Medicare Set-Aside: Compliance Overview

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The History of Medicare and the Medicare Secondary Payer Act

History of Medicare and Medicare Secondary Payer

- 1965 President Lyndon B. Johnson signs Part A and Part B Medicare into law
- 1980 The Medicare Secondary Payer Act becomes law (42 CFRCF 411.20)
- Prior to 1980 Medicare was a primary payer for covered beneficiaries in almost all cases, except those involving workers' compensation (and black lung disease).

History of Medicare and Medicare Secondary Payer

Medicare is for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
- Individuals receiving Social Security Disability Insurance (SSDI) benefits for 24 months (enrollment to Part A Medicare is automatic)

History of Medicare and Medicare Secondary Payer

- 2001 Patel Memo calling for the protection of Medicare's interests in all workers' compensation settlements involving Medicare beneficiaries gave rise to:
  - Medicare Set-Asides come into play
  - Medicare has a process for the review of Workers' Compensation MSA proposals
- 2003 Medicare Advantage Plans (Part C)
- 2004 - 2005 Regional Medicare Contractors begin to initiate recovery of Medicare conditional payments

History of Medicare and Medicare Secondary Payer

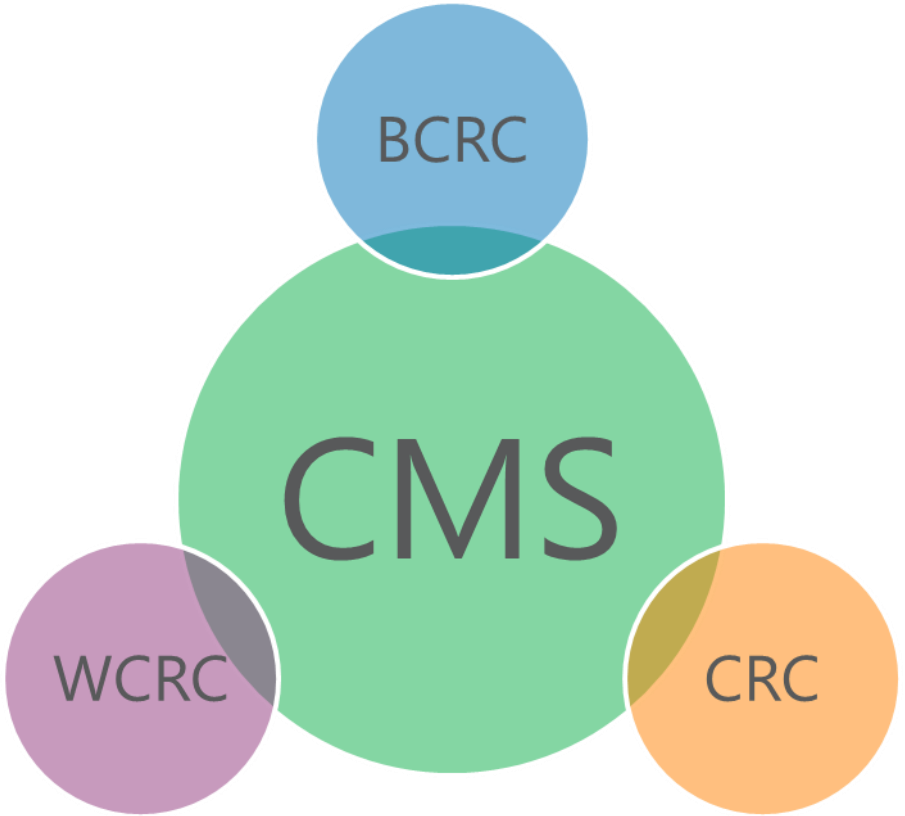
- 2006 Medicare Part D goes into effect
- 2007 Section 111 of the Medicare, Medicaid and SCHIP Extension Act enacted in December. Section 111 requires the providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance (to determine the Medicare-entitlement of all claimants and report certain information about those claims to Medicare
- 2009 Medicare announces the inclusion of prescription drugs in the review of MSA proposals

History of Medicare and Medicare Secondary Payer

- 2011 CMS issues a Memo addressing future medicals in non- Workers' Compensation cases
  - Stalcup Memo issued
  - Benson Memo issued
- 2013 CMS consolidates all Memos into Volume 1 of the Workers Compensation MSA Reference Guide
- 2013 to present: All parties to claim actively participate in Medicare compliance

Working with Medicare - Who's on First?

Working with Medicare- Who's on First?



Working with Medicare- Who's on First?

- Medicare (CMS) uses contractors to carry facilitate much of the work that it does.
- When working with Medicare it is important to know each contractor and the services that they provide
- Centers for Medicare and Medicaid Services (CMS)
  - Responsible for setting overall policy governing
  - Mandatory Insurer Reporting
  - Medicare Set-Asides
  - Medicare conditional payments
  - Medicare coverage of medical services and prescription medication

Working with Medicare- Who's on First?

- Benefit Coordination and Recovery Contractor (BCRC)
  - Responsible for activities related to the collection, management, and reporting of other insurance coverage for beneficiaries
  - Responsible for the recovery of mistaken liability, no-fault, and workers' compensation claims where the beneficiary must repay Medicare (i.e. Conditional Payments)
  - Issues conditional payment letters and demands letters for repayment
  - Accepts appeals related to the conditional payment demand letter from Medicare beneficiary or o/b/o Medicare beneficiary with appropriate authorization.
  - Responsible for reconciliation of Medicare Set Aside trust fund accounts

Poll Question #1

Working with Medicare- Who's on First?

- Commercial Repayment Center (CRC)
  - Effective 10/5/2015 responsible for recovery of Conditional Payments where CMS is pursuing recovery directly from the liability, no-fault or worker's compensation carrier/insurer
  - Issue Conditional payment letters and demands letters for repayment
  - Accept Appeals related to the conditional payment demand letter from carrier/insurer or an agent of the carrier/insurer with a signed Letter of Authority.

The MSA Allocation

The Purpose of an MSA

- To provide funds to the injured party to pay for future medical expenses the would otherwise be covered by Medicare

When to Request an MSA

- An MSA is applicable if future medical portion of a claim is being limited or closed by settlement
  - If the settlement is Indemnity only– no MSA is necessary
  - If the Medical is being left open – no MSA is necessary
- The MSA can be prepared and funded even if CMS does not or will not review
- The primary payer must not shift burden of paying for future medical costs to Medicare.
- To do so is a violation of the law

Documents Used to Complete the MSA Allocation

1. First Injury Report (if available)
2. Medical Treatment Records
   - Ideally 2 years of medical records
   - If the MSA will include multiple claims, 2 years of medical records should be submitted for each claim
   - IME, AME, QME, PQME are not considered medical treatment records by CMS
   - Physical, occupational and speech therapy services are not needed to complete the MSA allocation
3. Claim Payment Log (showing all medical, indemnity and expense payments)
4. Pharmacy Log showing the name, dose and date of pharmacy filled on claim)
5. Any denial letters sent to Claimant (if applicable)
6. Any Court Orders relating to denied claims/conditions/treatment (if available)

Zero Dollar and Limited Future Medical MSAs

Zero MSAs

- What do you do if you have a denied claim, where little or no benefits were paid on the claim and you have a client insisting on completing an MSA?
- Circumstances that point to a Zero MSA:
  - The claimant has been fully discharged from treatment and the treating physician has opined that future medical treatment is not necessary;
  - The claim has been fully denied and no medical or indemnity benefits have been paid on the claim.
  - In certain jurisdictions such as California CMS may approve a Zero dollar MSA even when minimal medical payments were paid on the claim as authorized by the state workers' compensation statute (See §5402 CA Labor Code)

Submitting the Zero MSA to CMS for Review

CMS requires that the submitter provide significant documentation to support the Zero dollar MSA including:

- First Injury Report (if available)
- A signed statement on carrier or carrier attorney letterhead confirming that no medical or indemnity payments have been made on the claim
- Medical records and pharmacy information (even if the carrier did not pay for treatment)
- Payment history
  - Itemized payment history run for the life of the claim that includes expense, medical and indemnity subtotals even if zero.
  - If the carrier is unable to provide a printable history the carrier or carrier attorney may provide a signed letter of explanation on letterhead stating why there is no printable history.
  - The letter should be accompanied by a signed copy of the available pay record noting that it is a complete representation of all payments on the claim.

Limited Future Medical MSAs

- A state Workers Compensation statute that limits the timeframe and nature of the claimant's future medical care may be use to limit the MSA allocation.
- CMS addresses these limitations in their WCMSA Reference Guide (See WCMSA Ref. Guide Section 9.4.5)
- According to the WCMSA Ref Guide CMS will recognize state specific workers' compensation statutes that address the limits of future treatment regarding the length and nature of future treatment if:
  - by finding from a court of competent jurisdiction, or appropriate state entity as assigned by law, that the specific WCMSA proposal does not meet the state's list of exemptions to the legislative mandate.
- If electing to submit a limited future medical MSA to CMS for approval parties should obtain a Court Order addressing the injuries associated with the claim, indicating that the claimant is not entitled to medical treatment beyond the timeframe indicated by statute and that the claims does not meet any of the exceptions found in the particular statute.
- Example: Georgia Code § 34-9-200 which limits the maximum period benefits to 400 weeks from the accident date if the injury is deemed as non catastrophic .

To Submit or Not Submit: That Is The Question

MSA Submission

- The primary benefit of submitting the MSA to Medicare (CMS) is the certainty associated with CMS' review process and approval of the appropriate amount that must be exhausted.
- CMS approval of a proposed Workers' Compensation Medicare Set-Aside (WCMSA) amount is not required. Submission of MSA submission is a voluntary process.
- "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures to obtain approval"
- CMS has a formal review process for the submission of a Workers' Compensation MSA proposal only. At this time CMS has no formalized review process for the submission of a Liability MSA proposal.

MSA Submission

- CMS will review a proposed WCMSA amount when the following workload review thresholds are met:
  - The claimant is a Medicare beneficiary and the total settlement amount is greater than$25,000.00; or
  - The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00.
- What is considered a reasonable expectation?
  - Claimant that is 62 ½
  - Claimant that is receiving SSDI benefits
  - Claimant with End State Renal failure
  - Claimant that has ALS
  - Claimant that is Federal Rail Retiree

Documents Necessary for WCMSA Submission

- Medical Treatment Records (most recent 2 calendar years; if there are multiple claims covered in the MSA records must be included for each claim)
- Consent to Release Note
- Rated Age Information or Life Expectancy
- Future Treatment Plan
- Settlement Agreement (if available)
- Total Proposed Settlement Amount
- How the MSA will be funded- lump sum or structured settlement
- How the MSA funds will be administered- self administered or professional administration
- Payment history (run date w/in 6 mos. of submission) Pharmacy History detailing RX filled on claim
- Supplemental Info e.g. FROI, Court Orders, Claim Denial letter, copy of state statute

Consent to Release Note

- Effective April 1, 2020 the language on the Consent to Release required for MSA submission changed
- Changes includes a statement that the need and process for the WCMSA have been explained to the injured worker, and that the injured worker has approved the contents of the submission, including the allocated funds.
- As a result of this change requires the claimant must both sign the Consent form an initial the statement regarding approval of the MSA submission.
- CMS will not review the MSA submission until they receive a properly signed and initialed Consent to Release

Consent to Release Note

CONSENT TO RELEASE

CMS Case Control Number:

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without express written permission from the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, _____, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and its contractors to disclose, discuss, and release orally or in writing, information related to my injury and settlement to the individual(s) and firm(s) listed below. The consent is for my current workers' compensation or liability claim and is on an ongoing basis. An additional consent to release will not be necessary unless and until I revoke this consent in writing. Additionally, the need for a Workers' Compensation Medicare Set-Aside Arrangement and the process has been explained to me, and I approve of the contents of my submission.

Beneficiary Initials _____

PLEASE CHECK

( ) Claimant's Attorney _____ (name and/or firm)

( ) Employer's Attorney _____ (name and/or firm)

( ) Workers' Compensation Carrier _____ (name and/or firm)

(X) Other **Genex Services, LLC**

Claimant Signature: _____ Date signed: _____

MSA Determination Letters

- The MSA proposal is submitted to CMS for review. The WCRC will review the MSA proposal and when review is complete the recommendation is sent to the CMS Regional Office for determination of the final CMS-approved WCMSA amount.
- If the MSA proposal was submitted via the MSA Portal the submitter will receive an alert when the final WCMSA amount is determined. The alert will provide a link to a copy of the MSA determination letter.
- The determination letter will provide the amount that CMS believes will adequately protect their interests.
- The determination letter should also provide an allocation breakdown and a rationale for the decision.
  - A Counter Higher is when CMS approves the MSA in an amount that is higher than what was proposed.
  - A Counter Lower is when CMS approves the MSA in an amount that is lower than what was proposed.

Poll Question #2

MSA Determination Letters

- A copy of the determination letter will be mailed to the claimant and claimant's attorney (if they are represented and the attorney information was provided with the submission)
- Approval of this WCMSA amount is not effective until CMS receives a copy of the final executed workers' compensation settlement agreement, which must include the approved WCMSA amount.
- If the recommended WCMSA amount (which is a combined total of medical and prescription costs) is within 5% of the submitter's total proposed WCMSA amount, the WCRC recommendation is approval of the submitter's proposed amount.
  - Change in MSA Funding Requests After CMS Decision
- Parties may request a change in how the MSA is funded (lump sum vs. structured payment) after the CMS determination has been issued.
- The claimant (and attorney if they are represented) must provide a signed letter indicating that they are aware of the request to change MSA funding request and understand and agrees to change the funding.

MSA Administration

MSA Self-Administration

- The MSA should be administered by a competent administrator
- The MSA can be administered either by the claimant (i.e., self-administered, if permitted under state law) or third-party trustee, such as a guardian. If self-administered:
  - Claimant receives settlement and MSA funds
  - Claimant deposits MSA funds in interest bearing account
  - the claimant must deposit MSA funds in a separate account and will only use the funds in this account to pay for future treatment.
  - Claimant notifies health providers of MSA
- Claimant visits health care provider for work injury related treatment
  - Claimant pays medical bills from MSA funds and keeps receipts and a record of expenditures
  - Claimant sends annual accounting and attestation to Medicare detailing the amount of MSA funds spent throughout the year

MSA Professional Administration

The MSA can be also administered by a professional administration company or trust company

- The professional administrator
  - receives MSA funds and establishes an account for the claimant's future medical care.
  - receives provider bills and pays them on behalf of the claimant
  - handles all required annual reporting
  - ensures compliance with Medicare
  - can negotiate rates and save money on treatment.
  - some professional administrators provide claimants with a debit card that they can use to pay for their medical treatment.
- CMS highly recommends professional administration when the claimant is taking controlled substances that CMS determines are "frequently abused drugs" according to CMS' Part D Drug Utilization Review policy.

Re-Review and Amended Review of the MSA Decision

MSA Re-review

CMS will review the MSA determination under the following circumstances:

1. You believe CMS' determination contains obvious mistakes (mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS has already occurred). Or
2. You believe you have additional evidence, not previously considered by CMS, which predated the WCMSA submission date of the original proposal and warranted a change in the CMS determination.
3. Re-review requests are typically made shortly after CMS issues the MSA determination

Amended Review

- In July of 2017 CMS established a formal MSA appeal process
- Today cases meeting the following criteria are appropriate for an Amended Review :
  - Request must be made at least 1 year after the CMS determination issued but not more than 6 years from the date of the original CMS determination a
  - The case has not yet settled as of the date of the re-review request
  - No prior Amended Review request has been made (you only get 1 shot!!)
  - A change in care of at least 10% or $10,000 since the previously approved MSA
  - The change in care is not solely based on medication going from brand to generic
  - Medical treatment records available and demonstrate the change in care
  - CMS will deny the request if submitter fails to provide the above justifications for review and submitters will not be permitted to supplement the request.

Medicare Conditional Payments (liens)

What is a Medicare Conditional Payment

- A conditional payment is a payment that is made by Medicare for medical care for which another party is responsible.
- According to 42 U.S.C. §1395y(b)(2)(B)(i) (also known as the Medicare Secondary Payer Act) where other insurance is available Medicare is to be a secondary not primary payer. When the primary insurer cannot reasonably be expected to pay promptly Medicare will make a conditional payment which is to be reimbursement at a later date.
- Medicare Secondary Payer (MSP) is the term generally used when the Medicare program does not have primary payment responsibility.
- Practitioner Tip: Be specific about what conditions are accepted on the claim. This information is reported to Medicare and it should be accurate so that you are not accepting any conditions unrelated to the claim. Also conditions that are reported to CMS via Section 111 reporting should match the information that is in the MSA report.

Conditional Payments

Are all of the charges on the Conditional Payment Letter (CPL)related to the claim?

- The Statement of Reimbursement/ Payment Summary Form will provide a listing of Part A and Part B medical claims conditionally paid for by Medicare.
- Each line item listed on the Statement of Reimbursement/ Payment Summary Form should be reviewed for to ensure that the included ICD codes relate to the reported injuries.
- If CMS issues a CPL and you disagree with what is listed you must submit a response prior to the response date listed on the letter.
- If no response is filed within the specified timeframe listed on the CPL a demand for repayment letter will be sent

Medicare Demand Letters

- You have 120 days from the date of the demand letter to dispute or appeal. The due date for the appeal will be listed on the letter.
- Interest begins to accrue on the debt within 60 days of the date of the letter if the debt is not fully resolved.
- You can pay CMS and still retain your appeal rights.
- If your appeal decision is favorable/partially favorable CMS will refund the monies paid.

Medicare Demand Letters

Dispute Response - If your organization submitted a dispute in response to the Conditional Payment Notice (CPN) or Conditional Payment Letter (CPL), the enclosed Payment Summary Form will identify the claims that were disputed and the outcome for each claim/claim line.

Payment - Please provide a check or money order made payable to **Medicare** in the amount of $18,596.01. If the amount payable under your coverage as primary payer is less than the demand amount, please provide documentation that explains the lesser payment along with the check or money order. The amount requested in this letter may not include payments received prior to the date of this demand letter. Please deduct any previous payments made to Medicare for this debt.

Submit payment and your organization's payment ledger or similar document on your organization's letterhead, identifying the claims the payment represents by the above-referenced due date for payment to the CRC address listed below.

Right to Appeal - If your organization believes the amount or existence of the debt is in error, an appeal may be filed. To file an appeal, send a letter explaining why the amount or existence of the debt is incorrect, including supporting documentation, if applicable. Medicare will continue collection efforts unless and until an appeal is requested. Medicare will suspend any recovery action while an appeal is pending; however, interest will continue to accrue on any outstanding balance from the date of this letter.

Your organization has 120 days from receipt of this letter to file an appeal. We must assume that your organization received this letter within 5 days of the date of the letter unless your organization provides proof to the contrary. This means the appeal must be filed no later than the above-referenced response due date for an appeal request.

CMS Demand Letters

Interest - Interest will accrue on any unpaid portion of this debt from the date of this letter. Interest will begin to be assessed if this debt is not fully resolved within 60 days of the date of this letter at an annual rate of 10.750% and is payable for each full 30 day period the debt remains unresolved. By law, all payments are applied to interest first, principal second. For provisions specific to interest on MSP debts, see 42 C.F.R. 411.24(m).

Referral to Treasury - The provisions of the Debt Collection Improvement Act of 1996 (DCIA) applies to all Medicare debts. The failure to respond as requested, within 60 days of the date of this letter, may result in the initiation of additional recovery procedures without further notice. The DCIS requires Federal Agencies to refer debts to the Department of Treasury or its designated debt collection center for recovery actions, which can include, collection by offset against tax refunds owed to your organization or other entities. DCIA also allows Medicare to refer delinquent debtors to the Department of Justice for legal action.

Poll Question #3

Top Tips for Handling Conditional Payments

1. Investigate and obtain Medicare conditional payments early on.
2. Do not ignore any correspondence that you receive from Medicare, any of its contractors (BCRC/CRC) or the US Department of Treasury. Read, review and respond.
3. Failure to timely respond to Medicare may cost you in the long run. Interest begins to accrue on demanded payment 60 days after the demand letter is sent
4. Pay Medicare and still dispute or appeal. You can repay Medicare's demand to avoid the accrual of interest and still retain your appeal rights. If you prevail Medicare will refund the money to you.
5. Any evidence or documentation that you have to support the dispute/appeal is key.
6. A Medicare beneficiary can change Medicare enrollment annually during open enrollment. There is the potential to have conditional payments from both Traditional Medicare (red, white and blue card) and Medicare Advantage Plans e(.g. Humana, Aetna, Anthem)

What are the Penalties for Failure to Repay Medicare?

- Pursuant to 42 U.S.C. 1395y(b)(2)(i)(ii)(iii), CMS may refuse to recognize a settlement and seek reimbursement for medical expenses paid by Medicare for which another primary payer was responsible.
- CMS has the right and may pursue a private cause of action for double damages against the carrier/insurer for failure to provide primary payment or reimbursement.
- CMS may also seek reimbursement directly from the Claimant and from Attorneys associated with the claim.
- The Medicare beneficiary could lose their Medicare benefits

Questions?

Thank you

for attending this MSA presentation

Please feel free to contact me with any additional MSA/MSP questions.

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