Verisk™

Medicare Set-Asides and Future Medical Allocation Offerings

An advocacy-driven approach to Medicare Secondary Payer compliance

Comply with Medicare requirements and resolve settlements with confidence

A critical step of Medicare Secondary Payer (MSP) compliance is to evaluate Medicare's exposure as a secondary payer and ensure medical costs are not inappropriately shifted to Medicare after a workers' compensation claim is settled. An accurate and defensible Medicare Set-Aside (MSA) or other future medical allocation can help evidence consideration for Medicare's interests, protect the Medicare trust fund, and provide injured workers with funds for needed future medical treatment.

As MSP requirements evolve, they have become increasingly complex and technical. For example, CMS now plans to collect MSA data as part of Total Payment Obligation to Claimant (TPOC) reporting, which will provide CMS with significantly more visibility and insight into how the industry is using MSA funds and overall compliance.

As the largest provider of MSP services with a developed and integrated data ecosystem, Verisk offers unparalleled expertise, data-driven insights, and flexibility to assist with developing and delivering your MSA compliance program, providing:

- Integration across MSA, Conditional Payment, and Section 111 compliance
- Deep knowledge of medical and legal aspects of injury claims
- A convenient online referral process with quick turnaround
- Monthly management reports
- Client newsletters, webinars, and training
- World-class data security and electronic storage service

With MSAs, experience matters

With help from Verisk, insurers have met every change and challenge related to MSAs for nearly two decades—providing peace of mind about compliance obligations. With the nation's largest legal and medical team dedicated exclusively to MSP compliance, we can quickly and accurately analyze whether a case settlement is feasible. We'll also identify any issues you can address beforehand to help reduce the MSA amount.

Pre-MSA

Evaluate and plan before the settlement process even begins.

To improve your chances of reaching a satisfactory settlement, you need an early, accurate MSA estimate. Unexpected MSA amounts can disrupt or derail settlements, causing insurers to stray from their primary goal of closing claims quickly and efficiently. Those disruptions cost extra time, resources, and money. And with CMS demanding ever-larger allocations for future medical costs, evaluating settlement potential has become increasingly difficult.

Verisk's fast and easy Pre-MSA tool provides a unique and cost effective "snapshot" of the likely MSA amount and potential MSA cost drivers. This allows for early intervention before the full MSA spend.

Our Pre-MSA tool offers:

- More accurate estimates to factor into reserving and settlement decisions
- Valuable analysis and a precise forecast of potential MSA exposure
- Increased accuracy based on claim-specific factors, treatment behaviors, and prescription drug requirements
- Identification of files ready for settlement versus those needing additional intervention

This approach ensures you'll settle claims at present-day value, paying only what's necessary—nothing more.

Medicare Set-Aside

Align with Medicare pricing policies and avoid cost-shifting of medical services to Medicare post-settlement.

At Verisk, our goal is to provide the lowest defensible MSA amount that CMS will approve. This helps parties evaluate potential future Medicare-covered treatment needs and protects against Medicare denying benefits post-settlement. We understand that every claim is unique, which is why we take an advocacy-driven approach. This focuses on accurately identifying both legal and medical arguments to keep the MSA allocation as low as possible.

As your partner, we also proactively identify and eliminate cost drivers in all our MSAs to mitigate costs and streamline CMS submission and approval. We closely review all CMS decisions for accuracy, monitor industry trends, and look for opportunities to challenge CMS adjustments.

Our MSA service includes:

- Medicare Set-Aside allocation report
- Medical/legal review
- Rated age
- Legal analysis letter
- Medicare status check
- Settlement language review and evaluation

Under-Threshold MSA

Navigating the new TPOC/WCMSA data requirements for Section 111 reporting

WCMSA/TPOC data is now mandatory for Section 111 reporting, regardless of whether a workers' compensation settlement meets the MSA review thresholds. This update gives CMS visibility into whether an MSA should have been included as part of your workers' compensation settlement.

Verisk offers a solution to help clients navigate this change.
Our Under-Threshold MSA is designed to:

- Comply with CMS's reporting requirements
- Provide accurate, lower cost allocation intended for low-dollar settlements not meeting the current CMS WCMSA review thresholds
- Evaluate the last 6 months of available treating records to allocate a medical summary report
- Use Evidence-based Medicine for analysis

Settle with confidence by having a reasonable, defensible and accurate allocation for those smaller settlements which CMS will not review.

Evidence-Based MSA

An alternative to help settle claims when submitting an MSA isn't the best option.

When CMS submission and approval is not an option, parties can still consider and protect Medicare's interest through an Evidence-Based MSA (EBMSA).

This approach calculates the claimants' future medical treatment needs using a combination of:

- Evidence-based medicine principles
- Medical treatment guidelines and standards
- Judicial rulings
- Physician recommendations
- The injured worker's treatment utilization over the two most recent treatment years

EBMSAs can be a valuable settlement tool in situations where:

- The claim does not meet CMS review thresholds
- The claim meets CMS thresholds, but the parties want to leverage evidence-based medicine guidelines/reasoning while still submitting to CMS for review and approval
- The claim meets the CMS review threshold, but the parties accept the potential risk of settling without CMS submission and approval
- The claim arises in a state (such as Maryland) where workers' compensation settlements must consider Medicare's interest
- Zero-dollar MSAs for claims settling after July 17, 2025

Potential post-settlement protections for qualifying EBMSAs

- Indemnification for both the carrier and the claimant if CMS determines there is an error leading to a denial of payment for Medicare-covered injury related treatment
- Provides additional peace of mind to the parties
- Aligns Section 111 reporting WCMSA and TPOC reporting data
- May be combined with Professional Administration for additional protections
- Requires certain coordination with the WC settlement process to trigger protections

Strategic MSA

Break away from CMS's unpredictable MSA pricing methods.

Verisk's Strategic MSA is an effective tool to evaluate risk and avoid ceding the initiative to Medicare in the WCMSA approval process. Through a strategic approach, Verisk will work with you to develop arguments to present a WCMSA value that aligns more closely with the injured workers' actual treatment status and recommendations. We'll also provide the potential and likely WCMSA value that CMS would approve based on their current pricing guidelines and trends.

By presenting a lower, more reasonable WCMSA value supported by medical and legal evidence, the approved amount may still facilitate settlement, even if CMS counters. Additionally, by including all applicable arguments in the initial submission, our Strategic MSA approach provides opportunities to dispute CMS's WCMSA practices through re-review.

MSA Link

With CMS's new MSA TPOC reporting requirement, it is more important than ever that an MSA is completed on all applicable claims based on your specific protocols.

Verisk's MSA Link does just this by leveraging Section 111 data to monitor claims and initiate appropriate MSA services when needed. Protocols and data rules are established, and adjusters are informed each step of the way. MSA Link simply provides data-driven risk monitoring to streamline the process and mitigate risk.

MSA Link is the only end-to-end, automatic, and programmatic solution for allocations providing:

- Integration and alignment of Section 111 reporting, your specific protocols, and future medical allocations
- Automated initiation of allocations services to ensure every claim gets the right allocation at the right time
- A streamlined approach that ensures compliance while reducing adjuster time

Additional benefits:

- Utilizes Section 111 data to establish protocols and automatically initiate allocation services for injured parties meeting specific criteria
- Complete allocation type directed by client
- Identify primary cost drivers
- Obtain a rated age
- Provide templates and assistance to mitigate cost drivers
- Provide medical and legal review
- Legal opinion
- Consultation with dedicated legal and medical staff

Medical Cost Projection (MCP)

Proactively determine potential future medical costs associated with a claim.

An MCP is helpful when you want to understand the medical exposure on a claim, regardless of Medicare compliance requirements. Our experienced team of registered nurses with extensive Medicare and Life Care Planning expertise carefully reviews medical, pharmacy, legal, and claims information to provide an accurate assessment of a claim's valuation.

An MCP can be a critical tool for:

- Setting up reserves
- Negotiating a settlement when you need to know lifetime medical costs
- Comparing different scenarios, such as medical costs with and without surgery
- Determining whether an MSA will be appropriate

By proactively assessing the potential future medical costs associated with a claim, an MCP gives you valuable insight to support your decision-making.

MSA Comparison Chart

	1 Pre-MSA	2 Medicare Set-Aside (MSA)	3 Evidence Based Medicare-Set Aside (EBMSA)	4 Strategic MSA	5 Medical Cost Projection (MCP)	6 Data-Driven MSA
	Improve settlement outcomes proactively	An advocacy-driven approach to compliance	Fast, economical medical allocation	Challenge CMS standard review practices	Determine future medical costs of a claim	A quick and accurate data-driven MSA for low-dollar settlements
	Determine the settlement potential of your claim with an early, accurate Pre-MSA estimate	Analyze and design an MSA with both medical and legal analysis to identify and mitigate costs and issues	Get a reasonable, defensible option that applies evidence-based medicine principles to consider medical treatment	Case-specific challenge of CMS' formulaic review in favor of treatment more aligned with the case fact pattern	Understand the medical exposure on any claim when a formal life care plan is more than you need	Comply with Medicare's WCMSA TPOC reporting requirements on low-dollar settle-ments with a quick cost-effective solution
Analysis	Snapshot of potential exposure	Full analysis of Medicare exposure, cost driver, and cost mitigation	Calculation of reasonable Medicare exposure using evidence-based medicine principles	Full analysis of Medicare exposure, using case-specific, evidenced-based principles and state law	Analysis of future lifetime spend based on fee schedule and current claim payment behavior	Automated allocation using claims data
Review	Review of six months of records	Review of two years of records	Review of two years of records	Review of two years of records	Review of two years of records	Section 111 data elements + automated review of records
Advantage	Quick and inexpensive service. Credited towards full MSA.	Facilitate a full, final, and compliant settlement	Consider Medicare's interest when a formal MSA and/or CMS submission is not warranted or sought. Available to apply certain post-settlement protections	The most reasonably aggressive MSA for CMS submittal with analysis of potential cost exposure	Use as a reserving or settlement analysis tool	Accurate, quick, and low-cost automated MSA for claims where a traditional MSA is cost prohibitive
Results	Provides an option for early prescription drug intervention	Provides an option for either legal or medical zero-allocation when warranted	Provides defensible figures, reasonable medical consideration, and streamlined settlement	Provides MSA approval letters which consistently fall below the formulaic MSA approach	Provides valuable insight into cost to settle versus cost to keep claim open	Provides an accurate cost- effective MSA figure for CMS' WCMSA TPOC reporting require-ments on low-dollar settlements

Supplementary MSA Solutions

Data-Driven MSA

With CMS's increased visibility on a micro and macro level regarding MSA use and spend, it is more important than ever for insurers to determine if an MSA is right for each claim.

The challenge has historically been that a fully automated approach to an accurate MSA, one that leveraged claim and medical data, was not available. Additionally, the cost of obtaining an MSA on low-dollar settlements has been cost prohibitive. Verisk's Data-Driven MSA is the ideal solution to address both challenges, and is a fully automated MSA, with no human intervention. However, Data-Driven MSA leverages Verisk's unparalleled medical, legal, and data science expertise to provide an accurate allocation based on the factors of the claim. This automation allows for a quick, low-cost allocation that can be used to ensure compliance on all Medicare involved settlements. By using claims data to automate an allocation, Verisk's Data-Driven MSA:

- Ensures consistent process and protocol adherence
- Provides rapid turn-around time
- Supplies a cost-effective solution to a current industry challenge
- Fuels compliance with the new MSA TPOC reporting requirements

Additional benefits:

- Extract key claim and medical data from claim records
- Automate allocation of future medical expenses using extracted claim data
- Provide one-page MSA including summary and future allocation totals

CMS Submission

CMS submission and approval is the best way to provide certainty and peace of mind that the MSA amount is appropriate.

We review and coordinate MSA submittals on your team's behalf, saving your organization time and money on processing. If the CMS decision involves a medical misinterpretation, mathematical miscalculation, or other mistake, we work directly with CMS to correct it.

Our client advocacy services include:

- Medical review before submission to identify any treatment changes
- Recommendations on required documentation
- Obtaining signed CMS release forms
- Preparing the complete submission package, as well as submission, tracking, and follow-up
- Reviewing and assisting with development and/or closing letters
- Submitting rebuttals for erroneous decisions

Medical/Legal Zero Allocation

Leverage all opportunities to argue and support scenarios where no settlement funds should be set aside.

CMS acknowledges certain scenarios where a "zero MSA" is appropriate based on the medical and/or legal facts of the case. Our team of highly experienced legal experts prepares case-specific arguments and stands ready to defend them before CMS.

We collaborate directly with adjusters and defense counsel to provide guidance on answering these key questions:

- Why should you allocate money for future medical treatment when you're not the primary payer?
- Why increase the cost of a settlement when you're dealing with a denied or disputed claim?
- Why abandon state law defenses just because the case involves Medicare?

By leveraging all opportunities to argue and support these zero allocation scenarios, we can help ensure a fair and equitable resolution for every claim.

Amended Review/MSA Second Look

Don't let an old CMS approval get in the way of settling your claim.

Our consultative approach to MSA Second Look helps maximize the one chance you have at obtaining an Amended Review approval from CMS—and gain savings for eligible claims. Our robust process tracks changes in CMS pricing and medications. We carefully compare the prior MSA approval against the current changes in the claimant's treatment. This allows us to deliver significant reductions and identify further cost mitigation opportunities before submitting for the Amended Review.

Common triggers for Amended Review include:

- MSAs with surgeries or treatments already provided to the claimant
- Claims with recommendations for spinal cord stimulators, intrathecal pumps, or costly durable medical equipment
- Claims in which the cost to adjust the file has significantly decreased

A file will qualify for Amended Review if all the following criteria are met:

- CMS permits a one-time request for Amended Review
- CMS has issued a conditional approval/approved amount at least 12 months prior
- The case has not yet settled as of the request for re-review
- The current treatment has changed by at least 10% or $10,000 (whichever is greater) compared to CMS's previously approved amount

By closely tracking changes and leveraging the Amended Review process, we can help you achieve significant savings on eligible claims.

Professional Administration

CMS highly recommends professional administration.

Verisk has partnered with Ametros to offer best-in-class professional administration services. This allows claimants to easily manage their future medical funds and provides them with practical resources to maximize care dollars.

Leverage professional administration to control MSA spend and to navigate reporting requirements post-settlement:

- Ensures MSA payments are made for claim related and Medicare covered treatment
- Uses network pricing and discounts to maximize every dollar in the MSA
- Assists with tracking MSA spend and filing MSA attestations

Liability and Legal Nurse Review Services

Thorough and clinically objective evaluations needed to ensure fair and final case resolutions.

A comprehensive medical analysis can be critical for any case involving medical liability—from expert record opinions to appropriateness of care, billing reductions to settlement preparation. For these situations, we offer the following solutions:

Liability Nurse Review (LNR): This report provides objective analysis and expert opinion on the necessity of the treatment and recommendations, supported by literature. LNR offers two options:

- Standard program: Full review of all records, including bill review (if requested)
- Snapshot program: Perfect for answering a specific case question

Rated Age Service: A comprehensive review of the medical records to identify a claimant's co-morbid conditions and calculate their adjusted life expectancy. This can reduce the frequency of future treatment factored into an MSA.

This deep clinical expertise and analysis can be critical for ensuring fair and final case resolutions.

Provider Outreach Services

We can help navigate communication with the providers to mitigate MSA costs.

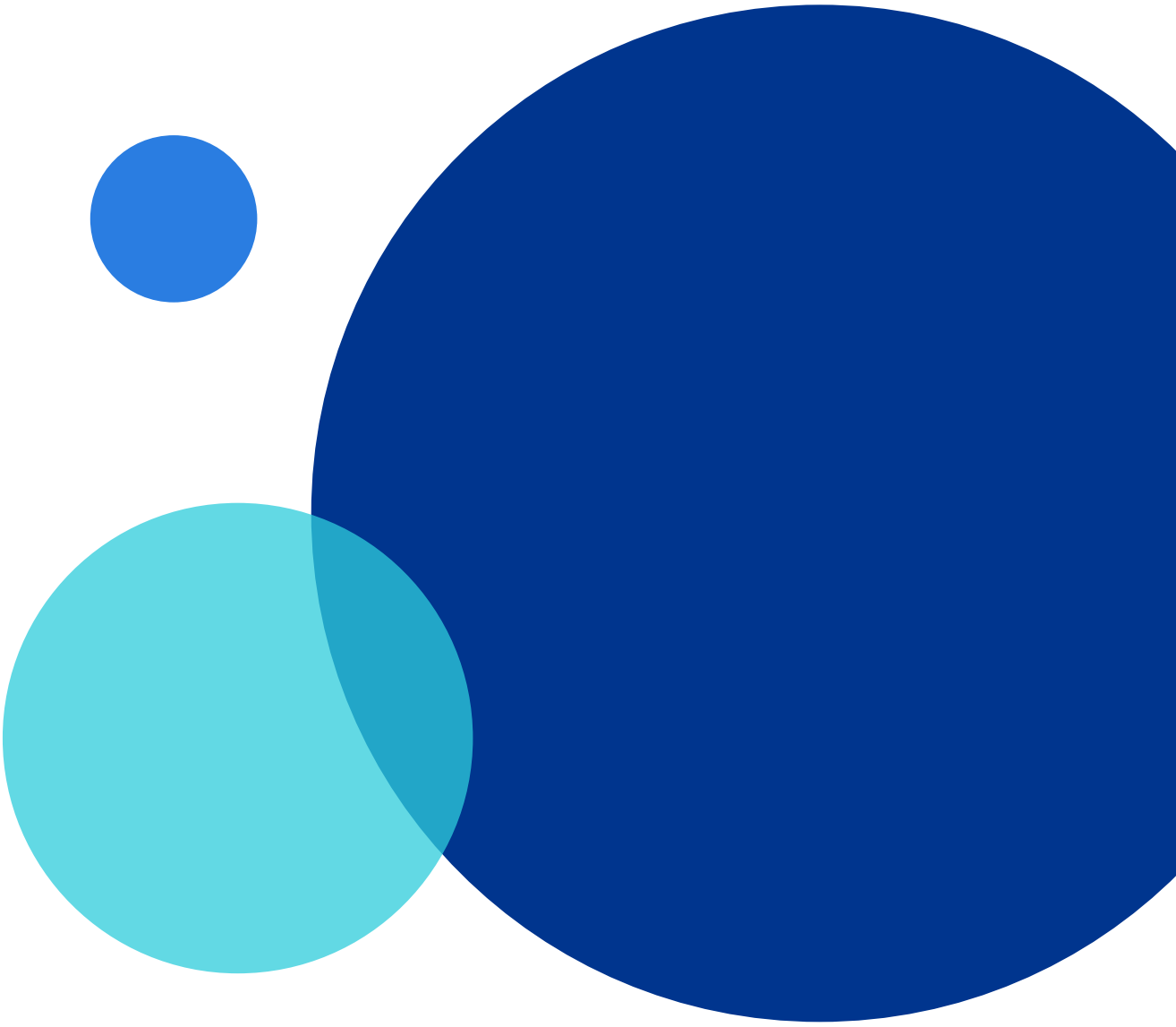
Verisk can enhance your cost mitigation efforts by handling crucial, time-consuming tasks on your behalf through direct provider engagement. We offer two services as part of our Provider Outreach program:

Cost Mitigation: Identifying Cost Mitigation opportunities is the first step, but CMS requires proper documentation from the treating physician to accurately reduce treatment in an MSA. This documentation must outline the recommendations and the medical basis to support changes in anticipated future medical treatment.

As part of our outreach services, we contact the claimant's treating providers to obtain necessary information or clarification regarding the claimant's treatment, recommended/referenced treatment options, and other information which may be helpful in providing a more accurate assessment of the current treatment plan and identify opportunities to reduce MSA cost drivers.

Record Acquisition: Let us ensure that your cost mitigation plans stay on track. We'll contact the claimant's treating providers on your behalf to obtain any missing or updated records, following up every two weeks until the information is obtained. Our program nurse specialists then review and analyze the records to determine the potential MSA impact and identify cost mitigation opportunities. We'll provide you with a detailed analysis and action plan.

By handling these critical but time-consuming tasks, Verisk can help elevate your cost mitigation efforts.



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