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NAMSAP news

National Alliance of Medicare Set-Aside Professionals

IMPORTANT NEWS

Final CMS Policy Regarding Inclusion of Pharmacy Costs in MSA Allocations Still Pending

A CMS representative provided some verbal information on this topic on September 10th, 2005 at the IAIABC Conference in Philadelphia advising that CMS intends to require that the cost of prescription drugs covered under the Medicare prescription drug benefit (Medicare Part D) be included in MSA allocations. CMS has indicated for some time that once a decision was made to require that covered prescription drugs be included in MSA allocations, the effective date would be for allocations received by the COBC on or after January 1 2006 (the anticipated launch date for the prescription drug benefit.) CMS again reiterated this position at the conference and added that the Average Wholesale Price (AWP) will be utilized in the calculation of the cost of covered prescription drugs in the MSA allocation.

However, it is important to note that CMS has not yet issued its final directive and a number of details are still unknown. The prescription drug benefit contains a deductible and several different levels of co-payments which vary based on the actual annual prescription costs and out of pocket payments. Without a written directive from CMS, the exact requirements for calculation of covered prescription drug costs as well as how the deductible and various co-payments will be considered is still speculation. CMS expects to issue its directive within the next few weeks which still allows ample time to complete allocations, and amend previously completed allocations, to include the prescription drug costs in appropriate cases.

Another consideration is that while the White House is resisting calls to delay the Medicare prescription drug benefit for one year to help fund the Hurricane Katrina relief effort, lawmakers are continuing to press for delaying the program launch. With additional concerns regarding damages from Hurricane Rita, this is still an area to monitor. NAMSAP

Cutting-Edge Presentations Planned for NAMSAP Educational Conference November 11, 2005

The first annual NAMSAP educational conference in Orlando, Florida is one that anyone interested in Medicare Secondary Payer compliance will not want to miss! The one day event features cutting-edge presentations by experts in the industry including how to consider Medicare's interest in cases that do not meet the CMS review threshold, how to utilize a Special Needs Trust to protect both Medicare's interests and Medicaid benefits for dual eligibility cases, conditional payment resolution from pre-settlement negotiation to post-settlement appeal and how to comply with the Medicare Secondary Payer statute in liability cases. The cost of attendance ($200 for NAMSAP members and $295 for nonmembers) also includes continental breakfast, beverage and snack breaks, buffet lunch and a cocktail party with exhibitors. Florida attorneys and adjusters will receive 5 hours of continuing education credits. The Commission for Health Care Certification has approved 5 hours of renewal credits for Certified Life Care Planners and Medicare Set-Aside Consultants-Certifed (MSCC). Credits may also apply toward those required for initial MSCC certification.The conference will be held at the Crowne Plaza Orlando Airport (407-856-0100). To register to attend or exhibit, please contact NAMSAP at 212-297-2155 or register on-line at http://www.NAMSAP.org (click education then annual meeting).

Space is limited and this event is sure to sell out so register early! NAMSAP

MSP Compliance in Low Threshold Cases and Cases not Meeting the CMS Review Thresholds

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On July 11, 2005, The Centers for Medicare and Medicaid Services (CMS) issued its most recent policy memorandum which addressed a number of issues including review thresholds for MSA arrangements. This update will discuss: the new CMS low dollar threshold for Medicare beneficiaries, the emphasis by CMS that its review thresholds are only workload review thresholds, that Medicare's interest must be considered in all WC cases, and offer practical considerations for MSP compliance in cases that do not meet the CMS review thresholds.

Low Threshold Cases

In answer 2 of the memorandum, CMS advised that they will no longer review MSA proposals for Medicare beneficiaries where the total settlement amount is less than $10,000. The CMS also instructed that the computation of the total settlement amount includes, but is not limited to: wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments. Considering the repayment of Medicare conditional payments when calculating the total settlement amount for the purpose of determining if a case meets the review threshold is a new directive by The CMS. At first blush it appears that this new low dollar threshold will save carriers' time and money on cases involving Medicare beneficiaries with a total settlement amount of less than $10,000. However, the addition of the requirement to consider repayment of Medicare conditional payments in the calculation of the total settlement amount, actually adds additional time (and therefore money) to the process in many cases.

In order to identify Medicare conditional payment amounts subject to repayment, the details of the case must be reported to the Medicare Coordination of Benefits Contractor (COBC). A working file will be created and a Fiscal Intermediary (FI) assigned. A request must then be made to the assigned FI to request an estimate of conditional payment claims made to date. A response to this request is averaging 4 months or more nationally. This response turn-around time results in a minimum delay of 4 months to obtain a conditional payment claim estimate in order to properly calculate the total settlement amount. One must also consider that any conditional payment claim amount by the FI prior to settlement is only an estimate and the amount could actually be higher as providers have up to 27 months from the date of service to submit claims to Medicare.

In addition, if any of Medicare's conditional payment claims appear inappropriate, additional time will be required to request the removal of these claims. If the conditional payment amount causes the total settlement to equal or exceed $10,000, then a CMS approved MSA allocation would be appropriate which would require an additional 3-4 months. Prior to the new low dollar threshold directive, the conditional payment inquiry occurred concurrently with the CMS submission so the total time to address both issues required an average of 4 months. Therefore, the new directives will not provide any reduction in processing time and have the potential to actually double processing time in many cases.

Insurers should make every effort to identify conditional payment claims as well as reduce or eliminate future exposure for conditional payment claims during the course of claim handling. By identifying WC claimants who are Medicare beneficiaries, calling details of the claim to the COBC and requesting a conditional payment estimate from the FI as early as possible, the current conditional payment claim amount can be identified and the Medicare database

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will be flagged to prevent payment of future claims related to the WC diagnoses thereby dramatically reducing the potential for future Medicare conditional payments.

Cases not meeting the Review Thresholds

The memorandum also emphasized that the thresholds for CMS review of a MSA proposal are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to WC and that Medicare's interest must always be considered when settling any workers' compensation case, even if review thresholds are not met.

To date, there is no specific direction from CMS regarding how to consider Medicare's interests in cases that do not meet the established CMS review thresholds—other than it must be done. Therefore, primary payers must develop their own internal protocols for compliance with the Medicare Secondary Payer Statute. The following are 2 options that are currently being considered. The decision regarding which option to use may vary within an organization based on certain criteria such as the total settlement amount. These options are not intended to provide MSP compliance advice.

Option 1: Cost Projection and Apportionment of Future Medical Costs

- Obtain a projection of future injury related medical costs; either through a cost projection or other method (see methods below).
- Identify this amount in the settlement documents
- The claimant must spend this amount for injury related medical care before submitting claims to Medicare
- The claimant must save all receipts for injury related medical care
- Annual accounting to Medicare is not required
- CMS approval is not required
- Include settlement language addressing MSP compliance (sample below)

1. Obtain and maintain a projection of future anticipated medical costs related to the injury

This may be addressed through a medical cost projection (this may be obtained through your allocation vendor) or other procedure that the primary payer feels adequately supports and defends the future medical apportionment of the settlement (i.e., treating physician recommendations for future care, life care plan, projection by an internal case manager, etc). This would not be submitted to CMS. This would not need to be approved by CMS. This would not delay the settlement of the claim. Annual accounting to Medicare would not be required.

2. Settlement funds intended to compensate for future medical care related to the injury must be clearly identified

Whatever the amount of future anticipated medical needs related to the injury, it should be clearly identified in the settlement documents and the claimant and his or her attorney must be put on notice of this amount and its intended purpose.

3. These funds must be spent for that purpose before injury-related claims are submitted to Medicare for consideration

The settlement documents must clearly reflect that the claimant agrees that the funds intended to compensate for future medical needs related to the injury are to be used only for that purpose (i.e., medical treatment related to the claim) and must be exhausted for that purpose before any injury related claims are submitted to Medicare for consideration. The claimant should be advised to maintain receipts for these expenditures in the event the that The CMS requires this at a later time.

4. Settlement language should clearly address how Medicare's interests are being considered in

all WC settlements including both the areas of injury related future medical expenses and Medicare conditional payments (if the case involves a Medicare beneficiary).

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Option 2: Non-CMS Approved MSA

- Obtain a non-CMS approved MSA
- Document this amount in the settlement documents
- The claimant must spend this amount for Medicare allowable; injury related care before submitting claims to Medicare
- The claimant must save all receipts for Medicare allowable, injury related medical care
- Annual accounting to Medicare is not required
- CMS approval is not required
- Include settlement language addressing MSP compliance (sample below)

1. Obtain a non-CMS approved MSA

Obtain a non-CMS approved MSA (this may be obtained through your allocation vendor). This would not be submitted to CMS. This would not need to be approved by CMS. This would not delay the settlement of the claim. Annual accounting and reporting to Medicare would not be required.

2. Settlement funds intended to compensate for future Medicare allowable; injury related medical care (MSA amount) must be clearly identified

Whatever the amount of future anticipated Medicare allowable medical needs related to the injury (MSA amount), it should be clearly identified in the settlement documents and the claimant and his or her attorney must be put on notice of this amount and its intended purpose.

3. These funds must be spent for that purpose before injury related claims are submitted to Medicare for consideration

The settlement documents must clearly reflect that the claimant agrees that the funds intended to compensate for future Medicare allowable medical needs related to the injury are to be used only for that purpose (i.e., Medicare allowable medical treatment related to the claim) and must be exhausted for that purpose before any injury related claims are submitted to Medicare for consideration. The claimant should be advised to maintain receipts for these expenditures in the event CMS requires this at a later time.

4. Settlement language should clearly address how Medicare's interests are being considered in all WC settlements including the areas of injury related future medical expenses and Medicare conditional payments (if the case involves a Medicare beneficiary).

Again, these are just options being considered by some primary payers. The decision regarding how to "consider and protect" Medicare's interest is one that must be carefully addressed and will often depend on the facts of the underlying claim. Some primary payers are implementing a "threshold" of their own for cases that do not meet the established CMS review threshold (i.e., in total settlements less than 50,000, a physician letter or internally prepared cost estimate will be utilized. In settlements between $50,000 and 100,000, an external vendor will be utilized to prepare a formal cost projection. In settlements between $100,000 and $250,000 a non-CMS approved MSA will be obtained). The important issue is not the exact methodology that is utilized to comply with the MSP rather that primary payers have a compliance protocol in place going forward in order to avoid any future exposure. NAMSAP