AMETROS

A STUDY OF CMS POLICY ON TREATMENT DENIALS FOR INJURED WORKERS WITH A MEDICARE SET ASIDE

ABOUT THIS STUDY:

Produced with data from researchers at ResDAC, this is the first study of its kind analyzing quantitatively how often The Centers for Medicare and Medicaid Services (CMS) denies coverage for otherwise Medicare-covered items for individuals after settlement of an insurance claim that involves medical liability. These denials impact individuals that have settled a workers' compensation claim with approved Workers' Compensation Medicare Set Asides (WCMSAs).

The purpose of this study is to share key metrics about the volume and frequency of these denials, examine the correlation between WCMSAs and the Medicare Part B Program, and discuss the broad implications they have for the individual and all constituents in the claims settlement process.

To provide feedback, ask questions, and stay informed about subsequent versions of this study, please contact us at ametros.com/medicaredenials

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ABOUT AMETROS:

Ametros makes healthcare easy for injured individuals and those paying for their medical needs out-of-pocket. Our mission is to protect and empower the future of medical care by helping our members save money on medical expenses and save time in dealing with the complex healthcare system.

Founded in 2010 and headquartered in Wilmington, MA, Ametros has over 100 employees who are committed to helping tens of thousands of members live healthier lives.

Learn more at ametros.com

BACKGROUND ON THE STUDY

Ametros collaborated with researchers at ResDAC to compile this medical claim data from the Centers for Medicare and Medicaid Services (CMS). ResDAC is a CMS contractor that helps researchers with CMS data. Learn more about ResDAC here.

The data Ametros analyzed demonstrates enforcement of the Medicare Secondary Payer Statute (MSP) for individuals who have settled workers' compensation claims with WCMSAs. Ametros researchers looked at a limited data set of a Carrier Line File showing data from the years 2018-2020. The data analyzed and discussed in this study was only for Medicare Part B claims; it does not include any Part A, C or D claim data.

This data set contains claims information from a random subset of 5% of all Medicare beneficiaries. The Carrier Line File includes fee-for-service claims submitted by professional providers including physicians, physician assistants, clinical social workers, and nurse practitioners.

KEY FINDINGS

In the past year, Ametros researchers conducted a study to answer a question that most people in the Workers' Compensation Medicare Set Aside (WCMSA) industry have wondered for quite some time.

What happens when a Medicare Beneficiary settles their claim with a Medicare Set Aside, and, without reporting proper exhaustion of those funds to Medicare, attempts to use their Medicare benefit to pay for a treatment or prescription that was included in the WCMSA settlement? Does Medicare have a process for denying those claims?

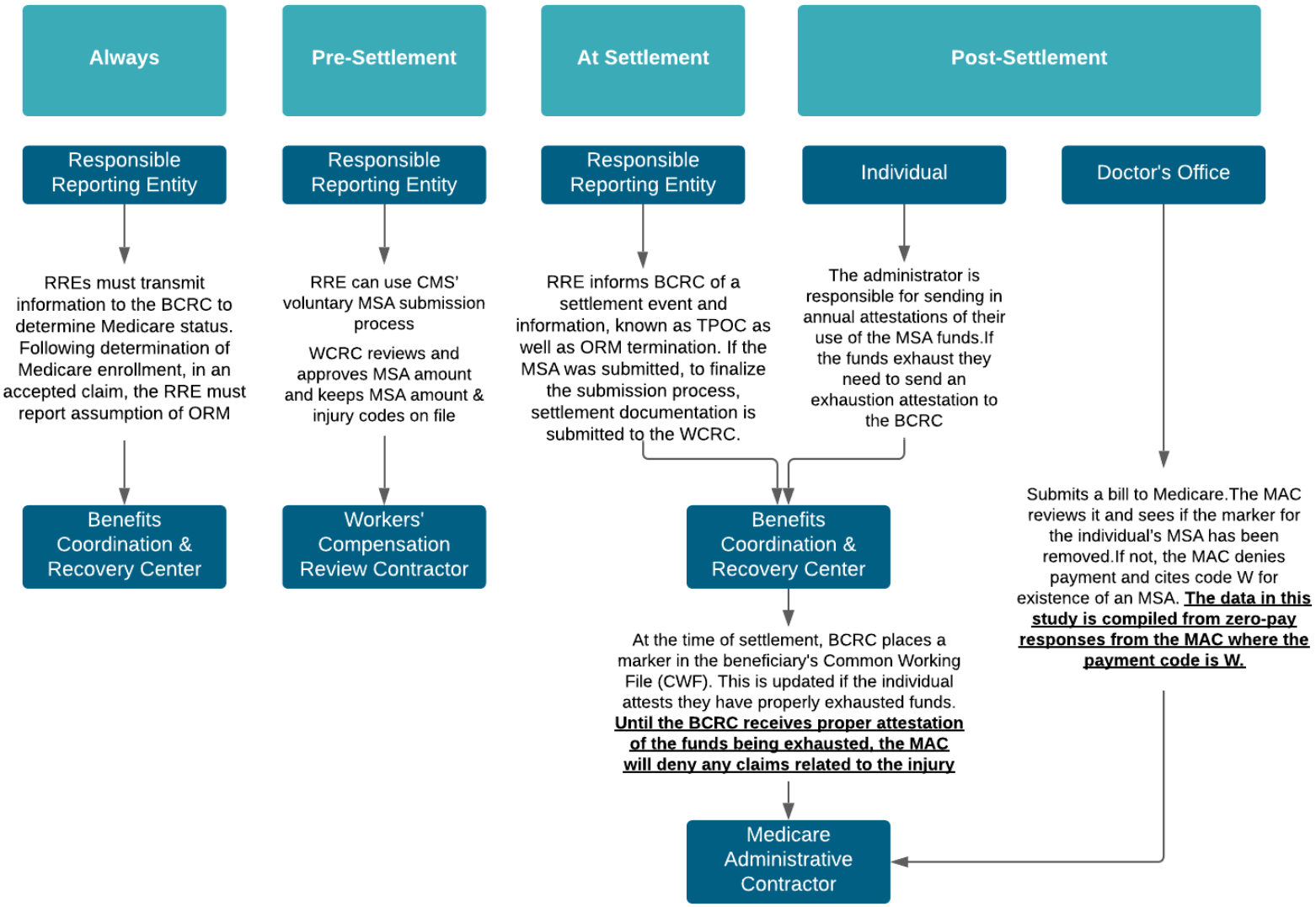
The answer is YES - Medicare is systematically denying MSA recipients' claims, and with steady frequency.

With data produced from Medicare, Ametros researchers looked at beneficiaries who had claims denied because the primary payment for that claim should have been funds from an individual's WCMSA account. It is assumed that these beneficiaries have settled the medical portion of their workers' compensation claim with a WCMSA being a part of that settlement. From there, Ametros analyzed other claims data, such as amount charged, and the total number of beneficiaries who had at least one claim denied. The results are demonstrated throughout this study.

HOW CMS TRACKS MSAs

CMS and their contractors find out about settlements, including the amount and injury codes involved, at a few key points in the process.

The chart below illustrates the various ways these communications take place, how CMS monitors the individual's file, and which entity is responsible for the notification.



Section 111 - Mandatory reporting requirements for settling beneficiaries
RRE - Responsible Reporting Entity - Party responsible for funding a claim payment
WCRC - Workers' Compensation Review Contractor
BCRC - Benefits Coordination & Recovery Center - Responsible for ensuring Medicare gets repaid for conditional payments
MAC - Medicare Administrative Contractor - Multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.
TPOC - Total Payment Obligation to Claimant
ORM - Ongoing Responsibility for Medicals

MEDICARE SECONDARY PAYER & WORKERS' COMPENSATION MEDICARE SET ASIDES

Medicare Secondary Payer (MSP) is federal law, including applicable regulations, with the purpose of preventing a cost-shift to the Medicare program when there is an applicable primary payer (insurance carrier or self-insured) who has responsibility to pay for a beneficiary's medical care as a result of a bodily injury insurance claim. See **42 USC 1395y(b)** and **42 CFR 411** et seq. The MSP also encompasses applicable CMS and MSP contractor policies and procedures.

Broadly, the MSP outlines three (3) areas of compliance with respect to general obligations of responsible parties.

1. CONDITIONAL PAYMENTS

The MSP mandates recovery of payments, referred to as "conditional payments," it made which should have been the responsibility of a primary payer. See 42 USC 1395y(b)(2)(B)(ii); 42 CFR 411.24.

2. SECTION 111

Electronic reporting is required for certain claim-related events involving Medicare beneficiaries. As it is referred to in the parlance, "Sec. 111" reporting mandates primary payers, referred to as Responsible Reporting Entities (RREs), submit electronic data to Medicare in order to properly coordinate benefits and facilitate the conditional payment recovery process. See 42 U.S.C. 1395y(b)(8); **CMS's Mandatory Insurer Reporting website**.

3. MEDICARE SET ASIDES

CMS has adopted a policy based on underlying MSP regulations which dictates parties to certain workers' compensation settlements which resolve future medical services to ensure Medicare's interests are protected. See **42 CFR 411.46**; **WCMSA Reference Guide, v3.5**.

"The term 'future medical services' refers to Medicare-covered and otherwise-reimbursable items and services [related to the work injury] that the beneficiary received after he or she obtains a settlement, judgment, award, or other payment." **See Workers' Compensation Medicare Set Aside (WCMSA) Reference Guide**, v3.5, Sec. 2.3.

Under the MSP, the CMS-sanctioned method of protecting Medicare's interest with respect to future medical services is the Workers' Compensation Medicare Set Aside, "WCMSA" or "MSA" for short. See **WCMSA Reference Guide, v3.5, Sec. 3.0**. The purpose of an MSA is to "… estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-injury related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost." Id.

In certain instances, CMS will voluntarily review WCMSA submissions "… in order to determine if the proposed WCMSA amount is sufficient to cover future claim-related medical expenses related to the settlement…" Id. Sec. 8.0.

MSA POST-SETTLEMENT ADMINISTRATION & COMPLIANCE OBLIGATIONS

Following settlement resolution of a workers' compensation claim, the MSA may only be used to "… pay for medical treatment or prescription drugs related to [the underlying] claim, and only if the expense is for a treatment or prescription Medicare would cover. This is true even if you are not yet a Medicare beneficiary…" **See Self-Administration Toolkit for WCMSAs, v1.3,** Sec. 4 & WCMSA Reference Guide, Sec. 17.3

"If payments from the WCMSA account are used to pay for services other than Medicare-allowable medical expenses related to medically necessary services and prescription drug expenses for the [workers' compensation] settled injury or illness, **Medicare will deny all [workers' compensation] injury-related claims until the WCMSA administrator can demonstrate appropriate use equal to the full amount of the WCMSA." WCMSA Reference Guide, v3.5, Sec. 17.3. "Medicare may also refuse to pay for future medical expenses related to the [workers' compensation] injury until the entire settlement is exhausted." Id. at Sec. 3.0 and see also Sec. 2.3 and 42 CFR 411.46(a).**

NOTE ON NON-SUBMIT MSAs

It is important to note that the denials data analyzed and reported in this study was based off claims data from Medicare beneficiaries who have a CMS submitted and approved WCMSA, and applicable denial code reported in the common working file. This paper did not cover any instances of denials related to WCMSAs which were not submitted to CMS for review. The authors are currently unaware of any available data around the prevalence of denials with respect to non-submit MSAs. However, there has been recent activity relative to non-submits – specifically, as it relates to CMS's policy position that a non-submit is a per se cost-shift and fails to recognize Medicare's interests. CMS asserts that in non-submit situations they may deny post-settlement Medicare-covered expenses related to the underlying workers' compensation injury until it can be shown that the funds were exhausted equal to the amount of the settlement. See **WCMSA Reference Guide, v3.5, Sec. 4.3**. Ametros will supplement this paper should data become available with respect to non-submit denials.

For more information on this update, **visit https://ametros.com/blog/cms-issues-position-on-non-submit-msas-in-updated-wcmsa-reference-guide/**

To find out more about submitted MSAs vs. Non Submit MSAs, check out **https://mspnetwork.org/news/545222/MSPN-Partner-Article-Submit-vs.-Non-Submit.htm**

MSA POST-SETTLEMENT ADMINISTRATION & COMPLIANCE OBLIGATIONS

An administrator is responsible for accurate record keeping of payments made from the account. On an annual basis, within 30 days from the anniversary of the settlement, the administrator reports attestation information to CMS. This attestation is a "statement that payments from the WCMSA account were made for Medicare-covered medical expenses and Medicare-covered prescription drug expenses related to the work-related injury, illness, or disease." **WCMSA Reference Guide, v3.5, Sec. 17.5.** An attestation is also reported in instances where an annuitized MSA has been temporarily depleted prior to annual re-funding of the account as well as when an account is permanently exhausted. Id.

In instances where there was a submitted and approved WCMSA, CMS has established Payment Code W, an "… MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, [and] will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. [This] MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence." See **MLN Matters Number: MM5371 Revised**.

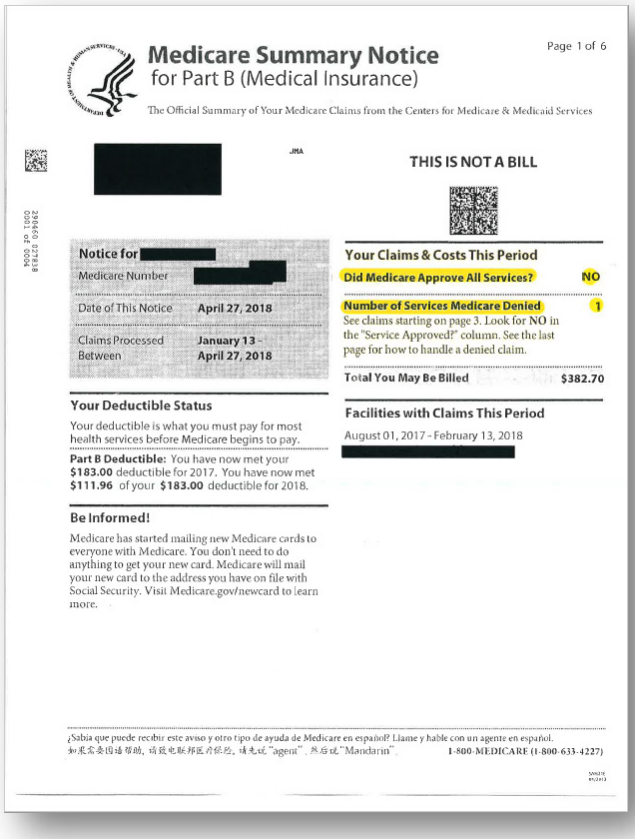
The marker, which is placed in a beneficiary's Common Working File (CWF) is utilized to coordinate benefits post-settlement, i.e., either pay or deny claims. "That marker is removed once the beneficiary can demonstrate the appropriate exhaustion of an amount equal to the WCMSA plus any accrued interest from the account. For those with structured settlements, the marker is removed in any period where the beneficiary exhausts their available funds; however, it is replaced once the anniversary fund deposit occurs until the entire value of the WCMSA is demonstrated as entirely exhausted." **WCMSA Reference Guide, v3.5, Sec. 18.0**.

See WCMSA Reference Guide, v3.5, Sec. 8.1: "CMS will review a proposed WCMSA amount when the following workload review thresholds are met: (1) The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00."

HUMAN IMPACT OF MEDICARE COVERAGE

Below is an image showing a denied claim from CMS. The following document is a Medicare Summary Notice sent to a Medicare beneficiary. On page 2, you can see that a service was not approved, and looking at footnote E, CMS explains:

"Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies)."



Medicare Summary Notice
for Part B (Medical Insurance)

Page 1 of 6

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

[redacted]

JMA

THIS IS NOT A BILL

Notice for [redacted]
Medicare Number [redacted]
Date of This Notice April 27, 2018
Claims Processed Between January 13 - April 27, 2018

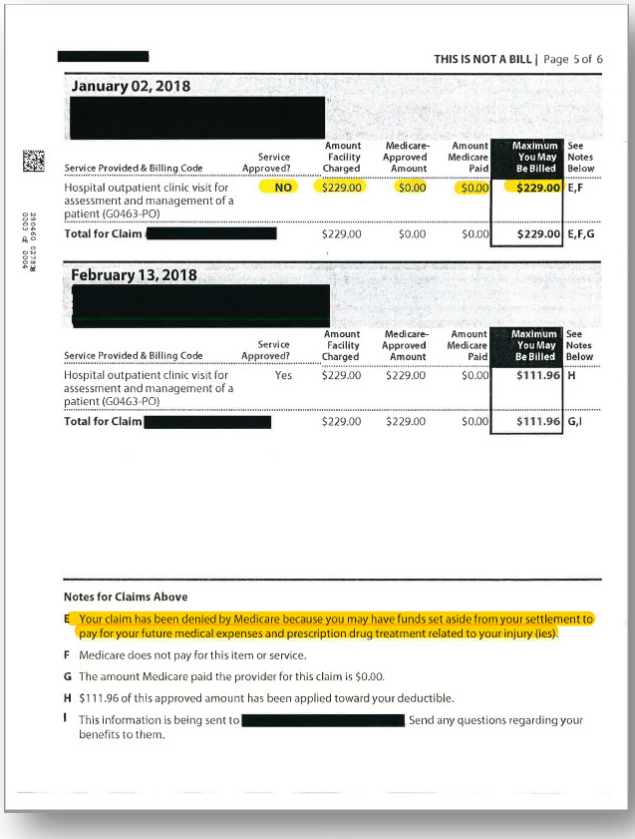
Your Claims & Costs This Period
Did Medicare Approve All Services? NO
Number of Services Medicare Denied 1
See claims starting on page 3. Look for NO in the "Service Approved?" column. See the last page for how to handle a denied claim.
Total You May Be Billed $382.70

Your Deductible Status
Your deductible is what you must pay for most health services before Medicare begins to pay.
Part B Deductible: You have now met your **$183.00** deductible for 2017. You have now met **$111.96** of your **$183.00** deductible for 2018.

Facilities with Claims This Period
August 01, 2017 - February 13, 2018
[redacted]

Be Informed!
Medicare has started mailing new Medicare cards to everyone with Medicare. You don't need to do anything to get your new card. Medicare will mail your new card to the address you have on file with Social Security. Visit Medicare.gov/newcard to learn more.

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
如果您要用语帮助，请致电联邦医疗经纪，请先说"Agent"，然后说"Mandarin"。 1-800-MEDICARE (1-800-633-4227)



[redacted] THIS IS NOT A BILL | Page 5 of 6

January 02, 2018
[redacted]

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G0463-PO)	NO	$229.00	$0.00	$0.00	$229.00	E,F
Total for Claim [redacted]		$229.00	$0.00	$0.00	$229.00	E,F,G

February 13, 2018
[redacted]

Service Provided & Billing Code	Service Approved?	Amount Facility Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Hospital outpatient clinic visit for assessment and management of a patient (G04G3-PO)	Yes	$229.00	$229.00	$0.00	$111.96	H
Total for Claim [redacted]		$229.00	$229.00	$0.00	$111.96	G,I

Notes for Claims Above

E Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies).

F Medicare does not pay for this item or service.

G The amount Medicare paid the provider for this claim is $0.00.

H $111.96 of this approved amount has been applied toward your deductible.

I This information is being sent to [redacted] Send any questions regarding your benefits to them.

Notes for Claims Above

E Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies).

ANALYSIS OF RESULTS

The following are aggregated results from the Medicare data provided by ResDAC. **The data shows a robust tracking system is in place for Medicare to identify and deny payment when an individual with an MSA submits a claim and they have properly attested to exhausting their funds.** The results for the volume of denied claims, unpaid claim dollars and individual beneficiaries affected and are extrapolated from the 5% of random Medicare claims reviewed for each annual period.

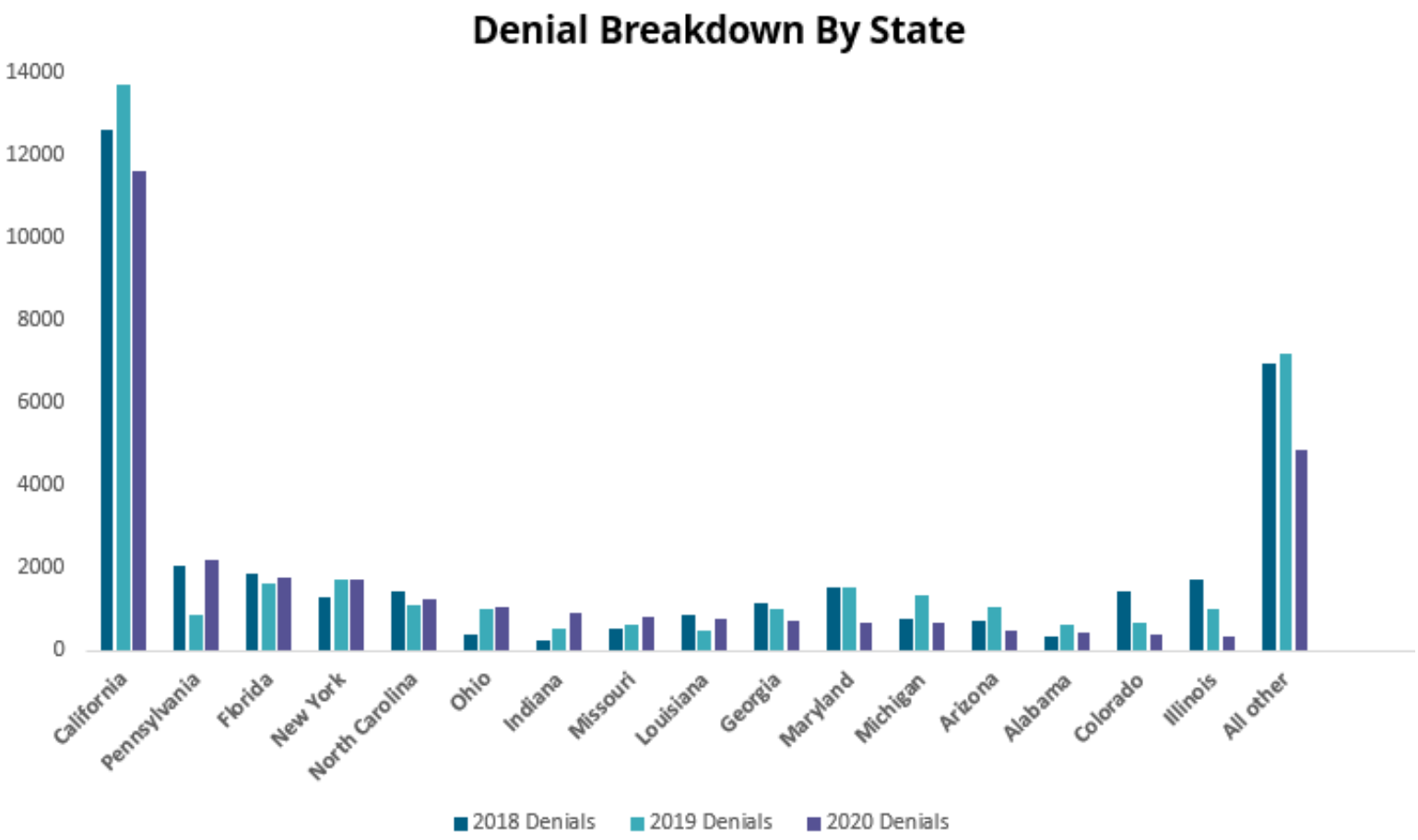
Claim Data Category	2018	2019	2020	3 Year Average
WCMSA Denied Claims*	35,980	36,060	30,720	34,253
Total Unpaid Claims (in Dollars)*	$19.2M	$14.3M	$11.8M	$15.3M
Individual Beneficiaries Affected	11,570	11,150	12,480	11,733
Average # of Denials per Beneficiary	5	5	6	5
Average Cost of Denied Claims	$1,729	$2,569	$2,830	$2,376

As mentioned earlier, Medicare clearly defines that they have the right to deny a claim if the beneficiary should have used their WCMSA funds for payment for that claim.

It is also important to note that when these claims are initially denied, they are still repriced to the Medicare fee schedule and sent back to the beneficiary and provider. The injured individual is then responsible for using their WCMSA funds to make payment to their provider.

*The WCMSA Denied Claims data and dollars are estimates based off of the data provided within the limited data set (a random sampling of claims from 5% of the Medicare beneficiary population). Denial data is those claims that Medicare responded with a zero-pay notice and Payment Code W. The number of annual individual beneficiaries have been confirmed by a CMS Data Contractor.

ANALYSIS BY BENEFICIARY STATE

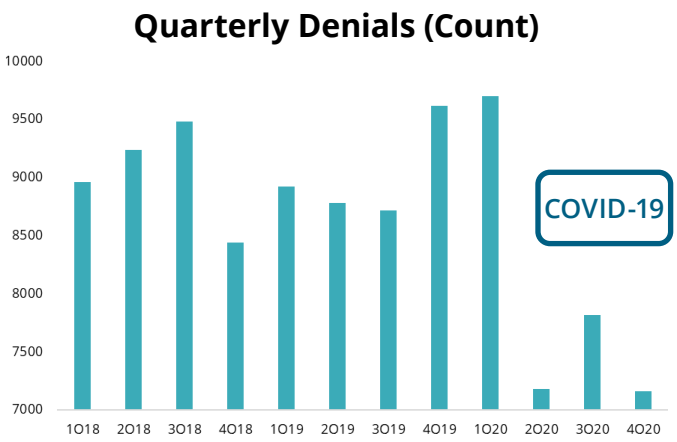


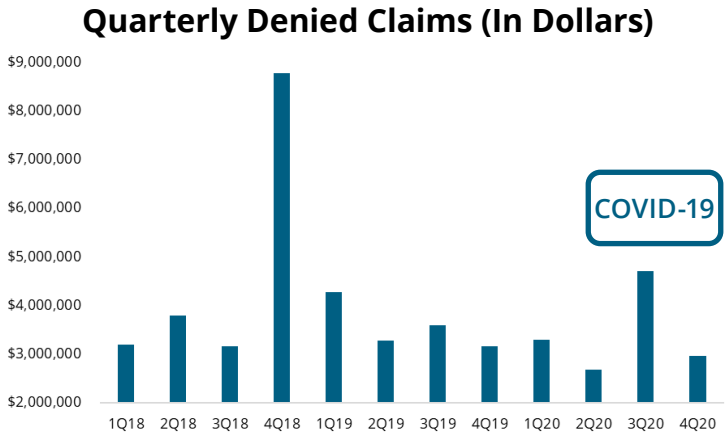
Almost a third of all denials were in California, the most populous state, which has a robust workers' compensation claim volume. Less populated states like Indiana, Colorado, and Maryland also had a substantial amount of denied claims.

It is important to note that the states provided within this report are representative of where the beneficiary is currently treating, and not necessarily the original jurisdiction state from their workers' compensation claim.

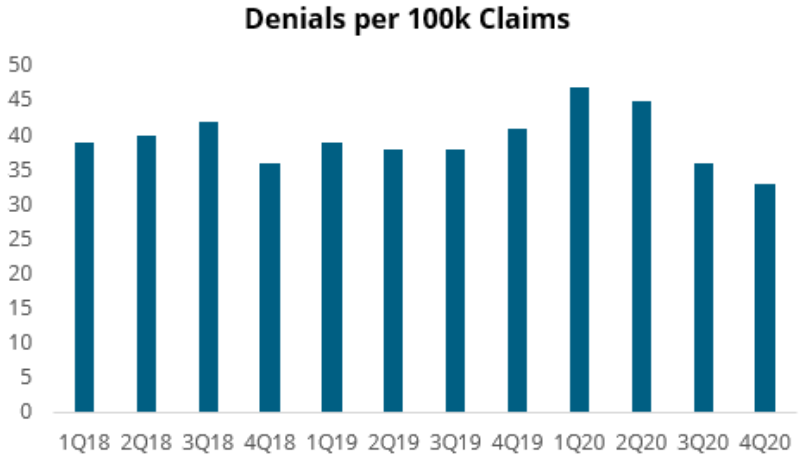
Overall, there is certainly a correlation between states with a large volume of workers' compensation claims also having a high amount post-settlement claim denials.

BREAKING DOWN CLAIMS DATA OVER TIME





There was a significant growth in denied claims between Q1 of 2018 and Q1 of 2020, which could potentially mean that more beneficiaries with a WCMSA were seeking treatment or that CMS was becoming better at applying denials. There was also a large drop off right at the beginning of the COVID-19 pandemic, likely because doctors and hospitals were only treating individuals with life-threatening medical issues for an extended period due to restrictions and that generally all provider claims for Medicare Part B dropped dramatically. Interestingly, despite less claims being denied in recent quarters, the dollar amount has remained steady and there is consistent tracking of denials proportional to total claims filed as shown below.



Despite the impact of COVID-19, Medicare's contractors have applied a steady approach to denying claims for existence of a WCMSA. Quarter by quarter, about 35-40 WCMSA claims are denied per 100,000 claims.

AMETROS

UNDERSTANDING & INTERPRETING THE DATA

IMPLICATIONS FOR THE INSURANCE CLAIMS SETTLEMENT INDUSTRY

How does this study impact the workers' compensation industry today?

Many workers' compensation claims professionals, attorneys, and other stakeholders deal with MSA settlements every day. These settlements are a resolution of the medical portion of an individual's workers' compensation claim. Once the claim settles, the responsibility of compliance to Medicare's guidelines rests solely on the injured individual, otherwise known as the Medicare beneficiary.

The individuals represented in this study are ones who are continuing to seek treatment after their claim settles. There are many different explanations as to why a beneficiary would receive this denial:

- Their provider could have billed their Medicare benefit when they should have billed the beneficiary or their administrator directly
- The individual could have been confused as to whether or not they should use their Part B benefit or their WCMSA funds for a particular treatment
- Or the individual could have not been able to adequately provide accounting of their WCMSA spend down which would generate the denial letter

No matter what the explanation, it's evident that individuals who choose to self-administer risk being denied future treatments and services by Medicare because they have not properly complied with Medicare's guidelines. This includes setting up their account incorrectly or not using their MSA settlement funds appropriately.

This data should be compelling to stakeholders to ensure injured individuals understand how to best handle their WCMSA funds at the time of settlement.

It also may serve as instructive for how Medicare may choose to track and treat future medical funds in liability or no-fault settlements in the future.

CONCLUSIONS & FUTURE CONSIDERATIONS

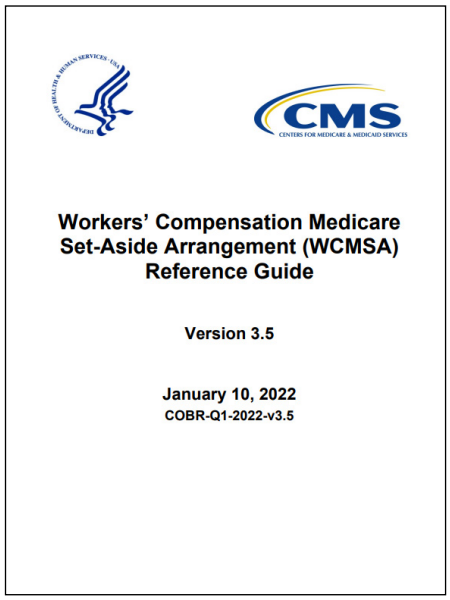
The purpose of this study was to determine if Medicare claims are being denied after settlement for beneficiaries who settled a workers' compensation case with a WCMSA.

The data shows that Medicare is actively monitoring claims and that beneficiaries with a WCMSA should use the funds in compliance with CMS' WCMSA guidelines, otherwise their claims for related treatments will be denied. This is not isolated to certain states, it is happening across the country to thousands of beneficiaries.

How do you ensure that you are being compliant with CMS' requirements?

It is not easy for a Medicare beneficiary or their caretaker to navigate CMS' WCMSA guidelines when it comes to compliance and administration. This can jeopardize payment for future claims.

Administrators commonly hear misconceptions individuals have about managing settlement funds that often result in billing coordination or annual filing mistakes. Beneficiaries have the option of having the WCMSA funds professionally administered by an expert. In fact, professional administration is "highly recommended" by CMS. Professional administrators ensure common mistakes are avoided - funds are spent in accordance with CMS guidelines, Medicare's interests are protected, and the beneficiary does not have to worry about reconciling unpaid claims. All the hassles of medical billing and timely exhaustion filing are left to the experts.



"It is highly recommended that settlement recipients consider the use of a professional administrator for their funds."

"CMS highly recommends professional administration where a claimant is taking controlled substances that CMS determines are 'frequently abused drugs' according to CMS' Part D Drug Utilization Review (DUR) policy."

- WCMSA Reference Guide

Professional administration has become much more affordable in the last decade and in many circumstances many employers and carriers pay the fee as part of the settlement agreement.

Ametros is America's largest, independent provider of professional administration and assists injured individuals every day to ensure their Medicare benefits are protected after settlement.

Questions about this study or its implications?

We'd love to speak with you. Send us a note at research@ametros.com.

AMETROS

ABOUT THE AUTHORS

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Jayson has an extensive background with managing business partnerships and educating the industry. He supports strategic initiatives for our national Carrier, TPA, and Employer partners. He also supports Ametros' product development initiatives and works alongside Ametros' industry partners. Jayson contributes his industry knowledge and expertise frequently by writing articles for the Ametros Industry blog, participating in industry-wide webinars, and attending and speaking at large industry conferences.

Jayson is a graduate of Assumption College with a bachelor's degree in Marketing. He currently resides in Maine and is an avid tennis player.

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Shawn is General Counsel at Ametros. He has over a decade of experience practicing law and in Medicare Secondary Payer (MSP) compliance as an industry thought leader.

Shawn is on the Board of Directors and Executive Committee for Kids' Chance of MA. He has been heavily involved with the Medicare Secondary Payer Network (MSPN), having served as chair of the webinar and education committees, on the Board of Directors, and was past President in 2017. He was also former executive committee member with the Medicare Advocacy Recovery Coalition (MARC). Shawn is faculty for the Certified Medicare Secondary Payer Professional Program (CMSP). Shawn's law degree is from the Massachusetts School of Law. He also holds a master's in education from Cambridge College and undergraduate degree from Berklee College of Music.