

What Medicare Set-Asides Mean for Workers' Compensation

I. Background

- a. Medicare was created in 1965 and celebrated its 50th birthday earlier this year.
 - i. Provides healthcare benefits for the elderly, the disabled and individuals with End Stage Renal Disease (ESRD)
 - ii. Congress made Medicare secondary to Workers' Compensation from the start of the program
 - iii. Medicare Secondary Payer laws extended to employer-sponsored Group Health Plans, Liability and No-Fault in the 1980s
- b. This presentation will cover the following:
 - i. Medicare's statutory authority and Medicare Secondary Payer (MSP) regulations
 - ii. Medicare's *past, present* and *future* interests
 - iii. Mandatory Insurer Reporting
 - iv. Medicare's recovery of mistaken and conditional payments
 - v. Workers' Compensation Medicare Set-Asides (WCMSAs)

II. Medicare's Statutory Authority

- a. Medicare Secondary Payer (MSP) Statute – Section 1862(b)(2) of the Social Security Act (42 USC 1395y(b)(2)) No Medicare payment [*except conditionally*] may be made for any item or service to the extent that payment has been made, or can be reasonably expected to be made, under a **workers' compensation** law or plan or under an automobile or liability policy or plan (including self-insurance), or under no-fault insurance.
- b. Codified at 42 C.F.R. 411.20 – 411.54
- c. Medicare Modernization Act (MMA) of 2003 §301
 - i. Clarified self-insured entities as: entities that engage in a business, trade or profession are deemed to either have purchased insurance or to be self-insured
 - ii. Re-defined primary payer's obligation: primary payer's obligation to repay Medicare is established when it is demonstrated that the primary plan has, or had at the time the services were provided, an **obligation** to make primary payment
 1. A primary plan's obligation for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (**whether or not there is a determination or admission of liability**) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

- d. Medicare, Medicaid & SCHIP Extension Act (MMSEA) of 2007, §111
 - i. Established Mandatory Insurer Reporting requirements
 - 1. Insurers (including self-insured) must report Ongoing Responsibility for Medicals (ORM) and lump sum settlements (Total Payment Obligation to Claimant (TPOC)).

III. Medicare's Interests

- a. Past – Medicare recovers conditional or mistaken payments
 - i. Prior to a settlement- from the primary payer
 - ii. After a lump sum settlement – from the Medicare beneficiary
- b. Present – Medicare avoids making incorrect primary payment
 - i. Medicare will pay *conditionally* if the primary payer has not or is unlikely to pay within 120 days (prompt payment)
- c. Future - Any lump sum payment conditioned upon a compromise, waiver or release of responsibility for future medicals is primary to Medicare
 - i. Medicare established the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) process
 - 1. Voluntary process by which parties can receive confirmation from Medicare that its future interest has been adequately protected
 - ii. Outside the WCMSA process parties must protect Medicare
 - 1. Some options are:
 - a. Creating a Life Care Plan
 - b. Provision for reopening medicals

IV. Mandatory Insurer Reporting

- a. Enables Medicare to protect its past and present interests
- b. Refer to the Non-Group Health Plan (NGHP) User Guide for technical information and policy guidance ⁱ
- c. Ongoing Responsibility for Medicals (ORM)
 - i. Must be reported when a Responsible Reporting Entity (RRE) assumes responsibility for injury-related medicals
 - ii. Applies to ORM that existed or exists on or after 1/1/2010
 - iii. Medicare denies claims with same/similar diagnosis but continues to pay claims that are not related to the work-injury
 - 1. Medicare may make *conditional payment* where primary payment is not likely to be made promptly (120 days from date of injury or ORM)
- d. Total Payment Obligation to Claimant (TPOC)
 - i. Lump sum settlement, judgment or award, typically a one-time payment must be reported for:
 - 1. Dates after 10/1/2010

- 2. Cumulative total of the TPOC is over the reporting threshold for most recent reporting date (\$300 after 10/1/2014)
 - ii. If a CMS-approved WCMSA exists Medicare will continue to deny work-injury related claims until the WCMSA funds are appropriately exhausted
- V. Recovering Conditional or Mistaken Primary Payment
 - a. Medicare contractor issues demand letters to WC carriers for work-injury related claims that Medicare paid conditionally or by mistake.
 - i. Benefits Coordination & Recovery Center (BCRC) currently performing recovery
 - ii. Effective October, 2015 the Commercial Repayment Center (CRC) will assume responsibility for recovery of mistaken payments where ORM is in place
 - b. If the claimant/beneficiary received a lump sum settlement and ORM has been terminated the BCRC will seek to recover from the claimant/beneficiary
- VI. Workers' Compensation Medicare Set-Asides (WCMSA)
 - a. Workers' Compensation Medicare Set-Asides (WCMSA) created in 2001 (*July 23, 2001, memorandum*ⁱⁱ)
 - i. Designed to protect Medicare where WC claimants receive a lump sum settlement which releases the WC carrier from responsibility for future medicals
 - ii. WCMSA rules and submission/review procedures formalized by Seattle Regional Office in 2002
 - iii. National uniform procedures established in 2005
 - b. Review Thresholds
 - i. Claimant is currently a Medicare beneficiary – total settlement amount is **greater than \$25,000**
 - ii. If claimant is not a Medicare beneficiary – must have reasonable expectation of becoming a beneficiary **within 30 months** AND the total settlement is **greater than \$250,000**
 - c. Submission/Approval process
 - i. Review the WCMSA Reference Guide for detailed information about submitting a WCMSAⁱⁱⁱ
 - ii. WCMSA Portal – CMS recommends that regular submitters use the WCMSA web portal to submit WCMSAs
 - iii. Workers' Compensation Review Contractor (WCRC)
 - 1. Performs independent review of WCMSA submissions and refers the case along with its recommendation to the Regional Office for approval
 - 2. CMS Regional Office considers the WCMSA submission and the WCRC recommendation and issues an approval

- d. Administering a WCMSA
 - i. Funds may be used only for medical services, supplies and prescription drugs related to the work-injury **that would otherwise be paid for by Medicare**
 - ii. If the WCMSA was priced/approved based on the state's WC fee schedule the claimant or administrator must ask the provider/supplier/pharmacy to honor the WC fee schedule price.
 - 1. If the provider/supplier/pharmacy refuses to honor the WC fee schedule CMS will not fault the claimant or administrator for paying actual charges
 - iii. The administrator must submit annual attestations providing the total amount spent during the year
 - iv. Medicare will deny claims related to the work-injury as long as the WCMSA is funded but will continue to pay unrelated claims
 - v. Medicare may recover any mistaken payments made after the establishment of the WCMSA from the claimant

ⁱ <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html>

ⁱⁱ <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Memorandums/Downloads/July-23-2001-Memorandum.pdf>

ⁱⁱⁱ <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2-3.pdf>