30 Minute Guide to

Medical Treatment after Settlement

Presented by Mediation and Ombudsman Services of Tennessee

800-332-2667

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Introduction

When Tennessee enacted its workers' compensation law in 1919, it set forth a promise that employers would take care of their workers who suffered on the job injuries. The pact has successfully helped many injured workers recover from their injuries for 100 years.

The law requires employers to provide "reasonable and necessary" medical care to eligible injured workers. The employers must provide this lifelong medical treatment unless the parties reach a financial settlement to close medical benefits.

Deciding between open lifetime medical treatment or closing medical benefits in exchange for a monetary payment is not a decision the parties take lightly. Closing medical benefits requires careful consideration of many factors.

This guide was created to provide injured workers a resource to better understand open lifetime medical benefits and what it means when injured workers choose to close their workers' compensation claims. The guide is for educational purposes to help injured workers more carefully consider their options and **make a more informed decision**.

The guide does not seek to persuade, dissuade or encourage any party to close medicals benefits. **It is not intended to provide legal advice** and does not intend to state a position on whether injured workers should close their medical benefits.

If you have questions you may ask the Bureau's Workers' Compensation Ombudsman Program by calling **800-332-2667** or by consulting with your attorney.

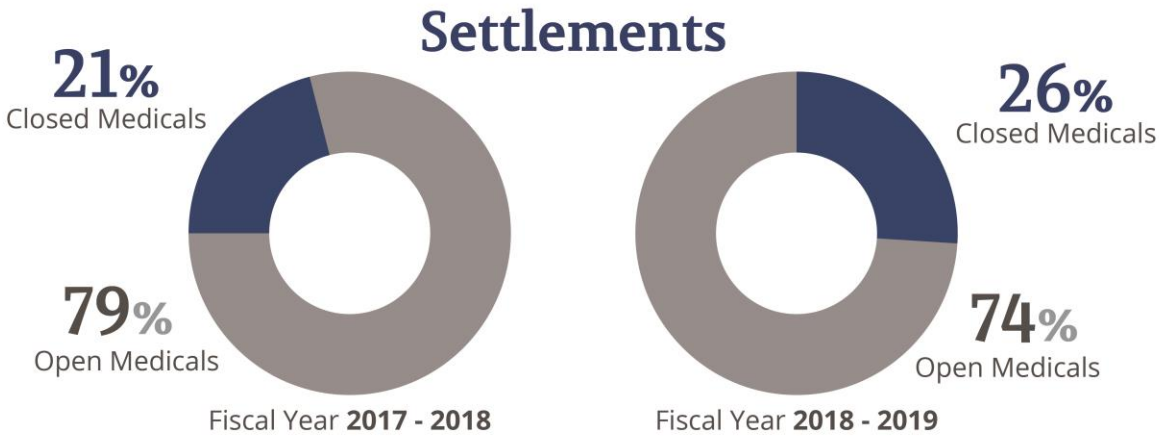
Section 1

Open Lifetime Medical Benefits vs Closed Medical Benefits

The workers' compensation law provides for the injured worker to receive medical treatment "made reasonably necessary" by accident as defined in the law. Injured workers have the option to close medical benefits and obtain post-settlement medical treatment without the employer's involvement.

Medical benefits may be closed with a voluntary financial settlement between the employer and the injured worker, unless the injured worker is determined to be permanently and totally disabled. An employer and its insurance company cannot force an injured worker to accept a settlement offer to close medical benefits. Likewise, an injured worker cannot make the employer accept a settlement demand.

If the parties do not settle the workers' compensation claim by agreement, it goes to trial. As long as the injured worker is found to be eligible for workers' compensation benefits, the trial court will not order medical benefits closed.



Why Do Some Injured Workers and Employers Prefer Open Lifetime Medical Benefits?

Many injured workers prefer open lifetime medical benefits because the idea of self-managing medical care does not appeal to them. Scheduling appointments, determining how much things cost and figuring out how insurance fits into the puzzle is more than they want to handle.

Open lifetime medical treatment provides security to those with limited treatment options. Injured workers can maintain relationships with their original physicians. These physicians are knowledgeable about past medical interventions. They also know what has worked and what hasn't. An injured worker's health often benefits from the continuity of care.

Unexpected events can occur. Errors are made. Hardware fails. Open lifetime medical benefits may provide an injured worker peace of mind by knowing that the employer will be responsible for medical treatment resulting from the work injury. If there is ever a dispute about the employer's liability, the injured worker may file a complaint with the Bureau of Workers' Compensation.

Many employers do not want to close medical benefits when an injured worker returns to employment with them. They believe experienced workers, who are receiving appropriate medical care, are an important key to having a happy and productive workforce. They like to make sure their injured workers are still able to treat for their work injury, if necessary.

A party may not want to close medical benefits because they think it does not make economic sense. The injured worker may not feel the employer's monetary offer to close medical benefits is sufficient. The employer may feel the injured worker's demands exceed an appropriate amount. Sometimes, the expected future medical treatment costs are just too high.

Injured workers who are unable to work any meaningful job may be declared permanently and totally disabled. The workers' compensation law prohibits the closure of workers' compensation lifetime medical benefits in those cases.

Why Do Some Injured Workers Close Medical Benefits?

Some injured workers choose to close medical benefits because they do not believe they will need additional medical treatment. The treating physician may say that an injured worker has fully recovered, or has recovered as well as she can; therefore there is no need for additional medical treatment. Injured workers are permitted to consider the full scope of the opinion and whether it refers to future surgical options, medications, or other non-surgical care.

Parties sometimes find closing future medical benefits is in their best interest despite an injured worker's need for ongoing medical treatment. In one instance, an injured worker moved to a place where the insurance claim handler could not efficiently provide lifetime medical treatment. In another, the injured worker needed care for non-work related conditions. The workers' compensation claim complicated the receipt of medical care for those conditions.

Some injured workers had non-work injuries that affected their work injury. One example is an injured worker who suffered a work-related shoulder injury. She then later had a car accident which caused an unconnected injury to the same shoulder. This subsequent injury impacted the employer's legal liability. In this instance, the parties agreed that the question of liability was too complicated legally and chose to enter into a settlement to avoid court.

Other injured workers have been unable to establish good relationships with their workers' compensation physicians. They preferred treatment from their own physicians. Oftentimes, they hoped treating with their personal physicians would result in a better medical outcome than what was obtained with the workers' compensation physician.

Reasons to Consider Closing Medical Benefits

- **Do Not Need Additional Medical Care**
- **Complications Caused by Other Health Conditions**
- **Available Medical Services**
- **Patient – Physician Relationships**
- **Legal Questions Regarding Liability**

Some parties could not agree whether the law provided for benefits. Rather than going to court, they agreed to settle their claim on a doubtful and disputed basis. The employers agreed to pay a sum of money instead of risking being ordered to pay more if they lost in court. The injured workers agreed to settle for less money than what the court might have awarded if she were to succeed, but more than if she lost. The payments were intended to release the employer from liability for future medical treatment.

Section 2

Medical Benefit Considerations

This section includes several factors injured workers may consider when using open lifetime medical benefits or before deciding to close their medical benefits. This list is not all-inclusive and other factors may apply. If you have questions about factors relevant to your claim, you may call 800-332-2667 or consult your attorney to learn more.

Risk

There is always risk involved in any financial decision. Injured workers who close their medical benefits may not receive enough funds to cover the costs of future medical care. Others may receive money that exceeds their medical needs. Those with open lifetime medical benefits may use them regularly or may never see the physician again.

Injured Worker Considerations

- **Choice of Physicians**
- **Treatment Authorization**
- **Medical Care Management**
- **Nurse Case Manager Relationships**
- **Adjuster Relationship**
- **Access to Medical Care**
- **Availability of Bureau of Workers' Compensation Services**
- **Insurance Coverage**
- **Medicare**

Paying for lifetime medical treatment out of pocket is not always easy. Great diligence is required to make payment arrangements with physicians and to pay for services at the correct prices. Many injured workers are unable to negotiate services at the same rate as their employer. Medicare and TennCare must be considered.

Once medical benefits are closed by approval of the Court, the workers' compensation claim is closed. The Bureau of Workers' Compensation no longer has jurisdiction to provide assistance. Any further disputes with providers or insurance companies are contractual issues the Bureau does not regulate.

Communication

Open lifetime medical benefits frequently require the employer's approval before a medical appointment. Poor communication with a claim handler or a doctor's office can delay the ability to obtain medical treatment.

Injured workers who use their benefits yearly, and who communicate with their claim handlers regularly, are less likely to experience problems. Extended periods of time between medical activities can result in file-closures, delays for the retrieval of old records, and working with persons who are unfamiliar with the claim. It is prudent to see the authorized treating physician once a year.

It is rare that the same claim handler or medical provider will be around for the injured worker's lifetime. They go on medical leave, take vacations, and find new employment. Claims are re-assigned. Changes in personnel can result in an injured worker feeling confused or ignored. Frequent contact with the claim handler and medical provider helps many injured workers avoid communication problems.

Injured workers may choose to transfer to a new physician when medical benefits are closed. It could also be necessary if an injured worker moves to a new city or if a physician retires or moves away. This process can be complicated. It may involve obtaining previous medical records and finding an appropriate specialist. Nurse case managers often simplify this process when an employer administers workers' compensation benefits.

Nurse case managers play an essential role in the workers' compensation system. They operate as a bridge between the physician, the injured worker, and the employer to provide timely medical treatment and a quick return to work. Their work involves discussing treatment options, obtaining approvals, and providing the physician relevant medical records. These services are not available to injured workers who close their medical benefits.

Private Health Insurance

Some injured workers choose to close lifetime medical benefits because they plan to use private health insurance through their employer or their spouse's employer. While this does give the injured worker a separation from the workers' compensation claim, it often leads to disappointment. The injured worker can potentially find themselves without a source to pay for future medical treatment because most private health insurance plans exclude coverage for workers' compensation injuries. Health insurance plans may attempt to recover payments mistakenly made for work injuries.

Medicare and TennCare

Medicare and TennCare do not want to pay for medical expenses for which another party should be responsible. They want to wisely manage their resources so that they can pay for their customers' medical bills. Paying for expenses that should fall under workers' compensation limits their ability to do so.

Federal law requires the parties to consider Medicare's and TennCare's interests in all settlements involving the closure of medical benefits. If they are not properly considered, then they may:

1. **Suspend All Benefits** – Medicare or TennCare may stop providing any benefits, including those for medical care not related to a work injury.
2. **Seek Re-Payment** – Medicare or TennCare may stop paying for medical care until the entire workers' compensation settlement is paid to them. This includes disability benefits, not just the amount of money paid to close medicals.
3. **Charge a Penalty –** Medicare or TennCare may sue for two times everything they've paid, plus interest.

There are several ways to protect Medicare's interests. They include maintaining open lifetime medical benefits, not charging treatment to Medicare, and entering into a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), as explained in section 5.

Medicare Advantage and Medicare Part D Plans

Medicare recipients are increasingly using private insurance plans to cover their Medicare benefits, called Medicare Advantage Plans. In 2018, the Kaiser Family Foundation released a study that shows thirty-four percent (34%) of Medicare recipients had a Medicare Advantage Plan for hospital insurance and medical insurance. In 2018, more than forty-three percent (43%) of Medicare recipients were enrolled in Medicare Part D for their prescription expenses.

Types of Medicare

- **Original Medicare**
- **Medicare Advantage Plans**
- **Medicare Prescription Drug Plans**
- **Medicaid Programs (such as TennCare)**

Although these plans are run by private insurance, they have Medicare Secondary Payer responsibilities to identify primary payers. Insurers of Medicare Advantage and Medicare Part D plans like to be consulted before recipients close their medical benefits and become primary payers.

Temporary Disability Benefits

Time missed from work for surgeries or medical treatment **after settlement** is not compensated by workers' compensation**.** This is true whether the injured worker has open lifetime medical benefits or closed medical benefits.

Section 3

Calculating Future Medical Costs

The value of lifetime medical benefits varies from claim to claim. Many different factors play a role in determining those costs and doing so is not an exact science. Most people know the major factors include the type of injury, the type of medical treatment received in the past and what is expected to be needed in the future. Not as many people are aware of the effect that location, unexpected costs, medical care inflation and prescription medication trends have on valuing lifetime medical treatment.

Varied Price of Medical Care

Tennessee uses a medical fee schedule to set the maximum price medical providers can charge and that employers can pay for a work-related injury. While this sets a ceiling for prices, it does not set a floor.

Many insurance companies and medical groups enter into network agreements. These medical groups agree to charge less for their services in exchange for access to more patients. This often means that an employer may be able to pay less than a self-pay patient for the same services. In addition, the size of the medical group and their negotiating power can result in varied prices.

Location

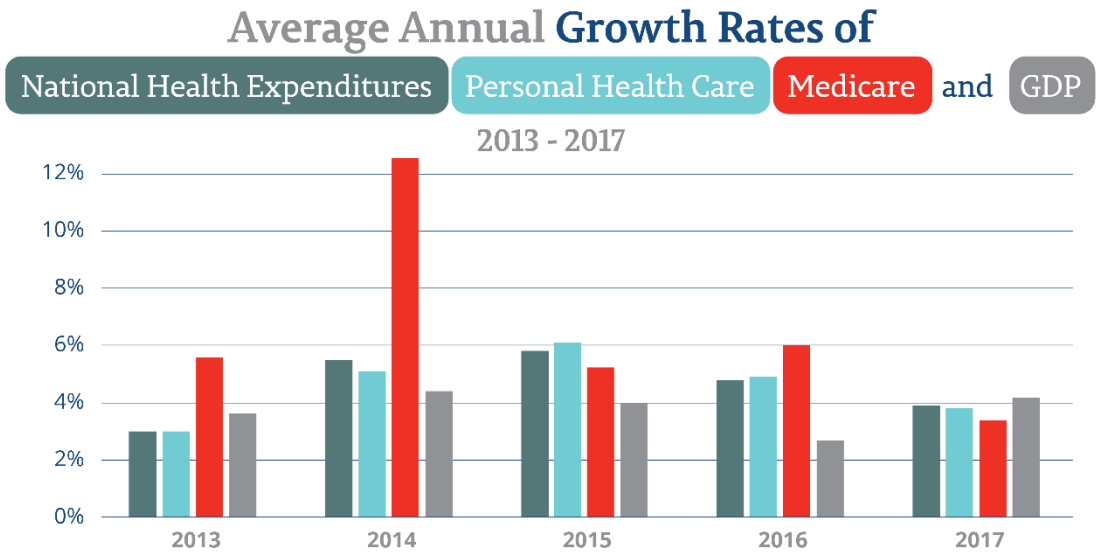
Where doctors are located is an important price factor. There is limited access to specialized medicine in some rural areas. Travel expenses from a small town to a larger city are allowed to be considered in the overall valuation of medical costs. Given these variations, it can be difficult to assess expected costs.

Unexpected Costs

While expected costs are challenging to estimate, it is even harder to provide for unexpected costs. Full recovery, even if anticipated by treating physicians, is not possible in every case and more treatment may be necessary. Many surgeries include installation of hardware such as prosthetics, screws or pins. These may or may not fail. Unforeseen consequences many years down the road are difficult to value, as are the costs of what those services will be.

Rising Costs of Health Care

Costs in health care continue to rise every year. Predicting how these costs will rise in the future is difficult. Calculations based solely on past expenses may not appropriately account for the rising costs of health care, especially prescriptions.



SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Prescription Services

In November 2018, prescription drug manufacturers collectively announced price increases for eight commonly-used prescription medicines. The American Hospital Association reports that some commonly-used older drugs increased in price over 600 percent in 3 years.[1] Price increases for prescription drugs are unpredictable, as is the accepted use of many drugs.

The opioid epidemic of the past decade has transformed the prescription evaluation process. Calculating the number of opioids expected to be consumed in a lifetime was once a routine practice. It is now complicated due to the abandonment of long-term opioid therapy. It is hard to know what other accepted practices will change over the next decade.

[1] https://www.aha.org/2017-12-11-high-rising-drug-prices-myth-vs-fact

Section 4

Settlement Negotiations

Open lifetime medical benefits often serve as a starting negotiation position for many injured workers. The closure of medical benefits then occurs through negotiation between the injured worker and his employer. The negotiators may receive assistance from a neutral third-party called a mediator. This section details common factors mediators have helped negotiate, although it is not a comprehensive list.

Authorized Treating Physician

When negotiating open lifetime medical benefits, the parties usually agree that the authorized treating physician will continue to provide treatment. Occasionally, a new panel of physicians is agreed upon. This occurs most often if the injured worker has moved or the physician retires. Many settlement documents will specify the authorized treating physician who will provide lifetime medical treatment.

Amount of the Payment

The most obvious factor to negotiate when closing medical benefits is money. One way to determine the value of closed medical benefits is to consider the expected future medical costs. Sometimes these costs are determined by hiring medical experts who sort through past records and billings to provide estimates.

Claim Handling

One often overlooked factor is the cost for claim administration. Verifying and paying bills, coordinating care, and scheduling appointments are valuable services many people are paid to perform. Additional work is required for injured workers who are closing their medical benefits and are on Medicare or TennCare.

Employers may be willing to pay for professional claim administration. These fees are often small in comparison to the overall costs of the workers' compensation claim, and the employer receives some protection against potential future liabilities from private or government provided health insurance plans.

How to Close Lifetime Medical Benefits

1. **Contact the employer or its insurance claim handler.**
2. **Consider consulting with trusted professionals such as physicians, lawyers, or financial advisers.**
3. **Negotiate an appropriate settlement amount.**
4. **Obtain approval from applicable agencies including a workers' compensation judge.**

Payment Structure

Payment structure is the method used to pay injured workers to close medical benefits. Some injured workers agree to accept a single, lump sum payment while others choose monthly or yearly payments. The method of payment is determined during the negotiation.

When negotiation results in a single payment, the employer usually brings the check to the workers' compensation settlement approval hearing. The injured worker may invest the money at his or her own risk. The money is then used to finance future medical treatment. This method is often preferred by those who might have a large payment due at one time, such as a surgery and its accompanying costs. It is also favored by those who do not expect to regularly follow-up with their care.

Other negotiations result in a series of payments. Sometimes the initial payment is larger than later payments. The parties decide the frequency and the amount of each payment. Some injured workers prefer a structured series of payments because it provides a safety net over a longer period of time.

Impact of Death

What happens in the event of an injured workers' death is an important consideration to have detailed in the settlement documents. Well-written agreements clearly specify what happens to the money upon the death of the injured worker. The terms may say leftover proceeds from a lump sum payment will pass to the worker's estate or they may be returned to the employer, the insurance company, or even paid the worker's attorney. Agreements often indicate structured payments discontinue after death, although some employers agree to guarantee payments for a period of time.

Medicare Eligible Expenses vs Non-Medicare Eligible Expenses

Some injured workers who choose to protect Medicare's interest with a WCMSA request a separate fund pay for non-Medicare eligible expenses. These are medical costs that are not covered by Medicare. Properly administered WCMSAs will only cover Medicare eligible medical expenses.

Section 5

Workers' Compensation Medicare Set-Aside Arrangements

WCMSAs[2] are settlement agreements in which employers pay injured workers appropriate amounts to close their medical benefits. An injured worker then puts the money into an independent account to pay for medical treatment for the work injury. The purpose of a WCMSA is to show Medicare's interest were appropriately considered.

Employers often hire experts to review the injured worker's medical history and other relevant information. They use this information to estimate the expected cost of future medical treatment. The parties use this estimate to negotiate the money paid to close benefits. Using appropriate procedures to accurately estimate future costs is one way to make sure there is enough money to pay for medical expenses.

Sometimes estimates are wrong and injured workers run out of money, even though they still need medical treatment related to their work injury. If this occurs, Medicare or TennCare **may, or may not**, agree to pay for medical treatment **if** there is a WCMSA. Medicare suggests parties:

1. have a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) that was approved by the Center for Medicare Services (CMS);
2. Follow the CMS rules regarding appropriate management of a WCMSA; (See Section 6 and Section 7); and
3. Report when the WCMSA runs out of money.

Obtaining CMS Approval

Obtaining CMS approval of a WCMSA involves a four step process:

1. Employer hires an expert to estimate future medical costs.
2. The parties review the estimate and agree to close medical benefits.
3. Employer submits the agreement to CMS for review.
4. After CMS approves the agreement, the parties finalize the agreement through a court approval.

CMS Qualifications

No statutory or regulatory provisions require that a WCMSA be submitted to CMS for review. CMS will only review WCMSAs that meet certain qualifications.

[2] This section was summarized from the Centers for Medicare and Medicaid Services WCMSA Reference Guide Version 2.9 January 2019. For complete information, use the most recent reference guide.

1. The injured worker is a Medicare beneficiary and the total settlement amount is greater than $25,000.00; or

2. The injured worker 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 $250,000.00.

   An injured worker has a **reasonable expectation** of Medicare enrollment within 30 months of settlement if any of the following apply:

   A. The injured worker has applied for Social Security Disability Benefits;
   B. The injured worker has been denied Social Security Disability Benefits but anticipates appealing that decision;
   C. The injured worker is in the process of appealing and/or re-filing for Social Security Disability benefits;
   D. The injured worker is 62 years and 6 months old; or
   E. The injured worker has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

Alternatives to CMS Approval

Injured workers are legally permitted to close their medical benefits without CMS approval. If a claim does not meet the CMS criteria, there are other options to close medical benefits that **do not include CMS-Medicare protections.** Such options include:

- hiring medical and legal experts to provide an estimate of the expected future costs and avoid using Medicare or TennCare to treat the work injury,
- doing the same as above and adding an insurance plan that provides protection if the fund is not sufficient to cover the expected costs, or
- obtaining a statement from the treating physician confirming the work injury has resolved and no future medical treatment is anticipated.

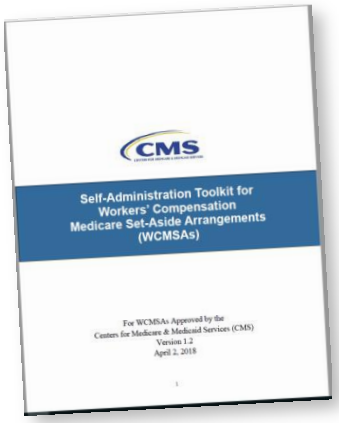
WCMSAs and Medicare are difficult to understand and explain. This section was written to simply introduce the subject. Attorneys are advised to refrain from using this guide as a source from which to provide legal advice to their clients. Everyone is encouraged to refer to the appropriate Medicare and CMS reference guide at CMS.gov.

Section 6
Self-Administration

CMS-approved settlements have rules, and Medicare will only pick up expenses if they are followed. Injured workers' can try to do so alone, or they can hire experts, known as MSA professional administrators, to help them. Self-administration is most commonly used, but requires injured workers to maintain and spend funds appropriately. CMS offers a toolkit to aid in self-administration, which is also a helpful guide for non-CMS approved WCMSAs.

CMS Toolkit

The toolkit is a 31 page guide to how to set up a bank account, report payments, negotiate with medical providers, and pay for prescription medications. The guide may be found by searching "CMS Toolkit" or by simply clicking on the icon to the right.



WCMSA money must be deposited into an interest-bearing bank account that is insured by the FDIC and must be separate from any other account. This account is to only be used for Medicare eligible expenses associated with the workers' compensation injury. The toolkit refers the user to a 120 page online booklet to help determine if a medical expense is Medicare eligible.

The toolkit also provides assistance with maintaining good records, which is critical since Medicare will use this information to determine if the funds were spent properly. It also provides organizational suggestions and formatted letters to inform medical providers about the WCMSA. These letters may help with coordinating medical payments.

The Bureau of Workers' Compensation maintains rules for medical payments on the internet. The Rules can found under "Available Resources" on the Bureau's website, www.tn.gov/workerscomp. The Tennessee Medical Fee Schedule is based upon Medicare rates. CMS provides information on services covered by the Medicare Physician Fee Schedule at this website: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.

The Bureau of Workers' Compensation does not regulate WCMSAs and cannot assist with price disputes when medical benefits are closed. This is true even though future medical expenses were estimated at Tennessee medical fee schedule prices.

Section 7
Professional Administration

While the CMS Toolkit may be helpful, self-administration of a WCMSA can be difficult. Professional administration offers injured workers: peace of mind, guidance on meeting requirements, help with investing funds appropriately, Medicare penalty avoidance and other benefits.

Professional administrators can often make WCMSA funds go further because of contracts they have for medical services. Their size allows them to negotiate lower rates for medical care and prescriptions. They also know which expenses are Medicare eligible. This helps make sure the WCMSA is only used for expenses permitted by Medicare.

They track payments and report to Medicare as required. If they make mistakes, they become liable to Medicare instead of the injured worker, employer, or insurance company. This extra line of protection for employers is often worth their paying the cost of administration fees. As a result, this service may be provided free of charge to injured workers.

Administrators work for injured workers. WCMSA funds are kept in individual accounts and are not commingled with other accounts. In most cases, injured workers can terminate contracts and either start services with a new administrator or self-administer their claim.

The reputation of professional administration continues to rise as their use increases. Some companies that offer alternatives to CMS approved WCMSAs require its use. In July of 2017, Medicare began highly recommending professional administration. Section 17.1 of the 2017 WCMSA Reference Guide issued by CMS stated:

> *"Although beneficiaries may act as their own administrators**, it is highly recommended that settlement recipients consider the use of a professional administrator for their funds."***

Many employers understand their value and routinely use a particular company. It is not uncommon to have a mediated settlement negotiation involve a representative from a professional administration company.

Injured workers may choose to use the company favored by their employer or seek a different company on their own. There are multiple firms who offer a variety of different services. The best professional administrator will vary according to the injured worker's needs.

Section 8

Conclusion

Injured workers are encouraged to make a decision after they've considered their best interests. Aside from this document, there are experts that may provide assistance. Your attorney can explain the process and provide legal assistance. Some injured workers also find it useful to seek planning advice from financial and tax professionals. Finally, physicians may be able to provide helpful information as well.

For more information call:

- Bureau's Workers' Compensation Ombudsman Program
  - **800-332-2667**
- Medicare
  - **800-Medicare**
- Center for Medicare Services
  - **855-798-2627**