

Keeping Data Straight in MSAs

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Medicare Set-Aside Arrangements (MSA) and the new reporting requirements of Section 111 of the Medicare, Medicaid, & SCHIP Extension Act of 2007 (MMSEA) are important elements of the Medicare Secondary Payer Statute as the Centers for Medicare and Medicaid Services (CMS) endeavors to achieve the long-term financial viability of the Medicare system.

The utilization of MSAs has been required for quite some time in workers' compensation claims. MSAs, of course, are the product of a meticulous review of the medical records by trained professionals who are then able to put the totality of the medical circumstances into context and thus to use that as the foundation for a well-reasoned, fair, and ultimately successful submission for approval to CMS. The primary goal of a proper MSA proposal to CMS is to limit the exposure of settlement proceeds to exhaustion on the plaintiff/claimant's future medical expenses. Thus, an MSA will segregate the projection for future, injury-related medical services and prescription drugs of the type covered by Medicare and use the projected costs for such items and services to arrive at a reasonable MSA funding amount. This information, with supporting documentation, is required for any CMS review of a proposed MSA.

Likewise, the prudent approach to fulfillment of Section 111 reporting protocols is to review substantively each of the variable data elements in order to accomplish accurate reporting and thus to diminish potential exposure to ancillary risk issues, separate and apart from the well-publicized civil penalties.

Inadequate or inaccurate completion of an MSA or a Section 111 report can lead to a denial of benefits for a Medicare beneficiary and unwanted and perilous litigation. Since the information required for submission of an MSA for CMS approval is also required as part of the information in a Section 111 report, the necessity for the MSA documents to be consistent and parallel with the Section 111 report is self evident.

The Match Game

For example, one of the core elements required for submission of both an MSA and a Section 111 report is the description to CMS of the ICD-9 codes that are applicable to

the beneficiary as a result of the injuries giving rise to the settled claim. Although it is possible that the codes could differ, that scenario would be an extraordinarily rare and unique situation. Thus, the overwhelming numbers of claims resolutions should have identical codes on the MSA submission and the Section 111 report. However, there is a logistical barrier that is created if the Responsible Reporting Entity (RRE) has failed to ensure coordination in the typical instance in which an MSA is produced by one entity and the Section 111 report is produced elsewhere, i.e., via internal resources or through the use of an agent. This functional separation and absence of coordination can lead to obvious instances of inconsistent data being submitted to CMS on the same claim, the gravamen of which obviously arose from the identical set of circumstances.

This is particularly the case if a simple data transfer protocol has been adopted to fulfill Section 111 reporting. Mere data transfer, without substantive analysis of data elements (typical in Section 111 reporting services that are offered as ostensibly "free," enhances the potential for a perfunctory download of superfluous and unnecessary ICD-9 codes. This heightens the risk and exposure. Taken together, the absence of coordination is a pathway to a predictable, negative outcome for the beneficiary and thus it has risk exposure for the RRE.

If the data submitted to CMS in connection with an MSA proposal with respect to a particular claim differs from the data submitted to CMS by the RRE in its Section 111 report for that same claim, potentially serious problems could arise. If the RRE's quarterly report contains ICD-9 codes for injuries not related to the plaintiff/claimant's workers' compensation or liability claim, CMS could improperly deny Medicare coverage for medical care unrelated to the plaintiff/claimant's injuries. If the plaintiff/claimant's MSA is still under review at the time the RRE files its quarterly reports, the inclusion of ICD-9 codes unrelated to the injury could result in a significant increase in the amount CMS may require to fund the MSA.

Finally, a significant difference between the data submitted with an MSA approved by CMS and data submitted by the RRE after the MSA has been approved could lead CMS to withdraw its approval of the original MSA submission and withhold Medicare coverage for injury-related care until the entire settlement has been expended on the plaintiff/claimant's injury-related medical expenses. Since there is currently no appeal process applicable to MSA submissions, these types of errors would be difficult, if not impossible, to correct.

Liability Abounds

We would suggest that exposure would also be extant in the foregoing scenario for the attorneys involved in the claim — plaintiff and defense — as well as the MSA professional and the Section 111 reporting agent if their actions are seen to have contributed to an unfavorable result to the plaintiff/claimant. This is because each of these participants in the process would almost certainly have a legal duty to the plaintiff/claimant to use reasonable care to ensure that the above scenario does not occur. Moreover, this example of the interrelationship between the data on an MSA and the Section 111 report is based upon the example of just one of the data fields.

Obviously, both an MSA and a Section 111 report contain many other variable elements, and thus there are many pitfalls that can arise from the absence of an acknowledgment of the interrelationship between MSA and Section 111 obligations and the failure to implement appropriate coordination protocols.

Analysis of the requirements of the different facets of the Medicare Secondary Payer Statute indicate unequivocally that the MSA and Section 111 reporting functions do not exist in a vacuum and thus must be addressed via an organic approach as part of an integrated claims resolution system. As part of such a system, it is essential that both the RRE or its agent and the professional responsible for submission of the MSA communicate with each other.

If the RRE or its agent has already submitted its Section 111 report on a particular claim, the information submitted must be made available to the entity responsible for submission of the MSA. Conversely, if the MSA has already been submitted, the RRE or its agent should be provided with a copy of the MSA proposal before submitting any Section 111 report with regard to the same claim. Only in this way can both the MSA professional and the RRE or its agent ensure that their respective duties are completed properly and coordinated so that no significant inconsistencies in data exist that may cause unnecessary damage to the plaintiff/claimant.

This application of a prudent and measured response to the requirements of CMS will assist with the fundamental and worthwhile goal of contributing to the viability of Medicare and the well-being of its beneficiaries, and reduce financial exposure to the RRE.

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