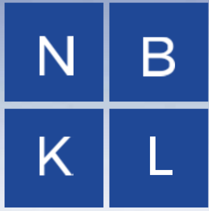

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WINTER 2019

Welcome to NBKL's "Medicare Secondary Payer Compliance Corner"

2018 was an eventful year for those involved in the area of Medicare Secondary Payer compliance. It ushered in two new contractors: Capitol Bridge, LLC replaced Provider Resources as the new Workers' Compensation Review Contractor and Performant Financial Corporation replaced CGI Federal in the Commercial Repayment Center (CRC) operations. Guides were updated, Medicare Secondary Payer Regulations were proposed and Private Cause of Action cases continued to be pursued. This edition of our NBKL MSP Compliance Corner highlights some of the more significant events of 2018 and identifies those likely to unfold in 2019.

Highlights of MSP 2018

A New WCRC Contractor, Changes to Allocations and the WCMSA Reference Guide / Julie Garrison

The Centers for Medicare and Medicaid Services (CMS) is tasked with approving future medical plans in settlements for workers' compensation claims of Medicare beneficiaries or those who will soon become Medicare eligible. Known as Workers' Compensation Medicare Set-Asides (MSA), these plans may be submitted to CMS who, in turn, contracts with a Workers' Compensation Review Center (WCRC) contractor to review the proposed plans and supporting documentation and issue approvals. After a September 1, 2017 contract award, Capitol Bridge, LLC became the WCRC contractor on March 19, 2018, taking over from Provider Resources, Inc., who had the contract since 2012. Capitol Bridge has a 25-year history of providing various support services to CMS and its current contract extends five years.

At the time of the March 2018 transition, Capitol Bridge announced goals of a 20-business day turnaround time after receipt of a complete submission and where indicated, determination letters seeking additional information were to issue within 10 business days. Consistent with these goals, the current turnaround time is around three weeks if no development letter is issued. Capitol Bridge advised its review staff would consist of experienced MSA nurse reviewers (all who hold Medicare Set-Aside Certified Consultant credentials), Medicare Secondary Payer (MSP) compliance attorneys, and physicians and pharmacists along with well-versed administrative staff. While Capitol Bridge also announced there would be no changes to calculation methodologies, some aggressive changes have been seen in Capitol Bridge's approvals.

Urine Drug Screenings: One such change involves the allocation of quarterly urine drug screenings for claimants taking Schedule II opiate medications. Prior to summer 2018, the standard allocation generally had one annual drug test. Capitol Bridge's rationale however is that quarterly urine drug screenings are appropriate given the 2015 prescribing requirements for Schedule II drugs whereby a single monthly prescription with no refills and no more than three monthly prescriptions between visits were allowed. While this also reflects current heightened awareness of opiate risks and abuse, evidence-based medicine guidelines do not support quarterly screens. Neither the Official Disability Guidelines, the Centers for Disease Control Guidelines, nor the Pain Management Physicians Guidelines recommend automatic quarterly urine drug screenings. These sources urge drug testing based on the treating physicians' assessment of risk and on a patient-specific, rather than formulaic, basis. In addition, the pricing for individual drug screenings has increased to the $115.00 to $140.00 per test range. Thus, the pricing for quarterly urine drug screenings significantly increased many MSAs and proved too costly for many settlements. After receiving industry-wide negative feedback, it is our understanding that CMS may instead return to projecting urine drug screens based on current and past treatment patterns. It remains to be seen whether this policy will be implemented by Capitol Bridge and the over-allocation of urine drug screenings adjusted.

Lyrica: Another change having significant cost implications is the allocation by Capitol Bridge of prescription Lyrica for chronic lumbar pain or neuropathic pain associated with lumbar radiculopathy. At several dollars per pill, brand-only Lyrica is FDA-approved to treat diabetic peripheral neuropathy, fibromyalgia, partial seizures, post-herpetic neuralgia, and neuropathic pain associated with spinal cord injuries. So, allocating Lyrica for radicular lumbar pain is an off-label, non-FDA-approved use that would not be covered by Medicare or included in MSAs.

However, in September 2018, Capitol Bridge started including Lyrica in MSAs, though prescribed for off-label neuropathic pain. In allocating Lyrica for chronic lumbar pain or neuropathic pain associated with lumbar radiculopathy, Capitol Bridge stated that Lyrica may be covered under Medicare if the individual carrier determines the use to be medically accepted after taking into consideration the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice. According to its WCMSA Reference Guide, when reviewing prescribed medications, the WCRC will "include medications that are Food and Drug Administration (FDA) approved or supported for inclusion in the approved compendia." (See Sec. 9.4.4). Micromedex's DrugDex database and the American Hospital Formulary Service Drug Information database are identified as CMS' preferred compendia for determining off label usage. If either or both compendia establish a medically-accepted off-label use or non-FDA-approved use of the drug, the medication is considered to be covered and reimbursable by Medicare. (See Sec. 9.4.6.2). When challenged in re-reviews of approved MSAs, Capitol Bridge noted that Lyrica has off-label indications listed in recognized compendia and peer review sources which would be covered under Medicare Part D benefits and should therefore be included in MSAs.

Another theory for Capitol Bridge's inclusion of Lyrica was an expansion of the definition of "neuropathic pain associated with spinal cord injury" which, again, is an FDA-approved use. Capitol Bridge interpreted spinal cord injury to include neuropathic pain secondary to lumbar radiculopathy. This interpretation was in fact confirmed in the newest release of the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, Version 2.9 released on January 4, 2019. Lyrica thus remains in the WCMSA when prescribed for radicular pain.

<u>"Possible" yet Unlikely Surgeries:</u> As part of future medical care projections, treating physicians often refer to possible surgical procedures if certain conditions develop or events occur. These statements are not conclusive or firm recommendations. Rather, they are references, made almost in passing and usually as part of a "laundry list" of potential treatment. Sometimes, they appear only once in remote office visit notes. Nevertheless, Capitol Bridge has added many such surgeries in approved allocations. The WCMSA Reference Guide contains conflicting provisions, first stating that items recommended in the medical record will be included in a MSA regardless of whether it follows medical guidelines, although every effort will be made to not include services that are not recommended and to consider proposals on a case-by-case basis. Considerations include treatment and usage patterns, treating provider recommendations, and documented responses to treatment and effectiveness of therapies, as well as evidenced-based medicine. (See Sec. 9.4.4 at step 9) Capitol Bridge's inclusion of speculative future surgeries should be challenged.

<u>Spinal Cord Stimulators:</u> While spinal cord stimulators have commonly been included in MSAs, the associated costs have greatly increased under Capitol Bridge. For several years, a default price of $30,274.00 was regularly allocated for initial and replacement implants with twice-annual reprogramming around $200.00 per service. Although the costs had jumped to the mid-$40,000 range, Capitol Bridge has now expanded the implant cost to $65,000.00 per procedure and doubled reprogramming pricing. At least in Illinois, recent medical fee schedule analysis confirms the increased costs, suggesting that earlier allocations were significantly undervalued. The recently released WCMSA Reference Guide, Version 2.9 supports this observation and provides clarification on pricing.

<u>The WCMSA Reference Guide:</u> As seen above, both the WCRC and submitters consider, cite and rely upon the WCMSA Reference Guide in proposing and approving MSAs. The Reference Guide's stated purpose is to understand the process used by CMS for approving proposed MSA amounts and as a reference for MSA submitters to CMS for approval. Although the Reference Guide consolidates information into a single point of reference, the most recent document is 135 single-spaced pages. It is periodically updated and in 2018, two updates were released. Version 2.7 of the Guide was issued on March 19, 2018 to coincide with Capitol Bridge's WCRC contract. Along with providing contact information for Capitol Bridge, a revised confidentiality provision clarified that explicit written consent/authorization from a Medicare beneficiary is required to obtain information from CMS.

The second update, Version 2.8, was released on October 1, 2018 and implemented CMS' policy to discontinue use of Social Security numbers (SSN). In their place, CMS is in the process of distributing Medicare Beneficiary Identifiers (MBI) for each Medicare beneficiary. The MBI is also referred to as the Medicare ID. During the transition process, the traditional HICN (health insurance claim number consisting of the SSN plus the alphabetical Medicare Part designation) is still accepted. The MBI will be used on MSA submission documents and also letters from CMS regarding approvals, development, and review threshold determinations.

The other Version 2.8 change involved formatting of steps used by the WCRC to verify proper jurisdiction and calculation source for MSAs. Under this provision, jurisdiction may be where the claim was filed, where the Claimant resides, the employer's location, and possibly the location of the parties' representatives. Rules for the use of state workers' compensation fee schedules or actual charges where no state schedule exists, as well as special rules for certain federal worker claims, were also re-formatted. Lastly, Version 2.8 also provided a link to updated CDC life expectancy tables and referenced a requirement for written justification for use of rated-age figures.

As noted above, CMS released Version 2.9 of the WCMSA Reference Guide on January 4, 2019. The Guide identified changes in the formatting of Development letter and Alert templates, the need to use 2015 CDC lifetables and the removal of certain references to CMS memoranda. Spinal Cord Stimulator pricing was clarified as well as the WCRC's plan to use the non-rechargeable spinal cord stimulator replacement frequency as the default projection in the absence of information to the contrary. The WCRC also explained their position regarding the inclusion of Lyrica as a Medicare covered drug when used for lumbar radiculopathy. The Guide states that "radiculopathy is a type of neuropathy related to peripheral nerve impingement caused by injury to the supporting structures of the spinal cord." In light of this, submitters should review all material to ensure that radiculopathy is truly the proper diagnosis in the claim.

The new Guide also added some additional bullets stressing CMS' recommendation that parties use the voluntary CMS review process when settlements meet CMS' internal workload review thresholds. CMS also cautioned that failure to meet CMS' internal thresholds did not excuse parties from giving Medicare's interests consideration in the settlement. Specific examples were provided. It would appear that these additional admonishments are a response to the growing trend of non-submit programs. We will keep you advised of further developments.

Conditional Payments; Then and Now / Christi Allison and Tim Mercer – MSA Paraprofessional Team

In February, 2018, Performant Financial Corporation (parent organization of Performant Recovery, Inc. "Performant") replaced CGI Federal as the lead contractor in the Commercial Repayment Center ("CRC") operations. Performant is now responsible for monitoring and collecting any conditional payments which Medicare may have made in Workers' Compensation claims at the CRC.

Once Performant was able to catch up with the backlog of work from the previous contractor, our team noted the following:

1. Performant has coordinated with the technology department to take advantage of the MSPRP portal making not only the amount shown on the portal more reliable, but the turnaround time for reviewing authorizations almost instantaneous. There is also an improvement in processing requests for conditional payment and case resolved letters. The MSPRP portal's addition of a Letter Activity tab is also a useful feature.

2. There was a period of time where disputes uploaded to the portal were not being processed correctly by the system technology. This resulted in the dispute department being unable to view the dispute images and disputes were closed without being addressed. This issue has reportedly been resolved and we have seen better results with disputes being addressed. There is still, however, some inconsistency in regards to timing of dispute processing, so it is vital that a timely follow up occur while waiting for dispute determinations.

3. The CRC now has cases which may reflect "closed" on the portal, but are in what representatives call "dormant" status. These cases do not reflect Section 111 TPOC or ORM termination dates and have loss dates prior to 10/1/2014. We have been informed that these cases are still in a "searching" status but there is no collection action. Once the Section 111 report gets updated, a duplicate case will open up with a new case number. In practice, this means that we cannot rely on the case "closed" status. If any conditional payments are made, a new case will open unless and until Section 111 ORM termination occurs.

4. We have also seen a drastic increase in the number of duplicative cases being opened up due to issuance of a demand letter. Once a demand letter has been issued, no additional conditional payments will be added to that case. Instead, a second or third case will be opened up with a change in the numbering of the middle grouping of numbers. These cases are now opened almost instantaneously and fairly consistently. In an effort to ensure that all cases have been addressed, if an underlying WC case is nearing settlement, it would be advantageous to perform the "Request Case Access" feature on the portal to make sure you have addressed all open conditional payment cases that may exist.

5. The biggest change we have encountered is Performant's reliance on Section 111 reporting. Performant uses Section 111 data to open a case to the exclusion of all other reports, including self-reporting. Additionally, Performant will only issue a final demand after Section 111 TPOC reporting occurs. A true final demand will no longer be issued just by uploading an approved settlement contract that closes out medical rights in the claim. Since every Responsible Reporting Entity has a different quarterly timeframe for reporting, this means that there may be up to a four month delay before a final conditional payment demand is made.

6. As of January 7, 2019, the MSPRP portal allows parties to "self-report" a workers' compensation, liability or no-fault claim. This feature should expedite the ability to initiate the opening of a conditional payment claim when there hasn't been any Section 111 ORM or TPOC reporting in the claim.

Overall, Performant has made positive strides with conditional payment cases at the Commercial Repayment Center. Although the MSPRP portal is a valuable tool with identifying, negotiating and resolving conditional payment issues, we have found that many times connecting with a representative and dutifully following up has had the most success. Throughout the year, we will continue to follow up and address any issues or changes that occur.

Private Cause of Action 2018 / Vinal Patel

The Private Cause of Action provision of the Medicare Secondary Payer Act (MSP) (42 U.S.C. Section 1395 y(b)(3)A) remained the focus of much of the MSP litigation in 2018. Although one form or another of the MSP Recovery LLC entity continued to file complaints on behalf of Medicare Advantage Organizations (MAOs) to recover payments made on behalf of their enrollees, the majority of the reported opinions focused on procedural issues as opposed to substantive ones. The procedural issues generally involved challenges to Plaintiff's standing to bring suit based on defects in the underlying assignments from the Medicare Advantage Plans.

The MAO-*MSO Recovery II, LLC. v. State Farm Mut. Auto. Ins. Co., 2018 U.S. Dist. LEXIS 117356,* case however is noteworthy. In this case, the U.S. District Court in Illinois held that assignee-organizations may pursue a private cause of action claim pursuant to the MSP Act on behalf of an assignor-MAO.

Plaintiffs in this case were not MAOs, rather, they were assigned rights of recovery under the MSP Act by several MAOs. Several beneficiaries who were also insured under Defendants' automobile insurance plans were involved in accidents requiring medical services. The assignor-MAOs were alleged to have issued conditional payments, giving rise to liability under the MSP Act.

Defendants challenged Plaintiff's second amended complaint, arguing a lack of standing to pursue the recovery rights. First, Defendants argued Plaintiff did not hold a valid assignment from the assignor-MAOs. In this case, the assignor-MAO first assigned their rights to recovery to an intermediary organization, which subsequently assigned the rights to Plaintiff. The Court rejected that argument and held the Recovery Agreement sufficiently demonstrated intent to transfer an identifiable recovery interest to an assignee. The Agreement included language stating the assignor-MAO assigned all rights it pertained to the rights pursuant to any State or Federal statute for any of its plan participants or members. The Court further pointed to a provision in the first assignment stating any subsequent assignment must be acknowledged and accepted by the assignor-MAO, as was the case here.

Defendants further argued that even if there was a valid assignment of recovery rights, Plaintiff did not suffer an injury required for jurisdictional standing requirements. Plaintiff used an exemplary beneficiary who was insured under Defendant's insurance plan and injured in an accident. Defendant alleged in the case of the exemplary beneficiary that they notified CMS there had been an accident in which the beneficiary had sustained an injury, and that Defendant paid a series of medical bills relating to that injury which exhausted the policy limits. Defendant argued since the MSP Act only allows recovery up to the statutory policy limits, the exhaustion of the policy here called into question the subject matter jurisdiction of the Court to hear this case.

The Court noted that the ultimate question here was whether Defendant as a primary payer failed to reimburse the assignor-MAO for conditional payments made, regardless if it already made payments under the policy to the beneficiary. Since the assignor-MAO made payments for the beneficiary's medical bills, it was obligated to reimbursement by Defendant. The Court viewed it immaterial that Defendant had already made payments up to the policy limit for the beneficiary's medical bills.

The MSP Act states that "the primary plan must reimburse Medicare even though it has already reimbursed the beneficiary or other party". *See Glover v. Liggett Group, Inc., 459 F.3d 1304 (11th Cir. 2006).* This case demonstrates another generously-construed judicial interpretation of the rights Medicare and MAOs have in recovery conditional payments, and the notion that reimbursement for conditional payments should remain a priority.

Looking Ahead to MSP in 2019

Section 111 Updates: Thresholds for 2019, Proposed Changes / Vinal Patel

On January 4, 2019, CMS released its updated Non-Group Health Plan User Guide Version 5.5 detailing changes made to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Section 111 of the MMSEA details the reporting requirements by Responsible Reporting Entities (RREs) to CMS regarding the potential recovery by Medicare to recoup payments made in cases where a primary payer existed.

The updated Guide also includes procedural updates necessary for uniform and improved resolution of cases.

TPOC reporting thresholds for 2019 remain the same

The total payment obligation to the claimant (TPOC) refers to payments made to a beneficiary intended to resolve, or partially resolve, a claim. In the updated Guide, CMS described the 2019 thresholds for mandatory reporting. There was no change from the 2018 reporting thresholds. In cases where a no-fault, workers' compensation, or liability settlement in which the carrier does not have an ongoing responsibility of medical care (ORM), reporting is required if the total settlement amount exceeds $750.00. For settlements below $750.00, no reporting is necessary and CMS will not pursue conditional payment recovery. By reporting these cases to CMS, CMS is able to determine whether reimbursement is warranted for conditional payments made.

In considering the thresholds, CMS has taken into account the cost associated with recovery efforts offset by the recovery amount. Pursuing recovery of claims below the $750.00 settlement threshold has been deemed financially inefficient for CMS, and therefore will not be required to be reported.

The updated Guide also included information regarding TPOC determinations. If TPOC is determined after the settlement date, RREs are required to provide the actual or estimate data for TPOC funding. Additionally, excluded ICD-9 and ICD-10 tables have been updated to match the excluded lists that are available through the Section 111 Mandatory Reporting Application (MRA) used for reporting data to CMS. The update also explains that the Guide will only include version and revision histories from the last four releases, in an attempt to reduce the number of pages.

Notice of Proposed Rulemaking

Recently, CMS issued a Notice of Proposed Rulemaking with a priority level of "significant", titled "Civil Money Penalties and Medicare Secondary Payer Reporting Requirements (CMS-6061-P)". The Notice states:

> Section 516 of the Medicare Access and CHIP Reauthorization Act of 2015 amended the Social Security Act (the Act) by repealing certain duplicative Medicare Secondary Payer reporting requirements. This rule would propose to remove obsolete Civil Money Penalty (CMP) regulations associated with this repeal. The rule would also propose to replace those obsolete regulations by soliciting public comment on proposed criteria and practices for which CMPs would and would not be imposed under the Act, as amended by Section 203 of the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act).

This Notice indicates that CMS plans to solicit public comment on proposed criteria and practices for which civil money penalties would and would not be imposed under the Medicare Secondary Payer Act. Recall that the Act initially imposed a $1,000.00 per day, per claim penalty for non-compliance with reporting requirements under Section 111. In January 2013, the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act) modified the previously-strict language of the penalties provisions and added a discretionary element to the imposition of those penalties. The SMART Act required CMS to introduce regulations and guidance for when penalties would and would not be imposed soon after its enactment. Shortly after, CMS issued a Notice of Proposed Rulemaking seeking public comments on the guidelines and criteria for penalties. After comments were received, CMS paused action on the topic until now. The Notice proposes a rule that would replace existing blanket reporting requirements with guidelines and criteria.

The Notice does not define any specific proposals or criteria. Rather, it signals that CMS is gearing up to issue proposed rulings that will be open for public comment in anticipation of promulgating set criteria and rules later in the year. As 2019 commences, we can expect significant changes and a focus on reporting requirements and penalties. Our attorneys will be aware of any updates and changes to Section 111 issues and plan to disseminate any important information.

Medicare and the Opioid Epidemic / Rasa Fumagalli

As of January 1, 2019, Medicare Part D prescription drug plans began implementing a three part plan to help combat the nation's opioid epidemic. The plan focuses on the prevention of new cases of opioid use disorder and the treatment of opioid dependent and addicted patients through the use of nationwide utilization data. Close partnerships with treating providers and pharmacies are essential to the success of the plan.

Four specific groups of patients are targeted by the plan: new opioid users; chronic opioid users; users at risk due to concurrent medications and those that are high risk opioid users. Improved safety edits for pharmacy dispensed opioids, access to drug management programs and close coordination with providers form the foundation of the new plan.

While we applaud the steps being taken by the Medicare Part D plans to curtail the opioid epidemic, CMS' current review process for Workers' Compensation Medicare Set-Aside Arrangements (WCMSA) involving opioids unfortunately only serves to fuel the opioid epidemic. For those unfamiliar with CMS' current drug projection methodology, CMS projects drugs on a monthly basis for life by extrapolating data from recent pharmacy history payment records. By recommending funding of future medical allocations that include the cost of lifetime opioids and requiring the use of the WCMSA funds to pay for the injury related Medicare covered drugs, claimants are not subject to any of the Medicare Part D plan or any drug plan oversight.

The inherent risks associated with opioid drug projections in the WCMSA have been brought to the attention of various members of Congress and CMS' Administrator by representatives from the National Alliance of Medicare Set-Aside Professionals (NAMSAP) over the past few years. On December 14, 2017 CMS posted an Alert on its Coordination of Benefits & Recovery website that acknowledged the WCMSA and opioid issue. The Alert stated "Any changes that Medicare pursues related to this issue will be reflected in our WCMSA amount review process." In light of the actions taken by Medicare's Part D prescription drug plans, it is time for CMS' Workers' Compensation Review Contractor to follow suit by modifying the opioid drug projection methodology used in the review of Workers' Compensation Medicare Set-Aside Arrangements (WCMSA).

The mystery of CMS Proposed Rule regarding "Miscellaneous Medicare Secondary Payer Clarifications and Updates:" Could it be tied to Opioids in the WCMSA? / Rasa Fumagalli

In the fall of 2018, the Department of Health & Human Services/CMS published an abstract of a proposed rule entitled "*Miscellaneous Medicare Secondary Payer Clarifications and Updates.*" The proposed rule is described as one that is both "major" and "economically significant." The purpose of the rule is to "ensure that beneficiaries are making the best ***health care choices*** possible by providing them and their representatives ***with the opportunity to select an option*** for meeting future medical obligations ***that fit their individual circumstances, while also protecting the Medicare Trust Fund."*** The abstract further states "Currently, Medicare does not provide its beneficiaries with guidance to help them make choices regarding their future medical care expenses when they receive automobile and liability insurance (including self-insurance), no fault insurance, and workers' compensation settlements, judgments, awards, or payments, and need to satisfy their Medicare Secondary Payer (MSP) obligations." September of 2019 has been identified as the target date for the Notice of the Proposed Rule Making.

The proposed rule also references related Regulatory Information Number (RIN) 0938-AR-43. This proposed rule was entitled "Medicare *Secondary Payer and "Future Medicals."* The abstract claimed that the proposed rule "would announce CMS' intention regarding means beneficiaries or their representatives may use to protect Medicare's interest with respect to Medicare Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation where future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care."

Recall this proposed rule discussed several options for considering Medicare's interest in a settlement. The options included limiting Medicare's interests in certain types of settlements, securing an attestation from the treating physician as to completion of care, submitting an MSA to CMS for review, a self-calculated or fixed payment option for future medical, upfront payment to Medicare for future medical or a compromise or waiver of Medicare's interest in future medical. This proposed rule never moved forward after the Advance Notice of Proposed Rule Making comment period ended in August of 2012.

The posting of the proposed rule has led to speculation in the MSP compliance industry that CMS is going to move forward with a review process for liability MSAs. There are however several clues that would suggest a different answer. Given Medicare's current Part D opioid policy, CMS' recognition of an issue with opioids in the WCMSA, the reference to the prior proposed rule that considered upfront payment to Medicare for future medical, and the stated purpose of the current proposed rule, i.e. to "ensure that beneficiaries are making the best *health care choices* possible by providing them and their representatives *with the opportunity to select an option* for meeting future medical obligations *that fits their individual circumstances, while also protecting the Medicare Trust Fund,*" Medicare may be contemplating a different way to administer WCMSA funds that include opioid projections.

Consider a scenario involving a Medicare beneficiary and a CMS reviewed WCMSA that includes significant funds for opioids. Under the current WCMSA self-administration process, the beneficiary cannot take advantage of a Medicare Part D plan's supervision when it comes to opioids. Although the Medicare Trust Fund is protected, the Medicare beneficiary's unlimited access to the funds for injury related opioids does nothing to curb opioid abuse. This problem however can be solved by a change in the way the WCMSA funds are administered. If CMS were to allow beneficiaries to enroll in Medicare Part D plans to secure the injury related opioid oversight/management, and beneficiaries were required to reimburse the Part D plans from the WCMSA funds at the end of the year for the Plan's payment of injury related Medicare covered drugs, Medicare would remain a Secondary Payer and the risk of opioid abuse would be decreased. Adding a requirement of professional administration of the WCMSA to ensure that the Part D plans are reimbursed with a reversionary interest back to the carrier would also help to ensure the funds are available. This type of reimbursement scenario has already been used by the World Trade Center Health program established under the Zadroga Act. Another way to do this is to have the beneficiary make the up-front payment of the portion of the WCMSA funds allocated for pharmacy to the Part D plan, with the Part D plan being responsible for the administration of these funds. If Medicare is contemplating any of this, it would be "major," "economically significant" and consistent with CMS' plan to combat the opioid epidemic.

As noted earlier, there is also speculation that this proposed rule will eventually result in CMS issuing guidance when it comes to liability MSAs. The guidance may include the establishment of a voluntary review process for liability that is similar to the arrangement in place for review of WCMSAs in workers' compensation settlements. Given the difference between liability settlements and workers' compensation settlements, it is speculated that CMS would be considering some type of apportioned liability MSA.

Whether or not this proposed rule is intended to address liability MSAs, parties in a liability settlement should avoid the appearance of an attempt to cost shift to Medicare the responsibility for payment of medical expenses for the treatment of the injury related condition. An apportionment of the negotiated settlement funds in an objectively reasonable manner would reduce the risk that Medicare may deny future injury related care. Although CMS has not provided the same degree of "guidance" in the area of liability MSAs as in the area of workers' compensation MSAs, MSP compliance obligations are determined by the MSP Act. The MSP Act clearly identifies liability plans as primary plans in certain situations in which Medicare is a secondary payer.

Answers by Amy / Amy Bilton

Question: *We recently learned that an injured worker is using an American citizen's Social Security number, and that American citizen is a Medicare beneficiary. The worker using that Social Security number is technically undocumented, however, and is 64 years old. What do I need to do in my settlement to remain in compliance with the Medicare Secondary Payer Act?*

At the risk of criticism for addressing this question in today's current political climate, I chose this question because it comes up often and the answer is not always straightforward.

The question begins with the premise that an injured worker is using someone else's, valid Social Security number (SSN) for their own employment purposes. This also means the injured worker is paying taxes under that American citizen's Social Security number, including Medicare taxes. While the injured worker will never really become a Medicare beneficiary under this Social Security number, the first and main concern is whether the undocumented worker used the American citizen's Medicare entitlement to receive medical care. If so, these payments would be considered "conditional payments" and should be addressed.

Practically, however, there are a couple of concerns in addressing conditional payments made using else's Medicare card. First, if the injured worker is not using the same exact name or date of birth as the true Medicare beneficiary, it may be very difficult to report the case using Section 111. If either of these data elements is not a match, CMS will reject the Section 111 report. Second, any authorization signed by the beneficiary is not technically valid for that conditional payment case since it is not being signed by the Medicare beneficiary themselves, but instead the individual illegitimately using that number. Accordingly, CMS could refuse to allow case access. In such a case, we recommend you do your best to report the claim using the Social Security number the injured worker provided, and if the entry is rejected due to a lack of a complete match, the BCRC be contacted by phone in an attempt to rectify the issue. Settlement language should also clearly place the burden of conditional payment reimbursement on the injured worker.

The next question is whether the employer/insurer has any duty to address future medical treatment in the settlement. Since the injured worker might use the citizen's Medicare entitlement to pay for post-settlement medical benefits, there technically can be a cost shift if the settlement does not address post-settlement medical expenses. The risk here, however, is on the injured worker. If the employee is not entitled to Medicare benefits, and there is no reasonable expectation that he or she will be entitled to Medicare benefits through some other means (such as naturalization), the Respondent has no affirmative duty under State or Federal Law to go outside of the normal negotiation process for a workers' compensation claim. There is no legal duty to protect Medicare's non-existent interests. For the Claimant, however, the risk is two-fold.

First, in order to shift the burden of the future medical care to the Medicare system, the Claimant would need to commit fraud by using the citizen's Medicare benefits to obtain those medical benefits. Civil and criminal penalties could apply against the injured worker in such a situation. Second, once a settlement has been effectuated which closes medical rights, the burden of post-settlement medical payments falls solely on the Claimant. The monies would be payable from the total amount of the settlement, hence insulating the employer from post settlement liability even further.

With that noted, settlement may be impossible without some type of future medical allocation, particularly in cases where future medical expenses are certain given the nature of the injury. A future medical allocation without a formal MSA could be appropriate. In the unlikely event that CMS ever looked to negate the settlement, such a future medical allocation can demonstrate that future medical interests were addressed.

I would be remiss if I did not mention that the Court of Civil Appeals in Oklahoma addressed a similar situation in 2013, where the employee was using his tax identification number at the time of the settlement, was not Medicare eligible at the time of settlement, and became a naturalized citizen two years after the settlement was effectuated. An MSA was not approved by CMS -- presumably because the Claimant was not a Medicare beneficiary on the settlement date and the case therefore settled for an amount below CMS' review thresholds. The Claimant tried to enforce payment of the future medical portion of the settlement by arguing that the employer agreed to pay him over $12,000.00 – though after the MSA was approved by CMS. The Court found that since a condition precedent to CMS submission of the MSA, i.e. that the Petitioner was a Medicare beneficiary, was a mutual misapprehension of the parties, and since the condition precedent (that CMS approval occur) never did happen, the Claimant could not complain of the employer's failure to pay the future medical (MSA) monies.

A word of caution: All cases on enforcement of the terms of a settlement contract are very fact specific. We strongly recommend careful drafting of settlement contract language, particularly when settlement is effectuated before CMS approval and/or before Medicare eligibility is confirmed. We help our clients draft settlement language on a regular basis, and are happy to assist any time you have issues such as these come along.

Our MSP Compliance Services

The Medicare Secondary Payer Act and supporting Regulations are complex. Our team of thought leading experienced MSP compliance attorneys, all with workers' compensation defense backgrounds, is here to help you navigate the MSP compliance path. Our full range of MSP compliance services includes the following:

1. Medicare Set-Asides
2. CMS submissions and review
3. Amended Re-review to CMS
4. Future Medical Allocations
5. Conditional Payment Negotiation
    a. Parts A & B
    b. Parts C & D
    c. Recovery of overpayments to CMS
6. Liability Payment Compliance
7. Medicaid Lien Resolution
8. Assistance with the Development and Implementation of internal MSP Compliance programs
9. Complex and Legacy Claim resolution

Contact us for information regarding the above services. Additional services may also be available upon request.