Medicare Set-Aside Self Administration:

Why are claimants failing miserably?

By Patty Meifert, RN, CRRN, CCM, CLCP, MSCC

Since the establishment of Medicare's Coordination of Benefits Contractor in 2001, the Workers Compensation (WC) industry has come, sometimes kicking and screaming, into the world of Medicare Set-aside (MSA) arrangements. Primary payers have been bombarded with education regarding the MSA allocation and most have become proficient on the subject.

Unfortunately, with the intense focus on the MSA allocation, the other aspects of the MSA arrangement, such as the method of funding and the method of administration, have been given little more than an honorable mention.

The vast majority of WC MSA arrangements are self administered by the claimant. Of all the MSA arrangements submitted to The Centers for Medicare and Medicaid Services (CMS) by NuQuest/Bridge Pointe since November 2007, 97% were self administered by the claimant. Of those 97%, only 3.2% were provided with a NuQuest/Bridge Pointe self administration support program.

NuQuest/Bridge Pointe's Administration Specialists speak with hundreds of claimants post settlement and report that a very small percentage of them were given the necessary tools and information at the time of settlement to enable successful self administration. In addition, most are given minimal and/or incorrect information regarding how the MSA funds must be utilized and the consequences of inappropriate use of MSA funds.

Nationally, claimants are failing miserably at self administration and the WC industry is beginning to experience the fall out. Post settlement calls to both primary payers and claimant attorneys are increasing as claimants realize they are not equipped to self administer or because their failure to successfully self

administer has impacted his/her Medicare benefits. Claimant attorneys are becoming increasingly concerned about malpractice exposure for failing to protect their client's Medicare benefits in the settlement. Primary payers are becoming concerned about the potential for case reopening and frustrated with the time being utilized to field calls on closed claims.

These issues and concerns are now impacting current settlement negotiations which in turn have become the catalyst for primary payers and attorneys to seek greater understanding of self administration requirements and to develop protocols to optimize successful self administration going forward.

This article will take an in depth look at the requirements for MSA self administration, some of the most difficult challenges facing self administering claimants and finally, some practical steps to optimize successful self administration.

Requirements for MSA Self Administration

A self administered MSA arrangement is subject to the same CMS rules and requirements as a professionally administered MSA arrangement[1] with minor exceptions relating to reporting and accounting. If a claimant is to be held to the same standard as a professional administrator, it is imperative that the claimant understand the following requirements.

Establishing the MSA Account

MSA funds must be placed in an interest bearing account. This account should be a separate account from the claimant's personal savings or checking account.[2] Proof of establishing the account and the initial deposit amount should be maintained in the claimant's records.

Funding the MSA Account

MSA accounts are funded in one of two ways: 1) a single lump sum payment or 2) a structured payment arrangement. If a single lump sum payment is utilized, the entire MSA amount is to be deposited into the MSA account at the time of settlement. If a structured payment arrangement is utilized, an initial payment (seed) amount is to be deposited into the MSA account at the time of settlement followed by annual payments over a defined period of time. The amount of the initial payment must include the amount necessary to cover the first surgery procedure and/or replacement and two years of annual payments. Subsequent annual deposits are based on a set anniversary date which cannot be more than one year after the settlement date.[3]

Allowable Expenses from the MSA Account

MSA account funds must only be used for medical and prescription drug expenses that are related to the WC injury and that would otherwise be reimbursable by Medicare.[4] An expense is considered WC injury related if the condition requiring the medical care or prescription drug treatment is a result of the illness or injury that was the subject of the WC settlement. Once it is established that the medical care rendered is related to the WC injury, the claimant must determine if the care is also otherwise reimbursable by Medicare before payment can be made from the MSA account funds.

Other allowable expenses payable from the MSA account include payments for document copying charges, mailing fees/postage and any banking fees, as long as the costs are directly related to the MSA account and there is adequate documentation to support the expenditures.[5] In addition, if there is adequate documentation of the amount of incremental tax that a claimant must pay for the interest earned on the MSA account funds, the claimant may withdraw the amount of the incremental tax liability from the MSA account.[6]

Interest Earned on MSA Account Funds

All interest earned on the MSA account funds must be allowed to accrue in the account and must be used solely for allowable MSA expenses.[7]

Amount of Payment to Providers

Payment from the MSA account for allowable expenses should be made based on the method used to calculate the MSA allocation. The claimant must know if the MSA allocation was calculated using the WC reimbursement rate for the State of claim jurisdiction or full and actual charges. Payments from the account should be made on the same basis.[8] CMS indicates that the administrator is responsible for obtaining fee schedule updates.[9]

Annual Self Attestation

A CMS self attestation form must be signed by the claimant and forwarded to the Medicare Secondary

Payer Recovery Contractor (MSPRC) no later than 30 days after the end of each year, beginning one year from the date of settlement. Annual self attestation must continue through depletion of the account. The claimant must indicate, on the self attestation form, the amount of the MSA funds that was expended for allowable medical services and for prescription drug treatment for the attestation period.[10] Expenses for medical treatment and prescription drug treatment must be listed separately.[11] The claimant is required to sign the following attestation:

> *I acknowledge and understand that failure to follow any of the Medicare requirements for use of this money will be regarded as failure to reasonably recognize Medicare's interests and that Medicare will deny coverage for all medical treatments and prescription drug expenses due to my work related injuries up to the total workers' compensation settlement amount.*[12]

Final Self Attestation

Once an MSA account becomes permanently depleted, a final self attestation form should be sent to the MSPRC. Medicare will then make the final determination as to whether or not the MSA account funds have been properly utilized and if Medicare benefits will be available for WC injury related care going forward. A MSA account that has been funded by a single lump sum payment is considered permanently depleted when the total CMS approved MSA amount has been expended for MSA allowable expenses. A MSA account that has been funded by a structured payment plan will become permanently depleted when all MSA funds have been properly depleted and there are no future structured payments. It should be noted that a MSA account funded with a "life only" annuity will never become permanently depleted as annual structured payments will continue until the death of the claimant.

Record Keeping and Audit

The claimant is responsible for keeping accurate records of all MSA account activity including payments made from the account. These records may be requested by the CMS contractor as proof of appropriate payments from the MSA account. CMS reserves the right to audit how the MSA funds were spent and recommends that the claimant retain MSA records for a period of seven years.[13] The author recommends MSA records be retained indefinitely.

Reimbursement to Medicare

If, prior to the depletion of funds in the MSA account, CMS determines that Medicare has paid benefits that should have been paid from the MSA account, CMS has the right to seek and receive reimbursement of any such payments to the extent that there are funds remaining in the MSA account at that time.

Carry Forward Amount (Structured Accounts)

If the MSA account is being funded annually by a structured payment plan, any funds that remain in the MSA account at the end of any annual period must be carried forward to the next annual period and utilized for MSA allowable expenses.[14] Carry forward must continue for the life of the MSA account.

Temporary Depletion of MSA Account Funds (Structured Accounts)

MSA accounts funded by a structured payment plan may become temporarily depleted. Temporary depletion occurs when all MSA funds, including the current year's annual structured payment, interest earned on account funds and any carry forward amounts from previous years, have been depleted. Once the MSPRC agrees that the MSA account is temporarily depleted, Medicare will pay for injury related medical care and prescription drug expenses otherwise covered by Medicare until the next annual structured payment is received.[15] However, Medicare will only pay these expenses to the extent that 1) the expense is otherwise covered by Medicare, 2) the claimant is enrolled in the part of Medicare that would provide coverage for the expense (Part A, B or D) and 3) the claimant does not have other coverage for these expenses that is primary to Medicare. The claimant will still be responsible for the applicable Medicare deductibles and co-payments.

Release of Unused MSA Account Funds upon Death of the Claimant

CMS should be notified of the claimant's death. The MSA account must remain open for some period after the date of death to enable the payment of any outstanding MSA allowable expenses and to enable CMS to recover any conditional payments, if indicated. It

should be noted that providers, physicians and suppliers are permitted to submit their initial bill to Medicare for a period ranging from 15-27 months after the date of service. Once CMS, or its contractor, determines that all allowable claims have been paid and that Medicare's interests have been considered, any remaining MSA account funds may be disbursed according to state law.[16]

Consequences of Improper Use of MSA Funds
If MSA account funds are used to pay anything other than MSA allowable expenses, Medicare will not pay any WC injury related claims until these funds are restored to the MSA account and then properly exhausted (permanently or temporarily).[17]

Most Difficult Challenges Facing Self Administering Claimant's

The following areas are particularly challenging for most claimants and require the most support to optimize successful MSA self administration.

Structured Funding Variables
MSA accounts funded by structured annual payments pose unique administration challenges which vary depending on the type of annuity utilized. Special attention should be given to self administering claimants whose MSA is funded with a structure to ensure they have the information necessary to successfully self administer and to navigate the following:

Temporary Depletion
Temporary depletion can occur in any annual period over the duration of a structured payment plan. When a MSA account becomes temporarily depleted, the claimant must send a self attestation letter to the MSPRC indicating the temporary depletion and requesting Medicare pay primary. Often the depletion of the MSA account funds requires making a partial payment to a provider and asking that the provider bill Medicare for the balance. Providers are typically uncomfortable with this type of request. In addition, due to the lag time associated with processing requests to Medicare for temporary depletion, providers who are willing to submit interim claims to Medicare may have their claim initially denied. This can create a frustrating and uncomfortable situation between the claimant and provider.

Alternating Primary Payers
During periods of temporary depletion, the MSA will be the primary payer for a portion of the annual period and Medicare will be the primary payer during the remainder of the period. Once the next annuity payment is received, the MSA will again become the primary payer. This alternation of primary payers can be confusing for both claimants and providers. The determination of who is the responsible payer will be based on dates of service, not dates of billing which requires careful date tracking to ensure the proper payer is billed.

Co-payments and Deductibles
During any year where Medicare becomes the primary payer for WC injury related expenses, the claimant will be responsible for payment of any applicable Medicare co-payments and deductibles. Since these are not payable from the MSA account, the claimant must utilize non-MSA funds to pay these amounts. Claimants often indicate that they were not informed of this potential expense prior to settlement and have not reserved adequate funds.

Determining Injury Related and Medicare Allowable Expenses
The question "is it related to or arising from the WC injury" is a familiar one to those who work in the WC industry. At times, it takes a team of physicians, attorneys and a judge to decide the answer. Post settlement, the claimant must rely on the physician to determine the answer to this question before payment is made from the MSA account and to provide documentation of same should CMS question the appropriate use of MSA funds. Medicare covers many medical care services and prescription drugs, but it does not cover everything. In addition, Medicare may cover a service under certain diagnostic conditions but not under others.

Determining if a certain medical or prescription drug cost is covered by Medicare can be a complicated process for claimants. The CMS website contains

Medicare coverage databases but it can be difficult to navigate for the lay person. The physician or provider's billing office can be useful in assisting the claimant with determining if a care expense would be otherwise covered by Medicare. The claimant should be given resources to assist in determining Medicare covered expenses including Medicare's toll free number: 1-800-MEDICARE, the CMS website at http://www.cms.hhs.gov/home/medicare.asp and the Medicare publication, "Medicare and You" available at any Social Security Administration office.

Determining Appropriate Reimbursement Rates for Services

The vast majority of MSA allocations are approved to pay allowable medical care costs at the WC reimbursement rate in the State of claim jurisdiction. Many states make available WC reimbursement rates via their State WC web site but these can be difficult to understand and require CPT codes before appropriate rates can be determined. The claimant may need to rely on the physician or provider to determine the WC reimbursement rate for a particular service or supply.

Providers Not Accepting WC Reimbursement Rates Post Settlement

Physicians and other providers are not obligated to extend WC reimbursement rates post settlement. Many providers see the MSA as private pay and therefore will charge for services accordingly. If the claimant is unable to obtain care at the WC reimbursement rate, the assigned CMS regional office should be contacted to obtain permission, in writing, to pay allowable expenses from the MSA account at the full and actual charges billed by the provider.

Communicating with Providers

One can only imagine the challenge that may be associated with explaining to a physician or other provider that WC injury related care otherwise covered by Medicare must be paid by the MSA account. Add in the potential of alternating primary payers and requests to bill at WC fee schedule and the situation can become quite frustrating for all parties. In our practice, we have found it helpful to provide the claimant with an explanatory letter to present to providers. For new provider visits, mailing the letter in advance with a follow-up call to the provider billing office helps alleviate problems at the time of the appointment.

Practical Steps to Optimize Successful MSA Self Administration

In order to optimize successful MSA self administration, steps must be taken to evaluate cases for appropriateness, provide claimants with necessary information and support and ensure that the requirements of self administration and consequences of non-compliance are clearly stated in the settlement language.

Evaluate Cases for Appropriateness

Self administration is not appropriate for all cases. Per CMS,

> *WC Medicare Set-aside Arrangements must be administered by a competent administrator (the representative payee, a professional administrator, etc.). Moreover, when an individual does (in fact) have a designated representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties must include that information in their Medicare set-aside arrangement proposal to CMS.*[18]

Establishing screening protocols to determine which cases are appropriate for self administration is an essential first step to optimizing successful self administration The author suggests the following guidelines be considered when evaluating the appropriateness of self administration in an individual case:

Self administration is not appropriate when:

- Claimant is mentally or physically incapable of managing payments or complying with CMS administration requirements, declared legally incompetent by a court or assigned a guardian or conservator
- Claimant has been assigned a representative payee by the Social Security Administration and the representative payee elects not to serve as administrator of the Medicare Set-Aside

In these cases, a professional administrator or other competent administrator should be utilized.

Self administration may not be appropriate when:

- Claimant has serious or complicated medical conditions
- Claimant has a lower education level
- Claimant is unable to read or write English
- Claimant's family or social dynamics place MSA funds at risk

These cases should be carefully evaluated to determine if a professional administrator or other competent administrator should be utilized or if a self administration support program may be appropriate.

Provide Necessary Information and Support Services

It is essential that the claimant receive and understand self administration requirements prior to disbursing the MSA funds. There may be some hesitancy to present the full scope of the self administration requirements during settlement discussions due to concerns that the settlement may be jeopardized or a demand could be made for professional administration. However, there are tools that can provide support when needed.

A self administration support program can be a beneficial tool for claimants who may be appropriate to self administer but who need assistance in order to optimize success. NuQuest/Bridge Pointe's self administration support program provides tools, resources and support personnel to optimize successful self administration at a nominal cost. This service may be a viable alternative to professional administration in some cases and may help calm concerns regarding self administration in general.

Settlement Language

The settlement release should contain language addressing the method of MSA administration. Self administration requirements are sometimes included as part of the settlement language or as an addendum to the settlement release. The settlement release language provides an opportunity to demonstrate that the claimant was provided with, and agrees to, the self administration requirements and understands the consequences of non-compliance.

In closing, MSA self administration is not a simple undertaking. Loss of future Medicare benefits for injury related medical care expenses can be a devastating consequence for claimants who were not equipped to successfully self administer. The time has come for the WC industry to ensure that claimants are properly evaluated for appropriateness to self administer and to provide claimants with the tools, resources and support necessary to successfully self administer. This will not only help protect the claimant's future Medicare benefits but also serve the interests of all parties to a WC settlement.

About the Author

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Endnotes

1 Grissom, Thomas. (April 22, 2003). CMS Memorandum: *MedicareSecondary Payer-Workers' Compensation (WC) Frequently Asked Questions.* FAQ No. 8.

2 CMS (April, 2005). *WCMSA Sample.* Attachment: *Terms and Conditions for Beneficiary Administered Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).* Retrieved June 9, 2008 from http://www.cms.hhs.gov/WorkersCompAgencyServices/ Downloads/samplesubmission.pdf

3 Walters, Gerald. (October 15, 2004). *Medicare Secondary Payer (MSP)- Workers' Compensation (WC) Additional Frequently Asked Questions*. FAQ No. 5.

4 CMS (April, 2005). *WCMSA Sample.* Attachment: *Terms and Conditions for Beneficiary Administered Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).* Retrieved June 9, 2008 from http://www.cms.hhs.gov/WorkersCompAgencyServices/ Downloads/samplesubmission.pdf

5 CMS (April, 2005). *WCMSA Sample.* Attachment: *Terms and Conditions for Beneficiary Administered Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).* Retrieved June 9, 2008 from http://www.cms.hhs.gov/WorkersCompAgencyServices/ Downloads/samplesubmission.pdf

6 Walters, Gerald. (July 11, 2005). *Medicare Secondary Payer (MSP)- Workers' Compensation (WC) Additional Frequently Asked Questions*. FAQ No. 6.

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10 Walters, Gerald. (July 11, 2005). *Medicare Secondary Payer (MSP)- Workers' Compensation (WC) Additional Frequently Asked Questions*. FAQ No. 10

11 CMS (2008). *Administering Your Lump Sum Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).* Standardized form attachment mailed with CMS review correspondence.

12 Walters, Gerald. (December 30, 2005). *Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) Questions and Answers.* FAQ No. 4

13 Walters, Gerald. (2008) *Workers' Compensation Medicare Set-aside Arrangement.* MSA proposal standardized CMS review response form letter.

14 CMS (2008). *Administering Your Lump Sum Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).* Standardized form attachment mailed with CMS review correspondence.

15 Grissom, Thomas. (April 22, 2003). CMS Memorandum: *Medicare Secondary Payer-Workers' Compensation (WC) Frequently Asked Questions.* FAQ No. 10.

16 Grissom, Thomas. (April 22, 2003). CMS Memorandum: *Medicare Secondary Payer-Workers' Compensation (WC) Frequently Asked Questions.* FAQ Nos. 9, 10.

17 Grissom, Thomas. (April 22, 2003). CMS Memorandum: *Medicare Secondary Payer-Workers' Compensation (WC) Frequently Asked Questions.* FAQ No. 21.

18 CMS (April, 2005). *WCMSA Sample.* Attachment: *Terms and Conditions for Beneficiary Administered Workers' Compensation Medicare Set-Aside Arrangement (WCMSA).* Retrieved June 9, 2008 from http://www.cms.hhs.gov/WorkersCompAgencyServices/ Downloads/samplesubmission.pdf

19 Walters, Gerald. (October 15, 2004). *Medicare Secondary Payer (MSP)- Workers' Compensation (WC) Additional Frequently Asked Questions*

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