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The Rocky Mountains of Workers' Compensation

CLIMBING THE PEAKS IN THE PRACTICE OF WORKERS' COMPENSATION

2023 WORKERS' COMPENSATION PRACTICE GROUP SEMINAR

SEPTEMBER 27-29, 2023 | PENDRY PARK CITY | PARK CITY, UTAH

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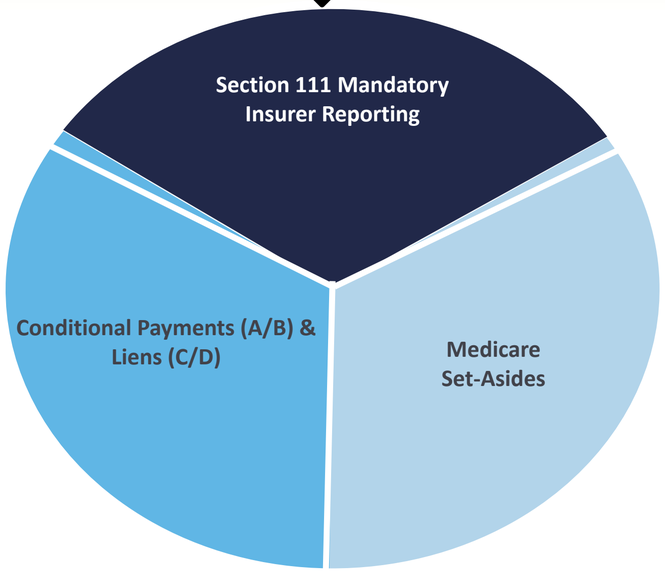
Tips and Strategies for Ascending the Mountains of Medicare Compliance and Risk Management: Section 111 Penalties, Conditional Payments and Double Damages, and Medicare Set-Aside Updates

Three Areas of Medicare Compliance

It All Starts Here



- 42 U.S.C. 1395y(b)(2)
- Regulations begin at 42 C.F.R. 411

Generated from Section 111 Data →

← Prevents burden shifting to Medicare to pay for injury-related expenses

Conditional Payments

Case Scenario

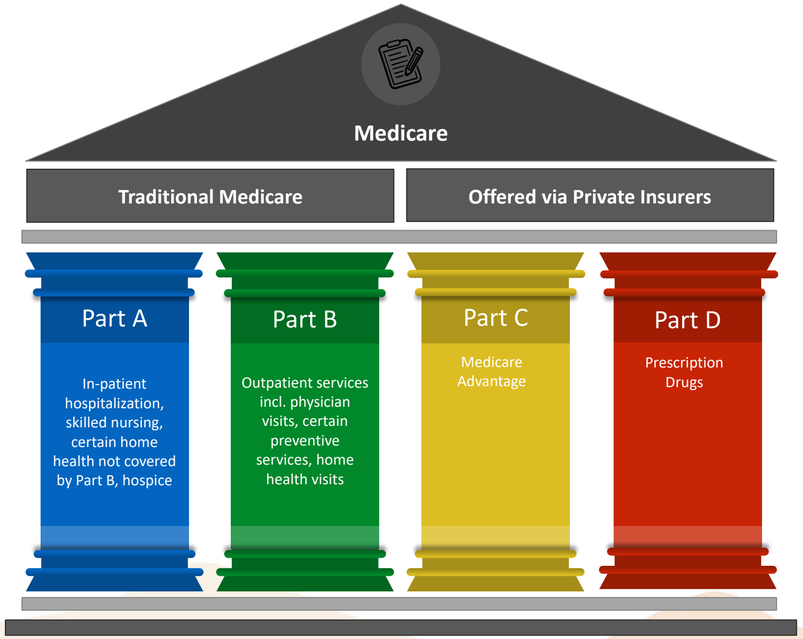
Ken is injured during the course and scope of his employment when he slips on roller blades. Due to his disability, he becomes Medicare eligible. Ken is represented by Allan and Barbie represents his employer, Mattel. The parties attend a mediation and settle the claim for $100,000. The claim is closed and Medicare asserts a lien in the amount of $50,000 and another lien is received for a Medicare Advantage Plan in the amount of $20,000.

Conditional Payments

- What could have been done differently before settlement to mitigate the conditional payment claim?
- Who is responsible for the liens?
- Does the Medicare Advantage Plan have a right of recovery for their lien?

Conditional Payments

What Are the Types of Potential Medicare liens?



Conditional Payments

Critical Questions to Ask Now

- Who is monitoring your internal conditional lien process?
- Are you resolving A, B, C, and D liens?
- Do you have a recovery agent?
- Are you disputing lien amounts?
- Have you paid liens because of missed time frames?

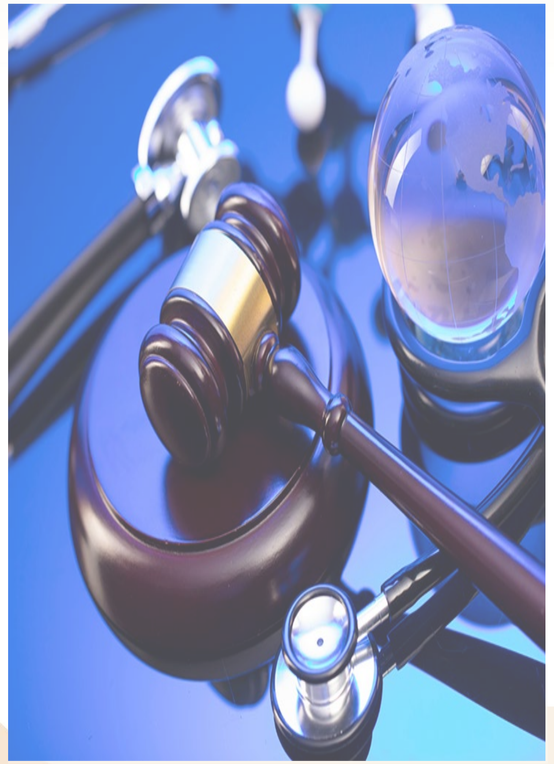
Conditional Payments

- 42 USC section 1395y
  - A primary plan and an entity that receives payment from a primary plan has or had responsibility to make payment with respect to such item or services
  - Claimant, claimant counsel, defense counsel, and defendant primary payors. Can seek from claimant's Social Security and tax refund.
- Treasury and DOJ collect the debt
  - 3 years to file complaint
  - 2 x the damages
  - In addition to damages the settlements include actions which must be taken in the future to avoid failing to pay the debt

Conditional Payments

Settlement Considerations Best Practices

- Start lien investigation process prior to settlement
- Determine by whom and how liens will be addressed
- Identify all potential liens (Section 111 Query Process)
- Don’t rely on representations from claimant (may not know)
- Have a policy and procedure in place on lien resolution
- Liens should be disputed based on multiple arguments
- The reopen process is viable



Future Allocations

Case Scenario

Iron Man is injured during the course and scope of his employment as an Avenger when his jet pack failed and he fell out of the sky onto Pepper Pots a.k.a. Gwyneth Paltrow. He sustained extensive injuries including a low back injury which was accepted. He also treated for depression which was denied. He was taking medications before the injury for anxiety and depression. His doctor prescribed multiple, costly medications for the back injury as well and recommended a potential spinal cord stimulator. The parties are resolving the claim for $250,000. Iron Man is Medicare eligible based upon disability.

Future Allocations

- What are your MSA options in this scenario?
- How would you resolve this claim?
- Accepted v. Denied parts of body, how do you ensure the allocation does not include denied parts of body?
- How do you avoid having the spinal cord stimulator as part of the allocation?

Types of Medicare Set-Asides

Submission to CMS

- CMS submission is voluntary and not required under the law
- Must meet the CMS review thresholds
- Based upon CMS pricing methodology (probable vs. possible)
- Potential development requests for lack of medical records/further documentation
- Potential increase from original submission

CMS - WCMSA Fiscal Year Statistics

Table 1: WCMSA Proposed Values

Reporting Period	Total WCRC Recommendations Completed	Total Settlement Amount	Total Settlement Amount Average	Total Proposed WCMSA Amount	Total Proposed WCMSA Average
FY 2022	13,752	$2,353,923,354	$171,169.53	$983,080,609	$71,486.37
FY 2021	14,816	$2,364,327,704	$159,579.35	$1,043,630,541	$70,439.43
FY 2020	16,517	$2,789,808,305	$168,905.27	$1,236,254,478	$74,847.40

Table 2: WCRC Values

Reporting Period	Total WCRC Recommendations Completed	Total WCRC Recommended WCMSA Amount	Total WCRC Recommended WCMSA Average	% Proposed Vs Recommended Change	Recommended Medical Amount	Recommended Medical Amount Average	Recommended Rx Amount	Recommended Rx Amount Average
FY 2022	13,752	$1,121,774,770	$81,571.75	14%	$836,056,957.09	$60,795.30	$285,717,812.91	$20,776.46
FY 2021	14,816	$1,196,257,790	$80,740.94	15%	$886,373,563.87	$59,825.43	$309,884,226.13	$20,915.51
FY 2020	16,517	$1,396,732,517	$84,563.33	13%	$957,804,564.25	$57,989.02	$438,927,952.75	$26,574.31

Types of Medicare Set-Asides

Non-Submits/Certified MSAs

- Not submitted to CMS for review
- Based upon probable vs possible methodology
- Reasonable consideration of Medicare's interest
- Can come with additional protections such as certification
- Parties can finalize settlement without delay

Types of Medicare Set-Asides

WCMSA Reference Guide: Section 4.3 The Use of Non-CMS-Approved Products to Address Future Medical Care

A number of industry products *exist for the purpose of complying with the Medicare Secondary Payer regulations without participation in the voluntary WCMSA review process set forth in this reference guide…* CMS **may** at its sole discretion deny payment for medical services related to the WC injuries or illness, requiring attestation of appropriate exhaustion equal to the total settlement as defined in Section 10.5.3 of this reference guide, less procurement costs *and paid conditional payments*, before CMS will resume primary payment obligation for settled injuries or illnesses, ***unless it is shown, at the time of exhaustion of the MSA funds****, that both the initial funding of the MSA was sufficient, and utilization of MSA funds was appropriate.* This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount.

Medicare Set-Asides Best Practices

- Determine what program is best for you i.e. submission, non-submit, certified, hybrid or case-by-case approach
- If submitting to CMS determine if allocations will be conservative or aggressive
- Mitigation for any MSA is key
- Vendor should work with adjuster and defense counsel on reducing MSA costs and helping to review complex cases
- Not every MSA vendor is the same, pick one that is right for you
- Vendor can provide education to defense counsel and adjusters on your total program approach

Section 111 Reporting

- Insurers, Self-Insurers, Liability and Workers' Compensation Insurers (Responsible Reporting Entities) must report to CMS when:
  - ✓ They have a case involving a Medicare beneficiary and
  - ✓ They have accepted medical and closed medical and/or
  - ✓ Have settled the medical portion of the claim

  CMS uses data submitted to determine if they have paid any injury-related medical expenses

Section 111 Reporting

- CMS proposed a rule and have a final rule before the Executive Branch imposing $1,000 per day, per claimant if an RRE fails to properly report
- Settlement documents should match what is reported to CMS including
  - Diagnosis codes/injuries/body parts
  - Dates of injury
  - What is denied and what is accepted
  - Total amount of settlement

Section 111 Reporting

Critical Questions

- What system(s) are you using? How often is it updated to account for CMS' changes?
- Who is providing information to be reported? Claims staff, IT, TPA?
- How is the information being reported? Is IT handling it, a vendor, TPA?
- Is anyone monitoring the CMS response files?
- Is your staff being trained? Who is doing the training? How often is it refreshed?

Section 111 Reporting

Best Practices

- Have policies and procedures in place to ensure a compliant program
- Make sure you are receiving PAID Act information and tracking this information
- Train people in the organization who are reporting and update training as needed
- Consider audit to avoid fines and costs

Section 111 Reporting and Conditional Payments

Case Scenario

Superwoman is injured rescuing Lois Lane from a meteorite. Superwoman strained her shoulder and low back in the rescue. DC Comics denies the injury. The parties reach a resolution of the claim for $100,000 with a zero MSA approved by CMS. Superwoman is age eligible for Medicare. After the settlement was approved, Superwoman received a demand from the Benefits Coordination & Recovery Center (BCRC) for a conditional payment totaling $85,000.

Section 111 Reporting and Conditional Payments

- What could have been done differently to ensure that there was no conditional payment claim by BCRC?
- What happens if the claim is reported to CMS as accepted, but the claim was denied from inception?

Key Takeaways

- Mitigate conditional payment claims before settlement
- Identify who will be responsible for the conditional payment claim as part of the settlement agreement
- Ensure accurate Section 111 reporting to Medicare from inception
- MSAs are not one size fits all. What is best for your program?
- Don’t wait until after the case settles to address conditional payments
- Consider a Re-review or Amended Review of the approved set-aside allocation by CMS
- Ensure counsel understands your objectives and risk tolerance

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