Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

SPRING 2019

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

Join Amy Bilton, Bill Delaney and Rasa Fumagalli on Monday, May 13th at 1:00 pm CST for a complimentary webinar on the "Top Ten Submitter Errors from a Law Firm's Perspective." We will discuss CMS determinations that we have seen over the years that failed to make the most of mitigation opportunities. Register here.

Can Remaining WCMSA Funds Revert to the Primary Payer or Not? / William Delaney

After a protracted settlement negotiation involving a high six figure Workers' Compensation Medicare Set Aside approved by CMS, the parties finally reached a settlement. One of the main issues in dispute was reversion of any remaining MSA funds upon death of the claimant and payment of any remaining related medical bills. The parties agreed that the funds would be professionally administered and any remaining WCMSA funds would revert to the employer. The settlement contract and the professional administration agreement stated the agreement reached by the parties. The carrier was happy to have finally resolved a high exposure case and congratulated the defense counsel on a job well done. The defense counsel thought all that was left was the formality of securing approval of the settlement contract from the Workers' Compensation Commission. Then, the unexpected happened. The claimant questioned why the remaining funds should revert back to the employer when the WCMSA correspondence approving the MSA provided otherwise.

One exhibit to the final settlement documents was the standard correspondence from CMS approving a professionally administered Medicare Set Aside. The WCMSA approval letter signed by the CMS Office of Financial Management stated on the second page:

> "Administrators must send attestations annually to the Benefits Coordination & Recovery Center * * *. Annual attestations should continue through final exhaustion of the account. We have enclosed instructions, titled 'Professional Administration of Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).'"

On page 1 of the Professional Administration "instructions" it stated in the second paragraph:

> "* * *, failure to adhere to any of the following requirements will be regarded as a failure to reasonably recognize Medicare's interests and Medicare will deny coverage for all medical treatments and prescription drug expenses due to work-related injuries. The **requirements** are as follows:
>
> 7. Distributions Following Death of Beneficiary – In the event the Medicare beneficiary dies before the funds in the WCMSA are depleted, the account will continue to exist for payment of any outstanding bills for work-related injury medical expenses and prescription drug expenses that would otherwise be covered by Medicare. **Any funds remaining in the WCMSA account** after payment of all outstanding bills for work-related medical expenses and prescription drug expenses **shall be paid to the beneficiary's estate or subject to State Law**."

After getting over the initial shock that the settlement was going to blow up because of a provision buried in the last page of the WCMSA approval correspondence from CMS, we stepped back and tried to figure out why CMS had included such a provision in their Professional Administration "instructions."

The latest version of the CMS Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, Section 17.1 addresses Administrators for the WCMSA account and provides in pertinent part:

> "WCMSAs should be administered by a competent administrator (a professional administrator, the representative payer, the claimant, etc.). * * * Claimants may also administer their own WCMSAs, if State law allows. * * * Although beneficiaries may act as their own administrators, **it is highly recommended that settlement recipients consider the use of a professional administrator for their funds**."

Of course, one of the primary benefits to the employer of professional administration of the WCMSA funds is the ability to enforce a reversionary provision providing that any remaining funds revert to the employer or original funder. With the funds in the hands of a third party administrator, there should be a seamless transfer of any remaining funds in the WCMSA on dissolution to the designated beneficiary. The employer's position is that without a reversion of the remaining funds to the employer, the claimant's estate reaps a windfall of monies that otherwise would not have passed to the claimant's estate. For many employers, the potential reversion of any remaining WCMSA funds is the incentive behind agreeing to fund a substantial WCMSA. Did the CMS Professional Administration instructions trump the party's right to contract? That was the claimant's position.

Section 19.0 of the Reference Guide addresses change of circumstances. Section 19.2 addresses the ultimate changed circumstance - the death of the claimant:

> "If the claimant dies before the WCMSA is completely exhausted, the RO (Regional Office) and the BCRC will ensure that all claims have been paid. Then any amount left over in the WCMSA may be disbursed pursuant to state law, once Medicare's interests have been protected. * * * **Often, the settlement itself will dictate the appropriate dispersal of funds upon the death of the claimant**."

This provision in the Reference Guide acknowledging that the settlement terms will often prescribe how the remaining WCMSA funds will be dispersed certainly supported the employer's position that the Professional Administration instructions was not a mandate from CMS that any remaining funds in a professionally administered WCMSA shall go to the beneficiary's estate.

Further supporting the employer's position that the parties had the right to agree on the beneficiary for any remaining WCMSA funds is Section 10 of the CMS Self-Administration Toolkit for Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) for WCMSAs approved by CMS, which provides:

> Section 10: Inheritance – "* * * **If there is money left in the account after all related bills are paid, the funds are distributed according to the last will and testament, the settlement decree that set up the account, or state inheritance laws**."

Of note, the CMS instruction for self-administration of a WCMSA account do not address what happens to remaining funds on the death of the beneficiary.

Our response to the claimant's assertion that the Professional Administration instructions trumped the settlement terms agreed upon by the parties referenced the foregoing provisions. Further, we contended that the provision relied on by the claimant provided that any remaining WCMSA funds shall be paid to the beneficiary's estate **or subject to State Law**. The applicable workers' compensation act allows the parties to reach a settlement of all disputed issues that upon approval of the State Workers' Compensation Commission had the same effect as a final judgment on the merits. As the applicable State law allowed for the parties to negotiate the beneficiary of any remaining funds of the WCMSA, the remaining funds did not need to paid to the beneficiary's estate.

Fortunately, after considerable additional effort the claimant backed down and executed the settlement documents as drafted. This situation was brought to the attention of the National Alliance of Medicare Set-Aside Professionals and has been escalated to CMS. Along with CMS, hopefully revising the professional administration instructions addressing the dispersal of remaining WCMSA funds on account dissolution, it is hoped that CMS will prioritize the dispersal of any remaining WCMSA funds as follows: (1) settlement decree; (2) if issue not addressed in the settlement decree then the claimant's last will and testament; and (3) if there is no will or the issue is not addressed in the will, then the remaining funds in the WCMSA will be dispersed according to State inheritance laws. As Medicare has no interest in any remaining funds in a WCMSA account following payment of all related Medicare-covered expenses, paragraph 7 of the current CMS Professional Administration instructions should be revised to avoid any further ambiguity with regard to the dispersal of any remaining WCMSA funds.

Economic Consequences of the Opioid Epidemic – Geraldine Balow

In March of 2018, the Centers for Disease Control and Prevention reported there were 63,632 drug overdose deaths in 2016; 42,249 (66.4%) involved an opioid. The CDC also reported America's overdose epidemic was spreading geographically and increasing across demographic groups. Overdose deaths increased in all categories of drugs examined for men and women, people ages 15 and older, all races and ethnicities and across all levels of urbanization. But beyond the human cost, are there economic consequences as well?

Douglas Sutherland, senior economist at the Economics Department of the Organization for Economic Cooperation and Development ("OECD"), reported the American experience stands out with respect to dealing with the consequences of opioid abuse due to significantly higher economic costs.[1] He noted the opioid crisis had negatively impacted the U.S. economy in the form of lost wages and productivity resulting from death, incarceration and decreased productivity. He reported estimates suggest this could amount to $40 billion annually. Lost productivity also impacts tax revenue and estimates suggest the combined impact reduced federal, state and local tax revenue by almost $16 billion in 2016.

He noted significant costs also arise from providing health care to victims. In 2014 alone, there were over 80,000 emergency room visits and over 60,000 hospitalizations due to opioid overdoes. Medicare and Medicaid were the primary payers in approximately two thirds of those cases.

[1] Sutherland, Douglas. "The Severe Economic Costs of the US Opioid Crisis, The Hill, 14 June 2018, Op-ed.

Mr. Sutherland reported, according to the OECD's Economic Survey of United States, opioid use and opioid-related death rates appear to be considerably higher in the U.S. than in other countries.[1] This was partly explained by the greater prevalence of opioids in the U.S. where prescription rates are four times higher on average. While it was acknowledged that causation was difficult to establish, the correlation with the proportion of people unemployed or not looking for work in the U.S. in areas most affected by opioids suggested this can ultimately lower participation in the labor force. He relied upon findings of economist Alan Krueger who found around 20% of males between the ages of 25 and 54 who were either not working or not looking for work were regularly taking opioid pain killers.

He also observed when addiction leads to criminality resulting in a felony conviction, employment options are reduced and much of the costs incurred in policing, law enforcement and other public services in dealing with drug overdoses and addiction treatment is borne by state and local governments.

The OECD also reportedly highlighted several immediate policy steps which can be taken to help mitigate the crisis, such as making the drugs that can reverse the effects of overdoses more widely available as this will help reduce avoidable deaths, tighten access to opioids as this will reduce the inflow of patients and other developing opioid dependence, expand the reach of medically-assessed treatment for those already suffering from addiction and re-integrate former addicts into employment and housing to prevent relapse.

Mr. Sutherland concluded given the economic impact of the current crisis inaction is simply not an option. So what is being done in the U.S. to stem the crisis?

According to the Secretary of Health and Human Services, Alex M. Azar II, HHS has a five point strategy to end the opioid crisis which uses the best science and evidence to directly address this public health emergency and combat opioid abuse, misuse and overdose:

> Access: Better prevention, treatment and recovery services. HHS issued over $800 million in grants in 2017 to support treatment, prevention and recovery, while making it easier for states to receive waivers to cover treatment through their Medicaid programs.
>
> Data: Better Data on the Epidemic. HHS is improving our understanding of the crisis by supporting more timely, specific public health data and reporting, including through accelerating CDC's reporting of drug overdose data.
>
> Pain: Better Pain Management. HHS wants to ensure payments, prescribing guidelines and more promotes healthy, evidence-based methods of pain management.

[1] OECD (2018), OECD Economic Surveys: United States 2018, OECD Publishing, Paris

Overdoses: Better Targeting of Overdoes-Reversing Drugs. HHS is working to better target the availability of lifesaving overdose-reversing drugs.

Research: Better Research on Pain and Addiction. HHS supports cutting edge research on pain and addiction, including through a new NIH public-private partnership.

Most employers, claims adjusters and attorneys involved in workers' compensation and liability settlements are also aware of the impact costly narcotic medications can have on Medicare set-aside allocations. These excessive allocations are the result of current Centers for Medicare and Medicaid Services ("CMS") policy which provides for pricing all Medicare-covered prescription drugs for the beneficiary's life expectancy. This policy also ignores the effects of long-term use of narcotics on individual health. However, in what many in the Medicare Secondary Payer community saw as a potential solution to this difficult problem, CMS issued the following statement in December of 2017:

CMS understands the concerns regarding the opioid crisis occurring in the United States. We are committed to ensuring the determination of Workers' Compensation Medicare Set Aside Arrangement (WCMSA) amounts are an adequate projection of claimant's needs for future medical services and prescription drugs. CMS continually evaluates all policies and procedures related to WCMSA amounts. Any changes that Medicare pursues related to this issued will be reflected in our WCMSA amount review process.

To date, however, we have not seen CMS take any actual steps to change its practice of allocating for opioid medications.

Mr. Sutherland noted the opioid crisis will only become manageable if our leaders at all levels of government work in concert with partners in the private sector and in local communities across the country to address not only the symptoms of this epidemic but the many complex underlying problems as well. The MSA Team at Nyhan, Bambrick, Kinzie & Lowry agrees with Mr. Sutherland that inaction is simply not an option and will continue to advocate for a change in CMS policy.

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

SPRING 2019

"Medicare for All" for the MSP Mindset / Julie Garrison

As the new Congress settles in and the presidential campaigns heat up, there is renewed talk of "Medicare for All." The possibility of universal health care insurance raises questions over how CMS/Medicare would manage workers' compensation claims and the coordination of benefits when everyone is covered by a government-run, single-payer system. No doubt there will be many impacts on workers' compensation and the larger insurance industry.

What is "Medicare for All?" A single, national health insurance program providing universal care is the basic concept, though most proposals provide for phased buy-in, beginning with people in their fifties. Other models include coverage for hospital and physician services while prescription medication and other costs would be borne by either private pay or private insurance. Single-payer coverage is likely to be more generous than the current Medicare program, eventually covering dental and vision benefits and possibly long-term care. CMS/Medicare would theoretically have bargaining power over reducing treatment costs. Ultimately, employer-based coverage, the Affordable Care Act, and public programs like Medicaid and traditional Medicare will disappear.

Coordination of Benefits Defined: Underlying Medicare Secondary Payer law is the policy that Medicare's interests must be considered with the shifting of costs away from Medicare to primary private coverage. The clear example is workers' compensation where Medicare does not cover medical expenses arising from work-related injuries. These expenses are properly paid under workers' compensation. Notably, CMS continues gearing up to enforce the law against liability and no fault plans.

In order to prevent cost-shifting to Medicare, CMS has rules for the coordination of benefits which determines what coverage is primary and what is secondary. Thus, when an injured worker has both Medicare and other health insurance or coverage for a job-related injury, workers' compensation is the primary payer while Medicare is secondary.

"Medicare for All" and the Coordination of Benefits and Claims Handling: For services provided by a "Medicare for All" program, employers and workers' compensation carriers and programs would still bear the costs of work-related injuries and illnesses. A single-payer system would hold employers financially accountable for employee injuries. Private supplemental Medicare insurance plans would also continue to seek coverage and reimbursement for work-related care like prescription drugs.

As a practical matter and similar to the Affordable Care Act, an injured worker with universal health care coverage will be able to see their primary care provider and participate fully in treatment decisions. Workers' compensation claims management would be minimized while administration largely reduced to financial accountability and reimbursement matters.

However, better access to healthcare should produce fewer and less questionable workers' compensation claims. Wellness initiatives and chronic condition management by primary care providers will also contribute to reduction in costs and Medicare reimbursement rates would be lower than those under workers' compensation.

Bigger Economic Consequences: Before any legislation is passed and the details worked out, there are many economic hurdles to clear. A special tax would have to be implemented to pay for universal health care insurance, though proponents insist that the overall total amount would be less than the current projections of ever-rising private health care costs. The impact of abolishing (or greatly restricting) the health care insurance industry - a large segment of the economy – would be significant. Yet, new and expanded markets will likely be created for supplemental and more inclusive private insurance products. Legislative proposals also seek to minimize the impact on investors and workers with job displacement services and benefits. Interestingly, insurers could be transformed into contractors necessary for administering a universal health care insurance program. We plan to stay tuned to the developing discourse and proposals and invite readers to do the same. A "healthy" discussion is always good!

Projecting for MSAs in the Midst of Differing Opinions in California Cases, a Nurse Allocator's Perspective / Andrea Hritz

Projecting for Workers' Compensation Medicare Set-Asides (MSA) in order to prevent a cost shift burden to Medicare has been an evolutionary process since it began. In the past, attorneys and Nurse Allocators largely depended on the injured worker's treatment records and payment histories to reasonably project for injured worker's future medical needs pertinent to their work injury. In the absence of a treating physician's recommendation, standards of care (SOC) and the Official Disability Guide (ODG) were secondarily relied upon. The Allocator would review stacks of medical records and payment histories spanning years or even decades to derive the significant medical information and project future medical care. Fortunately, the WCMSA Reference Guide eventually limited the information to be considered for projections to the last two years of available treatment records for each injury.

With the medical records narrowed down, but the future medical care at times ambiguous and often disputed, the involved parties began hiring medical-legal examiners referred to as Independent Medical Examiners (IME). These examiners were hired to steer the utilization review process, weigh-in on causality of a condition, negate or support future medical care indicated by the treating physician, or in the absence of a treating physician's opinion, to state potential future care based on the claimant's examination and SOC. Inevitably, this scenario lead to opposing opinions that sometimes lead the involved parties to court where workers' compensation judges made final determinations.

The California Worker's Compensation system redefined the IME role to a significant degree. When there is a question as to what benefits an injured worker should receive, a Qualified Medical Evaluator (QME) can be enlisted. This physician must take additional educational courses and obtain a license to qualify as a QME and be included on the randomly state-generated list. A Panel QME (PQME) is where three QME physicians are randomly chosen to resolve medical disputes or relatedness. The injured worker may then chose one of the three PQMEs or be assigned one of the three by the adjuster if a decision is not made within ten days. In cases where the injured worker's attorney and the claims adjuster want to avoid the state-run QME process and circumvent costly legal disputes, an Agreed Medical Examiner (AME) can be used. Both parties agree on using the particular medical professional, and in essence agree that their opinion is objective and trustworthy. https://www.dir.ca.gov/DWC/MedicalUnit/faqiw.html

More recently, Senate Bill (SB) 863 indicated that an AME and QME *could not* weigh in on *disputed* medical treatment for injuries occurring after July 1, 2013, but they could opine if an injured worker needed *future medical care* for an industrial injury. https://www.dir.ca.gov/dwc/Reports/SB863-Assessment-WC-Reforms-July-2014.pdf. SB 863 developed the Independent Medical Reviewer (IMR), which can only be requested by the injured worker when their care has been denied, delayed or changed by the insurance's utilization review process over the medical appropriateness of treatment recommended by a physician. The IMR then attempts to resolve the dispute in an effort to avoid the costly legal process. This newer method has cut the decision process from 9 to 12 months down to 40 days. Interestingly, the IMR's *medical decision* cannot be overturned by a judge. The judge will limit to the legality of the issues, not the medical. https://www.dir.ca.gov/dwc/sb863/SB863_Overview.htm.

Summarily, a case can become quite complicated with multiple opinions floating around. Therefore, the WCMSA Reference Guide stipulates that, "Independent Medical Examination (IME) reports, Qualified Medical Examination (QME), and Agreed Medical Examiner (AME) reports are not a substitute for medical records." https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2_9.pdf (see pg. 20). It is this Allocator's opinion that this means that the treating physician is the first source for projecting future medical care followed by the IME, QME, AME, and PQME. Although it would seem that an IMR that conflicts with the treating physician's recommendation should trump the treating physician, CMS does not necessarily defer to the IMR any longer.

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

SPRING 2019

As a legal nurse consultant who has been writing MSAs since 2002, I have seen countless medical legal evaluations. Many have been excellent, while others prompted distrust as a loss of objectivity compromised the legitimacy of their opinion. Experience, the treating physician, the ODG, SOC, and the WCMSA Reference Guide have shaped the outcome of each MSA that I have written. As an Allocator, I diligently strive for unbiased, reasonable MSA projections of future medical needs to protect the interest of Medicare to avoid cost shifting post-settlement. It is my personal commitment to develop an MSA that is written objectively, regardless of the referral source. Once the MSA is written, the NBKL MSA team further shapes it to reflect the relevant legal issues in the case. Our objectivity garners trust from our clients that they have chosen the best medical-legal team to provide an MSA that protects the interests of all involved parties to efficiently bring the case to settlement and satisfy the mission of protecting Medicare's interest.

Medicare Electronic Payments / Timothy Mercer and Christi Allison

Until recently, Beneficiaries were able to make payments electronically via Mymedicare.gov for conditional payment cases at the Benefits Coordination and Recovery Center (BCRC), but primary payers could only pay by check through the mail. On April 1, 2019, the Medicare Secondary Payer Recovery Portal (MSPRP) was updated with a new feature, offering primary payers to also pay conditional payment debts electronically.

Previously, all demand payments were mailed to either the BCRC or the Commercial Repayment Center (CRC). This process afforded multiple opportunities for clerical and processing errors which resulted in misapplied funds, unnecessary delays in application of payments, and, in some cases, Treasury collection referrals.

The new electronic payment option is available for all Non-Group Health Plan (NGHP) demands and available to all users who have access to the MSPRP. Once you have an authorization to access the case through the portal, there are no additional authorizations needed.

Here is how to use the payment feature: First, select the appropriate case from the MSPRP as you normally would do from your Case Listing screen. At the bottom of the Payment Information screen there will be a green button that reads "Make a Payment." This button appears only when case is in the demand stage; electronic payments cannot be made on cases that are at the Conditional Payment Notice (CPN) stage or after the case is referred to the Department of Treasury. Once you click this button, you will be taken to Pay.gov, a secure payment system administrated by the Department of Treasury. This should open in a new browser screen.

From here, you proceed as you would with any other online payment. First, you select your method of payment; there are multiple options available. The acceptable methods are: Checking or Savings account via a direct link; Debit card; and PayPal account - note the PayPal account must be linked to a bank account and not to a credit card. From there, the full demand amount will auto-populate in the payment information screen regardless of the method you chose. You can change the amount to pay, if needed. For instance, if you are disputing a portion of the payment, but paying the remainder to avoid interest while the disputes are processing, you can change the payment amount to that of your partial payment. The maximum allowable debit card payment is $24,999.99. Enter your account information based on the method you have chosen and click continue. You will then be taken to a Review and Submit Payment screen. This is your last chance to make sure everything is correct, so proceed with caution. As we all surely know, getting refunds is a lengthy process none of us want to undertake. After you have reviewed your information, click “continue” and you will be brought back to the MSPRP.

The pending payment will be instantly reflected on a Payment Status screen on the MSPRP. This page will either show a payment in process or a declined payment. Both screens will look the same with the exception of the payment amount. If the payment is declined, the payment amount will reflect $0.00. The reason the payment was declined will not be available via the MSPRP. Continue after you have reviewed the screen to return to the Case Information Screen.

There will also be a new tab here labeled Electronic Payment History. This page will show any electronic payments made on this case. It will have payment date, method, account holder name, payment amount, payment status and an updated demand status. The payment status will be one of three options: Accepted, Declined or Pending.

CMS advises the average processing time for payments will be 1-3 days, but of course this will vary based on your banking institution. All payments will appear on your statement as “HHSCMS.”

Hopefully this gives you a basic understanding of the new electronic payment capabilities of the MSPRP. Feel free to submit questions or ideas for other topics you would like to see discussed **here**.

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

SPRING 2019

Answers by Amy / Amy Bilton

A few months ago, we submitted an MSA in a case where Lyrica was being prescribed "off-label" for a diagnosis of lumbar radiculopathy. CMS included it in the MSA. The inclusion of Lyrica inflated the MSA astronomically, and nearly prevented the case from settling. I received this question: "How can the rules just change like this? Isn't there some sort of advance notice required for changes like this? This just isn't right!"

The Medicare Secondary Payer (MSP) industry started seeing the inclusion of Lyrica in cases with diagnoses of lumbar radiculopathy in late-2018, months prior to the publication of the updated Reference Guide in January of 2019. Prior to that publication, the Executive Board of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), including myself, discussed the Lyrica problem with the Division of MSP Program Operations at Medicare (CMS). Mr. Steve Forry and his team essentially explained that their team (now) sees radicular pain as neuropathic pain stemming from spinal cord injury. With that noted, local coverage determinations do not always support the coverage of Lyrica for lumbar radiculopathy. So how can a change like this, which was tremendously expensive, have happened without any notice? My cynical answer – Because every dollar in a CMS-approved MSA is accounted for as "savings" by Medicare, and the industry hasn't fought back on unannounced, big changes like this enough in the past.

The Lyrica question has now been answered in the Reference Guide as mentioned above, but this is not the only time CMS has made changes within their approval process without advanced notice to the Medicare Secondary Payer community. We have recently seen inclusion of quarterly urinary drug screens (UDS) in cases with opioid projections, over life, even when the treating physician has never prescribed a UDS. The Centers for Disease Control and Prevention do not recommend quarterly drug screens, and in fact notes that for UDS to be effective it should not be done on a schedule but instead randomly.

Another example is blood work. There are plenty of medications which do not require routine blood work, but any time any medication is included in an MSA, we see at least annual blood work included in the WCMSA approval. Why is this, and isn't this excessive?

The purpose of the MSP Program Operations division is to protect the integrity of the Medicare Trust Fund and ensure monies are not spent from that trust fund when a primary payer should be paying. The MSA program is a legal fiction, a voluntary process devised by Medicare in an attempt to avoid making post-settlement medical payments. It is in Medicare's best interest to over-include medications and services rather than under-include.

The MSA program does not adapt well for variations in state law; MSA pricing policies are applied across-the-board, regardless of whether there would be coverage under the state law. The workers' compensation industry has perceived such a benefit to closing all aspects of a file, and payers voice great concern about being made "the example" if they do not use the "voluntary" WC MSA submission. As I see it, both of these have led to complacency in fighting back against inappropriate and constantly changing CMS MSA policies. Unfortunately, too many insurers and self-insurers have resigned to over funding MSAs.

In answer to our questioner's inquiry, CMS' voluntary process is tweaked internally all the time without notice to the payers or submitters. In a system that oft surrenders to over-funding of MSAs, and constantly expresses concern of being "made an example of," CMS' behavior is not surprising. For this reason, NBKL and NAMSAP are leading the charge for notice, fairness and equity on this playing field.

I will be attending a meeting with Mr. Forry and his group on April 30, 2019 to address issues like this, including the inclusion of urinary drug screen and blood work, and will push for advanced notice of these types of changes and publication in the Reference Guide moving forward. We plan to underscore that when the rules constantly change in the middle of the game, people pick up their balls and go home. If CMS really wants to continue with this "voluntary" review process, the rules will have to be laid out in advance or CMS will be facing a reality of more "non-submit" programs. Currently, non-submit MSAs are not included in CMS' reported "savings," which means that over time, bullying MSA submitters will backfire.

As a workers' compensation defense attorney, a Medicare Secondary Payer professional who submits MSAs, and as the current President of NAMSAP, I will continue to push for fairness and transparency in the MSA process. Hopefully, with persistence and these demands for accountability, we will not see a repeat of the Lyrica debacle that cost payers hundreds of thousands of dollars without advance notice and due process.

Are you interested in being part of the fight? Consider joining NAMSAP: https://namsap.site-ym.com/page/MembershipBenefits

Nyhan Bambrick Kinzie & Lowry

Trusted Attorneys. Trusted Advisors.

SPRING 2019

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.