



*State of New Jersey
Department of Labor & Workforce Development
Division of Workers' Compensation*

MEMORANDUM

To: All Judges of Workers' Compensation
From: Peter J. Calderone, Director/Chief Judge of Workers' Compensation
Date: January 10, 2005
Subject: **Medicare Secondary Payer Statute (MSPS) Issues and Information**

The Medicare Secondary Payer Statute (MSPS) has become one of the most difficult and controversial issues affecting workers' compensation programs throughout the country. While there are efforts to amend the federal law, at this time we must implement the statute and regulations as currently in effect. Accordingly, we have had presentations addressing key Medicare issues at our judicial seminars. The recent Workers' Compensation Bench-Bar Conference also devoted a large portion of the program to MSPS-related topics.

Based upon recent discussions with officials from the Centers for Medicare and Medicaid Services (CMS) and the report submitted by the NJ Workers' Compensation Lien Task Force, this memorandum is intended to provide you with key information arranged in an easy to read "question and answer" format. We believe you will find it a useful summary of practices to consider when handling New Jersey workers' compensation cases where the MSPS must be addressed in order to resolve the case. Since the MSPS is an evolving area of law, there may be updates to this memorandum in the future.

It is noted that the literature, regulations, and various correspondence use terms such as Medicare entitled, Medicare eligible, and Medicare beneficiary. For the purposes of this memorandum, the term Medicare entitled will be used to include individuals who are eligible for Medicare benefits whether or not they are currently utilizing Medicare for medical coverage.

1. When must Medicare's interest be considered?

Medicare's interest must always be considered whenever:

- (A) Medicare has paid for treatment for a disability/injury alleged in the claim petition; and/or
- (B) In the closure of a workers' compensation case the petitioner is Medicare entitled and future medicals for a disability/injury maintained in the claim petition are being foreclosed.

2. When is a petitioner considered Medicare entitled?

A petitioner is Medicare entitled if he or she is:

- (a) 65 years or older (assuming sufficient work quarters); or
- (b) On Social Security Disability (SSD) for 24 months or longer; or
- (c) Suffering from End Stage Renal Disease (ESRD).

3. What does the CMS/Medicare review and approval process entail?

CMS has emphasized that there are two separate and distinct tracks or processes involved in MSPS cases (the “Past Payment” track and the “Future Consideration” track). Both tracks must be considered and appropriately managed when applicable to adequately deal with Medicare’s interests.

4. What is the “Past Payment” track?

This track involves repayment (or obtaining a waiver) for any conditional payments made by Medicare on behalf of the petitioner for injuries or disabilities alleged in the claim petition pending the closure of the workers’ compensation case. To initiate this “past payment” process, one should first call the “MSP Claims Investigation Project” at 1-800-999-1118 with the file and case information. CMS will take the necessary information, provide a bar code number, and send the necessary consent form. Further case information can be mailed to the “MSP Claims Investigations Project” address at CMS/COBC, P.O. Box 5041, NY, NY 10274. (Note: This address is not used for submission of set-aside proposals under question #5 below.)

Once the claim is reported, a fiscal intermediary is assigned by CMS, and one will then need to deal directly with the fiscal intermediary for resolution of any past payment issues.

Medicare providers have up to eighteen (18) months to file for Medicare payment when Medicare is being utilized. Counsel should therefore advise a petitioner who is Medicare entitled not to utilize Medicare for disabilities or injuries alleged in the claim petition. Additionally, it would be prudent for petitioner’s counsel to obtain information on all medical treatment petitioner received in the two years prior to the anticipated case closure to avoid medicare paid bills after the case is closed. An appropriate Motion for Medical Treatment is the proper mechanism to resolve treatment issues arising from alleged work-connected injuries or medical conditions.

5. What is the “Future Consideration” track?

According to CMS, a Workers’ Compensation Medicare Set-aside Arrangement (WCMSA) is appropriate whenever future medical benefits are foreclosed in the resolution of a workers’ compensation case. Specifically, a CMS/Medicare approved

WCMSA is required whenever future medicals are being foreclosed (e.g. all Section 20 settlements) and:

- (A) Petitioner is Medicare entitled (regardless of the settlement amount); or
- (B) Petitioner has a reasonable expectation of becoming a Medicare beneficiary within 30 months of the settlement date **and** the settlement totals more than \$250,000.00.

Note: Since very few workers' compensation settlements in New Jersey are over \$250,000, situations under this section would not be a common occurrence. A "reasonable expectation of becoming a Medicare beneficiary within 30 months of the settlement date" would likely include those situations where the petitioner: (1) has applied for Social Security Disability (SSD); (2) has been denied SSD, but is appealing or anticipates appealing the denial; (3) is 62 years and 6 month old (and thus would be eligible for Medicare within 30 months); or (4) has End Stage Renal Disease but does not yet qualify for Medicare based upon ESRD.

This track involves obtaining CMS/Medicare review and approval of any WCMSA whenever liability for future medical benefits is being foreclosed for an injury or disability maintained in the claim petition. (Situations where no monies need to be withheld are referred to as "\$0.00 WCMSA" situations.) Review and/or approval of such proposals can be initiated by submitting the proposal to "WCMSA Proposals" at CMS/COBC, P.O. Box 660, NY, NY 10274. The WCMSA proposal information will then be relayed to the WC Review Center (WCRC) for review. Upon completion of the review, the WCRC will forward a recommendation to a CMS regional office for final notification of CMS' review results. The CMS Atlanta Regional Office will send final notification for petitioners whose state of venue is New Jersey. An acknowledgement letter, sent upon entry into the WC Case Control system, will provide contact information and a control number that must be referenced on inquiries and subsequent document submission.

Note: The parties to the workers' compensation case must agree on how this two-track process will be handled and how the costs involved will be allocated. Options for obtaining Medicare approval may include: Petitioner's attorney doing the work; Respondent's attorney doing the work; or hiring specialized legal counsel or a vendor to do the work.

6. Is repaying Medicare for conditional payments (or obtaining a waiver), as previously discussed in Question 4 of this memo, always required when the petitioner has received Medicare benefits?

Yes. CMS recommends that the process outlined under Question 4 of this memo be initiated as soon as possible for petitioners who have received Medicare benefits. To ensure that a record of any Medicare benefits be established, this process must be initiated in all cases when the petitioner is a Medicare beneficiary. One should also keep

in mind that repaying CMS for past /conditional payments Medicare made on behalf of the petitioner is required even when no set-aside allocation review is required.

Therefore, pleadings become very important in determining the extent to which past/conditional Medicare payment issues may play a role in resolving a claim. Petitioners who allege work injuries or disabilities that clearly cannot be sustained may be subjecting their cases to more extensive CMS/Medicare review and delay for alleged injuries or disabilities that will be found “non-compensable” later in the proceedings.

In summary, adequate consideration must be given to the issue of conditional payments in all cases involving a Medicare beneficiary at the time of settlement. This includes cases resolved by Orders Approving Settlement, Section 20 Settlements, Judgments, and Second Injury Fund Awards. As long as the petitioner is a Medicare beneficiary, this issue must be addressed.

7. **What types of case closures trigger the need for CMS/Medicare review and approval of a WCMSA proposal (as previously discussed in Question 5 of this memo) because future medicals are being foreclosed? Which types of case closures do not require such review and approval?**

Workers’ compensation case closures to consider are:

a) Judgments - Where the judge issues a decision on the merits on all claims that is supported by the record, CMS/Medicare will accept the judge’s findings and conclusions, and no set-aside allocation review is required addressing future treatment. This is because a WCMSA is not appropriate where future medicals are not being foreclosed.

b) Orders Approving Settlement - Where all the injuries or disabilities alleged in the claim petition are covered by the settlement, no Medicare set-aside allocation review is required because, similar to judgments, there is a right to reopen for future medicals and, hence, no foreclosure on future medicals. Similarly, some injuries or disabilities alleged in the claim petition may be resolved by an Order Approving Settlement, and all others that cannot be settled can be resolved in a Judgment (as discussed in section “a” above), making CMS review and approval unnecessary.

c) Amended Claim Petitions with Orders Approving Settlement - Where a claim petition is amended to dismiss one or more injuries/disabilities with judicial review and consent based on the merits, and the remainder of the claim petition is settled by an Order Approving Settlement, then no set-aside allocation review is required since there is a right to reopen for future medicals on the compensable injuries or disabilities. **The judge in these situations must have conferenced the case and found good cause on the record to amend the claim petition.** This would include judicial review of the pleadings, medical records and reports, and, at the judge’s discretion, any additional evidence and/or testimony that the judge deems necessary in order to rule on the merits of the amendments to the claim petition.

d) Dismissals - Since the petitioner receives no benefits from a dismissal, a WCMSA would not be appropriate. A dismissal cannot be utilized, however, to circumvent Medicare's interest. Hence, failure of a petitioner to prosecute a case could result in CMS seeking recovery against individuals involved in hindering Medicare's interest or recovery.

e) Orders Approving Settlement with Dismissals (Section 20s) – According to CMS, it is appropriate to include a WCMSA in all Section 20 settlements involving a petitioner who is Medicare entitled regardless of the settlement amount or a petitioner who meets the threshold listed above in Section 5 (B) of this memorandum. The WCMSA must be reviewed and approved by CMS/Medicare.

f) Second Injury Fund (SIF) Awards and Settlements – Where the SIF accepts injuries or disabilities alleged in the claim petition as pre-existing, judicial review and consent on the merits is required (similar to that discussed in section “c” above). The judge in these situations must find good cause, on the record, to designate the alleged condition(s) as “pre-existing” and, therefore, not subject to future authorized medical care. This may include review of the pleadings, medical records, reports, and, at the judge's discretion, any additional evidence and/or testimony necessary to properly rule on the merits of the case.

Note: The Lien Task Force has included a flowchart at the end of its report which outlines procedures attorneys can follow in regard to handling certain Medicare set-aside allocation reviews. This flowchart is available on the Division of Workers' Compensation web-site and should be consulted where necessary.

8. How can cases filed by a Medicare entitled petitioner or a petitioner with a reasonable expectation of becoming a beneficiary within 30 months of the settlement date be expedited?

It is essential to recognize, understand and utilize the interplay between the Medicare requirements and the New Jersey workers' compensation process as outlined in this memorandum. For example, a \$5000.00 Section 20 settlement may be entered today involving a petitioner who has been on SSD for 22 months without any Medicare reviews or approvals. In this situation, the petitioner is not yet Medicare entitled and the settlement is less than \$250,000.00.

All applicable issues involving a Medicare entitled petitioner or a petitioner with a reasonable expectation of becoming a beneficiary within 30 months of the settlement date should be presented at the first pre-trial conference. Doing so will help all parties to determine the most expeditious manner of resolving a case (i.e., without Medicare involvement where appropriate, or ensuring that Medicare's interest is considered where required). It should be made clear which party will be responsible for resolving Medicare issues, and a timetable for Medicare filings should be imposed. There should also be

periodic judicial review of the status of the case, Medicare filings, and Medicare inquiries.

Currently, many more cases are marked “MCARE” than the parties have actually submitted for CMS review. A judge should therefore verify that the case has been submitted by asking for and reviewing the paperwork sent to CMS. Hence, an “MCARE” designation cannot be used unless the judge has verified that CMS has been correctly contacted.

Section 20 settlement proposals that involve Medicare entitled petitioners are particularly problematic and require careful scrutiny. Hence, where an Order Approving Settlement is not possible, it may be in the best interest of all parties to try the case (rather than attempt a Section 20 settlement).

Where the case involves a mixture of disputed and undisputed issues (e.g., where the petitioner’s back injury is accepted and it is agreed that it is compensable at 25% of total, but the petitioner’s psychiatric claim is not accepted), a trial on the disputed issue(s) may resolve the case. This could result in a settlement with the right to reopen for future medicals on the undisputed issue(s) and a judgment on the disputed issue(s). This type of case resolution process might be particularly useful in Second Injury Fund cases.

9. How can I get more information or advice?

Due to the work of the Lien Task Force and a separate specialized group of attorneys and judges who have directly communicated with CMS/Medicare in coordination with this office, New Jersey is in the lead nationally in clarifying and setting guidelines for Medicare related issues involving workers’ compensation cases.

Judges, but not parties to a claim petition, may contact Thomas Daly, Esq. (609-777-4924) of my staff on particular MSPS issues. We will use our best efforts to obtain necessary information for you.