Checklist for Medicare Issues in Your Georgia Settlements

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This checklist is divided into four parts and is meant to be a summary. It is not a comprehensive analysis of all Medicare issues and you should consult with a lawyer regarding how the law and regulations impacts each individual claim.

1. Where is the claimant in the process and what needs to be done?
   (only 4 possible scenarios)

2. MSA Strategy

3. Conditional Payment Strategy

4. Definitions and Use of Social Security Releases

Note: What you need to do to protect Medicare's interests generally depends on where they are in the social security system: Medical elligible, receiving SSDI but not yet medicare elligible, applying for (or appealing) SSDI, or has not applied for SSDI. To verify where in the system the claimant is, ask the claimant to set up an account with Social Security at www.ssa.gov/myaccount; A screen will appear showing his status. The claimant can then send it to you, or even take a picture of the screen.

Part One: Where is the claimant in the process and what needs to be done? Only Four Possible Scenarios Exist

Scenario #1: The claimant is a Medicare beneficiary. You must:

1) Follow the reporting requirements associated with an RRE
2) Have an MSA done (see p. 3)
3) Have CMS approve the MSA, unless the total settlement is less than $25,000 (see p. 3)
4) Address Conditional Payments (see p. 4)

Scenario #2: The claimant is not a Medicare beneficiary but the settlement (indemnity and medical) is greater than $250,000.* You must:

1) Have an MSA done (see p. 3)
2) Have CMS approve the MSA (see p. 3)
3) You do not have to address conditional payments.

* The assumption for purposes of this checklist is that if a settlement is at least $250,000 it is likely the claimant has already applied for SSDI.

Scenario #3: The claimant is not a Medicare beneficiary but has applied for SSDI and the total settlement is less than $250,000. You may

1) Need to have an MSA done**
2) You do not need to get CMS approval of the MSA.
3) You do not have to address conditional payments.

** Once the claimant has applied for SSDI, he or she is "in the system." You are always required to take into account Medicare's interest and protect Medicare from paying for treatment that should be paid for under workers' compensation. The requirements of when an MSA may be appropriate vary based on the facts and the requirements of the insurance carrier. At a minimum, there should be language in the settlement Stipulation showing that you considered Medicare's interest.

Scenario #4: The claimant is not a Medicare beneficiary, has not applied for SSDI, and the settlement is less than $250,000.

1) You do not need an MSA.
2) You do not have to address conditional payments.

You may still want to include language in the settlement Stipulation showing that you considered Medicare's interest. Also, under some circumstances a carrier may require an MSA be done if it is an older claim, the claimant has been off work for an extended period of time, or the claimant is near retirement age

Part Two: Medicare Set-Aside Allocations

Required v. Optional

1. MSA required* and must be approved by CMS if:

    A. The claimant is a Medicare beneficiary, or
    B. The settlement is at least $250,000 (indemnity plus medical) and the claimant is likely to be on Medicare within 30 months

* CMS has always taken the position that you never have to do an MSA or get CMS approval. What you must always do is take Medicare's interests into account and avoid shifting workers' compensation costs to Medicaid.

2. MSA may be appropriate but CMS approval not required if:

    A. The claimant has applied for SSDI
    B. The claimant is at or near 60 years old
    C. The claimant has been off work for at least a year

In this category, there is no firm rule on when an MSA is required. However, CMS requires that you always take into account Medicare's interests so an MSA is seen as the safest way to demonstrate that you have done so.

If you need to have an MSA done and approved by CMS, below are strategies to consider:

1. Generally, an MSA not approved by CMS yet is good for 1 year unless there has been a significant change in the claimant's medical status.

2. You can use an annuity to fund an MSA. However, Georgia State Board Rule 15 requires language in the settlement documents reflecting that if the annuity company fails, the employer/insurer will remain responsible for payments.

3. There are three basic options for how to settle a claim that involves an MSA which CMS must approve:

    - Settle indemnity only and leave medical open.
    - Settle indemnity and medical at the same time but have an "escape clause" in the Stipulation that states that if CMS requires the MSA to be higher than proposed that the employer/insurer can withdraw from the medical portion of the settlement and leave medical open.
    - Prepare a separate indemnity settlement and a separate medical settlement.

Part Three: Addressing Conditional Payments

Why this occurs:

This issue can only occur when the claimant is a Medicare beneficiary. Medicare can make payments for a variety of reasons:

1. The claim is initially controverted and then accepted.
2. The doctor's office mistakenly files under Medicare and not comp.
3. The claimant goes to an unauthorized doctor.
4. The claimant treats for a condition which is not part of the compensable claim

The following are strategies for addressing conditional payments:

1. Controvert unauthorized doctors or unrelated conditions as soon as you are aware; file the WC-3 with the State Board.

2. Verify the coding done by the doctor's office is correct so unrelated conditions are not lumped in with compensable conditions.

3. Request from CMS exactly what bills they have paid and how much they have paid. You are only responsible for reimbursing CMS for what CMS has paid. They take many fee reductions. Also, CMS will sometimes reduce what needs to be reimbursed by considering attorney fees associated with addressing this issue.

4. Provide CMS with documents which support your position.

5. For smaller amounts, you may consider reimbursing CMS even though you may not agree. You do not want this issue to come back later and you do want a letter from CMS stating that there is a zero balance with respect to any lien.

Part Four: Definitions and Use of Social Security Releases

Medicare Beneficiary: A claimant becomes a Medicare beneficiary generally in 2 ways: by reaching retirement age or by qualifying for social security disability income (SSDI) and then going through a waiting period.

RRE/Reporting Requirements: If a claimant is a Medicare beneficiary, then Federal law and regulations require that the workers' comp insurer report certain information to the Centers for Medicare and Medicaid Services (CMS), which administers Medicare. You determine if a claimant is a Medicare beneficiary by having the claimant sign Releases to get this information. CMS is also working on a system that will allow users to check on line. If a claimant is not a Medicare beneficiary, then no reporting is required.

Conditional Payments: If a claimant is a Medicare beneficiary, then it is possible some medical charges for the work injury were submitted to Medicare for payment and Medicare paid. If so, Medicare considers this a conditional payment for which the insurer must reimbursed Medicare at the time of the workers' comp settlement. Failure to do so could result in Medicare suing the insurer and all other parties and attorneys. This has actually happened. If a claimant is not a Medicare beneficiary, then there is no conditional payment issue

MSA: Medicare does not want to pay for medical treatment for a work injury. If you settle your claim, Medicare requires that you take their interest into account, specifically, making sure that future medical is not paid for by Medicare but by the insurer. This is done by use of the MSA which sets aside money to be used by a claimant after settlement. If a claimant is a Medicare beneficiary, you must submit the MSA to CMS for approval. If a claimant might become a Medicare beneficiary within 30 months of the settlement and the settlement is over $250,000 total (indemnity and medical) then you also must submit the MSA to CMS for approval. In almost all other situations, you do not need to have CMS approve the MSA. However, Medicare still requires that you take their interest into account so it may be necessary to have an MSA done but just not submit it to CMS for approval

Social Security Releases: Get the necessary Social Security/Medicare releases from the claimant so you can verify if the claimant is a Medicare beneficiary: Generally, there will be two releases. One release makes the request for information. The other release allows the Medicare vendor to act on behalf of the insurer/TPA in communicating with CMS. The authorization actually allows CMS to release information about the claimant to the Medicare vendor. Claimants are not required to complete these authorizations so it is not like a WC-207 (medical authorization) which the claimant is legally required to complete in order to pursue workers' compensation benefits. However, if a claimant will not sign the Social Security/Medicare releases then the claimant cannot complain that his/her claim is not settling.

Do not assume that because a claimant is working that he/she is not on Social Security disability and therefore no authorization is necessary. Do not assume that the claim will never be Medicare eligible (due to legal status within this country, lack of work and sufficient quarters, etc.). Also, you should not accept verbal or even written statements from the claimant or his/her attorney that the employee is not eligible for Medicare or has not applied for Social Security disability as a substitute for an authorization and confirmation by CMS.