What is Medicare Secondary Payer and What is a Medicare Set-Aside?

Medicare Secondary Payer – taken from CMS.HHS.GOV[1]

Medicare Secondary Payer" (MSP) is the term used when the Medicare program does not have primary payment responsibility on behalf of its beneficiaries —that is, when another entity has the responsibility for paying for medical care before Medicare. Until 1980, the Medicare program was the primary payer in all cases except those involving Workers' Compensation ("WC") or for care that is the responsibility of another government entity. With the addition of the MSP provisions in 1980 (and subsequent amendments), 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.

An insurer or WC plan cannot, by contract or otherwise, supersede federal law, for instance by alleging its coverage is "supplemental" to Medicare. 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. In order to comply with Section 1862(b)(2) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made *or can reasonably be 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." If responsibility for the WC claim is in dispute and WC will not pay promptly, the provider, physician, or other supplier may bill Medicare as primary payer. If the item or service is reimbursable under Medicare rules, Medicare may pay conditionally, subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. (See 42 C.F.R. § 411.21 for the definition of "promptly" with regard to WC.) Such payments are called "conditional payments" and Medicare expects reimbursement for same.

Medicare Set-Aside

A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a financial agreement that allocates a portion of a workers' compensation settlement to pay for future (i.e. post-settlement or judgment) medical services related to the workers' compensation injury, illness, or disease. These funds must be depleted before Medicare will pay for treatment related to the workers' compensation injury, illness, or disease. All parties in a workers' compensation case have responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's

[1] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html & Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, Publication COBR-Q1-2018-v2.7, March 18, 2018, at 2.

interests when resolving cases that include future medical expenses. CMS' recommended method to protect Medicare's interests is a WCMSA. The amount of the WCMSA is determined on a case-by-case basis, and CMS will review settlements that meet certain dollar and entitlement-status thresholds. Approximately 29,000 MSA proposals are reviewed by CMS' WCMSA review contractor each year, and this number is expected to increase in 2018 with the anticipated addition of liability MSA review.

In determining whether the amount allocated for future medical expenses is reasonable, CMS claims to look to the following factors[2]:

1. Date of entitlement to Medicare.
2. Basis for Medicare entitlement [disability, End-stage Renal Disease (ESRD) or age] – CMS notes if the claimant has entitlement based on disability and would also be eligible on the basis of ESRD, the medical expenses would be higher. This would also be true for claimants who are over 65, but had been entitled prior to attaining that age.
3. Type and severity of the injury or illness-- Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the claimant an amputee, paraplegic or quadriplegic? Is the claimant's condition stable or is there a possibility of medical deterioration?
4. Age of the claimant – And whether his/her related and/or co-morbid medical conditions would shorten the life span.
5. Workers' Compensation (WC) classification of the claimant (e.g., permanent partial, permanent total disability, or a combination of both).
6. Prior medical expenses paid by WC due to the injury or illness in the one or two year period after the condition has stabilize
7. Amount of the lump sum or structured settlement
8. Whether the commutation is for the claimant's lifetime or for a specific time period
9. Whether the claimant is living at home, in a nursing home, or receiving assisted living care, etc. from the medical benefits allocation of lump sum settlement, Medicaid, etc.
10. Whether the expected expenses for Medicare covered items and services are appropriate in light of the claimant's condition?-- Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. The CMS regional office should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare's interests into account.

CMS' Current Policy on Projecting WCMSA (Post-Settlement) Opioids

CMS currently projects all post-settlement injury-related medications using the same dosage and frequency as being taken in the six months prior to the WCMSA submission, and extrapolates

[2] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/determiningwcmsareasonable.pdf

that dosage and frequency over the beneficiary's expected lifetime. For example, if the beneficiary has been taking 90 milligrams of Hydrocodone per day over the last eight weeks, CMS will project future usage at 90 milligrams of Hydrocodone per day over the beneficiary's entire life expectancy. Even where the treating physician anticipates weaning and/or tapering, according to the most recent WCMSA Reference Guide published by CMS on July 10, 2017, "(usually), the latest weaned dosage is extrapolated or the life expectancy."[3]

Often, opioids are prescribed during a WC claim with other medications which are central nervous system depressants. According to the most recent WCMSA Reference Guide, CMS commonly sees drugs being used that come under the heading of warnings and precautions. The CMS-approved WCMSA will include such medications, even over warnings and precautions, if the use is not contraindicated and if the claimant "may have or has tolerated this in the past."[4] According to CMS, "(o)verall it is very rare that the WCRC (Workers' Compensation Review Contractor) would reduce a prescription set-aside allocation allotment due to a drug warning and precaution as defined by the FDA."[5]

This practice leads to dangerous polypharmacy considerations, particularly where the beneficiary has been taking multiple central nervous system suppressing medications, even where weaning and tapering are anticipated or are in process.

[3] Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, COBR-Q1-2018-v2.7, March 18, 2018, at 30.
[4] *Id.*
[5] *Id.*