2018 DWC CONFERENCE

Social Security Disability, Medicare, and Workers’ Compensation Settlements

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PARALLEL UNIVERSES

- Social Security Disability offsets
- Medicare Secondary Payer Act
- The MMSEA and SCHIP Extension Act of 2007, Section 111, 42 USC 1395y(b)(8)
- The SMART Act (Strengthening Medicare and Repaying Taxpayers) HR 1845 beginning 2016
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 $118,500.00 in wages
- Covers Retirement, Blind, and Disability (SSD-I and SSI) Programs
- Maximum monthly SSR benefit is $2,663.00

SOCIAL SECURITY RETIREMENT (AGED)

- 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-D
- 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 $2,663.00 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 $1,100.00 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 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 D

- 2.9% gross wages, no cap.
- 1.45% paid each by employer and employee
- This payroll deduction pays Medicare Part A
- $104.90 per month optional premium for Medicare Part B, deducted from SSD or regular SSR benefits for existing bennies. $147.00 per year deductible. Higher premiums for others.
- Variable per month premium for Medicare Part D Prescription Medication program

MEDICARE PART A

- Covers “major medical”
- Hospitalization
- Skilled nursing home care
- Hospice care
- $1,260.00 deductible for hospitalizations (repeats if you are hospitalized again after 60 days)
MEDICARE PARTS B and D

- Optional coverages
- Part B: Physician office visits, durable medical equipment, outpatient surgeries, diagnostic imaging studies, IV meds
- Part D: Prescription Medications (does not include off-label uses, does not cover eye wear, dentures)
- In WCMSA, Parts B and D are not optional

SSD, Medicare, and WC

Useful Websites

- www.socialsecurity.gov
- www.medicare.gov
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

SSD OFFSETS, AN UPDATE

- See 42 USCA 424(a), 20 CFR 404.317 and 404.408
- TTD rates today cover 67% of wages up to $86,056.88 (AWW = $1654.94 per week)
- 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 $2,663.00 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.

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

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: e.g. WCMSA ____________________________
   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 WCJ's 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
- RTW Benefits
- Penalties and interest
- Right to file a Petition to Reopen
- Death benefits
- Mileage reimbursement
- Insurance deductibles and co-payments (including those for Medicare Parts A, B, and 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.”
- Sometimes you cannot avoid an SSD offset because of a large C&R.
MEDICARE – THE FEAR FACTOR

Section 1862(b)(2) Social Security Act (42 USC 1395y(b)(2)), 42 CFR 411.46 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.

The SMART Act, HR 1845, 42 CFR 411.39

Effective October 2016

Covers conditional payments made prior to an OACR. A claim for conditional payments can be made before and after the OACR. CMS is not bound by any agreement between applicant and defendant within a C&R in regard to conditional payments made prior to the OACR.
MEDICARE – THE LAW

- Medicaid: Title XIX, 42 USC 1396, 42 CFR 435
- Federally and state funded < $32,900 family of 4; < $16,105.00 individual (<138% annual poverty level)
- 27 states opted in the Affordable Care Act
- States are mandated to obtain recovery for Medicaid (Medi-Cal) related expenses for work related medical treatment “Medicaid Lien Recovery” 42 USC 1396(a)(25) and 1396(k)
- This is separate from Medicare Conditional Payment recovery by CMS (CMS has no jurisdiction over Medi-Cal recovery)
- States have not set up collections for ACA related subsidized Medi-Cal recovery

MEDICARE – THE PROBLEM

- Medicare addendums to C&Rs should “adequately consider Medicare’s interest”
- 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 arrangements 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 – The Problem

- All claims systems have access to “flags” that can identify if the IW is a Medicare Beneficiary.
- 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
- Can Def Atty ask about Medi-Cal ACA subsidy?

MEDICARE SET-ASIDE ARRANGEMENTS

- Getting a proposed MSA arrangement is recommended when:
  - Applicant is already entitled to Medicare (Part A, B, or both) regardless of the settlement amount.
  - 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?

- IW’s health insurance claim number or SSN if not yet eligible for Medicare
- All parties’ information in a C&R, including legal counsel, if any
- Total amount of the settlement (CMS doesn’t need C&R itself yet)
- Proposed WCMSA amount (medical tx and medications)
- IW’s life expectancy or rated life expectancy (and how that was calculated)
- Life care plan (if necessary)
- Last two years of medical records and prescriptions
- Future anticipated treatment expenses
- IW’s prognosis and chances of recovery
WHAT ELSE IS REQUIRED IN AN MSA?

- Set aside funds are only used for injury related medical services that would otherwise be covered by Medicare at the time the IW becomes Medicare eligible (and not before).
- Can you appeal a denial of a proposed MSA? No, see 42 CFR 405.926 AND 928.
- Add some money and resubmit it!
- Or, have a more recent reporting from a treating physician who objectively notes medical improvement and submit a new WCMSA proposal.

Other WCMSA Considerations

- IW has to have a segregated interest bearing checking account for self-administered plans.
- Consideration should be given to Professional Administration when the MSA is very large and/or the injured worker may not have the sophistication to self administer.
- IW pays for Medicare Parts A, B AND D then Medicare agrees to pay.
- WCJs SHOULD APPROVE A C&R WITH AN MSA- whether submitted to CMS or not.
WCMSA IS RECOMMENDED 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 CMS $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 ≥ $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.
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 for past treatment costs.

2018 Tidbits

- 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!

- CMS maintains its “review threshold” of settlements that are < $25,000.00
2018 Tidbits

- CMS proposed regs to implement MSP but OMB said you don't need regs for a voluntary program

- On 11/19/14, FDA announced it is requiring one office visit per 90 opioid days since drugs with hydrocodone are deemed Schedule II narcotics and are no longer Schedule III. In 2016 the CDC adopted Morphine Equivalent Dosage (MED) standards. To date CMS has not incorporated the CDC standards in MSA approvals.

- CMS now requires one doctor office visit per month if WCMSA is submitted for approval

- Medicare formulary v. CA WC formulary?

- Medicare MTUS v. CA MTUS?
2018 Tidbits – CMS Trends

- If WCMSA vendor submits properly drafted proposal, CMS will act on proposal within 15 days
- If CMS sends any kind of development letter, once information is provided by the vendor, CMS approves on average in another 113 days
- About 44% of CMS submissions resulted in development letters from CMS (one vendor told us)

- CMS will consider medications not used in last 6 months but which were used in last two years
- CMS may add costs of UDT and yearly laboratory charges
- CMS still removes medications that are used off-label in workers’ compensation treatment (e.g. Lyrica for fibromyalgia even though FDA indicates use for that condition)
- CMS may approve capsule as opposed to tablet form of medications (which cost differently)
2018 Tidbits – CMS Trends

- CMS may look at medications the IW is getting outside the WC arena
- CMS will allocate for medication types that are currently on the market even if the IW took a different version, e.g. hydrocodone with acetaminophen (.5/500 mg off the market, .5/325 mg is now on the market)
- CMS is increasing the costs of surgery in its evaluations for WCMSA approvals

2018 Tidbits – CMS Trends

- CMS now sets cervical fusion surgery at $35,424.64
- CMS now sets total shoulder replacements at $35,370.55
- CMS is charging for additional physician visits, physical therapy and MRI testing, basically ignoring UR denials
- Despite the lawsuit, CMS included an H-wave TENS unit
- CMS may include costs of treatment that an IW has refused to accept in the past
CMS may consider a re-review for pricing of medications, accepting the lowest AWP (But will not accept PBN Pricing)

CMS is requesting medical records for treatment to parts of body that are in dispute in the WC claim

CMS is requesting pharmacy records in the last two years, printed within 6 months from submission of the WCMSA to CMS for approval
- This includes pharmacies that the IW uses for all purposes, not just the industrial injury

In 2017 CMS has allowed for previously approved MSA’s to resubmitted for review when there has been changed circumstances. This can occur up to five years after the MSA was initially reviewed. This could be very helpful where a MSA allowed for a surgery that is no longer needed, or medications that have been repeatedly non certified by UR/IMR.
2018 Tidbits - CMS Trends

- Claims administrators must state in writing exactly what parts of body are accepted and what are disputed and why.
- Despite operating under the same agency (HHS), CMS does not apply CDC recommended allowances for opiates.
- CMS wants to have a complete print out of indemnity payments plus all medical expenses to date, and an explanation of why there was no payment in some categories.

2018 The Bottom Line.....

- Do not submit settlements to CMS for approval in every case.
- Only consider submitting settlements to CMS for approval if the C&R is $250,000.00 and the IW is eligible for Medicare within 30 months from the date of the settlement.
- If the settlement is between $25,000.00 and $249,999.99 and the IW is eligible for Medicare, you DO NOT need to submit the C&R and proposed WCMSA to CMS! But you may want to have an advisory MSA incorporated into the C&R.
Do not submit settlements to CMS for approval in every case

The MSP only requires that the parties take Medicare’s interests into consideration at the time of the settlement

This means you obtain an evidence-based proposed WCMSA, you attach it to the C&R and make it a part of the C&R

You have a WCJ approve the WCMSA as taking Medicare’s interests into consideration and the IW will self-administer the WCMSA

The risk of rejection of a WCMSA by CMS at any point is the IW’s risk of loss

The risk of loss for claims administrators, employers, IWs, attorneys are failing to pay or negotiate conditional payments by Medicare for work related injury medical treatment

The WCAB can order Defendant to pay, negotiate (but not litigate) Medicare conditional payments made prior to the OACR.
The State of California may develop a collection/recovery system to recover money from claims administrators where a Medi-Cal subsidized ACA “Covered California” plan pays for treatment for a work related injury.

All states were required to have in place a mechanism for seeking reimbursement for industrial related benefits paid by Medi-Cal/Medicaid by 10/01/17 failing which the state faces potential forfeiture of Federal Funding.

The disadvantages to submitting a MSA for approval:

1. It can be extremely time-consuming.
2. It is a very inexact and inconsistent process.
3. The end result could be the MSA being approved for a higher amount.
4. There is no methodology for appealing an adverse determination.
Submittal v. Non-Submittal:
- Who is at risk when a MSA that CMS recommends be submitted is not?
- “Defend or Amend” provision in C&R
- Defendant agrees to add money to WCMSA if CMS requires a greater amount than what was included in the C&R as a WCMSA.

Q. Is approval of a MSA required?
A. NO!

4.0 Should I Consider Submitting a WCMSA Proposal?
4.1 Considerations and Guidelines

An individual or beneficiary may consider seeking CMS approval of a proposed WCMSA amount for a variety of reasons. The primary benefit is the certainty associated with CMS reviewing and approving the proposed amount with respect to the amount that must be appropriately exhausted. It is important to note, however, that CMS approval of a proposed WCMSA amount is not required.
Q. Is approval of a MSA required?  
A. NO!

4.2 Indications That Medicare’s Interests are Protected

- Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare’s interests. A WCMSA is not necessary under the following conditions because when all three are true, they indicate that Medicare’s interests are already protected:
  - a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);

8.0 Should CMS Review a WCMSA?

- If a proposed WCMSA meets the workload review thresholds outlined below, the proposal can be submitted to CMS for approval. If the parties to a WC settlement stipulate a WCMSA but do not receive CMS approval, then CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses in the case, even if they would ordinarily have been covered by Medicare. However, if CMS approves the WCMSA and the account is later appropriately exhausted, Medicare will pay related medical bills for services otherwise covered and reimbursable by Medicare regardless of the amount of care the beneficiary continues to require.

- 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.
Q. What if the workers compensation claim is disputed?

4.1.1 Commutation and Compromise

WC cases may involve past medical expenses, future medical expenses, or both. When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." When a settlement includes compensation for future medical expenses, it is referred to as a "WC commutation case." A settlement also has a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury. A WC settlement can have both compromise and commutation aspects. Please refer to the July 2001 WC RO Memorandum for more information.

Q. What if the workers compensation claim is disputed?

4.1.4 Hearing on the Merits of a Case

When a state WC judge approves a WC settlement after a hearing on the merits, Medicare generally will accept the terms of the settlement, unless the settlement does not adequately address Medicare’s interests. If Medicare’s interests were not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the dollar amount of the entire WC settlement. Medicare also will assert a recovery claim if appropriate.

- If a court or other adjudicator of the merits (e.g., a state WC board or commission) specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

- Is a good faith offer of proof in C&R that injury is in dispute sufficient to be a “Hearing on the Merits”?
There is still no evidence that CMS has the ability or even willingness to assert a claim for conditional payments made by the employer/insurer after a C&R has been approved.

There are a growing number of employers/insurers that approaching this as a decision making process that relates to assumption of risk (as opposed to a blanket requirement), that must take into account all factors of the claim including indemnity and non Medicare future medical care.

Example 1: IW is on Medicare, there is exposure of PD between 69% and 100%, there is a MSA proposal for 25k and there is no record of treatment for the last two years. The only admitted body part is the back, but there are still disputes regarding knees, RSD, hypertension and upper/lower GI.

Example 2: Same as example 1 except there is a current treatment record, including a few stray payments for medications for internal.

Example 3: IW is a 32y/o (maximum earner) paraplegic that is on Medicare. There is a significant AOE/COE issue. You are doing a C&R for 250k.

Example 4: Same as example 3 but your C&R is for $1.5M.
The Dog Was Yawning...

Thank you for your attention!

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