



2010 DWC CONFERENCE

SOCIAL SECURITY DISABILITY, MEDICARE AND WORKERS' COMPENSATION SETTLEMENTS

By: Robert G. Rassp, Esq.



SOCIAL SECURITY, MEDICARE AND WC

Question #1:

Which of the following is true:

- a. Fish can drown
- b. China has only one time zone
- c. Chewing gum while peeling an onion will prevent crying
- d. The average raindrop falls at 7 mph
- e. All of the above
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ANSWER: e



THE NIGHTMARE CONTINUES.....

- Applicant claimed injuries AOE/COE to her bilateral upper extremities, neck and back on a CT basis through 8/21/2000.
- AME opined that all injuries were compensable except the neck.
- IW was a Medicare beneficiary prior to the settlement and Medicare paid for treatment to the neck.
- On 11/16/07, C&R approved by WCJ with MSA approved by CMS on 11/5/07 for \$98,205.00. MSA notice says MSA does not cover conditional payments.
- C&R said "Def agrees to pay, adjust or litigate liens of record." IW was not held harmless from liens.



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- The only lien claimant was “United Government Services” who was replaced by “Medicare Secondary Payer Recovery Contractor” or MSPRC). WCJ set case for lien conferences.
- UGS, MSPRC and CMS failed to appear at numerous noticed lien conferences.
- On March 13, 2009 WCJ issued sanctions of \$1,000.00 to Medicare for its failure to appear and issued order granting Def Petition to Dismiss Medicare’s Lien.
- US Dept. of the Treasury sends WCAB letter objecting to sanctions order saying you can’t sue Uncle Sam
- WCAB grants recon on its own motion and vacates order of sanctions.



THE NIGHTMARE CONTINUES.....

- On December 8, 2008, the US Dept. of the Treasury, Debt Management Servicing Center notified the Applicant that they were garnishing her monthly SSD benefits to recover the costs Medicare paid for her medical treatment to her neck.
 - “Defendant attempted to adjust, and ultimately litigated, the lien of UGS, which is the lien claimant’s name as it still appears in our records. In response to defendant’s Petition for Dismissal of Lien, the WCJ’s self-executing order of Dismissal of Lien issued on March 5, 2009. Lien claimant did not object, and we received no petition for reconsideration. The order dismissing the lien therefore became final. Applicant’s case before the WCAB had concluded. To our knowledge, defendant has performed its obligations under the C&R. Lien claimant’s lien has been dismissed with prejudice.”
- What did the WCJ and the WCAB both do wrong in this case?



TWO PARALLEL UNIVERSES

- Social Security Disability offsets
- Medicare Secondary Payor Act

Now, we have effective 07/01/2009:

- The MMSEA and SCHIP Extension Act of 2007, Section 111, 42 USC 1395y(b)(8)



AGED, BLIND AND DISABLED

- 12.4% Gross wages (F.I.C.A.)
- 6.2% Paid each by employer and employee (by payroll deductions) up to \$106,800.00 in wages
- Covers Retirement, Blind, and Disability (SSD-I and SSI) Programs



SOCIAL SECURITY RETIREMENT (AGED)

- Full benefits at age 65 (“retirement age”) if born on or before 1938
- If born after 1938, “retirement age” is later, up to age 67
- There are no offsets against social security benefits if there is a workers’ compensation lump sum settlement after an IW becomes eligible for regular Social Security Retirement benefits.



SOCIAL SECURITY DISABILITY

- SSD-I vs. SSI
- SSD “earnings” AND “disability” requirements
- SSD-I requires 21 quarters contribution in the 40 quarters prior to the onset of disability (five years of contributions in last 10 years before onset).
- Payment of SSD per month equals the same amount as if the IW reached regular retirement age.
- Currently SSD is max of \$2,420.00 per month for individual, \$4,232.00 max for family.
- Applicant can return to work and reapply for SSD within 60 months without prejudice or keep working and earn a new 21 quarter earnings history.



MORE SOCIAL SECURITY DISABILITY

- Applicant can earn up to \$950.00 per month for a 9 month “trial work period” without prejudice to SSD benefits.
- Long term disability (LTD) plans require recipients to apply for SSD under ERISA plans
- ERISA (Employee’s Retirement Income Security Act of 1974)
- ERISA plans pay 60% or 70% of base salary if no one else pays (benefits are reduced by SDI, TTD, PD, SSD)
- Some LTD plans are “integrated benefits plans” which allow full credit against workers’ compensation benefits



MEDICARE A, B, C AND NOW D

- 2.9% gross wages, no cap.
- 1.45% paid each by employer and employee
- This payroll deduction pays Medicare Part A
- \$96.40 per month optional premium for Medicare Part B, deducted from SSD or regular SSR benefits for existing bennies. \$155.00 per year deductible. Higher premiums for others.
- \$31.94 base per month premium for Medicare Part D Prescription Medication program



MEDICARE PART A

- Covers “major medical”
- Hospitalization
- Skilled nursing home care
- Hospice care
- \$1,100.00 deductible for hospitalizations (repeats if you are hospitalized again after 60 days)



MEDICARE PART B

- Optional coverage - \$96.40 per month premium deduction from SSD or SSR for existing beneficiaries.
- Premium beginning for new members or “non-deductible members” as of 1/1/2010 varies depending on individual or joint income.
- Physician office visits, durable medical equipment, outpatient surgeries, diagnostic imaging studies, IV meds



MEDICARE PART B

Individual tax return	Joint tax return	You Pay
≤ \$85K	≤ \$170K	\$110.50
\$85K - \$107K	\$170K – 214K	\$154.70
\$107,001 - \$160K	\$214,001-\$320K	\$221.00
\$160,001 - \$214K	\$320,001-\$428K	\$287.30
> \$214K	>\$428K	\$353.60



MEDICARE CHOICE + (PART C)

- Medicare HMO, combines Parts A and B coverage
- Capitated plans like Kaiser Senior Advantage Plan (1997)
- Fee for service plan like Blue Shield/Blue Cross PPO
- Medicare recipient can change plans once a year
- “Medi-gap” plans are optional supplemental plans you can buy that pays deductibles and co-payments.



MEDICARE PART D Rx PLAN

- Optional except for Medi-Cal (Medicaid) recipients who are automatically enrolled
- \$31.94 per month “national base” premium
- Payments for first \$2,250.00 in annual drug costs
- “Donut Hole” No coverage between \$2,250.00 and \$5,100.00 in annual drug costs
- Medicare pays for 95% of prescription drugs over \$5,100.00 and recipient pays 5% co-payments
- At least \$3,600.00 per year medication costs are not covered by Medicare
- For MSA purposes, CMS uses average wholesale pricing of medications as of 3/3/09



SSD GENERALLY

- “Disability”: Person has medically determinable physical and/or mental impairments that given the Claimant's age, education, occupational history, medical conditions and residual functional capacities, he or she is unable to engage in any kind of substantial gainful activities for at least twelve consecutive months or which results in death 42 USCA 416(I).
- AMA Guides and “non-exertional factors
- ODAR hearings
- SSI – workers’ compensation cases almost always wipe out SSI benefits
- Steve Webster, Keith Dietterle, William Ordas, David Marcus are now ALJs with ODAR
- ALJs earn about \$150,000.00 per year plus benefits after about four years of service



SSD OFFSETS, AN INTRO

- See 42 USCA 424(a), 20 CFR 404.317 and 404.408
- TTD rates today cover 67% of wages up to \$76,908.00
- But only 104 weeks of TTD for DOI on or after 1/1/04.
- There is more pressure to file for SSD since the maximum rate for SSD is now \$2,500.00 per month, and about \$4,200.00 per month for family with minor children.



SSD OFFSETS – THE 80% RULE

- SSD benefits are reduced “If SSD benefits plus other public mandated benefits exceed 80% of the Claimant’s highest calendar year’s earnings in the last 5 years before the onset of disability.”
- Huh?
- Public mandated benefits = SDI, workers’ compensation indemnity.



THE 80% RULE

- Examples
- \$30,000.00 per year
- \$60,000.00 per year
- \$15,000..00 per year
- Federal “POM” (Procedure Operations Manual) requires SSA to use one of three formulas most favorable to the Claimant
- Is a workers’ compensation settlement wage loss or loss of bodily functions?
- TTD = wage loss, PD = loss of bodily functions due to AMA Guides



SOCIAL SECURITY ADDENDUM

Essential elements needed in an SSD addendum:

- Applicant’s pre-injury monthly earning capacity
- Applicant’s age on P&S date
- Applicant’s life expectancy as of the P&S or settlement date
- Gross C&R amount
- PD rating (not the impairment rating!)
- Less deductible amounts = net proceeds
- Future medical costs not covered by Medicare
- Life expectancy (in months) multiplies times pre-injury earning capacity = loss of earnings
- Amortization of net proceeds over the Applicant’s life expectancy as loss of future earnings caused by work related impairment(s)



SOCIAL SECURITY ADDENDUM

1. Applicant's pre-injury earning capacity is \$_____ per year which is \$_____ per month.
2. Applicant's date of birth: _____ and his/her life expectancy is _____ years which is _____ months.
3. Applicant's permanent and stationary date is _____ based on the report of Dr. _____.
4. Applicant's permanent disability rating before apportionment is _____% based on the report of Dr. _____.
5. Applicant requests an allocation/characterization of settlement proceeds as follows:
 1. Gross settlement: _____
 2. Less Attorneys Fees: _____
 3. Less SJDB: _____
 4. Less Other Deductions: _____
 5. Less Present Value of FMTx*: _____
 6. Net Proceeds: _____

*The present value of future medical treatment includes \$_____ per month for life for medical expenses not covered by Medicare or other insurance such as mileage reimbursement, deductibles, co-payments and Applicant's share of prescription costs.

Applicant requests that the WCAB make a finding that the Applicant's net proceeds, \$_____, based upon this allocation, be designated towards his/her loss of future earnings as the equivalent of \$_____ per month for life on account of his or her loss of bodily functions due to the industrial injuries that are settled herein.

Dated: _____ Signatures of Applicant and his/her attorney_____



WCJs AND SSD ADDENDUMS

- Should WCJs pay attention to them?
- Isn't it between the Applicant and the SSA; the WCAB and defendants have no interest in them?
- Is the Applicant's informed consent enough?
- See, Santa Maria Bonita School District vs. WCAB (Recinos) 2003, 67 Cal. Comp. Cases 848.
- Paragraph 11 of the C&R
- Allocation of benefits needs to be evidence based for SSA approval.
- If you ignore the C&R addendum you may make an otherwise adequate C&R inadequate



MORE WCJs AND SSD ADDENDUMS

- If the WCJ does not approve allocation of C&R proceeds then SSA will use whole C&R as SSD offset at the TTD maximum weekly rate until the total amount of the C&R is “paid out.”
- SSD benefits get reduced or eliminated as a result of a C&R without an allocation of benefits



THINGS NOT SUBJECT TO SSD OFFSETS

- Attorneys fees
- Vocational rehabilitation/SJDB
- Penalties and interest
- Right to file a Petition to Reopen
- Death benefits
- Mileage reimbursement
- Insurance deductibles and co-payments
- \$3,600.00 plus 5% of prescription drugs over \$5,100.00 per year that are not covered under Medicare Part D



BUT WAIT!

- There is no offset against regular social security retirement (SSR) benefits because of a Compromise and Release!
- But watch out for Medicare!!!!



WCJ'S SUPPLEMENTAL ORDER OF APPROVAL OF A C&R

- Protects the Applicant against an SSD offset
- Must be written on the original OAC&R and not on a "Supplemental Order" page.
- Example language: "The Court has considered the proposed characterization of proceeds in the Social Security Addendum attached to the C&R. The Court adopts, incorporates and accepts the proposed allocation of proceeds and finds that the Applicant's net recovery of \$_____ is equivalent to the sum of \$____ per month for life because of the Applicant's loss of future earning capacity that is caused by his or her impairments."
- Should DWC, WCAB OR Court Administrator have guidelines?
- Sometimes you cannot avoid an SSD offset because of a large C&R.



MEDICARE – THE FEAR FACTOR



MEDICARE – THE LAW

Question #2:

Which of the following is true:

- a. Frogs cannot swallow with their eyes open
- b. Koala and humans are the only animals with unique fingerprints
- c. Americans on average eat 18 acres of pizza per day
- d. Elephants are the only mammal that cannot jump
- e. None of the above
- f. All of the above, except e



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ANSWER: f



MEDICARE – THE LAW

- **Section 1862(b)(2) Social Security Act (42 USC 1395y(b)(2)) says Medicare may not pay for medical treatment that has been made or can be reasonably expected to be paid under a workers' compensation law or plan.**
- **The Medicare Secondary Payer Act, 42 USC 1395y, applies to auto accidents, personal injury claims and workers' compensation claims where there is a "primary payer."**
- **Sections 1862(b)(5)(D) and (b)(6) require that CMS ask beneficiaries about payers who may be primary to Medicare.**



MEDICARE – THE LAW

- **“Medicare, Medicaid, SCHIP Extension Act of 2007” (“MMSEA”)**
- **Section 111 of the MMSEA, 42 U.S.C. 1395y(b)(8) requires claims administrators to report claimants who are eligible for Medicare who have a personal injury, auto accident or workers’ compensation claim.**
- **Does a Defendant in a workers’ compensation claim become the “CMS police?”**



MEDICARE SECTION 111 MSP MANDATORY REPORTING

GLOSSARY

- **“RRE” = Responsible Reporting Entity (Claims Administrators)**
- **“NGHP” = Non-Group Health Plan (includes anyone who pays workers’ compensation benefits)**
- **“CMS” = Centers for Medicare and Medicaid Services (part of DHHS)**
- **“COBC” = CMS Coordination of Benefits Contractor who enforces MSP provisions and recommends CMS approvals of MSA agreements**



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- Absolutely necessary website:

WWW.cms.hhs.gov/MandatoryInsRep

This website is updated at least every month and information in this PPT program is current as of 8/18/2009

Claims administrators are advised to have a person in charge of Section 111 compliance



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- “The purpose of Section 111 reporting process is to enable CMS to pay correctly for Medicare covered medical treatment and services to Medicare beneficiaries by determining primary and secondary payer responsibility.”
- RREs must submit information to the Secretary in a form, manner and frequency to be determined



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- Reporting is required for both Medicare claims processing and for MSP recovery actions
- RREs will submit data electronically to the COBC when a Claimant is a Medicare beneficiary (think, “EAMS”)
- TPAs are not RREs! They only act as agents for an RRE
- If an entity is self-insured for a deductible but payments are made by an insurance company, the insurance company is the RRE
- All RREs in a settlement have to report



MEDICARE – THE PROBLEM

- Medicare addendums to C&Rs mean nothing
- Medicare set aside arrangement may or may not be necessary
- “Compromise” means settlement of past medical treatment that is included in a settlement
- “Commutation” means settlement of future medical treatment
- A C&R is both under Federal law
- Medicare set aside trusts apply only to settlement of future medical treatment
- Any identified claims for past injury related medical treatment must be reimbursed to the Medicare Trust Fund



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- If an RRE is in bankruptcy, does CIGA have to report?
- RREs cannot shift responsibility to report to an agent by contract or otherwise unless it guarantees accuracy and complete reporting
- RREs must register with COBC secure website by 6/30/2009, registration began on 5/1/09
- RREs must implement a procedure in their claims resolution process to determine whether an injured party is a Medicare beneficiary and must use the IW's SSN or Medicare Health Insurance Claim Number



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- RRE's initial file submissions must report all claims where IW is or was a Medicare beneficiary that are resolved or partially resolved through a settlement, judgment, award or other payment on or after 7/1/09 regardless of whether there is an award for future medical treatment.
- RRE must issue quarterly reports for all payments to Medicare beneficiaries where there is ongoing responsibility for medical payments ("ORM").



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- Defense attorneys can ask an IW to disclose whether or not he or she is currently eligible for SSR, SSD and/or Medicare
- Defense attorneys can ask IW to disclose whether or not he/she has applied for SSD
- Defense attorneys can require IWs to sign HIPPA and CMS releases to permit communications between the claims administrator and COBC whether there is a C&R or not.
- WCJs can sign an Order Compelling Answers to these questions



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- Payment for a defense evaluation only does not trigger Section 111 filing.
- RREs must report all settlements, judgments or awards as of 7/1/09 where there is award for future medical treatment and any claims pending a settlement or judgment as of 7/1/09 for any Medicare beneficiary.
- RREs must report on-going responsibility to pay for medical treatment and when such payments are terminated (as in a C&R).



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- RREs have an extension until July-October 2010 to identify IWs who have future medical treatment and who are Medicare beneficiaries as of 7/1/09.
- RREs must monitor IWs who are not Medicare beneficiaries at the time of a settlement, award or judgment with future medical treatment but who become beneficiaries prior to termination of medical coverage by the RRE.
- L.C. 5402(c) trigger RRE reporting even if injury is eventually denied AOE/COE, reporting occurs even if medical treatment is terminated and IW is a Medicare beneficiary.



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- RRE does not need to report if a settlement, award or judgment without future medical treatment if IW is not a Medicare beneficiary.
- RREs must report settlements, judgments, awards or payments regardless of whether or not there is an admission or determination of liability. A "Thomas" finding means nothing.
- No exception for de-minimus settlements
- CMS is not bound by any allocation of settlement proceeds made by the parties even where a court has approved such an allocation.



MEDICARE SECTION 111 MSP MANDATORY REPORTING

- There is no age threshold for reporting under 42 U.S.C. 1395y(b)(8)
- Inactive cases may still be reopened for future medical treatment so there is an on-going requirement to report and RRE cannot file a termination of medical treatment report.
- Federal law and regulations pre-empt state laws and state regulations.
- Defendants are permitted to have in place a discovery tool to require IWs to disclose whether or not they are Medicare beneficiaries at any time during a claim.



MEDICARE SET-ASIDE AGREEMENTS

- Applicant is already entitled to Medicare (Part A, B, or both) regardless of the settlement amount.
- OR
- Applicant has a “reasonable expectation” of Medicare enrollment within 30 months of the settlement date AND settlement is greater than \$250,000.00.



WHAT IS A “REASONABLE EXPECTATION?”

- Applicant has already filed for SSD; or
- SSD has been denied but the Applicant anticipates refiling or appealing the denial; or
- Applicant is 62 years, six months old (30 months from retirement age) at the time of C&R; or
- Applicant has ESRD; or
- Applicant is under 65 years but has been receiving SSD for at least two years; or
- Applicant is over 65 years old at the time of the C&R.



WHAT IS REQUIRED IN AN MSA?

- APPLICANT'S HEALTH INSURANCE CLAIM NUMBER OR SSN IF NOT YET ELIGIBLE FOR MEDICARE.
- THE SAME INFORMATION IN A C&R (EACH PARTY'S ADDRESS), CLAIM NUMBER AND COUNSELS' ADDRESSES.
- TOTAL WORKERS' COMPENSATION SETTLEMENT AMOUNT.
- PROPOSED MSA AMOUNT.
- APPLICANT'S LIFE EXPECTANCY.
- LIFE CARE PLAN.
- COPY OF C&R WITH ADDENDUMS.
- CURRENT TREATMENT INFO.
- FUTURE TREATMENT INFO., INCLUDING MEDICATION NEEDS (MEDICAL REPORTS).
- APPLICANT'S MEDICAL RECOVERY PROGNOSIS.



WHAT ELSE IS REQUIRED IN AN MSA?

- AMOUNT OF FUTURE MEDICAL TREATMENT.
- PROPOSED MEDICARE SET ASIDE AMOUNT.
- ADMINISTRATOR?
- FEES?
- SET ASIDE FUNDS ARE ONLY USED FOR INJURY RELATED MEDICAL SERVICES THAT WOULD OTHERWISE BE COVERED BY MEDICARE AT THE TIME APPLICANT IS MEDICARE ELIGIBLE (NOT BEFORE).
- CAN YOU APPEAL A CMS DENIAL OF AN MSA? NO, SEE 42 CFR 405.926 AND 928.
- ADD SOME MONEY AND RE-SUBMIT IT.



OTHER MSA CONSIDERATIONS

- APPLICANT CAN BE THE ADMINISTRATOR.
- SEGREGATED INTEREST EARNING CHECKING ACCOUNT.
- APPLICANT PAYS FOR MEDICARE PART A, B AND D THEN MEDICARE PAYS.
- IT TAKES 120-150 DAYS FOR CMS TO APPROVE AN MSA.
- WCJs SHOULD APPROVE A C&R WITH AN MSA APPROVAL PENDING IF PARTIES AGREE: "APPLICANT AGREES TO ADD FUNDING TO THE MSA FROM HIS OR HER NET PROCEEDS FROM THE C&R IF CMS REJECTS THE MSA THAT WAS PREVIOUSLY SUBMITTED. APPLICANT AGREES TO HOLD DEFENDANT HARMLESS FROM ANY ADDITIONAL LIABILITY FOR THE MSA AMOUNT SUBMITTED AS OF THE DATE OF THE C&R APPROVAL."



ADDITIONAL MEDICARE INFO

- WWW.MEDICARE.GOV has a drop-down menu for everything that is covered by Medicare
- MEDICARE COVERAGE INFORMATION:
1-800-MEDICARE
1-800-633-4227



ADDITIONAL MEDICARE INFO

- ALL WCMSA PROPOSALS SUBMITTED FOR CMS REVIEW MUST BE SENT TO:
 - CMS
c/o COORDINATION OF BENEFITS
CONTRACTOR
P.O. BOX 33849
DETROIT, MICHIGAN 48232
(800) 999-1118 [8:00 a.m. – 8:00 p.m. EDT]
- USE CD-ROM FORMAT



MSAs AND MEDICARE PART D

- **12/30/2005 Guidance memorandum**
- **MSAs have to take into account Medicare's interest in the cost of future prescription medication for work related injuries.**
- **If DOI is less than two years from the date of the settlement then DOI to year to date cost of drugs must be disclosed as part of the MSA proposal.**
- **If DOI is more than two years from the date of the settlement, then the last two years of costs of drugs must be disclosed as part of the MSA proposal.**
- **After 3/3/09, Medicare uses "AVERAGE WHOLESALE PRICING of medication costs regardless of how much Defendant actually had previously paid in the claim. .**
- **Recent case C&R was \$425,000.00 and WCMSA was \$235K, \$195K was for Rx!**



WHAT SHOULD WCJs DO?

- **AD/Court Administrator/WCAB should set up guidelines of what kind of addendums are allowed to be attached to a C&R.**
- **Paragraph 11 of the C&R form: "ACCEPTING A LUMP SUM SETTLEMENT OF A WORKERS' COMPENSATION CLAIM MAY AFFECT, REDUCE OR ELIMINATE OTHER BENEFITS SUCH AS LTD, SOCIAL SECURITY DISABILITY AND MEDICARE ENTITLEMENTS."**
- **Add area in C&R that allows an Applicant to initial the following: "MEDICARE AND/OR MEDI-CAL HAVE NOT PAID FOR ANY OF MY MEDICAL TREATMENT FOR THE ALLEGED INDUSTRIAL INJURIES AS OF THE DATE OF THIS SETTLEMENT"; or**
- **"THE IW CERTIFIES UNDER PENALTY OF PERJURY THAT HE OR SHE IS NOT CURRENTLY A MEDICARE BENEFICIARY."**



WHAT SHOULD WCJs DO, PART 2?

- Additional language: "I AM/AM NOT CURRENTLY ELIGIBLE FOR MEDICARE OR MEDI-CAL COVERAGE."
- If Medicare has paid for treatment for alleged industrial injury, Medicare has a lien as a matter of law and all parties and counsel are liable for failing to take Medicare's interest into account for conditional payments.
- WCJ may set matter for lien conference in accordance with Labor Code Sections 4904(a), 4903.05(b) AND 8 CCR 10250(a) and order Applicant or defense counsel to give notice to CMS, COBC. However: See GORY vs. US FOOD SERVICE, INC. 2010 LEXIS NPD ____.



WCMSA IS REQUIRED – RED FLAGS

- If Applicant is eligible for Medicare on the date of the settlement (Medicare has a lien as a matter of law) – has Medicare paid for treatment? If not, you still need an MSA regardless of the amount of the C&R (But see recent \$25,000.00 memo).
- Applicant is over 62.5 years of age on date of the settlement that is over \$250K.
- Applicant is going to receive SSD within two years from the date C&R is approved and settlement is over \$250K.
- Applicant is currently appealing an SSD denial and settlement is over \$250K.
- Applicant is getting SSD at time of C&R approval and was receiving SSD at least two years before date of approval and C&R is \geq \$25K
- C&R is over \$250,000.00 and C&R approval is within 30 months of becoming eligible for Medicare.



IF YOU DO NOT CARE...

- Medicare will not cover med tx for body parts claimed in the workers' compensation claim.
- Medicare will use the entire C&R amount as the "set aside" amount to cover future medical treatment for parts of body injured.
- Medicare will seek reimbursement for prior conditional payments from the Applicant, his or her attorney, the insurance company and its attorney.
- \$1,000.00 per day fine per IW who is a Medicare beneficiary and RRE fails to file a report to COBC.



WORSE CASE SCENARIO

- Worse case scenario is no SSD addendum and no MSA in a large C&R. Applicant may lose SSD payments based upon weekly TTD rate for entire C&R amount and Medicare will not cover future medical treatment for parts of body injured in work related injury and Medicare will sue the Applicant, his attorney, RRE and its attorney for past treatment costs.
- RRE gets fined by the feds for its failure to report IW who is a Medicare beneficiary.



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- AME opined that all injuries were compensable except the neck.
- IW was a Medicare beneficiary prior to the settlement and Medicare paid for treatment to the neck.
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- What did the WCJ and the WCAB both do wrong in this case?



THE NIGHTMARE CONTINUES.....

- What did the WCJ and the WCAB both do wrong in this case?
- The WCJ should not have let the Defendant off the hook until Medicare agreed that the neck condition was not work related and withdrew its lien claim from the WC case.
- The WCJ should have issued an Order Disallowing Lien issuing a “take nothing” on the basis that the AME report did not support a claim of industrial injury to the neck. Applicant’s attorney could have taken this WCAB order and sent it to the US Dept. of the Treasury collections agency.
- The WCAB should have reinstated jurisdiction over the Medicare lien and disallowed it the way the WCJ should have.
- GORY vs. US FOOD SERVICE, INC. 2010 LEXIS NPD ____



One Final Message

- Do not obtain a proposed WCMSA if you don't need one!
- If you obtain a WCMSA in a case where the IW is not a Medicare beneficiary, you are giving us prima facie evidence of the value of future medical treatment!



SOME EXAMPLES – QUESTION #1

1. 63 year old with a \$100,000.00 C&R, not Medicare eligible until 24 months after C&R approval.



ANSWER #1

- 1. No MSA, no Medicare lien for prior treatment, no RRE Section 111 reporting required.**



QUESTION #2

- 2. 68 year old with a \$40,000.00 C&R with a Thomas finding.**



ANSWER TO QUESTION #2

- 2. Yes, MSA; yes, lien for prior treatment, yes RRE Section 111 reporting**



QUESTION #3

- 3. 68 year old with an F&O that says "Take nothing" because claim of injury was non-industrial.**



ANSWER TO QUESTION #3

- 3. No MSA; there may be a lien for prior treatment but CMS recognizes WCJ's "Take nothing." Probable RRE Section 111 reporting because med tx "terminated."**



QUESTION #4

- 4. 45 year old with a \$300,000.00 C&R who has filed for SSD but has been denied SSD.**



ANSWER TO QUESTION #4

- 4. Yes, MSA; no Medicare lien for prior treatment, yes RRE Section 111 report if IW becomes a Medicare beneficiary.**



QUESTION #5

- 5. 45 year old with a \$300,000.00 C&R who is awarded SSD within 24 months before C&R approval.**



ANSWER TO QUESTION #5

- 5. Yes, MSA; Yes lien for prior treatment, yes, RRE Section 111 reporting.**



QUESTION #6

- 6. 45 year old with a \$100,000.00 C&R who is awarded SSD within 24 months before C&R approval.**



ANSWER TO QUESTION #6

- 6. No MSA needed, no lien for prior treatment, no RRE Section 111 reporting.**



QUESTION #7

- 7. 45 year old with a \$100,000.00 C&R who is awarded SSD within 24 months after C&R approval.**



ANSWER TO QUESTION #7

7. No MSA needed, no lien for prior treatment, no RRE Section 111 reporting.



THE DOG WAS JUST YAWNING...





.....WERE YOU?

■ **THANK YOU FOR YOUR ATTENTION!**

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