

Dealing with Medicare in Workers' Compensation Claims

By

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Table of Contents

1	Introduction.....	2
2	Medicare under Various Circumstances	2
3	Procedural and Other Issues.....	6
4	Other Issues.....	8
5	Legal and Legislative Issues	9

1 Introduction

There are a significant number of situations in which an individual might be eligible to have a medical bill paid for under either Medicare or workers' compensation. The Medicare as Secondary Payer Act 42 USC 1395y(b) provides that under these circumstances Medicare is secondary and workers' compensation is primary. Stated more simply, workers' compensation should pay the bill and Medicare should not. The Center for Medicare and Medicaid Services (CMS) manages the Medicare program. In about 2001, it began taking a very aggressive approach to the enforcement of the principle that Medicare is secondary to workers' compensation. This has caused considerable difficulties for workers' compensation practitioners.

This paper will discuss some practical aspects of dealing with Medicare in the handling of workers' compensation claims. We have also prepared a much more detailed paper discussing the various issues involved in the interrelationship between Medicare and workers' compensation. The paper, "An Analysis of Workers' Compensation and Medicare" is available on the website of the Workers' Compensation Center of Michigan State University at <http://www.lir.msu.edu/wcc/Medicare/Medicare.htm>. That page also contains a copy of this paper and a links to the CMS website.

Much of the discussion in this paper is based on a series of publications by CMS which can be found at:

<http://www.cms.hhs.gov/WorkersCompAgencyServices/>.

The situation at CMS changes frequently. Accordingly, we caution readers to check that webpage regularly.

2 Medicare under Various Circumstances

2.1 *Is Medicare Involved?*

These issues only apply if there is a current or potential future involvement of Medicare. Medicare is available to everyone over 65 and to workers who have been on Social Security Disability (SSDI) for more than two years. As explained below, CMS has set standards for when Medicare may be expected to be involved in the future. But generally speaking, if the worker is substantially under 65 and there is no prospect that he or she would qualify for SSDI, then one need not worry about any of this.

2.2 *Open Claims*

If there is an open ongoing workers' compensation claim and there is a medical bill that

could be paid under either workers' compensation or Medicare, it should be paid by workers' compensation. If it is discovered that there were past medical bills that could have been covered under workers' compensation and were paid by Medicare, then CMS should be contacted and arrangements should be made to reimburse Medicare for these bills.

Failure to repay CMS can result in double liability on the part of the workers' compensation carrier. In addition, there is some suggestion that it could result in liability on the part of attorneys involved in the case. For a case in which a worker sought and received double damages from a workers' compensation carrier for medical bills that were paid by Medicare but should have been paid for by the carrier, see *Manning v Utilities Mut Ins Co*, No 98 Civ 4790 (RCC), 2004 us Dist LEXIS 1674 (SDNY Feb5, 2004).

2.3 Settlements

Most of the problems that arise out of the relationship between Medicare and workers' compensation occur when workers' compensation claims are settled. They relate to the responsibility to repay Medicare for past bills, to the expectation of payments by Medicare for future medical expenses, and to some demands that CMS has placed on the workers' compensation system.

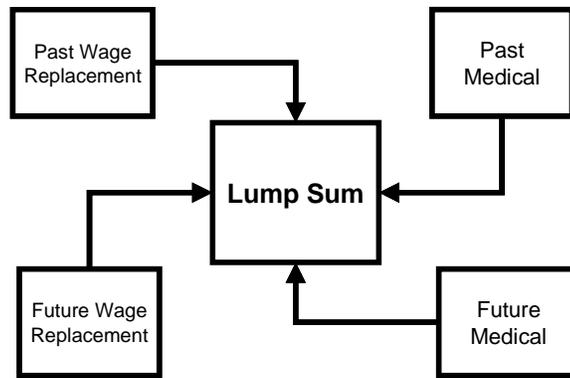
Settlements – Past Medical Expenses

If the worker is a current Medicare beneficiary, the parties must first determine if there are any past medical expenses that were paid by Medicare and could have been paid under workers' compensation. CMS calls these "conditional payments." If such payments exist, then Medicare must be reimbursed. In some states workers' compensation judges will not approve a settlement for a current Medicare recipient unless the parties present evidence that these issues have been resolved.

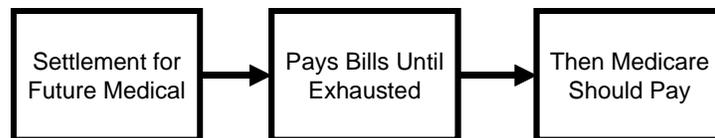
Settlements – Future Medical Expenses

Most workers' compensation settlements include the following components.

- Payment for past wage loss
- Payment for past medical expenses
- Payment for future wage loss
- Payment for future medical expenses



Concerning future medical expenses the *theory* is simple. The worker should first spend down the portion of the settlement attributed to future medical expenses and thereafter Medicare should pay medical bills for the work-related injury.



The implementation of this theory, however, has become very complicated. CMS takes the position that the parties must “consider the interest of Medicare” and make a determination concerning how much of the settlement represents future medical expenses that could have been paid under Medicare. It argues that this amount should be placed in a Workers’ Compensation Medicare Set-aside Arrangement (WCMSA) (These are discussed in more detail below), and that future medical expenses should be paid for from the WCMSA. When the WCMSA is exhausted, then Medicare will begin paying medical expenses related to the compensable injury.

Most of the problems arise because in addition to the above, CMS “recommends” that under certain circumstances discussed below, the parties must obtain pre-approval of the settlement from CMS. It takes the further position that if this “recommendation” is not followed, then CMS can treat the settlement as if the entire amount were for future medical expenses. The situation is actually much more complicated than this and is discussed in more detail in the paper *An Analysis of Workers’ Compensation and Medicare*, which is found at <http://www.lir.msu.edu/wcc/Medicare/Medicare.htm>.

The expectations of CMS depend upon the size of the settlement and whether the worker is currently a Medicare beneficiary. Based on this, settlements can be divided into five categories. This situation is summarized in the figure below.

Claimant is Currently a Medicare Beneficiary and the Total Settlement is Greater than \$25,000 – Under these circumstances, CMS takes the position that the parties must obtain pre-approval of CMS and set up a WCMSA.

The Claimant is Currently a Medicare Beneficiary and the Settlement is for \$25,000 or Less – CMS takes the position that under these circumstances the parties must consider the interest of Medicare and should establish a WCMSA. CMS, however, will not review these cases for pre-approval.

The Claimant is Not Currently a Medicare Beneficiary but has a “Reasonable

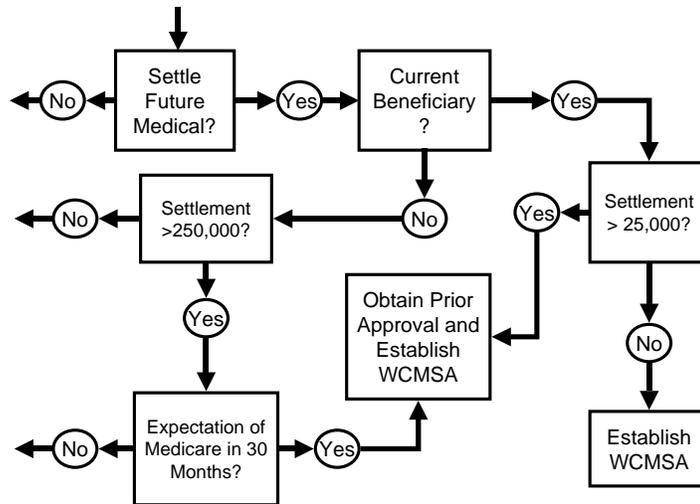
Expectation” of Medicare Enrollment Within Thirty Months of the Settlement Date and the Settlement is for \$250,000 or More – CMS takes the position that the parties must obtain pre-approval of Medicare and set up a WCMSA and that the parties obtain pre-approval from CMS.

The Worker is Not Currently Entitled to Medicare and the Settlement is for Less Than \$250,000 – Under these circumstances, CMS will not give prior approval and does not expect the parties to set up a WCMSA. CMS assumes that if the worker later becomes entitled to Medicare, he or she will have spent down whatever amount would have been allocated toward future medical expenses between the settlement date and the entitlement to Medicare. Accordingly, it will begin paying for all health care costs as soon as the individual is entitled to Medicare.

No Future Medical Expenses – It is not necessary to set up a WCMSA if there is no future medical involved. For example, in some states it is common to settle the indemnity part of workers’ compensation claims but not settle the employer’s liability for future medical benefits.

CMS also recognizes the possibility that there may be a settlement of a workers’ compensation case in which the carrier is settling its future liability and there is no expectation of future medical expenses related to the injury. CMS indicates that it will accept a written statement from a treating physician which includes that to a reasonable degree of medical certainty the individual will no longer require future medical care related to the workers’ compensation injury.

The figure below summarizes this situation.



2.4 Definitions

As discussed above, CMS has different expectations for settlements depending upon the “total settlement amount” and whether there is a reasonable expectation of Medicare entitlement.

The total settlement amount includes everything in the settlement, including wage replacement benefits, future medical benefits, and attorney fees. In a structured settlement, or a settlement involving an annuity, the total amount is measured by the total

payout, not the cost of the annuity, nor the present value of the payout.

CMS defines a “reasonable expectation” of Medicare enrollment as

- (a) The individual has applied for Social Security Disability Benefits;
- (b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
- (c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
- (d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
- (e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

3 Procedural and Other Issues

3.1 WCMSAs

Workers’ Compensation Medical Set-Aside Arrangement (WCMSA) is the term that CMS uses to describe the arrangements that are made for spending down the portion of the workers’ compensation settlement that is attributed to future medical benefits that could have been paid under Medicare. As discussed above, there are certain circumstances under which CMS believes that a WCMSA must be created and other circumstances on which CMS takes the position that a WCMSA must not only be created but that the amount must be pre-approved by CMS.

CMS indicates the following concerning WCMSAs:

- The amount of the WCMSA must be documented by medical records and should be projected over the life expectancy of the worker. It should include all projected future medical expenses, including prescription drugs, related to the compensable disability which would have been covered under Medicare were it not for the workers’ compensation claim.
- The cost should be based on the amount that the worker or workers’ compensation carrier would pay, not the amount that Medicare would pay. (This is not clearly spelled out in the Medicare publications, but appears to be the position they take.)
- The costs may be calculated with or without the use of the workers’ compensation fee schedule. It is possible that health care providers, knowing that treatment is for a work-related injury, will accept payment within the guidelines of the fee schedule. This is more likely to be true if the provider has been treating the patient and paid according to the fee schedule prior to the settlement. Once the case is settled, however, most state laws do not provide any mechanism for enforcing the fee schedule. CMS allows the parties to calculate the fees in either way. It expects the parties to indicate which method was used, and when payments are later made out of the WCMSA, they are to be calculated on the same basis by which they were calculated when the

WCMSA was created.

- Calculations for the MSA need not be indexed for inflation and may not be discounted to present value.
- CMS anticipates that some WCMSAs (presumably the larger ones) will be administered by a professional administrator or trustee, but that others may be self-administered by the claimant. Professional administrators must submit an annual accounting to CMS.
- Claimants who administer their own WCMSA are required to submit a “self-attestation.” It is not entirely clear whether this is required on an annual basis or only when monies have been exhausted. It is clear, however, that the claimant will be expected to document precisely where, when, and how the money has been spent. At the very least, claimants who administer their own WCMSA should set up a separate bank account for this purpose and pay bills from that bank account.
- Administrator and attorney fees and other expenses of the WCMSA may not be charged to it. They must be paid from another source and should not be included when calculating the amount of the WCMSA.
- It is expected that the WCMSA will accrue interest which will be paid into it.
- It is understood by CMS that under certain circumstances, including the death of the claimant, it may be appropriate to terminate the WCMSA before the amount is exhausted.
- It is expected that the professional administrator or claimant will use the WCMSA to pay for medical bills, including prescription drugs, that are related to the compensable injury and would have been covered under Medicare were it not for the workers’ compensation claim. When these are exhausted, the administrator provides evidence of this to CMS and Medicare will thereafter begin paying health care bills.

3.2 Contacting CMS

When initially contacting CMS concerning a workers’ compensation claim, the contact should be made through the CMS coordination of benefits contractor. Contact information is available at:

http://www.cms.hhs.gov/WorkersCompAgencyServices/03_reportingwc.asp.

CMS asks that the following information be provided.

- Your client’s name
- Your client’s Medical Health Insurance Claim Number (HICN) or SSN
- Date of incident
- Nature of illness/injury
- Name and address of the WC insurance carrier
- Name and address of the legal representatives

- Name of insured
- Policy/claim number

3.3 Submission of WCMSA

CMS requires a very detailed submission to justify the WCMSA. A listing of the format to be followed, a submission checklist, a sample submission, and information about where to send a submission are available at:

http://www.cms.hhs.gov/WorkersCompAgencyServices/05_wcmsasubmission.asp

CMS suggests that submissions can be made on CD-ROM.

3.4 Vendors

There are a variety of vendors who assist parties with the matters discussed here. Some attorneys and carriers find it very helpful to use these firms. Others find that they are able to do most or all of this without the expense of employing other parties.

4 Other Issues

4.1 Splitting the Settlement

The primary complaint about the CMS process is the delays involved. An alternative that has been suggested by CMS is that the parties split the settlement. They settle the indemnity or wage-loss portion of the claim without waiting for CMS approval. Then, after CMS approval is obtained, they settle the medical portion of the claim.

4.2 Settling before CMS Approval

Because of the delays involved in obtaining CMS approval, it has become the practice in some jurisdictions that the parties settle the workers' compensation claim without waiting for CMS approval. Ordinarily under these circumstances the parties agree as to who will bear the burden if approval is not obtained. They might agree, for example, that if CMS demands more money for future medical, then the employer will pay an additional amount into the settlement, or alternatively they might agree that if CMS demands more money the worker will take money from the indemnity part of the settlement and put it into the WCMSA.

CMS recognizes that this process occurs. It does not necessarily dispute it, but CMS takes the position that if full approval from CMS is not eventually obtained, then CMS may treat the settlement as if the entire amount were for future medical benefits.

4.3 No Appeal

CMS takes the position that its decision concerning WCMSAs is not subject to any appeal. The parties can ask for a re-evaluation by contacting the Coordination of Benefits Contractor, but CMS maintains the questionable position that this federal agency may make a final binding determination not subject to any legal appeal. It responds to complaints by pointing out that if, years later, a beneficiary seeks reimbursement for a specific bill and it is denied by Medicare, the beneficiary has appeal rights at that time.

4.4 Reporting Requirements

Late in 2007 Congress amended the Social Security Act to add requirements that under various circumstances plans, including workers' compensation plans, submit to CMS information about individuals who are entitled to Medicare. These will become effective in June of 2009. There are severe penalties for failure to comply.

4.5 Miscellaneous

- CMS has no process to accept up-front cash payments in lieu of a WCMSA.
- There is no means by which a claimant can waive his or her right to Medicare benefits.
- If the worker loses eligibility to Medicare, the WCMSA should still be used to pay for medical expenses that would have been covered.
- If a claimant establishes a WCSMA before he or she is entitled to Medicare, it may use the WCMSA during that period of time to pay for health care costs related to the workers' compensation claim.
- As discussed above, there are some circumstances under which CMS agrees that a WCMSA is not necessary or that it is not necessary to obtain pre-approval of the WCMSA. CMS refuses, however, to issue any form of confirmation or certification that a particular case fits into one of those categories.

5 Legal and Legislative Issues

This paper presents only a very brief overview of the procedures involved. A more detailed discussion is contained in *An Analysis of Workers' Compensation and Medicare* which may be found at <http://www.lir.msu.edu/wcc/Medicare/Medicare.htm>. Among other things, that paper questions the legal basis for some of the positions taken by CMS.

A bill has been introduced in Congress that attempts to resolve many of the problems that have arisen concerning the interaction of workers' compensation and Medicare. The bill has broad support from employers, insurance companies, trial lawyers, and some representatives of organized labor. The lead organization in supporting the bill is UWC—Strategic Services on Unemployment and Workers' Compensation (UWC) (<http://www.uwcstrategy.org>). Its president is Doug Holmes. He can be reached at holmesd@UWCstrategy.org.