January 2006

NAMSAP news

National Alliance of Medicare Set-Aside Professionals

# Calculation of Prescription Drug Costs in MSA Allocations

by Patty Meifert, RN, CRRN, CCM, CLCP, MSCC
and Robert T. Lewis, Esquire

On December 30, 2005 the Centers for Medicare and Medicaid Services (CMS) issued a Memorandum addressing the impact of Part D prescription drug coverage on workers' compensation settlements.

According to the CMS Memorandum, all workers' compensation settlements "that occur on or after January 1, 2006 must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare."

Beginning on January 1, 2006 CMS now requires a cover letter identifying, "separate amounts for: (1) future medical treatment, and (2) future prescription drug treatment." Additionally, the submission must include an explanation as to how the submitter calculated the future prescription drug treatment amount.

According to CMS, "If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, the submitter did not adequately consider Medicare's interests." Failure to adequately consider Medicare's interests may result in significant exposure to the parties involved in the settlement.

This directive will dramatically impact workers' compensation settlements nationwide. Medicare Set-Aside (MSA) allocations will increase considerably because prescription drugs can be one of the largest cost categories of future medical care. As a result, it is critical that every effort be made to appropriately contain the cost of future prescription drugs while still "reasonably considering" Medicare's interests.

At this time, Medicare has not established specific guidelines for the calculation of future prescription drug costs in MSA allocations. Furthermore, the Workers' Compensation Review Center-Joint Venture (WCRC-JV) will not be "independently pricing" the cost of future prescription drugs until on or after January 1, 2007. It is incumbent upon the industry to calculate these costs and it is anticipated that CMS will then compile statistics on the various methods used this year to develop policy for the future.

The CMS Memorandum provides that the submission, "... must include an explanation as to how the submitter calculated the future prescription drug treatment amount (i.e., actual costs, average wholesale price, etc.)." It is imperative that a method is used to calculate the future prescription drug treatment amount that: (1) can be justified, and (2) is the most cost effective method available. Some calculation methods to consider are the following:

*(1) Average Wholesale Price (AWP)*

The AWP was intended to represent the average price at which wholesalers sell drugs to physicians, pharmacies and other customers. According to the Red Book, the pricing information is "based on data obtained from manufacturers, distributors, and other suppliers." The available commercial publications of AWP include First Databank, Medi-span, and Red Book. Because of differences in methodology, a specific drug's AWP published by each of these sources may vary. Although there has been concern regarding the accuracy of the AWP, most State Medicaid programs and private health insurers base their reimbursement formulas on a fixed discount from AWP, largely because no alternative, more accurate, data source for drug pricing is currently available.

(2) *Workers' Compensation Reimbursement Rate*

This rate is the rate determined by statute in the state of jurisdiction. Typically, the workers' compensation reimbursement rate is higher than the AWP with some exceptions such as California where the WC reimbursement rate is lower than the AWP.

(3) *Actual Billed Amount*

This is the amount actually billed to, and paid by, the primary payer. This amount can be determined by reviewing the primary payer's medication claim payment ledger. The use of this methodology would enable payers who have negotiated discounted network rates below the workers' compensation reimbursement rate and AWP to utilize these rates in calculation of the future prescription drug component of the MSA.

In addition to these methods of calculation, it is incumbent upon anyone submitting a proposal to CMS to consider any other methods to reduce the prescription drug cost.

(A) *Rated Age*

Utilization of a rated age to reduce the life expectancy of a claimant is critical to limit the period of cost projection.

(B) *Substitution of Less Expensive Generic Equivalent*

Brand-name drugs are substantially more expensive then generic equivalents. Consequently, it is advisable to increase the use of generic equivalents and reduce reliance on brand-name drugs whenever possible.

(C) *Professional Judgment*

Professionals completing MSA allocation projections should use their best judgment to project future prescription drug use. It is a generally accepted practice in the field of future medical cost evaluation that if a definitive medical procedure, surgery, or treatment program is projected for the future, the professional will make the assumption that the procedure, surgery or program will be successful and adjust future medications accordingly.

(D) *Intervention with Prescribing Physician*

When the anticipated future use of prescribed drugs is not apparent based upon review of the medical records, it may be appropriate to obtain this information in writing from the prescribing physician so that drugs are not projected over the entire life expectancy inappropriately.

(E) *Pharmacy Utilization Review*

If a particular case appears to fall outside standard practice guidelines without documented justification, an independent pharmacy utilization review by a licensed pharmacist may be of benefit. This may provide the necessary documentation to support the allocation professional's projection.

(F) *Exclusion of Drugs not Otherwise Covered by Medicare*

The MSA allocation cost projection should only include future medical expenses that would otherwise be covered by Medicare. Since the addition of Part D covered services, allocation professionals will undergo a learning curve regarding which drugs are covered and which are not. This is further complicated by the fact that there are differences between what drugs will be covered among the various Part D prescription drug plans (PDP's). Note that the following drugs are excluded from Part D plans:

1. Drugs used for anorexia, weight loss or weight gain
2. Drugs used to promote fertility
3. Drugs used for cosmetic purposes or hair growth
4. Drugs used for the symptomatic relief of cough and colds
5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
6. Non-prescription drugs
7. Inpatient drugs
8. Barbiturates
9. Benzodiazepines

There is no guarantee as to whether CMS will take issue with any of the outlined approaches and they can certainly issue policy statements at any time. However, given the absence of specific CMS guidelines, the use of these mechanisms appears to be a reasonable consideration of Medicare's interest.

Patty Meifert, RN, CRRN, CCM, CLCP, MSCC is the CEO of NuQuest and Bridge Pointe specializing in Medicare Set-Aside allocation and professional administration services. Ms. Meifert is the founding President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) and can be reached at 866-858-7161 Ext. 4810.

Robert T. Lewis is an attorney with Capehart Scatchard specializing in Medicare Secondary Payer compliance. Mr. Lewis is the founding Vice President of the NAMSAP and can be reached at 856-914-2064.

## *Settling WC Medical Expenses Prior to CMS Approval of a Proposed MSA*

by Patty Meifert, RN, CRRN, CCM, CLCP, MSCC

In the July 11, 2005 CMS policy memorandum, question 5 addressed the settlement of WC medical expenses prior to CMS review of a proposed MSA and stated:

> *The parties may proceed with the settlement, but any statement in the settlement of the amount needed to fund the WCMSA is not binding upon CMS unless/until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount as specified by CMS that adequately protects Medicare's interests as a result of its review.*
>
> *If CMS does not subsequently provide approval of the funded WCMSA amount as specified in the settlement and proof is not provided to CMS that the CMS-approved amount has been fully funded, CMS may deny payment for services related to the WC claim up to the full amount of the settlement. Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA. This shall be demonstrated by submitting a copy of the final, signed settlement documents indicating the WCMSA is the same amount as that recommended by CMS.*

While the memorandum focused on the provision of proof of full funding to CMS, there are several other issues to be considered including repayment of Medicare conditional payments, responsibility for funding of additional amounts required by CMS and the potential for modification of the initial and annual payment amounts for MSA arrangements funded by a structure.

**Provision of Proof of Full Funding to CMS**

A NAMSAP board member submitted a request to CMS on July 22, 2005 for consideration of an alternative to use of the final signed settlement document indicating the MSA is the same amount as that recommended by CMS as proof that the MSA has been fully funded. The position we presented was that this policy is not practical as it would require an addendum to the previously finalized settlement document if CMS recommended an amount other than the original MSA amount outlined in the settlement document. It was suggested that an accounting ledger showing the deposit of the additional MSA funds recommended by CMS be considered as adequate proof of full funding.

The response from CMS central office received on December 9, 2005 states,

> *Under all circumstances, one of the parties or the submitter should send a copy of the final, signed settlement agreement. If the final, signed settlement agreement does not agree with the amount that CMS provided as adequate to protect Medicare's interest, then CMS will accept the Medicare Set-aside Agreement executed by the parties, which reflects the CMS approved amount; or a professional or self-administration accounting showing the deposit of additional funding to the WCMSA.*

**Repayment of Medicare Conditional Payments**

While CMS continues to improve its turnaround time for review of MSA proposals, there has been inadequate improvement in the turnaround time of

the Fiscal Intermediaries in response to requests for conditional payment estimates in cases involving Medicare beneficiaries. One national provider of Medicare Secondary Payer compliance services compiles statistical data on the response time of the Fiscal Intermediaries and reported that of 540 requests to Fiscal Intermediaries for conditional payment claim estimates, 319 of those took over 90 days to receive a response with the average response time being 143 days. With a national average CMS MSA approval turnaround time of 79 days for this provider, it is not uncommon to receive CMS approval far in advance of receiving an estimate of Medicare conditional payment claims. Therefore, settling cases prior to CMS approval of a proposed MSA typically also means that the case is being settled prior to obtaining a Medicare conditional payment claim estimate from the Fiscal Intermediary in cases involving a Medicare beneficiary. The issue of who will be responsible for the repayment of Medicare conditional payment claims post settlement should be addressed at the time of settlement. Typically, the primary payer agrees to assume the responsibility for repayment of Medicare conditional payments in this scenario. If the parties agree that the claimant will assume this responsibility, CMS still has a direct right of action to recover from the primary payer if the claimant does not repay Medicare.

**Responsibility for Additional MSA Amounts Required by CMS**

When settlements are finalized prior to CMS review of a proposed MSA, there is always the potential that CMS will require additional MSA funds to satisfy Medicare's interests. The parties should agree at the time of settlement who will be responsible for any additional funding requirements.

**Risk of CMS Modification to Initial and Annual Payments in MSA Arrangements Funded by a Structured Payment Plan**

MSA arrangements funded by a structured payment plan may face greater challenges if CMS requires additional MSA funding since an increase in the MSA amount will likely change the initial funding amount (seed) or the annual payment amount or both. When the case is settled prior to CMS approval, the initial MSA funding is dispersed and the annuity to fund the annual payments is purchased at the time of settlement. In this scenario, an additional lump sum deposit may need to be added to the original seed amount and/or an additional annuity may need to be purchased to supplement the annual payments. The settling parties should be aware of this possibility and agree who will be responsible for the additional funding and arrangements.

It is imperative that the parties to a WC settlement understand the potential pitfalls associated with settling cases prior to CMS approval of a proposed MSA Arrangement and ensure that the settlement documents address the responsibilities of the various parties in the settlement language.

Patty Meifert, RN, CRRN, CCM, CLCP, MSCC is the CEO of NuQuest and Bridge Pointe specializing in Medicare Set-Aside allocation and professional administration services. Ms. Meifert is the founding President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) and can be reached at 866-858-7161 Ext. 4810.

## *NAMSAP Welcomes New Board Members for 2006*

Elections for three available seats on the Board of Directors were held at the NAMSAP annual educational conference in Orlando, Florida on November 11, 2005. NAMSAP is proud to announce the following additions to the Board:

**Mark Popolizio, Esquire**

Mark Popolizio recently joined Charlie Martinez, P.A. as a senior associate. He is licensed to practice law

in Florida and Connecticut. Mr. Popolizio graduated Summa Cum Laude from Quinnipiac College with B.S. degrees in Legal Studies and Sociology. He attended Nova Southeastern School Law in Fort Lauderdale, Florida and graduated in 1995.

Mr. Popolizio's areas of practice

include workers' compensation defense and Medicare Seconday Payer compliance. He heads the Medicare Set-Aside department at Charlie Martinez, P.A. and brings a wealth of knowledge and experience to the program.

Mr. Popolizio speaks nationally on the topic of Medicare Secondary Payer compliance and is at the forefront in providing experienced and dedicated legal representation to the insurance industry.

Mr. Popolizio can be reached by phone: 866-542-9900
E-mail: Marcinpa@bellsouth.net
Mail: 8005 N.W. 155th Street, Suite A,
Miami Lakes, FL 33016

**Jill Gradwohl Schroeder, Esquire**

Jill Gradwohl Schroeder is an attorney at Baylor, Evnen, Curtiss, Grimit & Witt, LLP. The emphasis of Ms. Schroeder's legal practice is upon workers' compensation issues, Medicare Secondary Payer Act claims, issues arising under the Americans with Disabilities Act and other employment law matters.

Ms. Schroeder is admitted to practice law in the State and Federal Court systems in Nebraska, the United States Court of Appeals for the Eighth Circuit and the United States Supreme Court. She is a member of the International Association of Defense Counsel and the Defense Research Institute as well as the American Bar Association, Nebraska State Bar Association and Lincoln (Nebraska) Bar Association.

Ms. Schroeder earned a Bachelor of Business Administration degree from Texas A&M University in 1981 and a Juris Doctor degree from the University of Nebraska College of Law in 1984. She served as an Assistant Attorney General for the State of Nebraska for several years prior to entering the private practice of law.

Ms. Schroeder can be reached by phone: 402-475-1075
E-mail: jschroeder@baylorlaw.com
Mail: 1248 O Street, Suite 600, Lincoln, NE 68508

**Michael Westcott**

Michael Westcott owns and operates the Structured Financial Associates-O'Hare operation and has 24 years of experience in the structured settlement industry.

Mr. Westcott has expertise in the use of structuredsettlements in the resolution of claims involving Medicare Set Asides, Workers Compensation, Long Shore and Harbor Worker Claims, Common Carrier and Trucking Claims, Complex Medical Claims, Religious Organization claims and Specialty Risk claims.

Mr. Westcott received his B.A. from the University of Wisconsin and holds insurance licenses in multiple states. He is a member of the National Structured Settlement Trade Association and serves as Co-Chair of the Government Benefits Committee. He is also a member of the Long Shore and Harbor Workers Claims Association, the Trucking Industry Defense Association and is a charter member of the National Alliance of Medicare Set Aside Professionals.

Mr. Westcott may be reached by phone: 715-848-2816
Email: mwestcott@sfainc.com
Cell phone: 847-909-7453.

*We want to welcome each of them and we look forward to their contributions to our organization in 2006.*

In addition, here is the new NAMSAP committee structure:

Membership
Chair: Barbara Fairchild, RN

Education
Chair: Tracey Lazzopina, Knowledge Manager

Standards and Ethics
Chair: Nancy Heidrich, RN, Allocation Services Manager

Marketing and Communication
Chair: Sarah Gaidos, Marketing Specialist

Sponsorships and Finance
Open

Special Appointments
Professional Association Liaison: Michael Westcott