

WCMSA Policy Review

Current CMS policies that would benefit from reform include:

1. **Life Expectancy/Rated Age/Duration Limitations** – CMS policy assumes that individuals who have become injured or become ill in the course of employment will require treatment for the injury or illness using the standard Table 1 for life expectancy even if their life expectancy has been determined to be different because of a medical diagnosis specific to the individual. Also, many workers' compensation policies and laws limit the period of coverage or compensability. These limitations in workers' compensation coverage and compensability should be recognized in determining amounts to be set aside for future medical that may be paid by workers' compensation and included in a WCMSA arrangement.

Current CMS Policy

*Step 7: Calculate life expectancy using standard age or median rated age. Rated ages (RAs) are optional. For all cases with BCRC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), the submitter must supply a statement that all rated ages obtained on the claimant have been included. If this is missing, the WCRC will use actual age in processing the submission. If an RA is provided, acceptable proof of the RA is necessary. Rated ages must name the claimant, must be by an insurance company, must be on insurance company or settlement broker letterhead, must be independent, and must give a specific rated age or life expectancy. If there is not at least one RA that meets these criteria, the WCRC will use actual age in processing the submission. Reviewers may drop RAs that are not valid. If no RAs are provided, if there are no valid rated ages, or if the appropriate RA statement is not provided, actual age is used in calculating the life expectancy. The reviewer evaluates the issue date of the RA against the proposed settlement date (PSD). This date is the later of the following: BCRC receipt date plus 120 days, or the pricing date plus three months. One year is added to the RA if one year has passed from the issue date to the PSD. If two years have passed from the issue date of the RA, two years are added to the rated age. If three years have passed from the issue date of the RA, the rated age is not used in determining the median rated age. If there are multiple RAs from the same source, only the most recently issued RA from that issuer is used. When there is more than one valid RA, reviewers will use the median. When calculating the median RA, the reviewer drops decimals and uses the resulting whole number. For example, if the calculated RA is 49.5, the decimal is dropped and the age of 49 is used as the median RA. If you include a valid RA in a proposal, the reviewer will use that instead of actual age unless you request otherwise in writing. **WCMSA Reference Guide To determine life expectancy, the reviewer***

uses the current Centers for Disease Control (CDC) life expectancy table (see Section 15 – Rated-Age Information or Life Expectancy for details). Per CMS memo of May 20, 2008, Table 1 for total population is used.

Suggestion: the determination of life expectancy and rated age determined under the applicable workers' compensation law or policy should be used.

- 2. Duration of Medical Treatment for Workers' Compensation Injury** – CMS policy assumes that once an individual is determined to be disabled, that medical treatment for the workers' compensation injury will continue for life even if there is a treatment plan to enable the individual to recover from the injury. The return to work focus in workers' compensation should be recognized and modifications of future medical to be included in WCMSA arrangements should be open to change based on changed circumstances. Future medical amounts should be modified as needed in WCMSAs if there is a change in medical treatment.

Current CMS Policy

State-Specific Statutes the CMS will recognize or honor any state-legislated, non-compensable medical services and will separately evaluate any special situations regarding WC cases. CMS will recognize WC state-specific statutes addressing the limits of future treatment regarding the length or nature of future treatment, provided that the submitter has demonstrated that Medicare's interests have been adequately protected. A submitter requesting that CMS review the applicability of a state WC statute must include a copy of the statute with the submission and indicate to which section topic in the submission the statute applies. ***Submitters requesting alteration to pricing based upon state-legislated time limits must be able to show by finding from a court of competent jurisdiction, or appropriate state entity as assigned by law, that the specific WCMSA proposal does not meet the state's list of exemptions to the legislative mandate.*** For those states where treatment is varied by some type of state-authorized utilization review board, the submitter shall include the alternative treatment plan showing what treatment has replaced the treatment in question from the beneficiary's treating physician for those items deemed unnecessary by the utilization review board. Failure to include these items initially will result in pricing at the full life expectancy of the beneficiary or the original value of treatment without regard to the state utilization review board recommendation. ***Note: Failure to include the required documentation at the time of original submission will not constitute a reason for the request of a re-review.***

Suggestion: Future medical determinations should be open to modification to recognize changes in treatment plans and changes in WC law and policy.

3. **Prescription Drug Pricing** – CMS does not recognize workers' compensation rules and policy that reduce dosage for opioids and other addictive drugs in establishing amounts for Medicare set asides or that the cost of prescriptions may be reduced with generic alternatives. WCMSAs should recognize workers' compensation treatment plans and prescription dosage changes required under the applicable workers' compensation law and policy as well as changes based on evidence-based evaluation.

Current CMS Policy

9.4.6.1 Prescription Drug Review the WCRC reviewer verifies that the prescription drugs included are for the direct treatment of the work injury or injuries by reviewing the submitted clinical documentation.

- *Validate that prescription drugs ordered and taken in the past two years were directly for treatment of the injuries.*
- *Determine if the drug products would be covered under the Part D benefit. This includes assessment of medically accepted indications (drug usage), drug dosage, and drug frequency.*
- *Determine if the claimant is taking brand or generic drug products.*
- *Price all drug products using AWP, with generic drugs being priced at the lowest non repackaged generic AWP. At any time during the process, if a reviewer is unsure of drug pricing, indication, or allocation amount, those questions are deferred to a pharmacist or pharmacist's designee before the case is finalized. The WCRC allocates drugs into WCMSAs based on whether the drug is used for a condition related to the WC injury, is considered a Part D or Part B drug, and is used for a medically accepted indication. **The WCRC compiles a drug list from medical records and pharmacy records. This list is then used to project future drug costs for the duration of a claimant's life expectancy.** The reviewers must see prescription drug and medical treatment payment records/histories dated within 6 months of the date of submission or reopening. Specifically, for pharmacy records, the WCRC prefers the following:*
 - *First, the prescription claim records directly from the WC insurer. This gives a record of exactly what drugs have been used for the work injury. This might come on such a form as the National Council for Prescription Drug Programs (NCPDP) Workers'*

Compensation/Property and Casualty Claims Form. Many state WC programs use these forms to document drug payments.

- *Pharmacy Benefit Manager prescription claim records or third party administrator (TPA) pharmacy records provide a good sense of the totality of drug usage, especially if the claimant goes to multiple pharmacies.*

- *Individual pharmacy claim records are beneficial, but the WCRC is aware that claimants could go to multiple pharmacies. If at any time in the process the WCRC cannot compile an accurate picture of the claimant's drug needs, they will develop for further records. When evaluating drug use, the WCRC reviewers assess the drug dosage, frequency, formulation, patents expiring, newer more expensive drugs, and use of brand-name versus generic drugs. Various drug formulations can vary significantly in cost. For example, there are large differences in cost of oxycodone immediate release versus OxyContin (an extended release formulation of oxycodone). It is very important to gain an accurate picture of the specific formulation for an accurate pharmacy allocation. Both the medical and pharmacy records are used to compile a claimant's drug list. If the medical records are more recent than the prescription records, the WCRC will use the medical records to compile the drug list. However, if there are major discrepancies between the medical and pharmacy records, the WCRC will use the pharmacy records to compile the drug list, favoring actual use over possibly incomplete medical records. **The WCRC continues to price Part D drug products based on AWP and further based on brand or generic drug pricing. AWP pricing is pulled from a proprietary source, Truven Health Analytics' Red Book database. The WCRC uses a program for drug pricing that uses Red Book flat files that are updated monthly. For generic drugs, the WCRC uses the lowest non-repackaged generic drug AWP. The WCRC prices for generic drugs unless one of the following applies, in which case the WCRC uses brand-name:***

- *A brand-name drug is in the proposal and there is an indication that the claimant is actually taking the brand-name drug.*

- *A generic is in the proposal, but no generic exists.*

- *A generic is in the proposal, but all the evidence indicates that the claimant is taking the brand-name drug.*

- *The claimant or claimant's attorney insists on a brand-name drug in writing.*

- *No drugs are indicated in the submitted proposal, but the condition requires certain drugs, or the medical records indicate certain drugs. In this case, the WCRC will default to pricing for brand-name medications. Where multiple spellings and listings of a drug exist, the WCRC will price using the original manufacturer of the original brand-name drug for brand, and the lowest-price generic drug for generic. The reviewer will price*

drugs based on the lowest price from the manufacturer, ignoring prices from any repackagers or distributors. The WCRC uses a number of resources when determining drug coverage for WCMSAs. Reviewers consult Part D and Part B guidance documents, current WCRC operating rules, the Part D formulary reference file, and recognized drug compendia to assess drug coverage possibilities.

Suggestion: *The cost of prescription drugs included for future medical should follow the appropriate treatment plan as determined under the applicable WC law or policy, including any discounted prescription plans permitted under the applicable WC law or policy. To the extent that the cost of prescribed drugs is reduced as a Medicare item or service there should be a correlated reduction in the amount to be set aside to reflect Medicare pricing.*

4. **Allocation of costs in settlements** – CMS has chosen not to accept the allocation of amounts for medical expense and cash payments provided in WC settlements that have been agreed to by the state workers' compensation regulatory agency. Settlements often include compromised amounts for indemnity and wage replacement payments as well as amounts for past and future medical. Settlements may be compromised under the applicable workers' compensation law and policy in recognition that there is 1) a limitation in payment under the applicable workers' compensation law or policy, 2) there is a dispute as to whether the injury or illness is covered under the workers' compensation law or policy, 3) the amounts requested for payment are not justified based on medical expense for the disability, or illness caused in the course of and arising from employment.

Current Policy

10.5.1 Indicate How Much of the Settlement is for Past v. Future Medical Expenses *If the settlement does not specifically account for past versus future medical expenses, it will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.*

Example: A beneficiary is paid \$50,000 by a WC carrier, and the parties to the settlement do not specify what the \$50,000 is intended to pay for. If there is no CMS-approved WCMSA, Medicare will consider any amount remaining after recovery of its conditional payments as compensation for future medical expenses. Additionally, please note that any allocations made for lost wages, pre-settlement medical expenses, future medical expenses, or any other settlement designations that do not consider Medicare's interests, will not be approved by Medicare. Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the

WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.

Suggestion: CMS should accept the allocation of past medical, future medical and payment for lost wages or other expenses that are not covered under Medicare as shown in workers' compensation settlements.

5. Maintenance of Workers' Compensation Medicare Secondary Arrangement Accounts – CMS administrative practice is to require a Medicare eligible individual receiving the proceeds of a workers' compensation settlement payment for future medical to maintain the proceeds in an interest-bearing checking account and to use the funds in the WCMSA only to pay for Medicare covered items and services. All of the funds in the WCMSA must be exhausted before Medicare takes responsibility for payment. Individuals are required to report on the status of these accounts on an annual basis.

Although individuals may use professional administrators for this reporting and account maintenance, many settlements are too small to justify paying for professional administration, and CMS enforcement of reporting and accounting for these accounts is costly for CMS.

Current CMS Policy

Lump-sum annual attestation and expenditure letter: Exhausted lump-sum amount
Blank copies of this letter should be included in your MSA package. Follow these instructions for your annual attestation if you have completely used up (exhausted) your lump-sum MSA. You will check or circle #2 and fill in the amounts. You and a witness need to sign and date the document and send it within 60 days of your account being used up. In this sample, the claimant has filled in the date and total MSA funding amount near the top of the document, circled #2, noted the dates of the annual accounting period and the amounts spent for both medical expenses and prescription expenses, and signed and dated the document with a witness.

Suggestion: there is already a procedure under which individuals may submit lump-sum amounts to meet WCMSA obligations when WCMSA funds are exhausted. A similar lump-sum letter and procedure could be used to submit the total amount of the WCMSA when it is first established. This would reduce CMS administrative expenses, reduce WC payer expenses, reduce the confusion and expense for injured workers, and increase the amount paid into the Medicare trust fund during the ten-year federal budget period.

5. **Appeals** – The current CMS procedure provides no opportunity to appeal the results of a CMS review. Instead, there are limited circumstances under which there may be re-determinations at the discretion of CMS. This increases risk associated with the *amounts included in the WCMSA*.

Current CMS Policy

*10.5 Section – Settlement Agreement or Proposed or Court Order. The parties can proceed with the settlement of the medical expenses portion of a WC claim before CMS actually reviews the proposed WCMSA and determines an amount that adequately protects Medicare's interests. However, approval of the WCMSA is not effective until a copy of the final executed WC settlement agreement, which must include the funding information for the WCMSA amount, is received by CMS. **No statement in the settlement of the amount needed to fund the WCMSA is binding on CMS unless and until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount that adequately protects Medicare's interests as specified by CMS as a result of its review.** Include only official documents, such as WC petitions, mediation documents, prior awards and settlements, court orders, draft and final settlement agreements, and annuity rate sheets. **If CMS does not subsequently provide approval of the funded WCMSA amount as specified in the settlement or proof is not provided to CMS that the CMS-approved amount has been fully funded, CMS may deny payment for services related to the WC claim up to the full amount of the settlement. Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA.** This shall be demonstrated by submitting a copy of the final, signed settlement documents indicating the WCMSA is the same amount as that recommended by CMS. The claimant may be at risk if the WCMSA is funded for less than the amount that CMS determines to be adequate to protect Medicare's interests. Reminder: • If the case has already settled, please provide the settlement date. • If there is a proposed settlement date in the future, please provide that date. • If the settlement date is unknown, CMS will default to using four months from the date of submission as the proposed settlement date.*

Suggestion: *CMS should recognize court orders and settlements approved under workers' compensation law as determinative of the amounts of workers' compensation payments and future medical to be included in WCMSAs. There should be a process provided for appeal of WCMSA review determinations through which there is finality of disputes that is binding on all the parties, including CMS.*