Workers' Comp

Selecting the Right MSA and Regs to Know for 2025

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Tom Kerr (TK): As a P&C professional, you know the value of Medicare Set Asides (MSAs), but did you know there are different types of MSAs? To help us understand which MSA might be best for various situations, we've invited our MSA expert, Deborah Robinson Stewart, JD, national manager of Medicare Services, to break them down for us and also update us on any regulatory changes we should know about for 2025.

TK: Deborah, let's start with this. What are the various types of MSAs?

Deborah Robinson Stewart (DRS): So, most people who request an MSA request what we deem to be a standard MSA. And so, for us, a standard MSA is on we prepare that aligns with what CMS deems necessary if they're going to be reviewing an MSA.

A standard MSA contains two years' worth of medical records that have been reviewed by the MSA preparer, typically a rated age statement or a life expectancy. The rated age statement would be used if there are any comorbid conditions on the claim, and that's going to bring the number of years that cover the MSA down. We want to try to get a rated age statement whenever possible. We're going to ask for a claim payment log, a pharmacy log and, if there's any court orders, denials that are reducing a condition or an injury on the claim.

We want to have all that information. So, typically when people send us a referral, they send us a standard MSA.

TK: What is the non?submit MSA?

DRS: The non?submit MSA is an MSA that would not meet Medicare's or CMS' standard for review. In this case, we're going to use all the same information that I talked about for the standard MSA, but there may be something additional on that claim that if CMS were to review it, they would ask additional questions.

So, oftentimes our clients will say, "I want an MSA. I want to settle this case out, but we're not going to send it to CMS for review. We want a non?submit." So, when we have that kind of request, we know that we can prepare what we like to call a "real-life MSA."

Most people don't understand that for the standard MSAs, the way CMS looks at things, it's overfunding the MSA. And the reason Medicare does that is because they want to make sure that their interests are protected.

Whereas a standard MSA is going to allocate funds over the claimant's entire life expectancy, a non?submit MSA may be something that's more reality based. For instance, if the individual is taking narcotic medication, we know that somebody who has a life expectancy of 20 years cannot take narcotic medication successfully for 20 years. And so, a non?submit MSA may cut that off or may show that the doctor is weaning the person off a medication. The non?submit MSA may also take into consideration reporting from an independent medical examination or an agreed medical examination whereas, in a standard MSA, CMS does not consider independent medical examinations or agreed medical evaluations to be medical treatment records.

So, what we do with the non?submit MSA, again, can be more of an allocation. And usually, it's a lower allocation because it does not take all the things into consideration that a standard MSA does.

TK: What is the limited MSA then?

DRS: So, the limited MSA, again, it's not going to be a full allocation. Usually what we do in this case is take the same information — medical treatment records, claim information, pharmacy information, a rated age — but there may be other factors that allow us to curtail the allocation so that it's not for the full life expectancy. Some states have workers' compensation statutes, which do not allow the work comp carrier to pay for future medical care after a certain period.

A great example of this is the State of Georgia, on cases that have been deemed non?catastrophic, the carrier can only pay for future medical for about 7-and-a-half years after initial injury. That's a statute that would limit the MSA to a certain period.

There's additional information we need to present for CMS to review this limited MSA. We need a court order that deems the claim as non?catastrophic and that will be acceptable if we were going to send this MSA to CMS. The other thing that can limit an MSA is if the treating physician indicates that the person is not going to require future medical treatment.

So, you may have a claimant that had an accident in 2021, he or she was treated for a year or two, and the physician has sent a letter or provided a medical report that indicates to a reasonable degree of medical certainty

this person's not going to require future medical treatment. That would then be a reason to limit the MSA. Or, if the physician says the injured person is probably going to only need another year of treatment or something like that. That is how we use that information to limit the MSA.

The other way we could limit the MSA is, and this is a case I probably wouldn't send to CMS, but sometimes you'll have a physician that makes a recommendation for a surgical procedure or high-dollar durable medical equipment (DME), and it's in the medical record for a period of time. Sometimes what we'll do is get a field nurse or doctor through a peer to peer to go back and ask the treating physician if the recommendation is still on the table. If the treating physician comes back and says he or she is no longer recommending a surgical procedure or high-dollar DME, that is also a way we can limit the MSA.

So, these are tactics we utilize to reduce the cost of the MSA because these things can get very pricey, particularly on older claims where you've had somebody that's been treating for a very long time and nobody's really paying attention to the medication and what the physician is ordering in terms of treatments. So, we look for ways to help our clients contain costs.

TK: What about the zero MSA? Can you explain that to us?

DRS: Yes. So, the zero MSA is very interesting because it really seems like it shouldn't be a thing. It's basically saying there's no future medical allocation that's warranted. So, you would think if the client knew no future treatment is going to be needed, why prepare an allocation that says that?

In these cases, people often want to have something to document their file. So, the zero MSA is usually utilized to demonstrate there's no future allocation warranted. We see this a lot in claims that have been denied or disputed. Or again, if there's an indication that there's going to be no future care necessary.

Most typical cases where an individual has an accident or injury, the carrier immediately denies the claim. They make no payments on the claim, and again, it's just used for documenting the file that they've done their due diligence in attempting to protect Medicare's interest.

Now I will tell you that these zero allocations, they can be submitted to CMS for review. It is a very arduous task to get a zero MSA approved by CMS. CMS does not like them. The documentation you send to prove that a zero allocation should be applied, it must be pristine.

CMS, they go over everything with a fine-toothed comb, and even in cases where we send everything that they need for review, they still will send us what are called development letters asking for additional information. What's interesting for these zero MSAs also is that even when you have the case where the carrier has denied the claim from the outset and they haven't made any payments for medical treatment, if you send a zero MSA allocation to CMS for review, they will not review the request unless you send them medical records.

So, these cases get kind of hairy because the carrier may have denied it from the outset, so they don't have any medical records because they haven't paid for anything. And so sometimes we must jump through hoops to work with all parties to get medical information for CMS to review. It does take a long time to get these through to CMS, but we have been successful.

I always call these like my gold star files, because when we finally do get that letter from CMS that says they've reviewed our proposal, that no MSA is necessary, and they agree, we all shout for joy because again, it's a very arduous process.

TK: So, the zero MSA seems to be a pretty big challenge in terms of submission and making sure you have everything together. But is it more likely those in our industry would just pursue the standard MSA? And how

would they know when to choose the other types?

DRS: So, most people are choosing the standard MSA. But those who decide not to submit an MSA from the outset, they can change their mind. And if they do change their mind, then we must revise the report to align with how Medicare is going to review it.

The limited MSA is just a standard MSA that needs to address additional factors, which again, may be a state statute that limits future medical or physician information. So, what our referral forms just list standard MSA, non?submit MSA and a zero MSA. We don't necessarily have anything that says "limited MSA." We know that it's a limited MSA by the documentation we receive on our referral form. There's a space for special instructions. But usually, it's the documentation that shows us that it's a standard MSA.

MSA submission is voluntary, so even if you were to have a zero MSA prepared or a standard MSA prepared, you do not have to submit it to CMS for review. Medicare has a threshold that if the claimant on the case is a current Medicare beneficiary and the proposed settlement is going to be over $25,000, Medicare will then review that MSA proposal.

If the person is not yet a Medicare beneficiary but they have a reasonable expectation of becoming a Medicare beneficiary within 30 months of settlement, CMS will review the MSA proposal if the proposed settlement is going to be over $250,000.

So, you see, you have an area where the case may not fit in either of those. But I always remind people that even if CMS would not review your case, or even if you have no intention of sending it to CMS, you still need to protect Medicare's interest.

So, for someone who comes to us and asks for a standard MSA, even if they decide they do not want to submit it for CMS for review, I always remind them that you still need to do your due diligence.

And, in doing that, you would carry through and fund that MSA and instruct the claimant how to use the MSA after the claim has settled. So, it's up to the client to determine whether they want to submit the MSA to CMS for review and then we will instruct them accordingly on what is necessary to get that case through smoothly.

TK: Great information, Deborah. I'm curious, what is the typical time frame for when the review is completed and when you hear back from CMS?

DRS: So, right now, CMS is pretty fast. Typical turnaround is running between 12 and 14 days on a clean case. Those are cases we submit to CMS that need no additional information. If, for some reason, we submit the case and CMS finds the information insufficient and they send us a development letter asking for additional information for review, that adds to CMS' review time because they have to allow us an opportunity to obtain that information.

So, a development letter could be for anything like insufficient medical records, insufficient claim documents, or the claim payment history doesn't have a print or run date that's within six months of the date we submitted. We have to provide them with a detailed pharmacy log, which details the name, dose, and fill frequency for any medications that are included in the claim. Any of those reasons, if we didn't provide information, would be cause for CMS to send a development letter.

When we send the MSA for submission, we also have to send a signed and initialed claimant consent. CMS has become so detailed that we've had cases where the claimant has signed the consent, but the initials were typed in and CMS didn't accept it. So, in that kind of case, we have to go back and get the claimant to re?sign and hand initial the consent form. Anything like that causes a backlog or a lapse in time.

So what happens is when a development letter comes out, CMS stops reviewing the case until they get the information that they've requested. So, on a clean case, 12 to 14 days, and on a case with a developmental request … who knows?

TK: Well, that's a lot faster than I thought it would be.

DRS: Well, yes, the time frame has come down substantially. I can recall when it would take three to six months to get a decision back on a clean MSA.

TK: Is there any reason for that? Have they automated things?

DRS: I just think it's a different contractor. The federal government requires RFP for a contract for business every five years for workers' compensation MSA review. This latest contractor seems very efficient in what they're doing. And I like to be able to do tell clients that we'll get something back from them fairly quickly. Particularly because a lot wait until right before they're going to the settlement table, or right before they're going to a mediation to submit the MSA. I don't recommend that. Our nurses are very good at being able to tell the client whether the documentation looks good enough that it's going to get through CMS without any issues.

There are times that we have to tell our clients, "Hey, listen, we need you to get this information. We feel like CMS is going to ask additional questions." And sometimes we hold the cases to get that additional information before submitting. And sometimes the clients ask us to go ahead and submit and they'll supplement it after they get the letter, but a lot of times we know when we're going to receive a request for additional information.

TK: Are there new rules to follow for 2025 in terms of the MSA? And if so, can you expand on them?

DRS: Yes. A new rule that deals with Section 111, which is mandatory insurer reporting. Mandatory insurer reporting means if you have a Medicare beneficiary on your rolls, when you settle that claim, you must report certain details of the claim to Medicare. Usually that shows how much the claim settled for and what type of claim it is.

Before, you just had to report the claim settlement, and then if you submitted a Medicare Set Aside to CMS, they would mark that in their file. They would know that MSA had been submitted.

With this new addition to the total payment to the claimant obligation (TPOC) reporting, starting in the second quarter of 2025, this is the first time CMS requires the total MSA amount, the number of years the MSA covers, if the settlement for the claim is lump sum or annuity, and if it's a structured or annuity-based MSA. You're also going to have to report the initial and annual amount of deposit for the MSA.

This is really an effort for CMS to have all the information at its fingertips. Over the last couple of years, we've seen an uptick of MSAs being submitted and what happens is those cases remain open with CMS until they receive final settlement documentation. That's when CMS marks these cases complete in their system, and at that point they believe the MSAs they reviewed are now effective.

What we've seen a lot in the last, I would say, couple of years is there's been no reporting or CMS is not receiving the final settlement information. And so, they don't know necessarily if the case is settled, but they're getting an annual accounting statement from the claimant indicating that they're using their MSA.

So, when a case goes to submission. CMS issues a determination letter. And, in the determination letter they also give the claimant instructions on how to administer their MSA funds. As part of administering MSA funds, a claimant is required to report annually how much of the MSA funds they've expended. They just have to write the number down. They don't have to send receipts, and they have to sign an attestation and send it to Medicare.

Well, Medicare is getting all these attestation forms, but they've never received the settlement documentation.

So, I believe this change to reporting is to help CMS better coordinate whether it was reviewed by them or not, who has an MSA and the terms of it. And this will help CMS better coordinate and know when to pay and when not to pay for treatment.

But the thing I stress is MSA submission has always been voluntary and it will remain voluntary even after these new Section 111 reporting amounts go into effect.

TK: Thanks, Deborah. And this wraps up our Enlyte podcast series for 2024. We'll be back in January with experts speaking on topics that are most important to you. Until then, have a happy holiday and a peaceful New Year. And, as always, thanks for listening.

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