

CMS Moving To Close MSP Loopholes

As professionals in the claims community are no doubt aware, a number of changes in Medicare Secondary Payer compliance will be occurring early this summer. Though many of these changes will be prompted by the reporting requirements found in Section 111 of the Medicare, Medicaid & S-CHIP Extension Act of 2007 ("MMSEA"), they are not exclusive to those amendments to the MSP. Indeed, as three separate recent events make clear, Medicare is marking this summer as a major date for enforcement of the MSP. The first of these three key events is obviously the advent of mandatory reporting which we have been covering for many months now. The second is tailored to ensure MSA funds are being properly utilized through



changes in the Common Working File ("CWF"). Finally, the most recent major event is the CMS policy change on prescription drugs.

Common Working File Update

In the last week of March, Medicare finalized a little-noticed update to the Medicare Common Working File ("CWF") to deal specifically with workers' compensation Medicare Set Asides. See https://www.noridianmedicare.com/dme/news/docs/2009/03_mar/mm5371.pdf.

Effective July 1st, the CWF will be equipped to monitor treatment and deny payment where a claimant has a Medicare Set Aside that has been approved by CMS. In its notice, CMS explains that, "With the creation of the new MSP code, the Centers for Medicare & Medicaid

Services will have the capability to discontinue conditional payments for diagnosis codes related to such settlements."

This is a major step forward in MSP enforcement. CMS has rarely enforced the payment of funds from an approved Medicare Set-Aside (MSA). With the creation of this new code, Medicare will be empowered to closely track and filter the use of MSA funds. Moreover, the implementation of this code represents the closing of a major enforcement loophole. Until now, it has not been uncommon for claimants to continue to use Medicare to pay for treatment associated with their underlying claim.

Such scenarios are less likely to occur on a going forward basis. Under the CWF update, Medicare will now be equipped to deny coverage for treatment aligned with the injuries set forth in the MSA submission. At a minimum, this is a wake-up call for some claimants who may be mistakenly billing Medicare rather than utilizing their MSA funds. While claims organizations

are largely absolved from responsibility (assuming the MSA was fully funded) in these instances, claimants may face headaches and claimants' attorneys who failed to properly instruct their clients in the administration of the MSA could run into malpractice issues in the event that their clients' treatment or Medicare coverage is affected.

There is, however, a larger risk for claims organizations and claimants who fail to abide by the MSA review policies. When viewed through the prism of the Mandatory Insurer Reporting obligation under § 111, the implications of this addendum to the CWF become much more ominous. Not only will CMS have access to claims settlement data, it will be able to use that data to determine whether the parties requested CMS approval of a Medicare Set Aside. Because CMS claims the authority to treat the entire settlement amount as an MSA where no funds are set aside, one can imagine that parties who fail to submit WC settlements for review and approval will find that CMS has classified the entire WC settlement as "future medical."

New Prescription Drug policy

Perhaps not coincidentally, last week CMS released an updated prescription drug policy to take effect just one month prior – on June 1st. It is not surprising that Medicare would establish guidelines for the independent review of prescription drugs shortly before the onset of § 111 reporting. Not only does this coincide with the reporting requirements, but this new prescription drug policy announcement represents another step in the “nationalization” of the MSA review process.

The prescription drug policy has three major changes. First, it explains that for all submissions received on or after June 1st, CMS will “independently review” prescription drugs. Second, the new policy adopts “Average Wholesale Price” (“AWP”) as the preferred pricing method. Third, CMS will no longer allow submitters to substitute “generic” pricing at a future date when a brand-name drug is expected to go generic.

Until now, CMS had “noted” the amount that parties had set-aside for prescription drug use. For claims submitted prior to June 1, the defining standard was one of reasonableness. Now, in adopting AWP as the only viable prescription drug pricing model, CMS alters the settlement landscape by branding a controversial pricing system on all MSAs nationwide. Over the last few years, CMS has moved towards a “national” model of workers’ compensation MSA review and away from a jurisdiction-specific model. CMS has attempted to nationalize or regionalize a set of outcomes independent of the state WC fee schedule and state law. This is often seen with injections, surgeries and implantable devices, but it is also seen in CMS’ disregard of many state law realities like payment without prejudice statutes.

This “nationalization” has the potential to have a major effect on the MSA review process. Not only will the MSA review process likely be slowed, but we also anticipate that CMS will request an increase in the amount of prescription drugs allocated as it removes several self-correcting elements of the MSA approval process. As we can only speculate as to the form these policies will take, we anticipate that CMS’ enforcement of this policy will dictate the required response. It is important to note that CMS is not expected to release any information about its enforcement of this policy, and that parties will need to review cases as they are returned from CMS to determine if allocation methodology will continue to remain viable.

Those methodologies include sunsetting certain narcotics as a person ages, removing multiple medications that provide the same benefit and substituting generic for brand if a claimant is using a brand where a generic medication presently exists.

The potential for increased cost can be seen in two areas. First, if parties do not “consider” a particular drug and CMS “deems” that the drug should be included, CMS will cost the drug out at the brand cost – even if a generic is presently available. This element of the policy, which is substantially more punitive than any policy previously announced by CMS, is designed to scare MSA allocators into including prescription drugs on cases – even where little or no medical evidence exists to support the inclusion of particular prescription medications. This will likely result in an increase in the amount allocated as parties insure against the possibility of receiving a counter-higher.

Second, where there is a significant possible problem for claims where prescription drug use is litigated. It is quite likely that Medicare will side with the claimant’s treating physician for inclusion of work-related prescription medications. Even in the face of a DUR or an IME, it is likely that Medicare will side with a treating physician who links prescription drugs to the work injury. Thus, if a carrier is denying medications on the strength of a DUR or an IME, Medicare will likely ignore the state WC practice in favor of its “national” practice of agreeing with the treating physician almost without question.

There are two recommendations for dealing with this policy. First, for complex prescription drug cases with high “CMS exposure” but low real-world WC exposure due to a favorable IME or DUR, it makes sense to consider settling as soon as possible to avoid an unwanted counter higher. Second, after

June 1st, it is likely to make complicated prescription drug claims significantly more difficult to settle. For that reason, it makes sense to do a comprehensive evaluation of the claims that may provide the maximum benefit to settle them quickly.

Conclusion

We do not believe in coincidences. The convergence of the CWF update and a strengthening of the prescription drug policy in MSAs will have a significant effect on both the amount of MSAs, and the administration of MSAs. At the same time that CMS will be receiving mountains of data concerning WC settlements, it will be moving to ensure that more MSAs will be submitted for review and approval and containing higher prescription drug amounts. As CMS moves to close all loopholes, a highly professional organization equipped to handle reporting; and supplemented by a strong legal and medical response to the MSA challenge, is a required element of MSP compliance.