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COMMONWEALTH of VIRGINIA

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January 3, 2017

Re: Reasonable Consideration of Medicare's Interests

Thank you for your recent inquiry regarding the Virginia Workers' Compensation Commission's policy regarding MSA's that meet CMS thresholds for review. Because [redacted] is not a party to the case referenced in your letter, I am only going to address the Commission's general policy regarding such settlements.

I have reviewed your e-mails, the May 11, 2011 Memorandum from CMS, as well as subsequent reference guides which have been issued by CMS, which state that there "are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review." The Commission's understanding is that there has never been any statutory provision requiring that an MSA be submitted to CMS for review. In its July 11, 2005, Memorandum, CMS states that the review thresholds "are only CMS workload review thresholds." In this same memorandum, CMS acknowledges that parties may proceed with a settlement before a proposed MSA is reviewed and an amount is determined by CMS to adequately protect Medicare's interests. However, CMS advises that "any statement in the settlement of the amount needed to fund the WCMSA is not binding upon CMS unless/until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount as specified by CMS that adequately protects Medicare's interests as a result of the review." This memorandum further advises that if CMS does not subsequently provide approval of the proposed MSA "as specified in the settlement and proof not provided to CMS that the CMS-approved amount has been fully funded, CMS may deny payment for services related to the WC claim up to the full amount of the settlement. Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA." (Emphasis added.) CMS reiterates that the claimant

"may be at risk if the WCMSA is funded for less than the amount that CMS determines to be adequate to protect Medicare's interests."

The penalty for failure to obtain CMS approval is potentially harsh. For this reason, the Commission has always required CMS approval in situations where the approval thresholds are met. I am aware that the MSA is based upon a professionally prepared estimate. Unfortunately, it has been our experience that CMS does not always follow such proposals and at times will increase the required set-aside by significant amounts.

When approving proposed settlement, the Commission must find that the settlement is clearly in the employee's best interest as required by § 65.2-701. In order to make such a determination in a case where the settlement amount meets the CMS thresholds for review, the Commission requires one of the following:

1. The Petition and Order must include the amount being set aside in a Medicare Set-Aside Account (MSA) and the parties should file the CMS Letter approving the amount of the set-aside.

2. The Petition and Order should include the amount being set aside in a MSA and a statement that the parties are submitting this proposed amount to CMS for approval and that the defendants will be responsible for any additional amounts required by CMS for the MSA.

3. In appropriate cases, we might allow indemnification in place of CMS approval. We would require a professionally prepared MSA proposal, based upon reasonable and supportable assumptions as to future treatment, and the following agreement:

1. Claimant agrees to be fully compliant with all MSA administration requirements as outlined by CMS. Attached are the current requirements from CMS entitled, ADMINISTERING YOUR STRUCTURED WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT (NCEASA). The Claimant acknowledges, understands and agrees that either the lump sum or the initial seed money for the MSA and all subsequent MSA annuity payments received must be placed into a self-administered, interest-bearing account and exhausted specifically for Medicare covered medical expenses related to the specific work-injury conditions itemized above before any future injury-related claims are submitted to Medicare.

2. Although the parties have taken steps to avoid shifting the responsibility for payment of future medical expenses to Medicare, if this MSA should be found by CMS to be an attempt to shift the responsibility for payment of medical expenses to Medicare due to an MSA insufficiency, and medical coverage is being denied to the claimant on that basis, Carrier will resolve the issue with CMS, and agree to provide payment for Medicare covered services pertaining to the work-injury conditions until CMS agrees to assume primary payer status for Claimant's work-injury related medical care. The carrier will hold the claimant and claimant's attorney harmless from an action brought by or on behalf of CMS due to an MSA insufficiency. Carrier will not accept any liability to the

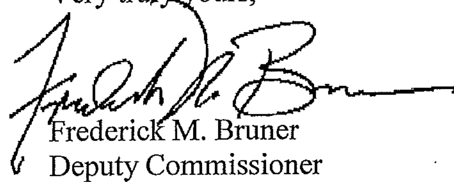
extent that the MSA was not properly administered by the claimant or agent. This agreement does not cover denial of any medical services where Medicare recognizes primary payer status and has denied coverage as part of its normal medical claims handling practices.

3. The Claimant, Employer and Carrier agree that should any dispute arise regarding Carrier's agreement to indemnify the claimant from CMS actions as noted herein, the parties consent to the jurisdiction of the Virginia Workers' Compensation Commission.

Note: The above language must be used and we will not accept any deviations of this language.

At this time, the Commission will not accept any alternatives to the above options.

Very truly yours,



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Deputy Commissioner

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