WORKERS' COMPENSATION CLAIMS AND MSA PITFALLS WE ALL NEED TO AVOID

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By now all workers' compensation practitioners should understand when an issue of the necessity of a Medicare Set Aside (MSA) is raised in a workers' compensation case and must be addressed. The penalties for failure to adequately consider Medicare's interests as required by federal law may be severe and have already resulted in lawsuits being filed. The Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)(2), and the regulations implementing it, 42 C.F.R. §411.20 et. seq., mandate that Medicare's interests must be taken into consideration. The Federal government is aggressively enforcing the requirements as they relate to workers' compensation settlements, through the Centers for Medicare and Medicaid Services (CMS).

In United States of America v. Stricker, et.al., CMS and the Secretary of Health and Human Services filed suit seeking reimbursement for conditional payments made by Medicare against various parties, including individual plaintiffs' attorneys and law firms. This suit arose out of a liability claim, not a workers' compensation claim, however, the Medicare Secondary Payer Act provides similar remedies to the United States to recover from a primary payer, whether a liability insurer or a workers' compensation insurer. Stricker arose out of consolidated lawsuits alleging injuries related to production of PCBs in the Anniston, Alabama area. A global settlement agreement was reached in the amount of $300,000,000. Of this amount, approximately $171,000,000 was payable to the plaintiffs and $129,000,000 to the various plaintiffs' attorneys involved in the complex litigation. CMS brought suit against: the underlying defendants; their insurers; and *individual attorneys* and law firms representing the plaintiffs. The attorneys and their firms were named pursuant to 42 U.S.C. § 1395y(b)(2)(B)(iii) which gives the United States a right of action against "any entity" that "has received payment from a primary plan." "Any entity" is in turn defined in the C.F.R. to include an attorney. 42 C.F.R. § 411.24(h). The United States alleged that 907 of the plaintiffs in the underlying lawsuits were Medicare beneficiaries on whose behalf Medicare had made payment for treatment for injuries or illness. See, United States of America v. Stricker et.al., CAF # CV-09-PT-2423-E (USDC Northern District of Alabama, Eastern Division, filed December 1, 2009).

A prior lawsuit, United States of America v. Harris, 2009 U.S. Dist. LEXIS 23956 (USDC Northern District of West Virginia, CAF # 5:08CV102) sought reimbursement from plaintiff's attorney, individually. In Harris, the evidence showed that the plaintiff and his attorney settled a products liability case resulting from a fall from a ladder for $25,000.00. The plaintiff was a Medicare beneficiary and Medicare paid $22,549.67 in benefits. Medicare sought reimbursement from the settlement funds in the total amount of $10,253.59 and notified plaintiff's attorney. Nevertheless, the plaintiff and his attorney failed to either pay the reimbursement or to follow the CMS administrative

appeals process. The United States brought suit against Harris, individually, and the district court granted summary judgment for the United States on March 26, 2009.

To avoid the pitfalls of settlement without taking into account Medicare's interests, first check eligibility status of the claimant. This is essential and many insurers are now requiring execution of Medicare releases, such as the Form 3288, that will allow the insurer to independently verify (through a vendor or directly with Social Security) the claimant's Medicare status. The claimant also has the ability to go to his local Social Security office and obtain a statement, on Social Security letterhead, confirming his Medicare status. This provides protection to both the insurer as well as the claimant and claimant's counsel. Attorneys and parties should cooperate with such requests and provide such releases, that is, if they want to settle their claims. Any required releases and confirmation of Medicare eligibility status will ideally be obtained and completed before mediation or final agreement on a settlement amount.

If the claimant is enrolled in Medicare (Class I) then Medicare's interests must be considered in all cases and an MSA must be prepared and approved by CMS if the total settlement amount is over $25,000.00. If the claimant has a reasonable expectation of enrollment in Medicare within 30 months of the settlement (Class II) then Medicare's interests must also be considered, and an MSA prepared and approved by CMS if the total settlement amount is over $250,000.00. CMS has made it crystal clear that the review threshold amounts do not constitute safe harbors and instead are merely based on CMS workload levels and the reality that CMS does not have the resources to review every settlement. Medicare's interests must still be taken into account in every settlement where the claimant is a Medicare beneficiary or has a reasonable expectation of becoming Medicare eligible within 30 months, regardless of whether CMS approval is required. The normal method of doing this is to prepare a MSA, or a so-called Claim Settlement Allocation (CSA) which will be included as part of the settlement but will not be submitted to CMS for approval.

CMS provides guidelines for when and how its interests must be taken into consideration, including definitions of "reasonable expectation". This information can be obtained electronically or manually. CMS maintains a website and an overview of its policies with links to policy memorandums issued from July 23, 2001, through May 2008 can be found at: http://www.cms.hhs.gov./WorkersCompAgencyServices/ .(Link current as of January 28, 2010) All workers' compensation practitioners should review each policy memorandum and regularly visit this site for the latest in CMS updates. These policy memoranda determine what information CMS will require and how they will analyze your effort to "take into consideration Medicare's interests."

Visit the CMS site to get the current memorandum on when a Medicare Set Aside (MSA) will be required, when an MSA will be reviewed by CMS, what must be included in a MSA, and other issues of relevance to settlement of a workers' compensation claim. These policy memorandums, which essentially clarify and implement the C.F.R. (which in turn implements the statute) are our guidelines until the courts decide specific issues of compliance.

Determining who is currently eligible for Medicare is a fairly straightforward process and any questions concerning status can be resolved through the use of a properly completed SSA Form 3288 or similar release. "Reasonable expectation" is more complex. A claimant may have a reasonable expectation of eligibility within 30 months based on age (if a claimant is at least 62.5 years old – Medicare eligibility begins at age 65) or he may have a reasonable expectation of eligibility based on a disability which qualifies for Social Security Disability Insurance (SSDI). Medicare eligibility begins after a beneficiary has received SSDI for 24 months. Social Security benefits begin 6 months after the date of disability for SSDI, so a claimant has a reasonable expectation of being Medicare eligible 30 months from his date of disability for SSDI.

If a claimant is already enrolled in Medicare, there may be an issue of conditional payments. These are payments already made by Medicare for past medical treatment, for which Medicare is entitled to reimbursement. Any claim for repayment of conditional payments must be addressed and resolved.

The manner in which the interests of Medicare in <u>future</u> medical payments are considered has traditionally been by obtaining a Medicare Set Aside. This MSA may be self administered or professionally administered.

The MSA is a document that is based on past medical history, diagnoses codes, and standards of care among other things. A huge consideration is the future prescription drug treatment. This projection often results in exorbitant MSA projections, sometimes rendering settlement impractical. CMS currently requires lifetime allocations for the full panoply of prescriptions that a claimant is receiving from his or her pain management provider. The opinion of the authorized treating physician(s) is needed ON HIS OR HER LETTERHEAD to address the future treatment, and attempt to obtain CMS approval of tapering of future medications. A pre-prepared questionnaire is not acceptable to CMS nor is an affidavit from the claimant that he or she will not now or ever have a procedure sufficient. An IME or peer review opinion indicating future tapering of prescription medications is not typically accepted by CMS, but, again, the authorized treating physician's written opinion on letterhead may be accepted by CMS and may be utilized to obtain significant reductions in the future prescription set aside. A meeting between counsel for both parties and the authorized treating physician may be very useful in explaining the MSA process to the physician and obtaining an accurate opinion from the treating physician regarding future medical needs for the MSA. Although the physician may typically charge $500 to $1,000 for his time in such a meeting, this could be the best money you ever spend on your case if it results in the physician preparing an accurate and thoughtful opinion regarding future medical needs that saves you tens or even hundreds of thousands of dollars on the MSA.

Once the MSA is obtained there are numerous issues that may arise such as: 1) how will the MSA be funded- lump sum or annuity?; 2) will the MSA be self or professionally administered?; 3) will the Stipulated Settlement be submitted to the State Board of Workres' Compensation before or after CMS approval of the MSA allocation?;

4) will the Stipulation be held and therefore either party can "back out" of the settlement?; 5) how will the carrier deal with an increase requested by CMS?; 6) if CMS determines the MSA is too high, how will the carrier collect the overpayment?; 7) when is the seed money to be paid and how does the carrier collect an overpayment, if any?; 8) is SITF involved and are SITF MSA requirements being met?

These and other questions can and must be successfully addressed. To do so requires an understanding of CMS requirements by the parties and the drafting of documentation that addresses these issues. Communication and cooperation between the parties and their attorneys is essential in order to successfully complete such a settlement. Careful analysis of the need and desire for settlement leads to careful analysis of the answers to the issues raised above. If you have any questions for which I can offer assistance please feel free to contact me. Rryan@mcdr-law.com.