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**Initial Intake to Final Settlement:**
**The Complete Blueprint for Your Workers' Compensation Catastrophic Claim**

## I. Workers' Compensation Claim Involves a Catastrophic Injury

Defending what is, and is not, a catastrophic claim can vary from business to business. In general, catastrophic claims involve a severe loss or injury such as a spinal cord injury, amputation, blindness, brain injury, severe burns, or death. Other catastrophic claims can be psychological claims and claims where it appears the Claimant will be unable to return to regular work. Catastrophic claims are uncommon and represent approximately 1% or less of the total claims in the United States.

Catastrophic claims are handled differently for a number of reasons. First, they usually involve multiple medical providers for various injuries. Coordination of care can therefore be difficult, and medical treatment and response to treatment is often unpredictable. Some states define catastrophic injuries, such as the State of Georgia, and such injuries may have different limits.

### Accepted Claims vs. Disputed Claims-Legal Questions

Just as with other claims, catastrophic claims can be disputed, accepted, or a hybrid of both. Also, as with other claims, immediate questions need to be asked regarding whether there is coverage, whether there are legal disputes, whether the reserves are properly set, whether there is an immediate mitigation plan in place and whether we anticipate there will be cooperation between the parties involved. Accordingly, immediate investigation into the facts of the claim at its onset is paramount to good claim handling.

### Investigation

The first thing to be done in any catastrophic claim is that the claims handler, and any other parties involved, should clear their desk of any other matters and put 100% of their efforts into the immediate investigation of the claim. The first 48 hours of investigation, like with crime scene investigation, are key. Goals should be immediately set, both short term and long term.

Good investigation of a catastrophic claim almost always requires one of the stakeholders to immediately view the site of the injury or accident, segregate any machinery or devices involved in the injury, obtain immediate witness interviews, and identify any other companies or individuals present at the scene at the time of the incident. First responders should be interviewed, 911, emergency room, primary care doctor records, job descriptions, and employment files should immediately be obtained. Blood and urine samples, if applicable, should be requested from the hospital, or at least demanded to be presented. It is also important to get a signed medical authorization as soon as possible.

Other tools that may be used outside of the first few hours or days from the incident may accident reconstruction; investigation of cellular phone records; and the initiation of nurse case management. Any legal defenses such as intoxication (if available in that venue) should be investigated. Social media searches should also be performed and legal representation should be obtained.

**Compassion vs. Hardball**

If an injury is clearly compensable, compassion is often your best tool to claim mitigation. Keeping the injured worker and his or her family in a position of comfort allows for the most effective claim mitigation. If at all possible, a company representative should go to the hospital with the employee at the time of the occurrence and meet with family members to express the company's concern and facilitate a smooth introduction to the claim handler and any nurse case manager assigned. This not only serves to keep communication lines free and open but helps to ensure the injured worker receives the best medical care available and hopefully the best outcome possible.

**Unintended Consequences**

With the above noted, use caution. Being compassionate versus playing hardball can backfire. Accepting a claim that should not be accepted may have the unintended consequences of creating a large Medicare Set-Aside ("MSA") in the future, or sending a message to the co-workers that the company is "soft." Conversely, denying a clearly compensable case can send the opposite message and may have unintended public relations consequences.

**Involving Lawyers**

Sometimes an employee needs to have an attorney representing him or her after a catastrophic injury. Examples would be for: a medically sedated, unmarried person; a single parent (where the children need to be attended to); when it is unclear who should be receiving TTD checks; when it is impossible to obtain releases of necessary specimens or when medical records are not being provided. Difficult psychiatric claims may also require the involvement of an attorney to have a guardian appointed on the Claimant's behalf.

## Claim Management

### Medical Treatment Phase

At the onset of the claim, team conferences may need to occur daily. Thereafter, once the initial investigation is performed, team conferences are recommended weekly and then possibly every other week. All players need to be on the same page and exchange information.

### Nurse Case Managers

Nurse Case Managers can be vital to claim mitigation strategy, and can help facilitate the best, most timely care. However, remember that if the nurse case manager is on the phone the conference between the employer and the employer's attorney is no longer privileged. Therefore, strategy or reserves should not be discussed with the nurse present.

### Second Opinion/Independent Medical Examiners

With catastrophic claims, second opinions and independent medical evaluations are often necessary to ensure the best care, as well as to obtain certain facts that might not be readily obtained from a represented injured worker. Questions to such experts should be posed thoroughly and carefully, and experts with excellent credentials and credibility should be used. There is a lot on the line with a catastrophic claim, so you should get your money's worth from that opinion. During this time in the case management, medical treatment should be very carefully monitored and every medical record should be read carefully. Defenses often appear in medical records beyond the first date, including physical therapy records and notes from discussions with family members.

### Medication Management: Brand Name vs. Generic

Brand name medications can get very costly, and are often pushed by pharmaceutical representatives to treating physicians. For this reason, medication should be managed closely and, where a generic is available and appropriate, should be promoted or requested.

Opioids are a hot topic in the news, and have been for some time. Often catastrophic claims will see the utilization of opioids at the acute stages. Careful attention should be kept to the opioid/Morphine Equivalent Dosages, and weaning should be promoted as soon as possible.

### Claimant Behavior

Among other things, head injuries, depression and opioid usage can lead to a change in claimant's behavior. Depression and pain often go hand in hand. Opioid seeking behavior should be watched very carefully, and in such cases urinary drug screens to confirm the

presence (or absence) of medication should be requested. A good claims handler will also watch for signs of malingering or exaggeration and drug seeking behavior.

Claimant behavior should be closely monitored for inconsistencies, as should family support issues and Claimant motivation. The use of surveillance, social media searches and even Google searches can be helpful in mitigating a loss.

**Rated Ages**

Catastrophic claims often lead to a reduced life expectancy. The use of rated ages to set reserves is a good practice. Rated ages can also be used for Medicare Set-Asides and, ultimately, any settlement package that is offered.

**Return to Work Versus Vocational Rehabilitation**

Any catastrophic claim should put focus on the possibility of return to work at the early stages of the claim. The Claimant should be involved in this decision as much as possible. An individual who believes they will be returning to work is much more likely to do so than one with a disability mentality. A Claimant who wants to return to work is more likely to do so, but one who is not motivated to return to whatever type of work a vocational rehabilitation specialist identifies unilaterally unlikely to return. In catastrophic claims, retraining and schooling can often be good mitigation tools.

**Subrogation**

Of course, in the early investigative portions of the claim subrogation possibilities should be investigated. Personal injury negligence, products liability and medical malpractice claims opportunities should be monitored throughout the claim.

**Negotiations and Settlement Considerations**

The resolution of most catastrophic claims requires creativity, and both a carrot and a stick can be used. Consideration of the family's needs moving forward (including needs unrelated to the injury, such as college needs, housing situations, retirement savings) should be considered. Some Claimants do better with lump sums while other do better with annuities; many attorneys push for lump sums. Future medical allocations, even where no formal Medical Set-Aside is needed, can also be helpful in resolving a catastrophic claim.

Examples of "sticks" that can be used would be: only agreeing to settle with a lump sum if certain terms are met; ending TTD to keep negotiations on track; using early medical mitigation strategies to make the MSA more palatable; and surveillance.

The longer you keep the Claimant at the table, the more invested they are in negotiations and the less likely they are to walk away. Always listen for their lowest number, because they will take it.

In severe cases, a special needs trust may be necessary where an individual needs to protect Medicaid entitlement. Furthermore, in cases with an unreliable or unstable Claimant, professional administration of future medical monies may be required. Professional administration is also very helpful in situations where a future medical allocation is very large but the employer has concerns that it will not be fully utilized.

## Managing the Medicare Mine Field

### II. Medicare's Interest in a Settlement:

The Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)2(a), provides that Medicare is a secondary payer when "payment has been made or can reasonably be expected to be made under a workman's compensation law or plan of the United States or a state or under an automobile insurance policy or plan (including a self-insured plan) or under no fault insurance." The exception to this occurs when payment is not reasonably expected to be made "promptly" or within 120 days after receipt of the claim by the primary payer. This would generally occur in disputed or denied claims. If Medicare makes payment, the payment must be reimbursed to the appropriate Medicare trust fund. A primary payer's reimbursement obligation to Medicare may be demonstrated by: a judgment; a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination of liability); or by other means. Medicare's Section 111 mandatory reporting obligations help to enforce Medicare's secondary payer status.

### Accepted Claim

Since Medicare is a secondary payer when a primary payer is available, workers' compensation settlements which close out future medical should avoid a cost shift of these future injury-related expenses to Medicare post settlement. One way to do this is through the use of a settlement tool known as a Medicare Set-Aside arrangement (MSA). The MSA estimates the cost of the future injury related Medicare covered expenses that may then be included in the settlement. The decision to include an MSA in the settlement may depend on whether the claim has been accepted, disputed or denied. A settlement involving an accepted workers' compensation claim with exposure for future injury related Medicare covered treatment will often include an allocation for future injury related Medicare covered expenses. This type of settlement is called a commutation settlement. (42 CFR Section 411.46)

**Disputed or Denied Claim**

When a settlement is disputed, it is considered to be a lump sum compromise settlement. Medicare may still have an interest in it despite the disputed nature since Medicare views any payment by a primary plan as evidence that Medicare is a secondary payer. If the settlement appears to represent an attempt to cost shift to Medicare the responsibility for payment of these medical expenses for treatment of a work-related condition, Medicare will not recognize the settlement. If, however, the lump sum compromise settlement does not attempt to shift injury-related expenses to Medicare and rather allocates for future medical services, 42 CFR Section 411.46 indicates that Medicare will not pay for services until medical expenses related to the injury or disease equal the amount of the lump sum settlement that is specifically allocated for the future medical expenses.

**Future Injury Alleged Medical Costs**

There are several different types of MSAs that can be used in connection with a settlement that closes out future medical rights. When settling a catastrophic claim, parties should be aware that some of the future injury related medical needs, such as nursing home care, will not be covered by Medicare. The cost of the non-Medicare covered injury related care may be negotiated as a separate damages item.

## I. Medicare Set Aside Arrangement Types

**Traditional Commutation MSA**

Parties are likely to be most familiar with the traditional commutation MSA that is voluntarily submitted to CMS for review when the projected settlement meets CMS' internal workload review threshold. CMS review is available when the settlement involves a current Medicare beneficiary and the projected settlement exceeds $25,000.00. CMS review is also available when the claimant has a reasonable expectation of Medicare entitlement within thirty months of settlement and the projected settlement exceeds $250,000. The traditional commutation MSA projects future treatment based on the treating physician's medical records, past treatment, and looks to the Claimant's injury-related prescription drug usage over the past year to extrapolate future drug projections. If the MSA will be submitted to CMS for voluntary review, CMS has requested that the guidelines set forth in the Workers' Compensation Medicare Set-Aside Arrangement Reference Guide be followed.

**Compromise MSA**

When a claim is disputed, rather than fully funding the future injury-alleged Medicare-covered treatment, parties may apportion some of the settlement to reflect funds for future injury-alleged Medicare-covered treatment. This type of apportionment is done through the use of a compromise Medicare Set-Aside that is based on the MSP Regulations found in 42 CFR Sections 411.46 and 411.47. The formula set forth in Section 411.47 looks to the ratio between

the total potential trial exposure and the MSA. This percentage is then carved out or "set-aside" from the net settlement funds and used to pay for injury alleged Medicare covered treatment. By using this formula, parties are able to show that there was no attempt to cost shift injury-related expenses to Medicare in the settlement. CMS will not review, or approve formally, compromise MSAs.

**Evidence Based Medicine MSA**

A non-submitted evidence-based medicine MSA is also an alternative to the traditional MSA. It projects treatment which is consistent with the ODG Guidelines for a particular injury. Rather than applying a formulaic frequency of diagnostic studies and assuming ongoing monthly drug refills every year for life, the evidence-based medicine MSA projections provide for a more realistic allocation for future treatment. It is also unlikely to exhaust during the Claimant's lifetime.

**Legal Opinion Zero**

Completely denied claims should also address Medicare's interest as a secondary payer. Since Medicare will view any payment by a primary payer as an indication that Medicare is secondary, many parties seek to submit a zero MSA waiver request to CMS for review prior to settlement. In the past, CMS has been willing to waive their interest when no medical or indemnity payments have been made and there is a legitimate basis for the dispute or denial. Once Medicare agrees it has no interest in the future medical, settlement may move forward and the CMS determination letter may be incorporated into the settlement terms.

**Administration of Funds**

After a Medicare Set-Aside arrangement is funded, the Medicare Set-Aside funds must be properly exhausted before Medicare will become the primary payer. The most recent version of the Workers' Compensation Medicare Set-Aside Tool Kit, published by CMS on April 2, 2018 provides instructions as to the proper administration of the MSA account. The MSA account may be Self-Administered as long at the Claimant is competent.

**Self-Administered WCMSA**

The proper administration of the WCMA requires that the funds be managed in a specific way. Proper administration requires the following:

1. That the funds be placed in a separate interest-bearing workers' compensation Medicare Set-Aside account;
2. That the funds only be used to pay for injury related Medicare covered medical and pharmacy expenses;
3. That the Medicare covered medical and pharmacy expenses be paid out in the same manner as the MSA was funded;

4. That annual attestation be sent to the Benefits Coordination & Recovery Center showing proper exhaustion of the funds.

The Medicare Set-Aside funds may also be used to pay for certain costs, such as the cost of copying documents, mailing fees/postage, banking fees related to the account, and for reimbursement of income tax on interest income from the account. The funds may not be used to pay fees for trustees or other professionals that help administer the account, expenses for administration of the account other than those previously identified, attorneys' costs for establishing the MSA, or for Medicare premiums, co-payments, and deductibles.

**Self-Administered with Support**

Determining whether certain injury related treatments or drugs are covered by Medicare may be confusing at time. In light of this, it may be beneficial to enroll the Claimant in a self-administration support program which provides Claimant with access to assistance from a Professional Administration company.

**Professionally Administered**

Oftentimes professional administration of the MSA funds is the best option for a catastrophic claim. Some administration companies offer discounted medical and prescription drug options to help ensure the life of the funds is extended. The professional oversight also ensures that the funds are not used improperly. Another benefit to professional administration is that the terms of the administration agreement may include a reversionary clause whereby the unused portions of the fund are returned to the insurance carrier upon death of the claimant.

## II. Conditional Payments

When Medicare makes payments on a conditional basis, Medicare is entitled to reimbursement of the payments. Under 42 U.S.C. Section 1395 y(b)(2), Medicare may pursue recovery of the conditional payments from the primary payer, the beneficiary, a provider, a supplier, a physician, an attorney, a state agency and a private insurer that has received a primary payment. In light of this, it extremely important that parties address the issue of conditional payment reimbursement prior to settlement. It is also important to note that Medicare is not bound by the parties settlement terms and may pursue recovery against any of the above entities.

**Traditional Medicare**

The conditional payment investigation process for a traditional Medicare Part A or Part B Plan begins with the reporting and opening up a claim with the Benefits Coordination and Recovery contractor. If the claim is accepted, the Section 111 reporting of Ongoing Responsibility for Medical will trigger the opening of a conditional payment claim. If the claim has been disputed,

the claim may be opened through self-reporting. The Medicare Secondary Payer Recovery Portal is also an effective way to secure conditional payment information and request updated Conditional Payment Letters. In the event that a Conditional Payment Notice is generated, the parties must respond generally within 30 days of the letter in order to prevent an initial determination, formally known as a Demand Letter, to be issued. Failure to comply within specific timeframes will result in interest accruing and a possible referral to Treasury for collection. It is important that a system be set up within your organization to ensure a timely process is followed in your claims handling.

**Medicare Advantage Plans – Part C and Part D**

In addition to traditional Medicare Part A or Part B, Medicare beneficiaries may elect to enroll in a Medicare Advantage Plan under Medicare Part C. These types of plans are administered by private insurance carriers who contract with Medicare. Although the Medicare Advantage Plans must provide the basic level of coverage for services included in Medicare Part A and Part B, additional services are often provided as well. Medicare Part D Plans are plans that provide prescription coverage.

Medicare Advantage Plans generally claim the same rights of recovery as traditional Medicare. Information regarding their payments however cannot be obtained in the same manner as payments under Medicare Part A and Part B. This is also further complicated by the ability of Medicare beneficiaries to enroll in different plans over different coverage periods during the pendency of the workers' compensation claim.

In order to secure this information, we recommend that claims handlers ask the claimant about any and all types of Medicare and medical coverage when taking a recorded statement. This information may also be pursued through depositions that may occur in the claim. Claimants may also be asked to provide copies of the Medicare coverage cards since they will show the names of the Medicare Advantage Part C Plans and Part D Plans. These plans can then be contacted to determine whether they have any claims associated with the Claimant. We also recommend that this information be updated during the life of the claim.