

The Journal of
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Medicare Set-Asides

- ▲ Overview of the Medicare Set-Aside
- ▲ The Workers' Compensation System: Origins & Overview
- ▲ The Workers' Compensation Medicare Set-Aside Arrangement
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- ▲ Online Resources for MSAs and Workers' Compensation Law
- ▲ Malpractice Insurance for the LNC



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LEGAL NURSE CONSULTING

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Lori Hinton, DrPH APN RN CLCP MSCC & Mark Popolizio, Esq.

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Mark Popolizio, Esq.

This article focuses on the Medicare Secondary Payer Statute and the obligations of primary payers and other parties for repayment of what are referred to as Medicare conditional payments. To obtain a better perspective of this topic, it may be helpful to take a step back to understand how consideration of Medicare conditional payments differs from the parties' obligations regarding MSAs.

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The Torch Is Passed



I am truly honored to be appointed Editor of *The Journal of Legal Nurse Consulting* for the ensuing term. I believe *The Journal* is an invaluable tool for LNCs and an exceptional resource for practicing attorneys. I would be less than honest to say I am not somewhat in awe of the list of distinguished Editors who preceded my appointment. Their legacy is an undeniable highly regarded publication and sets the bar at a well-placed high. My greatest tribute to them is to maintain this standard. My heartfelt thanks to the members of the JLNC Editorial Board for their time and talent – their expertise and support of *The Journal's* tremendous Editorial Board makes this task, at least, less daunting.

My sincere appreciation and thanks to the authors of this issue who have generously provided a wealth of information on a very timely topic. The issue of protecting Medicare's interests is rapidly permeating all fields of legal representation (worker's compensation, domestic, elder law, and more). Here, the authors have provided an excellent introduction and coverage of the concepts involved in Medicare Set-Asides and Worker's Compensation. My thanks to Barbara Boschert from the St. Louis Chapter for the Q&A on the issue of malpractice insurance.

In this and future issues, I encourage you to hone your critical thinking skills in looking beyond what we have provided here. What questions do these articles provoke? What is the future of MSA and personal injury claims? Why is the interest generated in a MSA account automatically subject to Medicare expenditures only? What is the process used by CMS in choosing contractors to administrate programs? The ability to critically analyze from a third dimension perspective is just one of the defining parameters of the exceptional LNC.

The Journal belongs, first and foremost, to the readers. With this in mind, I would invite you to share your knowledge. Through your submissions, *The Journal* is able to expand knowledge and provide a network of informational resources. I extend an open invitation to submit your topic. Everyone who has ever written for *The Journal* had to take the step of submitting that first article.

One of the items we will be including in each issue of *The Journal* is a table of online references and resources for potential sources of authoritative sites and standards of care. In keeping with this issue's theme, I have assembled a table of online resources for worker's compensation laws of the fifty states and the District of Columbia. I have also included a table of online resources with reference to Medicare Set Aside Arrangements. Once again, this is an area where you may wish to contribute your resources.

I look forward to sharing each issue with you.

KARA DiCECCO, MSN, RN, LNCC

Kara DiCecco, MSN RN LNCC
Editor, *The Journal of Legal Nurse Consulting*

Overview of the Medicare Set-Aside

Mark Popolizio, Esq.

KEY WORDS

Medicare, Medicare Set-Aside, MSA

One of the more significant changes to hit the workers' compensation scene in recent years has been the Medicare Set-Aside (MSA). Without a doubt, the MSA has introduced added complexity and challenge to claims handling and settlement. This is the first in a series of articles designed to provide an introductory understanding of this important and complex topic to aid all parties involved in a workers' compensation case better assist their clients, more accurately evaluate claims, and, most importantly, assure that Medicare's interests have been adequately considered and protected. This article provides a brief overview of the Medicare program, explores the origins of the MSA, and outlines pertinent legal considerations under the Medicare Secondary Payer Statute. The scope of this article concentrates on laying the groundwork to protecting Medicare's "future" interests through MSA arrangement. The issue of reimbursing Medicare conditional payments (payments made by Medicare for treatment of accident related injuries) must also be considered. The issue of conditional payments will be addressed in a subsequent article.

Medicare is a federal health insurance program created by Congress in 1965 for individuals 65 years old or older. In 1972, the program was expanded to cover certain individuals younger than age 65 with certain disabilities and people of all ages with End Stage Renal Disease (ESRD). Medicare now covers approximately 43 million individuals. The program is divided into four parts (Parts A-D).

Medicare Part A covers inpatient hospital, skilled nursing facility home health, and hospice care, subject to certain limitations. Part A is funded primarily through payroll taxes paid by employers and workers. In general, if an individual has made payroll contributions for at least 40 quarters, he or she will be entitled to premium-free Part A. Individuals who do not qualify for premium-free Part A can purchase this coverage. The premium cost depends on the number of quarters an individual made payroll contributions. In 2007, the premium for an individual who made payroll contributions for 30 to 39 quarters is \$226 per month. The premium is \$410 per month for those who made payroll contributions for less than 30 quarters. Part A has certain cost-sharing provisions, consisting of deductibles and co-pays based on defined "benefit periods" over the course of a year.

Medicare Part B covers a host of outpatient and home health services. Subject to certain limitations and exclusions, Part B covers such services as office visits, diagnostic studies, supplies, and durable medical equipment. Part B also has cost-sharing provisions. In 2007, the yearly deductible is \$131. In addition, each beneficiary pays a monthly premium. Beginning in 2007, the premium amount is based on income depending on tax filing. For example, the monthly premium for single individual with an income of \$80,000 or less or a married couple filing jointly with an income of \$160,000 or less is \$93.50. The monthly premium amount then increases based on income level. The top premium amount is \$161.40 for single individuals earning above \$200,000 or married individuals filing jointly with an income over \$200,000.

Medicare Part C is comprised of the "Medicare Advantage Program." Part C was created by Congress in 1997

to offer beneficiaries an alternative to traditional Part A and Part B. Medicare Advantage Plans (MA plans) offer services through a variety of different arrangements such as HMOs, PPOs and private fee-for-services plans. MA plans provide services as contained under traditional Part A and Part B and often offer additional coverage options and services.

Medicare Part D is Medicare's new prescription drug program that began in January 2006. Part D is funded through several sources, including general revenues, state contributions, and beneficiary premiums. The program is provided through private companies under contract with Medicare. Part D is available for beneficiaries with Medicare coverage through traditional Part A and Part B or through Medicare Advantage. There are numerous plans that vary in terms of coverage and price. In general, the average Part D monthly premium for 2007 is estimated at \$27.35. The maximum yearly deductible for 2007 is \$265. In addition to the premium and deductible, the standard Part D plan has co-pay provisions. In 2007, after payment of the deductible, under the standard Part D plan, the beneficiary is responsible for 25% of yearly prescription costs between \$265 and \$2,400, and Medicare pays 75%. The beneficiary is responsible for 100% of yearly drug costs from \$2,400 to \$5,451.25. This is known as the "doughnut hole." Once a beneficiary's yearly prescription costs exceed \$5,451.25, the beneficiary's responsibility is only 5%, while Medicare picks up 95% of the costs (*Medicare Fact Sheet*, November 2006; *Medicare & You*, 2007, p. 43-56). Again, it must be noted that the above premium, deductible, and co-pay provisions can vary greatly depending on the exact Part D program. A comprehensive outline of Part D coverage and a state-by-state breakdown of available Part D programs can be found at www.Medicare.gov.

The federal agency responsible for administering the Medicare program is the Centers for Medicare and Medicaid Services (CMS). CMS has 10 regional offices throughout the country: Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco, and Seattle.

Origins of the MSA: Protecting Medicare's Future Interests

The origins of the MSA take us back 25 years. In 1980, Congress passed the Medicare Secondary Payer Statute (MSP) codified at 42 U.S.C. § 1395y, et. seq., in an effort to control the increasing costs of Medicare. Section 1395y (b)(2)(A) states that Medicare will not pay for items and services for which payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance. Under the MSP, other forms of insurance coverage are considered "primary." The basic purpose of the MSP is to assure that primary payers, and not Medicare, assume responsibility for medical treatment pertaining to accident-related injuries. The MSP is designed to prevent a responsible third party from "shifting" the burden of an individual's medical care to Medicare.

In addition, the Federal Code of Regulations (CFR) contains specific provisions related to Medicare and workers' compensation found at 42 C.F.R. § 411.40, et. seq. The regulation with particular applicability in the worker' compensation context is 42 C.F.R. § 411.46(a), which states: "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."

While the above provision was on the books for about 20 years, it was not until the late 1990s that the Federal government began to more aggressively assert Medicare's rights to assure that primary payers assumed responsibility for injury claims and that Medicare's future interests were adequately protected in workers' compensation settlements. The end result was CMS' establishment of the modern-day MSA. Over the past 5 years, CMS has issued a series of policy memoranda defining the basic MSA framework, establishing certain review thresholds, and addressing other collateral requirements, such as funding and administration of the MSA account. The dates of these memoranda are July 23, 2001; April 21, 2003; May 23, 2003; September 26, 2003; October 15, 2004; July 11, 2005; December 30, 2005; April 25, 2006; and July 24, 2006. It is strongly recommended that each of these be read in their entirety and in conjunction with each other because CMS has modified and, in some instances, replaced previously stated requirements and policies. For example, the CMS memorandum of April 25, 2006, revised the low dollar threshold requirement initially announced in the July 11, 2005, memorandum. In its July 24, 2006, memorandum, CMS clarified several aspects relating to prescription drugs as initially outlined on December 30, 2005, and indicated that the July memo actually "supercedes" the directives outlined in the December memo.

On a basic level, the MSA can be defined as the arrangement recommended by CMS through which the parties in a workers' compensation settlement set aside a sum of money from that settlement to cover future anticipated medical expenses related to a claimant's compensable injuries that would otherwise be covered under Medicare. The purpose of the MSA is to protect Medicare's future interests by preventing the responsible primary payer from shifting the burden of future medical care to the Federal government.

The scope of this article is limited to considerations of MSAs in the context of workers' compensation settlements. To date, the author is not aware of any memoranda or other written directive from CMS regarding the applicability of MSAs in non-workers' compensation cases. Furthermore, whether MSAs are required outside of workers' compensation (e.g. tort claims) under the Medicare Secondary Payer Statute or Code of Federal Regulations is currently a source of debate and outside the scope of this article.

MSA Threshold Issues

Commutation v. Compromise Settlements: The initial screening test in determining whether a MSA could be required involves the "type" of settlement at issue. CMS views workers' compensation settlements in terms of *commutation* or *compromise* settlements (CMS memorandum, July 23, 2001). A "commutation settlement" compensates workers for *future* medical expenses related to the work injury. In contrast, a "compromise settlement" compensates only *current* or *past* medical expenses. MSAs are only required in settlements possessing a commutation aspect.

It is important to note that admission of liability is not the sole determining factor of whether or not a settlement is considered a compromise or commutation. CMS looks to the agreement to determine if the settlement intends to provide compensation for future medicals, improperly attempts to maximize other aspects of the settlement to Medicare's detriment, or otherwise improperly attempts to shift the burden of the claimant's medical care to Medicare. If the settlement possesses a commutation aspect, the parties then need to determine whether inclusion of a MSA is required. If the proposed settlement intends to compensate an individual for future medical expenses, Medicare's interests will need to be considered and inclusion of a MSA may be applicable. Medicare's interests must also be considered in denied claims, as they may also qualify for review by CMS if they meet the agency's current review thresholds as outlined in the next section. Furthermore, CMS may require the inclusion of an MSA in settlements of denied claims.

CMS Review Thresholds ("MSA Threshold Cases"): CMS has established specific review thresholds, defining when the parties to a workers' compensation case must submit a MSA allocation proposal to CMS for its review and approval in conjunction with a proposed settlement. Under the current review thresholds, a "CMS-approved MSA" is required if 1) the claimant is a Medicare beneficiary at the time of settlement and the total settlement amount is greater than

\$25,000 or 2) the claimant has a “reasonable expectation” of Medicare enrollment within 30 months of the settlement date and the total settlement is greater than \$250,000 (CMS Memoranda July 23, 2001; April 22, 2003, July 11, 2005; December 30, 2005; and April 25, 2006). Please note that CMS has reserved the right to adjust, modify, or even eliminate the review thresholds.

Two components warranting particular attention are computation of the “total settlement amount” and the definition of “reasonable expectation” of Medicare enrollment. In its April 25, 2006, memorandum, CMS stated: “Total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement” (CMS Memorandum, April 25, 2006).

CMS takes a liberal view of “reasonable expectation” stating that this concept includes, but is not limited to, situations where the claimant has “applied” for SSD, has been denied SSD, but “anticipates” appealing the decision or re-filing for SSD, is 62 years and 6 months old (in this case the claimant would be eligible for Medicare within 30 months based on age), or has end stage renal disease but does not yet qualify for Medicare based upon ESRD (CMS Memorandum, April 22, 2003).

Non-Threshold Cases (Non-Threshold MSAs): CMS has stated that the review thresholds outlined above are considered agency “workload review” thresholds and should not be viewed as the only instances when their interests may need to be considered. CMS has consistently taken the position that Medicare’s interests must always be considered. CMS’ July 11, 2005, memorandum illustrates the point: “The thresholds for review of a WCMSA proposal are only **workload review** thresholds, not substantive dollar or ‘safe harbor’ thresholds for complying with the Medicare Secondary Payer law. Under [the MSP], Medicare is always secondary to workers’ compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare’s interest when settling any workers’ compensation case; even if review thresholds are not met, Medicare’s interest must always be considered” (CMS Memorandum, July 11, 2005).

The applicability of “non-threshold” MSAs has been an area of considerable questioning and debate from the inception of the MSA. In part, this stemmed from what many considered the ambiguous nature of CMS’ initial policy memoranda and general questions of applicability under the Federal Code of Regulations. Despite the uncertainties, many in the industry included “non-threshold” MSAs as part of their settlements in certain contexts prior to CMS’ July 11, 2005, memo. The July memo was viewed by many as providing clarification on this issue to some degree, and,

accordingly, the inclusion of “non-threshold” MSAs has become more widely accepted.

Determining exactly when a non-threshold MSA should be included involves consideration of many factors. The crux of the problem involves the lack of defined parameters. Unlike the MSA “review thresholds” established by CMS, there are no “neat” guidelines or categories defining non-threshold MSAs. In this regard, most in the industry are of the position that inclusion of a MSA is not necessary in every non-threshold case. However, inclusion of non-threshold MSAs in certain contexts where the individual is already on Medicare or will, or may, become a Medicare beneficiary shortly after the settlement has been widely recognized.

For example, inclusion of a non-threshold MSA in a case where the claimant is on Medicare at the time of settlement but where the settlement is \$25,000 or less would appear to be appropriate per CMS’ July 11, 2005, and April 25, 2001, memos. Other examples may include, but may not be necessarily limited to, settlements involving a claimant who is not Medicare eligible at the time of settlement but will become so shortly after the settlement either based on age (e.g., the claimant is 64 years old at the time of settlement) or in conjunction with an award of social security disability benefits (e.g. cases where an individual’s Medicare will commence at a defined point after his or her social security disability benefits commence). In addition, insurance carriers, employers or third party administrators may have internal protocols establishing when a non-threshold MSA should be considered or included. Formal approval of the MSA is not required in the context of non-threshold cases.

Consequences for Failure to Consider Medicare’s Interests: Failure to include a MSA when required, or failing to fund the MSA in the amount required by CMS, could have significant consequences. For example, under 42 C.F.R. § 411.46(b)(2), Medicare has the power to disregard the settlement and deny treatment for accident related injuries if it “appears” that the settlement unreasonably shifts payment of the claimant’s future medical expenses to Medicare. Medicare could deny payment of services for related injuries up to the full amount of the settlement (CMS Memorandum, July 11, 2005). Under 42 C.F.R. § 411.47, Medicare could apportion the lump sum between indemnity and medicals. Furthermore, CMS has a direct priority right of recovery against any entity, including a “beneficiary, provider, supplier, physician, state agency, or private insurer that has received any portion of a third payment directly or indirectly,” and a right of subrogation (CMS Memorandum, April 22, 2003; 42 C.F.R. § 411.24(b), (e) and (g) and 42 C.F.R. § 411.26).

Conclusion

Under the MSP, Medicare’s interests must be adequately protected in workers’ compensation settlements. The above provides a general background regarding key aspects of the Medicare program and outlines the issues and thresholds involved in determining the applicability of the MSA. Once it is determined that a MSA is required, the focus

turns to preparing an actual MSA allocation. Preparation of the actual MSA allocation is an involved process requiring consideration of various medical and legal issues and requires the expertise and experience of different professionals. With the general MSA backdrop set, the forthcoming articles will now examine the actual MSA allocation process in greater detail from a practical perspective.

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Mark Popolizio, Esquire, is a Senior Account Executive for NuQuest/Bridge Pointe, providing in-house carrier training and presentations regarding Medicare compliance and addressing pertinent legal and related matters relative to the MSA submission process. Prior to joining NuQuest, he practiced law for approximately 10 years in the areas of workers’ compensation defense and insurance defense litigation. He developed a national Medicare practice that included Medicare Set-Asides and general compliance with the Medicare Secondary Payer Statute. He also served as Medicare counsel for a national TPA. While in private practice, Popolizio represented numerous carriers, third party administrators, and self-insureds. In addition to his workers’ compensation and Medicare practices, he served as the Executive Director of the Negotiated Workers’ Compensation Insurance Program (NWCIP), an alternative dispute resolution system under the Florida workers’ compensation act. He is the Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP) and a regularly featured instructor on Medicare and Life Care Planning issues with the Medipro Seminars, LLC. Over the past few years, Popolizio has been a featured presenter at seminars and other industry events across the country, delivering presentations on Medicare Basics, Medicare Set-Asides, and Medicare Part D (prescription drugs).

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The Workers' Compensation System: Historical Origins & Basic Overview

Mark Popolizio, Esq.

KEY WORDS

Medicare, Medicare Set-Aside, MSA, Workers' Compensation

This is the second article in a series regarding Medicare Set-Asides (MSA) in the context of workers' compensation claims. Calculating the proposed MSA figure is at the core of the overall MSA process. This component of the MSA is typically prepared by a medical professional who possesses the requisite training and practical experience to formulate the MSA allocation amount. Before exploring the "nuts and bolts" of putting together an actual MSA arrangement, however, it is necessary to take a step back to obtain a better understanding of how the workers' compensation system operates and how particular components of the system impact the MSA. The purpose of this article is to provide a basic understanding of the workers' compensation system from a historical and practical perspective.

Workers' Compensation: A Historical Perspective

The development of the modern workers' compensation system in the United States dates back to the early 1900s. According to Clayton (2003/2004), the origins of workers' compensation in the United States are widely credited to the establishment of such laws in Germany and England in the 1880s and 1890s. In 1884, Germany enacted the first modern workers' compensation system of "Sick and Accident Laws," while England enacted a similar law in 1897.

The enactment of the first workers' compensation laws in the United States occurred in 1910. Prior to specific workers' compensation laws, an injured worker had to sue his or her employer for medical expenses, lost wages, and other benefits in a formal civil action. In this setting, the worker had to prove that the employer was negligent in some manner. Establishing employer negligence proved difficult in most settings for a variety of reasons including the availability of several defenses for the employers that either limited a worker's recovery or prevented any recovery at all.

It is significant to note that, under some defenses, an injured worker's ability to recover damages was significantly limited or completely barred if it was found that his or her actions contributed even in the slightest way to the accident. Accordingly, it was often difficult for the worker to prove employer negligence. One study estimated that only about 17% of work accidents were due to fault of the employer (Clayton, 2003/2004). Another study concerning fatal accidents found that only about half of the families of victims of these accidents received some type of payments, with the average payment being only equal to about one year's income (Clayton, 2003/2004).

Prior to the enactment of workers' compensation laws, an injured worker faced a time-consuming, expensive, and unpredictable process in the attempt to obtain medical and lost wage benefits in conjunction with his or her work injury. Despite enjoying several defenses at law that often helped them prevail, employers still faced substantial monetary damages

if found liable. This created an element of unpredictability for employers that could potentially have severe business consequences. Moreover, employers had to contend with increasing liability insurance premiums as the incidences of work accidents increased and, over time, erosion of certain liability protections it had traditionally enjoyed (Clayton, 2003/2004). Thus, by the early 1900s, the stage was set to explore a different approach to compensating workers for injuries sustained on the job.

The uncertainties and potentially harmful economic consequences that resulted from addressing work accident claims in the civil context provided an incentive for both sides to devise a different system. The end result was the enactment of worker's compensation laws. The establishment of such laws was significant on many levels and represented a concerted effort between labor, employers, and government to create a system of providing injured workers with basic medical and economic benefits while providing employers with protection from potentially greater civil damages.

Workers' Compensation: Basic Principles

It is important to understand from the outset that, in the United States, there is no single workers' compensation system. Rather, each state has its own system. On the federal level, there are specific workers' compensation systems for federal employees workers employed in particular professions. The reference to the "workers' compensation system" is typically used, and is used in the context of this article, to denote the concept of a general system of compensation for injured workers, taking into account that the "system" is really comprised of several different programs per the separate laws of each state or pursuant to federal statute.

On the federal level, non-military federal employees are covered under the Federal Employment Compensation Act (FECA) (5 U.S.C. § 8101, et. seq). Longshoremen and other maritime employees are covered under the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C §901, et. seq). The Merchant Marine Act (known as the "Jones

Act”) covers sailors and seamen (46 U.S.C. §688). Coal workers suffering from Black Lung Disease are eligible for benefits under the Black Lung Benefits Act. The Federal Employment Liability Act (FELA) covers railroad workers (45 U.S.C §51, et. seq).

It should be noted that not every worker is covered for workers’ compensation purposes, as certain employers may be exempt from providing coverage. While exemptions from workers’ compensation vary, general exceptions include employers with fewer than three to five employees, farm workers, and certain domestic servants (Clayton, 2003/2004). Another possible exception concerns “independent contractors,” as that term is defined under the workers’ compensation laws.

While benefit types and levels vary, and the administrative processes to obtain benefits differ from state to state and program to program, there are certain shared principles and core elements that form the basic framework of each system. Most modern workers’ compensation systems are based on the premise of “no-fault” liability. An exception to the no-fault approach involves railroad workers covered under FELA.

Under the “no-fault” approach, an injured worker is eligible for benefits without regard to fault. With few exceptions, under a no-fault workers’ compensation system, an injured worker will be covered regardless of who caused or contributed to the accident. Exceptions to the “no-fault” basis of workers’ compensation include, although are not necessarily limited to, accidents involving intoxication or drugs (see e.g. Fla. Stat. § 440.09 (3) (2006) and Cal. Labor Code § 3600(a)(4) (2006)). Furthermore, benefits could be denied or reduced if the injury was caused by an employee’s failure to use a safety device or observe a safety rule (see e.g. Fla. Stat. § 440.09 (5) (2006)).

The no-fault basis of most workers’ compensation systems eliminated a significant impediment to injured workers with respect to *eligibility* for workers’ compensation benefits. Clearly, the no-fault approach expanded and simplified an injured worker’s ability to pursue benefits. Notwithstanding, the injured worker must still meet certain legal and medical requirements in order to be *entitled* to benefits. The requirements and standards vary amongst states and programs.

A typical “legal” requirement involves the definition of a “work accident.” The definition of what constitutes a “work accident” is an important factor as it sets the boundaries for the type of accidents that are, or could be, considered for workers’ compensation purposes. The almost universal test for compensability is that the alleged work injury must “arise out of work performed “in the course and scope of employment” (see e.g. Fla. Stat. § 440.09 (1) (2006)). Each system has its own particular tests and requirements defining this concept.

The underlying test to establish compensability is important in that not every accident that occurs either on the job or in relation thereto will be compensable. For example, many states have specific rules regarding the compensability of accidents that occur while a worker is traveling to and

from work often referred to as the “coming and going rule” (see e.g. Fla. Stat. § 440.091(2) (2006)). In this context, while a worker may have a motor vehicle accident en route to or returning from work, the accident may not be considered a compensable work accident. Other examples include accidents sustained in certain recreational and social contexts, the result of a deviation from employment, or the result of a subsequent intervening accident (see e.g. Fla. Stat. §440.091(1) (2006); Fla. Stat. §440.091(3) (2006); Fla. Stat. §440.091(5) (2006)).

Certain medical requirements must also be met in order for the injury to be compensable. Under workers’ compensation, there must be a sufficient nexus between the work accident and the resulting alleged injury. This is important as workers’ compensation is limited to compensating a worker for the injuries directly related to the work accident. Certain evidentiary standards must be met for an alleged injury to be considered compensable. For example, Florida’s workers’ compensation system provides that the alleged injury must be established “to a reasonable degree of medical certainty, based on objective relevant medical findings, and the accidental compensable injury must be the major contributing cause of any resulting injuries.” The phrase “major contributing cause” is defined as “the cause which is more than 50% responsible for the injury as compared to all other causes combined for which treatment or benefits are sought” (Fla. Stat. § 440.09(1) (2006)).

If the injured worker meets the required legal and medical requirements, the claim is considered compensable thereby entitling the worker to benefits, subject to any specific limitations. If the applicable requirements are not met, or if there is a question as to whether they can be met, the claim may be “denied.” The term used to denote a claim that has not been accepted as compensable varies according to jurisdiction, but common terms include “denied,” “controverted,” and “disputed.”

In this later context, it is important to note that many states allow benefits to be paid for a certain period of time while an investigation is undertaken. For example, the Florida workers’ compensation act provides for a 120-day investigation period that allows a carrier to make payments without prejudice to its rights to deny the claim within the allotted 120-day investigatory period upon compliance with various procedural compliance requirements (Fla. Stat. § 440.192 (8) (2006); Fla. Stat. § 440.20(4) (2006)). These payments are allowed to be made “without prejudice,” meaning that they are not construed or deemed as an admission of liability.

While the accident and certain resulting injuries may be accepted as compensable, often certain claims made within the context of an otherwise compensable claim are denied. For example, a worker may have sustained a compensable low back injury in the accident, for which treatment is provided through workers’ compensation. He or she may also claim compensability of another body part that is denied for specific reasons.

Workers' Compensation: Basic Benefits Outline

Once compensability has been established, the injured worker is entitled to workers' compensation benefits. Workers' compensation benefits can be divided into four basic classifications: medical, indemnity, vocational, and death benefits.

Medical benefits provide injured workers with a host of medical services for their compensable work injuries. Examples of typically provided services include office visits, diagnostic testing, therapy, surgery, durable medical equipment and psychiatric/psychological services. However, it is important to note that entitlement to specific types of medical services may be limited. For example, in Florida chiropractic treatment is limited to 24 treatments or 12 weeks beyond the date of initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the worker is catastrophically injured (Fla. Stat. § 440.13 (2)(a) (2006)). Under most workers' compensation laws, liability for medical benefits is generally for the life of the injured worker.

Indemnity benefits are monetary payments provided to the injured worker related to his or her inability to work due to the compensable work injuries. To a certain extent, indemnity benefits can be viewed as compensation for lost wages. Payment of indemnity benefits is based on a percentage of the injured worker's pre-injury earnings. The specific percentage and calculation method varies by jurisdiction. In most states, indemnity benefits are calculated by taking 66-2/3% of an injured worker's average weekly wage over a specific period of time prior to the accident (Clayton, 2003/2004; Fla. Stat. § 440.15(2)(a) (2006)). The compensation may be payable at a higher rate if the worker sustains a significant or catastrophic type injury. For example, in Florida, indemnity benefits are calculated by taking 80% of an injured worker's average weekly wage in situations where the injured worker loses an arm, leg, hand, or foot; has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparetic; or has lost sight in both eyes (Fla. Stat. § 440.15(2)(b) (2006)).

Indemnity benefits are typically divided into specific categories. In most states, workers are eligible for "temporary" disability indemnity benefits for periods in which he or she cannot work at all for a specific and limited period of time. Likewise, an injured worker may be entitled to temporary disability benefits if the worker returns to work in a limited capacity but earns less than a certain pre-injury monetary threshold. The number of weeks of eligibility for temporary disability varies by jurisdiction. For example, temporary disability indemnity benefits for a non-catastrophically injured worker in Florida is limited to 104 weeks (Fla. Stat. § 440.15(2)(a) (2006)). Furthermore, entitlement to temporary disability benefits generally ceases when the injured worker reaches maximum medical improvement or some other benchmark in his or her medical treatment.

In most states, there are also "permanent" total disability benefits. This class of indemnity benefits is intended to

compensate an injured worker in situations where he or she has been rendered unable to return to work in any capacity or where the medical and/or vocational evidence otherwise meets specific requirements establishing entitlement to permanent total disability benefits. Permanent total disability indemnity benefits may be payable for the life of the claimant or capped at a specific dollar amount or week limit (Clayton, 2003/2004).

There is also a category of indemnity benefits called permanent partial disability benefits. These benefits typically provide a specific and limited amount of indemnity benefits to the injured worker, often based upon certain components of the injured worker's medical treatment. In some states, an injured worker may be entitled to permanent partial disability benefits based on the permanency rating assigned by the treating provider. For example, an injured worker in Florida is entitled to "impairment benefits" once he or she is placed at maximum improvement which are paid per a statutory scale based on the assigned impairment rating (Fla. Stat. § 440.15 (3)(g) (2006)). This category of indemnity benefits is diverse on many levels. A thorough review and discussion of these benefits is beyond the scope of this article.

Vocational benefits typically provide an injured worker with educational and vocational services to assist him or her in developing work skills in a different occupation or field. In some states, an injured worker may be entitled to temporary indemnity benefits while he or she is pursuing vocational rehabilitation (see e.g. Fla. Stat. § 440.491 (2006)).

Death benefits are intended to compensate an injured worker's spouse and certain family members when an injured worker's death is the result of a work accident or occupational disease.

Workers' Compensation: Settlement Considerations & Factors

Under the modern workers' compensation system, an injured worker is eligible for a whole host of benefits that were largely unavailable before enactment of formal workers' compensation laws in the early 1900s. Over the past century, a more comprehensive system of compensating injured workers has developed that did not exist at the turn of the 20th century. Despite these advances, the workers' compensation system remains less than perfect in many respects. The current system is often plagued by delays in benefit determination and delivery, encumbered by administrative backlogs, and considerably expensive for employers and workers' compensation carriers.

These problems, along with other challenges and limitations, often provide an incentive for the injured worker and employer to explore claim settlement. For the injured worker, settlements are often appealing as they provide an opportunity to obtain a lump sum of money directly, as opposed to the provision of benefits over time. Moreover, many injured workers grow tired of the delays and inefficiencies of the overall process and system. From the employer's perspective,

settlements make sense from a business standpoint because they halt potential long-term exposure that could, in turn, increase their workers' compensation premiums.

There are various types of workers' compensation settlements. The parties may decide to settle only the indemnity or medical aspect of the claim, or they may decide to settle both components. As outlined in the first article, consideration of the MSA comes into play when a settlement closes out an injured worker's eligibility for future medical benefits. It should be noted that settlement of future medicals is not permitted in every jurisdiction. These settlements are referred to as "commutation settlements" that, according to Medicare, must consider Medicare's interests.

Settling a workers' compensation case involves calculating a monetary value on the potential exposure for benefits over an injured worker's life expectancy or some other applicable time measure. The claimant's medical status and potential future medical needs are key considerations, as are the prospect for future indemnity benefits. Unlike tort cases, compensation for pain and suffering is generally not available under most state workers' compensation acts; however, damages for pain and suffering may be available in Jones Act cases and railroad claims under FELA. The actual settlement process involves the injured worker and employer each performing an independent assessment of the claim. Each side then presents their respective "settlement demand" and "settlement offer" to the other. This is usually followed by a period of negotiation, either informally between the parties, through a mediation process, or with a combination of the two. This process often results in claim settlement.

Conclusion

There are several different factors and considerations that comprise the modern day workers' compensation system and form the basis of the underlying workers' compensation case and settlement. In this context, the MSA is but one component of a larger process. With an understanding of basic workers' compensation principles and benefit structure, the focus can now shift to a more practical discussion concerning the "nuts and bolts" of putting together an actual MSA arrangement.

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The Workers' Compensation Medicare Set-Aside Arrangement: Protecting Medicare's Interests

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KEY WORDS

Medicare, Medicare Set-Aside, MSA, Workers' Compensation

This is the third in a series of articles discussing the topic of Medicare Set-Asides (MSA) in the context of workers' compensation (WC) claims. This article discusses the many factors that must be taken in to account when considering Medicare's interests in a WC settlement.

The Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) was first introduced by The Centers for Medicare and Medicaid Services (CMS) in 2001 as a mechanism for complying with the Medicare Secondary Payer (MSP) Statute (Patel, 2001). The MSP Statute, created by the Omnibus Reconciliation Act of 1981, was meant to ensure that Medicare was secondarily responsible for paying medical expenses to beneficiaries who were also covered by another insurance policy or plan. The MSP Statute was amended by the Deficit Reduction Act of 1984, which provided the government statutory right of recovery against primary payers for Medicare overpayments. The Omnibus Budget Reconciliation Act of 1987 and the Medicare Modernization Act of 2003 further amended the MSP Statute to allow for, then strengthen, private right of action against primary payers to recover Medicare payments for which a third party payer is responsible.

The enforcement of the MSP Statute intensified in 2001, when CMS began a comprehensive effort to identify Medicare beneficiaries who may have another payer primary to Medicare, to identify and recover any Medicare payments that should have been paid by another primary payer (conditional payments/overpayments) and to prevent future Medicare payments when another primary payer exists. Beginning in July 2001, CMS issued a number of policy memorandums regarding the consideration of Medicare's interests in WC settlements (Patel, 2001). These memorandums answer frequently asked questions regarding MSP compliance and establish CMS review thresholds. CMS describes the WCMSA as follows:

All parties in a Workers' Compensation (WC) case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses. The recommended method to protect Medicare's interests is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate. Once the CMS approved set aside amount is exhausted and

accurately accounted for to CMS, Medicare will agree to pay primary for future Medicare covered expenses related to the WC injury (CMS, 2005 Workers' Compensation Medicare Set-aside Arrangements [WCMSAs]).

Medicare Contractors

CMS utilizes three major contractors to assist in its MSP enforcement efforts: the Coordination of Benefits Contractor (COBC), the Workers' Compensation Review Center (WCRC), and the Medicare Secondary Payer Recovery Contractor (MSPRC). The COBC is primarily an information gathering entity utilizing various sources to collect information regarding health coverage for Medicare beneficiaries that may be primary to Medicare and to establish an MSP record to prevent mistaken payment of Medicare benefits. The COBC is utilized to report a liability, auto/no fault, or WC case involving a Medicare beneficiary or to ask general MSP questions. Additionally, the COBC receives and tracks WCMSA proposals (CMS, 2007 *COB-General Information*).

The WCRC is responsible for reviewing all WCMSA proposals and providing a recommendation to CMS regarding the adequacy of the proposed arrangement. The CMS Regional Office assigned to the claim state of jurisdiction is responsible for issuing the final approval of the WCMSA.

The MSPRC is responsible for most MSP conditional payment/overpayment recoveries. The MSPRC has assumed all new MSP recovery claims since its implementation on October 2, 2006 and most existing claims (CMS, 2007 *Medicare Secondary Payer Recovery-General Information*). The MSPRC is utilized to obtain an estimate of Medicare conditional payment amounts, obtain Medicare's final recovery claim amount, request information regarding repayment of MSP debt, and to request a waiver or appeal of a recovery demand. The MSPRC is also responsible for post settlement MSP reconciliation of WCMSA arrangements that have been approved by CMS.

The CMS Review Thresholds

CMS, through its policy memorandums, has established review thresholds. When a WC settlement meets the CMS review thresholds, CMS review of the adequacy of a

WCMSA is appropriate. CMS indicates that the CMS review thresholds are only CMS workload review thresholds and not a substantive dollar or “safe harbor” for complying with MSP law and that Medicare’s interests must be considered in any WC case, even if the review thresholds are not met (Walters, July 2005).

If a primary payer is settling future medical benefits for an individual meeting the following CMS review thresholds, a CMS approved WCMSA is appropriate. There are two established thresholds, one for cases involving claimants who are Medicare beneficiaries at the time of settlement and one for cases involving claimants who are not Medicare beneficiaries at the time of settlement:

1. **CMS Review Threshold for Medicare Beneficiaries:** The individual is a Medicare beneficiary at the time of settlement and the total settlement exceeds \$25,000 (Walters, April 25, 2006).
2. **CMS Review Threshold for Non-Medicare Beneficiaries:** The individual is not a Medicare beneficiary at the time of settlement but the total settlement exceeds \$250,000 and there is reasonable expectation of Medicare entitlement within 30 months of the settlement date (Patel, 2001).

As defined by CMS (Grissom, April 2003), reasonable expectation of Medicare entitlement includes but is not limited to:

- Claimant is receiving Social Security Disability (SSD) benefits at the time of settlement
- Claimant has applied for SSD or has applied and been denied but anticipates appealing the decision;
- Claimant is in the process of appealing and/or re-filing for SSD benefits;
- Claimant is age 62.5 or greater at time of settlement; and
- Claimant has ESRD condition but does not yet qualify for Medicare based on ESRD.

Total settlement is defined as including, but not limited to wages, attorney fees and costs, all future medical expenses, repayment of any Medicare conditional payments and any previously settled portion of the claim. If an annuity is used to fund any of the above, the total pay-out should be used, not the cost or present value of the annuity (Walters, April 2006). When a WC settlement does not meet the CMS review thresholds, CMS will not review the case or provide the settling parties with verification letters that approval of a WCMSA is unnecessary.

CMS Review Thresholds

In order to determine whether or not a case meets the CMS review thresholds, both the settlement amount and the Social Security and Medicare entitlement status must be known. Medicare entitlement based on age occurs at age 65, assuming eligibility criteria are met. Prior to age 65, Medicare entitlement based on disability will occur automatically after

receiving 24 months of Social Security Disability (SSD) benefits (Social Security Administration, 2007).

The determination of SSD and Medicare entitlement involves obtaining a Social Security Administration (SSA) release of information from the claimant. A request for entitlement information is then sent to the local SSA office for the zip code of the claimant’s residence. The SSA can provide Medicare entitlement dates (Parts A, B, and D), the basis of Medicare entitlement (age or disability), SSD application date, SSD application status (pending, denied, on appeal), and the SSD entitlement date. The SSA charges a fee to third party requesters for this information.

The WC Medicare Set-Aside Arrangement

The MSA Arrangement consists of three primary components: 1) an MSA allocation amount to be placed into an MSA account at the time of settlement; 2) a mechanism to fund the MSA account; and 3) a mechanism to administer the MSA account after settlement.

The MSA Allocation

The MSA allocation is the amount of settlement dollars to be set aside for future WC injury-related medical and prescription drug expenses that are expected to occur during the claimant’s lifetime or commutation period and that would be otherwise covered by Medicare. The MSA allocation is determined by comprehensive review of medical records, medical claims payment history, physician recommendations and accepted standards of care. CMS has compiled a suggested format and content for MSA allocations being submitted to CMS for review (CMS, 2006 Sample Submission).

The MSA allocation must include details regarding current treatment, future treatment and medical recovery prognosis. Current treatment includes the treatment that the claimant regularly receives as a result of the WC injury. Future treatment includes the frequency and duration of medical care services and supplies that are expected in the future as a result of the WC injury. Future treatment must be based on the evaluation and recommendation of a physician, for example, the primary care physician, orthopedic surgeon or other applicable specialist. An independent medical exam may be sufficient under certain circumstances, for example, if the claimant has not received treatment in several years and there is no primary care physician (CMS, 2007 WC Submission Checklist).

CMS will not allow compromise of the future medical expenses related to a WC injury to be included in the MSA proposal. CMS addressed this issue in a 2005 memorandum as follows: “Some submitters have argued that 42 C.F.R. §411.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a WC injury” (Walters, July 2005).

Required Documentation: In cases that meet the CMS review threshold and will be submitted to CMS for review, the

submitter must include the cover letter content as outlined by CMS, a CMS Release of Information signed by the claimant, the last 2 years of injury-related medical treatment records, the last 2 years of claims payment history for both medical and indemnity payments, rated age on life insurance company or settlement broker letterhead (if used) and the proposed settlement document (CMS, 2006 Sample Submission).

Types of Future Expenses: The MSA allocation should include only anticipated future medical expenses and prescription drug expenses that are related to, or arising from, the WC injury and that would be otherwise covered under Medicare (CMS, 2006 Sample Submission p.21). The amounts projected for future medical treatment and future prescription drug treatment should be designated separately. If no amount is designated for future prescription drug treatment, an explanation must be provided such as a physician's statement that no future prescription drug treatment is indicated.

Method of Calculation: The future medical treatment amount may be calculated at the WC reimbursement schedule for the claim state of jurisdiction or at actual charges (Walters, 2004), although it is generally calculated at the WC reimbursement schedule. The calculation method used must be identified. All WC settlements that occur on or after January 1, 2006 must include projection of future prescription drug costs otherwise covered by Medicare Part D in addition to future medical costs. If the claim settled prior to January 1, 2006, the MSA proposal does not need to include a projection of future prescription drug costs otherwise covered by Medicare Part D (Walters, July 2006). Because CMS has not yet issued policy regarding the calculation method to be used for projecting future prescription drug costs otherwise covered by Medicare Part D, these costs may be calculated at Average Wholesale Price (AWP), actual charges, or another selected method and the submitter must include an explanation of how the future prescription drug amount was calculated (Walters, December 2005).

Duration of Projection: The MSA allocation should be projected over the claimant's life expectancy unless state law specifically limits the duration of WC medical coverage. A rated age can be used to reduce the life expectancy if applicable.

Inflation Index and Present Day Value: The MSA allocation does not need to be indexed for inflation and may not be discounted to present day value (Walters, 2004).

In order to submit the MSA allocation to CMS for review, the MSA proposal is first submitted to the COBC. The proposal will then be recorded in a centralized database and electronically forwarded to the WCRC for review. Once the WCRC completes its review, the proposal will be forwarded to the appropriate CMS Regional Office who will render its decision regarding the adequacy of the proposal. The most efficient method for submitting a MSA proposal is by CD-ROM which can be directly imported into the COBC's processing system (CMS, 2005 *Submissions of WCMSAs*).

MSA Funding

The mechanism to fund an MSA account can be either a lump sum payment or a structured payment vehicle. When a lump sum payment is utilized, the entire amount of the MSA allocation is deposited into an MSA account at the time of settlement. Once CMS approves the lump sum funding arrangement, Medicare will become the primary payer for WC injury related medical and prescription drug expenses that are covered under Medicare if: (a) the MSA account becomes permanently exhausted; (b) CMS agrees the funds were exhausted properly (Grissom, April 2003); and (c) the claimant is enrolled in the Medicare program that provides coverage for the expense.

When a structured payment vehicle, such as an annuity, is used to fund the MSA account, an initial deposit is made into the MSA account at the time of the settlement and additional payments are made annually. The proposed initial and annual payment amounts are calculated per CMS requirements (Walters, 2004) and included in the MSA proposal submitted to CMS for review. Once CMS approves the structured funding arrangement, Medicare becomes the primary payer during any year in which (1) the MSA account becomes temporarily exhausted, (2) CMS agrees the funds were exhausted properly, and (3) the claimant is enrolled in the Medicare program that provides coverage for the expense. Medicare will only become the primary payer in the event of temporary exhaustion until the next annual payment is made into the account (Grissom, April 2003).

MSA Administration

An MSA account may be either professionally administered or the claimant may self-administer the account, if permitted under State law (CMS, 2007 *Administering WCMSAs*). In a CMS memorandum, Walters (2004) states:

WC Medicare Set-aside Arrangements must be administered by a competent administrator (the representative payee, a professional administrator, etc.). Moreover, when an individual does (in fact) have a designated representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties must include that information in their Medicare set-aside arrangement proposal to CMS (p.2).

CMS has established requirements for administration of a MSA account. The requirements are generally the same whether the account is professionally administered or self-administered by the claimant (Grissom, 2003). Failure to adhere to the CMS requirements will be regarded as failure to reasonably recognize Medicare's interests and Medicare will deny coverage for all medical and prescription drug expenses related to the WC injury up to the total WC settlement amount. The following is a general overview of MSA administration requirements.

- Funding an MSA Account: MSA funds shall be placed in an interest bearing account. This account shall be a separate account from the claimant's personal savings or checking account. A copy of the documents demonstrating establishment of the MSA account must be sent to CMS within 30 days of disbursement of the WC settlement.
- Interest Earned on MSA Funds: Interest earned on the funds in the MSA account must be allowed to accrue in the account and must be used solely for allowable expenses.
- Documentation of Appropriate Funding: CMS must be provided with documentation that the MSA account has actually been funded for the full amount as specified and approved by CMS. If proof is not provided, CMS may deny payment for services related to the WC claim up to the total CMS approved MSA amount.
- Allowable Expenses from MSA Account Funds: The funds in the MSA account shall be used solely for legitimate medical or prescription drug expenses related to, or arising from, the WC injury, which would otherwise be covered by Medicare. If the WC settlement occurred prior to January 1, 2006, WC injury related prescription drug expenses otherwise covered by Medicare Part D cannot be paid from the MSA account (Walters, July 2006). MSA account funds may also be used to pay for any incremental tax paid on the interest income earned by the MSA account (Walters, July 2005), photocopying charges, mailing fees/postage and any banking fees as long as the costs are directly related to the account and there is adequate documentation to support the expenditures (CMS, 2006 *Sample Submission*). If payments from the MSA account are used to pay for other than allowable expenses, Medicare will not pay injury related claims until these funds are restored to the MSA account and then properly exhausted.
- Reimbursement Schedule: Payment from the MSA account for allowable expenses should be paid based on the method used to calculate the MSA allocation.
- Annual & Final Accountings: Annually (beginning within one year from the WC settlement) an accounting separately identifying the expenditures for the medical treatment and prescription drug treatment must be submitted to the MSPRC. If the MSA is self administered, the claimant must sign and forward a CMS self-attestation form stating that payments from the MSA account were made appropriately.
- Accounting Records: Accurate records of the distributions and expenditures from the MSA account must be maintained. The CMS recommends that evidence of expenditures be retained for a period of seven (7) years. Evidence of expenditures may be requested by the Medicare contractor as proof of appropriate payments from the MSA account. Records for medical expenses should include the date of service, name of the service provider, diagnosis, amount of payment and date of payment.
- Reimbursement to Medicare: In the event the CMS determines that Medicare has erroneously paid benefits,

CMS, or its designated contractor shall have the right to seek and receive reimbursement of any such conditional payments or overpayments from the MSA account to the extent that there are funds remaining in the account at that time.

- Release of Unused MSA Account Funds: If the claimant's treating physician concludes that his/her condition has improved enough to justify at least a 25% reduction in the remaining MSA account, a MSA proposal covering future expected medical expenses may be prepared and submitted to CMS. The new proposal may not be submitted until at least 5 years after the date of the previous CMS approval letter and the new proposal should be accompanied by all supporting documentation not previously submitted with the original MSA proposal (Walters, July 2005)
- Distribution of Medicare Set-Aside Funds Following Death: If death occurs prior to the permanent depletion of the MSA account, the account shall remain open after the date of death to enable the payment of any outstanding allowable medical expenses. Once the appropriate CMS Regional Office and the Medicare contractor responsible for monitoring the case agree that all claims have been paid, any funds remaining in the MSA account may be disbursed pursuant to state law (Grissom, April 2003).
- Administrative Expenses: Administrative fees and expenses for the administration of an MSA account as well as attorney fees or costs associated with establishing an MSA arrangement cannot be paid from the MSA account funds (Kuhn, May 2004).

The Industry

Since CMS released its first policy memorandum in 2001, an entire industry has emerged to assist settling parties with MSP compliance. CMS does not mandate the credentials or experience of individuals who prepare MSA allocations or submit MSA arrangements to CMS for review. Therefore, the industry, which is comprised of multiple disciplines, is working to establish best practice standards. Two organizations, The National Alliance of Medicare Set-Aside Professionals, Inc. (NAMSAP) and The Commission on Health Care Certification (CHCC), have been actively involved in this endeavor and have both fostered a multidisciplinary approach to the practice of MSP compliance consulting.

The mission of NAMSAP, a non-profit organization founded in 2005, is to foster the highest standards of integrity and competence among Medicare Set-Aside professionals and those they serve. NAMSAP's purposes are to develop standards and define best practices for the industry; to promote a multidisciplinary approach to the Medicare Set-Aside practice; to provide a forum for learning and shared knowledge between all associated disciplines; to provide a unified voice to affect change and improve the Medicare Set-Aside process; and to protect the interests of all parties in settlements involving Medicare Set-Aside related issues (NAMSAP, 2005).

The CHCC began accreditation for the Medicare Set-Aside Consultant - Certified (MSCC) in 2004. The current criteria to sit for the MSCC certification exam requires that a candidate must complete 30 hours of CHCC approved training related to Medicare Secondary Payer compliance. Additionally there are license and experience requirements consisting of a minimum of 12 months of acceptable full time employment within the past 3 years in one of the following disciplines: Insurance Claims Adjusters, Attorneys, Life Care Planners, Case Managers, Disability Management Professionals, Rehabilitation Specialists and Nurses (i.e., Registered Nurses, Licensed Practical Nurses or Licensed Vocational Nurses). Candidates must also complete a MSA submission proposal with a successful peer review by a CHCC MSCC Commissioner (CHCC, 2006).

The majority of professionals practicing in the MSP compliance industry provide a full continuum of services to insurance carriers, third party administrators, self insured employers and attorneys including determination of Social Security and Medicare entitlement status, preparation of the MSA allocation, submission of the MSA proposal to CMS for review and Medicare conditional payment claim resolution. Some professionals choose to partner with another discipline with each providing a particular aspect of service. The most common partnering arrangement involves utilizing a professional nurse, life care planner, etc. to compile the MSA allocation and an attorney to submit the MSA allocation to CMS for review. Whether interested in partnering with another professional or developing a comprehensive practice, the area of MSA compliance offers a myriad of exciting and challenging opportunities to a wide variety of disciplines.

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Understanding the Roles of MSA-Related Professionals

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KEY WORDS

Claims, Medicare, Medicare Set-Aside, MSA, Workers' Compensation

This is the fourth in a series of articles regarding Medicare Set Asides (MSA) and general compliance matters with regard to the Medicare Secondary Payer Statute in the context of workers' compensation claims. This article turns the spotlight on the various professionals typically involved in the claims process and with the actual construction of the MSA proposal. The contribution of each professional is imperative in terms of addressing the various issues involving Medicare and, ultimately, to posture the claim for successful resolution.

Claims handling activities directed at determining the need to consider Medicare's interests, either via a Medicare Set Aside (MSA) or conditional payment considerations, should start from day one of the claim and should continue at pivotal points throughout the course of the claim. Far too often, the parties do not begin to consider Medicare's interests until the time of settlement negotiations or until *after* a settlement has been reached. Early and continuing consideration of Medicare's interests, coupled with the active participation of the various professionals involved in the claim, will greatly increase the chances of successful claim settlement. With this backdrop, the discussion moves to an examination of the various professionals integral to the MSA process.

Adjuster

The professional who typically starts the process is known as the insurance adjuster or claims examiner (hereinafter "adjuster"). The adjuster is the individual from the workers' compensation carrier (or its third party administrator) assigned to the workers' compensation claim. Adjusters are required to be licensed in each state in which they handle claims and must complete continuing education courses throughout the year or within a required time period.

Often, at the beginning of a claim, only medical issues are involved because the injured worker may continue to work. In this situation, the claim may be assigned to a "medical only" adjuster who concentrates on medical issues and medical claims. If the claim later evolves to also include an indemnity component, the file will often then be transferred to another adjuster specializing in both medical and indemnity aspects of claims handling.

The adjuster is responsible for administering the claim, which involves a whole host of activities, including background investigation and addressing requests for benefits and exposure evaluation. As part of this process, the adjuster will conduct an initial intake interview to obtain all relevant background information regarding the injured worker, the work accident, and alleged injuries. In addition to the typical biographical questions, the initial intake interview is an excellent opportunity to commence inquiry into areas related

to Medicare. For example, an injured worker's age is an indicator as to potential Medicare interests. An injured worker 65 years or older is likely already a Medicare beneficiary. In this situation, a copy of the injured worker's Medicare card should be requested (if such request is allowed under the procedural rules of the applicable jurisdiction). If the injured worker is younger than age 65, inquiry into whether he or she has applied for social security disability should be made along with a request that he or she executed a social security release (to the extent such requests are permissible under the procedural rules of the applicable jurisdiction). In the absence of a catastrophic injury, an injured worker typically does not apply for social security disability at the initial phases of the claim. Thus, it is important to diary specific follow-up dates to re-address the issue of an injured worker's social security and Medicare status.

Counsel

In the typical case, the injured worker and carrier have not retained the services of counsel during the initial phases of a claim. Initially, therefore, the adjuster and injured worker communicate directly regarding various issues related to the claim. It is not unusual, however, for the injured worker to eventually retain counsel to assist with the claim. There are a variety of reasons why an injured work may decide to obtain counsel, which are beyond the scope of this article.

Retention of counsel introduces another player into the process. Counsel for the injured worker (typically referred to as "claimant's counsel" or "applicant's counsel") helps the injured worker pursue his or her claim. In this regard, claimant's counsel typically files formal legal pleadings to request medical or other benefits, conducts depositions and other discovery activities to prove compensability of the claim or entitlement to requested benefits, and employs other measures to secure claimed benefits for the injured worker.

Once the injured worker retains counsel, the carrier may in turn hire counsel of its own. Counsel for the carrier is often referred to as "carrier's counsel" or "E/C counsel." Carrier's counsel undertakes a variety of different services to assist the carrier in administering and defending the claim. Carrier's

counsel typically conducts discovery and medical depositions, and performs other discovery necessary to address the filed claims and related matters. Carrier's counsel can play a pivotal role in assisting the carrier in determining whether Medicare's interests are implicated in the claim. Carrier's counsel should question the injured worker regarding his Medicare and social security statuses as part of the discovery process, via deposition and requests for production (to the extent permitted under applicable procedural rules).

Although the dealings between claimant's counsel and the carrier are often adversarial, both sides usually share a common interest in obtaining the necessary information to determine if protecting Medicare's interests are necessary. Claimant's counsel should seriously consider cooperating with carrier requests for information aimed at determining the injured worker's Medicare and social security status. In this regard, claimant's counsel should promptly return the requested informational releases necessary to allow the carrier or its Medicare vendor to determine the injured worker's Medicare and social security statuses and placing Medicare on notice of the claim. All too often, delays in returning the needed releases unnecessarily delays addressing the MSA and Medicare aspects. Claimant's counsel should also notify the carrier when the injured worker has applied for social security disability benefits, has been awarded such benefits, or has become entitled to Medicare.

At some point during the typical claim, the parties may entertain settlement negotiations in an effort to totally settle a claim, settle certain portions of a claim, or resolve past issues. It is important to note that, in some jurisdictions (such as Florida), the parties are required to participate in mandatory mediation of the claim. As outlined in the previous articles, addressing MSA- and Medicare-related matters is an involved process that can have a significant impact on settlement discussions and the ability of the parties to actually reach a workable settlement.

The better prepared the parties are in terms of addressing MSA threshold issues and other Medicare related matters prior to mediation or settlement negotiations, the better the chances for successful resolution of the claim. Along these lines, it is imperative that the adjuster and the injured worker (if unrepresented), or respective counsel, take the necessary measures to address MSA and Medicare issues *before* entering into settlement discussions. This, to a large extent, is a matter of discovery and cooperation between the parties with respect to obtaining and sharing relevant information. Knowing whether the claim potentially meets one of CMS' MSA review thresholds and/or involves Medicare conditional payments are crucial factors in terms of helping the parties reach a workable settlement. Unfortunately, the parties often discuss settlement, and may even reach a settlement, without addressing these issues beforehand. Consequentially, there is a greater risk that the settlements will unravel as the agreed upon terms become unworkable or unacceptable upon obtaining a MSA allocation or addressing a Medicare conditional payments post settlement.

Allocator

Retaining the services of a Medicare professional (who can be either an individual or vendor) *prior* to entertaining settlement discussions should be seriously considered by the parties. A Medicare professional can help determine Social Security and Medicare status, and commence the Medicare conditional payment verification process. Perhaps most importantly, the MSA allocator can prepare an MSA allocation projection that will apprise the parties of the approximate range of the MSA. Knowing the MSA amount helps in formulating case value, which in turn can assist the parties in arriving at an acceptable settlement range. If desired, the MSA allocator can also prepare a cost projection regarding future non-Medicare covered expenses.

Currently, CMS has not established any specific credentialing criteria or qualifications for individuals preparing actual MSA allocations or medical cost projections. There are national credentialing programs offered by entities that are emerging to instruct professionals with the factors and intricacies of formulating an MSA allocation. Due to the inherent medical nature of the MSA, it is common for the MSA allocator to have a medical background such as nursing, medicine, occupational therapy, physical therapy, psychology, case management, to life care planning.

One such entity is The Commission of Health Care Certification (CHCC) (May, 2004). CHCC provides a certification for Medicare Set-Aside Consultant Certified (MSCC). Criteria for MSCC certification includes: completion of 30 hours of approved training related to MSA compliance; licensure or certification as insurance claims adjuster, life care planner, case manager, disability management professional, rehabilitation specialist, nurse, or attorney; professional experience of at least 12 months of acceptable full time employment within the past 3 years within the Workers' Compensation or Liability insurance industry as an insurance claims adjuster, life care planner, case manager, disability management professional, rehabilitation specialist, nurse, or attorney; and passing a MSCC examination. Maintenance of MSCC certification requires documentation of 20 hours of approved education every 3 years.

Some allocators hold certification as a life care planner in addition to MSCC certification. The oldest agency providing certification for life care planning is the Commission of Health Care Certification (CHCC), which has specific criteria for certification for Certified Life Care Planner (CLCP), including approved 120 hours of post-graduate or post-specialty degree in life care planning; experience in life care planning; certification, licensure, or meeting the mandated of candidate's respective state that allow a person to practice service delivery within the definition of person's designated health care related profession; and passing of Certified Life Care Planner examination. Maintenance of the CLCP certification is documentation of 48 hours of approved education every 3 years.

There is continuing discussion in the field of the role of the life care planner and an allocator. In general, the life care planner addresses all aspects of the injured person's current and future needs and associated costs as related to the disease/injury using usual and customary regional prices. An MSA addresses a more limited set of needs as determined by the Medicare payment system and is only required in specific cases as determined by CMS criteria.

In addition to the CLCP, the National Alliance of Medicare Set-Aside Professionals, Inc. (NAMSAP) is an organization that provides education and other resources to professionals practicing in the MSA arena. The mission of NAMSAP, a non-profit organization founded in 2005, is to foster the highest standards of integrity and competence among MSA professionals and those they serve. NAMSAP's purposes are to develop standards and define best practices for the industry; to promote a multidisciplinary approach to the MSA practice; to provide a forum for learning and shared knowledge between all associated disciplines; to provide a unified voice to affect change and improve the MSA process; and to protect the interests of all parties in settlements involving MSA-related issues (NAMSAP, 2005).

While the MSA allocator plays a pivotal role in calculating the MSA allocation amount, the adjuster and counsel play an equally important role with respect to "educating" the allocator as to pertinent background information regarding the claim. This information typically includes: the compensability status of the claim (whether the claim has been accepted or denied), compensable versus denied injuries, applicable statutory limitations on available medical benefits (e.g., limitation on chiropractic treatment under the statute of the applicable state), outstanding medical recommendations, information obtained from medical providers, and other information regarding the underlying claim and settlement that could impact the MSA allocation. It is important that the MSA allocator be apprised of this information so that an accurate MSA allocation projection can be rendered.

Broker

As part of the MSA allocation process, the services of a structured broker may be retained. A structured broker can assist the parties in exploring the various elements of funding the actual settlement and/or MSA arrangement. In addition, structured brokers are often called upon to obtain "rated ages." Procurement of a rated age can be an integral part of the MSA allocation process as it often helps reduce the actual MSA allocation amount.

Depending on the claim, it may also be necessary to contact other professionals or entities, such as the injured worker's social security lawyer, DME provider, pharmacist, and professional MSA administrator. In addition, the services of an elder law attorney may be required to address issues that may arise with regard to the potential impact the settlement and/or MSA could have on the claimant's eligibility or entitlement to Medicaid.

Conclusion

The development of the MSA arrangement involves several professionals from various backgrounds. Communication between the various professionals is essential in formulating an accurate MSA allocation and addressing other Medicare matters. The issue and the players should not be viewed as independent parties to the process. Rather, each professional plays an integral part in the process. Cooperation between the parties is crucial for procuring the most accurate MSA allocation possible and properly accounting for other Medicare issues, such as conditional payments, that in turn can greatly increase the chances of reaching a workable settlement to close out the claim.

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Medicare Conditional Payments: Protecting Medicare's Interests for Payments Issued By Medicare

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KEY WORDS

Medicare, Medicare Conditional Payments, Medicare Set-Aside, MSA

This is the final article in this series addressing compliance with Medicare regulations in the context of worker's compensation settlements. This article focuses on the Medicare Secondary Payer (MSP) Statute and the obligations of primary payers and other parties for repayment of what are referred to as Medicare conditional payments. To obtain a better perspective of this topic, it may be helpful to take a step back to understand how consideration of Medicare conditional payments differs from the parties' obligations regarding Medicare Set-Asides (MSA).

In the context of the Medicare Set-Aside (MSA), the focal point is on protecting Medicare's *future* interests through the inclusion of an MSA arrangement. By contrast, Medicare conditional payments concern protecting Medicare's interests for past medical bills that Medicare may have paid for injury related treatment and Medicare's right to recover funds paid for these medical expenses. In this context, the focus is on determining whether Medicare has paid for medical treatment associated with work-related injuries.

Medicare Conditional Payments: Legal Bases & Considerations

The applicable section of the Medicare Secondary Payer (MSP) Statute dealing with Medicare conditional payments is found in Title 42 of the United States Code, subsection 1395y (42 U.S.C. § 1395y), entitled *Exclusions from Coverage and Medicare as Secondary Payer*. There are also several provisions in the Code of Federal Regulations concerning Medicare conditional payments, including 42 C.F.R. §411.20, et. seq. and 42 C.F.R. §411.40, et. seq.

The term "conditional payment" is defined in 42 C.F.R. §411.21 as follows: "Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed" (2006). Subparts C through H, as referenced in this section, concern specific limitations on Medicare payments and services in the context of various situations as specifically outlined in 42 C.F.R. §411.40 through 42 C.F.R. §411.206. The provisions related to workers' compensation are found at 42 C.F.R. §411.40 through 42 C.F.R. §411.47. The references to "intermediary" and "carrier" relate to the entities used by Medicare to assist in its subrogation recovery efforts. This will be more fully addressed later in this article.

From a practical standpoint, there are several possible reasons why Medicare may issue payment for accident related

treatment in the context of a workers' compensation claim. For example, the claim can be denied by the workers' compensation carrier and, accordingly, the carrier refuses to pay for medical treatment. Medicare may determine that payment from the carrier cannot be expected to be made promptly and therefore decides to issue payment, or the injured worker fails to file a claim against the carrier (42 C.F.R. §411.45[a], 2003). Alternatively, the treating provider's billing department may mistakenly submit bills to Medicare instead of the workers' compensation carrier.

While Medicare may issue payments, under the MSP, it has the right to seek reimbursement of these payments from primary payers and other parties. The concept is for Medicare to make these payments upon the "condition" that it is reimbursed. This concept is in keeping with the general premise of the MSP. Medicare is to be secondary to other forms of insurance in the context of accident related claims.

The following excerpts are taken from 42 U.S.C. § 1395y (b)(2)(A) and outline the parameters establishing Medicare as a secondary payer (2003). This section provides as follows:

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided under subparagraph (B), with respect to any item or service to the extent that –

- (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
- (ii) payment has been made, or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability policy or plan (including a self insured plan) or under no fault insurance.

In this section, the term "primary plan" means a group health plan or large group health plan, to the extent that

clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no-fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

Subparagraph (B) of this section provides that Medicare may make a "conditional payment" for medical treatment in certain circumstances. In this regard, 42 U.S.C. § 1395y (b)(2)(B)(i)(2003) states:

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund...

42 U.S.C. § 1395y (b)(2)(B)(ii) sets forth the statutory basis for reimbursement of Medicare conditional payments. This section, in pertinent part, states as follows:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

In addition to the items listed above, "settlements" or "contractual obligations" are items considered to "demonstrate" a primary payer's responsibility to reimburse Medicare per 42 C.F.R. §411.22(a)(3). It is also important to note that under 42 U.S.C. § 1395y (b)(2)(B)(ii), Center for Medicare and Medicaid Services (CMS) has the authority to obtain reimbursement of conditional payments even in relation to settlements of denied or disputed claims.

Under the MSP, Medicare is afforded wide latitude with respect to seeking reimbursement of conditional payments. Pursuant to 42 U.S.C. § 1395y (b)(2)(B)(iii), Medicare "may bring an action against any and all entities that are or were required or responsible (directly, as an insurer or self-insurer, as third party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan" (42 U.S.C. § 1395y(b)(2)(B)(ii), 2003).

In addition, Medicare may bring suit for repayment of conditional payments against the carrier, a self-insured defendant or employer, or any entity that receives proceeds from the settlement, including the plaintiff and/or attorney. Under 42 C.F.R. §411.24(g), "CMS has a right action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency private insurer that has received a primary payment."

Medicare also has subrogation rights against the parties and entities listed immediately above, as well as the right to "join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid" (42 C.F.R. §411.26, 2003). The regulations provide that a "beneficiary or other party" that receives a primary payment must reimburse Medicare within 60 days (42 C.F.R. §411.24(h); 45 C.F.R. §30.13, 2003).

With respect to repayment, Medicare can seek double damages (twice the amount of the conditional payment amount) if it is required to file suit to obtain reimbursement (42 U.S.C. § 1395y (b)(2)(B)(ii), 42 CFR 411.24 (c)(2)). If CMS does not need to take legal action, Medicare may recover the lesser of either the Medicare primary payment, or the amount of the full primary payment that the primary payer is obligated to pay (42 C.F.R. §411.24(c)(i)(ii)).

While Medicare has broad power to seek and enforce its reimbursement rights, Medicare's claim may be waived either in full or in part. Under 42 U.S.C. § 1395y (b)(2)(B)(v), Medicare may "waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program..." Under 42 U.S.C. § 1395gg(c), Medicare's claim can be compromised in certain situations involving economic hardship, where recovery would be against "equity and good conscience", and for reasons beyond the fault of the claimant.

Under 31 U.S.C. § 3711(a)(3), Medicare's claim may be reduced or waived "when it appears that no person liable on the claim has the present or prospective ability to pay a significant amount of the claim" or where "the cost of collecting the claim is likely to be more than the amount recovered."

Medicare Conditional Payments: Practical Considerations

As outlined in the previous section, consideration of Medicare conditional payments is an important component in the overall process of considering Medicare's interests. The obligation to protect Medicare's interests is well-established. How, then, does the process work?

From an administrative standpoint, the overall responsibility of the Medicare program rests with the Department of Health and Human Services (DHHS). In turn, the DHHS has delegated this authority to CMS. CMS, in turn, employs contractors referred to as "carriers" and "fiscal intermediaries" (FIs) to assist it in administering the Medicare program. Until the passage of the Medicare

Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS had 46 FIs performing bill processing and benefit payment activities for Medicare Part A claims, while various contractors performed related activities for Part B claims. At that time, CMS also used four Durable Medical Equipment Regional Carriers that handled Part B DME claims (Meifert & Lewis, 2006).

The MMA made significant revisions to the FI/Contractor arrangement. Under the MMA, the FIs and contractors are being phased out and being replaced with competitively based Medicare Administrative Contractors (MAC)s. This process and transition is expected to occur over a 4-year period. In addition, as of October 2, 2006, CMS consolidated MSP recovery functions (including conditional payment reimbursement) into one MSP contractor, the Detroit-based Chickasaw Nation Industries (CNI), Inc. – Administration Services, LLC. With the exception of certain pending conditional payment claims, CNI is now the contractor responsible for processing Medicare's conditional payment functions and claims.

From the standpoint of primary payers and practitioners, it is important to establish practices and procedures to address the issue of Medicare conditional payments. The starting point in this process is identifying claims that involve Medicare beneficiaries. An individual's Medicare status can be obtained directly from the Social Security Administration with proper authorization. To avoid potential delays, this request should be made upon discovery of information indicating that possible Medicare entitlement.

Examples of information that could suggest Medicare entitlement include an injured worker who is 65 years old or older, an injured worker who has applied for social security and an injured worker who has been out of work for 30 months or more. Inquiry regarding the injured worker's social security and Medicare status should also be incorporated as part of the general discovery process, including initial intake interviews and other discovery practices such as requests for production and deposition testimony.

If it is determined that the injured worker is entitled to Medicare, the potential claim should then be reported to the CMS Coordination of Benefits Contractor (COBC). This reporting may be made via phone (800/999-1118) or in writing (Medicare, c/o COBC, P.O. Box 5041, New York, NY 10274-5041). As part of the reporting process, it will be necessary to provide basic identifying information including the injured worker's name, birth date, health insurance claim number social security number, and a description of the work-related injury with corresponding diagnostic codes (i.e. ICD-9). In addition, the injured worker's Medicare coverage and entitlement information should be provided. A request should be included for the name and contact information of the assigned Medicare contractor. The COBC should be placed on notice as soon as it is determined that the claim involves a Medicare beneficiary as waiting to notify the COBC until the time of settlement will delay the process and could delay finalization of the settlement.

Once the COBC receives notice of the claim, it will issue a "right of recovery" letter placing the parties on notice of Medicare's rights and the assigned Medicare contractor. (As noted above, for most claims reported after October 2, 2006 the assigned contractor will be the CNI). Upon receipt of this information, a request should then be made to the assigned Medicare contractor for a summary estimate of Medicare's alleged conditional payments to date. In response, Medicare will notify the parties if it is claiming conditional payments and, if so, will provide a claim summary form listing the alleged conditional payments.

Upon receipt of the claim summary form, it is necessary to closely scrutinize the listed payments to determine if they relate to the subject injury or are otherwise appropriate. If the list contains inappropriate or questionable payments, it will be necessary to negotiate the removal of incorrect charges with the assigned Medicare contractor in writing. Once the settlement is approved, the assigned contractor should be notified accordingly and a request for a "final" conditional payment demand should be made.

The issue of which party will assume responsibility for reimbursement of conditional payments needs to be addressed as part of settlement negotiations. A frequent problem is the lack of sufficient information by the parties involved with regard to the potential Medicare conditional payments at the time of settlement. This usually occurs because the claim is reported late to the COBC, which, in turn delays the conditional payment identification process.

There could also be a delay on CMS' end in providing the information, despite situations where the claim is reported early. It is interesting to note that often times the parties end up receiving CMS approval of the MSA *before* resolving the conditional payment issue, or many times before even receiving any information from CMS regarding conditional payments.

As a practical matter, the workers' compensation carrier often times agrees to assume responsibility for Medicare conditional payments in an effort to finalize settlement and disburse funds. A word of caution is warranted here: While the case is then technically settled, the carrier will need to keep its file open until the issue of conditional payments is resolved. Alternatively, the injured worker may be made the responsible party. It should be noted, however, that CMS would still have a right of action against the primary payer to the extent the injured worker failed to reimburse Medicare for conditional payments.

Conclusion

This article is intended to serve as a basic overview and introduction to the important issue of Medicare conditional payments. Protecting Medicare's interests regarding conditional payments presents many practical challenges to all parties in a workers' compensation claim. While examination of all potential issues concerning conditional payments is obviously beyond the scope of this article, the overriding intent of the foregoing is to acquaint primary

payers and practitioners with the need to consider and protect Medicare's interests.

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Worker's Compensation Laws of the 50 States and District of Columbia

These resources are a link to the workers' compensation law for these areas. Most links also contain additional workers' compensation related resources.

Alabama	http://dir.alabama.gov/wc/	Alabama Department of Industrial Relations
Alaska	http://labor.state.ak.us/wc/	Alaska Division of Workers' Compensation
Arizona	http://www.ica.state.az.us/workersCompensation/index.html	Industrial Commission of Arizona
Arkansas	http://www.state.ar.us/labor/	Arkansas Department of Labor
California	http://www.dir.ca.gov/	California Department of Industrial Relations
Colorado	http://www.coworkforce.com/	Colorado Department of Labor and Employment
Connecticut	http://www.ctdol.state.ct.us/	Connecticut Department of Labor
Delaware	http://www.delawareworks.com/industrialaffairs/services/WorkersComp.shtml	Delaware Department of Labor/Office of Workers' Compensation
District of Columbia	http://michie.lexisnexis.com/dc	District of Columbia Workers' Compensation Click on the folder for District of Columbia > Division of Local Business Affairs > Title 32 Labor > Chapter 15 Workers' Compensation
Florida	http://www.fldfs.com/wc/	Florida Department of Financial Services/ Division of Workers' Compensation
Georgia	http://sbwc.georgia.gov	Georgia State Board of Workers' Compensation
Hawaii	http://www.hawaii.gov/labor/	Hawaii Department of Labor and Industrial Relations
Idaho	http://www.iic.idaho.gov/	Idaho Industrial Commission
Illinois	http://www.state.il.us/agency/idol/	Department of Labor State of Illinois
Indiana	http://www.in.gov/workcomp/	Workers' Compensation Board of Indiana
Iowa	http://www.iowaworkforce.org/wc/	Iowa Division of Workers' Compensation
Kansas	http://www.dol.ks.gov/WC/html/wc_ALL.html	Kansas Department of Labor
Kentucky	http://www.ky.gov	Kentucky home page Choose Employment (left hand menu) > Employee Rights > Scroll down to Workers' Compensation
Louisiana	http://www.ldol.state.la.us/	Louisiana Department of Labor
Maine	http://www.maine.gov/labor/	Maine Department of Labor
Maryland	http://www.wcc.state.md.us/	Maryland Workers' Compensation Commission
Massachusetts	http://www.mass.gov	Massachusetts home page Enter "Health and Human Services" in search box > click Health and Human Services > choose Consumers > scroll down to Insurance (including Mass health) > click on workers' compensation
Michigan	http://www.michigan.gov/wca http://www.michigan.gov/cis/0,1607,7-154-10573_35828_36096---,00.html (in depth resource)	Michigan Department of Labor and Economic Growth
Minnesota	http://www.doli.state.mn.us/	Minnesota Department of Labor and Industry
Mississippi	http://www.mwcc.state.ms.us/	Mississippi Workers' Compensation Commission
Missouri	http://www.dolir.mo.gov/wc	Missouri Department of Labor Industrial Relations
Montana	http://erd.dli.mt.gov/wcclaims/wcchome.asp	Montana Department of Labor

Nebraska	http://www.dol.state.ne.us/	Nebraska Workforce Development Department of Labor
Nevada	http://dirweb.state.nv.us/WCS/wcs.htm	Nevada Division of Industrial Relations
New Jersey	http://www.nj.gov/labor/wc/wcindex.html	New Jersey Department of Labor and Workforce Development
New Hampshire	http://www.labor.state.nh.us/	New Hampshire Department of Labor
New Mexico	http://www.dol.state.nm.us/	New Mexico Department of Labor
New York	http://www.labor.state.ny.us/	New York State Department of Labor
North Carolina	http://www.nclabor.com/	North Carolina Department of Labor
North Dakota	http://www.nd.gov/labor/	North Dakota Department of Labor
Ohio	http://www.serb.state.oh.us/	Ohio State Employment Relations Board
Oklahoma	http://www.state.ok.us/	State of Oklahoma Choose Business and Employment (left hand menu) > Employer Resources > Workers' Compensation and Unemployment
Oregon	http://www.boli.state.or.us/	Oregon Department of Labor
Pennsylvania	http://www.dli.state.pa.us/	Pennsylvania Department of Labor and Industry
Rhode Island	http://www.dlt.state.ri.us/wc/	Rhode Island Division of Workers' Compensation
South Carolina	http://www.llr.state.sc.us/	South Carolina Department of Labor, Licensing and Regulation
South Dakota	http://www.state.sd.us/	South Dakota Choose Employment > Department of Labor > (left hand menu) Business > Labor and Management
Tennessee	http://www.state.tn.us/labor-wfd/wcomp.html	Tennessee Department of Labor and Workforce Development
Texas	http://www.twc.state.tx.us/ui/lablaw/lablaw.html	Texas Workforce Commission Labor Law
Utah	http://laborcommission.utah.gov/indacc/indacc.htm	Labor Commission of Utah
Vermont	http://www.labor.vermont.gov/	Department of Labor State of Vermont
Virginia	http://www.vwc.state.va.us/	The Virginia Workers' Compensation Commission
Washington	http://www.lni.wa.gov/	Washington State Department of Labor and Industries
West Virginia	http://www.labor.state.wv.us/	West Virginia Division of Labor
Wisconsin	http://www.dwd.state.wi.us/	Wisconsin Division of Workforce Development
Wyoming	http://wydoe.state.wy.us/doe.asp?ID=9	Wyoming Workers' Safety and Compensation Division

References & Resources

Online Resources for Medicare Set-Asides and Workers' Compensation Law

Kara DiCecco, MSN RN LNCC

Below is a list of online resources to learn more about Medicare Set-Aside issues and Workers' Compensation law. This list is not exhaustive and is not an endorsement of any commercial sites. As with any online resource, the reader must confirm its authority and credibility.

<p>www.hhs.cms.gov Three informative choices are 1) Medicare Worker's Compensation Set Aside Arrangements; 2) Overview; and 3) Structured Set Aside Arrangements (pdf)</p>	<p>Center for Medicare and Medicaid Services This is the home page for the Center for Medicare & Medicaid Services. In the upper right search box, type "medicare set aside" and hit enter. Continue to browse to familiarize yourself with the information.</p>
<p>www.gpoaccess.gov/cfr/index.html</p>	<p>Code of Federal Regulations Online source from the government's GPOAccess. Authoritative listing for the Code of Federal Regulations.</p>
<p>www.ssa.gov/</p>	<p>Social Security Administration Home page for the SSA. If complete information known, choose Benefit Eligibility Screening Tool (BEST) screening tool on left for an informal eligibility status.</p>
<p>www.namsap.org/</p>	<p>National Alliance of Medicare Set Aside Providers Non-profit agency addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on worker's compensation liability settlements.</p>
<p>www.chickasaw.com</p>	<p>Chickasaw Nation Industries, Inc. The home page for CNI, click on Contact Us, choose Business Units and then scroll to CNI Administration Services, LLC.</p>
<p>www.cdec1.com/</p>	<p>The Commission for Health Care Certification Home page for information regarding certification. Additional resources, two of which are a) research policy guidelines and 2) sample depositions.</p>
<p>www.workcompcentral.com/</p>	<p>Work Comp Central By entering Medicare Set Aside in the search box, you can access a wealth of topic articles. Registration required for this commercial site to fully use all services.</p>
<p>http://sevarino.lawoffice.com/ Offers a tremendous amount of information on MSA, and the section of frequently asked questions (FAQs) is especially helpful. Click on Articles in the right hand menu.</p>	<p>Law Offices of Angelo Paul Sevarino Commercial website of independent practitioner in workers' compensation law.</p>
<p>www.nqbp.com Offers articles, forms, and information on the MSA process.</p>	<p>NuQuest Bridge Pointe Commercial site that advertises its services as One Source for Medicare Secondary Compliance.</p>
<p>www.capehart.com Check out the Resource Center in the left hand menu of the home page.</p>	<p>Capehart Scatchard Commercial site for the New Jersey corporate law firm of Capehart Scatchard.</p>
<p>www.gouldandlamb.com/index.htm Offers basic information on a variety of MSA scenarios.</p>	<p>Gould and Lamb, LLC This is a commercial Web site (medical-financial services company).</p>
<p>http://wilg.org/index.asp Plaintiff's resource.</p>	<p>Work Injury and Law Advocacy Group Non-profit Web site promoting plaintiff advocacy.</p>
<p>www.nwcdn.com/index.shtml Defense resource.</p>	<p>The National Workers' Compensation Defense Network Nationwide network of law firms representing the interests of employers and insurers.</p>
<p>www.expertlaw.com/library/comp_by_state/</p>	<p>ExpertLaw.com An excellent resource for state-by-state worker's compensation laws.</p>
<p>www.dol.gov/esa/regs/statutes/owcp/stwclaw/stwclaw.htm State workers' compensation laws. Excellent List of Benefits Table.</p>	<p>US Department of Labor From the Department of Labor/Employment Standards Administration.</p>

Malpractice Insurance for the LNC

Barbara A. Boschert, RN BSN

Q: As the sole owner/employee of an incorporated business, do I purchase LNC malpractice insurance for myself, for my business, or for both?

A: There are three basic plan options – Employed, Firm, and Self-employed. Determine which is appropriate for your business and work activity.

Some of you may recall the thread of conversation that ran on the chapter leader listserv about 2 years ago regarding malpractice insurance for the legal nurse consultant (LNC). It went something like this:

“How do I know that the same malpractice insurance I carried as a clinical nurse will protect me in my capacity as an LNC? Do I need a special rider on my policy? Is there any one company that seems to truly understand our scope of practice and can unequivocally state that the coverage is appropriate for the specific actions/responsibilities of the LNC?”

This conversation was the impetus for research into the issue, the ultimate outcome of which was the recent announcement by AALNC Headquarters of the endorsement of NSO (Nurses Service Organization) as a provider of malpractice coverage for the LNC. As my professional liability policy is coming up for renewal soon, I decided to call a customer representative at NSO to pose a question that, to date, I had never received a clearly stated, understandable answer.

As it was explained to me, there are three basic plan options – Employed, Firm, and Self-employed. As LNCs, it is our responsibility to determine which is appropriate for our individual businesses and work activities. The following is a recap of their explanation to me. But first, two disclaimers:

1. *This information pertains only to LNC policies purchased through NSO.* Other companies may have their own variety of policies from which to choose, each having their own distinct coverage limits.

2. *This is not intended as advice on the purchase of malpractice insurance.* I consider myself “Jane Q. Public” as an LNC, and I figured that if I have this question, it is likely that many of my colleagues may as well. Each of you should consult with the insurance professional of your choice in an effort to ensure that you are receiving current, relevant information regarding malpractice insurance for you and/or your business.

Employed: The “Employed” policy appears similar to the coverage I purchased when I worked in the hospital doing bedside nursing, providing me with malpractice protection over and above what my employer may carry on me. This sort of policy will cover me for all work I do as an employed LNC of

any entity – except that which I personally own. In other words, the “Employed” policy will not cover me if/when I am working as an employee of my own incorporated or LLC practice.

Firm: In contrast, I could purchase a “Firm” policy that not only covers me as a practicing LNC, but also provides protection for my business, if it is incorporated or an LLC. In addition, any/all owners, employees, and subcontractors providing services are also covered vicariously. Should I choose to provide additional services as an individual subcontractor to another firm/company, I can add a “Moonlighting Endorsement” to protect me while functioning in that capacity.

Self-Employed: My third choice is a “Self-Employed” policy that will cover only me. This type of policy is appropriate for the independent LNC whose business is set up as a sole proprietorship or DBA (“Doing Business As”) – not as a corporation or LLC.

So, to answer my original question:

My business is set up in an S-corporation format, and I do not “moonlight” as an employee or subcontractor for any firm/company other than my own. Therefore, the “Firm” policy (without the “Moonlighting Endorsement”) would be the perfect fit for me. I’d like to take a moment to exercise my literary license, if you will, and say “Thank You” to everyone over the past few years who has heard our concerns/questions regarding malpractice insurance for the LNC and acted on them.

Barbara A. Boschert, RN BSN, has been a member of AALNC, and practicing as an Independent LNC, since 1998. She has served in numerous board positions for the St. Louis Chapter - including President - and is the chair of the Membership Committee at the national level. Boschert teaches all the required courses and two of the elective classes in an LNC Certificate program through the St. Louis Community College system – which proudly uses AALNC’s *Principles and Practice* as the core text. She can be reached at barbcr82@yahoo.com.

Submission Guidelines for *The Journal of Legal Nurse Consulting*

The Journal of Legal Nurse Consulting (JLNC), a refereed publication, is the official journal of the American Association of Legal Nurse Consultants (AALNC). The journal's purposes are to promote legal nurse consulting within the medical-legal community; to provide both the novice and the experienced legal nurse consultant (LNC) with a high-quality professional publication; and to teach and inform the LNC about clinical practice, current national legal issues, and professional development.

The journal accepts original articles, case studies, letters, and research studies. Query letters are welcomed but not required. A manuscript must be original and never before published, and it should be submitted for review with the understanding that it is not being submitted simultaneously to any other journal. Manuscripts should be addressed to Katie Fitzgerald, Managing Editor, Journal of Legal Nurse Consulting, 401 North Michigan Avenue, Chicago, IL 60611-4267; email: kfitzgerald@sba.com (email preferred), phone: 312/321-5177.

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Manuscripts should not exceed 12 pages (approximately 3,000 words) in length. The title page should include the title of the manuscript and the authors' names, credentials, work affiliations and addresses, daytime phone numbers, fax numbers, and e-mail addresses. One author should be designated as the corresponding author. The title page, the tables and figures, and the reference list should each appear on a separate page. Pages, beginning with the title page, should be numbered consecutively.

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Submit one paper copy and one electronic copy (on a 3.5-in. disk) or via email kfitzgerald@sba.com. Microsoft Word is preferred. Use a minimum of formatting; do not use unusual fonts or a variety of type, and do not insert headers or footers except for page numbers. Create a separate file for tables and figures—do not insert them into the text file. Clearly label the disk with the submission title, word processing program name and version, and name of the corresponding author.

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- Permission for including or reproducing previously published information (e.g., tables and figures) is enclosed.
- Numbers and percentages have been checked against one another and the text for accuracy.
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- The pages are numbered consecutively, beginning with the title page.
- Photographs are black-and-white glossy prints.
- One author has been designated as the corresponding author.

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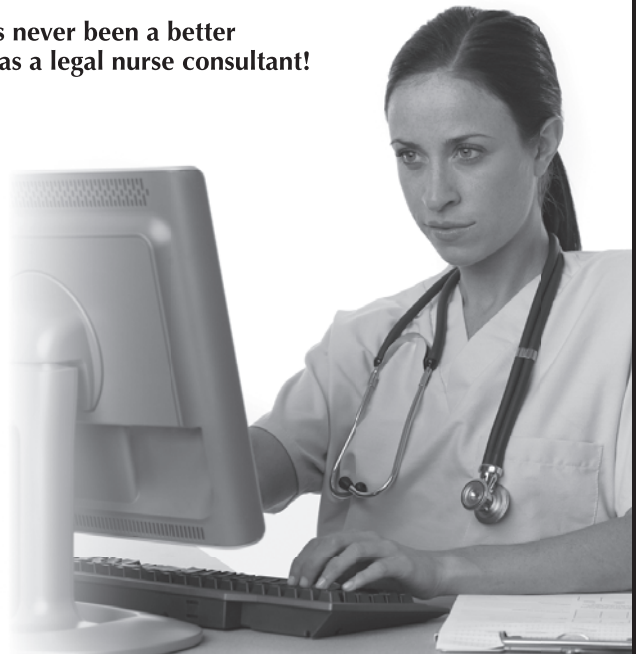
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