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Section I

Legal

MSP Foundation

- 1965 Medicare Trust Fund created
- 1980 MSP Regulation
- 2001 Initial CMS ‘Guidance’
- 2013 Initial WCMSA Reference Guide

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Chronology of CMS Memos

- July 23, 2001 - The “Patel Memo”
- April 22, 2003
- May 23, 2003
- May 7, 2004
- October 15, 2004
- July 11, 2005
- December 30, 2005
- April 25, 2006
- July 24, 2006
- August 25, 2008
- April 3, 2009
- June 1, 2009
- May 14, 2010
- June 8, 2010
- May 11, 2011

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Section 2.0 Introduction to Workers' Compensation and Medicare

2.1 - Medicare as a Secondary Payer

- "Medicare is secondary payer to group health plan insurance in specific circumstances, but is also secondary to liability insurance (including self-insurance), no-fault insurance, and WC."

- In order to comply with 42 U.S.C. Section 1395(y)(b)(2) and Section 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Section 3.0 What Are Workers' Compensation Medicare Set-Aside Arrangements?

- CMS-approved WCMSA amount must be **appropriately exhausted** before Medicare will begin to pay for care related to the beneficiary's settlement, judgement, award, or other payments
- Goal: to estimate as accurately as possible the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-injury-related conditions during the course of claimant's life, and to set aside sufficient funds from the settlement, judgement or award to cover that cost
- May be funded by lump sum or structured annuity

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Section 3.0 What Are Workers' Compensation Medicare Set-Aside Arrangements? Cont.

- If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received any portion of a third-party payment either directly or indirectly
- Medicare may also refuse to pay for future medical expenses related to the WC injury until the entire settlement is exhausted
- Once the CMS-approved set-aside amount is exhausted and accurately accounted for to CMS, Medicare will pay primary for future Medicare-covered expenses related to the WC injury that exceeded the set-aside amount

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Section II

WCMSA Reference Guide

- **Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide**

- Current Version:

March 19, 2018

COBR-Q1-2018-v2.7

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WCMSA Reference Guide

1.0: About This Reference Guide

2.0: Introduction to Workers' Compensation and Medicare

3.0: What Are Workers' Compensation Medicare Set-Aside Arrangements?

4.0: Should I Consider Submitting a WCMSA Proposal?

5.0: WCMSA Funding Structures

6.0: Who Can Help with the WCMSA Process?

7.0: How is CMS Approval of a WCMSA Amount Obtained?

8.0: Should CMS Review a WCMSA?

9.0: WCMSA Submission Process Overview

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WCMSA Reference Guide

10.0: Information Needed for WCMSA Submission

11.0: How do I Submit a WCMSA?

12.0: What Happens After a WCMSA Has Been Submitted?

13.0: Sample Submission

14.0: Tips for Improving Your WCMSA Review Process

15.0: Review Process and Policies

16.0: Re-Review

17.0: Account Set-Up and Administration

18.0: CMS' Monitoring

19.0: What Happens if Circumstances Change?

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Section 1.0 About this Reference Guide

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 requests that you comply with CMS' established policies and procedures.

- **Section 1.1 Changes in This Version of the Guide**

This section tracks the changes made from the previous version of the guide.

Section III

Significant Updates

Section 4.0 Should I Consider Submitting a WCMSA Proposal?

4.1.4 - Hearing on the Merits of a Case

- CMS prices based on what is claimed, released or released in effect
- CMS must have documentation as to why disputed cases settle future medical costs for less than the recommended pricing
- When a state WC judge or other binding party approves a WC settlement after a hearing on the merits, Medicare will generally accept the terms of the settlement

Section 4.0 Should I Consider Submitting a WCMSA Proposal?

4.1.4 - Hearing on the Merits of a Case

- **Unless** the settlement does not adequately address Medicare's interests
- Includes all denied liability cases
- If interests not reasonably considered, Medicare will refuse to pay for services related to WC injury until such expenses have exhausted the entire dollar amount of the entire WC settlement.
- If court specifically designates funds to a portion of a settlement that is not related to medical (ex= wages) Medicare will accept that

Section 9.0 WCMSA Submission Process Overview

9.4.4 – Medical Review (10 Steps)

1. Validate demographics and contact information
2. Verify that the total settlement amount (TSA) is clear and that the review threshold is met
3. Verify that the dates of injury and conditions being settled re clear
4. Verify the proposed set-aside amounts
5. Verify jurisdiction and calculation method
6. Verify payout method: lump sum versus annuity
7. Calculate life expectancy using standard age or median rated age
8. Verify that treatment records, payment records, and pharmacy records are up-to-date, complete and valid
9. Review records and submitter's proposed plan. Price the appropriate future medical and pharmacy services
10. Provide an explanation in the decision rationale for counter higher or counter lower determinations

9.4.4 Medical Review –

Step 5: Verify Jurisdiction and Calculation Method

- Claimant lives in same state where claim filed, price based on claimant's zip code
- Claimant lives in different state from where claim was filed, price based on employer's zip code
- Claimant and employer addresses are in different states from where claim was filed, price based on claimant's attorney's zip code
  - If no attorney, price based on WC carrier zip code in state in which claim filed
  - If WC carrier address is in different state from where claim was filed, price based on WC carrier's attorney zip code

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9.4.5 Medical Review Guidelines

Spinal Cord Stimulators

- Replacement every 7 years when non-rechargeable
- Replacement every 9 years when rechargeable

State-Specific Statutes

- CMS will recognize “provided that the submitter has demonstrated that Medicare’s interests have been adequately protected”
- If treatment varied by UR, submitter shall include “alternate treatment plan showing what has replaced the treatment in question”

Section 16.0 Re-Review

- No formal appeals process

Re-Review if:

1. Mathematical Error
2. Missing Documentation
   - Additional evidence not previously considered by CMS
   - Dated prior to the submission date of original proposal

Section 16.0 Re-Review

Amended Review

- One time request
- Submission of:
  - new cover letter
  - all documentation since the previous submission date
  - Most recent six months of pharmacy records
  - Consent to Release
  - Summary of future care
- Treatment changed due to state-specific requirement
  - Life-care plan showing replacement treatment for disallowed treatment will be required (if med records do not show change)

Section 16.0 Re-Review

Amended Review cont.

Requirements:

- ❑ CMS has issued an approval at least 12 but no more than 48 month prior
- ❑ Case has not yet settled as of date of request for re-review
- ❑ Projected care has changed so that new proposed amount would result in 10% or $10,000 change (whichever greater) in previous approved amount
- ❑ New approved amount takes effect on date of settlement regardless if it is increased or decreased
- ❑ Can submit via paper or portal

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Section 16.0 Re-Review

Amended Review cont.

- FDA generic release does not constitute reason to amended review
- Not permitted to supplement the materials after submitted

16.1 – Required Resubmission

- If closed for inactivity for one year or more from original date of submission, full file re-submission required

Section 17.0 Account Set-Up and Administration

17.1 – Administrators

- ‘competent’ administrator
- If claimant has guardian/conservator or declared incompetent - must include in the submission
- Can administer on their own
- Submit annual self-attestations
- “Although beneficiaries may act as their own administrators, it is highly recommended that settlement recipients consider the use of a professional administrator for their funds”

Section IV

Practice Tips
For
“Good Allocating”

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What is “Good Allocating”?

- Is your client/ customer seeking a “match” with CMS’ determination?
  - Look to CMS WCMSA Reference guide recommendations

- Lowest defensible allocation based on Evidence Based Medicine guidelines and state law?
  - “ avoid a cost shift of injury related expenses to Medicare”

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Where do you begin?

Identify the conditions that should be addressed in the MSA

- Accepted
- Denied
- Disputed
- Unrelated

Are there any state specific limitations based on relevant state law?

Example- Georgia 400 week medical cap on medical benefits when the claim is non catastrophic

- Court Order to support that the claim falls within the limit

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Review injury related medical treatment and pharmacy records

- CMS wants last two years of injury related treatment records
- Older medical and pharmacy records may be relevant to show claimant's treatment and drug usage patterns haven't changed since accident
- Check for co-morbid conditions that may impact future treatment.
  - Co-morbid conditions also relevant for rated age quote

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Rated Age ("RA") Rules

- Must name the claimant
- Must be by an insurance company
  - Must be on insurance company or settlement broker letterhead
  - Must be independent
  - Must give a specific rated age
  - If more than one, use median age

Rated Age (“RA”) Rules

- The WCRC will use actual age if none of the RA meet the criteria

- Look at the issue date of the RA and compare with the Proposed Settlement Date (PSD)
  - PSD is BCRC receipt date plus 120 days
  - If one year has passed , add one year to the RA
  - If two years have passed , add two years to the RA
  - If more than three years have passed, cannot use the RA

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Rated Age ("RA") Rules

- Submissions with RAs must include the following language:

" Our organization certifies that all rated ages we have obtained/and or have knowledge of regarding this claimant, and generated at any time on or after the Date of Incident for the alleged accident/illness/injury/incident at issue, have been included as part of this submission of a proposed amount for a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) to the Centers for Medicare & Medicaid Services."

Life Expectancy

CMS determines claimant's life expectancy, using the Centers for Disease Control (CDC) Tables

- As of 12/11/17, CMS using CDC's Table 1: Life table for total population: United States, 2014

Seek clarification of inconsistencies in medical records prior to submission

Is the “Current Medication” list on the electronic medical records accurate when compared with the pharmacy history or is it just pulling with every new visit?

Seek additional details

- Is the Spinal Cord Stimulator a rechargeable one or non rechargeable?

  - Impact frequency of replacements

- Can the laundry list of “possible” future treatment in treating physician’s records be narrowed down ?

Section 9.4.4 to 9.4.6 of Reference Guide

Medical Review:

- Treatment and usage patterns
- Treating physician recommendations
- Life expectancy
- Response to treatment
- Effectiveness of therapies based on records

WCRC references Evidence-Based Guidelines (Milliman and the Official Disability Guidelines)

Section 9.4.5 Medical Review Guidelines

- Diagnostic projection frequencies:

  - X-rays: every 3 to 5 years for life unless there was or will be a major joint replacement, then annual

  - MRI: every 5 to 7 years. If the physician's order is not specific as to "with or without contrast", WCRC allocates for both

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- Intrathecal pain pumps
  - Permanent placement IT pump devices / every 7 years for life. Drop decimals
  - IT surgery pricing :
    - Physician fees
    - Facility fees (Diagnostic Related Grouping (DRG) codes for inpatient procedures)
    - Anesthesia fee : reasonable time for the specified procedure
    - Preadmission Testing
    - Trials: If have trial for SCS , assume trial successful

- Spinal Cord Stimulators
  - Permanent placements of SCS :
    - Non-rechargeable every 7 years
    - Re-chargeable every 9 years
    - Pricing:
      - Physician fees,
      - Facility
      - Anesthesia

- Labs:
  - Line item for each lab test
  - State- Specific Statutes
    - " will recognize or honor any state-legislated , non-compensable medical services and will separately evaluate any special situations regarding WC cases"
    - " for those states where treatment is varied by some type of state-authorized utilization review board, the submitter shall include the alternative treatment plan showing what treatment has replaced the treatment in question from the beneficiary's treating physician for those items deemed unnecessary ."

- Pharmacy
  - Look at last two years of pharmacy printouts
  - Medicare covered:

  - FDA, off label compendia approved
    - (Micromedex's DrugDex database and American Hospital Formulary Service Drug Information database)

  - Is the drug type excluded from Medicare coverage?
    - Example: bulk powder

  - Is the drug hydrocodone combination product?
    - If C-II controlled substance, a practitioner may issue up to three consecutive 30 day prescriptions in one visit/ WCRC allocates a minimum of 4 physician visits per year.

- PRN or as needed drugs
  - Distinguish between non compliance and “as needed”.
  - Dual designation drugs
    - Drugs that come in both over the counter and prescription versions
    - An OTC drug when dispensed by prescription can become a Part D drug

- Drug weaning/tapering
  - Absent evidence that weaning process is successful, WCRC assumes it isn't
  - WCRC usually extrapolates latest weaned dosage every month for life
  - Consider holding off on submitting until wean completed

- Part D drugs priced based on Average Wholesale Pricing (AWP) : (Truven Health Analytics' Red Book database)

- Price for generics UNLESS
  - claimant is using brand name
  - no generic exists
  - "claimant or claimant's attorney insists on brand-name drug in writing".

Conclusion

WCMSA Reference Guide provides valuable information for submitters

- Since review also looks to specifics of case, not always have same result
- By knowing what WCRC looks for, as you go through the process, you can work with an eye towards securing the lowest defensible MSA for CMS' consideration.