

7/12/2017 | Articles

CMS Green-Lights Approved MSA Re-Review

With the coming of spring, the most significant change that is usually anticipated by the Medicare Secondary Payer community is the publication of the updated *Workers' Compensation Medicare Set-Aside Arrangement Reference Guide*. The guide, published by the Centers for Medicare & Medicaid Services ("CMS"), controls virtually all aspects of MSA production and interaction with the Workers' Compensation Review Contractor. Changes are made annually, some subtle and of little consequence, others of greater importance. This year, spring came and went without publication of a new reference guide. However, as summer has now descended upon us, this year's big guide update has actually been made in the *Workers' Compensation Medicare Set-Aside Portal User Guide*, a distinct guide that provides instruction for online WCMSA submission to CMS. Through this update, CMS has announced changes to their MSA re-review process. This is sure to be a hot topic of conversation within the MSP community. A copy of the new *WCMSA Portal User Guide* can be accessed by clicking [here](#).

Re-review of an approved MSA has previously been a frustrating undertaking. Prior to these recent changes, CMS had no formal re-review process in place to speak of and limited re-review requests to consider only mathematical error or failure of the review contractor to recognize/interpret records provided with the original submission. Any additional evidence to be provided with a re-review request had to be dated prior to the original MSA submission. In an already cumbersome review process, the inability to provide evidence dated after the initial submission left parties unable to provide clarity on issues of contention or documented a change in care and rendered the prior re-review process ineffective to address inequities in a disputed MSA approval.

CMS has now formalized and expanded their re-review process and will consider a re-review request for a disputed MSA approval from a Regional Office in three instances: when there is an obvious error (mathematical errors or failure to properly consider all records); when additional evidence is available, not previously considered by CMS and dated prior to the submission date of the original MSA proposal; and when the future medical care for a case has changed so much that the new settlement value of the claim differs from the prior approved MSA amount by 10% or \$10,000, whichever is greater.

This new "Amended Review" option will be available one time per case, when the following criteria are met:

- The approved MSA must remain in "approved status" with the Regional Office.
- There is no pending re-review request (presumably under the prior process).
- The original MSA submission occurred between one and four years from the Amended Review request.
- The New Proposed MSA Amount differs from the prior submission by at least 10% or \$10,000.

From a policy perspective this makes good sense for CMS. A broader re-review option can only help to further increase submissions from parties that participate in the voluntary review program on more of a case-by-case basis and may also help to induce parties that have previously had cold feet about participating in the voluntary review program to now do so. If CMS is able to expand participation in their review program, they increase their access to claims and will be in a more advantageous position to protect the Medicare Trust Fund.

Suffice to say, this is also a very positive step for the MSP community and represents a reprieve from the previous “all or nothing” stakes of workers’ compensation MSA review. By having an opportunity to provide CMS with medical records and care details dated after the initial MSA submission, parties are able to more directly address disputed care in an approved MSA. However, it may be premature to herald the new Amended Review option as a true second bite at the apple, as only a small body of claims will meet the above criteria.

The time factor of a case only being eligible for Amended Review one year after the initial submission will put carriers in a precarious position of having to assess the risk of keeping their claim open for what will ultimately remain an uncertain outcome. Is it worth shouldering the burden of administering care until the claim is ripe for Amended Review, only to see a Claimant deteriorate in the interim and require more care than at the time the original MSA was submitted? Or would the carrier be better off accepting the original Approved MSA with disputed care, just for the benefit of having their claim settled?

No doubt this change will give the MSP community much to think about, including how best to utilize the new Amended Review option.

The Dickie, McCamey & Chilcote **Medicare Compliance Group** is available to help your organization with all aspects of MSP compliance. If you have any questions regarding the information outlined above or any other inquiries, please feel free to contact us.



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