-filed for SSD. This information is indeed important, but it is only part of the analysis.

In this situation, per CMS' definition, if the claimant "anticipates appealing that decision" or is "in the process of appealing and/or re-filing" for SSD, CMS considers him/her to have a reasonable expectation of Medicare enrollment. Thus, primary payers and practitioners should develop the necessary practice protocols to properly address this aspect of CMS' definition in terms of documenting (as best as possible) a claimant's intentions and representations. Defense practitioners should consult with their clients to determine if they have any specific protocols to be followed in this particular situation, and in relation to the larger issue of determining whether a claimant has a reasonable expectation of Medicare enrollment as defined by CMS.

PART II

My Case Does NOT Meet CMS' WC-MSA Review Thresholds –What Should I Do?

Practical Options & Considerations

If it is determined that the settlement does not meet CMS' WCMSA review thresholds, the focus shifts to those obligations the parties may have under the MSP to consider and protect Medicare's interests in "non-threshold" cases.

To tackle this topic in an orderly fashion, it may be helpful to analyze the issue using the following three-step approach:

Step One: Assess CMS' Policy Statements

The starting point in this analysis is CMS' July 11, 2005 policy memo (Q/A#1) which states as follows:

Question: Clarification of WCMSA Review Thresholds – Should I establish a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) even if I am not yet a Medicare beneficiary and/or even if I do not meet the CMS thresholds for review of a WCMSA proposal?

Answer: The thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered.

CMS revisited the issue in its April 25, 2006 policy memo stating, in pertinent part, as follows:

CMS wishes to stress [that the $25,000 monetary threshold related to Medicare beneficiaries] 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. (Emphasis by CMS).

From CMS' policy statements, important pieces of the puzzle fall into place:

- First, CMS does not consider its WCMSA review thresholds to be safe harbors.
- Second, CMS indicates that its interests must be considered in all WC settlements, regardless of whether or not the settlement meets the WC MSA review thresholds.

But what does this all mean exactly?

Unfortunately, CMS has not really provided much by way of guidance and thus has basically placed the industry in the very peculiar position of having to develop its own practice protocols to determine when, and how, to consider and protect Medicare's interests in relation to non-threshold WC settlements.

Step Two: Develop Practice Protocols to Address Non-Threshold WC Cases

In addressing the issue of non-threshold WC cases, primary payers and practitioners should consider establishing specific non-threshold protocols to ensure that Medicare's interests are properly addressed.

In this regard, it must be recognized that there may not necessarily be a universal or "one size fits all" approach. Rather, each primary payer and practitioner will likely approach the issue differently based on a variety of factors such as, different interpretations of the MSP and CMS' policy statements, and different views and approaches relating to general compliance philoso- phies and objectives, risk tolerance, and other specific considerations.

While approaches may differ in terms of degree and scope, core elements in developing non-threshold protocols generally involve:

(a) Identifying when and in which cases specific measures should be taken to protect Medicare's interests; and

(b) Determining exactly how that will actually be done, such as perhaps including a non-threshold MSA or some other form of future medical projection. (Step Three of this analysis below will address possible options and mechanisms to be utilized).

Regarding concept (a), primary payers and practitioners essentially need to determine in which non-threshold situations they believe specific action should be taken to protect Medicare's interests.

In heading down this path, the question that generally first surfaces concerns whether specific action should be taken in all non-threshold cases. On this point, many take the position that employing specific measures in every non-threshold settlement is unrealistic and unnecessary. This is based upon the premise that Medicare's future interests are not necessarily implicated (or potentially implicated) in every non-threshold situation. Examples often cited from this perspective include claimants with minor injuries that have resolved, or settlements involving younger claimants with minor or non-significant injuries.

More typically, non-threshold protocols generally revolve around such considerations as the claimant's proximity to Medicare entitlement, the claimant's social security status, the severity of the claimant's injuries, and the settlement amount. To a certain degree, these approaches either take into account specific criteria from the WCMSA review thresholds, or are based on some direct variation of the review thresholds.

The following often serve as key factors dictating when parties are more likely to take direct measures to protect Medicare's interests in non-threshold settlements:[19]

1. A settlement involving a Medicare beneficiary where the total settlement amount (per CMS' definition) is $25,000, or less. In this instance, Medicare's interests are already implicated as the claimant is a Medicare beneficiary. (CMS' April 25, 2006 memo could be viewed as supporting this rationale).

2. A settlement involving a non-Medicare beneficiary where only one prong (but not both prongs) of review Threshold 2 is met. (Review Threshold 2 is outlined on p. 2 above).

Example A: A case involving a non-Medicare beneficiary is settled for $250,000 or less, but the facts indicate that the claimant has a reasonable expectation of Medicare enrollment as defined by CMS in its April 22, 2003 policy memo.

Example B: A case involving a non-Medicare beneficiary is settled for $250,000 or less, and it has been determined that the claimant will become a Medicare beneficiary at some point after the settlement (e.g. the claimant is a SSD beneficiary at the time of the settlement, and his/her Medicare benefits in connection with the SSD award are scheduled to commence at some point after the settlement).

In both of these examples, review Threshold 2 is not met. This is so because while the claimant has a reasonable expectation of Medicare enrollment, the total settlement amount in these examples is below the $250,000 monetary component of Threshold 2. However, in terms of non-threshold consideration, the key factor is that Medicare's interests could be implicated (Example A), or will be implicated (Example B) at some point after the settlement.

3. A settlement involving a non-Medicare beneficiary that exceeds the $250,000 monetary threshold, but where the claimant does not have a reasonable expectation of Medicare enrollment as defined by CMS. This is the reverse of point 2 immediately above in that this time the monetary component of Threshold 2 is met (i.e. the total settlement amount is greater than $250,000), but not the reasonable expectation prong. In these situations, there could be several different rationales or concerns at play in relation to the size of the settlement prompting the primary payer or practitioner to include cases such as these as part of their non-threshold protocol.

The above considerations are by no means inclusive, and each non-threshold case should be closely analyzed to determine if taking affirmative steps to protect Medicare's interests is appropriate.

In addition, primary payers and practitioners should determine if there are any applicable administrative regulations, guidelines, or other authority in their jurisdiction addressing non-threshold cases. On this point, the Maryland Workers' Compensation Commission recently proposed formal regulations that would require the parties to take specific measures to ensure that Medicare's interests are properly considered in non-threshold WC settlements.[20]

Importantly, primary payers and their defense counsel need to be on the same page when it comes to how non-threshold cases will be handled and settled. Primary payers should communicate any specific non-treshold protocols to their claims adjusters and defense counsel. Defense counsel should also contact their clients to determine if they have established specific non-threshold protocols. Knowing this information up front and prior to commencing settlement negotiations is crucial in terms of ensuring that the claim is handled and settled in accordance with protocol. If the primary payer has not established non-threshold criteria, the defense practitioner should consult with the client to confirm that they have a complete and proper understanding of the issue.

As for claimant practitioners, it would be prudent to inquire as to whether or not the primary payer involved inyour case has non-threshold settlement guidelines. Additionally, claimant practiioners should independently address this issue and consider developing their own non-threshold practice parameters.

Step Three: Determine the Specific Non-Threshold Settlement Mechanism to Be Used

Once it has been determined that specific measures will in fact be employed to protect Medicare's interests in a non- threshold settlement, the question becomes: What are some practical options and mechanisms that could be used to accomplish this?

With respect to this question, there are conceivably a number of possible options that the parties may wish to consider or deem appropriate under the circumstances.

In regard thereto, the following outlines two options as examples of mechanisms which are commonly used to protect Medicare's interests in relation to non-threshold settlements:[21]

Option A: Non-CMS Approved MSA (Non-Threshold MSA)[22]

This option involves obtaining a non-CMS approved MSA, or non-threshold MSA, from a Medicare set-aside vendor or other MSA allocation specialist. Remember, in this instance since the settlement does not meet the WCMSA review thresholds, the non-threshold MSA would not be submitted to CMS for review and approval.

Aside from obtaining the actual MSA projection, there are several practical considerations that should be addressed. For example, the claimant and his/her lawyer should be placed on notice regarding the specific intent and purpose of non-threshold MSA; namely, that said amount is limited and restricted to compensating the claimant's future accident related medical expenses post-settlement that would otherwise be covered by Medicare. Consideration should also be given to whether or not the claimant has the competency and skills to properly administer the non-threshold MSA account; or whether some form of administration assistance would be appropriate.

In addition, primary payers should consult with their legal counsel to ensure that appropriate settlement language and provisions regarding the non-threshold MSA (as well as any other applicable MSP compliance issues) are properly addressed as part of the settlement agreement. Some general considerations in this regard include, but are not necessarily limited to, documenting exactly how the parties are considering and protecting Medicare's interests; clearly stands and agrees that he/she may only use the non-threshold MSA funds for their intended purpose; addressing pertinent account administration issues and responsibilities, and, in cases where the claimant is self-administering the account, confirming that the claimant understands and agrees that he/she must properly exhaust the non-threshold MSA funds before submitting bills to Medicare for accident related medical treatment.

Option B: Projection & Apportionment of All Injury Related Future Medical Costs

This option involves obtaining a projection and appor- tionment of both Medicare allowable and non-allow- able accident related expenses. Again, since the case in this instance does not meet the review thresholds, the mechanism used under this option would not need to be submitted to CMS for review and approval.

This information can be obtained through a medical cost projection, or some other method, such as the projection of future medicals from the claimant's treating physician, or a cost-projection prepared by an internal case manager, nurse, or other medical professional. Obviously, whatever approach is ultimately selected it should be defensible in the event that CMS ever questions same at some point down the line.

Importantly, similar practical considerations as discussed immediately above in relation to the non-threshold MSA need to be also addressed in regard to whatever mechanism is used under this option. Likewise, counsel should incorporate the necessary and proper settlement language and provisions into the settlement agreement documenting the specific measures being taken to consider and protect Medicare's interests, the intent and purpose of the account funds, the claimant's responsibilities in relation thereto, and matters pertaining to the claimant's proper utilization and administration of account funds.

Conclusion

As the foregoing demonstrates, the issue of MSP compli ance in non-threshold WC cases involves a host of complex issues and considerations that ultimately need to be addressed and determined by WC primary payers and practitioners as part of their MSP compliance programs.

The absence of clear guidance on this issue has, in many respects, created a practical and logistical compliance nightmare on many levels, with concerns regarding potential liability swirling in the balance. The complexity of the issue may defy black and white answers, and the wide array of factual situations that can dot this troubled landscape can present several practical challenges in devising compliance approaches. Nevertheless, as part of any inclusive MSP compliance program, primary payers and practitioners need to address the issue of non-threshold cases and develop the necessary practices and protocols to ensure that Medicare's interests are being properly considered.

Endnotes

[1] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001.

[2] The Medicare Secondary Payer Statute (MSP) is codified at 42 U.S.C. § 1395y, et. seq. In addition, pertinent provisions relat- ed to MSP compliance are contained in Subparts B, C and D of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 411.20 through 411.50, et. seq.)

[3] NQBP understands the larger arguments raised in some quarters questioning the underlying validity of the WCMSA process in general, the agency's WCMSA review process in particular, and the legal "authority" of CMS' policy memoranda. While NQBP acknowledges these issues and arguments, that larger debate is not the focus of this article.

[4] CMS provides a lengthy overview of commutation vs. compromise cases in the Patel Memorandum which should be carefully reviewed in its entirety. See, Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 2-5. See also, Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 2 (FAQ No. 4) and Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Additional Frequently Asked Questions, October 15, 2004, p. 3 (FAQ No. 6).

[5] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 3.

[6] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 3.

[7] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 3.

[8] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 2.

[9] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 2-3.

[10] Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 2-3.

CMS further addresses its commutation vs. compromise distinction in its April 22, 2003 policy memorandum stating as follows: What's the difference between commutation and compromise cases? And can a single WC case possess both? Answer: When a settlement includes compensation for future medical expenses, it is referred to as a "WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire set- tlement has been used to pay for those services.

Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 2 (FAQ No. 4).

[11] CMS sets forth and discusses its WCMSA review thresholds in the following agency policy memoranda:

Parasher B. Patel, CMS Memorandum to All Regional Administrators, Workers' Compensation Commutation of Future Benefits, July 23, 2001, p. 4-6;

Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 1-2 (FAQ Nos. 2 and 17);

Gerald Walters, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions, July 11, 2005, p. 2 (FAQ Nos. 1 and 2); and

Gerald Walters, CMS Memorandum to All Regional Administrators, Workers' Compensation Medicare Set-Aside Arrangement (WC-MSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries, April 25, 2006.

It should be noted that CMS reserves the right to adjust or modify the review thresholds at any time.

As stated, the WCMSA and CMS' review process regarding same is the agency's recommended method to protect its future interests under the MSP. In this regard, CMS has stated that its review procedure is a voluntary compliance process.

While CMS' WCMSA process is technically a voluntary process, a significant segment (if not the majority) of the claims industry has been, and is, complying with the agency's WCMSA review process. Industry compliance with CMS' review process is based primarily upon the belief that obtaining CMS approval provides a degree of security from future liability. The thought being that the parties would be in a far better position to defend any future claim by CMS if the agency was afforded the opportunity to review and approve the proposed WCMSA.

By way of note, in certain quarters some are currently questioning continued participation in the WCMSA review process in light of the difficulties the industry is experiencing in relation to CMS' prescription drug calculation methods (which have been- widely criticized as being unreasonable and unrealistic) that are, in many cases, resulting in significant increases in the WCMSA amount ultimately being required by CMS.

[12] Gerald Walters, CMS Memorandum to All Regional Administrators, Workers' Compensation Medicare Set-Aside Arrangement (WCMSAs) and Revision of the Low-Dollar Threshold for Medicare Beneficiaries, April 25, 2006.

[13] See also, Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions, April 22, 2003, p. 6 (FAQ No. 17).

[14] One example (of many) that could arise in the WC context involves whether CMS would consider an administrative lump sum payment to the claimant to "resolve" a dispute concerning past due indemnity (versus payment made via a formal settlement agreement) a "previously settlement portion of the WC claim?"

[15] In the stated example, per CMS' October 15, 2004 policy memo, at the time of the indemnity settlement, a WCMSA would not have been applicable as medicals were to remain open. In addressing this scenario, CMS provides as follows:

WC Claim Resolution Where Medicals Remain Open – Is a WC Medicare Set-aside Arrangement appropriate when res olution of the WC claim leaves the medical aspects of the claim open?

No. However, a WC Medicare Set-aside Arrangement is appropriate where the resolution of the WC claim permanently closes the medical aspects of the claim, and the claimant will require future medical services related to the WC claim that Medicare would otherwise reimburse.

Thomas L. Grissom, CMS Memorandum to All Regional Administrators, Medicare Secondary Payer – Workers' Compensation (WC) Additional Frequently Asked Questions, October 15, 2004, p. 3 (FAQ No. 6).

[16] A Medicare conditional payment can be defined as a Medicare payment for services for which another payer is responsible and regarding which Medicare is entitled to be reimbursed per the terms and directives of Medicare Secondary Payer Statute. See, 42 U.S.C. § 1395y, et. seq.

[17] As referenced, there remain several unknown and troubling questions in terms of the practical application of this factor.

For example, CMS' use of the word repayment is interesting in that taken literally this could be interpreted to mean the "final" conditional payment amount that CMS ultimately determines is reimbursable. However, under CMS' current policy, the parties generally cannot obtain CMS' "final" conditional payment amount until after the claim is settled and the executed settlement agreement is sent to the agency's contractor. At that point, CMS issues its final conditional payment figure and demand for pay- ment. Accordingly, if it is CMS' intent to apply this factor in said manner, this would seemingly create an impractical and, per haps, unworkable scenario on many levels, and would likely inject additional delay, complication and risk to the process.

As mentioned, absent clarification from CMS, primary payers and practitioners are left to deal with how best to address and apply this

definitional component. Along these lines, addressing this issue would at least seem to entail considering CMS' claimed conditional payment amount, or at the very least the conditional payment amount of which the parties are aware of, at the time of settlement. In doing so, this figure when added to the actual settlement amount to be paid to the claimant could end up yielding a total settlement amount that exceeds the $25,000 threshold amount.

However, this approach (assuming that CMS would even endorse same as an acceptable interpretation of this factor) raises certain practical questions and issues in its own right. For instance, how should the concept of using the conditional payment amount at the time of settlement be measured? The fact that it could take a few months to obtain a conditional payment figure under CMS' current process would seemingly complicate this determination. As it is unlikely that the exact conditional payment amount could be obtained at the exact time of the settlement, would CMS allow the parties to use an interim conditional payment estimate that they may have received during the course of the claim? If so, how recent would the figure have to be?

[Note: Another possible consideration in this regard is how and to what extent (if at all) conditional payment information that may be obtained from MyMedicare.gov could possibly be used. Through this site, it may be possible to obtain conditional payment information. However, from a few accounts received by NQBP, this site may not always contain the most current information. Furthermore, there may be issues regarding informational accuracy and system access in particular situations.]

Another issue would involve the conditional payment amount that should be used for calculation purposes. Should the gross conditional payment figure be used? Utilizing this figure would likely increase the prospects that the monetary threshold amount would be exceeded. Or, would CMS allow the parties to use a reduced figure taking into account removal of inappropriate claims; or perhaps a reduction via application (in some form) of the permitted conditional payment reduction factors contained in 42 C.F.R. § 411.24 and 42 C.F.R. § 411.37?

The following examples may help illustrate the approach and ideas presented:

Example 1:
Note: The following examples assume that the conditional payment (CP) amount could in fact be obtained at the time of settlement or, alternatively, that a CP figure is at least "known" based on an interim conditional payment estimate received by the parties during the course of the claim.

The parties reach a WC settlement agreement (SA) involving a Medicare beneficiary for $20,000. At the time of the settlement, it is determined that Medicare is claiming conditional payments as of that time in the amount $5,000.01.

In this example, if CMS took the position that it is the gross conditional payment amount being claimed at the time of the settlement which must be included in calculating the total settlement amount for WCMSA purposes, then the settlement in this instance would exceed CMS' $25,000 monetary threshold as the combined sum of these figures equals $25,000.01 [$20,000 SA + 5,000.01 CP = $25,000.01]. Thus, using this approach, this settlement would meet CMS' WCMSA review thresholds.

Example 2:
The parties reach a WC settlement agreement (SA) involving a Medicare beneficiary for $12,000. At the time of the settlement, it is determined that Medicare is claiming conditional payments in the amount of $14,000.

If, as in Example 1, CMS took the position that it is the gross CP amount which needs to be included in calculating the total settlement amount, then the settlement would exceed CMS' $25,000 monetary threshold as the combined sum of these figures equals $26,000 [$12,000 SA + 14,000 CP = $26,000]. Thus, using this approach, the settlement would meet CMS' WCMSA review thresholds.

However, a different result could seemingly be reached if CMS in this instance permitted an application of 42 C.F.R. § 411.24(c). Under this section, the amount of recoverable conditional payments is the lesser of either (a) the Medicare primary payment, or (b) the amount of the full primary payment that the primary payer is obligated to pay.

Assuming that CMS would permit an application of this formula at this juncture of the claim, then Medicare's conditional payment recovery would be limited to $12,000 [this amount represents the lesser of factors (a) and (b) above]. Thus, in this instance, the settlement would not meet the WC-MSA review thresholds as the combined figures would only total $24,000 [$12,000 SA + $12,000 CP = $24,000] which is below the $25,000 threshold.

An additional and interesting question that could arise using these approaches involves how, if at all, CMS would allow the includable conditional payment amounts to be reduced by specific claims that the parties dispute or question. Also, to what extent (if at all) would CMS permit the includable conditional payment amount to be reduced by procurement costs per 42 C.F.R. § 411.37?

By way of caveat, the above are presented solely for illustrative discussion purposes only to highlight the significant conceptual and practical difficulties posed by this underdeveloped definitional component. In presenting same, NQBP is not stating or otherwise suggesting that the above approaches represent, or could represent, a proper interpretation of CMS' policy.

[18] Section 111 of the MMSEA is codified at 42 U.S.C. § 1395y(b)(7) and (8).

[19] The outlined factual situations are presented for illustrative purposes only and are not intended to represent legal advice, nor should same be construed as providing legal advice, by NuQuest/Bridge Pointe. Primary payers and practitioners need to independently determine what they believe their compliance obligations are, or may be, under the Medicare Secondary Payer Statute and to formulate the necessary practices and approaches in regard thereto.

[20] In January, 2011, the Maryland Workers' Compensation Commission released proposed regulations to ensure that Medicare's interests are considered in relation to Maryland WC settlements.

These proposed regulations are published in the Maryland Register (Issue Date: January 3, 2011, Volume 38, Issue 1, p. 57-59). These proposals set forth specific directives to be followed by the parties regarding (a) settlements which meet CMS' WCMSA review thresholds and (b) non-threshold settlements.

In regard to settlements that meet CMS' WCMSA review thresholds, the proposed regulations state as follows:

B. Future Medical Expenses.

> (1) In determining whether a settlement must be reviewed and approved by [CMS], the Commission shall apply the Medicare thresholds set forth in the most current memoranda or regulation available at the CMS website.
>
> (2) A settlement that falls within the Medicare thresholds must be approved by CMS before it will be approved by the Commission. (Md. R. p. 58). (Emphasis Added).
>
> In regard to non-threshold settlements, the proposed regulations would require that the parties take certain affirmative measures to ensure that Medicare's interests are considered as follows:
>
> (3) A settlement that falls outside the Medicare thresholds may be approved by the Commission provided that the settlement agreement:
>
> (a) Contains a statement confirming that the interests of Medicare have been considered in reaching the settlement;
>
> (b) Identifies the amount of the proposed settlement:
>
> (i) Apportioned to future medical expenses; or
>
> (ii) Set aside for future medical expenses through a formal set-aside allocation. (Md. R. p. 58).
>
> The proposed regulations also set forth specific evidentiary and documentary requirements as follows:
>
> (4) The apportionment of the amount the settlement associated with future medical expenses shall be supported by medical evidence such as a medical opinion or evaluation.
>
> (5) A formal set-aside allocation shall comply with the guidelines established by Medicare for set-aside allocations. (Md. R. p. 58). The proposed regulations were open for public comment through February 2, 2011. The contact individual to which comments were to be submitted is referenced as: Amy S. Lackington, Administrator, Workers' Compensation Commission, 10 East Baltimore Street, Baltimore, MD 21202, Phone: (410) 864-5300, Fax: (410) 864-5301; E-mail: alackington@wcc.state.md.us. The proposals also noted that a public hearing had not been scheduled in relation to these proposed regulations.

Important note: At the time this article was prepared, the above outlined provisions were proposed (non-final) regulations. As noted, the public was afforded a period of time to "comment" on the proposals. Accordingly, the reader will need to follow up with the Maryland authorities to determine whether or not the above proposed regulations were ultimately enacted (either as proposed, or in some modified version).

[21] NQBP wishes to acknowledge that the "options" outlined in this section are essentially an adoption in large part (with some modifications) of those as presented by Patty Meifert in her very excellent 2007 article entitled MSP Compliance in Settlements NOT Meeting the CMS Review Thresholds: Options for Primary Payers. This article can be obtained by logging onto www.NQBP.com; select News & Resources, and then choose Articles.

[22] The information discussed under these options is not intended to provide (nor should it be interpreted as providing) legal advice from NuQuest/Bridge Pointe. Rather, the information presented is intended for illustrative discussion purpos- es only to provide an example of methods currently being used by primary payers and practitioners in regard to considering and protecting Medicare's interests in non-threshold WC cases. Primary payers and practitioners need to independently determine what they believe their compliance obligations are, or may be, under the Medicare Secondary Payer Statute and to formulate the necessary practices and approaches.