Fact Versus Fiction

Assumptions and Insanity About MSAs in Denied Workers' Compensation Claims

By John V. Cattie, Jr.

"Assumptions are made and most assumptions are wrong." Albert Einstein

Medicare set asides (MSAs) continue to frustrate parties resolving workers' compensation (WC) claims. For many, the MSA is the last major hurdle to a closed file. Sometimes, the hurdle involves an MSA report from a third-party vendor, which does not have legal training, that does not seem to make sense based on the facts of the case. Other times, it is the federal government's response to a request from the settling parties that it review an MSA report that causes the frustration. The fact that the claim in question may be a denied workers' compensation claim only serves to intensify that frustration. The root cause of that frustration, though, is the assumptions that people in the workers' compensation industry make about using MSAs to close future medical exposure.

The purpose of this article is to separate fact from fiction when it comes to MSAs in denied workers' compensation claims. In short, MSAs are not needed when an employer or an insurance carrier has not accepted and does not accept responsibility for a claimant's future medical expenses as a part of resolving a claim. Asking the Centers for Medicare & Medicaid Services (CMS) to review and approve your zero-dollar MSA, though, is problematic. As 2018 approaches, now is the right time to find an alternate risk transfer solution that creates efficiencies for your clients' claim-handling processes.

After reading this article, your goal should be to review your clients' current processes and think about the time and the

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money that they spend on denied workers' compensation claims. Instead of the problems associated with CMS reviewing $0 MSA proposals, you should instead propose that they close the file by relying on a legal opinion. The workers' compensation system could achieve enhanced cost containment if it believed this one basic fact.

Fact: Medicare's Recovery Rights Under the Medicare Secondary Payer Act Are Not Automatic

The Medicare Secondary Payer (MSP) Act does not grant Medicare unlimited recovery rights. It does not even grant Medicare automatic recovery rights. Instead, two things must happen for Medicare's recovery rights to ripen: (1) a primary plan or payer must accept responsibility for a claimant's medical expenses; and (2) that responsibility must be evidenced by a judgment, a compromise for release, or by other means. 42 U.S.C. §1395y(b)(2)(B)(ii). Unless both occur, Medicare does not have recovery rights under the MSP Act, period. That also means that it does not have a right to have an MSA funded to pay for a claimant's future medical care. When a client denies a workers' compensation claim from the outset and never accepts responsibility for future medicals, the MSP Act is not triggered.

Fiction: The MSP Act Requires MSAs

Nowhere in the MSP Act does it mention MSAs, Medicare set asides, or even future medical expenses. It does not even mention the phrase "considering and protecting Medicare's interests," which currently and erroneously seems to have become the standard. What it does say is that Medicare won't pay for a beneficiary's medical expenses when payment has been made under a workers' compensation plan. 42 U.S.C. §1395y(b)(2)(A)(ii). An MSA gets funded to pay for those future medical expenses that a claimant anticipates incurring down the road that the employer or the insurance carrier already paid for in the settlement. While the law does prohibit Medicare from making payments for those expenses with one exception, it does not obligate anyone to use an MSA to ensure that Medicare does not pay for those same items, services, or expenses that an employer or an insurance carrier previously paid for in a workers' compensation award.

Fact: An MSA Might Be Appropriate for Anyone, Not Just Current Medicare Beneficiaries

While the MSP Act contemplates that Medicare will not pay for a Medicare beneficiary's medical expenses when payment has already been made under a workers' compensation plan, other scenarios are conceivable. First, a claimant may not yet be Medicare enrolled but could be close. Those in the MSP industry refer to these individuals as having a "reasonable expectation" of Medicare enrollment. Typically, the time frame in play here is 30 months from settlement. So you will see MSA issues arise if a claimant's anticipated enrollment falls within this period of "reasonable expectation."

But an MSA could also be an issue for other claimants. Since the MSP Act prohibits Medicare from making a payment that duplicates another payment, an argument exists that funding for an MSA would need to be examined for other claimants, too. In any workers' compensation settlement, it's possible that the employer or the insurance carrier is paying for future medical expenses. The MSP Act prohibits Medicare from paying when payment has been made under a workers' compensation plan. 42 U.S.C. §1395y(b)(2)(A)(ii). A claimant could take the proceeds and then enroll in Medicare at some point post-settlement.

Let's assume that happens five years after settlement. If the claimant still has money remaining for future medicals from the workers' compensation award, the statute would prohibit Medicare from paying for his or her future medicals that were paid for in the WC award. Now that the claimant is a Medicare beneficiary and has money remaining for that specific purpose, the MSP Act would apply. To comply with the law, the claimant should spend his or her remaining future medical proceeds on injury-related care otherwise covered by Medicare before billing Medicare.

Of course, all that presumes that the claim was accepted, and the employer or the insurance carrier included dollars for future medical expenses in the workers' compensation award paid to the claimant. When a workers' compensation claim is denied and ultimately settled on a doubtful and disputed basis, no future medical dollars change hands since the employer or the insurance carrier does not accept responsibility for future medicals. Thus, no MSA would be needed, and you would simply want to document the file appropriately.

Fiction: An MSA Must Be Funded When Future Medicals Are Expected

Future medical expenses do not mean that MSA funding is required in every case. Only when Medicare's right of recovery is triggered would an MSA need to be funded. So those future medicals must be related to a *compensable* claim for an MSA to need funding. Even then, there are options available other than funding an MSA to comply with the law stating that Medicare will not pay when payment has been made under a WC plan. 42 U.S.C. §1395y(b)(2)(A)(ii). One option is to obtain a legal opinion, which will be discussed more later.

Fact: A Denied Workers' Compensation Claim Creates a Compromise Situation, Not a Commutation Case

CMS explains the distinction between a compromise case and a commutation case in the Medicare regulations. A commutation occurs when the amount of a workers' compensation award is intended to compensate the claimant for all future medicals required because of the work-related injury or disease. 42 C.F.R. §411.46(a). In addition, "a lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan." 42 C.F.R. §411.46(b)(1). This regulation is titled "Lump-Sum Compromise Settlement." This means that denied workers' compensation claims must be compromise situations, not commutations, under the Medicare regulations.

Fiction: The WCMSA Reference Guide Is the Only Place to Look for Guidance on Future Medical Expenses

While most will point to the Workers Compensation Medicare Set-Aside Arrangement Reference Guide, or the "WCMSA Reference Guide," as the definitive statement about future medical expenses, it represents unofficial guidance from CMS on the issue. Official guidance can be found in the Code of Federal Regulations. *See* 42

C.F.R. §411.46. The Code of Federal Regulations discusses the differences between future medicals in commutation cases versus compromise cases. Since a denied WC claim would be considered a compromise case, the regulations should be the first place to start when examining the MSA issue for a denied claim.

Future medicals must be related to a compensable claim for an MSA to need funding. Even then, there are options available other than funding an MSA to comply with the law stating that Medicare will not pay when payment has been made under a WC plan.

Fact: The Regulations, Similar to the Statute, Do Not Address MSAs

Hard to believe, but it is true that the regulations do not address MSAs. Both the statute and all the regulations promulgated by CMS in support of the statute fail to mention "MSAs" or "Medicare set asides" even once. Since the regulations are what explain a federal administrative agency's official statutory interpretation, it is accurate to say that no substantive legal standard exists today when it comes to MSAs, even in workers' compensation. 42 U.S.C. §§1395hh(a)(1), (2).

Fiction: The Regulations Treat Future Medicals for Commutation Cases the Same as They Treat Compromise Cases

CMS's own regulations treat compromise cases much differently than commutations. As for commutations,

> [i]f 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.

42 C.F.R. §411.46(a).

Commutations are paid (presumably) at 100 cents on the dollar. Thus, this regulation highlights the law that says that Medicare will not pay if payment has been made under a WC plan. 42 U.S.C. §1395y(b)(2)(A)(ii). Again, if an employer or an insurance carrier is paying dollars for future medicals, then Medicare won't pay for those same items, services, or expenses.

CMS treats compromise cases differently. In compromise cases, CMS advises as follows:

> (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.

42 C.F.R. §411.46(d).

We reach a very different result for a compromise claim compared to a commuted claim. Denied workers' compensation claims would be considered compromise claims, no matter who you ask. In those cases, CMS tells us that its basic rule is that CMS pays future medicals, except when an allocation for future medicals exists. When an allocation exists, then the claimant should spend and exhaust it before Medicare will pay. The rules for denied WC claims are different from the rules for accepted WC claims, regardless of whether CMS and its contractor admit it when it is reviewing the $0 MSA proposal for your denied claim.

Fact: Submitting an MSA Is a Voluntary Process

Remembering that the statute and the regulations are both silent about MSAs, we can look to the WCMSA Reference Guide. There, CMS tells us, "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review." CMS, WCMSA Reference Guide §1.0 (ver. 2.6 July 10, 2017).

Fiction: Workload Review Thresholds Provide Safe Harbors

Perhaps the biggest fiction about MSAs in the workers' compensation industry is that CMS workload review thresholds offer safe harbors. While CMS is willing to review certain MSA proposals, it does not have the resources to review everything. Thus, it imposes certain workload review thresholds, based on a claimant's Medicare enrollment status and the gross WC award, which help its contractor determine which cases to review and which not to review.

If a case fails to meet the threshold, it does not mean that the parties can ignore the MSA issue. Medicare specifically counsels otherwise: "These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases." CMS, WCMSA Reference Guide, *supra*, at §8.1. CMS goes on to say, "Regardless of the low dollar threshold, Medicare beneficiaries should always consider Medicare's interest in all WC cases and ensure that Medicare is secondary to WC." *Id.* at §14.0.

The same holds true in the event of a denied WC claim. While Medicare would not be willing to review a $0 MSA proposal in a denied WC claim when the matter fails to meet the threshold, the parties should still ensure that the files are documented appropriately with evidence that Medicare's recovery rights under the MSP Act were never triggered in that case.

Fact: CMS Is Willing to Review a Zero-Dollar MSA Proposal

Not only will CMS review a zero-dollar MSA proposal, CMS provides an example of the letter that you will receive in return if it approves your $0 MSA proposal. *See* CMS, WCMSA Reference Guide, *supra*, at Appendix 5–Sample Letters. You might be interested

to know that this conclusion, just as the conclusion in any other approval letter, is not considered final by Medicare unless or until you provide Medicare with a copy of your final executed WC settlement agreement.

Fiction: It Takes CMS the Same Amount of Time to Review a $0 MSA Proposal as Any Other MSA Proposal

You might have experienced this. You submit a $0 MSA proposal to Medicare, but instead of an approval letter, you receive a development request seeking additional documentation related to medicals or evidence that the employer or the insurance carrier never accepted responsibility for medical expenses. Despite your best efforts, it seems that you're destined either to receive a development request or a close out letter, forcing you to start the process over again. While CMS has a stated goal of reviewing a matter within 45 to 60 days, it seems that $0 MSA proposals take longer, sometimes much longer, to review and to approve.

Fact: Once You've Voluntarily Asked CMS to Review Your $0 MSA, You've Agreed to Play by CMS' Rules

Medicare is clear about its expectation here: "If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures." CMS, WCMSA Reference Guide, *supra*, at §1.0. If you believe that a claim is denied properly under your state law, temper your expectations if you ask CMS to review and approve a $0 MSA proposal in the case. By agreeing to bring CMS into the process and ask for its approval, you have relinquished control of the matter, and your client is subject to the policies and procedures that CMS establishes and changes from time to time.

Remember also that "[w]hen CMS does not believe that a proposed set-aside adequately protects Medicare's interests, and thus makes a determination of a different amount than originally proposed, there is no formal appeals process." CMS, WCMSA Reference Guide, *supra*, at §16.0.

While CMS does have a limited second review process, it only applies in two situations: (1) when you believe that CMS' determination contains obvious mistakes; or (2) when you have additional evidence, not previously considered by CMS, which was dated prior to the submission date of the original proposal. CMS, WCMSA Reference Guide, *supra*, at §16.0.

Recently, CMS announced that it would implement an amended review process. If CMS disagrees with an MSA total and returns a "counter-higher" letter to the submitter of the MSA, there is an opportunity to ask CMS to revisit the matter at a later date. To qualify for this amended review process, the case must meet the following criteria:

- CMS has issued a conditional approval or approved amount at least 12 but no more than 48 months prior;
- The case has not yet settled as of the date of the request for re-review;
- Projected care has changed so much that the submitter's new proposed amount would result in a 10 percent or $10,000 change (whichever is greater) in CMS' previously approved amount; and
- Where a re-review request is reviewed and approved by CMS, the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased.

CMS, WCMSA Reference Guide, *supra*, at §16.0.

This program is in its infancy and no data exists today about its success. However, the thought of having to keep a denied claim open for that long simply to obtain CMS approval is risky and expensive. Thus, make sure that your client is willing to open that door. Once you've asked CMS to review, it's a door that is quite difficult to close if you don't like the response.

Fiction: The MSP Act Always Preempts State Law with Respect to Future Medical Expenses

This one might be surprising, but it's false. There are at least three examples of cases in which the court has concluded that state law dictated Medicare's recovery rights in an MSP situation, not vice versa.

In *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010), the court concluded that Medicare's recovery right was limited to that portion of the award that had been allocated to medical expenses. The allocation was based on a Florida state probate court's allocation of a wrongful death settlement between claims of the survivors and the claims of the estate.

In *Caldera v. The Insurance Company of the State of Pennsylvania*, 716 F.3d 861 (5th Cir. 2013), the court concluded that the MSP Act does not go as far as to eviscerate all state law limitations on workers' compensation payments.

> **We reach** a very different result for a compromise claim compared to a commuted claim. Denied workers' compensation claims would be considered compromise claims, no matter who you ask. In those cases, CMS tells us that its basic rule is that CMS pays future medicals, except when an allocation for future medicals exists.

In *CIGA v. Burwell*, 2017 U.S. Dist. Lexis 1681 (Jan. 5, 2017), the court concluded that state law creates Medicare's recovery rights based on what is compensable versus what is not compensable. The law does not allow Medicare to recover conditional payments for items deemed unrelated to the compensable WC claim, even when bundled together with at least one code that was accepted by the employer or the insurance carrier as compensable. This case calls into serious question CMS' recovery practices under the MSP Act.

More examples exist. The moral here is that Medicare's recovery rights and the need to take certain actions with respect to MSAs originate from your state law granting property rights to par-

ties in the first place, based on issues of compensability.

Fact: Medicare Is Not a Party to the Claim; It's the Most Important Potential "Lienholder" to Consider When Resolving the Claim

Some think that Medicare must approve an MSA to validate a workers' compensation settlement. Medicare is not a party to the settlement. The parties to the settlement are the injured worker, the employer, and (perhaps) its insurance carrier or third-party administrator. Medicare does not have the power to accept an offer on behalf of the claimant. Medicare does not have the power to extend an offer to settle on behalf of the employer or the insurance carrier. Medicare is not a party to your WC settlement.

Likewise, Medicare does not have the authority to approve a settlement once struck. That is the job of the workers' compensation industrial commission or board in your state. Asking Medicare to review your MSA proposal is a voluntary step in Medicare's eyes, and you should also consider it to be voluntary. If your state industrial board or commission mistakenly believes that it is required to submit MSAs to CMS for review and approval or makes that a condition of its approval, it falls on you to educate members why that is not so. 2018 is the right time to consider alternate forms of "considering and protecting" Medicare's interests, including legal opinions, which can provide the same protection as a CMS-reviewed and approved MSA.

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The MSP Act is in place to help ensure that the Medicare program will be around long term. MSAs are created to comply with the law enacted to ensure the longevity of the Medicare program. But it does not follow that Medicare has a right to an MSA in every settlement. And with denied WC claims, a denial really means that Medicare never has a right to an MSA.

Fiction: MSA Vendors Who Only Review Medical Records When Calculating MSAs Provide Accurate, Legally Compliant Conclusions

You've likely had a report similar to this. Claim has been denied in full. No medicals or indemnity has been paid. The employer or insurance carrier hires one of its approval MSA panel members to calculate an MSA. In its report, the vendor, which is not a law firm or lawyer, concludes that an MSA of $X is needed since the claimant is expected to incur future medical expenses. What these vendors might not realize is that future medicals under the MSP Act are a legal obligation, not a medical obligation, to address.

This is where most similar MSA vendors fall short. Their teams of nurses are charged with reviewing medicals and calculating an MSA. The report that results is less that of an MSA and more along the lines of a medical cost projection. This report, when it involves a denied WC claim, bears no relation to the actual legal position taken by the employer or the insurance carrier. As discussed above, MSAs for those cases should never be funded since Medicare's right of recovery never ripens under the law.

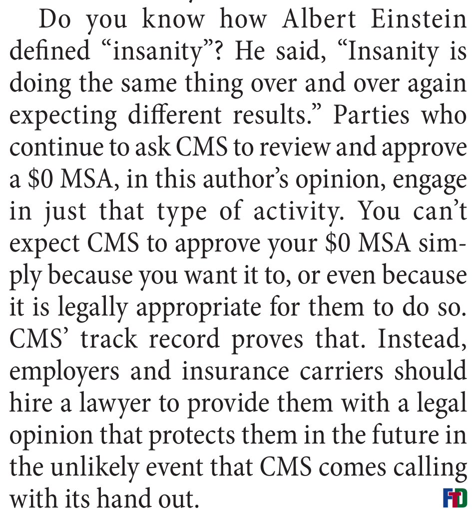
But understand that those same MSA vendors may not be able to arrive at that legal conclusion because they have medicine-related qualifications alone. Citing and relying on the law in its MSA report comes dangerously close to the line for such medically trained vendors when it comes to the unauthorized practice of law. These MSA vendors cannot issue legal opinions on MSA issues. They can issue reports based on their experience and knowledge of MSA issues involving CMS, but they cannot provide those as a legal opinion, unless the vendor is also a law firm that practices law. This might explain why those MSA reports say that the proper MSA figure is $X when everyone working on the file in your firm knows that they should have nothing allocated to them since the WC claim was denied.

Fact: Obtaining a Legal Opinion from a Lawyer Experienced with the MSP Act in the Suitable Cases Offer the Same Protection as CMS-Approved MSAs

Wouldn't it be great if we knew with certainty that CMS would agree with our $0 MSA proposal at first glance? That would alleviate a lot (but not all) of the frustration with the current system. Unfortunately, we never know that up front. In fact, as soon as you voluntarily ask CMS to review an MSA, you have lost all control of the case. Chances are good that you will receive in return either a development letter asking for more information supporting your assertion that a $0 MSA is appropriate, or you will receive a counter-higher letter. Neither result is good for the file. Now, how many times has that happened to you over the past 12–24 months?

Instead of playing CMS' workers' compensation MSA review game, you can choose not to play. As a lawyer, you can draft and provide your client with a legal opinion that provides the same protection as CMS approval of the MSA. If that option is not appealing, you can seek a legal opinion instead from a lawyer who has more experience with MSA issues. A legal opinion provides all the same benefits that you get from CMS approving the workers' compensation MSA: the ability to close the file with confidence and complete risk transfer on the future medical issue, among other things. And you can do this without involving the federal government. An added benefit of working with a lawyer here for an employer or an insurance carrier is that they establish an attorney–client relationship. That alone opens the door to other benefits such as privilege that simply cannot be had when the client works with as MSA vendor that does not have legal training on these issues.

If you had the choice, would you voluntarily ask the federal government to audit your tax return for accuracy? I didn't think so. Workers' compensation MSAs are the same. If you are an employer or an insurance carrier, why ask the federal government to audit your conclusion for accuracy when perfectly valid alternatives exist and you can avoid federal scrutiny while passing all risk of the MSA issue to the law firm providing the legal opinion? It just doesn't make sense today.



Do you know how Albert Einstein defined "insanity"? He said, "Insanity is doing the same thing over and over again expecting different results." Parties who continue to ask CMS to review and approve a $0 MSA, in this author's opinion, engage in just that type of activity. You can't expect CMS to approve your $0 MSA simply because you want it to, or even because it is legally appropriate for them to do so. CMS' track record proves that. Instead, employers and insurance carriers should hire a lawyer to provide them with a legal opinion that protects them in the future in the unlikely event that CMS comes calling with its hand out.