DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

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TO: Rose Crum-Johnson
Region IV Administrator
Centers for Medicare & Medicaid Services

JAN 10 2003

FROM: Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

SUBJECT: Survey of Medicare Payments to Worker's Compensation Recipients in the State of Florida (A-04-01-07003)

Attached is a copy of our final report providing the results of our self-initiated Survey of Medicare Payments to Worker's Compensation Recipients in the State of Florida.

In written comments, the Centers for Medicare & Medicaid Services (CMS) Region IV generally concurred with our recommendations and agreed to take corrective actions. The CMS comments are included as an appendix to our report.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please contact me or Andrew Funtal, Audit Manager, at (404) 562-7762 or through e-mail at afuntal@oig.hhs.gov. To facilitate identification, please refer to report number A-04-01-07003 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

SURVEY OF MEDICARE PAYMENTS TO WORKER'S COMPENSATION RECIPIENTS IN THE STATE OF FLORIDA

JANET REHNQUIST
Inspector General

January 2003
A-04-01-07003

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

OBJECTIVE

The objective of our survey was to determine whether the Medicare program might be paying for services that should be covered by the Florida Workers' Compensation (WC) program.

FINDINGS

Potential erroneous Medicare payments to WC beneficiaries fall into two broad categories that can be described as open cases and settled cases. Open cases involve claims submitted on behalf of individuals who have sustained a work-related injury and sought medical treatment. Settled cases, are the result of injured individuals and their representatives reaching a legally binding agreement with the employer and/or the employer's WC insurance carrier. These settled cases routinely involve payment amounts for medical expenses as well as lost wages, depending on the severity and expected duration of the injury.

Our survey indicated that there is a high vulnerability of the Medicare program to erroneous payments being made to WC beneficiaries in the State of Florida (State).

- With respect to open WC claims, the "trauma codes" relied upon by First Coast Service Options (FCSO), the primary Medicare contractor for the State, failed to list many of the codes for which WC claims have been filed. In addition, providers failed to adequately complete the required paperwork necessary to determine if other insurance, namely WC, applied for specific claims.

- With respect to settled WC claims, Medicare is potentially paying for services that should be paid from WC settlement proceeds.

RECOMMENDATIONS

We recommend that Centers for Medicare & Medicaid Services (CMS) Region IV:

- continue to implement procedures within the Regional Office (RO) for acquiring, tracking, evaluating, and responding to WC settlements. These procedures should include, but not be limited to:

    - establishment of a specific point of contact for injured parties, their representatives, and WC carriers to reach in order to get questions answered regarding CMS' policies on WC claims;

    - development of a standardized set of documentation and wording requirements for settlements that could lead to a faster turnaround time for reviews; and

    - implementation of the new system of records being developed by CMS Central Office (CO).

- provide training to RO staff, and direct FCSO to do the same, on the impact of financial assumptions and structures on WC settlement amounts, and required documentation to support the medical expenses claimed.

- establish a point of contact with a representative of the State Division of WC, and persuade the individual of the need for CMS to have access to State WC records on a continual basis in order to match potential claims. Request that this contact person provide regular updates on what data is available from the State and how it may be obtained by CMS.

- consider the ICD-9 diagnosis codes that we identified in this survey as being associated with WC claims in the State, in developing any future edits that may be implemented by CMS. This should help minimize any attempt on the part of other stakeholders in the State WC system to burden the Medicare program with claims for which it should not be liable. See Appendix A of this report for a complete list of the ICD-9 codes identified.

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We would like to express our appreciation for the time and assistance that your staff has provided to us during the course of this survey. We are aware that the CMS is currently developing procedures that should reduce the potential for erroneous Medicare payments to WC beneficiaries. However, we recommend that CMS take the above additional steps to ensure that the Medicare program is adequately protected against such erroneous payments.

The CMS generally concurs with our findings and has supplied additional detail regarding procedural improvements either recently undertaken or currently being developed. A summary of CMS's responses is included in the Findings and Recommendations section below, and the response is included in its entirety as Appendix B.

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Glossary of Abbreviations and Acronyms

CMS	Centers for Medicare & Medicaid Services
CO	Central Office
ECRS	Electronic Correspondence Referral System
FCSO	First Coast Service Options
FDLES	Florida Department of Labor & Employment Security
ICD-9	International Classification of Diseases (9th Revision) – Clinical Modification
MSP	Medicare Secondary Payer
OIG	Office of Inspector General
RO	Regional Office
SSA	Social Security Administration
State	State of Florida
WC	Workers Compensation
WC Beneficiaries	Individuals whose medical claims meet the requirements to be paid under the workers compensation coverage of an admitted carrier in the State of Florida

INTRODUCTION

BACKGROUND

Workers Compensation Claims

Potential erroneous Medicare payments to WC beneficiaries fall into two broad categories that can be described as open cases and settled cases. Open cases involve claims submitted on behalf of individuals who have sustained a work-related injury and sought medical treatment. Whether Medicare is erroneously charged for this treatment depends to a large extent on the completeness and accuracy of information supplied by the injured individual to the Medical provider at the time of treatment (see the Findings section of this report for details).

The second area of potential erroneous payments, settled cases, are the result of injured individuals and their representatives reaching a legally binding agreement with the employer and/or the employer's WC insurance carrier. These settled cases routinely involve payment amounts for medical expenses as well as lost wages, depending on the severity and expected duration of the injury. Settled cases can be subdivided into two types: compromises and commutations, each of which is handled differently. In compromise cases between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid all of the medical bills relating to the accident. Generally, compromise settlements are relatively low and allocations for income replacement (lost wages) and medical costs may not be disaggregated. In addition, the settlement amounts for medical costs are based on past and current medical expenses. Commutation cases, on the other hand, are settlement awards intended to compensate individuals for *future* medical expenses required because of a work-related injury or disease.

In both compromise and commutation cases, the ability of the Medicare program to prevent payment for claims that should be paid by WC carriers is largely dependent on CMS' and its contractors' awareness of the existence of such settlements. For that reason, our survey focused on this awareness issue. Many settlements have elements of both compromises and commutations and therefore require separate analyses for each element (see the Findings section of this report for details).

State Workers Compensation System

Title XXXI, Chapter 440 of the Florida statutes, governs the WC system, and has been amended several times in recent years. The State has over 1,100 admitted insurance carriers, although only between 250 and 300 of them offer WC policies to their clients. The State's system also utilizes medical cost containment strategies, including managed care.

The Florida Department of Labor & Employment Security (FDLES), Division of Workers Compensation, oversaw WC in the State during the period of our survey. However, the Division is currently undergoing restructuring as the FDLES is dismantled and its functions dispersed to other departments. Some functions previously housed within the WC Division are being transferred to the Florida Agency for Health Care Administration. The WC system in the State is supposed to be "self actuating," i.e., injured workers, or their representatives, are expected to be able to obtain payment for lost wages and/or medical treatment for any work-related injuries from an employer without needing to contact a state WC representative. This decentralized administrative approach on the part of the State results in a minimal amount of information being gathered and retained at a central State agency. The information that is gathered by the WC Division is closely held for privacy reasons and has not been made readily available to other state or federal agencies (see the Findings section of this report for details).

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our survey was to determine whether the Medicare program might be paying for services that should be covered by the State's Workers' Compensation program.

Scope

Our survey covered open WC cases (accidents) occurring between July 1, 1999 and June 30, 2000 and focused on WC beneficiaries in the State only. Our discussions and review of the treatment of settled cases covered the period January 1, 1999 through December 31, 2000 and was similarly limited to a review of procedures at CMS Region IV, FCSO, and the State's WC system. We did not perform any medical review as part of our survey.

Fieldwork was performed at the offices of various State agencies, at FCSO in Jacksonville, Florida, at CMS Region IV office in Atlanta, Georgia, at the offices of the Social Security Administration (SSA) Inspector General in Atlanta, the Tallahassee and Atlanta offices of the Office of Inspector General (OIG), Office of Audit Services.

We conducted our survey in accordance with generally accepted government auditing standards.

Methodology

We met with officials from the Secretary of State's office, and the Division of Workers Compensation/Bureau of Information Management, to discuss the structure of, and information available through, the FDLES WC Division. We subsequently obtained a database from the State of all WC claims for the survey period including the related diagnosis codes. After determining which of these WC beneficiaries was Medicare eligible, we compared the associated diagnosis code on their respective WC claim with the list of trauma codes checked by FCSO. We then analyzed the number and dollar amount of WC claims that fell outside of the list trauma codes that were being reviewed by FCSO.

We also met with a Judge of Compensation Claims responsible for hearing WC cases in one north Florida district in order to gain an understanding of the process by which WC cases have historically been adjudicated, and how that process is changing.

We met with individuals in the Medicare Secondary Payer (MSP) division of FCSO to discuss the process by which they identify, adjudicate, and follow-up on, potential WC claims. Our discussions involved procedures relating to both open claims, and WC settlements.

We met with individuals at CMS Region IV who are responsible for assisting in the development and implementation of CMS' policies regarding WC settlements. We were also invited to participate in a national teleconference in which CMS discussed future plans for the approval, monitoring, and follow-up on WC settlement cases. From these meetings we learned of the ongoing efforts on the part of CMS to address the issue of WC related claims and settlements.

Finally, we met with an individual in the SSA Inspector General's office to discuss their findings in recent reports regarding SSA's awareness and processing of WC-related data among SSA disability income recipients. Our survey of SSA's work was directed at determining whether CMS could rely on the timeliness, accuracy, and completeness of SSA data when making determinations of whether an individual had received, was currently receiving, or was eligible to receive in the future, WC payments.

FINDINGS AND RECOMMENDATIONS

CRITERIA

Open Claims

Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following:

(i) Workers' compensation
(ii) Liability insurance
(iii) No-fault insurance

Settled Cases

The Code of Federal Regulations, Title 42, Section 411.46 contains the limitations for Medicare payments for services covered under workers compensation. Specifically, the regulations under this section state:

(a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual

for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(b) Lump-sum compromise settlement.

1) A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan.

2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

(c) Lump-sum compromise settlement: effect on services furnished before the date of settlement. Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in Section 411.47.

(d) Lump-sum compromise settlement: effect on payment for services furnished after the date of settlement—

(1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.

(2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

CONDITION

Our survey indicated that there is a high vulnerability of the Medicare program to erroneous payments being made to WC beneficiaries. With respect to open WC claims, the “trauma codes” relied upon by FCSO failed to list many of the codes for which WC claims have been filed. In addition, providers failed to adequately complete the required paperwork necessary to determine if other insurance, namely WC, applied for specific claims.

With respect to settled WC claims, Medicare is potentially paying for services that should be paid from the WC settlement proceeds.

Open Claims

The two primary means used by FCSO during the period of our review to detect WC claims were inadequate. The first method involved analyzing the diagnosis codes on claims for those items that routinely appear in work-related injury cases. These codes, referred to as "trauma codes," included such diagnoses as concussion, cerebral laceration, and other diagnoses that would be common to injuries, whether work-related or not. In situations where a claim is submitted with one of the "trauma codes" a letter is generated to the beneficiary requesting additional information regarding the nature of the illness/injury, and inquiring about the possibility that the claim may be work-related. The second method of identifying potential WC-related claims during the period of our survey relied on medical providers to appropriately assess whether or not the claim is work-related and therefore, whether or not Medicare should be billed. Providers are to accomplish this assessment by means of a CMS-mandated questionnaire that is to be given to every patient (MSP questionnaire).

Trauma Codes

For the period July 1, 1999 through June 30, 2000, our survey indicated that the most frequently occurring 5 percent of the ICD-9 codes in our WC database applied to $1,213,047.49 in Medicare claims that were not further reviewed by FCSO. A few of the diagnoses that were not among the proscribed Trauma codes, but that appeared on our WC claims listings, include ICD-9 codes:

719.47	joint pain, ankle and foot
724.2	low back pain
820.80	fracture of lower limb, unspecified part of neck of femur, closed

See Appendix A for a complete listing of the top 5 percent of the most frequently occurring ICD-9 codes on the WC database, and for which FCSO did not flag as being related to a "trauma code."

MSP Questionnaires

This survey was not designed to identify the extent or dollar impact of providers' compliance with CMS' MSP questionnaire requirements as they existed during the period reviewed. However, we note that in two recent reviews, the OIG has identified weaknesses in providers' completion of the required information. In a recent report on the effectiveness of this identification method, the OIG concluded that 284 out of 444 questionnaires, or 64 percent, at 1 provider were either missing or failed to record essential information in identifying the primary payers.[1]

[1] Review of Hospital Medicare Secondary Payer Issues, CIN: A-04-01-07002

Settled Cases

The CMS' Region IV office is increasingly involved in the WC settlement process, and has assigned one individual with primary responsibility for WC-related issues. This responsibility is in addition to her other scheduled duties and has become an increasingly difficult burden as the volume of WC-related cases has increased. The Medicare program has a strong interest in settlements of WC cases, and the responsibilities inherent in protecting those interests are numerous. For example, determinations must be made regarding:

1. whether or not it is cost-effective for Medicare to be involved in a particular settlement case;

2. whether the assumptions of the parties involved in the settlement regarding future medical treatment and degree of disability are reasonable;

3. whether the costs associated with those medical treatments or disabilities are reasonably accounted for, financially sufficient, and properly discounted for the time over which the injury is expected to last; and

4. whether all prior medical expenses related to the injury that has been paid by Medicare have been acknowledged in the settlement.

Our discussions with CMS Region IV have disclosed that procedures vary widely between regions with respect to the issues listed above. At the time of our review, the CMS' CO was in the process of developing some uniform procedures to assist in answering some of the questions. For example, with respect to items 1 and 2 above, while it would clearly not be cost-effective for Medicare to be involved in every settlement, a preliminary determination has been made regarding which cases should warrant further review by CMS. The current thresholds for review are set as: (1) all cases in which Medicare is requested to compromise any pre-settlement or post-settlement recovery amounts, and (2) all cases involving individuals currently eligible for Medicare, or "reasonably expected" to be eligible within 30 months, with a total settlement amount for future medical expenses and lost wages is at least $250,000.

Unfortunately, the system as currently structured does not provide a standard procedure that ensures that Medicare is informed of all such settlements that meet the above criteria. Our findings with respect to the State alone indicate that such procedures will be even more difficult to put in place in the future than they have been in the past. With recent amendments to the State's WC statutes, an injured worker who obtains representation may enter into a binding agreement with a WC carrier for settlement of any and all claims, *and the State does not require that the agreement undergo further review*. There is no requirement for a judge to sign off on the sufficiency of the agreement. Furthermore, there is no requirement in the State's statutes that a statement concerning the applicability or non-applicability of Medicare be included in a settlement.

According to a WC judge, the only federally mandated element in settlement agreements within the State that she was aware of is a statement regarding whether the individual owes child support. Thus, without enforcement of any federally mandated notice, and in the absence of any state requirement, it is likely that CMS Region IV will not be aware of all cases within the State that meet the criteria for review.

Items 2, 3, and 4 above require sophisticated analysis of the medical conditions involved in the injury as well as the financial structure of the settlement agreement. The CMS Region IV and its contractors currently rely on individuals who have not been adequately trained for this function. Furthermore, when questioned about the specifics involved in determining whether a particular settlement agreement was sufficient, CMS Region IV and FCSO officials were unable to reference exact guidelines, procedures, or financial calculations. These individuals indicated that they attempted to do the best they could and return an opinion to the requesting party in as tight a timeframe as possible.

The CMS has already implemented some training and new procedures in response to the growing number of WC-related cases they are being asked to review. It is anticipated that a new system of records will be established, based on Electronic Correspondence Referral System (ECRS), which should allow an increased ease of tracking settlements on behalf of individuals who can reasonably be expected to become eligible for Medicare within the coming 30 months. The CMS' CO has also indicated that they intend to place reliance on the staff at the RO for monitoring settlements to the contractors.

CAUSE

We believe the potential erroneous Medicare payments are due to three factors:

- The procedures, including training, at CMS Region IV, and at FCSO, used to identify, track, and follow up on potential WC cases are inadequate.

- The State is hesitant and/or unable to assist in identifying potential erroneous Medicare billings on behalf of WC beneficiaries.

- There is an incentive on the part of other stakeholders in the State to burden the Medicare program with claims for which it should not be responsible.

These three causes are detailed below.

Procedures at CMS Region IV and FCSO

The CMS' Region IV office has stated that it does not routinely get involved in the identification of open WC cases, i.e., cases in which the injured party has sought medical treatment and has not yet entered settlement discussions with a WC carrier. The CMS Region IV stated that it relies primarily on its contractors, in this instance, FCSO to identify claims that appear to be WC related and to prevent or follow-up on the these claims prior to being paid.

As noted in the Findings section above, our survey indicated that this list of trauma codes was not adequate to detect a number of the diagnoses related to WC claims. Providers do not appear to demonstrate compliance with Medicare guidelines and it's policies and procedures regarding the completion and adequacy of MSP questionnaires.

With respect to training, without extensive training in both the medical and financial aspects of a long term injury, it will be extraordinarily difficult for CMS Region IV to ensure that it is adequately reviewing the settlements that do meet the review criteria.

Access to WC Data in Florida

The State is hesitant and/or unable to assist in identifying potential erroneous Medicare billings on behalf of WC beneficiaries. As discussed previously, the State WC program is designed to be "self-actuating," meaning that an injured worker does not need to contact a government agency when seeking treatment, or even when settling claims for lost wages and future medical expenses. There are minimal records maintained at the state level that could provide a resource for CMS to use in identifying WC-related claims. We obtained access to a listing of WC injuries/accidents occurring between July 1, 1999 and June 30, 2000. Officials with the State were hesitant to release the information and indicated that they were required under privacy regulations by the State to keep the data as secure as possible. Individuals from FCSO's MSP department stated that they also had encountered difficulty in obtaining data from the State on WC related claims. In particular, they mentioned that there had been previous attempts made by FCSO to perform data matches using State WC data until such point as the State terminated the sharing of the information.

Based on our discussions with the State, we believe they would be willing to be cooperative to the extent allowed by State statute. However, even if they willingly provided the data they have available, problems would remain. As discussed previously, not all future WC settlements will be reviewed by a judge, and therefore may not be noted on a central database. Absent a federal mandate that a statement regarding Medicare applicability be included in each settlement agreement, it is likely that CMS will remain unaware of numerous WC settlements that could result in overpayments from the Medicare program.

Our survey revealed that SSA must ultimately rely on beneficiaries to accurately self-report any WC settlements received. This reporting is hampered by the fact that a beneficiary may be involved in WC settlement negotiations at the same time they apply for Social Security Disability Income, and may not be able to accurately state the WC benefits they will ultimately receive. Additional findings from the SSA Inspector General's review are that the timeliness of the data available is suspect. *Therefore, although data sharing with SSA may provide a basis for a post payment screen of claims, it would not appear to provide a reliable source for learning of potential WC settlements in the State.*

Incentives to Shift Liabilities to Medicare

We believe there is an incentive on the part of other stakeholders in the State to burden the Medicare program with claims for which it should not be responsible. It is worthwhile noting that the interests of the injured worker, the WC carrier, the employer, and the State in the WC arena are either neutral to the interests of CMS at best or hostile to it at worst.

EFFECT

Open Claims

For the period July 1, 1999 through June 30, 2000, FCSO did not follow up on claims from WC beneficiaries that contained diagnosis codes outside of a pre-established range. Our survey indicated that the most frequently occurring 5 percent of these ICD-9 codes applied to $1,213,047.49 in claims that were not further reviewed by FCSO. *Since we did not perform any medical review to determine whether a specific WC claim was related to a particular Medicare claim, we were unable to identify a dollar amount of claims that were paid erroneously.* This limits our finding to identifying the potential amount of erroneous Medicare claims payment.

Settled Cases

We did not analyze the specific circumstances surrounding any particular settled case and are therefore unable to identify a dollar amount of claims that were paid erroneously. Our finding is based on our discussions with representatives of CMS, FCSO, the FDLES Division of Workers Compensation, and a Judge of Compensation Claims for the State.

RECOMMENDATIONS & CMS RESPONSE

Recommendation

We recommend that CMS Region IV continue to implement procedures within the RO for acquiring, tracking, evaluating, and responding to WC settlements. These procedures should include, but not be limited to:

- establishment of a specific point of contact for injured parties, their representatives, and WC carriers to reach in order to get questions answered regarding CMS' policies on WC claims;

- development of a standardized set of documentation and wording requirements for settlements that could lead to a faster turnaround time for reviews; and

- implementation of the new system of records being developed by CMS CO.

CMS Response

The RO has continued to implement procedures for acquiring, tracking, evaluating, and responding to WC settlements. The CMS has refined the process by assigning several individuals with primary responsibility for daily contact with beneficiaries, attorneys, and consultants to address questions and other concerns.

The CMS does not concur with the recommendation to develop a standardized set of documentation and wording requirements for settlements due to the variations in State WC laws. However, the CMS has developed a checklist of information that attorneys and consultants must include in their Workers Compensation Set-Aside Arrangement packages when submitting cases to the RO.

The CMS RO has access to the ECRS system and is utilizing it for tracking individuals who are not yet entitled to Medicare.

OIG Comment

We believe that all of the actions above should improve the RO's ability to monitor and respond to ongoing WC settlement actions and inquiries from Florida attorneys and WC beneficiaries.

Recommendation

We recommend that CMS Region IV provide training to RO staff, and direct FCSO to do the same, on the impact of financial assumptions and structures on WC settlement amounts, and required documentation to support the medical expenses claimed.

CMS Response

The CMS notes that CMS' CO conducted a WC training session on November 15, 2001 in order to provide the ROs with guidance on handling WC cases. Additional training is scheduled for January 2003.

OIG Comment

The OIG is aware of the training session that was held in November 2001, and noted many of the issues raised by various ROs during that session with respect to WC. We believe that the additional training scheduled for January 2003 should be able to address recent developments with respect to WC claims development.

Recommendation

We recommend that CMS Region IV establish a point of contact with a representative of the State's Division of WC, and persuade the individual of the need for CMS to have access to State WC records on a continual basis in order to match potential claims. Request that this contact person provide regular updates on what data is available from the State and how it may be obtained by CMS.

CMS Response

The CMS has initiated inquiries to all States to determine whether WC regulations permit CMS to access their WC claim databases to perform a data match with Medicare eligibility records. Specifically with respect to Florida, CMS is discussing a data match with the State WC Division. The CMS has encountered the same privacy issues that the OIG encountered while conducting this review.

OIG Comment

The OIG commends the CMS on taking this step in pursuing potential WC claims. The OIG has attempted to aid this process by providing contact names and telephone numbers for individuals at the State who may be useful to CMS. The OIG is willing to assist further in this endeavor at CMS's request.

Recommendation

We recommend that CMS Region IV consider the ICD-9 diagnosis codes that we identified in this survey as being associated with WC claims in the State, in any future edit that may be implemented by CMS. This should help minimize any attempt on the part of other stakeholders in the State WC system to burden the Medicare program with claims for which it should not be liable. See Appendix A of this report for a complete list of the ICD-9 codes identified.

CMS Response

The CMS agrees that the ICD-9 diagnosis code is vital in identifying WC claims that should be paid primary by State WC Divisions. In preparation of a WC data match with Florida, the coordination of benefits contractor is preparing to match all ICD-9s present on WC claims with CMS eligibility files to develop a Medicare beneficiary WC occurrence on the CWF record that contains diagnosis codes, to prevent future mistaken Medicare payments.

OIG Comment

The OIG has already responded to some CMS inquiries regarding the nature of the data obtained for purposes of this review, and we have provided the contact name and telephone numbers for individuals at the State who supplied the original data. The OIG is willing to assist further in this endeavor at CMS's request.

Additional CMS Response and OIG Comment

Although not specifically addressed among the recommendations in our draft report, we noted in the ***Settled Cases*** section above that the only federal mandate that one WC judge was aware of in the State involving WC settlements concerned child support. We did not intend to imply that the WC carrier does not have to consider Medicare in settlements. However, we note that CMS agrees that it would be advantageous for Medicare reimbursement to be federally mandated, and will pursue such a mandate in the future. We agree that, as a long-term solution, such a mandate would aid greatly in preventing Medicare's interests from being inadvertently overlooked in future WC settlement negotiations.

APPENDICES

APPENDIX A

Diag Code	Diagnosis Description	Total Paid Medicare Claims for this WC Population	Number of Times Diag Appeared among Medicare Paid Claims for this WC Population
847.20	Sprain and strain in the lumbar region	$4,411.45	102
724.20	Low back pain	$32,854.86	381
719.41	Joint pain, shoulder region	$0.00	0
722.10	Lumbar intervertebral disc without myelopathy	$7,171.30	48
724.40	Thoracic or lumbosacral neuritis or radiculitis	$38,909.46	146
354.00	Carpal tunnel syndrome	$13,590.84	107
846.00	Sprains and strains of lumbosacral (joint) (ligament)	$3,181.25	38
719.46	Joint pain, lower leg	$12,468.57	193
840.40	Sprain and strain of rotator cuff	$8,899.08	41
836.00	Tear of medial cartilage or meniscus of knee	$5,726.96	35
822.00	Fracture of the patella, closed	$975.10	14
723.10	Cervicalgia, pain in neck	$13,360.66	165
724.02	Spinal stenosis, other than cervical, lumbar region	$185,956.62	96
813.42	Fracture of radius and ulna, other fractures of distal end of radius	$1,729.70	14
840.90	Sprain and strain of shoulder and upper arm	$867.34	14
724.50	Backache, unspecified	$4,904.36	87
726.10	Disorders of bursae and tendons in the shoulder region	$6,034.28	106
820.21	Fracture lower limb,closed pertrochanteric fracture,intertrochanteric section	$144,665.36	98
959.80	Multiple injuries in specified sites	$8,730.80	19
844.90	Sprain and strains in unspecified site of knee and leg	$1,023.20	18
820.80	Fracture of lower limb, unspecified part of neck of femur, closed	$240,381.05	130
722.52	Degeneration of lumbar or lumbosacral intervertebral disc	$5,109.91	50
727.61	Complete rupture of rotator cuff	$2,249.38	3
722.83	Intervertebral disc disorders, postlaminectomy syndrome, lumbar region	$2,425.21	24
845.00	Sprains and strains of ankle and foot	$2,429.82	27
719.45	Joint pain, pelvic region and thigh	$5,935.86	67
719.47	Joint pain, ankle and foot	$3,263.42	35
924.11	Contusion of the knee	$990.60	15
959.10	Unspecified trunk injury	$7,926.34	90
813.41	Colles' fracture of radius and ulna	$49,418.16	41
550.90	Inguinal hernia	$3,359.07	33
726.20	Affections of the shoulder region, not elsewhere classified	$4,939.73	21
923.00	Contusion of the upper limb	$574.80	8
715.16	Osteoarhrosis, localized, primary in the lower leg	$11,184.46	68
924.01	Contusion of the hip	$230.56	6
722.00	Displacement of lumbar intervertebral disc without myelopathy	$17,374.42	16
825.25	Fracture of the metatarsal bone	$1,555.30	15
959.90	Injury of unspecified site	$154.72	3
842.00	Sprain and strain of the wrist	$2,149.09	18
729.50	Pain in limb	$9,897.44	142
727.03	Disorder of synovium, tendon, and bursa in the trigger finger	$869.81	14
786.50	Chest pain	$242,054.21	667
722.20	Displacement of intervertebral disc, site unspecified without myelopathy	$1,594.33	15
843.90	Sprain and strain in unspecified site of hip and thigh	$50.46	1
726.32	Lateral epicondylitis of the elbow region "golfers' elbow" or "tennis elbow"	$1,133.70	11
959.70	Injury of the knee, leg, ankle and foot	$1,266.51	19
717.70	Internal derangement of knee, chondromalacia of patella	$1,539.21	11
812.00	Upper end, closed, fracture of scapula	$85,586.60	23
724.30	Nueralgia or neuritis of sciatic nerve, back disorder	$5,447.31	84
723.40	other disorders of cervical region, brachial neuritis or radiculitis	$6,056.04	46
824.80	Unspecified closed fracture of ankle	$0.00	0
808.80	Unspecified closed fracture of the pelvis	$294.36	7
924.20	Contusion of foot	$144.42	4
	Total	$1,213,047.49	

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Centers for Medicare & Medicaid Services
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

RECEIVED
DEC 2 3 2002
Office of Audit Svcs.

Date: December 23, 2002

From: Rose Crum-Johnson
Region IV Administrator

Subject: Survey of Duplicate Coverage
Medicare / Workers' Compensation (CIN A-04-01-07003)

To: Regional Inspector General
for Audit Services, Region IV

Attached is CMS' response to the OIG survey of Medicare payments to Workers' Compensation recipients in the State of Florida. This response incorporates comments from the MSP staff in the Central and Regional Offices. Thank you for giving us the opportunity to make comments regarding this report.

If you have questions, please contact Jimmy G. Brown at 404-562-7303 or Juanita Dixon at 404-562-7313.

Patricia A. Harris for
Rose Crum-Johnson

Attachment

FINDINGS AND RECOMMENDATIONS

Finding: Our survey indicated that there is a high vulnerability of the Medicare program to erroneous payments being made to WC beneficiaries in the State of Florida.

With respect to open WC claims, the "trauma codes" relied upon by FCSO, the primary Medicare contractor for the State, failed to list many of the codes for which WC claims have been filed. In addition, providers failed to adequately complete the required paperwork necessary to determine if other insurance, namely, WC applied for specific claims.

With respect to settled WC claims, Medicare is potentially paying for services that should be paid from the WC settlement proceeds.

CMS Comment:

CMS agrees with the Office of Inspector General (OIG) finding that the Medicare Program is vulnerable to making mistaken payments to Workers' Compensation (WC) claimants in the State of Florida. Since this vulnerability is not unique to the State of Florida, CMS is actively pursuing methods, discussed in these comments, to reduce associated risk.

The OIG survey occurred while the Florida Medicare contractor, First Coast Service Options (FCSO), was responsible for establishing a WC occurrence on the Medicare beneficiary's Common Working File (CWF) record that is used to verify and validate beneficiary information during claims adjudication. On January 8, 2001, CMS implemented Phase III (MSP Claims Investigations) of a contract with Group Health, Inc., our Coordination of Benefits Contractor (COBC), to nationalize the coordination of health benefits in an effort to provide increased efficiency and effectiveness, while ensuring benefit payments are made by the appropriate payer. This includes coordinating Medicare and other health benefit payments such as WC. Below are some of the means COBC employs to establish or update Medicare beneficiary CWF records to reflect WC information:

- Beneficiary reporting on the Initial Enrollment Questionnaire;
- Beneficiary or attorney inquiries directed to the COBC;
- Notification of WC settlements through CMS Regional Offices;

- COBC receipt of development requests from Medicare contractors as a result of claims processing or inquiries; and
- Data matches between State WC Divisions and CMS (recently initiated).

While the contractor responsible for establishing a beneficiary WC record on the CWF has changed since the OIG survey, many of the methods used, and problems encountered in obtaining WC data remain for CMS and our partner, the COBC.

Our comments on the following findings and recommendations address the action CMS is taking to obtain valid WC data from Florida, as well as all other States.

Prior to nationalizing the coordination of benefits processes, CMS identified, for Medicare contractors, certain ICD-9 codes that may indicate possible accident or traumatic injuries. Claims containing these "trauma codes" led to further FCSO development as to the existence of another payer that may have primary responsibility for medical claims related to the accident or injury. CMS agrees the list could be expanded; however, both resources and outcomes restrict the number of potential trauma codes that can lead to further development. COBC's Phase III experience revealed that routine development at the national level produced a low response to questionnaires generated from trauma code alerts: only five (5) percent of the responses were positive (acknowledging a WC occurrence that may be the responsibility of another primary payer). The process proved to be less cost efficient than the current methods of identifying WC situations listed above and, therefore, was suspended.

Providers are required to file correct and accurate claims with Medicare. All providers that bill Medicare for services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services. CMS provides a list of suggested questions designed to help providers identify primary payers, including WC carriers among others. Medicare intermediaries are annually funded to perform a limited number of hospital provider audits to identify noncompliance with such CMS requirements and to implement corrective action plans, as necessary. While audit funds are limited, CMS does sponsor Provider Open Door Forums, a platform to share CMS and provider concerns, such as noncompliance of the requirement to file complete and accurate claims. In addition, the COBC participates in outreach presentations to educate providers about coordination of benefits, including the necessity to obtain information from beneficiaries that identifies primary payers.

We want to note that open claims will be affected by 42 CFR 411.45 which allows Medicare to make conditional payments in workers' compensation cases where prompt payments are not being made.

Finding: *MSP Questionnaires* - This survey was not designed to identify the extent or dollar impact of providers' compliance with CMS' MSP questionnaire requirements as they existed during the period reviewed. However, we note that in two recent reviews, the OIG has identified weaknesses in providers' completion of the required information. In a recent report on the effectiveness of this identification method, the OIG concluded that 284 out of 444 questionnaires, or 64 percent, at one provider were either missing or failed to record essential information in identifying the primary payers.

CMS Comment: As stated earlier, providers are required to file correct and accurate claims with Medicare. All providers that bill Medicare for services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services. CMS provides a list of suggested questions designed to help providers identify primary payers, including WC carriers among others. Medicare intermediaries are annually funded to perform a limited number of hospital provider audits to identify noncompliance with such CMS requirements and to implement corrective action plans, as necessary. While audit funds are limited, CMS does sponsor Provider Open Door Forums, a platform to share CMS and provider concerns, such as noncompliance of the requirement to file complete and accurate claims. In addition, the COBC participates in outreach presentations to educate providers about coordination of benefits, including the necessity to obtain information from beneficiaries that identifies primary payers.

Finding: The Medicare program has a strong interest in settlements of WC cases, and the responsibilities inherent in protecting those interests are numerous. For example, determinations must be made regarding:

1. Whether or not it is cost-effective for Medicare to be involved in a particular settlement case,

2. Whether the assumptions of the parties involved in the settlement regarding future medical treatment and degree of disability are reasonable,

3. Whether the costs associated with those medical treatments or disabilities are reasonably accounted for, financially sufficient, and properly discounted for the time over which the injury is expected to last,

4. Whether prior medical expenses related to the injury that has been paid by Medicare have been acknowledged in the settlement.

CMS Comment: CMS understands that additional training is needed by staff in order to determine what is or is not cost-effective for Medicare to pursue. To compensate for the lack of medical knowledge of the MSP staff, the RO is using its medical review staff to assist with the review of complex medical cases. CMS has scheduled training for its staff in January 2003 to deal with questions and procedures relating to on-going WC issues.

The RO instructs the beneficiary/attorney and the WC carrier to contact the local Medicare contractor and determine the amount of the Medicare conditional payment before finalizing the settlement. The RO provides the Medicare contractor with a copy of the entire file for its development purposes. The contractor's file remains open until the amount Medicare paid is determined and the debt satisfied.

Finding: Our discussions with CMS Region IV have disclosed that procedures vary widely between regions with respect to the issues listed above. The CMS' Central Office is in the process of developing some uniform procedures to assist in answering some of the questions. For example, with respect to items 1 and 2 above, while it would clearly not be cost-effective for Medicare to be involved in every settlement, a preliminary determination has been made regarding which cases should warrant further review by CMS. The current thresholds for review are set as: (1) all cases in which Medicare is requested to compromise any pre-settlement or post-settlement recovery amounts, and (2) all cases involving individuals currently eligible for Medicare, or "reasonably expected" to be eligible within 30 months, with a total settlement amount for future medical expenses and lost wages is at least $250,000.

CMS Response: The issuance of the July 23, 2001 memo has provided uniformity to the WC process. As noted earlier, CMS plans to further train its staff in January 2003 to ensure that all regions are utilizing the same procedures to process WC cases and respond to on-going questions. The correct current thresholds for CMS review of WC settlements were outlined in an All Associate Regional

Administrators (ARA) memorandum issued to the CMS Regional Offices on July 23, 2001. These thresholds are 1.) all cases involving injured individuals who are already Medicare beneficiaries must be reviewed by the Regional Offices (RO) regardless of settlement amount; and 2.) all cases that involve injured individuals (who are not yet Medicare beneficiaries) should be reviewed by the ROs when the injured individual 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/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000. Contractors refer all compromise requests to the RO for appropriate action. Note that the Associate Regional Administrators memorandum is available on the CMS website at http://cms.hhs.gov/medicare/cob/pdf/wcfubene.pdf.

Finding: With recent amendments to the State's WC statutes, an injured worker who obtains representation may enter into a binding agreement with a WC carrier for settlement of any and all claims, *and the agreement is not required to undergo further review.* There is no requirement for a judge to sign off on the sufficiency of the agreement. Furthermore, there is no requirement in the State's statutes that a statement concerning the applicability or non-applicability of Medicare be included in a settlement.

According to a WC judge, the only federally mandated element in settlement agreements within the State that she was aware of is a statement regarding whether the individual owes child support. Thus, without enforcement of any federally mandated notice, and in the absence of any state requirement, it is likely that CMS Region IV will not be aware of all cases within the State that meet the criteria for review.

CMS Comment: CMS believes that this implies that the WC carrier does not have to consider Medicare's interest and can dismiss the Medicare claim. CMS believes that the Medicare claim cannot be dismissed, and that the WC carrier, attorneys/beneficiaries must comply with the Federal law.

In order to protect Medicare interest in WC cases, CMS agrees that it would be advantageous for Medicare reimbursement to be federally mandated. CMS will pursue this in the future. The RO has experienced an increase in the number of attorneys and consultants requesting information related to the Workers Compensation Set-Aside Arrangement (WCSAA) requirements. This increased awareness is due in part to workshops sponsored by specific attorneys and

consultants to ensure that attorneys and WC carriers are educated about Medicare and the regulations governing the WCSAA. From July 1, 1999 to the present, the RO has received a substantial increase in the number of WC cases related to beneficiaries in the State of Florida.

Finding: Items 2, 3, and 4 above require sophisticated analysis of the medical conditions involved in the injury as well as the financial structure of the settlement agreement. The CMS Region IV and its contractors currently rely on individuals who have not been adequately trained for this function. Furthermore, when questioned about the specifics involved in determining whether a particular settlement agreement was sufficient, CMS Region IV and FCSO officials were unable to reference exact guidelines, procedures, or financial calculations. These individuals indicated that they attempted to do the best they could and return an opinion to the requesting party in as tight a timeframe as possible.

Comments: Before the issuance of the July 23, 2001 Memo, the RO processed WC cases based on a **draft document (similar to the 07/23/2001)** issued by CO to all ROs. Upon receipt of the July 23, 2001 Memo, the RO immediately started applying these procedures. Subsequent to the July memo, the RO received several questions and answers related to the processing of the WCSAA. From the July 23, 2001 memo, the RO developed a list of information that is required to process the WCSAA. This list is sent to attorneys and consultants who have requested information on what CMS needs to process the WCSAA cases. The medical review staff reviews the cases with complex medical issues. We anticipate expanding the medical review of WCSAA cases in the future. The RO has implemented a financial calculation process that aids in computing the WCSAA amounts.

OIG Recommendation:

We recommend that CMS Region IV:

- continue to implement procedures within the Regional Office for acquiring, tracking, evaluating, and responding to WC settlements. These procedures should include, but not be limited to:

    - establishment of a specific point of contact for injured parties, their representatives, and WC carriers to reach in order to get questions answered regarding CMS' policies on WC claims;

CMS Comment: The RO has continued to implement procedures for acquiring, tracking, evaluating, and responding to WC settlements. We have refined the process by assigning several individuals with primary responsibility for daily contact with beneficiaries, attorneys, and consultants to address questions and other concerns. A Criteria Worksheet (based on information taken from the 07/23/01 Memo) is being used to assist the reviewers in pinpointing specific items necessary for evaluating and approving the WCSAA. All incoming cases are tracked in an Access Data Base and are filed and worked based on the date of receipt. In addition, we are using a checklist for information that attorneys and consultants must include in their WCSAA packages when submitting cases to the RO. The package also includes copies of the current policy memos, questions and answers, WC information found in the Code of Federal Regulations, the Social Security citation, CMS web-site address, and the web-site information. The RO has developed a set of standardized letters (templates) that assists the review specialists in processing the WCSAA cases timely. Specialists only need to insert the specific information related to their respective cases into the templates. This saves valuable time and allows the specialists to process cases more efficiently.

OIG Recommendation:

- development of a standardized set of documentation and wording requirements for settlements that could lead to a faster turnaround time for reviews; and

CMS Comment:

CMS believes that it would be very difficult to have a development of standardized set of documentation and wording requirements for settlements. We would need to develop a set of standardized documents for each of the 50 states, since Workers Compensation is State specific.

OIG Recommendation:

- implementation of the new system of records being developed by CMS Central Office.

CMS Comment:

The RO has access to the Electronic Correspondence Referra System (ECRS) and upon approval of a WCSAA, the case is entered into the ECRS (with all the required information necessary for tracking individuals who are not yet entitled to Medicare).

OIG Recommendation:

- provide training to Regional Office staff, and direct FCSO to do the same, on the impact of financial assumptions and structures on WC settlement amounts, and required documentation to support the medical expenses claimed.

CMS Comment:

CMS would like to note that the ARA memorandum issued on July 23, 2001 addressed several of the OIG's concerns. The ARA memorandum provided clarification on how the ROs should evaluate and approve WC settlements to help ensure that Medicare's interests are properly considered and to assist the ROs in "turning around" cases. Moreover, the ARA letter directs the ROs to seek input from RO medical consultants (who are on staff at the RO) when determining whether the amount of the lump sum or structured settlement has adequately taken Medicare' s interests into account. Additionally, CMS' Central Office conducted a WC training session for the ROs on November 15, 2001 in order to provide the RO's with additional guidance with respect to handling WC cases. The ROs will receive additional training in January 2003. This RO plans to share applicable information gained from this training with its Medicare contractors.

OIG Recommendation:

- Establish a point of contact with a representative of the State's Division of WC, and persuade the individual of the need for CMS to have access to State WC records on a continual basis in order to match potential claims. Request that this contact person provides regular updates on what data is available from the State and how it may be obtained by CMS.

CMS Comment: CMS has initiated inquiries to all States to determine whether WC regulations permit CMS to access their WC claim databases to perform a data match with Medicare eligibility records. State responses vary regarding privacy issues and the content and location of the WC data they maintain. CMS is currently responding to States that require more information on our authority to

access state WC data and how the matching process would be implemented. CMS has recently entered a pilot data match with one State by accessing its public records. CMS is awaiting analysis of the value of the pilot to the Medicare program; it is our assessment that WC data matches will prove to be the most effective and efficient method to prevent mistaken Medicare primary payment.

Specifically to Florida, CMS is discussing a data match with the State WC Division. We have encountered the same issue that the OIG found in Florida regarding privacy of the State WC data. However, we have found the State open to discussion and review of its privacy laws. CMS plans to move forward to find solutions to satisfy the State's need to protect individually identifiable data and the Medicare Program's need to pay Medicare claims properly.

OIG Recommendation:

- Consider the ICD-9 diagnosis codes that we identified in this survey as being associated with WC claims in the State, in developing any future edits that may be implemented by CMS. This should help minimize any attempt on the part of other stakeholders in the State WC system to burden the Medicare program with claims for which it should not be liable.

CMS Comment: We agree that the ICD-9 code is vital in identifying WC claims that should be paid primary by State WC Divisions. While the State of Florida may use the ICD-9 code as part of its claim data, other States use body parts, nature of injury, etc. In preparation of a WC data match with Florida, the COBC is preparing to match all ICD-9s present on WC claims with CMS eligibility files to develop a Medicare beneficiary WC occurrence on the CWF record that contains diagnosis codes, to prevent future mistaken Medicare payments. For other State WC data matches, the COBC is developing a crosswalk from body part/nature of injury to an ICD-9 code.

ACKNOWLEDGMENTS

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