Newsletter of the Nebraska Workers' Compensation Court — Autumn 2000

BULLETIN

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http://www.nol.org/workcomp/

Medical Expenses — What Must Be Reported?

Legislative Resolution 480 was introduced during the last legislative session to address the issue of whether employers who are not approved for self-insurance should be allowed to directly pay for some medical services in workers' compensation cases. Related issues of the effectiveness of the medical deductible provision of section 48-146.03 and the definition of "medical treatment" under section 48-144.01 were also included. Section 48-144.01 defines "reportable injuries," including medical treatment, that must be filed with the court.

Under current law employers are not allowed to directly pay for medical expenses in workers' compensation cases, but instead must submit bills to the workers' compensation insurer which then makes payment directly to the service provider. If a medical deductible has been selected as part of the workers' compensation insurance policy the insurer is then reimbursed by the employer for any deductible amounts paid. The employer will have received a premium reduction as a result of selecting the medical deductible.

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Compensation Court Public Hearing Set for December 19

A public hearing of the Nebraska Workers' Compensation Court is set for Tuesday, December 19, 2000 at 1:30 p.m. in Room 1524 of the State Capitol Building, 1445 'K' Street in Lincoln.

Proposed amendments to several of the court's procedural rules will be considered. To obtain a copy of the proposed changes, please contact the Clerk of the Nebraska Workers' Compensation Court, P.O. Box 98908, Lincoln, NE 68509-8908. The Notice of Public Hearing and proposed changes may also be accessed on the court's website at http://www.nol.org/workcomp/ on the "What's New" page under Notices and Press Releases. For further information, call the court's toll-free information line: (800) 599-5155 in Nebraska only, or (402) 471-6468 for Lincoln and out-of-state callers. ❖

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The Use of Medicare Set-Aside Trusts in Workers' Compensation Settlements

By Susan G. Haines & Thomas D. Begley, Jr.

The Health Care Financing Administration (HCFA) has announced an all out effort to collect monies owed to Medicare under the Medicare Secondary Payment statute qualified at 42 U.S.C. §1395y. HCFA intends to make referrals to the Department of Justice for prosecution. A pilot project is already underway in New York. HCFA has stated, "We are vigorously investigating liability and worker's compensation settlement situations where in settlements involving Medicare beneficiaries have occurred absent the knowledge, consent and participation of HCFA such that Medicare's interest was not considered and protected." Insurance carriers

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Medical Expenses — What Must Be Reported?

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In spite of the law some employers attempt to directly pay for medical expenses under the assumption that this will save money by avoiding an impact on premium costs. Whether the employer in fact benefits economically is debatable given recent changes to the experience modification system. Nevertheless, this practice can also result in employees not receiving other benefits to which they are entitled, including wage loss benefits and vocational rehabilitation. It is also not uncommon for an employee to be taken through the collection process by a health care provider due to the employer's failure to pay bills as promised.

LR 480 grew out of these and other concerns. The primary issue identified for study was whether it is possible to continue to require submission of all first reports of injury, including medical only claims, while still allowing the employer to directly pay some small medical bills. Despite several meetings between interested parties and members of the Legislature's Business and Labor Committee no appropriate mechanism or legislative solution could be identified to accomplish this. As a result, no legislative action was recommended for the upcoming session.

Also discussed as part of the study was the meaning of the term "first aid" under section 48-144.01. That section provides that injuries requiring medical treatment must be reported to the court, but that medical treatment does not include first aid treatment that does not ordinarily require medical care. Some employers have referred to this language as justification for failure to submit medical expenses to the insurer. Once again, no appropriate definition could be determined.

However, it was also recognized that there is confusion as to the application of section 48-144.01. On its face, that section applies only to reporting to the Nebraska Workers' Compensation Court. It does not apply to reporting of injuries from an employer to its workers' compensation insurer. Instead, reporting of injuries from the employer to the insurer is governed by the workers' compensation insurance policy and related provisions of the Nebraska Workers' Compensation Act. The standard workers' compensation policy provides that the insurer "will pay promptly when due the benefits required of you by the workers' compensation law . . . ," and that the employer must "[t]ell us at once if injury occurs that may be covered by this policy." The Nebraska Workers' Compensation Act establishes the benefits that are owed under Nebraska law, and section 48-120 provides that reasonable expenses for medical care are benefits that are owed.

Therefore, the "first aid" language of section 48-144.01 cannot be used to justify failure to submit medical expenses to the insurer. Questions as to what injuries must be reported under the workers' compensation policy should be directed to the insurer. Concerns about medical expenses that are not being paid or reported should be directed to the insurer or to the court. ❖

Have You Visited Our Web Site Yet?

Several publications and forms produced by the Nebraska Workers' Compensation Court, as well as information regarding the court's operations, are available on the court's Internet web site at:

http://www.nol.org/workcomp/

A recent addition to our web site is an online service which provides automatic notice, by email, of the court's Electronic Data Interchange Advisories as well as updates to the "What's New" page.

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and claimant's attorneys are in jeopardy if they fail to obtain Medicare's approval of any settlement and set aside sufficient funds to cover the claimant's future medicals.

Under the applicable federal regulations, Medicare can assert a secondary payer claim for conditional payments that have been made prior to a personal injury settlement. (42 C.F.R. §411.24.) Under the regulations, a "conditional payment" is a Medicare payment for services for which another payer, such as a products liability insurer or a worker's compensation insurer, is responsible. (42 C.F.R. §411.21.) Medicare may make a conditional payment for services if Medicare does not reasonably expect the third party insurer to make its primary payment promptly. (42 C.F.R. §411.24(a)(2).) This is especially true if Medicare has information that services for which Medicare benefits have been claimed are for treatment of an injury or illness that was allegedly caused by another party.

(42 C.F.R. §411.52.) There is no provision under the regulations that would permit Medicare to assert secondary payer claims because of services paid for after receipt of a lump sum personal injury settlement, provided Medicare's conditional payments were reimbursed prior to settlement. Medicare's right to recover prior to settlement is described in the regulations as a Medicare secondary payer claim.

The regulations regarding Medicare's secondary payer claim for services provided prior to settlement are the same whether the third party is a liability insurer, a no-fault insurer or a worker's compensation insurer. In the context of either a commutation or a compromise, a worker's compensation plan is a primary payer with respect to services also covered under Medicare. (42C.F.R. §§411.20(a)(2)(1) & 411.40.) Conditional payments may be made by Medicare if the beneficiary has filed a proper claim and Medicare determines that the worker's compensation plan will not pay promptly (including cases where the worker's compensation claim has been denied) or if the beneficiary, because of physical or mental incapacity, failed to file a proper worker's compensation claim. (42 C.F.R. §411.45.) Medicare may assert secondary claims for conditional payments made prior to settlement, just as in the case of a personal injury settlement. (42 C. F. R. §§411.20, 411.21 & 411.24.)

Medicare is not likely to make any secondary payments at all until all worker's compensation benefits and remedies have been exhausted by the beneficiary. (42 C.F.R. §411.43(b).) A lump sum settlement from a worker's compensation plan is deemed to be a worker's compensation payment for Medicare purposes, regardless of the language in the settlement. (42 C.F.R. §411.46(b)(1).)

Differences Between Personal Injury Settlements and Worker's Compensation Settlements

The most significant difference in Medicare's secondary payer status with regard to personal injury settlements and worker's compensation settlements is that, in the context of worker's compensation settlements, the regulations permit Medicare to retain secondary payer status for injury related medical expenses incurred after settlement. Specifically, the regulations provide that Medicare will not pay for any future medical expenses after a lump sum settlement is received until the total future medical expenses related to the employee's injury equals the amount of the lump sum settlement which was allocated to future medical expenses. (42 C.F.R. §411.46(d)(2).) If the settlement agreement does not make a reasonable allocation of a portion of the lump sum to future medical expenses, Medicare can make the allocation itself according to a formula set out in the regulations. (42 C.F.R. §411.47(a).)

This striking difference between third party liability settlements and worker's compensation settlements is perfectly logical.

Only in the context of a worker's compensation settlement is the carrier liable for the claimant's lifetime medicals. Medicare will resist any attempt by the worker's compensation carrier to shift liability for lifetime medicals to Medicare. Accordingly, some part of the worker's compensation settlement will need to be set aside to pay for future medicals

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until the requirements of 42 C.F.R. §411.46(d)(2) are satisfied and Medicare will again pay the claimant's medical expenses.

The Medicare Set-Aside Trust

The solution to this problem lies in the utilization of a Medicare Set-Aside Trust. HCFA has accepted this trust. Here is how the Medicare Set-Aside Trust is implemented in practice.

In either a commutation or a compromise, the release must allocate an amount roughly equal to the amount of the lump sum settlement allocated to future medicals. (42 C.F.R. §411.46(d)(2).) However, not all future medicals allocated in the agreement need be set aside in a trust. Only those medicals that Medicare would normally cover are required to be set aside. Thus, monies for custodial care, prescriptions, nursing home care and other items not covered by Medicare need not be placed into the Medicare Set-Aside Trust.

The regulations envision that carriers are likely to negotiate a settlement, whether that settlement is a commutation or a compromise. (42 C. F R. §§411.46 & 411.47.) Therefore, the amount allocated to the Medicare Set-Aside Trust may reflect that negotiation. That is, the monies allocated to the Medicare Set-Aside Trust need not necessarily equal the claimant's calculated medical expenses for life. After all, the claimant may die within a year or less of the settlement. Rather, the amount allocated to the Medicare Set-Aside Trust must be sufficient to demonstrate that Medicare's interests have been reasonably considered.

Typically, where the worker's compensation settlement fails to allocate a specific dollar amount or a specific percentage of the lump sum settlement to future medical expenses and no set-aside trust has been created, the actual amount allocated can be negotiated based upon a rough application of the formula contained in 42 C.F.R. §411.47(a)(2). Presumably, Medicare would then require the beneficiary to place the negotiated amount into a Medicare Set-Aside Trust to insure that Medicare will pay future benefits once the set-aside portion is gone.

However, it is a far better practice to make a fair allocation of future medical expenses in the settlement itself; and then to set aside a portion of those funds in a Medicare Set-Aside Trust. If a worker's' compensation settlement comprises (represents a commutation of) all future medicals and disability benefits in an undifferentiated manner, Medicare is not required to negotiate, and can deem the settlement attributable entirely to future medicals. On that basis, Medicare may deny coverage for any post-settlement, injury-related medical expenses until all settlement proceeds are exhausted. Medicare's regulatory scheme reveals the rationale that a worker's compensation settlement must give reasonable consideration, and accordingly segregate a reasonable allocation, to the claimant's future medicals.

Our offices routinely seek Medicare's approval as to the reasonableness of the monies set aside in the trust. By securing Medicare's approval of the proposed settlement before the claimant releases the carrier, the claimant is assured that Medicare will pay for future medical expenses once the set-aside monies are spent.

A proper Medicare Set-Aside Trust must be customized to fit the individual needs of each worker's compensation claimant. A so-called "form" trust should never be used. No "form" can accommodate the many variables involved in these complex cases. In each instance, the Medicare Set-Aside Trust must be modified to consider:

- Medicaid;
- Tax consequences;
- Other public benefits programs;
- Accounting requirements to HCFA;
- The situs of administration
- Whether court oversight is necessary;
- To whom the trustee must report;
- Whether the trustee can be removed;
- The status of the fund on the death of the trust beneficiary, including but not limited to:
- Coordination with other sources of insurance coverage; and

- Arrangements for the protective oversight of incapacitated trust beneficiaries.

Determining The Allocation Amount

Reasonableness of a future-medicals allocation can be established to Medicare's satisfaction by both a treating physician's report and by the claimant's medical-expense history. The physician can be asked to devote a section of the prognostic analysis to the question of future medicals, and a settlement amount can be set aside on that basis. When the settlement plan is presented to Medicare for review and express approval (this is possible and advisable as a protective measure), the physician's report becomes "Exhibit A." Similarly, the claimant's medical-expense history, which the billings will document fully, can be used as a basis for a future-medicals projection, and that becomes the foundation for the set-aside amount.

Presented with: (a) a proper and reasonable proposal, comprising a medical-expense history, medical records and a physician's report, (b) a detailed settlement agreement, or (c) a thorough life care plan outlining the personal and financial needs of the claimant, Medicare can determine that the settlement plan allocates a reasonable portion of the settlement to future medicals. The settlement plan has "attended" to Medicare's interests.

It is important to note here that every worker's compensation case is different, and thus requires advocacy. Each claimant will have different needs.

Pleadings

The "pleadings" to Medicare must be drafted to outline the claimant's history, the status of his care, his unmet medical needs and his personal financial situation. There must be disclosure to HCFA whether the claimant has family who attend him or whether the claimant will need custodial care. His pleading is then coordinated with the worker's compensation settlement agreement to ensure that the monies allocated to the Medicare Set-Aside Trust are specified in the release and settlement as being for future medicals, We differentiate the release into five categories: (1) past medicals (a lien can only be asserted against that portion allocated to past medicals); (2) future medicals (exclusive of skilled care); (3) future medicals (those that encompass skilled care); (4) indemnity (life-time lost wages); and finally, (5) attorneys' fees and costs. Unless the release is drafted to accommodate these categories, the claimant risks losing his Social Security Disability payments and his Medicare benefits.

More importantly, the Medicare Set-Aside Trust is part of a package (pleading, release and trust) which must all be presented to HCFA.

Conclusion

The Medicare Set-Aside Trust, along with the pleading to HCFA and the release must all be coordinated and drafted with regard to the specific facts of each case. The determination of public benefits, the consideration of tax implications, the facts of the particular case, and the coordination of other sources of insurance—all make the Medicare Set-Aside Trust a unique instrument in every case. ❖

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EDI Production Reaches 85 Percent

Currently 85 percent of all first reports of alleged occupational injury or illness are being filed with the Nebraska Workers' Compensation Court via Electronic Data Interchange (EDI).

EDI, as used in many industries, is the computer-to-computer exchange of standard business data using telecommunications. In workers' compensation, EDI refers to the electronic transmission of claims information from Claims Administrators to a state workers' compensation agency.

The number of first reports being filed electronically is expected to increase even further in the current fiscal year as a result of a recent mandate by the Nebraska Workers' Compensation Court. Effective July 1, 2000, the court now requires electronic submission of all first reports filed by or on behalf of insurers, self-insureds, employers, or risk management pools, with the exception of those entities for which an implementation plan has been approved.

EDI In The Workers' Compensation Arena

Since the beginning of workers' compensation in the United States, administrators have struggled with developing uniform practices and statistics. Throughout the years, various models were introduced. Jurisdictions modified these models to meet their individual requirements, thus defeating the purpose of a standard format.

In the 1970s legislators began questioning how their workers' compensation systems were working compared to other state systems, and in the 1980s the International Association of Industrial Accident Boards and Commissions (IAIABC) created a Statistics Committee, whose task it was to identify, compare, and standardize injury data across jurisdictional boundaries.

As technology boomed in the 1990s, carriers and jurisdictions met in an effort to continue the standardization process in order to develop electronic reporting of injury data. The result was the formulation of the IAIABC Electronic Data Interchange Steering Committee, which focused on defining common data elements used when filing claims and developed a standard format for the electronic transfer of claims data from jurisdiction paper report of injury forms.

EDI In Nebraska

An EDI working group began meeting in 1994, setting the foundation to accomplish several goals laid out by management of the Nebraska Workers' Compensation Court. The court's first EDI trading partner began production May 5, 1997. The court then communicated its desire to go EDI, resulting in additional insurers and claim administrators signing trading partner agreements and transmitting claims information. Currently the court has 100 trading partners in EDI production.

Meanwhile, the court's Information Technology section continued to re-write the computer system, moving from a mainframe environment to a personal computer based client/server environment. A new First Report of Alleged Occupation Injury or Illness (FROI) was adopted and in 1999, the court mandated the use of EDI (as noted above).

To prepare claims administrators for the mandate, the court sent out advisory notices and began rejecting paper FROIs that did not conform to the EDI mandatory requirements, opening the lines of communication and preparing claims administrators for EDI reporting. To facilitate this process, the court has developed an EDI Implementation Guide to help claims administrators understand specific details for reporting in the Nebraska.

Plans For The Future

In Nebraska, EDI replaces the court's adopted paper copies of the first report (Form 1) and in the future will replace the Record of Compensation Insurance (Forms 12 and 12P) and the Compensation and Expense Report (Form 4).

Keeping informed about the progress of the court's EDI project has never been easier. The court web site (http://www.nol.org/workcomp/) has a page devoted to EDI which includes:

- the court's Procedural Rule 29, effective December 1, 1999, which mandated electronic filing effective July 1, 2000;
- all EDI advisory notices, as well as an electronic form which can be submitted to the court to subscribe to automatic notification of advisory updates.
- the court's downloadable EDI Implementation Guide;
- record formats and layouts;
- electronic links to the IAIABC's EDI Project; and
- a list of the court's current EDI trading partners. ❖

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NWCC Relocation Reminder:

The Nebraska Workers' Compensation Court's State Capitol Offices, located on the 12th and 13th floors, have been temporarily relocated to the old Federal Courthouse, 129 North 10th Street, Lincoln, Nebraska. Office phone numbers will remain the same.

Mail: All mail, including certified, registered, and express mail should continue to be addressed to the court's post office box: Nebraska Workers' Compensation Court, P.O. Box 98908, Lincoln, NE 68509-8908.

Deliveries: When a physical location address is required (FedX, UPS, deliveries, etc.) please use: Nebraska Workers' Compensation Court, 129 North 10th Street, Suite 300, Lincoln, NE, 68508.

Filings (By Mail): All filings by mail should continue to be addressed to: Nebraska Workers' Compensation Court, P.O. Box 98908, Lincoln, NE 68509-8908

Filings (In Person): Please bring paperwork to 129 North 10th Street, 3rd Floor. Use the northwest corner elevators.

Hearings: ***You are advised to call in advance of any hearings scheduled to confirm our location.*** ❖

Workers' Compensation Court Fax Numbers

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