Workers' Comp

Frequently Asked Questions About Medicare Set-Aside

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Author profile image

Deborah Robinson Stewart

National Manager, Medicare Services

Q: Are MSAs only used for workers' compensation claims?

A: An MSA can be prepared for both workers' compensation and liability claims. However, CMS only has a formal MSA review process in place for workers' compensation MSAs. There is no current MSA review process for liability MSAs.

In the absence of formal CMS guidance for liability MSAs parties can still create and fund the liability MSA to demonstrate how Medicare's interest are considered.

Q: If MSA submission is voluntary what happens if we do not submit the MSA to CMS for review?

A: CMS states that it has sole discretion to deny payment for medical services related to the WC injuries or illness equal to the total settlement before CMS will resume primary payment obligation.

Professional MSA Administration should be considered when the MSA is not submitted for CMS review to ensure that the MSA funds are appropriately exhausted.

Q: What happens if the injured individual passes away prior to using all MSA funds?

A: CMS will first ensure all outstanding claims have been paid. This may require the MSA to be left open for some time to allow providers to submit billing. Thereafter any leftover funds may be dispersed pursuant to the settlement agreement or state law.

Q: When, and how often, after submitting an original MSA, can we submit an updated MSA?

A: After the MSA is submitted for review and CMS issues a determination letter the decision is final. CMS will permit a one-time request for review of the MSA decision known as Amended Review when supporting medical documentation is provided if the following criteria are met:

- The claim has not settled
- CMS issued a conditional approval/approved amount at least 12 months prior to the request
- Care has changed that would result in a change in the amount of the previously determined MSA of 10% or $10,000

Frequently Asked Questions about Medicare Cond. Payment (Liens)

Q: Do Medicare Conditional Payments apply to Medicare Supplemental Plans as well?

A: No, a Medicare Supplement plan (aka Medigap) is an insurance policy that can purchased by the Medicare recipient with traditional Medicare (red, white, and blue card) to cover out-of-pocket expenses (co-payments, deductibles) that won't be covered.

Q: **What is a Recovery Agent?**

A: A Recovery Agent is an individual or organization that is authorized to work with CMS or its contractors to address conditional payments and recovery on behalf of a liability insurer, no-fault insurer or workers' compensation entity. The authorized agent must have a valid authorization for each recovery case.

Liability, no-fault, or workers' compensation insurers may also designate a recovery agent via Section 222 reporting.

Q: What if we file a dispute/appeal after the stated timeframe?

A: If you submit a dispute/appeal outside of the stated CMS timeframe you can still file, but you may have to demonstrate "good cause" for why the appeal/dispute was not filed timely or your request could be dismissed.

The conditional payment letter (CPL) or conditional payment notice (CPN) will provide specific details for how, when, and where to send your dispute/appeal as well as what supporting documentation is needed. Treasury letters can also be appealed. The Treasury letter will provide instructions on how to appeal.

Q: What is the timeframe for Medicare to review and respond to a dispute/appeal request?

A: When CMS receives a dispute/appeal request they have 45 days from the date of receipt to issue a response.



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