Medicare is the Prickly Cactus in the Desert of Workers’ Compensation: This Session Will Make Your Life a Little Sweeter
An Oasis in the Workers’ Compensation Desert

ALFA INTERNATIONAL 2018 WORKERS’ COMPENSATION SEMINAR

October 3-5, 2018
Mountain Shadows Resort
Paradise Valley, Arizona

www.alfainternational.com
MEDICARE IS THE PRICKLY CACTUS IN THE DESERT OF WORKERS’ COMPENSATION

THIS SESSION WILL MAKE YOUR LIFE A LITTLE SWEETER
A BARBED MEDICARE UPDATE

Case Law Update

In *Aetna Life Ins. Co. v. Guerrera* (2018 U.S. Dist. Lexis 41450), the 2nd Circuit allowed a Medicare Secondary Payer (Medicare Advantage Plan) to bring a suit for a private cause of action for recovery, but only against the tortfeasor.

Private Cause of Action: There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement). 42 USC §1395y(b)(3)(A)
• Aetna brought suit against Big Y, the injured plaintiff and plaintiff’s attorney after the parties failed to reimburse Aetna.

• The Court held that the intent of Congress in enacting the Private Cause of Action provision, was to only allow suit against a Primary Plan, i.e., an insurance company or self-insured entity.
• In *Mayo v. NYU Langane Med. Center*, 2018 NY Slip Op 30456, (unpublished), a final conditional payment ruined a settlement. This is a trial court level opinion with no precedent, but it does present an interesting problem.

• Plaintiff obtained a preliminary conditional payment letter from CMS before settlement totaling $2,824.50 and the parties relied upon the preliminary amount when settling the case for $725,000 inclusive of liens on 1/20/16.
• On 1/22/16, CMS advised plaintiff’s counsel that the final conditional payment claim was $145,764.08.
• How do you avoid a similar problem?
  • Request that the case be put into the “Final Conditional Payment Process” which notifies the Benefit Coordination & Recovery Center that the case is within 120 days of settlement.
  • Request the Final Conditional Payment Amount within 3 business days of settlement via Medicare’s Secondary Recovery Portal.
  • Now insurers, recovery agents and insurer representatives, in addition to beneficiaries and their representatives have access to the portal.
A GLIMPSE OF A MIRAGE FROM CMS

- Improvements by CMS
  - Amended Review Process: as of 12/2016 parties may now request an updated decision of prior CMS decisions with medical evidence post-dating the CMS submission date.
  - If CMS issued a decision in the past 1-4 years.
  - Updated records support a reduction (or increase) in the MSA of 10% or $10,000, whichever is greater.
  - Use to remove DME no longer needed, adjust prescription frequencies, remove medications not covered by Medicare, correct rated age & exclude unneeded surgeries.
MEDICARE ADVANTAGE & PRESCRIPTION DRUG BENEFIT UPDATES

- Medicare Prescription Drug Plans (Part D) will implement management program in 2019 to reduce misuse of opioids.
- Plans will use case management to limit frequently abused drugs by at-risk beneficiaries.
- CMS includes benzodiazepines as frequently abused.
AT RISK BENEFICIARIES

- How does CMS identify at-risk beneficiaries?
- Clinical guidelines based on opioid use from multiple prescribers and/or multiple pharmacies.
- Exempt active cancer patients receiving palliative or end-of-life care in hospice, or long term care from drug management programs.
- Will we see a change in CMS projections for opioids in set-aside amounts?
CHANGES TO MEDICARE ADVANTAGE PLANS

- Redefining health-related supplemental benefits to include:
  - Non-skilled in-home supports.
  - Portable wheelchair ramps.
  - Other assistive devices/modifications when needed.
- A supplemental benefit will be allowed if it compensates for physical impairments, diminishes the impact of injuries or health conditions &/or reduces avoidable emergency room utilization.
MEDICARE’S SPINES GO BEYOND CONDITIONAL PAYMENTS

• Utilization by claimant of Medicare Advantage Plans, Part D plans and Medicaid who also have a right of recovery.
• Legislation (H.R. 5881) has been introduced in the House of Representatives to amend the Social Security Act to allow CMS to share information regarding enrollment in MAP, Part D & Medicaid.
• For now continue to identify all possible sources early and inquire with claimant and/or opposing counsel.
DAY 1 MANAGEMENT OF CLAIMS IN THE DESERT OF MEDICARE COMPLIANCE

- Strategies for Controlling MSA Costs:
  - Control Diagnosis Codes from the beginning of a claim.
  - Section 111 reporting or Mandatory Insurer Reporting.
  - Utilize Pharmacy Fee Schedules where available.
  - Avoid non-generic medication.
  - Limit Opioid Use.
  - Will Part D Drug Management Programs apply to set-aside amounts?
  - Consider alternatives to opioids, e.g. Marijuana.
PRICKLY CACTUS EXAMPLE

Facts:
- DOI: 1/10/16 back; 2/20/17 bilateral CTS
- DOB: 8/15/1993 (age = 25yrs male)/8/15/1953 (age = 65yrs female)
- Conditional Payments: $55,000 (including one surgery) ($5,000 is for PT paid by mistake for an unrelated non-occ knee condition).
- MSA $180,000 for back (includes $90,000 for future anticipated opioid use); $25,000 for proposed MSA for bilateral CTS injury.
- CMS preapproved MSA $475,000, including cost of opioid use and spinal cord stimulator procedures (referred to in medical records but not yet recommended or performed) for back case and $15,000 for bilateral CTS case.
• Settlement agreement of $210,000 for indemnity for back case; $75,000 for indemnity for CTS case, plus employer funding of MSA.
• Structure quote for MSA is $145,000 for the vendor proposal; $395,000 for CMS pre-approved proposal.
• Spouse works and has family coverage, which includes coverage for pre-existing conditions.
• What if employee has VA coverage?
• What are the strategies available for management of the MSA issues to obtain the best value in the settlement?
SETTLEMENT IDEAS FOR WHEN MEDICARE STICKS YOU

- Leave future medical care open.
- Obtain judicial finding limiting the parts of body.
- Ensure your TPA is aware of your desire to reign in costs.
- Structure the exposure; get professional administration.
- Deal with treating physicians who over treat.
- Often Utilization Review is not enough.
- Seek zero MSA in denied claims.
- Opt out of submitting to CMS.
- Multiple MSAs and split settlements.
USING BIG DATA TO DRAIN THE COSTS FROM SET-ASIDES

- Big data analysis of the actual costs of future medical claims involving Medicare Set-Asides.
THORNY CONDITIONAL PAYMENT ISSUES

- Why Do we Care?
- Request conditional payments from CMS 20 days before settlement and within 3 business days of settlement.
- Section 111 Mandatory Reporting.
- How it affects your conditional payments from the beginning?
- Liens
- Medicare Advantage Plans, Veterans Affairs Administration, Medicaid, Medicare Prescription Drug Plan.
MAKING MEDICARE TROUBLES A MIRAGE

GOLDEN NUGGETS OF KNOWLEDGE

• Manage your claim from day 1 with Medicare in mind.
• Perform strategic Section 111 reporting of ICD Diagnosis Codes.
• Pay attention to the diagnosis codes paid from the beginning of the claim.
• Do not add 15 months onto the life of your claim with late Medicare analysis, use the 15 month life of the claim to best position for Medicare.