Medicare Set-Aside
The Basics

March 2016

Agenda

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- FMQ (Frequent Medicare Quandaries)

History of Medicare and Medicare Secondary Payer Act

- Medicare was enacted in 1965 to provide national health insurance
- 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 consecutive months are automatically entitled to Part A Medicare benefits.
- Today there are 4 Parts associated with the Medicare Program:
  - Part A Hospital Insurance
  - Part B Medical Insurance
  - Part C Medicare Advantage Plans
  - Part D Prescription Drug Coverage

Medicare Secondary Payer Statute

- The Medicare Secondary Payer (MSP) statute was enacted in 1980 to curb the rising cost of Medicare.
- The MSP regulations can be found in section 42 Section 411 of the Code of Federal Regulations.
- The intent of MSP Act was to reduce federal spending and to protect the financial integrity of the Medicare program.
- The relevant part of the Act states that in instances where certain types of other health care coverage are available the other insurance would act as the Primary Payer for health care services and Medicare would be a Secondary Payer.

Medicare Overpayments and Recovery

- Federal law (42 U.S.C.§ 1395y(b)) not only establishes that Medicare is a secondary payer to WC, but also that Medicare has a priority right of recovery over any other entity to the proceeds of any settlement. To the extent that Medicare has made any "conditional payments", Medicare will recover those payments pursuant to 42 C.F.R. § 411.47.
- Pursuant to 42 C.F.R§ 411.21, "conditional payments" are Medicare payments for services for which another payer is responsible, made either on the bases set forth in 42 C.F.R. § 411 subparts C through H, or because the intermediary or carrier did not know that the other coverage existed.
- Workers' Compensation (WC) is a primary payer to the Medicare program for Medicare beneficiaries' work-related illnesses or injuries. Medicare beneficiaries are required to apply for all applicable WC benefits. If a Medicare beneficiary has WC coverage, providers, physicians, and other suppliers must bill WC first.

Medicare as a Secondary Payer

- Any payments made by Medicare where other insurance is involved are considered to be conditional and Medicare has a right to seek recovery.
- . Medicare is the secondary payer to:

  No Fault /Liability Insurance

  Workers' Compensation

  Employer Group Health Plan Insurance (in certain instances e.g. EY has 20+ employees)

What are the Penalties for Non-Compliance?

- 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 for failure to provide primary payment or reimbursement.
- CMS may also seek reimbursement directly from the Claimant and from Attorneys.
- The claimant could lose their Medicare benefits.

Poll Question

What year was Medicare enacted?

- 1981
- 1944
- 1975
- 1965

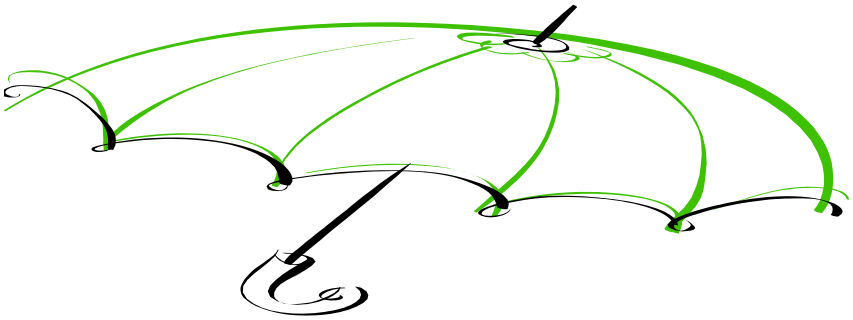
Overview: CMS, BCRC, WCRC, CRC

CMS, BCRC, WCRC, CRC

Centers for Medicare and Medicaid Services

(CMS)

- Medicare is a huge enterprise that has oversight over several areas in the MSA arena. The work that Medicare does is not all centralized and is often handled by a Medicare Contractor.



BCRC **WCRC** **CRC**

- A brief look at each of these entities and their particular functions are noted here:

CMS, BCRC, WCRC, CRC

- **Centers for Medicare and Medicaid Services (CMS)**
  - Responsible for overall policy governing Section 111 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 Responsible Reporting Entities (RREs) for Mandatory Reporting
  - Intake for claim reporting
  - Responsible for Medicare Conditional Payments as well as recovery demand letters
  - Medicare Set Aside Reconciliation for MSA Trust Fund Accounts
- **Workers' Compensation Recovery Contractor (WCRC)**
  - Responsible for the review of WCMSA proposals
  - Responsible for developing the MSA case if submitted documentation is incomplete or insufficient
  - Responsible for issuing MSA determination
- **Commercial Recovery Center (CRC)**
  - Responsible for Medicare Conditional Payments where carrier/insurer has been designated as the debtor.
  - 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 as well as recovery demand letters
  - Accept Appeals from carrier/insurer

Poll Question

CMS stands for Centers for Medicare & Medicaid Services?

- True
- False

What is a Medicare Set Aside and Do I really Need One?

What is a Medicare Set Aside (MSA)?

- The MSA is an allocation of anticipated lifetime medical treatment for the work-related injury.
- An MSA is a projectionof the injured worker's future medical costs, including but not limited to: doctor's visits, hospital stays, surgical procedures, diagnostic tests, laboratory studies, physical therapy, prescriptions and some durable medical equipment.
- Only services, supplies and prescription medications that would otherwise be covered by Medicare are included in the allocation.
- The MSA includes a comprehensive medical summary which documents the injured individuals past, current and future care.

File Handling Considerations

- Things to consider before requesting an MSA:
- Is medical being left open or will the settlement include payment for future medical expenses?
- Is the claimant 65 years or older or turning 65 any time soon?
- Is the claimant a Medicare beneficiary?
- Is the claimant a Medicaid not Medicare beneficiary?
- Has the claimant been receiving Social Security Disability Insurance (SSDI) benefits for 24 consecutive months or more?
- Will the claimant become a Medicare beneficiary within 30 months of settlement due to age (62.5) or SSDI entitlement?
- Has the carrier received any letters from Medicare, COB, BCRC, CRC notifying them of Medicare involvement?

What Information is Needed For an MSA

- The following documents are used to complete the MSA the allocation:
  - First Notice of Injury
  - most recent 2 years of medical records
  - claims payment history (detailing all payments made by the carrier/insurer on the claim)
  - pharmacy history (ideally reflecting the name, dose and frequency of all accident related medications)
  - rated age (if injured worked has any co-morbid conditions a rated age statement will be requested and the rated age information will be included)
  - claim denial letters or Court Orders related to denials (if applicable)

I've Got This MSA – Now What?

Option 1 – The Traditional Process

Submission of the MSA to Medicare (CMS) for review

- 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.
- Once the MSA proposal is approved by CMS, the settlement can occur with confidence that Medicare's interests have been protected.

MSA Submissions

Submission of the MSA for review by CMS is a recommended not required process (See CMS Memo dated 5/11/2011 and WCMSA Reference Guidance Version 2.4)

CMS has established criteria for when they will review a MSA proposal.

The Current CMS Review Threshold:

a. The claimant is currently a Medicare beneficiary and the total settlement is more than $25,000.00. This type beneficiary is also known as a *Class 1 beneficiary* .

OR

b. The settlement amount exceeds $250,000 and the claimant has a reasonable expectation of becoming a Medicare beneficiary within thirty (30) months of the settlement date. This type beneficiary is also known as a *Class 2 beneficiary*.

If your file does not meet CMS' current review criteria CMS will not review the MSA proposal.

Reasonable Expectation- Class 2 Beneficiary

A claimant has a reasonable expectation of Medicare enrollment within 30 months if any of the following apply:

- The claimant has applied for Social Security Disability Benefits
- The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision
- The claimant is in the process of appealing a denial of or re-filing for Social Security Disability benefits
- The claimant is 62 years and 6 months old
- The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD

MSA Submission Requirements

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

- Submitter/cover letter
- Consent to Release form signed by claimant
- Rated age information or life expectancy
- The total tentative or proposed settlement amount or a copy of the draft/final settlement
- Method of MSA funding- lump sum or structured settlement
- Medical records - last 2 full years of 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 Submission Process

- 99.9% of MSA proposals are submitted online via the WCMSA Portal and go directly to the WCRC for review.
- An MSA proposal via hard copy (paper documents, including faxes) or via CD can also be submitted for review.
- Submitters opting to use the WCMSA portal will receive an alert that acknowledges that the case was received by WCRC. Submitters that submit a hard copy proposal will receive written acknowledgement indicating receipt of the proposal.
- WCRC first reviews the case in detail for completeness and accuracy. If errors are found in a submitted case, the submitter is notified.
- Errors may include co-mingled records, missing documentation etc.
- WCRC evaluates the likely need for medical treatments and prescription medications, for the expected duration of the claimant's life.
- Based on these findings, the WCRC ultimately renders an opinion to CMS as to whether the WCMSA amount proposed is adequate to protect Medicare's interests.

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MSA Submissions- CMS Development Letters

During review of the MSA proposal CMS may need additional information or documentation to complete their review and issue a decision. If this occurs CMS will send a development letter.

The 5 most frequent reasons Medicare lists for case development requests are:

- Insufficient or out of date medical records;
- Insufficient payment histories (no breakdown of medical, indemnity, expense payments);
- Failure to address draft/final settlement and court rulings (this must be done in a separate letter submitted to CMS on adjuster or attorney letterhead with the adjuster or attorney's signature. Electronic signatures are not accepted by CMS.);
- Documents referenced in the file are not provided;
- References to state statutes or regulations without providing sufficient documentation.

Option 2- The Alternative Process

No submission of the MSA

- Again, MSA submission is a voluntary process and not required even if the CMS submission review threshold is met.
- Protecting Medicare's interest is what is required when the settlement includes payment towards the settlement of future medical.
- Parties may choose to create and fund the MSA without submitting it to CMS for review and approval.
- Parties who opt not to submit the MSA should provide details about the MSA Arrangement in the settlement agreement and instruct the claimant how to properly use the MSA funds (MSA administration will be addressed in the next section)

Poll Question

Submission of the Medicare Set- Aside is a voluntary process?

- True
- False

MSA Funding and MSA Administration

MSA Funding

The MSA can be funded with either a **lump sum** or **annual (structured)** payment.

If the MSA is funded via lump sum payment all MSA funds are provided to the claimant at the time of settlement.

If the MSA is funded via an annual/structured payment then MSA seed money may be provided to the claimant at the time of settlement and the claimant will received a yearly payment for the life of the MSA.

MSA Administration

The MSA account may be self administered by the claimant or professionally administered by an organization that specializes in professional/custodial administration for Medicare Set Asides.

Whether self or professionally administered the MSA funds must be placed in an **interest bearing account**. That is separate and a part from the claimant's checking/savings account.

Interest earned on the MSA funds must be allowed to accrue in the account and may only be used for MSA allowable expenses. This interest earned on the MSA account is taxable.

Using the MSA funds

Once the MSA Account is established, the injured worker should pay all bills for accident related treatment and medication from the MSA Account.

If the MSA account is depleted and medical treatment is still needed, Medicare should be notified . Medicare will become the primary payer and begin paying for treatment related to the work injury as long as the funds were properly spent and correctly reported to Medicare.

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.

  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.

Medicare Conditional Payments- "The Lien"

Conditional payments - payments made by Medicare when another insurance is responsible. When a claim is reported to Medicare either via Mandatory Insurer Reporting or via a call to the BCRC, the diagnosis code(s) 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.

Medicare will issue either a *conditional payment letter (CPL)* or *conditional payment notice (CPN)* depending on how the case is reported to them. The **CPL** and **CPN** are not requests for payment ; they are an opportunity to ensure an accurate listing of conditional payments.

Effective 10/5/2015 Medicare will no longer wait to receive **settlement, judgment or award information** prior to sending a request to the carrier/insurer for repayment of conditional payments.

Medicare Conditional Payments

- CMS will issue a CPN giving the carrier/insurer notice of the claims paid by Medicare. The CPN indicates a **due date for response** by the carrier/insurer if they disagree with the relatedness of claims. If the carrier/insurer does not respond within specified timeframe CMS will issue a demand letter. Interest begins to accrue on the demand amount from the date of demand letter but will only be assessed if repayment is not made within 60 days. CMS encourages parties to pay and dispute to avoid interest accruing. If the dispute is successful all monies will refunded.

File Handling Tip: Be specific about what conditions are accepted on the claim. This information is reported to Medicare and you want it to 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.

Medicare Conditional Payments- Disputes and Appeals

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.
- A request to remove unrelated claims should be filed prior to settlement of the file. This ensures that unrelated injuries are not associated with the accident. This also protects the claimant/Medicare beneficiary from experiencing denied Medicare claims post settlement.
- If CMS issues a CPN a dispute of unrelated claims must be filed prior to the response due date listed. If no response is filed within the specified timeframe listed on the CPN a demand for repayment will be issued.

Medicare Conditional Payments- Disputes and Appeals

- Effective April 28, 2015 Medicare extended appeal rights to liability, no-fault and workers' compensation plans in relation to recovery demands for conditional payments. This rule applies to all recovery demand letters issued on or after April 28, 2015.
- Repayment of the conditional payment demand must occur within 60 days of the receipt of the demand for repayment letter or interest will begin to accrue on the debt.
- CMS encourages parties that believe that the demand amount is in error to pay and appeal in order to avoid interest accruing on the debt as interest continues to accrue during the appeal process.
- If you win the appeal CMS will refund the money that was paid to them.
- If payment is not made within 120 days after the demand for repayment notice the debt will be referred to the US Department of Treasury.

FMQ

Frequent Medicare Quandaries

genex℠

Quandary 1- Medicare and VA Benefits

Claimant is a veteran and is entitled to receive both VA and Medicare benefits. Claimant treats exclusively at the VA Medical Center and does not use his Medicare benefits.

Is an MSA still necessary when settling out future medical?

Yes, According to CMS a MSA is still necessary because the claimant (could lose VA benefits and could begin using Medicare benefits

Quandary 2- Deceased Beneficiary

You have settled the file and you learn that the Claimant has died. You realize that no MSA will be necessary but is it still necessary to repay the Medicare conditional payments (lien)?

Yes, conditional payments relate to treatment that the Medicare beneficiary already had. CMS expects to be reimbursed for these payments. The death of the Medicare beneficiary does not alter the repayment obligation.

Quandary 3- Undocumented Workers and Legal Residents

Claimant is an undocumented worker and is using an illegal SSN. Is a MSA needed?

Undocumented workers do not pay into the Social Security and Medicare system and therefore cannot receive SSDI or Medicare benefits. An MSA would not be necessary in this scenario.

Claimant is a legal resident of the U.S., but not a citizen is an MSA needed?

Legal residents of the U.S. (aka green card holders) do pay into the Social Security and Medicare system just like citizens do and are assigned SSN's. If a legal resident has enough work quarters, they can become eligible for SSDI and Medicare benefits just like U.S. citizens. Additionally, a legal resident of the U.S. can "buy into" Medicare at age 65 by paying a premium whether or not they have the required work quarters (this option is also available to U.S. citizens). Therefore, a MSA should be considered in settlements with legal residents just as they should with U.S. citizens.

Quandary 4- I'm settling my case for under $25,000 so I don't need an MSA, right?

The $25,000 figure is simply CMS' workload review threshold that helps them to determine whether they will review an MSA proposal where a Medicare beneficiary is involved..

If your settlement does not meet this threshold it does not necessarily mean that no MSA is needed.

To determine if an MSA is needed evaluate whether the claimant will require future treatment for accident related injuries and if settlement will include payment for future medical expenses.

Thank you

for attending this MSA presentation

Please feel free to contact us with your questions

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