THE MSA TODAY

MEDICARE SET-ASIDE UPDATES FROM CATTIE, P.L.L.C.

WELCOME TO THE MSA TODAY!

The MSA Today is our law firm's periodic newsletter. It provides readers with updates about Medicare Set-Asides (MSAs) and the issues related to MSAs. It's one of the only places to get MSA updates from the legal perspective.

"**This [MSA] program is caused by a legal requirement for Medicare to not make payment where another entity has responsibility. This can be found in 42 CFR 411, and the Social Security Act 1862(b).**" Anonymous CMS Official

The obligation to determine if Medicare has a right to not pay certain future medical expenses related to a settlement/judgment/award is a legal obligation. While the law does not "require" MSAs, it does require that Medicare not pay when payment has been made under a workers' compensation plan, an automobile plan, a liability insurance plan (including self-insurance) or a no-fault plan.

Too often, folks miss the forest for the trees on MSA issues. They seek a black/white MSA requirement in the liability insurance context, or they strictly follow informal policy memos or reference guides from Medicare in the workers' compensation insurance context. Instead, following what the law says and the regulations say about future medicals leads you to a more compliant (and often cheaper) conclusion. Claims are resolved faster, settlements are approved faster and injured workers get out of the workers' compensation system faster.

The goal here is to be educational and informative. While nothing here is intended to provide you legal advice about a current or previous case, I'd be happy to weigh in on those as well if you engage Cattie, P.L.L.C. for that purpose.

Your feedback is critical to a successful newsletter. Please reach out with your comments, suggestions and constructive criticism. Send that to us in an email at jcattie@cattielaw.com, via Twitter @MSALawyer or by phone at (704) 232-7297. With that, please keep reading to get the latest scoop about MSAs and related issues.

CMS INTRODUCES NEW MSA REVIEW CONTRACTOR

In a town hall call held March 7, 2018, CMS introduced Capital Bridge, LLC ("Capital Bridge") as its new Workers' Compensation Review Contractor ("WCRC") to handle review and approval of WCMSAs. Holly Havens from Capital Bridge outlined the goals of the transition from the previous contractor to Capital Bridge. Those goals include making transition as seamless as possible. Ms. Havens noted Capital Bridge's long history of working with CMS (over 25 years of CMS support experience).

What's Changing? As of 3/19/18, everyone should use the Capital Bridge contact info (found in the materials) to reach out to the CRC. Both phone number and email will change as a result of the transition. She noted that production at the old contractor will cease on 3/16/18 and Capital Bridge goes live on 3/19/18.

What Stays the Same? All current cases and info at the current WCRC will be transitioned to Capital Bridge. CMS' processes will remain the same once Capital Bridge assumes control. Ms. Havens stressed a focus on quality, timeliness and customer service. This transition also has no effect on anything happening at the BCRC or the CRC for conditional payments for past medicals.

Remember that previous transitions between MSA review contractors has led to increased delays, more development requests, and more counter higher letters. Time will tell if Capital Bridge is up to the task, but Ms. Havens stated she does not anticipate any backlog due to the transition. By all accounts, a seamless transition is anticipated.

During the question/answer section, the issue of LMSA review arose. As you know, CMS holds the discretion to charge Capital Bridge to begin reviewing LMSA and NFMSA proposals starting as soon as July 1, 2018. That subject was deemed to be outside the scope of today's call. General policy questions were also deemed to be outside the scope of today's call.

To access the info and slides shared during the presentation, please look to the CMS website in the near future.

CMS REPORTS TO A NEW SECRETARY OF HEALTH & HUMAN SERVICES

CATTIE IS NOW HIRING!

Do you have a background in Medicare Secondary Payer (MSP) or Medicare Set-Asides (MSAs)? Are you seeking a new challenge? I challenge you to join the law firm that is revolutionizing how clients extinguish medical

reimbursement obligations! Cattie, P.L.L.C. is now hiring!
Attorneys, paralegals, risk managers, claims examiners and legal assistants should submit your CV, resume and salary requirements to jcattie@cattielaw.com today. Competitive compensation, attractive benefits package and flexible work environment are just some of the reasons to accept our challenge. Don't wait! Accept the challenge now before your position is filled.

Cattie, P.L.L.C. – A Higher Standard in MSA Compliance

COMMUTATION OR COMPROMISE: THE CRITICAL QUESTION FOR WCMSAS

Though unwilling to provide specific regulations about MSAs to date, CMS has provided regulations about future medicals in WC. These regulations, found at 42 C.F.R. § 411.46, contemplate two distinct situations found in WC: commutations and compromises.

§ 411.46 Lump-sum payments.

(a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(d) Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement -

(1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.

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

Importantly, CMS does not define the terms 'commutation' and 'compromise' by regulation. 42 C.F.R. § 411.21 provides all the definitions for the regulations supporting the MSP Act and those terms are not there. CMS has chosen to not define those for us.

Luckily, we can figure out what they mean for ourselves based on common understanding. Compromise is well known to us. It's the negotiation that goes back and forth between the Employer/Carrier (E/C) and the claimant before a WC claim is resolved, right? It's the tit for tat to reach middle ground. In WC, this happens all the time. We see it in a denied claim where the E/C does not accept responsibility for medicals. We also see it on an accepted

claim where the parties might dispute how to treat a claimant's condition and the necessity to undergo certain procedures.

Commutation is the opposite of compromise. Commutations occur when the E/C accepts the WC claim and, in fact, pays for everything. This includes all indemnity/wage loss owed under state law, all past medicals and all future medicals. Commutation settlements epitomize the "Grand Bargain" our WC system has represented for over 100 years.

Commutations don't happen nearly as often as you might expect anymore. Here's an example: E/C accepts a WC claim for a back injury and pays medicals. Medical reports indicate that the claimant may need a spinal cord stimulator (SCS). The E/C does not want to pay for the SCS and settles the claim without paying for the SCS. Is this a commutation settlement since the E/C paid past medicals and will be paying some future medicals? Or is it a compromise settlement because it refuses to pay for the SCS which the claimant may need in the future?

For the E/C, the distinction means everything to the final MSA answer. If you call this a commutation, then you agree to pay for everything medically "required", including the SCS. *42 C.F.R. § 411.46(a)*. If you call this a compromise though, 42 C.F.R. § 411.46(d) would apply since you're not paying for everything. Remember the basic rule and the sole exception under the regulation, Medicare's official statutory interpretation on point. Medicare will pay for future medicals unless there is a specific amount allocated for future medicals. If there is, then the claimant must spend down and exhaust before billing Medicare.

Note again, the regulation does not mention a MSA as the means to calculate the allocated medical figure. Silence from CMS via regulation means that options exist. Note also that the regulation does not speak to penalties for failure to utilize a MSA under those circumstances. It also does not speak to CMS review/approval of the allocated future medical figure.

There is no substantive MSA legal standard. There is, however, a substantive legal standard to meet about classifying the claim as a commutation or a compromise. The E/C spend millions of dollars trying to gain CMS approval of a MSA based on medical documentation. The goal is to mitigate risk in the future on CMS collecting future medical dollars. That's what the MSA vendor industry has always told you without providing alternatives. However, alternatives to traditional MSAs exist since there is no substantive legal standard to meet about MSAs. All it takes is an open mind, a willingness to listen to reason and common sense, and a true desire to extinguish your future medical exposure.

For more, read MSAs the Legal Way.

NEW MSP GRAND BARGAIN BILL TO CLARIFY MSP REIMBURSEMENT OBLIGATIONS

Do Medicare reimbursement issues frustrate you? Tired of worrying about Medicare's past interest AND future interest on every case or claim? If so, the following might interest you. A bill has been drafted to address Medicare reimbursement obligations, and it makes all

the sense in the world. It directs Medicare to pursue one side and one side only depending on whether the issue is conditional payments for past medicals or MSAs/future medical exposure post-settlement.

In short, if enacted as is, Medicare would be barred by statute from pursuing insurance carriers and self-insureds for future medical expenses paid by Medicare post-settlement. The trade-off (or Grand Bargain) part of the deal is that Medicare would look only to the insurance carrier or self-insured entity to repay Medicare conditional payments for past medicals (a/k/a the Medicare "lien"). A Grand Bargain indeed.

The goal of the legislation is to clarify what parties have reimbursement responsibilities and exposure during certain points of a case or claim. Think about never having to worry about another MSA issue (if you're an insurance carrier or self-insured) or never needing to worry about another Medicare "lien" (if you're a plaintiff attorney). Defense handles all past medical issues with Medicare (date of loss to date of claim resolution); plaintiffs handle all future medical issues with Medicare (date of claim resolution going forward). And Medicare can only pursue the appropriate party at the appropriate time.

To read a full version of the bill, click below. After that, let us know if the bill makes sense to you by emailing us at jcattie@cattielaw.com. If you like it enough, you should let your representative or senator know about it. Sure seems like we could use a Grand Bargain and some good old-fashioned compromise in Washington these days.

pdf

Medicare Reimbursement Bill.pdf

Medicare can only pursue defense on past medical payments and plaintiffs for future medical payments. It's as simple as that.

Download

38.5 KB

CLICK FOR MSA HELP

ATTENTION CLAIMS ADJUSTORS – GET A MSA LEGAL OPINION TO CLOSE CLAIMS FASTER

Have any claims you cannot close because of the MSA issue? Open claims cost you money, professionally and personally. While you may have a panel of MSA vendors to choose from, none of them seem to have a solution that makes sense to close that troublesome claim. That's because they provide MSAs based on medical records instead of the law itself.

Enter the MSA Opinion Letter from Cattie. Instead of an MSA report based on medical records, you can obtain legal advice about MSA exposure from an experienced attorney. The MSA Legal Opinion allows you to close the file with confidence that Medicare cannot collect an additional dime from you for future medicals successfully. The risk of the MSA

issue passes from you to us. If Medicare ever seeks to collect post-settlement medicals, our clients know it only takes one call for Cattie to defend its opinion. Does your current MSA vendor do that?

Call or email us today about how we can help. Ultimately, it likely makes sense to have at least one law firm like Cattie on your MSA panel. Some claims can be resolved using a standard MSA process. Other claims require a different set of skills. Cattie brings that different set of skills to every case we work, and the results speak for themselves.

For more information, see my recent article titled "Why You Need a Law Firm on your MSA Panel."

EXTINGUISH YOUR FUTURE MEDICAL EXPOSURE

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ATTENTION PLAINTIFF ATTORNEYS – TAKE STEPS TO PROTECT YOUR CLIENTS' FUTURE MEDICARE COVERAGE

If you're a plaintiff attorney reading this, ask yourself the following question, "Do you want to protect your future Medicare coverage as part of this settlement?" Is that a question you typically ask the client before settlement? Likely not, but if you changed the word "Medicare" to "Medicaid", you almost certainly would ask that question.

Healthcare expenses and insurance to cover healthcare expenses has become our generation's hot button issue. The vociferous debate about the Affordable Care Act aka Obamacare over the past decade proves that point. Government benefit preservation is an issue, however, that does not get enough attention when a plaintiff's attorney settles a case on behalf of their client.

As an observation, plaintiff attorneys do a good job of protecting a client's future Medicaid coverage. Knowing that Medicaid coverage is based on income/assets, they know that by receiving settlement proceeds without taking certain steps first, they would jeopardize the client's Medicaid coverage going forward. Thus, the question they routinely ask the client is "Do you want Medicaid after settlement?" If yes, then the attorney moves to create a Special Needs Trust, an ABLE account or some other vehicle by which to protect the client's Medicaid eligibility.

Attorneys are not as good about protecting a client's future Medicare coverage. Seldom is the question asked, "Do you want to protect your future Medicare coverage after settlement?" Instead, plaintiff attorneys by and large only broach this issue if the other side has made some statement about an MSA requirement as part of settlement. It should not

take the other side to drag the attorney to ask the client about protecting future Medicare benefits.

While Medicare benefits are entitlement based instead of needs based, the potential exists for the client's Medicare coverage to be challenged by Medicare post-settlement. This can occur one of two ways. First, Medicare could receive bills from a client's health care provider and reject them, telling the provider to collect from the patient's MSA instead. Second, Medicare could pay that bill in error, realize the error and then seek reimbursement from the responsible party. That responsible party, under the terms of the settlement agreement signed previously, would be the client. Either way, the client's Medicare coverage with respect to that particular bill is jeopardized, and that could lead to future coverage being jeopardized for future medical bills.

There's a easy solution to this. Just ask the client the following: "Do you want to protect your future Medicare coverage as part of this settlement?" If they say yes, then examine your client's future medical exposure under the MSP Act. If you need assistance with that, Cattie would be happy to assist. If the client says no, you should document that in the file in the event settlement related Medicare issues arise at a later date. No need to open yourself up to a potential malpractice action or state bar report when all it takes is a simple question.