National Alliance of Medicare Set-Aside Professionals

NAMSAP Board Members Meet with CMS MSP Program Operations Management Team

On June 15th, several NAMSAP board members had the pleasure of meeting with the current management team over the Division of MSP Program Operations within the Office of Financial Management. CMS representatives included Steve Forry, Director; Suzanne Mattes, Team Lead; Medicare Secondary Payer Policy & Performance; John Jenkins, Contracting Officer's Technical Representative/WCRC Contract; and Erica Watkins, Health Insurance Specialist. Board attendees included Leslie Schumacher, Tom Spratt, Shawn Deane, and Kim Wiswell. The goal of the meeting was to provide additional input concerning the possible expansion of the re-review process for WCMSAs.

Opening discussions concerned the newly introduced Senate and House Bills concerning MSAs. CMS expressed concern over a few aspects of the bills, including the increased case load that might be created for the Administrative Law Judges (ALJ); their interpretation that the bill as written might eliminate forecasting of services at UC&R rates; and also that it appeared that self-administration of MSA funds might be eliminated. While NAMSAP members present didn't really share the last two concerns, discussion ensued regarding the potential for overloading the ALJs.

From there, the conversation moved to expansion of the re-review process. Mr. Forry explained what had led to the delay in moving forward on their end, which involved resolution of the WCRC backlog you may recall from early 2014's streamlined review process. Once the backlog was resolved, the MSP Program team was called upon to assist in finalization of the various processes in the conditional payment area called for within the SMART Act. They had just recently completed this work and were ready to evaluate the comments received and to move forward again with re-examining the re-review process.

As the conversation progressed, some interesting discussions took place regarding the volume currently submitted for re-review (4.4%), the re-review requests approved by the CO/RO's (2.3%) and the number of re-review requests where the original approval was upheld (70% of those re-reviewed). Based on these numbers, the CMS staff seemed to believe perhaps the expansion of the re-review process was not needed. Our BOD members present assured them that it was in fact crucial to the functioning of the system and that there were many areas

where a re-review would be in order. We discussed the areas in which NAMSAP felt a re-review would be appropriate: 1) where the treatment plan had changed significantly; 2) where the pharmaceutical regimen has changed significantly; and 3) where there was a difference in interpretation of a jurisdictional statute or code. Examples of cases from each of these areas were discussed.

The next topic concerned the timeframe in which a re-review request might be granted. CMS's initial suggestion was 180 days; NAMSAP had suggested one year. We discussed how long it may take the claim to actually progress from a medical perspective following a counter-higher approval that stalled the settlement. Of note, the CMS representatives were unsure of what actually transpired in many of the counter-higher cases for which settlement documents had never been received and were curious as to whether those cases moved on to settlement. NAMSAP volunteered that many of these cases did not in fact move forward to settlement, but rather medical was left open under the claim. Often this was due to either the counter-higher approval amount making the settlement completely untenable or to the payer's wanting to manage the medical on the claim to move the claimant to a less intensive pharmacy or other treatment regimen, including possible detoxification and/or weaning, thereby hopefully resulting in a more reasonable approval amount. NAMSAP suggested that 18 months might be a more reasonable timeframe, given the nature of WC claims.

This led to a discussion of the pharmacy aspect of the WCMSAs. Mr. Jenkins volunteered that opioids were not the true cost-drivers in the pharmacy portion of the WCMSAs but rather psychiatric drugs – anti-depressants and the like. NAMSAP explained that narcotics and opioids often lead to many other drugs being prescribed to deal with the side-effects of the pain medications; examples including Abilify/ Provigil (to promote wakefulness), Ambien/Lunesta (for insomnia), Zofran (anti-nausea), Prilosec/Nexium (for GI upset/GERD), and Cymbalta/Lexapro (anti-depressants) were discussed and explained in terms of how they tied into the overall true costs of the pain medication regimens.

Later on, we discussed how a claim may not settle right away for other reasons, approved MSA non-withstanding, which might then result in the claim being settled much further in the future, sometimes years. NAMSAP provided some examples of this and explained how the claimant's medical condition and thus treatment and medication needs would likely change over a longer period of time. In some cases, a contemplated surgery or medication may no longer be needed; in others, the claimant's condition may have deteriorated to the extent that more intensive treatment will be required. In these types of situations, a revised WCMSA would be indicated, however under the current guidelines, the payers stuck with the original approval and it is suggested that they set additional monies aside if they feel additional treatment is needed; there is no suggested avenue for setting less monies aside if treatment needs have in fact decreased. At this point, Mr. Forry asked why it appeared that WCMSAs were submitted for cases where the claimant had not yet reached MMI/P&S status. NAMSAP explained that for the most part, WCMSAs were only submitted where the claimant had reached MMI, however even so, the claimant's medical condition and corresponding treatment needs may still change over time due to other medical conditions or external factors. After much discussion on this topic, Mr. Forry suggested that after a certain period of time, perhaps three of five years, it might make more sense to discard the old WCMSA and have a

completely new one created based on current medical records and payment histories. NAMSAP agreed that this would likely be step in the right direction.

Lastly, Mr. Jenkins requested we make a plea to the submitter community – the WCRC has been receiving copies of medical records with “Do not submit to CMS” scrawled across the medical record. He asked that we share with the submitters that all medical records should be submitted as clean copies with no handwriting across the page. Since these appear to be received primarily in situations where development had ensued, it does make it look to the WCRC and CMS that the records might have been purposely left out of the initial submission. NAMSAP assured him that this is not a common practice among MSA vendors and that the records may have been marked as such by someone at the payer or attorney’s office for a variety of reasons. Regardless, we agreed to share the request with our membership.

All in all, it was a great meeting. We had the opportunity to spend an hour and forty minutes talking with the MSP team and exchanging perspectives on how the system might be made to work better. CMS was hopeful that they could resurrect the re-review expansion and release some new guidelines for this area, hopefully by the end of 2015. We closed by thanking them for meeting with us and let them know we were looking forward to future meetings. We also extended them an open invitation to speak at the annual meeting or regional meetings in the future; while they’re not able to do so this year, hopefully they or the WCRC staff will be in the position to do so in the future, as they have good information to share that the MSP community would love to hear!