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EDITOR'S PERSPECTIVE 5

EXECUTIVE SUMMARY 7

ARTICLES

MSA PHARMACY ALLOCATION – AVOIDING A DRY WELL 9
LISA M. DATELLE AND EILEEN F. RAMALLO

**THE TWO T'S OF REDUCING RISK:
MINIMIZING HEALTH-CARE WORKPLACE INJURIES
BY TRACKING AND TRENDING HAZARDOUS INCIDENTS** 21
DAVID LENNOX, PH.D.

**PHYSICIAN PEER-TO-PEER INTERVENTION AS AN ABSENCE MANAGEMENT
TOOL FOR WORKERS COMPENSATION** 27
JACOB LAZAROVIC, JERRY BEAVERS, AND JOHN J. BRUSK

CHIROPRACTIC IN THE WORKERS COMPENSATION SYSTEM 35
WAYNE M. WHALEN, D.C.

WILL WORKERS COMPENSATION BE AFFECTED BY BIRD FLU? 49
JEFFREY WEISS, ESQ.

COLUMNS

NCCI NOTES 53
TANYA RESTREPO, HARRY SHUFORD, AND NATHAN BEAVEN

FROM THE COURTS 82
ALAN S. PIERCE, ESQ.

OSHA OUTLOOK 73
JON GICE

BOOK REVIEW 89
JEAN LUCEY

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MSA PHARMACY ALLOCATION – AVOIDING A DRY WELL

LISA M. DATELLE AND EILEEN F. RAMALLO

Payers and other parties with a stake in Medicare set-asides (MSA) have known since the Medicare Prescription Drug Improvement and Medicare Modernization Act of 2003 (MMA)¹ that prescription drug cost allocations must be included in workers compensation settlements that qualify for MSA.²

The importance of complying with the Act is easy to understand—Medicare can recoup from a workers compensation payer twice the amount of a claim plus interest if Medicare pays for medical care that should have been covered by the payer.³ What may not be so evident is a settlement-planning detail that could help ensure that the allocated dollars last through the life expectancy of the claimant.

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What seem to be sufficient reserves can be depleted quickly if the controls or tools needed to cost-effectively manage the account are overlooked. This is especially true if the claimant has control of the checkbook and lacks the know-how to spend the funds prudently, lacks the buying power to negotiate the best rate, and is unable to apply the best economics to expenditures.

The best claim managers can calculate a sound projection of future medical and prescription drug costs that fit the injury and the beneficiary's life expectancy; however, if a developing trend is future reality, the well of MSA funds could run dry postsettlement.

An informal poll of 10 Medicare set-aside allocation organizations shows that an estimated 90 percent of the allocations they arrange are managed by the individual claimant. The remaining 10 percent are being administered professionally or with some type of custodial management organization, through either an annuity or other structured settlement.

This means that the vast majority of claimants are being given the sole responsibility for managing their medical funds throughout their life expectancy without the tools to maximize the duration of these funds. Currently, the Centers for Medicare and Medicaid Services (CMS) does not require consideration of inflation costs when establishing reserves — all the more reason the money should be managed judiciously.

The experience of Ryan Roth, president of MedVal, LLC, a Maryland-based MSA allocation and custodial management firm, illustrates the point. Approximately 90 percent of the MSA allocations MedVal completes are not managed by the custodial management arm of the organization once the settlement is finalized.

It's a question of perceived value. While employees generally favor having their accounts professionally managed, insurers often resist. That's because administrative fees and expenses for administration of the workers compensation MSA and attorney costs associated with establishing it cannot be charged to the set-aside arrangement.⁴

"Employees feel it should be the carrier's responsibility and made part of the settlement evaluation," Roth said. However, "Unless it is a catastrophic injury or very large settlement, carriers typically do not want to pay a percentage of the settlement for the management of their future medical funds."

This leaves a large volume of allocated funds "managed" by individual beneficiaries, a scenario with the potential of putting the funds at risk. Transferring the funds without good management safeguards exposes them to erosion by high-cost drugs or, in some cases, inadvertent diversion to purchases other than what is intended.

5/7/04 Memo).

- 5 See note 1.
6. Memo to associate regional administrator (July 23, 2001), available at http://www.dir.ca.gov/dwc/educonf12CMS/CMS_letter.pdf, memo to regional administrators (April 22, 2003), available at http://wcc.dli.mt.gov/Medicare_report/CMS_Medicare_Mem_Freq_Asked_Ques.pdf; memo to regional administrators (May 23, 2003), available at http://wcc.dli.mt.gov/medicare_report/5-23-03_Medicare_Mem_Add%271_Freq_asked_Quest.pdf; memo to regional administrators (May 7, 2004), available at <http://www.cms.hhs.gov/medicare/cob/providers/wcadminfees5-7-04.pdf>; memo to regional administrators (October 15, 2004), available at http://www.cms.hhs.gov/medicare/cob/pdf/wc_faqs101504.pdf.
7. United States General Accounting Office's Report to Congressional Committees May 2001 GAO-01-367 "WORKERS' COMPENSATION Action Needed To Reduce Payment Errors In SSA Disability and Other Programs," available at <http://www.gao.gov/new.items/d01367.pdf>.
8. Sestito, J.P., et al., eds., "Characteristics of U.S. Workers," *Worker Health Chartbook*, 2004, DHHS (NIOSH) Publication No. 2004-146 (September 2004).
9. Di Donato, T., and D. Brown, *NCCI Research Brief*, 2006 (August 2006).
10. See note 7.
11. See note 2.
12. Mealy, D.C., "Analysis of Workers' Compensation Results," *NCCI State of the Line Report*, 2006 (July 2006).
13. CMS's booklet, *Medicare & You 2006*, lists services that are and are not covered by Medicare. It is available at www.medicare.gov/publications/pubs/pdf/10050.pdf.
14. 42 C.F.R. § 411.46(d)(2) (2005).
15. Center for Medicare & Medicaid Services, *Administering WCMSA's*, available at http://www.cms.hhs.gov/WorkersCompAgencyServices/07_administeringwcmsas.asp (Ref: 7/23/01 Memo Q3).

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- **Prescription Card** — Are personalized and customized pharmacy prescription cards available?
- **Network Penetration** — Does the PBM have a large nationwide network of pharmacies to make access easier?
- **Security** — Is the PBM's electronic access system secure? Does it monitor and record account access, have built-in password expiration protection, and have automatic password expiration notification for HIPAA compatibility?
- **Electronic Claims Management** — Does the PBM use the most advanced online claims management technology that allows for real-time instant updates to claims processing?

It is clear that insurance payers and Medicare set-aside allocation organizations will be challenged with both appropriately assessing future medical needs and applying tools to maximize duration of benefits. Custodial management firms can further assist in this process by applying cost management tools — including pharmacy benefits management and preferred provider services — that have historically delivered these benefits.

ENDNOTES

1. Medicare Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 42 U.S.C. § 1395). Section 301 further clarified the government's right to reimbursement that it had been seeking in *Thomas v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003) and *United States v. Baxter Int'l, Inc.*, 345 F.3d 866 (11th Cir. 2003).
2. Social Security Act § 1862, as amended, 42 U.S.C. §§ 1395(b)(2), 1395y(b)(2), 1395(b)(5)(d), 1395y (b)(6), amended by Pub. L. No. 109-171, 120 Stat. 4 (2006); see also memo from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management, to all regional administrators, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC), Additional Frequently Asked Questions" question & answer No. 2 (July 11, 2005), available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf.
3. Memo from Thomas L. Grissom, Director, CMS Center for Medicare Management, to all regional administrators, "Medicare Secondary Payer - Workers' Compensation (WC) Frequently Asked Questions" (April 22, 2003), question & answer No. 13, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf.
4. Center for Medicare & Medicaid Services, Administering WCMSA's, available at http://www.cms.hhs.gov/WorkersCompAgencyServices/07_administeringwcmsas.asp (Ref:

LARGER FUNDS TO MANAGE

While MSA fund management represents only a portion of the custodial accounts administered by FARA Healthcare, the addition of pharmacy has had a big impact on the size of the MSA accounts that FARA administers, according to Leta R. Sharkey, division manager of Settlement Options for FARA Healthcare. The size of the funds is changing the way her company helps negotiate and manage the settlements.

Sharkey saw the handwriting on the wall in 2005 and began thinking creatively months before Medicare's pharmacy mandate for workers compensation took effect.⁵ "I knew adding pharmacy to some settlements would triple or quadruple the allocation," she said. To protect the fund assets, "I wanted to create a structure that would be acceptable for all parties — the adjuster, claimant, defense and plaintiff attorney and Medicare."

Such was the case of a Social Security disability claimant whose decade-old work injury and high-priced pain medication created a multi-million dollar settlement with annual pharmacy costs in six figures. "Because the claimant chose to self administer the pharmacy allocation, we had to find the means to allow him to do this, but with assurance the funds would last."

Sharkey sought out several pharmacy benefits management (PBM) companies and found that managing postsettlement MSA pharmacy allocations prospectively was new to PBMs. "As far as I know, PBM management of a structured MSA settlement had never been done," she said. "It took some creativity on both sides and a commitment from the PBM to make it work."

By partnering with a PBM with experience in workers compensation, a structured pharmacy management plan was tailored to the claimant's need. More importantly, the PBM was familiar with Medicare rules and fee schedules. CMS approved the plan in a matter of weeks.

The claimant not only is saving money because of the PBM network discount, Sharkey said, but the system is set up to dispense only plan-approved drugs, and an account activity report is generated that meets CMS' requirement for annual reporting. Moreover, the PBM created a debit payment system from the claimant's bank account so the funds are used appropriately.

"The claimant is also saving money because he is set up on home delivery that saves time and travel costs," she said.

THE LOW-HANGING FRUIT

As Medicare continues to search for ways to make ends meet, CMS is likely to scrutinize MSA allocations more closely, and MSA organizations and health-care custodial managers are paying attention.

While MSA requirements for workers compensation have been around

since the 1980s, it was not until early 2000 that CMS aggressively focused on enforcing the rule.⁶ That's when Medicare funds were being noticeably depleted and workers compensation, considered the low-hanging fruit, became a target. Over a period of 15 years, Medicare paid approximately \$43 billion towards medical care that originated from work-related injuries.⁷

Today, seven years later, the first wave of baby boomers is approaching Medicare eligibility. Add the increasing number of older workers who are staying in the work force longer, and another dimension to MSA cost projections emerges that makes proper management of pharmacy expenses even more critical.⁸

While better workplace safety programs have led to a decline in injury frequency, the severity of the injuries is known to be higher in older workers. Severity equates to greater future medical needs, putting more Medicare dollars at risk if processes are not put in place pre- or postsettlement to manage the funds appropriately.

In an already challenged system — with the population in the workforce longer, injury severity on the rise, and MSA funds exposed — Medicare

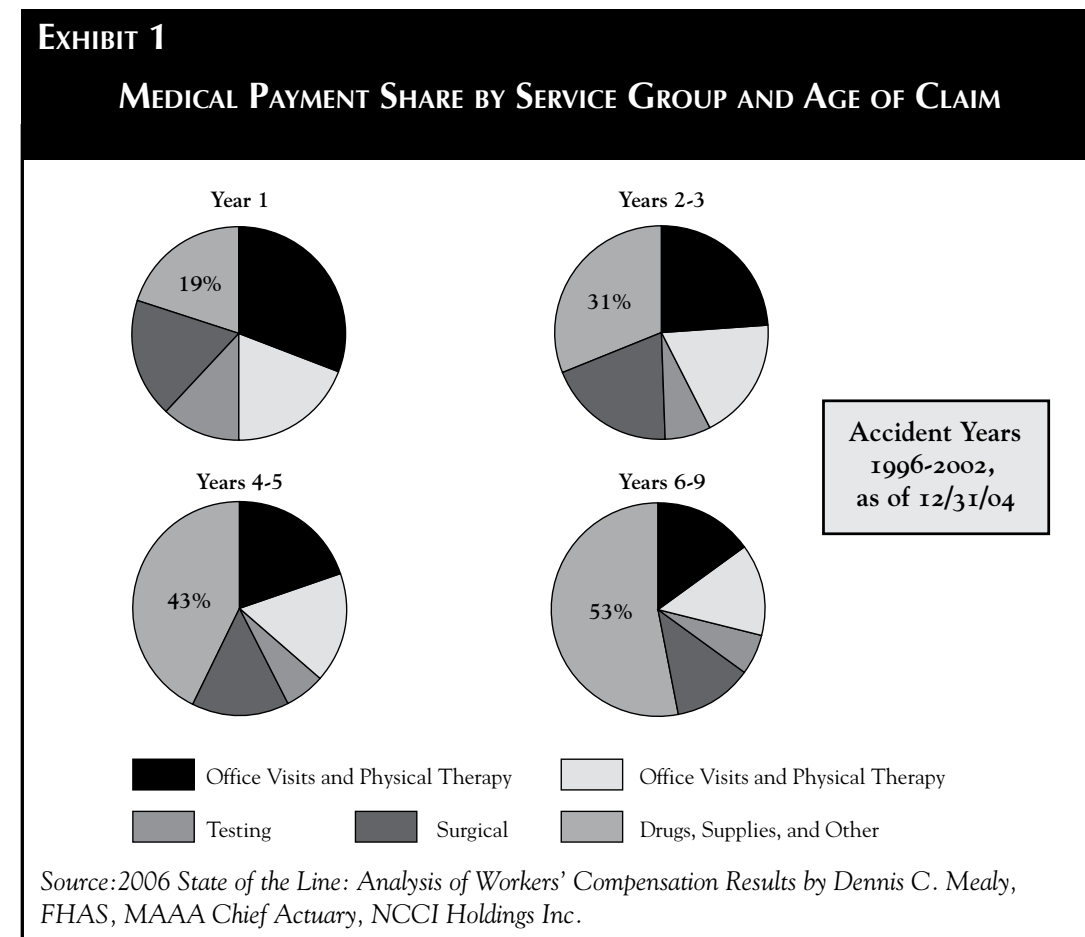
claimant or the custodial manager to generate automatic bank drafts as an Automated Clearing House (ACH) transaction. To realize savings right away, the PBM or PPO also needs the claimant's Medicare renewal date, so no time is lost transferring benefit services.

- **Submit annual accounting on use of allocation funds to CMS.** Whether the account is managed by the beneficiary or the custodial manager, an annual report must be submitted to CMS annually. Therefore, a process must be established with the PPO or PBM for submitting account information in a timely way so that the claimant or the custodial manager can comply with CMS protocol.¹⁵

PBM AND MSA COMPETENCY

Finding the right PBM for MSA pharmacy fund allocation management means asking the right questions to be sure the company has the credentials to provide the best service and savings.

- **Competency** — Does the PBM have expertise in workers compensation and experience managing funds from MSA structured settlements? Or is the bulk of its business group health, with only a small portion dedicated to workers compensation? Is the company well-versed in Medicare fee schedules and Medicare regulations?
- **Utilization** — Does the PBM have the ability to deliver the right medication to the right claimant at the right time? Does its process ensure that patients are taking the proper medication to prevent use of inappropriate or noncompensable medications?
- **Accountability** — Does the PBM have advanced reporting systems that provide information in a manner and format easily understood for review by the claimant, custodial manager, and, more importantly, by CMS?
- **Productivity** — Is it easy for the custodial account manager or the claimant to access account information 24/7? Does it have knowledgeable service representatives on-call around the clock to address questions and solve problems?
- **Home Delivery** — Are patients offered the option of nationwide home delivery?



documents shared during the claim settlement discussions.

Formulary management with automatic brand-to-generic conversion, preferred provider rates, and prescription cards are just some examples of savings opportunities possible through access to managed care benefits. These will level the playing field and give the claimant the favored position enjoyed by the insurer. With an allocation based on a preferred provider rate, for example, the beneficiary can pay up to 20 percent below fee schedule, when the retail rate for the same drug could be 120 percent of the fee schedule price.

So by extending managed care tools that exist in a structured payment system, such as PPO and PBM services, to the MSA beneficiary, the MSA dollar is stretched, Medicare's interests are protected, and claimants can continue to have their medical treatment needs met in a seamless process.

SETTING UP THE PHARMACY MANAGEMENT PROCESS

Whether the PBM is brought into the process in the pre- or postsettlement stage of the MSA allocation, custodial account managers would be wise to consider taking steps ahead of time so savings can be put into effect immediately, delays in service are minimized, and the benefits are not interrupted.

- **Obtain all the Health Insurance Portability and Accountability Act (HIPAA) compliant medical releases.**

Remembering that once the MSA case is settled and closed and it is no longer a workers compensation claim, all transfer and dissemination of medical information falls under HIPAA protection. To avoid obstacles to medical treatment and preferred rates, custodial and benefits managers should obtain medical release and authorization forms signed by the claimant prior to settling the workers compensation claim. This allows the medical vendor to request information from the beneficiary without infringing on HIPAA.

- **Establish a process for billing and collection.**

Establishing claimant billing information is fundamental to setting up a structured fund allocation management system. This allows the PBM and PPO to access the information needed to process claims easily. Setting up an automatic payment system is helpful, as this allows the PBM or PPO to debit or credit the claimant's or custodial manager's bank account for services such as PBM card use or home delivery of medication. This requires a bank release form from the

has even more opportunity to search for offenders if settlements are improperly managed.

MEDICARE PART D AS THE NEW PRIORITY

To fully understand the risk, it is necessary to examine the history of MSAs, to look at the trends in medical expenditures,⁹ and to further examine the role that a combination of a structured payment system and pharmacy benefits management is playing to help MSA beneficiaries control drug spending.

Since it issued its accounting report in 2001, CMS has aggressively focused on making the workers compensation payer markets accountable for protecting Medicare's interest. The report stated that Medicare and other federal benefits programs were spending billions of dollars because of conditional payments in workers compensation cases that should have been addressed by the workers compensation insurers.¹⁰

With the introduction of Medicare Part D in January 2006 and subsequent inclusion of pharmacy benefits in Medicare set-aside allocations prior to settling workers compensation claims, the issue of accurately calculating pharmacy along with medical benefits — and ensuring that allocations last as long as anticipated — has reached a new level of priority.

First, if legal action is taken to recover Medicare Secondary Payor (MSP) funds from the primary workers compensation payer, Medicare may seek double the amount of issued payments plus interest.¹¹ This exposure further requires that the workers compensation payer not only make strides in appropriately identifying claims that require MSA allocations, but also address how the allocation funds will be managed following the settlement to maximize the duration of these funds through the life expectancy of the beneficiary.

Second, maximizing use of the funds requires that services be managed with some degree of preferred payment structure to the providers rendering the medically necessary health-care and prescription-drug services. As in traditional HMOs in the group health setting — where the cost of medical care is reimbursed at a pre-arranged contracted rate to manage the use of medical services — applying these same principles to the allocation fund further helps to extend the duration of the available medical dollars.

OLDER CLAIMS, MORE DRUG SPENDING

In its 2006 State of the Line Report, the National Council on Compensation Insurance Inc. (NCCI) looked at the distribution of medical service utilization based on the age of the claim.¹² The study shows that prescription drug costs in new claims account for less than 20 percent of the total

medical dollars spent for treatment of the injury. In claims where payments extend beyond six years from the date of injury, the cost of drugs increases dramatically, accounting for over 50 percent of the medical dollars spent for treatment of work-related injuries.

Considering that payments in many claims meeting the criteria for MSA allocation will exceed six years from the date of injury, the probability is high that a large portion of these allocations will have future pharmacy needs exceeding 50 percent of the total settlement amount. That's because the cycle of the common work-related injury starts with the acute phase, which generally includes surgery, followed by increased physical medicine, then shifting to a prescription-drug-focused maintenance mode.

One industry expert points to another trend that is edging up the pharmacy spending in some workers compensation cases. "More and more, prescription therapies are being utilized as a key component of conservative treatment of work injuries and may even eliminate the need for invasive procedures," said Jean Feldman, vice president of care management operations at CHOICE Medical Management/Unisource Administrators.

As the injury cycle settles into long-term pain management, prescription medication and doctor visits frequently become the norm over alternative

methods for easing the pain to accommodate the activities of daily living. It is in this third, chronic stage that medical dollars are absorbed by monthly visits to the doctor for new prescriptions and supportive medical equipment such as TENS units, supplies, and other durable medical equipment.

Considering the high number of MSA allocation settlements being managed by individual beneficiaries and the likelihood that more than half their medical dollars will be spent on pharmacy in later years, there is considerable incentive to implement responsible MSA funds management.¹³

CONFRONTING THE CHALLENGE

Several custodial plan administrators are beginning to apply tried and true network provider strategies to address and manage the cost of medical and ancillary services rendered on settled workers compensation claims.

Central to their strategy is the recognition that workers compensation claims payments, once they are transferred into MSA settlement accounts, are no longer subject to workers compensation regulation. There are no fee schedules established for post-claim care, thus exposing the fund to escalating prices and the chance that the costs associated with rendering the medical care and treatment on these settled claims can far exceed the allocations — especially for those claims with long benefit duration expectancy.¹⁴

Adding to the challenge is that several programs focus on retrospective payment for medical services rendered. This can result in a lower per-unit cost of care, but, with no management of the medical necessity or relatedness of the services rendered, the cost might be too high or unnecessary.

The challenge is clear: Regardless of how the funds are managed — professionally or beneficiary-managed — after the allocation amount is settled, the funds are no longer subject to regulations that provide the best avenue for cost savings. Favorable fee schedules and other means of cost control, including network mandates on where the dollars are used and for what purpose, are out of reach. In either case, but especially for the individual claimant who has none of the buying power of a provider network, the allocated funds are in even greater peril.

ADDRESSING THE ISSUES

Some claims organizations are addressing the challenge by informing the claimant, MSA allocation companies, and custodial managers that there are ways to access a PBM or prescription card services as well as Preferred Provider Organizations (PPO) where medical rates are similar to what the insurers and payers access while the claim is active under workers compensation. In many instances, they are providing the information as part of the

