PRIUM

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# Increase Satisfaction and Healthiness in the Settlement Process

**Imagine a world** in which all constituents of the Workers' Compensation Medicare Set-aside Arrangement (WCMSA) process – patient (claimant), plaintiff attorney, defense attorney, treating physician(s), payer (insurance carrier or TPA) – are **satisfied** with a **lower-than-anticipated overall settlement**. In a situation where typically everyone starts in opposite camps, there are ways to bridge the negotiation gap that yields a higher upfront payout to the patient and plaintiff attorney and a lower overall commitment by the payer. Even more importantly, the long-term health patient is enhanced by focusing on medical necessity and therapeutic benefit while positively addressing Iatrogenic ("due to the doctor", probably inadvertent) Therapeutic Escalation. This allows everyone to reach the common goal of meeting lifetime therapeutic needs of the patient while controlling financial exposure.

**First, some background on what is required …**

Effective in 2001, all parties in a Workers' Compensation (WC) claim have significant responsibility under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses and where there is a reasonable expectation of Medicare enrollment with WC benefits "cut-off". This means that Medicare could potentially be liable for payments of that future medical care, and wants to protect itself. Under those MSP laws, the Insurance Carrier or TPA is required to report any claims that include medical treatment to the Centers for Medicare & Medicaid Services (CMS), so it is a responsibility that you cannot defer or ignore.

The WCMSA is done by estimating all future expenses (including, but not limited to, wages, attorney fees, all future medical expenses (including prescription drugs), previous settlements, and repayment of any Medicare conditional payments) for the work-related injury through the claimant's expected lifetime. The costs estimated to be incurred once the claimant becomes eligible for Medicare coverage are included in the overall WC settlement, and on a case-by-case basis reviewed by the CMS for accuracy. The budgeted amount is paid out when the claimant reaches Medicare-age, and only once exhausted and properly accounted for by the CMS will Medicare agree to be primary payer for remaining treatment as related to the WC injury.

There are conditions and thresholds for CMS review, circumstances where a WCMSA is not recommended, and specific guidelines for when the claimant is already a Medicare beneficiary. For more information, please reference the US Department of Health & Human Services at http://www.cms.hhs.gov/workerscompagencyservices/04_wcsetaside.asp.

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**Why is this important for an insurer or payer?**

It means that you need to be as accurate as possible in these estimates. CMS expects, and MSA calculations typically assume, that the current treatment plan can just be extrapolated over the injured worker's potential lifetime. However, that does not take into account what is **most** appropriate current treatment and what conditions might change over time. And since the medical treatment portion of claims have grown to exceed the wage loss portion in many cases, creating the proper assumptions for those medical costs is even more important. If you over-estimate, that is money put into an annuity or lump-sum payment that you will never get back. If you under-estimate there is a possibility that the patient runs out of money before they exhaust their needs for medical care. Thus, it is extremely important to get an **objective, third-party review** of their potential total cost.

Some triggers for asking for that objective review are:

- Settlement is desired or mandated
- Future medical costs to exceed $5000/year
- Lifetime medical treatment is expected
- Causal relationship issues to WC persist
- Co-morbidity conditions effect treatment

An effective review that can be used in negotiations with the CMS should include at least the following:

- Comprehensive review for unnecessary or redundant or misapplied care, including:
    - Treatment regimen
    - Planned procedures
    - Medications (dosage, frequency, weaning, alternatives, FDA-approved usage, interactions)
    - Pain management programs
    - DME (durable medical equipment)
    - Corroboration of treatment to diagnoses
    - Relatedness to the Workers' Compensation injury
- A physician discussing the current/future treatment plan with the current treating physician(s)
    - Not perfunctory attempts but a concerted effort to achieve physician discussion
    - Recommendations for treatment modification (if applicable)
    - Collaborative discussion can yield a consensus in opinion
    - If possible, a signature from the treating physician(s) and patient indicating acceptance that can included in the filing to CMS
- Evidence-based medicine as an objective baseline for treatment
    - Standards like ODG (Official Disability Guidelines) and ACOEM Guidelines

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- State-specific guidelines
- Clinical trials, research, evaluative studies, whitepapers

- Reconciliation of medication costs over time
  - Prorated at AWP but discount options evaluated
  - Brand vs. Generic
- Compliance with CMS guidelines
  - Applying knowledge of the system to ensure best possible outcome
- Proactive management of all constituents by the reviewer
  - Patient, plaintiff attorney, treating physician(s), insurance carrier or payer
  - Ensure no miscommunication or misunderstanding or invalid assumptions
  - **Case Management of the review process is paramount to its overall success!**

There is a potentially high Return on Investment (ROI) for these kinds of review because of the total dollars involved and the potential for over-estimation based on incomplete medical assessment. While not all reviews will uncover unnecessary or redundant or misapplied care, unless a full medical review is done then their possibility exists. A Nurse Case Manager (NCM) will typically do the initial review, but experience shows that a treating physician responds more often and more open to suggestion when a peer physician (similar education, certification, background, experience) is involved. And the higher possibility of agreement and acceptance by the treating physician to a peer physician can lead to a lower MSA budget, higher savings and higher ROI.

Some of the ***wins*** that come out of this are:

Patient (claimant, plaintiff)

- Peace of mind about the treatment plan due to the objective review of current and long-term medical care to optimize therapeutic benefits
- Education about options, involvement in their own care
- Potentially higher injury settlement payment (in lieu of modified long-term care)

Plaintiff Attorney

- Higher commission payout for injury settlement
- More satisfied client with confirmation of long-term healthcare prognosis

Defense Attorney

- Tool for stronger and more collaborative negotiation with plaintiff attorney

Treating Physician

- Second opinion on treatment plan, current and long-term
- Participation in the review process
- Stronger possibility of ongoing treatment being paid

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Payer

- Evidence of fiduciary responsibility
- Potentially lower set-aside for long-term medical care
- Stronger likelihood that CMS will accept the WCMSA plan
- Stronger likelihood of a healthier patient (even return-to-work if applicable)

**PRIUM**, a longtime URAC-certified Utilization Review company based in Duluth GA, has just such a product that provides the comprehensive review needed to achieve this kind of result. Our *Medicare Set-Aside Clinical Review* (MSA-CR) product delivers on the promise of collaborative dialog with the treating physician, and coordination with the Payer case managers, that enable a more precise WCMSA Report to be submitted to the CMS.

In a recent such review, the patient was a 52-year old male who has suffered from chronic low-back pain since his work-related injury in mid-2002. The patient had a spinal cord stimulator embedded and treated with six medications for pain management. The original assessment by the Nurse Case Manager assigned to establish the MSA (Medicare Set-Aside) was to maintain the existing medication regimen as well as planning for stimulator replacements over the patient's expected lifetime. The total amount initially recommended by the NCM to CMS was **$305,547** (basically, a continuation of the current treatment regimen). PRIUM was engaged to perform a MSA-CR that resulted in a written agreement from both the treating physician and patient that weaning off the medication regimen, leaving the spinal cord stimulator implant with no future replacement, and engagement in a pain management program for pain coping skills were not only **in the patient's best long-term health interests** but also **fair to the Workers' Compensation claim**. After the MSA-CR was finalized, a revised budget of **$121,872** was submitted to and accepted by the CMS, resulting in a **savings of $183,675!**

The end result of the review and subsequent discussion amongst all parties is a patient with a healthier future (over-treatment, whether through surgery or PM&R or pain control, is never in the best interests of the patient). And on top of what is best for the patient, the financial impact and exposure by the payer and ultimately Medicare to those ongoing treatment needs are lessened.

In other words, **everyone wins**. In the insurance industry, and especially Workers' Compensation, there are very few *Win* (patient) – *Win* (physician) – *Win* (insurance) scenarios. If done correctly, the clinical review of a WCMSA to help in the budgeting process can qualify for that ultimate success.

For more information, please contact PRIUM at sales@prium.net.