2011 DIVISION OF WORKERS' COMPENSATION CONFERENCE

SOCIAL SECURITY DISABILITY, MEDICARE AND WORKERS' COMPENSATION SETTLEMENTS

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FOUR ISSUES IN EVERY CASE?

- Social security disability offset – The "80% Rule"
- Medicare conditional payments
- Shifting future medical treatment to Medicare
- The Medicare and Medicaid State Children's Health Insurance Program Extension Act of 2007 ("MMSEA"), Section 111 reporting, 42 U.S.C. 1395y(b)(8)

FOUR ISSUES IN EVERY CASE?

- When is someone entitled to Medicare?
  - Entitlement to Medicare is indexed to entitlement to Social Security benefits
  - Medicare eligibility does not occur at the same time as entitlement to SSDI or SSI but eligibility is related to social security entitlement
  - Medicare “entitlement” is the same thing as Medicare “beneficiary.”

HOW DOES SOMEONE QUALIFY FOR SOCIAL SECURITY DISABILITY?

- SSA programs: 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 (2011 reduced to 4.2%)
- 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 (Title II) vs. SSI (Title XVI)
- 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, $4,500.00 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.
- There is a 5 month waiting period for SSD payments to begin from onset date of disability. Disability payments begin on the first day of the sixth month after the onset date.
- IW becomes eligible for Medicare 24 months after eligibility for SSD begins.

WHAT IS MEDICARE?

MEDICARE PARTS A, B, C AND D

- 2.9% gross wages, no cap.
- 1.45% paid each by employer and employee
- This payroll deduction pays Medicare Part A
- $96.40/$110.50 per month optional premium for Medicare Part B, deducted from SSD or regular SSR benefits for existing bennies. $162.00 per year deductible. Higher premiums for others.
- $32.34 base per month premium for Medicare Part D Prescription Medication program

MEDICARE PART A

- Covers “major medical”
- Hospitalization
- Skilled nursing home care
- Hospice care
- $1,132.00 deductible for hospitalizations (repeats if you are hospitalized again after 60 days)

MEDICARE PART B

- Optional coverage - $96.40/$110.50 per month premium deduction from SSD or SSR for existing beneficiaries.
- Premium beginning for new members or “non-deductible members” as of 01/01/2010 varies depending on individual or joint income.
- Physician office visits, durable medical equipment, outpatient surgeries, diagnostic imaging studies, IV meds

MEDICARE PART B – 2011 PREMIUMS

Individual tax return	Joint tax return	You Pay
≤ $85K	≤ $170K	$115.40
$85K - $107K	$170K – 214K	$161.50
$107,001 - $160K	$214,001-$320K	$230.70
$160,001 - $214K	$320,001-$428K	$299.90
> $214K	>$428K	$369.10

MEDICARE CHOICE + (PART C)

- Medicare HMO, combines Parts A, B and D coverage through a private insurer
- 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
- $32.34 per month 2011 “national base” premium
- Payments for first $2,840.00 in annual drug costs
- “Donut Hole” No coverage between $2,840.00 and $6,447.50 in annual drug costs (will be eliminated by 2020 – 50% reimbursement for generics 2011)
- Medicare pays for 95% of prescription drugs over $6,447.50 and recipient pays 5% co-payments
- At least $4,550.00 per year medication costs are not covered by Medicare
- For MSA purposes, CMS uses average wholesale pricing of medications as of 04/03/2009

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

SSD OFFSETS – THE "80% RULE"

- See 42 U.S.C.A. 424(a), 20 C.F.R. 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 01/01/2004
- There is more pressure to file for SSD since the maximum rate for SSD is now $2,800.00 per month, and about $4,500.00 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."
- Public mandated benefits = SDI, workers' compensation indemnity.
- LTD plans are not "publically mandated" but plan will assume SSDI entitlement after one year of eligibility for LTD payments and will reduce monthly payments by amount of SSDI payments.

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___

MESSAGE TO 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
- 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 $6,440.00 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 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

- The Medicare program, as originally enacted in 1965, served as primary health insurance for eligible individuals, regardless of access to other means of coverage, with the exception of workers' compensation.
- The Medicare Secondary Payer Act, 42 U.S.C. 1395y(b)(2) was passed in 1980 and made auto, liability, no-fault and workers' compensation insurances "primary" to Medicare, and provided statutory recovery rights for payments made conditionally to ensure treatment received while coverage disputes worked out.
- Sort of like CIGA – If there is "other insurance" Medicare does not pay. WC claims administrator is primary payer.

3 MSP CONSIDERATIONS IN ANY SETTLEMENT

- Medicare Conditional Payments: Payments made by Medicare prior to settlement of WC case for medical treatment that should have been paid for by the WC claims administrator.
- Medicare Set-Asides: Costs and expenses of future medical treatment for industrial injuries cannot be shifted from WC claims administrator to Medicare without "considering Medicare's interests."
- MMSEA Section 111 Reporting: Insurers must report settlements involving Medicare beneficiaries to CMS or be subject to a $1,000 per day per claim penalty

MEDICARE – THE PROBLEM

- Medicare addendums to C&Rs mean nothing – the parties cannot waive or diminish Medicare's rights by agreement
- Medicare has a statutory right to be reimbursed for past injury related medical treatment in full before any other entity receives any funds.
  - If conditional payments exceed the amount of total settlement, Medicare is only obligated to reduce by procurement costs so Applicant could potentially receive nothing.
- Medicare set-aside arrangement not always necessary
  - "Compromise" means settlement of past medical treatment that is included in a settlement
  - "Commutation" means settlement of future medical treatment
  - Medicare set-aside arrangements apply only to settlement of future medical treatment

MSP GLOSSARY

- "MSP" = Medicare Secondary Payer Act [42 U.S.C. 1395y(b)(2)]
- "CMS" = Centers for Medicare and Medicaid Services (part of DHHS)
- "RO" = Regional office of CMS / divided into 10 territories
- "COBC" = CMS Coordination of Benefits Contractor who enforces MSP provisions and recommends CMS approvals of MSA agreements
- "MSPRC" = Medicare Secondary Payer Recovery Contractor – took over duties from COBC to collect conditional payments – Chickabe Tribe has contract.
- "CPL" = Conditional payment letter
- "WCMSA" = Workers' compensation Medicare set-aside arrangement
- "WCRC" = CMS contractor that reviews WCMSAs
- "EIEIO" = That's a joke!

MEDICARE – CONDITIONAL PAYMENTS

- Medicare has a priority right of recovery as a matter of law against Applicant, Defendant, attorneys – everyone except the WCJ - who was responsible for primary payment or received money from a primary payer.
- SSA Sections 1862(b)(5)(D) and (b)(6) require that CMS ask beneficiaries about payers who may be primary to Medicare.
- Contact Info:

Report a Claim:	Conditional Payment Info:
Medicare Coordination of Benefits	MSPRC - NGHP
Medicare Claims Investigation Project	P.O. Box 138832
P.O. Box 33847	Oklahoma City, OK 73113
Detroit, Michigan 48232	866-677-7294
Or call: 800-999-1118	

MEDICARE – CONDITIONAL PAYMENTS

- When contacting the COBC or MSPRC by phone or in writing, be prepared to provide the following information:
  - Applicant's name
  - Applicant's SSN or Medicare Health Insurance Claim Number (HICN)
  - Date(s) of injury
  - Nature of illness or injury (parts of body injured or claimed)
  - Name, address of WC claims administrator
  - Names and addresses of all legal representatives
  - Name of employer
  - Claim number(s)

MEDICARE – CONDITIONAL PAYMENTS

Important things to remember when negotiating conditional payment demands:

- List of services often contains unrelated treatment or combined treatment of related & unrelated services in the same visit – Become familiar with ICD-9 & CPT codes
- CMS will reduce recovery by procurement costs
  - [(Atty fees + Expenses) / total settlement amount] X CPL demand
- Hardship waivers and reductions only granted in very compelling situations

MEDICARE SET-ASIDE ARRANGEMENTS

An MSA should be considered if:

- Applicant is already entitled to Medicare (Part A, B, or both) at the time of settlement regardless of the settlement amount.

OR

- Applicant has foreseeable future related medical treatment anticipated at a time when Medicare enrollment is likely

MEDICARE SET-ASIDE ARRANGEMENTS

An MSA may be reviewed by CMS prior to settlement if:

- Applicant is already entitled to Medicare (Part A, B, or both) AND the settlement amount exceeds $25,000.

OR

- Applicant has a “reasonable expectation” of Medicare entitlement within 30 months AND the total settlement amount exceeds $250,000

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 1/2 years old (30 months from automatic entitlement at age 65) at the time of C&R; or
- Applicant has ESRD

Applicant already entitled if:

- Under 65 but has been receiving SSD benefits for at least two years; or
- Applicant is 65 years or older at the time of the C&R

WHAT IS REQUIRED IN A WCMSA?

- Set-aside funds are intended only for payment of WC injury related medical services that would otherwise be covered by Medicare post-settlement
- Applicant's medical treatment history
  - Current treatment info – most recent 24 months of active treatment
  - Applicant's medical recovery prognosis / AMEs, QMEs, etc.
  - Life care plan if available
  - Corresponding payment records, Rx and medical
- Proposed Medicare set-aside amount / future medical + Rx

MSAs AND MEDICARE PART D

- MSAs have to take into account Medicare's interest in the cost of future prescription medication for work related injuries.
  - See 12/30/05 Guidance memorandum
- After 4/3/09, Medicare uses "AVERAGE WHOLESALE PRICING" of medication costs regardless of how much Defendant actually had previously paid in the claim or permitted by state fee schedule
- 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.
- Recent case C&R was $425,000.00 and WCMSA was $235K, $195K was for Rx!

MEDICARE DOES NOT COVER EVERYTHING

- Medicare Part D does not cover:
  - Vitamins, supplements
  - Over-the-counter medications
  - Benzodiazepines (tranquilizers such as Valium, Xanax)
  - Barbiturates
  - Off-label drugs (see 5/14/10 memo)
  - Limited opioid or opiate based pain medications
- Medicare Parts A and B do not cover:
  - Home assistance for laundry, gardening, window cleaning, meal preparations, other maid services
  - Mileage reimbursement
  - Transportation services (taxis, limos, bus passes)
  - Home modifications
  - Most dental & vision care

ADDITIONAL MEDICARE COVERAGE INFO

MEDICARE COVERAGE INFORMATION:
1-800-MEDICARE [800-633-4227]

- WWW.MEDICARE.GOV has a drop-down menu for everything that is covered by Medicare
- See also http://www.cms.gov/mcd/search.asp?clickon=search
- Applicants can access benefit, coverage, entitlement & CPL info, as well as status of requests & appeals through www.mymedicare.gov

WHAT ELSE IS REQUIRED IN A WCMSA?

- Applicant's life expectancy & appropriate proof if diminished
- The same information in a C&R (each party's address), claim number and counsels' addresses
- Applicant's health insurance claim number or SSN if not yet eligible for Medicare
- Total workers' compensation settlement amount, inclusive of past settlements & 3rd party claims
- Copy of draft C&R with addendums
- Signed release
- Post-settlement administration information

OTHER WCMSA CONSIDERATIONS

- Segregated interest earning checking account
- Medicare will pay once MSA is properly exhausted / may occur year after year if a structured settlement is utilized
- It takes 90-120 days for CMS to approve a WCMSA
- Can you appeal a CMS denial of an WCMSA?
  - No, see 42 C.F.R. 405.926 and .928
- CMS may counter higher, so prepare for the possibility of adding additional funds
- WCJs should approve a C&R with an WCMSA approval pending if parties agree: "Applicant agrees to add funding to the WCMSA 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 WCMSA 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
    Attn: WCMSA Proposal
- For more info:
  https://www.cms.gov/WorkersCompAgencyServices/
- WCRC may be contacted after 45 days for status (301-575-0160)
- If CD-ROM format used, see website for proper file naming
- WCMSA proposal not sent in proper format to the proper P.O. Box or missing any requirements will not be reviewed and you may not be notified

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."

WCMSA 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 $\geq$ $250K.
- Applicant is going to receive SSD within two years from the date C&R is approved and settlement is $\geq$ $250K.
- Applicant is currently appealing an SSD denial and settlement is $\geq$ $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 $\geq$ $250,000.00 and C&R approval is within 30 months of becoming eligible for Medicare.
- Applicant recently applied for SSD but DOI is more than 2 years old – be cautious of possibility of retroactive award

MEDICARE AND MEDICAID SCHIP EXTENSION ACT (MMSEA) OF 2007

- Section 111 of the MMSEA, 42 U.S.C. 1395y(b)(8) requires insurers/self-insureds (RRE) to report settlements (TPOC) involving individuals who are eligible for Medicare in personal injury, auto accident, no-fault or workers' compensation claims.
- Requires RREs to notify CMS of an ongoing responsibility for medical (ORM) and when it has terminated (WC & no-fault)
- $1,000 per day per claim penalty for noncompliance applies only to the responsible reporting entity (RRE)
- "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."

MSP - MMSEA GLOSSARY

- "NGHP" = Non-Group Health Plan (includes liability, no-fault, auto, workers' compensation, and any form of P&C insurance that pays benefits for a personal injury). May be formal or informal self-insured plan to meet definition as well.
- "RRE" = Responsible Reporting Entity (Claims Administrators)
- "ORM" = Ongoing Responsibility for Medical
- "TPOC" = Total Payment Obligation to Claimant
- "EDI" = Electronic Data Interchange
- "DDE" = Direct Data Entry

MMSEA SECTION 111 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 01/10/2011

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

MMSEA SECTION 111 MANDATORY REPORTING

- RREs will submit data electronically on a quarterly basis to the COBC when a Claimant is a Medicare beneficiary (think, "EAMS")
- RREs with less than 500 reportable annual settlements may report on instance using the DDE option
- Monthly query available to RREs to determine Medicare eligibility
- TPAs are not RREs! They may 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 – follow the money to determine the RRE
- All RREs in a settlement have to report their TPOC share
- Payment for a defense evaluation only does not trigger Section 111 filing
- L.C. 5402(c) triggers RRE reporting even if injury is eventually denied AOE/COE, reporting occurs even if medical treatment is terminated and IW is a Medicare beneficiary

MMSEA SECTION 111
MANDATORY REPORTING

- Beginning 01/01/2011, RREs must report all TPOCs occurring on or after 10/01/2010 involving a Medicare beneficiary, with the exception of liability insurance (inclusive of self-insureds) which was delayed to 01/01/2012 for all TPOCs on or after 10/01/2011.
- RREs must report all ORM existing as of 01/01/2010.
- Interim TPOC reporting thresholds have been extended by 1 year
  - No reporting under $5,000 prior to 01/01/2013
  - No reporting under $2,000 prior to 01/01/2014
  - No reporting under $600 prior to 01/01/2015
  - All TPOCs must be reported for settlements occurring on or after 01/01/2015
- No de minimus dollar threshold for ORM reporting
- WC ORM reporting exception for certain med only claims extended through 12/31/2012

MMSEA SECTION 111
MANDATORY REPORTING

- 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.
- 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 CMS HIPPA, Consent to Release and Notice of Representation forms to permit communications between the claims administrator, CMS, COBC and MSPRC whether there is a C&R or not.
- WCJs can sign an Order Compelling Answers to these questions
- 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.

IF YOU DO NOT CARE...

- Medicare will not cover med treatment for body parts claimed in the workers' compensation claim.
- Medicare may use the entire C&R amount as the "set-aside" amount to cover future medical treatment for parts of body injured.
- Medicare may seek reimbursement for prior conditional payments from the Applicant, his or her attorney, the insurance company and anyone in receipt of funds from the settlement.
- Medicare may seek reimbursement a second time from a primary payer even if medicals were paid to Applicant at the time of settlement but not used to reimburse Medicare.
- $1,000.00 per day fine per claim involving a Medicare beneficiary applies if RRE fails to file a timely report to COBC.

WORSE CASE SCENARIO

Worse case scenario is no SSD addendum and no MSP provisions in a large C&R:

- Applicant entire SSD payment is off-set based upon weekly TTD rate for entire C&R amount
- Medicare denies coverage of future medical treatment for parts of body injured in work related injury
- Medicare sues the Applicant, his attorney, and the RRE for twice the past treatment costs + interest
- Applicant sues his attorney for malpractice and the insurer for bad faith settlement practices
- RRE is fined $1,000/day by the feds for its failure to report IW who is a Medicare beneficiary.

CALIFORNIA FLAVOR

- Does IW need an WCMSA?
  - Age ≥ 65 (C&R is ≥ $25,000.00); entitled to SSDI or SSI-D on date of settlement approval, or "reasonable expectation" of entitlement to Medicare within 30 months of settlement AND ≥ $250,000.00 C&R.
- If IW needs an WCMSA, does the C&R need to be sent to CMS?
  - No, just the amount of the settlement needs to be submitted to CMS for CMS approval of a WCMSA.
  - You send a copy of the signed C&R AFTER CMS has approved the WCMSA to complete the process.

CALIFORNIA FLAVOR

- Should Defense require CMS approval of a WCMSA prior to submission of a C&R to the WCAB for approval?
  - No, if the WCMSA is relatively low cost and IW or Defendant agrees to fund any deficiency CMS says exists, OR if IW is over 65.
  - Yes, if the WCMSA is very high cost OR IW is young (<60 years old) OR if WCMSA is structured amount.
- Don't forget SSD Addendum to avoid the "80% Rule."
- "Thomas" findings mean nothing to CMS.

CALIFORNIA FLAVOR

- What if WCJ makes a specific finding of no injury AOE/COE or no industrial injury to specific body parts?
  - CMS will give full faith and credit to judicial decision of no injury AOE/COE or a specific judicial finding of no injury to specific body parts. [ruling on the merits]
  - CMS will not give any credit to a stipulation between the parties that AOE/COE is in issue or a body part is disputed.
- Does an IW with an WCMSA have to pay separately for the "donut hole?"
  - No, there is no donut hole in a WCMSA. All payments from the MSA account must be for only Medicare covered expenses under Parts A, B and D.

CALIFORNIA FLAVOR

- Is there any way to avoid a WCMSA in a typical case where the IW is a Medicare beneficiary at the time of the settlement?
  - Yes, if the IW has a group health plan that covers him or her until death, regardless of age.
  - Yes, if the parties enter into a Stipulation With Request for Award that essentially settles everything except future medical treatment.
    - Use WCMSA to determine future mileage reimbursements.
    - Include costs for medical treatment that is not covered by Medicare, including off-label use of Rx or non-covered Rx such as OTC drugs.
    - Include home assistance costs if justified by the medical evidence.

ONE FINAL MESSAGE

- Do not obtain a proposed WCMSA if you don't need one!
- WCMSA proposals are VOLUNTARY – there are no statutes, regulations or legal mandates to have them, only office memos from CMS/HHS headquarters in Baltimore to its Regional Offices ("ROs").
- 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!

THE DOG WAS JUST YAWNING…

.....WERE YOU?

THANK YOU FOR YOUR ATTENTION!

PHOTOGRAPH OF ARMAQUE BY: JESSICA L. RASSP