Workers' Comp

When Do You Need an MSA?

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Author profile image

Deborah Robinson Stewart

National Manager, Medicare Services

This article is authored by guest blogger, Deborah Robinson Stewart, National Manager of Medicare Set-Asides, Genex Services. In its simplest form, the Medicare Set-Aside (MSA) is a pool of funding reserved for future accident-related treatment once a workers' compensation case is settled. However, because of its complex nature, some employers will go the MSA route when there are better options available, or they'll incorrectly believe a settlement agreement will cover these expenses and decide not to pursue. As an attorney who provides support on compliance issues involving disability, Medicare and workers' compensation, I've encountered many claims professionals who are puzzled about how the MSA works. So, to gain a better understanding, let's start with the basics. MSAs are typically implemented when a person is a Medicare beneficiary — 65 years or older, or an individual who's been adjudicated disabled through the Social Security disability process. The Code of Federal Regulation directs that Medicare typically does not have primary payment responsibility when another entity is involved. In a work injury claim, workers' compensation is the primary payer for health care items or services related to that injury. If future medical care related to a workplace injury is necessary, the carrier must take measures to ensure that Medicare remains the secondary payer and that there's funding available for the injured employee to pay for their future care in the settlement. An MSA is the tool designed to pay those expenses and "protect Medicare."

Going Through the Process

Submitting an MSA to the Centers for Medicare & Medicaid Services (CMS) is a voluntary process and is not required. Some payers view CMS review as a "safety net" to ensure they are protecting Medicare. However, once one goes down this route, they must adhere to Medicare's specific guidelines regarding the MSA review process. A better course for some is to establish and fund a set-aside on their own. In these cases, the payer must still ensure Medicare is the secondary payer by providing adequate funding for future medical care. In these settlements, CMS has recommended that recipients consider the use of a professional administrator for their funds. If MSA self-administration is chosen, educating the claimant on how to properly utilize MSA funds is strongly recommended. To have an MSA reviewed by CMS, the minimum amount of the total settlement must be more than $25,000 for a Medicare beneficiary, or $250,000 for a claimant with reasonable expectation of

Medicare enrollment within 30 months of the settlement date. However, these dollar amounts should not be used to govern whether an MSA is appropriate, they simply indicate when CMS will agree to review the set-aside proposal. Some have mistakenly used the CMS workload review thresholds to determine if they need to include a set-aside if the settlement is less than $25,000 or $250,000. No matter the settlement amount, if post-settlement treatment is indicated, the payer must still ensure that future health care costs from the workplace injury are covered. Quality MSA programs also include the review and resolution of Medicare conditional payments. Conditional payments are payments made by Medicare for treatment related to the work injury. CMS has, on occasion, included erroneous or unrelated claims for treatment in summary of payments. It is essential that conditional payments are identified, reviewed and handled in a timely manner as directed by Medicare, to avoid interest accrual, referral to the US Department of Treasury or collections. So, when considering Medicare Set-Asides, it's important for payers to do their due diligence. Following these basic guidelines can go a long way in ensuring the injured employee receives the care he or she needs and the payer has covered its bases. *This article is for general information purposes and is not intended to be and should not be taken as legal advice.*



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