



**ALTERNATIVES FOR CONSIDERING MEDICARE'S INTERESTS IN
SETTLING WORKERS COMP AND LIABILITY CLAIMS**

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Medicare Set-Asides are a Legal Fiction

- No Law Requires an MSA
 - Statute
 - Regulation
 - Memos
- Tool to Avoid Burden Shift
 - Mid 1990's, multimillion dollar catastrophic claims
 - 2001 CMS memo changed landscape
- Changing climate
 - Increased MSA amounts
 - Increased time
 - No assurances, CMS unpredictable



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Medicare Set-Asides are a Legal Fiction

- More attention to alternatives
- Evidence-Based Medicine and Non-Submit Programs increasing in WC area
- National Alliance for Medicare Set-Aside Professionals Annual Conference topics for past several years



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Types of MSAs

- Commutation: fully funds future injury-related Medicare-covered treatment
- Compromise: apportions the future medical in a net settlement based on the relative value of the various damage elements asserted in the claim.
- Partial Waiver: fully funds the future injury-related Medicare-covered treatment for the accepted conditions and seeks a waiver from CMS for the denied conditions.
- Zero Dollar MSA / Total Waiver
- Nuisance Value
- Evidence-Based Medicine, Standards of Care MSA (hold harmless/indemnification protection)



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Submission or Non-Submission ?

- **CMS Review is Voluntary in Nature**

Section 8.0 of the WCMSA Reference Guide, March 19, 2018:

“There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS’ WCMSA review process, the Agency requires that you comply with CMS’ established policies and procedures in order to obtain approval.”

Section 4.2 of the WCMSA Reference Guide, January 4, 2019:

“Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare’s interests.”



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CMS WCMSA Workload Review Thresholds

For Medicare Beneficiaries

The claimant is a Medicare beneficiary at the time of the settlement and the total settlement amount is greater than \$25,000.

For Non-Medicare Beneficiaries

The claimant is not a Medicare beneficiary at the time of the settlement, but the total settlement amount is greater than \$250,000 AND the claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date.



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CMS WCMSA Review Thresholds

Example 1:

A recent retiree aged 67 and eligible for Medicare benefits under Parts A, B, and D files a WC claim against their former employer for the back injury sustained shortly before retirement that requires future medical care. The claim is offered settlement for a total of \$17,000.00. However, this retiree will require the use of an anti-inflammatory drug for the balance of their life. The settling parties must consider CMS’ future interests even though the case would not be eligible for review. Failure to do so could leave settling parties subject to future recoveries for payments related to the injury up to the total value of the settlement (\$17,000.00).



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CMS WCMSA Review Thresholds

Example 2:

A 47 year old steelworker breaks their ankle in such a manner that leaves the individual permanently disabled. As a result, the worker should become eligible for Medicare benefits in the next 30 months based upon eligibility for Social Security Disability benefits. The steelworker is offered a total settlement of \$225,000.00, inclusive of future care. Again, there is a likely need for no less than pain management for this future beneficiary. The case would be ineligible for review under the non-CMS-beneficiary standard requiring a case total settlement to be greater than \$250,000.00 for review. Not establishing some plan for future care places settling parties at risk for recovery from care related to the WC injury up to the full value of the settlement.



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CMS Submission Process

WCMSA Reference Guide

Documents needed for submission

- ✓ Cover letter
- ✓ Consent to Release
- ✓ Rated Ages with specific statement
- ✓ Life Care/Future Treatment Plan
- ✓ Settlement Agreement/Proposed Order (or statement that there are none)
- ✓ WCMSA Administration Agreement (or info regarding type of admin)
- ✓ Medical Records
- ✓ Payment History
- ✓ Supplemental or Additional Information



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Documentation and Development Letters

- Form is important for these documents
 - Inconsistency regarding acceptable formatting
- Development letters
 - BCRC or WCRC determines they need additional information before review
 - 30% of all submissions end up with one or more
 - May seek inappropriate information, i.e. reserve details
- Section 16.1 WCMSA Reference Guide – case closed for more than one year from original submission, need to restart submission process



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Determinations

- May approve the amount submitted or “counter”
- Determination based on CMS guidelines is generally overfunded and unlikely to exhaust
- Rationale often analyzes information incorrectly

EXAMPLE:

“ The CMS position is not whether a carrier demonstrates liability, but whether Medicare would reasonably pay for something in the future that should have been covered as it related to the WC claim.”



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Determinations cont.

- Medicare **ONLY** becomes primary when you have accepted finalized determination and have proper exhaustion and accounting of the MSA
- Doesn't matter if you have funded the CMS determination, if claimant doesn't administer the funds correctly, Medicare won't become primary until the amount of mismanaged funds are returned to the MSA account.



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Alternatives to Traditional MSA

- Do nothing
- Non-submission of traditional MSA following CMS standards
- Evidence based medicine/standards of care allocation
- Compromise allocation



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Do Nothing

- General release, no allocation
- Section 111
- Burden on claimant
- Possible action to set-aside settlement
- Joint and several liability for conditional payments
- Private cause of action?



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Non-Submission of Traditional MSA

- Expedient
- Overfunded allocation
- No protection from future CMS actions



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EBM/Standard of Care Allocation

- Standards of Care/Evidence Based Medicine vs. CMS Methodology, 35-50% savings
- MSA is based on the probable versus the possible
- Medically and legally defensible
- Increases the ability to settle the medical portion of the claim



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Compromise

- Allows for reasonable consideration of Medicare’s interests while taking into account the disputed nature of certain claims
- 42 CFR 411.46 and 411.47
- SSR 70-38
- Looks to the ratio between:
 - The full possible indemnity and non-Medicare covered exposure (i.e. – full amount claimant would get if defense lost the case) AND
 - The MSA (which includes both accepted and disputed)
- Compromises allow you to settle your case for whatever you can settle it for, the MSA is then ‘fit into’ the settlement



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Compromise – Creating the Percent

Example:

MSA amount: \$50,000

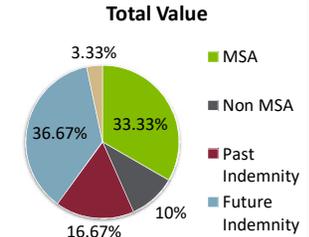
Non-Medicare covered medical: \$15,000

Past Indemnity Exposure: \$25,000

Future Indemnity Exposure: \$55,000

Liens: \$5,000

TOTAL EXPOSURE: \$150,000



Ratio of MSA to the TOTAL EXPOSURE: \$50,000 / \$150,000

Percentage: 33.33%



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Compromise – How to Apply

Percentage is applied to the NET of the Claimant

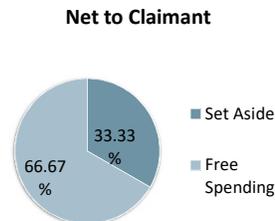
Case settles for \$40,000

- Attorney fee is 20%: \$8,000

- Lien: \$5,000

= **\$27,000 NET to Claimant**

33.33% of \$27,000 or: **\$8,999.10**

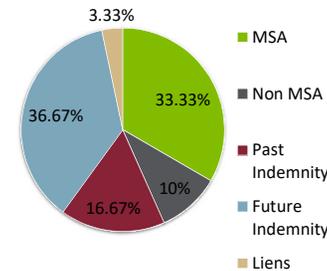


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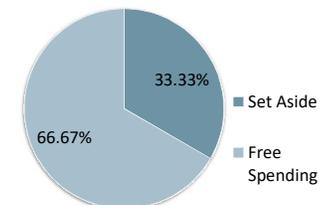
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Comparison

Total Value



Net to Claimant



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Other Considerations

- Administration
- Who bears the risk
- Legal basis
- Documentation
- Insurance
- Hold Harmless and Indemnification



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attention



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