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The Importance of Teamwork / Michelle Hitsch

At NBKL, we pride ourselves in our ability to take teamwork to the next level, and in a recent MSA case, we put this teamwork to the test. The case involved a complex injury with multiple reconstructive surgeries and significant ongoing care, but our client was only able to provide limited medical records. With some sleuthing, we were able to gather extensive records from the claimant's treating physicians. Our nursing specialist then drafted two comprehensive life care plans for our client, each including Medicare and non-Medicare covered treatments. One life care plan provided a low-end estimate of the MSA, and the second provided what we determined to be a worst-case, high-end scenario for the MSA.

We submitted the low-end MSA proposal to the Centers for Medicare and Medicaid Services ("CMS") for review. Unfortunately, CMS approved an MSA at just below our high-end estimate. Our team immediately went to work analyzing the approval to determine if there were any grounds to request re-review and pinpointed several potential grounds for dispute. We worked with the client, defense counsel, and even the claimant's counsel to obtain evidence to support the exclusion of certain line items, and ultimately, it was the claimant himself who provided the medical records needed for the dispute. On re-review, CMS reduced the MSA by more than $300,000.00. The NBKL teamwork in this case quite literally paid off for our client.

Uncertain Surgery Costs: A Call for Transparency in WCMSA Pricing of Allocated Surgeries / Joseph Gregorio

One of the most significant cost-drivers in MSAs can be surgeries. In addition to CMS becoming more aggressive in allocating for surgeries, we have recently seen the costs of these procedures increase as well. This brings back not-so-fond memories from a few years ago when CMS began including urine drug screens in MSAs where there was little, if any, evidence to substantiate the frequency of these tests. The number of tests included was not the only problem: the costs of each test could be staggering. Due to the variety of potential tests and procedure codes available for urine drug screens, submitters were left to guess at how and why CMS was pricing these the way they did. Our office has started noticing similar trends with surgeries in approved-MSA: CMS is allocating for surgeries where they shouldn't be; and the pricing does not appear to match-up with the applicable fee schedules. Like many processes in the WCMSA review and approval

process, CMS tends to keep their guidelines and procedures for surgery pricing vague, general, or just down-right confusing.

The inclusion/exclusion of a surgery alone can certainly make a big difference between the proposed and approved WCSMAs. But the difference in pricing can sometimes create as much of an impact as including the procedure itself. Whether a specific procedure should be included or excluded in an MSA is very case-specific, and usually an issue or argument of degree: in many situations, it is impossible to know at the time of settlement whether a claimant will definitively need or undergo a future surgery. While primary payers and submitters will argue that future need for the surgery is speculative, CMS can always argue that it is better to be on the safe side.

For the other half of this issue, the pricing of these procedures, it appears that CMS is not adhering to the applicable state fee schedule or practical facts of the case.

Fee Schedules and the WCMSA Reference Guide

Most states have some form of a workers' compensation fee schedule that limits or reduces medical costs based on a set amount or a percentage of the charge. According to WCMSA Reference Guide Version 3.1, the states without fee schedules are Indiana, Iowa, Missouri, New Jersey, Virginia, and Wisconsin.

The Reference Guide allows submitters to base the pricing of their proposed WCMSAs on either actual charges or the jurisdiction's applicable fee schedule. But that is not the end of the story. The Reference Guide provides restrictions and guidelines on how a proposed surgery should be priced. The problem is that these do not provide any clear guidance or insight into how or why CMS will price surgeries a certain way.

To be fair, even if it is extremely likely that a beneficiary will require and undergo a surgery, there are certain aspects of a future procedure affecting the fee schedule price that cannot be definitively predicted or quantified in advance: anesthesia time, use of an assistant and to what degree, and separately reimbursed supplies such as drugs and implants. Further, even though the surgery itself might be likely, the specific procedures might be a game-time decision; for example, it is not unreasonable for a shoulder surgeon to indicate that a rotator cuff repair versus debridement would be decided based on the intraoperative findings. Finally, many fee schedules calculate reimbursement of some procedures based on a percentage of the provider's charge, which again, cannot be easily refined to a prospective formula.

The Reference Guide also allows submitters to provide an explanation or breakdown of how they calculated the costs of surgeries included in their proposal which the reviewer will "consider;" however, oftentimes that is met with a counter-higher and insightful explanation that "MEDICAL SERVICES PRICING WAS HIGHER THAN THE SUBMITTED PROPOSAL." If CMS is dictating what amount needs to be allocated, they should be able to provide the data behind it.

Solutions? Or More Problems?

To its credit, CMS does provide *some* guidance on how submitters should price surgeries in their submissions. They have even added detailed sections on how they are pricing some of the more expensive and "common" procedures like spinal cord stimulators (SCSs). However, their guidance in general seems to be lacking, and sometimes at odds with the real world.

Section 9.4.3 of the Reference Guide states:

"The WCRC strives to comply with the laws of the state determined to be the appropriate state of venue. The reviewers research the applicable state regulations and fee schedules. In previous years, the WCRC has priced WCMSAs using the highest fee schedule zone possible within any state that uses fee schedules. Currently the WCRC prices WCMSAs according to the correct region for the state of venue. Hospital fee schedules are currently determined using the Diagnosis-Related Groups (DRG) payment for the median Major Medical Center within the appropriate fee jurisdiction for the pricing ZIP code, unless otherwise defined by state law."

The Section discussing SCS's which, presumably, (but not explicitly) is intended to apply to surgeries generally, states that SCS replacement procedures can be priced as inpatient or outpatient. It states that they price inpatient procedures based on DRG codes "priced for a major medical center in that state, unless the fee schedule has pricing for that DRG (like Illinois)."

The problems here are that 1) CMS does not state how procedures should be categorized as inpatient or outpatient, and 2) they do not provide any guidance for what constitutes a major medical center.

Inpatient v. Outpatient

The Reference Guide does not provide much guidance on whether a given surgery should be priced for an inpatient or outpatient setting; however, the difference in pricing between those two categories can be significant. The SCS section states that the procedure may be inpatient or outpatient "depending on previous surgeries or physician recommendations." However, this information is not always available from the medical records, and there is no indication of what pricing scheme CMS will default to in those situations.

A potential source for differentiating between outpatient and inpatient procedures could come from CMS' own inpatient only (IPO) list which designates certain procedures as only being covered in inpatient settings. However, it is unclear whether CMS is utilizing the IPO list for pricing WCMSAs, and although incorporating it might provide submitters with more certainty, it might not provide the best results. The IPO list makes sense for CMS: some procedures are more likely to result in complications that could require significant care beyond the surgery itself, so having them performed in an inpatient setting allows critical care to be readily available and helps consolidate costs.

Still, the IPO list does not always accurately reflect the availability to undergo procedures in a more cost-effective outpatient or ASC setting, and it is constantly changing: in 2018, total knee replacements were removed, and hip replacements were just removed in 2020. Ultimately, even if CMS were to incorporate the IPO list for WCMSAs, the benefits from clearer expectations in pricing proposals may be outweighed by increased costs in allocating for inpatient surgeries that are more likely to be performed in a more cost-effective setting.

Regardless, all allocations are speculative, and default to a "best-guess" as to where they might be performed. But, if it is likely that a procedure would actually be performed in an outpatient setting, why would they not be priced that way?

"Major Medical Center"

The reference guide uses the term "major medical center" three times when discussing pricing for inpatient procedures, but nowhere does it provide a definition or any insight whatsoever as to what it considers a "major medical center." A web search does not identify any other references to this phrase with CMS specifically. We couldn't even find one specific definition or listing, this might be because it is not a discrete term. The closest

we got to a definition came from Wikipedia's page on "medical centers in the United States" which has a subsection titled Major Medical Centers. However, that merely "describes some of the largest and most prominent centers in the nation," and does not provide any other definition.

The issue isn't that CMS is seemingly basing their pricing on the most expensive facilities, it is that they are using a vague term which has no discrete limitations whatsoever. If they were to directly state that they are using the facilities with the highest conversion factor or reimbursement rate under the fee schedule, that would at least be something that could give primary payers predictable results. As it stands now, submitters are just left guessing.

Potential Solutions

Continued variance in surgery pricing in WCMSAs and ill-defined standards could push primary payers away from submission. While the preferable solution would be discrete and definable standards that provide clear guidance on how submitters should expect surgeries to be priced in WCMSAs, this could have the negative effect of locking submitters into pricing based on facility settings that do not realistically account for the likely costs, and may result in vastly overfunded MSAs.

Any changes should of course involve input and feedback from the MSP community, and will take time to develop. In the meantime, however, CMS should be more amenable to proposed surgery pricing from submitters and defer to their calculations if they accurately reflect the facts of the case and fee schedule pricing. CMS should also readily provide more detailed explanations for why their pricing in the approval was higher than the proposal. If CMS is basing their pricing on discrete variables or standards, they should be able to, at the least, provide the procedure codes, regions, and/or fee schedule types they are using.

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Timing Your Total Payment Obligation to Claimant (TPOC) Report Under Section 111 / Rasa Fumagalli

Most workers' compensation claims adjusters would agree that the best claim is a closed one. Although the ideal settlement closes all aspects of the claim at once, this is not always feasible. The unique circumstances of a claim may result in an indemnity only settlement with future medical rights remaining open. The settlement terms will often provide that the open medical rights will close after either a fixed period of time, or once a specific event occurs, such as the carrier's election to secure and fund a Centers for Medicare and Medicaid Services (CMS) approved Medicare Set-Aside (MSA) determination. If the parties subsequently elect to close out open medical, a second settlement agreement will be entered into for the agreed upon value of the future medical rights.

The two distinct settlements are a straightforward occurrence for the claims handler. The two settlement dates however may cause confusion when it comes to the Section 111 reporting obligations under the Medicare, Medicaid, and SCHIP Extension Act of 2007. This article will address the guidance provided by CMS as well as some of the ways in which these bifurcated settlements are being reported.

By way of background, Section 111 reporting obligations may arise in settlements involving a Medicare beneficiary. If the Medicare beneficiary claimant's claim has been accepted, the Responsible Reporting Entity ("RRE") has an obligation to report the carrier's/employer's Ongoing Responsibility for Medicals (ORM) in the claim and the accepted diagnosis codes. If the claim has been denied, there is no obligation to report ORM.

The second Section 111 reporting obligation involves the Total Payment Obligation to Claimant (TPOC) once the case fully settles. The Total Payment Obligation to the Claimant is defined as "the dollar amount of a settlement, judgment, award or other payments in addition to or apart from ORM." (MMSEA Section 111 NGHP User Guide, Version 5.9) If the case was denied and no ORM report was made, the RRE should only report the TPOC settlement provided the settlement exceeds the applicable Section 111 reporting threshold. Currently, the Section 111 TPOC reporting threshold is $750.00. If the case was accepted and the settlement closes out all aspects of the claim at the same time, the RRE should report both the termination of the ORM and the TPOC under Section 111. The TPOC date is the date that the appropriate court approves the settlement agreement. If court approval is unnecessary, the TPOC date is the date that the written agreement is

signed. In this scenario, the ORM date will be the same as the TPOC date since all the issues are being resolved simultaneously.

Now consider a situation involving an accepted case with a Section 111 ORM report and a settlement agreement to pay a specific amount for indemnity while keeping medical open for a fixed number of years. Since Section 111 ORM reporting options do not allow for the ORM termination date to fall in the future, and the value of the open medical for a fixed number of years cannot be definitively established, what is the best way to address this under Section 111? According to information provided during one of CMS' early Section 111 Non-Group Health Plan Town Halls, the ORM report should not be terminated until the fixed number of years passes. The TPOC report however should be made since an indemnity agreement was reached. A second TPOC report would be made when the future medical obligation closes and ORM terminates. This position appears to be consistent with subsequent guidance issued in the MMSEA Section 111 NGHP User Guides. The definition of TPOC states that it "generally reflects a "one time" or "lump sum" settlement, judgment, award, or other payment intended to resolve *or partially resolve* a claim." (emphasis added). Our recent discussions with the Commercial Repayment Center (CRC) and Benefits Coordination & Recovery Center (BCRC) however, suggest that only one TPOC report should be made in this fact pattern, *i.e.* when the ORM terminates. This is not always the practice that is being followed by claims handlers.

There are also situations where the ORM termination date may occur before the TPOC date. According to the MMSEA Section 111 NGHP User Guide (Version 5.9), ORM may be terminated under the following circumstances:

- the beneficiary's treating physician has provided a signed statement that no additional injury related medical items or services will be needed;
- the medical benefits available to the beneficiary have exhausted under applicable state law; or
- the insurer's responsibility for ORM has been terminated under the terms of the applicable insurance contract, such as when the maximum coverage benefit has been paid out.

An exhaustion of benefits under state law may occur when the parties go to trial and the judicial body issues a full and final order that terminates the employer's obligation for ongoing medical benefits. Although the parties may settle the indemnity months or years later, ORM may be terminated after the judicial order becomes final. It is important to note that an ORM termination date should not be reported if the ORM is subject to

reopening or otherwise subject to an additional request for payment. If state law prohibits the closure of future medical, you may have a TPOC report without ever terminating the ORM.

Conclusion:

Section 111 mandatory reporting is intended to keep Medicare as a Secondary Payer when a primary payer with a demonstrated responsibility for the claim is available. It impacts both conditional payment recovery and generally allows Medicare to avoid making future payment for injury related medical services. Proper reporting by the RRE is required to facilitate the Section 111 goals and to prevent the imposition of penalties.

Claims handlers should be mindful of the need to properly terminate ORM since the termination date serves as the cutoff date for the CRC's conditional payment recovery efforts in the claim. The TPOC date in cases without ORM reporting serves the same purpose; conditional payment recovery shifts to the BCRC. When reporting bifurcated settlements, CMS' guidance is ambiguous. Since the termination of ORM is key to limiting conditional payment recovery efforts by the CRC against the insured, best practices may dictate one TPOC report at the time that ORM is being terminated. Additional clarification may be provided during the upcoming CMS Section 111 Non-Group Health Plan reporting webinar on August 13, 2020 at 1:00 pm ET.

Our MSP compliance team is here to keep you informed and aid with your Medicare Secondary Payer compliance needs.

Diagnostic Studies in the Allocation: Guiding Principles / Julie Garrison

Almost every Workers' Compensation Medicare Set-Aside (WCMSA) includes future diagnostic imaging studies, usually x-rays and MRIs. For most work injuries, and especially orthopedic ones, diagnostic imaging studies are commonly done early in treatment. They may be done on an emergent basis. And it is not unusual for repeat studies to be conducted for more serious and/or ongoing conditions. This article will provide an overview of diagnostic imaging allocation per the WCMSA Reference Guide, Official Disability Guidelines, and other physician and standard of care guidelines as well as strategies for allocating future imaging studies.

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The WCMSA Reference Guide Provisions

Section 9.4.3 WCRC Review Considerations of the WCMSA Reference Guide (v.3.1 May 2020) states *"[t]he WCRC team reviews all of the submitted records and attempts to determine the future care required for the individual claim, taking into consideration the claimant's specific condition, other comorbidities, and the claimant's past use of healthcare services. Reviewers use evidence-based rationale for the determination, taking into account both published guidelines and current peer-reviewed medical literature."* Later, in the same section, the Reference Guide provides *"[t}he WCRC considers both the claimant's past history of treatment and the recent trending treatment in determining plans for future treatment frequency. … There is currently no plan to establish a set of standards for specific conditions."*

In addition, at Section 9.4.5 Medical Review Guidelines-Diagnostics, the Reference Guide contains the following provision:

"In general, the reviewers include x-rays every 3 to 5 years, but include yearly x-rays there was or will be a major joint replacement. Magnetic Resonance Imaging (MRI) scans are included every 5 to 7 years. These are guidelines only. Since the determination is made on a case-by-case basis, other factors are considered, such as claimant life expectancy, past surgeries, functional status, age of injury, treatment pattern and provider recommendations."

These Reference Guide provisions are somewhat conflicting. On one hand, a case-by-case analysis of several factors is advised. On the other hand, there is a suggested formulaic range closely adhered to by WCRC reviewers. Within the ranges, claims where surgeries have been performed result in more frequent diagnostics while diagnostic studies for non-operative conditions are allocated less frequently. The ranges may be reasonable for claims involving ongoing medical conditions and treatment, but too often, CMS reviewers take the formulaic approach while failing to consider the other factors set forth in the Reference Guide.

Strategies for Allocating Diagnostic Imaging Studies

Rather than defaulting to allocations within the ranges, actual treatment patterns and where offered, specific recommendations by treating physicians should be favored. Repeat x-rays or other diagnostic studies may be indicated while recovering from an acute injury, but not once that recovery is complete. Some injuries do resolve. Claimants,

discharged after appropriate and successful treatment and who may have returned to work, are less likely to return to physicians or seek further care. Consider the example of a healed closed fracture. After active treatment consisting of casting and perhaps physical therapy, a claimant is released by the treating physician with no concerning ongoing issues. In such instance, the claimant is unlikely to return to the doctor unless there is a new injury. Based on these facts, it seems unnecessary and speculative to allocate x-rays and especially MRIs every few years. Depending on life expectancy, perhaps only a single additional imaging study or test is reasonable.

Many accidents involve a laundry list of complaints and diagnoses where diagnostic studies are often done on multiple body parts. Yet, not all reveal acute problems leading to treatment. No future care may be recommended or otherwise indicated. In such cases, no allocation of any care for those body parts including diagnostic studies is appropriate. Similarly, during the course of treatment, a claimant may complain of another body part. A classic situation involves a shoulder injury and same-side neck complaints. A single imaging study might be conducted or the new complaints, but if no related treatment is needed, no repeat studies should be included in future care.

In addition, an evidence-based approach considers current research and best standards of care. Sources like the Official Disability Guidelines (ODG), American College of Physicians' Clinical Practice Guidelines, and guidelines of the American Colleges of Radiology and of Occupational and Environmental Medicine should be consulted by allocators and reviewers. For example, routine imaging for low back pain alone may not provide any benefit and may even lead to unnecessary intervention. Research on lateral epicondylitis suggests the use of MRIs lead to over-treatment. Specific guidelines for ankle/foot and knee (such as the Ottawa rules) promote the avoidance of imaging and unnecessary health care. These resources can provide solid rationale for more conservative allocations, whether submitted to CMS for approval or not.

Best Approach

In allocating future diagnostic studies along with other medical services, we view each claim on individual case-by-case basis and consider all facts, standards of care and strategies and then weigh each medical service to be included or excluded from allocation. We regard the formulaic Reference Guide ranges as guidelines only and look to actual treatment patterns and treating provider recommendations (or lack of any recommendations). We exclude diagnostic studies where appropriate. We strategize and assess the benefits and risks in proposing conservative WCMSAs. Ultimately, our

approach produces more precise and cost-effective results. Our team of credentialed and experienced MSP attorneys can help insurers and employers achieve better MSAs.

Answers by Amy / Amy Bilton

Prescription drugs can make up a large part of a Medicare Set-Aside. Since Medicare prices future prescription drugs using average wholesale price, the ultimate cost of the drugs through a pharmacy benefits manager (PBM) is often less than the average wholesale price. The question posed is: ***"I would like to price out the future drugs based on the pricing we have available through our PBM. Can I do this?"***

At least as of the writing of this answer, submission of Medicare Set-Aside is still voluntary. Should you choose to submit your MSA to Medicare for approval, the only pricing methodology CMS presently accepts for pricing prescription drugs is average wholesale price. This is true even in states with a medication fee schedule; CMS ignores those fee schedules. CMS does not acknowledge PBM pricing in its MSA review process.

With that noted, since the submission process is voluntary, you still have other options beyond traditional submission. The main question is whether the methodology you use in allocating future medical costs for a non-submit MSA will result in a cost shift to the Medicare program. If, as is sometimes the case with self-insurer programs, you are able to keep the claimant in your PBM indefinitely, pricing future medical using PBM pricing could be acceptable. However, if the claimant will no longer have access to the PBM post-settlement, using the PBM pricing may no longer be considered reasonable since the claimant will need to obtain their medication at retail prices higher than PBM pricing.

You may also have alternatives available for prescription drug mitigation. Perhaps the claimant is on a brand name drug and can be moved to a less expensive generic. Perhaps the claimant is no longer taking the medication; all that is needed is documentation from the doctor supporting this to remove the drug from the MSA. Perhaps the medication is one that is not safe to take over the entire life expectancy, such as drugs on the Beers list which are unsafe for seniors to take indefinitely, so alternative medications could be priced or pursued.

Despite Medicare's often "cookie-cutter" methodology for pricing future medical and prescription drugs, we all know post-settlement medical treatment is not that straightforward. Medications change and conditions wax and wane. Accordingly, mitigation strategies for MSAs should always be considered, just as you would consider

cost mitigation strategies during the pendency of the workers' compensation claim itself. Our MSAs are all written and proofed by attorneys with backgrounds in workers' compensation claims, which means we look at our MSAs with an eye toward these mitigation strategies. If you have a case which is difficult to settle because the MSA is too large due to prescription drugs, we would love to help you develop mitigation strategies for that case, whether you submit the MSA for approval or not.

Our MSP Compliance Services

Our dedicated team diligently and efficiently streamlines and navigates the Medicare Secondary Payer (MSP) landscape for our clients. The attorneys, nurses, and paraprofessionals at NBKL guide you through the entire process from initial investigation through post-settlement. Our team's vast experience in workers' compensation defense, personal injury claims and MSP compliance makes us industry leaders in partnering with clients to achieve optimal claim resolutions while meeting all MSP requirements.

Services We Provide:

- Medicare Set-Asides ("MSA") (traditional and non-submit) including:
  - Legal Zero MSAs
  - Evidence Based Medicine MSAs
  - Future Medical Allocations/Life Care Plans
  - Advice and Recommendations to Mitigate MSA exposure
  - Analysis and Mitigation of competitor's MSA proposals
- Medicare Parts A & B Conditional Payment Analysis, Negotiation and Resolution
- Medicare Advantage Plan (Part C) and Prescription Drug Plan (Part D) Lien Investigation, Negotiation and Resolution
- Medicaid Lien Negotiation and Resolution
- Settlement Contract drafting to protect against past and future Medicare exposure
- Settlement Consulting on all aspects of MSP Compliance in Workers' Compensation and Liability cases
- Design and Implementation of MSP Compliance Programs

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