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Zero Allocation Medicare Set Aside Proposals and Conditional Payment Waivers in Denied/Disputed Workers' Compensation Claims: Underutilized Cost Mitigation Tools in Medicare Secondary Payer Compliance

By: Shawn R. Deane, Esq.

Background of the Medicare Secondary Payer Statute

When Medicare was created in 1965, it acted as the primary insurer, and therefore the primary payer, for medical services provided to its beneficiaries. The only exception to this, however, was with respect to workers' compensation. When Medicare reasonably expected a workers' compensation plan to cover a Medicare beneficiary's claims, Medicare would only make payment on the condition that the workers' compensation plan would reimburse Medicare. In this instance, Medicare would act as the secondary insurer, i.e., the "secondary payer."

Notwithstanding this exception, from its inception until 1980, Medicare acted as a primary payer for all the claims of Medicare beneficiaries. [The Medicare Secondary Payer Act \("MSP"\)](#) was enacted in 1980 as a cost-shifting effort designed to mitigate government spending by ensuring that primary payers, and not Medicare, assumed the burden of paying for items



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Compensation, Vol 18, No. 2,
Winter 2009:

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By: Kenneth J. Paradis, Esq.

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and services. The MSP clearly defines when Medicare will assume either a primary or secondary payer status. The two existing MSP recovery vehicles are the Workers' Compensation Medicare Set Aside Trust and Medicare Conditional Payment reimbursement. In addition to these, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 is a comprehensive reporting requirement for group health plan arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation. This mandatory insurer reporting (MIR) will provide Medicare with unprecedented visibility into claims where parties have responsibility complying with existing MSP policies.

Workers' Compensation Medicare Set Asides

Since 2001, the Centers for Medicare and Medicaid Services ("CMS") has requested the utilization of Workers' Compensation Medicare Set Aside Trusts ("WCMSA") in worker's compensation settlements where there a resolution of future medical expenses. A WCMSA is simply an administrative and funding mechanism where money is "set aside" for anticipated future Medicare-covered items and services arising out of the workers' compensation injury.

Through various policy memoranda, CMS has attributed its authority for authorizing a WCMSA directly from the MSP. See 42 CFR. 411.46. While Medicare distinguishes between workers' compensation cases which involve "commutation of benefits" and those that are purely "compromise" cases, Medicare is clear that, "[i]f a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized." 42 CFR. 411.46(b)(2). Moreover, CMS is unequivocal that "[a]ll parties in a workers' compensation case have significant responsibilities under the MSP laws to protect Medicare's interests when ring workesolver's compensation cases that include future medical expenses." CMS's only recommended method to protect Medicare's interest when settling a workers' compensation case that closes future medicals is to implement a WCMSA.

Failure to Comply With the MSP

Failure to adhere in protecting Medicare's interest in a workers' compensation settlement by foregoing the utilization, and if applicable, the submission for review and approval of a WCMSA by CMS, could result in harsh consequences for all parties involved.

"The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly." "Additionally, if Medicare's interests are not adequately considered in any settlement, then Medicare may refuse to pay for services related to the workers' compensation injury until such time as expenses for such services have exhausted the amount of the entire settlement." CMS also has a right of subrogation to recover payments made by Medicare prior to the settlement. Furthermore, with the implementation of Section 111 of the MMSEA, Medicare will have significant visibility into cases where a WCMSA should have been implemented and where conditional payments were made. The new reporting requirement could also affect the claimant's entitlement to future Medicare benefits and if conditional payments are not addressed, Medicare could deny benefits under the MSP. If such claimant has their Medicare benefits denied, the claimant could potentially file suit against the insurance carrier for failure to reimburse Medicare for conditional payments and double damages may be awarded. See 42 U.S.C. 1395 (y)(b)(3)(A).

Review Thresholds for Workers' Compensation Medicare Set Asides

The CMS's policy is that it is not in Medicare's best interest to review every WCMSA. The CMS requests the submission of a WCMSA for review and approval in the following circumstances:

1. When the employee is a Medicare beneficiary and the workers' compensation settlement exceeds \$25,000.00; or,
2. When the employee possesses a "reasonable expectation" of Medicare eligibility within thirty (30) months of the date of settlement and the workers' compensation settlement exceeds \$250,000.00.

It is important to note that these review thresholds are CMS workload levels and are not to be considered "safe harbors" or substantive dollar thresholds for complying with MSP. **"Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered."**

The MSP Issue: Denied Workers' Compensation Claims

Many states' workers' compensation laws allow for lump sum settlements which foreclose future benefits, including medical treatment. When medical treatment benefits are discontinued in a workers' compensation settlement, a thorough medical-legal analysis should take place before funding a WCMSA with potentially unnecessary monies.

It is a common occurrence that a workers' compensation claim is denied or disputed, but that the insurance carrier, nonetheless, desires to resolve the matter with the claimant through a lump-sum compromise settlement without future liability. A claim may be denied for various reasons, including a good-faith dispute over causal relationship or, on a purely legal basis, such as lack of statutory notice or an applicable statute of limitations. Unfortunately, and all too frequently, however, unnecessary funds are allocated for in a WCMSA in an overly-cautious effort to comply with the MSP. Without the proper legal/medical analysis, precious resources are wasted on gratuitous MSP compliance "solutions."

1) WCMSA Solution: Zero Allocation Medicare Set Aside Proposals

There are many instances in denied and disputed workers' compensation settlements, even when future medicals are being closed and, when the settlement meets CMS's review thresholds, **where setting aside no money (\$0.00) is appropriate under the MSP**. A "zero allocation" is essentially a proposal submitted to CMS (or not submitted, if the settlement doesn't meet review thresholds), with supporting documentation, which posits that it is appropriate to set aside no money for future Medicare-covered medical expenses. Zero allocations are a lost opportunity in disputed and denied claims, and can be a very effective MSP cost-mitigation tool. Many times needless WCMSAs are submitted to CMS and unnecessary money is spent on WCMSA allocations in circumstances where a zero allocation is the precise and most cost-effective compliance vehicle.

Usually, the basis for a zero allocation rests upon a legal argument. "Legal-zero" WCMSA proposals are normally appropriate when no payments have been made on the claim (for medical benefits or indemnity) and the claim has been denied and/or disputed from the outset because of a valid legal argument, i.e., causation, jurisdictional issues, statutory notice, etc. Another form of zero allocation, the "medical-zero," is appropriate in circumstances where an injured employee has completed all medical treatment, has reached a state of maximum improvement and a treating physician can certify to a reasonable degree of medical certainty that the claimant will never again require Medicare-covered medical treatment or services arising out of the industrial injury. Both the "legal-zero," and the less common "medical zero" are often overlooked MSP compliance techniques.

a) The Legal-Zero WCMSA Proposal

In the case of a denied or disputed workers' compensation case where no payments have been made, for either medical or indemnity, save for payments made in defense of the claim, a "legal-zero" WCMSA proposal is entirely appropriate. In this type of case there is usually a legal basis for denying payments for workers' compensation benefits, i.e., the alleged injury was not casually related to the course and scope of employment. Therefore, this category of zero allocation is termed a "legal-zero," because allocating zero dollars (\$0.00) is based upon a legal argument resulting from a good-faith legal dispute over the claim. Crowe Paradis Services Corporation has been very successful in submitting legal-zero allocation proposals and obtaining approval from CMS in these instances.

There are four (4) critical elements to a claim in order to be justified in preparing a legal-zero and/or obtaining success in submitting the same CMS for review and approval. **1) Denied Claim** In the claims that are appropriate for legal-zero WCMSA proposals, typically, there is a legal justification for denying the claim, such as a real dispute over liability or causation. **2) No Payments** In order to obtain approval from CMS with a legal-zero proposal, no payments, either medical or indemnity, can have been made. However, it is acceptable for payments to have been made in defense of the claim, i.e., legal defense payments, copying costs, medical-legal services (IME/QME). **3) Pay History Reflecting No Payments** The pay histories in the file will have to reflect that no indemnity and medical payments were made as CMS requires a copy of the pay history printout in the submission packet. **4) Denial Letter/No Payments Statement** Finally, when submitting a legal-zero proposal for review and approval, CMS requires, a "denial letter/no payments statement," which is simply a letter, on carrier letterhead, written and signed by the adjuster or authorized insurance representative, affirming that the claim is denied and that no medical or indemnity payments were made.

In other instances, Crowe Paradis has been successful, albeit in limited circumstances, with obtaining approval of legal-zero WCMSA proposals where medical and/or indemnity payments were made by the carrier. These cases usually have been limited to jurisdictions which allow for "payments without prejudice." In some "pay without prejudice" jurisdictions, the law allows for medical and/or indemnity payments to be made to the worker, at the carrier's discretion, while they investigate the validity of the claim. These payments do not "prejudice" the carrier's right to later contest the compensability of the claim or to dispute the necessity for future medical or indemnity benefits owed to the claimant. In other types of pay without prejudice jurisdictions, the carrier actually must begin to pay benefits on the claim and then has a certain amount of time for which time it can investigate compensability without being prejudiced for payments it makes in the interim.

In circumstances where medical or indemnity payments have been made, even where there is an applicable "pay without prejudice" provision, CMS's approval of a legal-zero can be difficult to obtain. This is because it is CMS's unwritten policy that any payments made on the claim, medical or indemnity, are a "bright-line" indicator of whether the workers' compensation carrier has attained primary payer status. The CMS's reasoning is that if the carrier has made payments, they have accepted responsibility and are thus responsible for ongoing medical care and, therefore, the primary payer under the MSP. In pay without prejudice situations, a well-crafted legal memoranda is provided along with the CMS submission, citing specific statutory references and an explanation of how the pay without prejudice provision applies to the case and why the payments made should not prejudice the carrier from obtaining a zero allocation. This argument is analogous to the same right afforded to the carrier in the workers' compensation arena at the state level. Crowe Paradis' experience has been that where pay without prejudice issues arise, the legal-zero WCMSA proposals are usually submitted to the CMS's applicable regional offices for review and, as a result, can oftentimes take longer to obtain a decision on.

Lastly, with respect to legal-zero proposals, Crowe Paradis has been successful, in very limited circumstances, in instances where payments were made in error or by mistake in non-pay without prejudice jurisdictions. As stated before, the CMS uses a bright line test for determining primary responsibility in a workers' compensation claim, i.e., "were any medical or indemnity payments made?" In very limited instances, it is possible to obtain approval of a legal-zero proposal where payments were made in error or by mistake, if: 1) it is apparent and clearly documented that these payments were made by mistake/error; 2) they were later disputed; 3) that they were disputed by lodging objections in the workers' compensation board; 4) that reimbursement is being sought; or 5) the carrier was successful in recovering the mistaken payments and was reimbursed; and 6) a workers' compensation board decision awarded the carrier reimbursement without prejudice. Finally, it is also helpful if there is an applicable statutory provision which provides no prejudice to the carrier for payments made by mistake. Obtaining approval of legal-zero proposals where payments were made in "non-pay without prejudice jurisdiction" are rare and very difficult to achieve. These classes of claims should be reviewed on a case-by-case basis to ascertain the merits of success.

When the CMS review thresholds are met and a legal-zero allocation proposal is approved by Medicare, it gives all parties involved a sense of finality relative to the MSP and peace of mind that Medicare's interests were protected. In a disputed/denied workers' compensation claim, a legal-zero can be a highly effective cost-mitigation tool which is often and, unfortunately overlooked.

b) The Medical-Zero Allocation

While there are some instances when it is appropriate to allocate no funds in a WCMSA because of a legal basis, there are also circumstances where there is a valid medical argument which supports a zero (\$0.00) allocation WCMSA. The hallmark of a "medical-zero" is when 1) an injured employee is discharged from treatment and; 2) the treating physician concludes that the employee will no longer require any future treatment (specifically, Medicare covered-treatment) stemming from the industrial injury. Moreover, in a situation where a medical-zero is appropriate, the treatment records and pay history usually indicate that the claimant has not treated for some time.

If there is a payment history which reflects recent treatment for the work-related injury, the likelihood of a successful submission to CMS with a medical-zero proposal is greatly reduced. The requirement for a medical-zero is a written statement from the primary treating physician which indicates that to a reasonable degree of medical certainty the claimant will no longer require Medicare-covered treatment for the industrial injury and as a result, the claimant is discharged from treatment. A thorough medical review of all treatment records in the file must be conducted in order to identify situations where a medical-zero proposal is appropriate. While claims for medical-zero proposals are more infrequent than those possessing the requirements of a legal-zero, the medical-zero proposal is often a missed opportunity to save on MSP compliance funds.

2) Conditional Payments Solution: Request Waiver of Conditional Payments

Analogous to the zero-allocation MSA proposal as it relates to future Medicare-covered medical expenses, a waiver for conditional payments is akin to requesting a zero allocation for past payments made. Medicare has a right to collect any payments that it has made that could, or should, have been covered by an applicable primary insurance plan, including a workers' compensation carrier. See 42 U.S.C. §1395y (b)(2)(B)(ii)(iii). These "conditional payments" are effectively a lien on a workers' compensation settlement, but Medicare can request payment from the carrier, the claimant and even the claimant's attorney. See 42 USC 1395y(b)(2)(B)(iii); 42 CFR 411.24.

Unfortunately, Medicare's policies attach conditional payment status to any payments that are made which are plausibly related to the workers' compensation injury. Section 1395y(b)(2)(B)(ii) of Title 42 of the United States Code states that reimbursement is required under the statute "if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." This requirement is also evidenced in 42 U.S.C. §1395y(b)(2)(B)(iii), which provides that the United States may only bring an action against an entity that is "required or responsible" to make payment with respect to an item or service.

In the situation of a denied claim, it should be the position of the MSP advocate that the workers' compensation carrier was **not required or responsible to make payment for the denied injury**. Without responsibility, the carrier would not be considered the primary payer. It follows logically that if the workers' compensation carrier is not the "primary payer," Medicare cannot be the "secondary payer." Oregon Ass'n of Hosp. v. Bowen, 708 F. Supp. 1135 (1989). In the instance of a denied claim, Crowe Paradis would argue that the MSP does not apply to payments made for treatment for any denied injuries and, we would request a waiver from Medicare for any payments made on the beneficiary's behalf.

Conclusion

All too often a workers' compensation claim will go without the proper MSP legal-medical analysis and, as a result, unnecessary funds will be allocated for in a WCMSA which are not required. Moreover, a waiver will not be requested for conditional payments made where the carrier is not the primary payer. At Crowe Paradis, an experienced MSP attorney and nurse are assigned to every workers' compensation claim, utilizing a unique blended medical-legal approach to assess every legal and medical argument in resolving MSP issues. This technique results in creative compliance solutions and reduced MSP compliance costs.

1. The term "MSP" is commonly utilized vernacular in the parlance of the industry, however, the term is often misunderstood and misused. The MSP is a broad statutory and regulatory framework which encompasses Section 1862(b)(2) of the Social Security Act (42 U.S.C. § 1395y et seq.), a collection of accompanying Federal Regulations (42 CFR 411 et seq.), policy memoranda issued by the Center for Medicare and Medicaid Services ("CMS") and manuals published by CMS, such as the Medicare Intermediary Manual ("MIM") and the Medicare Carrier's Manual ("MCM"). See also U.S. v. Baxter Intern., Inc., 345 F.3d 866, 874 (2003).

2. See 42 U.S.C. 1395y(b)(2).

3. Codified at 42 U.S.C. 1395y(b)(7) (8).

4. For more information see <http://www.cms.hhs.gov/MandatoryInsRep>.

5. See July 23, 2001, CMS Memorandum; also referred to as the "Patel Memo."

6. Id.

7. "If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment." 42 CFR 411.46(a).

8. http://www.cms.hhs.gov/workerscompagency/services/04_wcsetaside.asp

9. CMS Memorandum, April 22, 2003, question No. 13, citing 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26.

10. Id.

11. See 42 CFR 411.47. The payments made by Medicare prior to settlement are deemed "conditional payments." While a misnomer, as they are not a lien in the legal sense of the term, are also referred to as a "Medicare liens," since they effectively act as a lien upon any settlement proceeds. See also U.S. v. Harris, 5 F.3d 866, 874 (2003).

12. "Reasonable expectation" is defined in one of the following circumstances: 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. See April 22, 2003 CMS Memorandum, Question No. 2.

13. July 11, 2005, CMS Memorandum, Question No. 1.

14. Id.

15. See e.g. California Labor Code, § 5000 et seq.; New York Workers' Compensation Law, Article 2, § 32; Colorado Workers' Compensation Act, §8-43-204.

16. The insurance carrier should not simply deny payments in an accepted, albeit specious, workers compensation claim just to later propose a "legal-zero" for purposes of saving money in MSP compliance. Nearly every state's workers' compensation system has a punitive component in place for an insurer's failure to pay benefits which are statutorily due.

17. See e.g. Delaware's "pay without prejudice" provision: "An employer or insurance carrier may pay any health care invoice or indemnity benefit without prejudice to the employer's or insurance carrier's right to contest the compensability of the underlying claim or the appropriateness of future payments of health care or indemnity benefits." Del. Code Ann. Title 19, Ch. 23, § 2322 (h).

18. See Massachusetts' pay without prejudice provision and requirement to begin payment within 14 days and has up to 180 days to dispute compensability without prejudice. G.L. Ch. 152, §§ 7(1), 8(1).

19. "Pay without prejudice" legal-zero proposals are oftentimes difficult to obtain approval on by CMS. It should be noted that Crowe Paradis cannot guarantee approval simply because payments were made in a pay without prejudice jurisdiction and the case was later denied or disputed.

20. See e.g. Cal.Lab.C. §4909, which encourages the prompt voluntary payment of benefits but is also meant to protect employers that mistakenly make payments for a nonindustrial condition. Sea-Land Service, Inc. v. Workers' Comp. Appeals Bd. (1996) 58 Cal.Rptr.2d 190, 14 Cal.4th 76, 925 P.2d 1309.

21. See April 21, 2003 Memo, Question 20.

22. "[T]he term 'primary plan' means a group health plan or large group health plan...workmen's compensation plan, automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." 42 USC 1395y(b)(2)(A)(ii).

Notice Regarding Registration Deadline

By: Martin Cassavoy, Esq.

The Centers for Medicare & Medicaid Services (CMS) have set September 30, 2009 as the target date for non Group Health Plan (NGHP) Responsible Reporting Entities (RREs) to register for Section 111 mandatory insurer reporting. This is an important deadline that will provide RREs and CMS sufficient time to test the exchange of data prior to the exchange of live data in April 2010. Testing cannot begin until January 2010, and CMS has explained that the three month window between September 30, 2009 and the commencement of testing in January is designed to provide RREs enough time to go through all the necessary steps that will allow for a smooth transition to testing in January 2010.

CMS representatives have been clear about two additional considerations. First, RREs will be able to register even after September 30th. Second, there is no monetary penalty for registering after September 30th. Nevertheless, the longer an RRE delays registration beyond September 30th, the less likely that the full quarter of testing will be achievable for the RRE. This could delay reporting. RREs are requested to register if they have a "reasonable expectation" of having claims to report within the following reporting quarter in order to allow a full quarter of testing. If an RRE anticipates having claims to report in the quarter beginning April 1, 2010, the RRE should make every effort to register by September 30th. The longer an RRE delays after that date, the more likely it will become that the RRE will be unable to test and report in time to avoid penalties.

Upcoming Events

September 30-October 1	NAMSAP Annual Meeting & Educational Conference	Rio All Suites Resort- Las Vegas, NV
September 30-October 2	Montana Governor's Conference on WC	Hilton Garden Inn- Missoula, MT
October 7-October 9	Northwest Longshore Fall Seminar	The Governor Hotel- Portland, OR
October 7-October 9	North Carolina Workers' Comp Educational Conference	The Raleigh Convention Center- Raleigh, NC
October 8-October 9	New Jersey Workers' Comp Conference	Sheraton Atlantic City Convention Center- Atlantic City, NJ
October 13	Workers' Comp Claims Association Fall Seminar	Wilsonville Holiday Inn- Wilsonville, OR
October 15-October 16	Vermont Dept. of Labor Workers' Comp Conference	Hilton Burlington- Burlington, VT
October 28-October 30	California Workers' Comp Forum	Hyatt Regency Huntington Beach Resort- Huntington Beach, CA
October 28-October 30	Virginia Association Defense Attorneys Annual Meeting	Westfield Marriott- Chantilly, VA

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