Medicare Set-Aside: Compliance Overview

October 2017

Traditional Medicare and Medicare Advantage Plans

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- Medicare was enacted in 1965 by President Lyndon B Johnson to provide national health insurance coverage for certain individuals.
- Today Medicare is a health insurance program 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

Traditional Medicare

- Medicare Programs are run via the Centers for Medicare and Medicaid Services (CMS).
- The Medicare Program has 4 Parts:
- Part A - Hospital Insurance,
- Part B -Outpatient Medical Services
- Part C -Medicare Advantage
- Part D -Prescription Drug Coverage

Medicare Advantage Plans

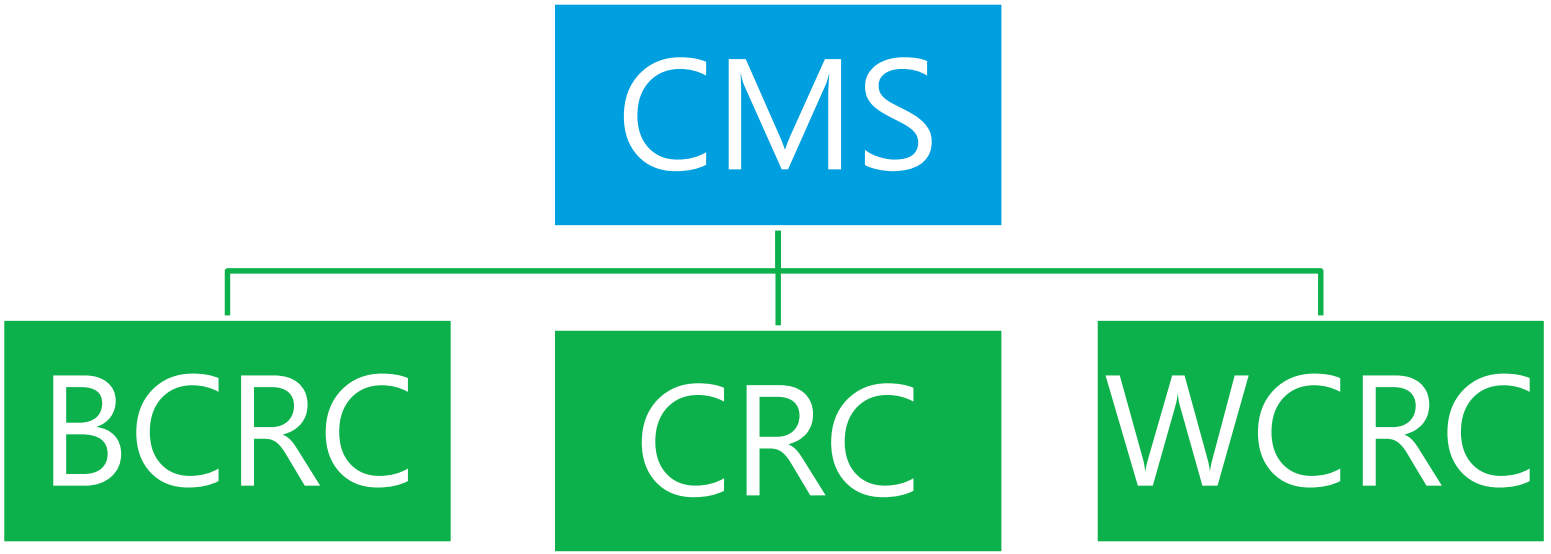
- Medicare Advantage Plans (MAP's) are run by private health insurance companies that are approved by Medicare.
- MAP's include:
  - HMO
  - PPO- Preferred Provider Organization
  - PFFS- Private Fee-for-Service Plans

Medicare Advantage Plans

- Unlike Traditional Medicare (Parts A&B) there is no centralized benefit coordination for MAP's so if you need to obtain information (e.g. conditional payments) from a MAP, the specific plan name and address is needed.
- Medicare beneficiaries can switch back and forth between Traditional Medicare and Medicare Advantage Plans during Medicare open enrollment (annually).

The Big Four

An Overview: CMS, BCRC, WCRC and CRC



An Overview: CMS, BCRC, WCRC and CRC

- Centers for Medicare and Medicaid Services (CMS)
  - Responsible for overall policy governing Mandatory Insurer Reporting, Medicare Set Asides and conditional payments
  - Overall responsibility for MSA Submissions
  - Final settlement documents are submitted to CMS

- Benefit Coordination and Recovery Contractor (BCRC)
  - Responsible for Mandatory Reporting
  - Data Collection from RREs for Mandatory Reporting
  - Intake for claim reporting
  - Responsible for Medicare Conditional Payments
  - Medicare Set Aside Reconciliation Medicare Set Aside Trust Fund Accounts

An Overview: CMS, BCRC, WCRC and CRC

Workers' Compensation Review Center (WCRC)

- Responsible for the review of WCMSA proposals
- Responsible for developing the MSA case if submitted documentation is incomplete or insufficient
- Responsible for issuing a MSA approval letter

Commercial Recovery Center (CRC)

- Responsible for Medicare Conditional
- 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 Notice or Conditional Payment Letter
- Accept Appeals from carrier/insurer

Poll Question

In what year was Medicare enacted?

- 1965
- 1975
- 1985

Best Practices for File Handling

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File Handling Considerations- First Things First

On every file you should determine what you will need to do to achieve claim resolution

- First, determine the claimant's status:
- Is the claimant of Medicare age or receiving Social Security Disability Insurance (SSDI) benefits?
- Will the claimant become a Medicare beneficiary within 30 months of settlement due to age (62.5) or SSDI entitlement?
- Obtain written confirmation of the claimant's status from Social Security Administration (relying on the claimant or counsel's self reporting of Medicare status may be to your detriment)

File Handling

- Have you received any letters from Medicare or its contractor's putting you on notice of Medicare's involvement on the claim?
- Will the medical portion of the claim be left open or will the settlement include future medical expenses?

The Purpose of an MSA Allocation

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

Medicare Set Aside

If the claimant is a current Medicare beneficiary or will become a Medicare beneficiary within 30 months of settlement and the settlement will include future medical treatment consider a MSA Allocation:

- The MSA allocation determines future medical/pharmacy exposure for Medicare and is a component of the future medical settlement of a file
- The MSA documents past, present and future medical/pharmacy treatment
- The MSA may include a rated age decreasing the life expectancy of the claimant and thus reducing the allocation

Medical Cost Projection

If the claimant is not a Medicare beneficiary consider a Medical Cost Projection

- A Medical Cost Projection can help establish claim reserves?
- Medical Cost Projections also serve to establish a medically accurate picture of future medical exposure.

Submission of the MSA

MSA Submissions

- The primary benefit of submitting the MSA to Medicare for approval is the certainty associated with Medicare's review and approval of the appropriate amount that must be exhausted.
- Submission of the MSA is always a **voluntary** process
- If you choose to use the review process, the CMS requests that you comply with established policies and procedures.

WCMSA Submission Thresholds

- CMS will review an MSA proposal 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 becoming a Medicare beneficiary within 30 months of the settlement date and the anticipated total settlement amount is expected to be greater than $250,000.00.
- ** If the settlement does not meet MSA submission thresholds you can still create and fund an MSA without sending to CMS for review.**

MSA Submission Requirements

The following documentation is requested by Medicare when submitting a MSA proposal for review (WCMSA Reference Guide Section 10.0):

- Submitter/cover letter
- Consent to Release form signed by claimant
- Rated age information or life expectancy
- Total tentative or proposed settlement amount or a copy of the draft/final settlement

MSA Submission Requirements

- Method of MSA funding- lump sum or structured settlement. (Genex will defer to annuity funding- ask me why?)
- Medical records- last 2 full years of medical treatment records
- Claim payment history showing the total payments for all medical, indemnity and expense paid
- Prescription history detailing the name, dose and frequency of all medication filled by claimant in relation to the claim
- Supplemental or additional information e.g. court orders, copy of state statute

MSA Determination Letters

- After review of the MSA proposal CMS will issue a MSA determination letter.
- The letter will indicate the amount that Medicare has determined to adequately protect their interests
- If the MSA is to be funded via a structure, a seed and annual payment breakdown will be included in the determination letter.
- When an MSA is submitted to CMS for review CMS will not close out their file until Final Settlement Documentation is received.

Use of the MSA funds

- The majority of MSA's are self administered or self directed i.e. the claimant is given the MSA funds and must establish and maintain the MSA account.

- The claimant should be advised that once the MSA Account is established all bills for accident related treatment and medication are to be paid from the MSA Account.

MSA Allowable expenses include:

- photocopying charges
- mailing fees/postage
- banking fees directly related to the account
- incremental tax paid on the interest income earned by the WCMSA Account
- Legal fees and professional administration fees are not WCMSA allowable expenses
-

Use of the MSA funds

- If the MSA account is depleted and medical treatment is still needed, Medicare should be notified immediately. This is true even in a case when the MSA funds are received via a structured settlement as it is possible to have a shortfall of funds in any given year.
- Medicare will assume the role of the primary payer and begin paying for accident related treatment as long as the funds were properly spent and correctly reported to Medicare.
- If there is any doubt as to the ability of the claimant to properly administer the MSA funds professional or custodial administration should be considered. e.g. Claimant has a designated Payee Representative
- If payments from the WCMSA are used to pay for non-allowable expenses, Medicare will not pay bills for the work injury until the funds are restored to the MSA Account and then properly exhausted.

Poll Question

Submission of the Medicare Set Aside is required by law?

- True
- False

Re- Review and Amended Review

MSA Re-review

CMS will however undertake a 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.

Amended Review

- Effective 7/10/2017 CMS outlined criteria in their WCMSA Reference Guide for when CMS will take another look at older CMS determinations for claims that have not yet settled .
- Cases meeting the following criteria are ripe for an Amended Review of the CMS determination:
  - CMS issued a approval at least 12 but no more than 48 months prior
  - The case has not yet settled as of the date of the re-review request
  - A prior Amended Review request has not been made (you only get 1 shot!!)
  - Projected care has changed so that the new proposed MSA would result in a 10% or $10,000 change (whichever is greater) in the previously approved MSA
  - If approved by CMS the new approval amount will take effect on the settlement date regardless of whether the amount increased or decreased

Amended Review Cont'd

- The Amended review request is technically a new submission of the WCMSA. It may be delivered either via paper or portal submission.
- In order to justify the request the submitter must provide the CMS Recommendation Sheet that was included with the original approval and justification for the request:
  - 1) if treatment/surgical procedure was included in the original determination and claimant has already had treatment/surgery must provide specifics to CMS.
  - 2) If care/treatment was included in the original determination and is no longer required must provide specifics to CMS.
  - 3) If additional care/treatment is required that was not included in the original determination must provide specifics to CMS.
- If the reason for the request for Amended Review is related to a change in pharmacy from brand to generic CMS will not entertain the request for Amended Review
- 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)

Conditional Payments

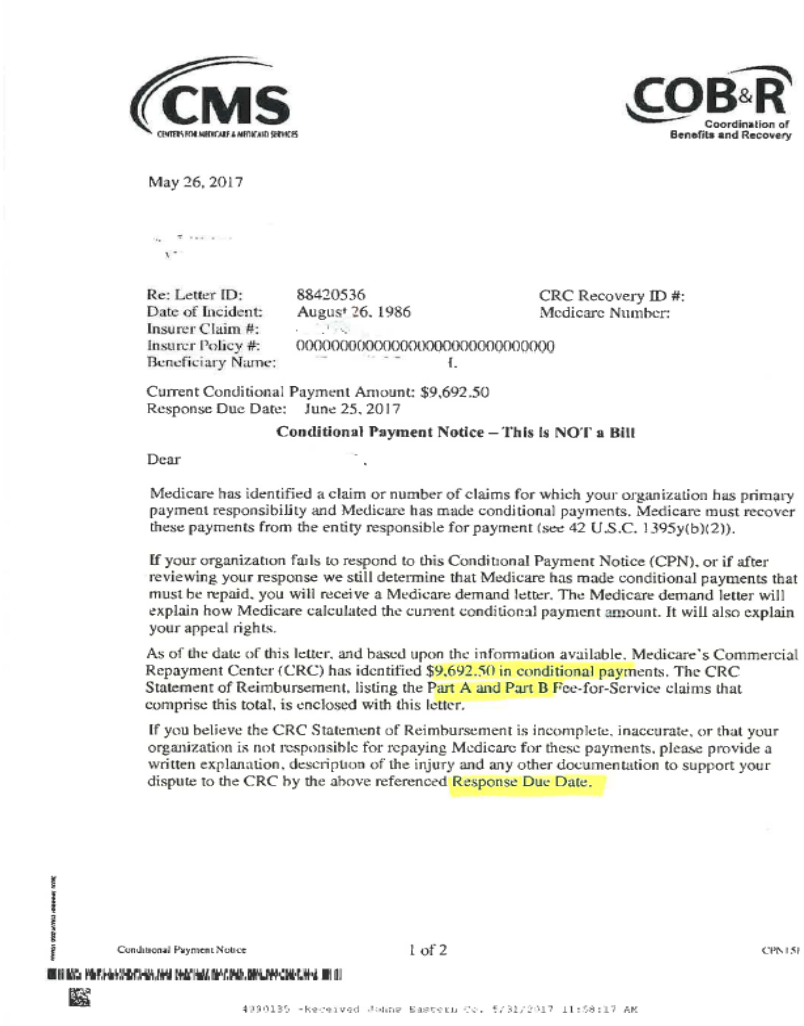
- When a claim is reported to Medicare all ICD codes associated with the claim are reported. The reported diagnosis code(s) are compared to payments Medicare has made for treatment received by the Medicare beneficiary. From the injury/accident date forward, any payments Medicare has paid with the same diagnosis code(s) must be refunded to Medicare.

Conditional Payments

- Medicare will issue either a conditional payment letter (CPL) or conditional payment notice (CPN) detailing services that they have paid for in relation to the reported ICD codes.
- 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 Payment Process

Sample Conditional Payment Notice



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

May 26, 2017

Re: Letter ID: 88420536 CRC Recovery ID #:
Date of Incident: August 26, 1986 Medicare Number:
Insurer Claim #:
Insurer Policy #: 00000000000000000000000000000000
Beneficiary Name:

Current Conditional Payment Amount: $9,692.50
Response Due Date: June 25, 2017

Conditional Payment Notice – This is NOT a Bill

Dear

Medicare has identified a claim or number of claims for which your organization has primary payment responsibility and Medicare has made conditional payments. Medicare must recover these payments from the entity responsible for payment (see 42 U.S.C. 1395y(b)(2)).

If your organization fails to respond to this Conditional Payment Notice (CPN), or if after reviewing your response we still determine that Medicare has made conditional payments that must be repaid, you will receive a Medicare demand letter. The Medicare demand letter will explain how Medicare calculated the current conditional payment amount. It will also explain your appeal rights.

As of the date of this letter, and based upon the information available, Medicare's Commercial Repayment Center (CRC) has identified $9,692.50 in conditional payments. The CRC Statement of Reimbursement, listing the Part A and Part B Fee-for-Service claims that comprise this total, is enclosed with this letter.

If you believe the CRC Statement of Reimbursement is incomplete, inaccurate, or that your organization is not responsible for repaying Medicare for these payments, please provide a written explanation, description of the injury and any other documentation to support your dispute to the CRC by the above referenced Response Due Date.

Conditional Payment Notice 1 of 2 CPN151

4090135 -Received Johns Eastern Co. 5/31/2017 11:58:17 AM

Sample Statement of Reimbursement

Commercial Repayment Center (CRC)
Statement of Reimbursement

May 26, 2017

Letter ID: 88420536
Medicare Number:
Beneficiary Name:

CRC Recovery ID #:
MSP Case Type: Workers' Compensation
Date of Incident: August 26, 1986

Total Principal Amount Due Medicare: $9,692.50
Reported Diagnosis Code(s): 72283

TOS/Line # ICN	From Date To Date	Provider NPI #	ICD Indicator ICD 9/ICD 10	Diagnosis Code(s)	Total Charges	Reimbursement Amount	Conditional Payment
60/0 21414201822507NTA	05/14/2014 05/18/2014	HMA SANTA ROSA MEDICAL CENTER LLC 1528015302	9	496.515,71590.2724,7226. 99811,4240,53081,99813,2 749.4779.5770.E8788.401 9,53560,311,41401	$37,652 46	$9,562 59	$9,562.59
71/1 590217025683280	01/16/2017 01/16/2017	DAVID A DISANTO 0	0	M5410,M1288,M4692,M7 91,M542,G894,M5412	$199 49	$129 91	$129 91
				Total	$37,851.95	Total $9,692 50	Total $9,692 50

Conditional Payments-Are all of the charges on the CPN/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 relatedness to the claim.
- If CMS issues a CPN and you disagree with what is listed you must submit a response prior to the listed date. If no response is filed within the specified timeframe listed on the CPN a demand for repayment will be issued.

Conditional Payment Disputes/Appeal

Conditional Payment Appeals

When CMS issues a demand for repayment the demand amount must be paid within 60 days of the receipt of the demand letter or interest will begin to accrue.

- If you disagree with CMS you may file an appeal.
- CMS does encourage parties that appeal the demand to pay and dispute/appeal in order to avoid interest accruing on the debt.
- Interest continues to accrue during the appeal process if the debt remains unpaid.
- If payment is not made to CMS within 120 days after the demand notice the debt will be referred to the US Department of Treasury.

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 claimant could lose their Medicare benefits.

Poll Question

When CMS issues a demand for repayment letter the Medicare conditional payments must be satisfied within this time frame or the debt will be referred to the Department of Treasury?

- within 60 days of the date of the demand letter
- within 120 days of the date of the demand letter
- within 180 days of the date of the demand letter

Conditional Payments

Practitioner Tips:

- Investigate conditional payments early on, don't wait until you are headed to the settlement table.
- Don't ignore correspondence that you receive from CMS or any of its contractors. Read, review and respond (if necessary).
- Failure to timely respond to CMS may cost you in the long run.
- Make sure that you take a proactive approach to ensuring that conditional payments are satisfied so that you can close your file knowing that there are no loose ends.

Thank you

for attending this MSA presentation

Please feel free to contact me with any additional MSA questions

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