A proven cost-reduction strategy for the Medicare Set-Aside environment

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Introduction

Steadily escalating medical costs — driven by the explosive growth of prescription drug use and abuse in the United States — is perhaps the most pervasive problem afflicting workers' compensation claims today. According to CompPharma's 2012 Prescription Drug Survey, employers and insurers spent an estimated $4 billion on prescription drugs in 2012.[1]

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NCCI's May 2012 Research Brief "Narcotics in Workers' Compensation" reports that:

- Prescription drugs account for 19 percent of workers' compensation medical costs
- The cost of narcotics per claim is increasing[2]

Across the country, in corner offices and on the desks of claims professionals, payers are on the front lines of an epidemic of prescription drug use and abuse. In some cases, a payer can feel powerless to stop the rolling stone of steadily escalating treatment associated with prescription drugs.

The dollars spent on the drugs are often merely the tip of the iceberg. The cascading financial and social costs surrounding large-scale prescription narcotics (and the drug cocktails required to treat side effects) include increasing drug dependency and the growth of co-morbid conditions that can complicate a claimant's medical treatment.

Where Medicare beneficiaries are involved, the scope of the problem increases when the payer attempts a settlement and moves to create a Medicare Set Aside (MSA). Simply put, it's often impossible to settle claims with Medicare beneficiaries whose claims involve large-scale prescription drug costs.

Fortunately, there's good news for workers' compensation payers wishing to control the drug costs associated with MSAs submitted to the Centers for Medicare and Medicaid Services (CMS).

Over time, a common sense methodology has proven to mitigate prescription drug costs in MSAs. Pharmacy costs are a key driver to increased MSA calculations, often representing 70 percent or more of the total dollars. Claims professionals are working with prescribing physicians to reduce or remove inappropriate treatment. The process helps insurers take control of post-settlement medical allocations, facilitating workers' compensation settlements. A collaborative approach among experts in utilization review and MSAs is challenging the assumptions surrounding future medical costs and enabling parties to settle claims in a cost-effective manner. From that has come a specific strategy to methodically create a "package of evidence" so compelling that CMS will agree.

The Scope of the Problem

The CMS Medicare Set Aside program originated in the early part of the last decade, as the government attempted to prevent settling parties from shifting the post-settlement burden for medical care from the insurer to the Medicare program. In states where the law permits lump sum settlements to cover future medical costs, the MSA arose as the primary means of:

- Demonstrating to Medicare the parties' intent not to shift the primary payment responsibility to Medicare
- Protecting the claimants' Medicare coverage

Under the program, after reviewing and approving a post-settlement medical allocation, Medicare gives the parties written assurance that it will not enforce its right to deny coverage or recover against either of the parties (the claimant and the insurer or self-insured) for improperly shifting the burden of medical treatment to Medicare.[3]

Medicare coordinates **hundreds of millions of dollars** of medical treatment per year

Settling workers' compensation parties instituted the MSA process, and some jurisdictions even effectively mandated that settling parties always obtain Medicare approval of an amount where applicable. The widespread adoption of such policies results in more than 25,000 MSAs submitted to CMS annually, allowing Medicare to coordinate several hundred million dollars of medical treatment each year.[4]

Since MSAs have become part of the everyday claims handling process, complaints have increased about rising allocation amounts. There are three principal reasons for this occurrence:

- **The CMS medical review methodology makes unrealistic assumptions about future medical care.** To approve a settlement amount, Medicare often requires parties to include medical treatments that the physician suggests may be possible, rather than those likely to be necessary. Also, the CMS methodology demands that parties assume that future medical care will occur at the same intervals and at the same rate for a person's full life expectancy. CMS reviews an individual's MSA based upon a snapshot of the person's medical treatment at the time of the most recent medical records. Future medical allocations are not subject to a larger — and more realistic — narrative that assumes medical care will increase or decrease as a person grows older, adequately manages pain and responds to appropriate prescription drug regimens.

- **The CMS methodology arguably penalizes responsible claims payers seeking to curtail medically unnecessary treatment and prescription drug use.** CMS policies nominally support the use of outside opinions, drug utilization review and independent medical evaluations. However, the CMS review methodology closely tracks (and frankly prefers) the opinion of a treating physician. CMS methods alter the purpose of the patient's medical record by assuming that any statement by the physician suggesting the mere possibility of more costly future treatment will come true. By contrast, CMS requires proof that a physician's suggestion to curtail or eliminate a treatment option (such as surgical intervention or prescription drugs) has actually occurred.

- **The CMS methodology persistently ignores attempts to curtail or control the need for long-term care.** In determining treatment for an injury, CMS assumes that the claimant will remain in his or her most recent medical condition for life, regardless of alternative measures. In many cases, the treating physician will propose several methods of treatment to resolve an injury. The CMS review procedures typically result in including *all* possible treatments, even where the proposal is an "either/or" scenario.

Did you know?

Escalating dosages of prescription drugs and the negative side effects can **dramatically reduce quality of life and function** over time. The drugs can create new co-morbidities that affect life expectancy and future treatment.

CMS review procedures result in elevated future medical allocations — particularly in the area of prescription drugs. Such unrealistic allocations lead to high settlement calculations based on expected lifetime medical expenses. The high estimates tend to prevent the parties from actually settling claims. For claimants nearing Medicare age or already on Social Security Disability Insurance (SSDI), the MSA is part of the settlement process, but **the CMS review methodology often further complicates the process.**

When medications are involved, the cost can be substantial. The 30-year cost (based on RED BOOK™ Average Wholesale Price) of each of five commonly prescribed medications starts at roughly $150,000. Treatment with those drugs, left unattended, can derail a settlement, even as the long-term prognosis of the claimant continues to decline.

The 30-year cost
of each of five commonly prescribed medications
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MEDICATION COSTS* OVER A 30 YEAR LIFE EXPECTANCY

Abilify	10mg	$251,521.50
Duragesic	100mcg	$173,052.00
Butrans	20mcg	$165,984.00
Imitrex	20mg	$164,628.00
OxyContin	80mg	$147,606.00

** Frequency presumes typical dosing per medication*

MSA providers can do everything right when calculating expected costs — necessarily based on the CMS methodology — but they must serve as the bearer of bad news about an allocation amount that could shut down the settlement process.

The bottom line is this: a CMS review is not typically based on the clinical appropriateness of treatment or the achievement of true maximum medical improvement (MMI). If there are treatments that an independent reviewer may deem inappropriate when compared to evidence-based medicine (EBM), the implementation of changes to achieve a realistic MSA allocation requires altering the treatment regimen. In cases with potentially inappropriate treatment, our understanding of the CMS review process has proven that modifying physician and patient behavior is necessary to achieve a clinically appropriate MSA allocation.

CMS clearly will not accept a *promise* to make changes that will reduce costs. It also will not accept *evidence* that treatment will taper off. The agency wants *proof* that the changes have already occurred, are resulting in better health and are permanent. In an arena this complex, with so much at stake, **one strategy has proven to make a clear difference**.

Despite their best efforts, workers' compensation payers have **limited success in lessening the "sticker shock"** of the MSA process by "grooming" the claim for an MSA in advance of settlement

The Strategy for Creating a Package of Evidence

To change CMS's perspective on what to include in an allocation, the settling parties must execute a well-conceived prescription mitigation strategy. The guiding principle for such a strategy is to create a ***package of evidence*** demonstrating the effect of the tactics and directly tying the results to the proposed allocation amount. Following are the steps for implementing this approach:

1. **Be proactive.** Evaluate the cost drivers of lifetime medical expenses before proceeding with an MSA calculation. A high-level estimate can be as easy as taking the life expectancy and multiplying by the current monthly medical costs. The life tables are available free at CMS's workers' compensation MSA web page or at the CDC's life tables web page.[5]

2. **Assess the clinical appropriateness of ongoing treatment.** Base the assessment on an objective standard of care and apply it to the patient's specific condition. For prescription drugs, a pharmacological evaluation can identify patterns in prescribing, dispensing, or administering drugs while also evaluating their causal relationship to the original work injury. A PharmD can perform a third-party review, but the most effective method to promote change is to have a collegial peer physician discussion with the treating physician. As peers, the physicians can evaluate the effectiveness of current and future treatment. Using EBM as a standard of care helps to keep the conversation collegial and productive, even in jurisdictions that have no mandated standard of care for workers' compensation. If treatment is not helping the patient reach MMI, an agreed-upon plan to modify the treatment (and the clinical outcomes) is the goal of the conversation. Documenting the EBM recommendations, the clinical rationale of both the reviewing physician and treating physician, and the results of the conversation are all highly important to CMS.

Package of Evidence Part 1	A objective written assessment by both the treating physician and a reviewing peer physician of the most appropriate current and future treatment.

3. **Secure written agreement to the changes in treatment.** Although an oral agreement between peers is helpful to get the process started, having that agreement in writing is key. A written agreement is important not only for holding the treating physician accountable for implementing the changes, but also for showing CMS that the discontinuance of inappropriate treatment was by design.

Package of Evidence Part 2	A signed written agreement between the treating physician and reviewing peer physician of changes to the treatment regimen.

4. **Enforce the changes.** Once the treating physician agrees to the changes, a formulary — customized for the patient — within the pharmacy benefit manager (PBM) system can block or require prior authorizations for all drugs deemed inappropriate or unrelated. In addition, continued dialogue with the treating physician's office before and after each patient visit will increase the likelihood of enacting the changes through accountability (consistent engagement) and flexibility (adjusting the plan as necessary). Those two collaborative tactics provide a sentinel effect and greatly enhance success in implementing the changes while providing proof of the process.

5. **Have a strategy for non-cooperative treating physicians.** If necessary, use the dispute resolution process unique to each jurisdiction to push for changes. Not all treating physicians will accept input from others and have complete confidence that their current and future treatment plans are appropriate, even in the face of conflicting evidence. There may be a variety of motivations for their intransigence, but unfortunately discussion and agreement do not happen on every single claim. Do not take "no" for an answer, and be creative within the statutory process to find ways to compel the treating physician to cooperate in at least assessing the care.

6. **Prove that the drugs are no longer in use.** Demonstrating a change in prescribing behavior is important to CMS. To do that, provide data from the PBM proving discontinuation of the drugs. Also keep evidence of ongoing engagement showing that the discontinuation was a conscious effort by both the treating physician and the payer, not just happenstance. CMS will not remove drugs from the allocation based only upon recommendations. You must provide proof of the change.

Package of Evidence Part 3	A transactional record from the PBM showing discontinued drugs and/or reduced dosages tied to the timeline of engagement.
Package of Evidence Part 4	A clinical record of engagement that documents the progress of the treatment change over time.

Keep in mind that these steps take time. It may be beneficial to suspend the MSA process in claims with elevated prescription drug costs. The proposal to CMS should be the best offer, and it may not be one that includes clinically inappropriate treatment.

Case Study

When implemented correctly, a cost reduction methodology can mean the difference between settling and not. In one case study, a workers' compensation claimant's doctor prescribed Flector patches, but she found them ineffective. During the MSA preparation, the payer noted that the most recent medical records still showed a prescription for the patches. Because of the roughly $110,000 allocation for the patches, the MSA total exceeded $140,000. The payer had set a total maximum settlement amount for the claim at $80,000, including medical, indemnity and attorney's fees.

Even with annuity funding, the payer could not reduce the cost of the MSA enough to fit within the settlement authority, and settlement discussions ground to a halt. Without resolution of the problem, the case could not settle.

The payer then contacted the physician and inquired about the need for continuing to recommend the patches, even though the claimant found them ineffective. The physician agreed that the patches were no longer necessary. Upon request, the physician prepared a letter of discontinuance for the Flector patches. Armed with that information, the payer reduced the allocation to approximately $30,000 and submitted the MSA to CMS for approval. CMS ultimately approved the MSA as submitted, and the parties settled the case and closed out the file.

This strategy delivers value for everyone involved:

- CMS benefits because the settlement considers Medicare's interests
- The payer benefits from a more accurate prediction of future medical costs
- The treating physician benefits by delivering better clinical outcomes
- The patient benefits by becoming healthier and more functional

THE PACKAGE OF EVIDENCE FOR CMS SHOULD INCLUDE:

1. A document outlining what the science (EBM) says about current and future medical treatment and how the treating physician received those recommendations
2. The treating physician's written agreement to enact necessary changes
3. A transactional history from the PBM proving discontinuation of drugs, reduction of dosages, and transition to generic or therapeutic equivalents
4. Evidence of ongoing oversight of and engagement with the physician to prove that the discontinuation was a strategy and not an accident

About ISO Claims Partners

ISO Claims Partners is the new brand name for the company formerly known as Crowe Paradis Services Corporation. The company is a leading Medicare compliance firm and a member of the Verisk Insurance Solutions group at Verisk Analytics (Nasdaq:VRSK). By leveraging legal, clinical, and technological expertise, ISO Claims Partners provides insurers, third-party administrators, and employers with a suite of solutions to meet their Medicare compliance needs. ISO Claims Partners is headquartered in North Reading, Massachusetts, and has offices throughout North America. For more information about ISO Claims Partners, visit www.cpscmsa.com or call 866.630.2772.

About PRIUM

PRIUM sets the industry standard for workers' compensation medical interventions through its ability to secure higher agreement rates and ensure compliance with modified treatment plans. The hallmark of the medical intervention company's success is a collaborative physician engagement process encompassing evidence-based medicine, clinical oversight, and jurisdictional guidelines to ensure optimal financial and clinical outcomes. PRIUM eliminates unnecessary treatment through a comprehensive approach that includes complex medical interventions, utilization reviews, and independent medical exams. Based in Duluth, Ga., PRIUM can be reached at www.prium.net or 888.588.4964. For insight on workers' compensation medical issues, read PRIUM's blog at www.priumevidencebased.com.

Learn more.

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