WCMSA Thresholds

WCMSA THRESHOLDS

Medicare Secondary Payer compliance requires an understanding of the law, and CMS policy. The law itself requires that parties consider Medicare's interests in all personal injury, and workers' compensation settlements. This includes an analysis of each case based on its unique facts.

In workers' compensation cases, parties have the opportunity to submit a Medicare Set-aside allocation for review and approval. This is permissible when a case meets established review thresholds as defined by CMS policy.[1] Cases that do not meet these workload review thresholds will not be reviewed. CMS has also stated,

> There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval.[2]

Failure to consider Medicare's interests in a settlement may result in CMS not recognize it – consider it null and void.[3]

CMS REVIEW THRESHOLDS

CMS will review a workers' compensation settlement under the WCMSA review process that meets the following criteria:

1. The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or
2. The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be greater than $25,000.00[4]

[1] Workers' Compensation Medicare Set-Aside Arrangement Reference Guide (WCMSA Reference Guide) v3.2, Section 8.1 - Review Thresholds;
[2] WCMSA Reference Guide v3.2, Section 8.0, p. 8; [3] 42 C.F.R. § 411.46(b); [4] WCMSA Reference Guide v3.2, Section 8.1, p. 9

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CMS does caution parties,

> These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases.[5]

POLICY DEFINITION OF "REASONABLE EXPECTATION"

Questions arise as to when there is a "reasonable expectation" of Medicare enrollment. In order to assist interested stakeholders, CMS policy defines this standard as:

1. The claimant has applied for Social Security Disability Benefits;
2. The claimant has been denied Social Security Disability Benefits, but anticipates appealing that decision;
3. The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits;
4. The claimant is 62 years and 6 months old; or
5. The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.[6]

CMS will not issue "verification letters" for non-threshold cases submitted for review. Multiple non-threshold cases submitted via the Workers' Compensation Medicare Secondary Payer Portal (MSPRP) can result in the user being barred from future online access.

[5]

[6] *Id.*

WCMSA THRESHOLDS

POLICY DEFINITION OF "TOTAL SETTLEMENT AMOUNT"

Interested stakeholders should also understand the definition of "total settlement amount," and how it applies to the WCMSA review and approval process. This is a term or art, not found in statute, or regulation. It is instead found only and CMS policy, which has been subject to changes over the years.[7]

> **10.5.3 TOTAL SETTLEMENT ACCOUNT**
>
> The computation of the total settlement amount includes, but is not limited to, an allocation for future prescription medications of the type normally covered by Medicare, in addition to allocations for other Medicare covered and non-covered medical expenses, indemnity (lost wages), attorney fees, set-aside amount, non-Medicare medical costs, payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), amounts forgiven by the carrier, prior settlements of the same claim, and liability settlement amounts on the same WC claim (unless apportioned by a court on the merits).

It is important to note CMS policy does not limit the "total settlement amount" to what is listed in the Stipulation for Settlement. This amount includes what has been settle or paid in the past. This is based on the fact most commutation settlements include those benefits paid/closed out in the "past, present, and future."

[7] WCMSA Reference Guide v3.2, Section 10.5.3, p.48

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EXAMPLE

Injured party sustained a work injury, and was paid various workers' compensation benefits that included $5,000 in wage loss benefits (TTD, TPD, and/or PTD), and medical benefits totaling $8,000. The case has now settled on a full, final, and complete basis closing out all future workers' compensation benefits for the lump sum of $10,000, plus a Medicare Set-aside of $5000. The settlement also includes the resolution of $5,000 (the amount actually paid to the medical providers/Medicare) in outstanding medical bills, and/or conditional payments. A determination of the "total settlement amount is as follows:

Prior Indemnity Benefits	$5,000
Prior Medical Benefits	$8,000
Lump Sum Paid	$10,000
Medical Settlements	$5,000
Medicare Set-Aside	$5,000
TOTAL SETTLEMENT AMOUNT	**$33,000**

It is important to itemize these amounts in the Medicare Set-aside submission, and other documents. Failure to do so can result in the submission being rejected by the review contractor, and cause unnecessary delay.

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