Additional Q& A Regarding Implementation of the Emergency Settlement Regulations Maryland Workers' Compensation Commission - (10/27/2010)

Why do the Commission's regulations require that future medicals be apportioned or allocated in all cases particularly when those cases are outside the Medicare thresholds?

The Medicare Secondary Payer Act and implementing regulations effectively require that Medicare's interests be considered in all settlements.

Medicare may always evaluate whether the settlement adequately protects it interests and determine whether it should recognize the settlement, recover any conditional payments or otherwise take action.

See generally 42 CFR § 411.46 (b)(2) ("If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.")

See also 42 CFR § 411.46 (d)(2) ("If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.")

If the parties do not have a medical opinion regarding anticipated future medical treatment, how does the doctor get paid for the opinion needed to support the allocation of apportionment of future medicals?

First, it is anticipated that prospectively all IMEs will include a section addressing future medical treatment, e.g., no further treatment is needed, claimant will require certain procedures or therapy, etc. Best practices suggest that all future IMEs should include this information.

With respect to those cases in the pipeline where an IME has already been obtained and does not contain information concerning future medicals, it may be necessary for the doctor to review the medical history and address the issue of future medicals as an addendum. The doctor may then be paid a fee for the addendum.

I can't get the IME doctor to do a cost analysis of the future medical treatment. How do I determine the cost of the anticipated treatment?

The requirement that the apportionment be supported by medical documentation goes to the issue of having a medical opinion support the anticipated necessary medical treatment. The doctor must determine what treatment or procedures are reasonably necessary. An adjuster or attorney may then apply the fee guide to determine the total expenses associated with the anticipated treatment. Show your work so that the Commission has a reasonable basis upon which to evaluate the calculation.

Are indemnity payments that have already been made included in the calculation of the total value of the settlement for the purpose of determining whether the settlement falls within the CMS review thresholds?

Only prior settlements are included in the calculation of the total value of a settlement when determining whether the settlement is within the thresholds. Any previously settled portion of the workers' compensation claim, all future indemnity payments, all future medical expenses (including prescriptions), repayment of any Medicare conditional payments, attorneys' fees, and the gross total of all future payments to be paid pursuant to an annuity (not the present value).

See CMS memo dated July 11, 2005, Question 4.

May an insurer/employer place language in the settlement agreement that limits its contractual obligation to pay conditional payments to conditional payments that were made prior to the date of the settlement agreement?

Yes, an insurer/employer may limit their contractual obligation to reimburse CMS for conditional payments to payments made prior to the date of settlement. This does not, of course, foreclose further review or recovery by CMS.

How do I handle a compromise settlement?

Make sure that the text of the settlement agreement clearly indicates that the settlement is a compromise case and whether compensability and/or causation is contested.

How can I get a settlement approved involving the compromise of a workers' compensation lien and a third party insurer?

Because it is unclear how CMS will treat liability cases involving a compromise (the same review thresholds do not apply to liability cases) and a third party insurer, the Commission will not apply the requirements of § B (allocation and apportionment of future medicals) to third party settlements where the third party settlement is a compromise case involving the release of the workers' compensation lien, or the case is a policy limits case involving the release of the workers' compensation lien. In order to get this kind of case approved by the Commission, you must include the allocation of third party funds, the amount of the workers' compensation lien being compromised, and an explanation of why settlement was necessary (i.e., policy limits, poor liability, etc).

However, you and the third party insurer/attorney should be aware of CMS's position with respect to cases involving both a workers' compensation claim and a third party liability claim:

> Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further WC claim related medical services. A Medicare Set-aside arrangement is also unnecessary if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.

See CMS memo dated April 22, 2003, Question 19.

You should also be aware that CMS has successfully recovered conditional payments from attorneys in liability cases. *See United States v. Harris*, 2009 WL 891931 (N.D.W. Va. 2009).

How do I handle a settlement in a case that is on appeal?

Make sure that the text of the settlement agreement clearly indicates that the case is currently on appeal and identify the issues in dispute.

Will the Commission approve settlements in which the parties seek to settle the entire case and agree to pay whatever "number" CMS determines to be the appropriate amount of future medicals?

No. The Commission will not approve a settlement that is subject to the CMS thresholds for which the parties have not obtained prior CMS approval. If the parties are concerned that the pending CMS approval will take too long, or the parties seek to stop paying indemnity during the pending review, the parties may essentially bifurcate the settlement by settling the indemnity portion of the case and leaving medicals open. Once CMS approval has been obtained, the parties should submit the settlement to close the medicals.

See CMS memo dated July 11, 2005, Question 4.

Do I need to complete a settlement worksheet if we are leaving medicals open or there are no future medicals?

Yes, you still need to complete a worksheet but you should include in the comments section of the worksheet and in the body of the settlement a statement that medicals will be left open or that there are no future medicals. If there are no future medicals this alleged fact must be supported by medical documentation.