Maryland Workers' Compensation Commission
Introduction

Medicare Secondary Payer Act & Workers' Compensation Settlement Process

What this is not . . .

This presentation is not a tutorial on how to create and fund a formal set-aside allocation or Medicare Set-Aside

So, what is this?

This is a roadmap for ensuring that your settlements can be approved by the Commission.

This is an explanation of the regulations designed to ensure compliance with the requirement that Medicare's interests are adequately considered in settlements.
Medicare Secondary Payer Act ("MSPA")

Medicare acts as a secondary payer in the context of workers' compensation ("workers' comp pays first")

Regulations set forth in 42 CFR § 411

MSPA
Medicare is authorized to make "Conditional Payments" if primary plan does not promptly pay

MSPA creates a private cause of action against primary plan that fails to reimburse Medicare

Medicare Medicaid and SCHIP Extension Act Of 2007 ("MMSEA")
Aimed at enforcing MSPA by creating settlement reporting requirements

Workers' compensation insurers must report workers' compensation settlements to CMS

Bottom Line:

All parties in a workers' compensation case have responsibility to protect Medicare's interests when settling a case that involves future medical expenses.

In some cases, protecting Medicare's interests requires getting CMS approval of the amount allocated for future medical expenses (Medicare Set-Aside) in the settlement

Why You Should Care:

CMS may impose harsh sanctions on claimants who do not obtain CMS approval of a settlement when required under CMS thresholds and may:

1. **Deny claimant future medical care**

2. **Designate its own allocation which may be the entire settlement**

3. **Sue for re-payment from everyone involved including the claimant's attorney**

United States v. Stricker, et al., 2009cv02423, U.S. District Court of Alabama, filed December 1, 2009

Plaintiffs' settled liability case against defendant corporations for $300 million
CMS sued to recover conditional payments – defendant corporations, insurers, and plaintiffs' counsel

What Now?
The Commission promulgated emergency regulations, effective 1/4/10, to ensure adequate consideration of Medicare's interests in Commission-approved settlements. Regulations now require:

If your settlement falls within CMS review thresholds, you must obtain CMS approval before the Commission will approve your settlement.

If your settlement falls outside the CMS review thresholds, the settlement must:

Contain a statement that Medicare's interests have been considered and

Identify the amount of the proposed settlement apportioned to future medical expenses

OR

Identify the amount of the proposed settlement that is set-aside for future medical expenses through a formal set-aside allocation

How to protect Medicare's Interests
There are three methods for protecting Medicare's interests:

Formal Set-Aside Allocation or MSA

Apportionment of the amount associated with future medicals

Language confirming that Medicare's interests have been considered

Medicare Set-Aside ("MSA")

Account created in the settlement of an individual's workers' compensation claim that is used to pay for future medical expenses that are attributable to the work-related injury/disease

Formal Set-Aside Allocation

Document created in the settlement of an individual's workers' compensation claim reflecting a comprehensive analysis and projection of future injury-related medical needs & associated costs

COMAR 14.09.01.01B(3)

When is CMS approval required? When settling a workers' compensation claim and future medical benefits are being settled and either of the following two thresholds are met:

Total Settlement is worth more than $25,000 and claimant is current Medicare beneficiary

OR

Total Settlement is worth more than $250,000 with "reasonable expectation" of Medicare within 30 months
Total Settlement Includes:

- **All future Indemnity payments**
- **All future medical expenses (including prescriptions)**
- **Repayment of any Medicare conditional payments**
- **Total Settlement (cont'd.)**
- **Attorneys' fees**
- **Any previously settled portion of the workers' compensation claim**
- **The gross total of all future payments to be paid pursuant to an annuity (not the present value)**

"Reasonable Expectation" defined:
Claimant is 62.5 years old

OR

Claimant is current recipient of SSDI

OR

Reasonable Expectation (cont'd.)
Claimant has applied for SSDI or unfavorable SSDI ruling is on appeal

OR

Claimant suffers from end-stage renal disease (ESRD) but has not yet qualified for Medicare

Medicare Thresholds

For settlements within the Medicare thresholds, CMS approval must be obtained BEFORE the Commission will approve the settlement

Attorneys should use the newly revised Settlement worksheet (H-07) to assist in determining whether the settlement falls within the CMS review thresholds

COMAR 14.09.01.19B(2)

Settlements Outside

Medicare Thresholds

For settlements outside Medicare thresholds, the settlement agreement must contain:

A statement that Medicare's interests have been considered

AND EITHER

2(a) A statement identifying the amount of the proposed settlement apportioned to future medical costs supported by a medical opinion or evaluation

OR

2(b) A statement identifying the amount of the proposed settlement that is set-aside for future medical expenses through a formal set- aside allocation

Apportionment

Apportionment of the amount of the settlement associated with future medical expenses must be supported by medical evidence such as a medical opinion or evaluation

COMAR 14.09.01.19B(4)
Formal Set-Aside Allocation
Formal Set-Aside Allocation shall comply with the guidelines established by Medicare for set-aside allocations

COMAR 14.09.01.19B(5)
ALL Settlement Agreements Must Now Also Include:

Specific language confirming that the interests of Medicare have been considered

AND

A statement that the Insurer shall reimburse Medicare for any provisional payments made by Medicare which were ultimately determined to be the responsibility of the employer/insurer

AND

If the insurer makes an assignment of any of its obligations to a third party, the agreement must contain affirmative language confirming that the Employer/Insurer shall resume its obligation for all remaining payments in the event of a default by the third party

AND

Total value of all indemnity benefits previously paid to the claimant

AND

Gross total of all future payments to be paid pursuant to an annuity (not present value)

AND

Payment sheet identifying the precise distribution of all settlement proceeds

AND

Claimant's average weekly wage

AND

Claimant's date of birth and age in years and months

Remember:
The existing requirements of COMAR 14.09.01.19A still apply.

Settlement MUST include:

(1) Total amount of settlement

(2) Inclusive dates of TTD

(3) Date on which payments are to begin

(4) If compensation was previously awarded or paid, a statement indicating whether the settlement includes, is in addition to, or is in place of all or part of that compensation

(5) A statement indicating the rate of payment and whether settlement is to be paid as a lump sum

Q & A . . .

- **Do I need to comply with this regulation if the claimant has no future medical expenses?**

Yes, you will need to include the mandatory elements in the settlement agreement set forth in COMAR 14.09.01.19A.

You will also need to include medical evidence establishing that there are no future medical expenses. Section B of this regulation does not apply to a settlement in which there are no future medicals.

- **What if I don't know whether my client currently receives Medicare?**

FIND OUT.

- **Do different rules apply if this is a structured settlement?**

No.

- **How do I find out if the CMS review thresholds have changed?**

Go to https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/workers-compensation-medicare-set-aside-arrangements/wcmsa-overview for changes to the thresholds or changes in CMS' policy and procedure.

- **Are the CMS review thresholds a safe harbor?**

No, the thresholds do not create a safe harbor. The thresholds create a workload review standard for CMS.

- **What should an attorney do when the attorney's client seeks to ignore Medicare's interest in the settlement of a workers' compensation case?**

In its April 21, 2003 memorandum, CMS advises "the attorney should consult their national, state, and local bar association for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26."

- **Will the Commission make a new settlement template available on the website?**

No.

- **Will the Commission approve settlements in which the medicals are left open?**

Yes. Medicare's interests are protected when medicals are left open because the employer/insurer will continue to pay future medicals associated with the accidental injury or occupational disease.

Where to Get More Information

http://www.wcc.state.md.us/Adjud_Claims/Reg_Changes.html

https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/workers-compensation-medicare-set-aside-arrangements/wcmsa-overview

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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.