Medicare Set Aside = CYA

April Pettengill, RN, CRRN, CDMS, CNLCP, MSCC, CBIS

Objectives for today

• Understand the Medicare Secondary Payer Act
• Understand the SCHIP and SMART Acts
• Understand the Medicare Set-Aside process and requirements in settlements
• Discuss administration of the MSA
Medicare Secondary Payer Act

• Medicare Secondary Payer Act:
  - A collection of statutory provisions codified during the 1980’s with the intention of reducing federal health care costs (see Zinman v. Shalala 67 F.3d 841,845 9th cir. 1995)
  - Provides that CMS may pursue damages against any entity that attempts to shift the burden of medical costs to Medicare.

• Medicare Secondary payer act requires:
  - Medicare interests must be taken into account for all settlements where future medical care is settling
  - 2004 CMS began enforcing
  - Specific criteria for submission
  - Requires that all Medicare covered goods and services be included
  - Non-covered costs are not required to be added into the allocation
  - Costs should be by State Fee schedule or Usual and Customary if no fee schedule. Longshore is priced using federal fee schedule.

Workers Compensation

• CMS has a formal process in place
• Consequences of non-compliance can be severe. Among these, the Centers for Medicare and Medicaid Services (CMS) may:
  - Deny the claimant future medical care
  - Designate its own allocation, which may be as much as the entire settlement amount
  - Sue the claimant, claimant’s attorney, and/or insurance carrier (where double damages can be sought)
Liability Cases

- Good Faith Determination – Does the settlement include costs for future medical treatment?
- Medicare must be considered a secondary payer to protect the carrier from potential damages.
- 2003 Memo states MSA needed in Subrogation:
  - if Liability relieves Workers Comp settlement

**Enforcement in Liability** - CMS has now begun auditing settlements
- Implementation of Recovery contractor
- Mandatory reporting

Medicare and Medicaid SCHIP Extension Act of 2007

- December 29, 2007 President Bush signed the Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2007:
  - As of July 1, 2009 primary payers handling workers compensation, third party liability, self –insurance, no fault insurance and automobile claims will need to identify to CMS claimants entitled to Medicare.
  - Identifying claimants per the legislation provides it is necessary to “determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis.” [section 111(a)(8)(A)(i)]
  - What needs to be reported includes identity of the claimant as well as “other information deemed necessary by the Secretary to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable claim recovery.” [section 111(a)(8)(B)(ii)]
  - Time frame for reporting was not defined HOWEVER $1,000 per day fine for “each day of non-compliance with respect to each claimant” if not reported
  - The same thresholds will most likely be used, but those thresholds are rumored to be changing – going lower.
SMART Act

Strengthening Medicare and Repaying Taxpayers Act

- Adds a discretionary element to the civil penalties for non-reporting under Section 111 of the MMSEA (safe harbor)
- Expedites the conditional payment demand process
- Added an “appeal” process
- Limits the timeframe for claims against plans/beneficiaries
- Stop using SSN or HCIN numbers for the MSP process

Mandatory Reporting information

https://www.cms.hhs.gov/MandatoryInsRep/

- The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers’ Compensation found at 42 U.S.C. 1395y(b)(8):
  - Add reporting rules; do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS’ existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment.
  - Include penalties for noncompliance.
- Who must report: “an applicable plan.”
  - “…[T]he term ‘applicable plan’ means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement: (i) Liability insurance (including self-insurance), (ii) No fault insurance. (iii) Workers’ compensation laws or plans.”
- What must be reported:
  - the identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue as well as such other information specified by the Secretary to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim.
- When/how reporting must be done:
  - In a form and manner, including frequency, specified by the Secretary
  - Information shall be submitted within a time specified by the Secretary
  - After the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability.
  - Submissions will be in an electronic format.
COBC and MSPRC Merger

• As of February 11, 2014 the Coordination of Benefits and the Medicare Secondary Payer Recovery contractors have merged.
• New entity is called the Coordination of Benefits and Recovery Center (COB&R)
• New contact information: Phone: 855-798-2627

When to contact COB&R

• To obtain conditional payment (lien) amounts
• To obtain final recovery (demand) amount
• Questions about repaying Medicare
• Request a waiver of recovery
• Request a first level of appeal with respect to the determination contained in demand letter or determination made on a waiver of recovery request.
Satisfying Medicare in Non-Group Health Plan Liability Settlements

- Specific information has now been identified:
  - Name, address, telephone #, DOB, gender, SSN, and HCIN
  - Primary plan type, policy #, claim #, incident information, ICD-9 codes, body parts, policy holder

- Resolution of claim:
  - Settlement date if known
  - Amount of settlement
  - Claim resolution including
    - Contested or non-contested
    - Ongoing responsibility if any
    - Funding

- Expect more memos as the process becomes more defined.
- Liability (3rd party claims) are now being discussed.

Criteria’s Met – Now what?

- A MSA or Medicare Set aside Allocation is developed.
  - The allocation is a report that addresses the Medicare covered goods and services to be submitted to CMS Coordination of Benefits Center in Detroit
  - Must summarize injury covered, previous care, medications, anticipated care and associated costs

- Conditional payments need to be identified

- The MSA is submitted along with other information required by Medicare and the COBC
  - Submitter letter
  - Consent form
  - Rated age or life expectancy
  - Life care plan
  - Settlement agreement or proposed or court order
  - Set-Aside Administrator or copy of agreement
  - Medical records
  - Payment history
  - Future treatment plan (allocation report)
  - Supplemental or additional information
What is a Medicare Set-Aside Allocation?

- A Medicare Set-Aside (MSA) allocation is a document that specifies future injury-related medical needs and associated costs. Only Medicare-covered expenses are required to be identified.
- Federal government audit of 2002 found more than $40 Billion in legitimate and enforceable liens against claims settlements that did not contain approved MSA allocations.
- Effective October 2006, CMS is auditing both Workers Compensation and Liability
  - Need to be sure that if the MSA is not submitted to CMS then the information must be addressed in the settlement paperwork.

When is a Medicare Set Aside Allocation Necessary?

A Workers’ Compensation MSA is reviewed by CMS in the following two situations:

- When claimant is currently eligible for Medicare**
  AND
  “a total settlement amount” of greater than $25,000.00

- Claimants with a “reasonable expectation” of Medicare enrollment within 30 months of the settlement date
  AND
  a total settlement of greater than $250,000.00

Medicare’s interest MUST be taken into consideration in all settlements.

**When a claimant is currently Medicare Eligible, a MSA must be completed regardless of settlement amount
How is a Medicare Set-Aside Allocation Developed?

• Information is provided to the company who will be developing and submitting the MSA
  • Specific information is required
  • Conditional payments also need to be identified
• CMS developed a WCMSA Reference Guide that is available online
  • Goes through the whole process and requirements.
• The submitter sends the document to the referral source
• If all parties agree then it is submitted to the contractor to review

Medicare Prescription Part D

• All MSA’s developed and submitted must include medications
• Medicare does not pay for all medications
• Medicare Part D
  • All beneficiaries are supposed to sign up so assume they have part D coverage.
Who Is Qualified to Develop a Medicare-Set Aside?

Medicare Set-Aside Consultant Certified (MSCC)

- **Training**
  - The candidate must complete 30 hours of training course related to MSP compliance that has been approved by the CHCC and pass the examination administered by CHCC

- **Professional Experience**
  - A minimum of 12 months of full time employment within the past 3 years in any of the following industry disciplines (within the Workers' Compensation or Liability insurance industry).
    - Nurses
    - Life Care Planners
    - Insurance Claims Adjusters
    - Attorneys

- Following the course, there is an exam, a peer review, and requirements of 15 clock hours of approved education every three years 5 hours of which need to be specific to MSA’s.

**End Result:**
- Accurate Medicare set-aside allocations that protect CMS AND your interests.

MSA Process

- MSA and documents are sent to the COB&R
  - Portal
  - Mail

- The contractor reviews the information
  - Contractor can agree, develop for more information or counter the MSA

- The contractor sends their review and recommendations to the Regional Office.

- Regional office reviews the recommendation

- The submitter, beneficiary, and attorneys receive a copy of the determination.
Development Demands

- Requests for clarification of denied or unrelated conditions, or documents not provided.
- Request for current records, current payment records, current medication information.
- Requests for settlement information, type of settlement (lump v. annuity), and administration type (self v. professional).
- Cases closed in 10 days!
- It will re-open when the information is provided.

MSA after Settlement

- Money must be in a separate interest bearing account just to be used for the items in the MSA.
- Money must not be used until recipient is on Medicare.
- An annual accounting summary must be submitted to Medicare.
  - This can be either the recipient or a paid Administrator.
- If the money is not used in its entirety during the year it is rolled over into the next year.
- If the money is used up before the end of the year or totally used, Medicare will then pay for the injury care.
**MSA Administration: Self v. Professional**

- Self administration: the beneficiary is responsible for paying the bills incurred for injury related expenses.
- Professional administration: paying someone to administer the MSA.
  - Two types currently available:
    - Full professional custodial
      - Medical accounts
    - Self-administration support

**What Happens When a Client Seeks Treatment in Self v. Professional Administration**

<table>
<thead>
<tr>
<th>Self Administration</th>
<th>Professional Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill arrives in the mail</td>
<td>Bill sent to company</td>
</tr>
<tr>
<td>Person has to determine if covered by MSA</td>
<td>Company determines coverage</td>
</tr>
<tr>
<td>If not, they need to notify provider to bill other insurance or Medicare for non-injury related care</td>
<td>If not covered, issue letter to provider with explanation</td>
</tr>
<tr>
<td>Person determines what to pay</td>
<td>Company re-prices bill per fee schedule (if appropriate)</td>
</tr>
<tr>
<td>Person sends check to provider</td>
<td>Company cuts check and issues an EOB</td>
</tr>
<tr>
<td>Person may need to explain to provider why they are paying at certain rate</td>
<td>Provider can call company with questions</td>
</tr>
</tbody>
</table>
The Take Away

- Medicare’s interests need to be considered in all settlements.
- MSAs are not required and they are not required to be submitted.
- Conditional payments (liens) need to be resolved.
- Report the final settlement.
- Consider type of administration.

For More Information:

Questions??

Contact Information

April Pettengill, RN
CRRN, CDMS, CNLCP, MSCC
802-849-2956
april@alpmedicalconsultants.com