



MEDICARE AND ITS IMPACT ON WORKERS' COMP SETTLEMENTS

The Centers for Medicare and Medicaid Services (CMS) has strengthened its enforcement of the Medicare Secondary Payer (MSP) Act regarding injury-related medical expenses paid by Medicare after settlement of workers' compensation (WC) cases. The cases affected by the Act are disputed claim settlements (WC-DCSs) that impact the right to past and future medical benefits. This article reviews developments in CMS enforcement, explains when Medicare's interests must be addressed as part of settlement agreements involving future medical bills, and outlines the process.

BACKGROUND

Medicare is a federal health care plan available to individuals who (1) are 65 years or older; (2) have received Social Security Disability Insurance (SSDI) benefits for at least two years; or (3) have End Stage Renal Disease (ESRD). Since the 1980s, the MSP statute, 42 U.S.C. 1395y(b)(2), has provided that Medicare will not pay for any items or services for which a Medicare beneficiary has received payment or can reasonably expect payment from a "primary payer." Until 1999, however, CMS's predecessor (the Health Care Finance Administration) focused only on the recovery of Medicare payments of *pre-settlement* medical expenses. CMS continues to enforce this right to reimbursement of past or conditional Medicare payments when Medicare is secondary to a primary payer.

In 2001, CMS stepped up its efforts to prevent Medicare payments for *post-settlement* medical expenses arising from the claim when a Medicare beneficiary resolves a WC claim through a WC-DCS. WC-DCSs involving Medicare beneficiaries have been *subject* to the MSP statute since its inception. Only since 2001, however, has CMS actively pursued enforcement through Medicare Set Aside (MSA) arrangements (defined in the next section).

As a result, to fully protect their clients' interests, attorneys who handle WC cases that involve Medicare-covered future medical expenses must include CMS when settling these cases. An MSA proposal approved by CMS must be part of the settlement.

WHAT IS A MEDICARE SET ASIDE ARRANGEMENT?

An MSA arrangement is an injury-specific projection of the claimant's future Medicare-covered medical expenses, approved by CMS, that allocates and sets aside a specific portion of a settlement to be spent *only* on such expenses. When the MSP statute applies, as outlined in the next two sections, Medicare will not pay for post-settlement, injury-related expenses until the entire MSA amount designated for post-settlement, injury-related expenses is spent.

MSA arrangements apply only to post-settlement, injury-related Medicare-covered services and do not apply to a Medicare lien for past or conditional Medicare payments, nor do they apply to open accepted WC claims. (Past or conditional payments by Medicare should be

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reimbursed to Medicare at the time of settlement.) If the claimant's specific injury could result in future Medicare payments and the MSA review threshold requirements are met, as discussed below, an MSA is necessary.

WC settlement documents should specifically state how much of the proceeds are allocated to future injury-related medical expenses. Omitting a specific amount for future medical expenses in settlement documents will not preclude CMS enforcement. If the settlement documents do not allocate any amount for future injury-related medical expenses, CMS will consider the entire settlement, after payment of past medical expenses, to be allocated for future medical expenses.

To be certain, then, that the claimant's settlement will not be subject to a CMS enforcement action and that the claimant's Medicare benefits will not be unexpectedly denied, CMS must be involved in the settlement. The amount allocated for future medical expenses must then be placed into an MSA and exhausted before Medicare will pay future injury-related expenses.

WHAT ARE THE CONSEQUENCES OF NOT USING AN MSA?

Before 2003, many lawyers questioned the authority of CMS to ask for, let alone require, preapproval of WC-DCSs. Nothing in the original MSP statute seemed to support CMS's position. Accordingly, many attorneys, insurers, and employers chose to ignore CMS's requirement.

In December 2003, however, amendments to the MSP statute greatly strengthened CMS's position. Section 301 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 made technical corrections to the MSP statute and provided additional teeth for recovery of Medicare benefits and enforcement of lien rights.

Now, if Medicare determines that it paid a post-settlement, injury-related medical expense when a primary plan was responsible, the amended MSP statute authorizes CMS to seek recovery from the claimant, medical providers, *attorneys*, structured settlement brokers, state agencies such as SAIF, private insurers, or any other party receiving a payment from the case. If CMS has to litigate to recover payments, Medicare is entitled to *double damages*, and CMS can garnish the claimant's Social Security ben-

efits and income tax refunds. Attorneys who ignore CMS's requirement expose themselves and their clients to these damages.

How does CMS find out that a primary plan was responsible or that the parties didn't involve CMS in the settlement process? The MSP statute requires CMS and its medical providers and suppliers to ask Medicare beneficiaries about payers that are primary to Medicare. Such inquiry is made at the point of service delivery, such as a hospital or doctor's office, as part of the process of opening the medical chart. CMS regularly audits compliance.

Suppose, for example, that Joe, a current Medicare beneficiary, enters into a WC-DCS that allocates \$25,000 for future medical expenses relating to his injury. Joe's attorney does not obtain CMS approval for an MSA arrangement. When Joe next goes for treatment, any health care provider who has not treated him before will ask whether another payer is primary to Medicare. If Joe goes to see the same provider who treated him before the settlement, the provider will already be aware that the injury is related to the WC claim. In either case, the provider will then report this information to CMS, who will investigate the case and deny Joe's claim for the post-settlement, injury-related medical expenses.

In addition, the Workers' Compensation Division of the Oregon Department of Consumer and Business Services has launched a pilot project under which it has agreed to share information regarding WC claims with CMS. This arrangement will allow CMS to identify Medicare recipients with WC claims and to more actively monitor whether its interests are being protected.

WHEN IS AN MSA ARRANGEMENT REQUIRED?

Since July 2001, CMS has required preapproval of MSA arrangements in WC-DCS cases in which either (1) the claimant is a current Medicare beneficiary or (2) there is a reasonable expectation of Medicare enrollment within 30 months of the settlement date *and* the amount of the settlement exceeds \$250,000.

Note that injured individuals who are already Medicare beneficiaries must *always* consider Medicare's interests before entering into a WC-DCS, regardless of whether the total settlement amount exceeds \$250,000. In other words, an MSA is required

in all WC-DCSs, regardless of amount, for current Medicare beneficiaries.

Medicare defines “reasonable expectation of Medicare enrollment within 30 months of settlement” in the following manner, including, but not limited to:

1. Claimant is receiving Social Security Disability Insurance (SSDI) benefits at the time of settlement.
2. Claimant has applied for SSDI or has applied and been denied but anticipates appealing the decision.
3. Claimant is in the process of appealing and/or refile for SSDI benefits.
4. Claimant is age 62.5 or older at the time of settlement.
5. Claimant has End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD.

For injured individuals who are not yet Medicare beneficiaries, both threshold requirements must be met before an MSA is necessary. If the settlement is \$250,000 or less, or the claimant does not anticipate Medicare enrollment within 30 months of settlement, the parties do not need to use an MSA arrangement. If the claimant eventually applies for and receives Medicare coverage, CMS will assume that the claimant has spent down the portion of the settlement amount allocated to future medical expenses and will provide coverage as soon as entitlement occurs.

WHAT ARE ATTORNEYS’ REPORTING OBLIGATIONS?

CMS imposes two separate reporting obligations on attorneys. The first arises when an attorney becomes aware that a client with an injury claim is a Medicare beneficiary. According to CMS, when an attorney is first retained to represent a current or potential Medicare beneficiary on *any injury-related claim*, including both WC and tort claims, the attorney must report to the CMS Coordination of Benefits Contractor (COBC). CMS imposes this obligation on all injury-related claims, and not just WC claims, because of its commitment to recovering past or conditional Medicare payments when a primary payer is responsible.

CMS lists the information the attorney must provide to the COBC at www.cms.hhs.gov/medicare/cob/attorneys/att_detail.asp, and at www.cms.hhs.gov/

medicare/cob/factsheets/fs_attorneys_msplaws.asp. You may contact the COBC by mail, phone, or fax:

Medicare - COBC
MSP Claims Investigation Project
P.O. Box 5041
New York, NY 10274-5041
Phone: 1-800-999-1118
Fax: 646-458-6762

The COBC establishes a case file for your client, enters the submitted information into its main database, and assigns the case to a Medicare contractor, who then handles the details of your client’s case.

The second reporting obligation arises in denied or disputed WC cases. When the parties have reached a tentative WC-DCS, the attorneys should submit their proposed MSA for review to the COBC at:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 660
New York, NY 10274-0660
Attention: WC MSA Proposal

Once recorded in the centralized database, the WC MSA proposal will be electronically forwarded to the CMS Regional Office having jurisdiction for review.

If you have questions about the review process, contact the CMS Regional Office responsible for a particular state for approval of an MSA arrangement. The inquiry should be directed to the attention of the Regional Office Medicare Secondary Payer Coordinator. For Oregon attorneys, the contact information is as follows:

Jonella Windell
Centers for Medicare & Medicaid Services
Region X
2201 Sixth Avenue, MS-40
Seattle, WA 98121
Phone: 206-615-2385

While this process contemplates that the attorney for the claimant will initiate the report, an attorney representing a party considered a primary payer under the MSP statute should be aware that CMS takes the position that *any* party may be liable for damages if the party participates in a settlement without considering Medicare’s interests.

WHAT IS THE MSA PROPOSAL AND REVIEW PROCESS?

In January 2004, CMS published a checklist of information that must be submitted with the request for approval of the MSA amount, known as the allocation proposal. The checklist of requirements can be found at www.cms.hhs.gov/medicare/cob/pdf/wcchecklist.pdf.

Although the demographic information of the MSA proposal is a routine part of the attorney's case file, the medical workup requires extensive expertise about the claimant's medical condition and a thorough understanding of the Medicare billing system. The attorney may need to consult or retain registered nurses, certified life-care planners, and certified disability management specialists experienced in projecting future expenses to develop the medical workup.

After the proposal is submitted to CMS for approval, CMS evaluates it to determine whether the proposed amount is reasonable. In evaluating the reasonableness of the proposed MSA amount, CMS considers numerous factors, set forth in its July 23, 2001, letter found at www.cms.hhs.gov/medicare/cob/attorneys/att_wc.asp. (This Web page also contains links to other letters and Frequently Asked Questions (FAQ) issued by CMS.) CMS may make a counterproposal, but it has taken the position that it retains the final authority to determine the MSA amount. According to CMS, there is no appeal from its decision.

Although CMS has recently set a turnaround target of 60 days from receipt of the MSA proposal, many regional offices take six months to one year for approval. Once approved, the settlement documents are then finalized to include language describing the MSA arrangement, signed, and entered into the CMS case file. The approved MSA amount is then deposited into an MSA account as detailed in the next section.

WHAT ARE THE FUNDING OPTIONS FOR THE MSA?

Three funding options are available for an approved MSA allocation: (1) lump sum; (2) structured settlement annuities; or (3) a combination of the two. Payments to the MSA account are tax-exempt, but earnings are taxed. Structured settlement annuities may be preferable to a lump sum since they require less immediate capital. However, the total lifetime an-

nuity payments are used to determine whether the \$250,000 review threshold amount is met, not the amount used to purchase the annuity. If a structured annuity is used, CMS has specific requirements for initial "seed" money and "annual exhaustion" reports. Regardless of which funding option is used, the claimant's eligibility for other government benefits such as Medicaid must be considered and preserved.

WHAT ARE THE ADMINISTRATION OPTIONS FOR THE MSA FUNDS?

CMS currently permits three administration options: (1) administration by a trustee in accordance with an MSA trust; (2) administration without a trust but subject to a custodial agreement; or (3) self-administration by the claimant. Self-administration is not permitted if the claimant is a minor, incapacitated, or has an appointed Social Security Representative Payee. Self-administration is a malpractice land mine because few claimants are able to follow CMS requirements for MSA documentation and exhaustion.

In all cases:

1. Funds must be segregated in an MSA interest-bearing account and spent only on Medicare-covered, injury-related services after Medicare eligibility is established.
2. Funds must be paid out according to the WC fee schedule in the governing jurisdiction or by the method used in the MSA allocation.
3. An annual accounting and attestation of all payments and account balances, including medical diagnosis codes and medical procedure codes, must be submitted to the Medicare contractor assigned to the case by CMS.

Medicare retains the right to refuse to pay for future medical benefits if it later finds that the CMS administrative requirements were not met.

Most MSA amounts involve a current Medicare beneficiary who is receiving between \$10,000 and \$75,000. Few MSAs exceed \$100,000, and those amounts are seen only in cases of catastrophic injuries. An MSA that involves large amounts of money is best administered by a "Special Needs" MSA trust (the requirements of which are dictated by the MSP statute) to preserve Medicaid and Medicare benefits. These benefits are crucial in most catastrophic injury

cases.

As of May 2004, administration costs and attorney fees may *not* be charged to the MSA and must be paid through some other source completely separate from the MSA funds. CMS no longer permits reasonable costs and fees to be charged to the MSA.

CONCLUSION

CMS enforcement of the MSP Act remains an evolving process. Given the increased focus of CMS to avoid cost-shifting to Medicare, attorneys who handle WC cases involving current or potential Medicare beneficiaries cannot assume that they have protected their clients' interests unless they have addressed Medicare's rights.

Attorneys handling any injury claim for a Medicare beneficiary must give CMS early notice of the claim, and attorneys handling WC-DCS cases for a Medicare beneficiary must comply with all MSA requirements and obtain CMS approval of the MSA amount.

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