Service: MSACP (Medicare Set-Aside Certified Planner)
Module: LEARNING MODULE 6
Evidence-Based and Non-Submit Medicare Set-Asides
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Summary
In Module 6, Deanna Lawrence and Johanna Owens explore the concepts of Evidence-Based Medicare Set-Asides (EB-MSAs) and non-submit Medicare Set-Asides (MSAs), contrasting these with traditional Workers' Compensation MSAs (WCMSAs). This session provides an in-depth understanding of how evidence-based guidelines and alternative submission practices improve MSA preparation while balancing compliance with Medicare requirements.

Evidence-Based MSAs: EB-MSAs utilize scientific evidence and clinical guidelines to create precise and realistic treatment plans. These MSAs prioritize the claimant's clinical condition, provider recommendations, and evidence from clinical research. Unlike WCMSAs, which globally include all potential treatments, EB-MSAs exclude treatments that lack demonstrable benefit and do not meet standards of care based on evidence-based guidelines. This results in significant cost savings and optimized care, often enabling claimants to settle claims faster and retain more settlement funds. Key features include:

- Guideline Application: EB-MSAs rely on nationally accepted guidelines like ODG (Official Disability Guidelines) and ACOEM (American College of Occupational and Environmental Medicine). State-specific guidelines may also influence treatment allocations.
- Treatment Optimization: EB-MSAs evaluate prior treatment effectiveness. For example, if Lumbar Epidural Steroid Injections (LESIs) yield less than 50% improvement, they may be excluded from future allocations.

Non-Submit MSAs: Non-submit MSAs are alternatives that allow claimants to address Medicare's interests without CMS review. Types include:

1. Liability MSAs (LMSAs): Used in liability claims where CMS lacks a review process but still requires proper allocation for future medical care.
2. Zero MSAs: For claims where no future treatment is anticipated, provided all conditions are resolved and medical records confirm no treatment is necessary.
3. Medical Cost Projections (MCPs): Used for settlement purposes or reserve setting, often avoiding CMS review entirely.

Documentation Requirements: All MSAs require thorough documentation:

- Medical and Payment Histories: At least two years of detailed records ensure accurate future care projections.
- Support for Exclusions: Utilization Reviews (URs) and Independent Medical Reviews (IMRs) often substantiate treatment exclusions based on evidence-based guidelines.

For EB-MSAs, physician-directed recommendations and historical treatment outcomes play a critical role in determining future allocations.

Cost Savings and Tapering: EB-MSAs often achieve cost reductions by applying evidence-based guidelines. For example:

- Medication Adjustments: Prescriptions can be converted to cost-effective alternatives, such as switching from brand-name to generic or over-the-counter drugs where appropriate.
- Tapering: Medications with weaning schedules are allocated only for the tapering period rather than a claimant's full life expectancy.

These strategies, supported by robust documentation, minimize expenses while maintaining compliance and care quality.

EB-MSAs and non-submit MSAs provide innovative approaches to MSAs. They emphasize efficiency, scientific rigor, and patient-centered care while reducing unnecessary costs. It is important to remain current on evolving guidelines and documentation standards to leverage these alternatives effectively. By integrating evidence-based practices, MSAs can better balance Medicare's interests with claimant and payer needs.

Learning Objectives

1. Understand the principles and applications of EB-MSAs and non-submit MSAs in comparison to traditional WCMSAs.
2. Identify the requirements for supporting documentation in EB-MSAs, including the use of UR and evidence-based medical guidelines.
3. Learn how nationally accepted and state-specific guidelines influence treatment plans and future care allocations in MSAs.
4. Explore strategies for reducing lifetime medical costs by applying evidence-based methodologies, including tapering and exclusion of unsupported treatments.
5. Recognize the differences between evidence-based and WCMSA approaches to medication, treatment frequencies, and physician follow-ups.

Primary Takeaways

1. These utilize scientific evidence and clinical research to optimize treatment plans, leading to improved patient outcomes and cost efficiency compared to WCMSAs.

2. These include liability MSAs, zero MSAs, and medical cost projections, designed to address Medicare interests without requiring CMS submission.
3. Nationally accepted guidelines like ODG and ACOEM, along with state-specific rules, determine allocations, allowing for the exclusion of unsupported treatments.
4. Accurate medical records, pharmacy histories, and payment histories remain essential for all types of MSAs, ensuring compliance and accuracy.
5. Evidence-based methods, such as tapering medications and adjusting treatment frequencies, significantly reduce the projected costs of future care.

Course Outline

1) Introduction to Evidence-Based and Non-Submit MSAs
   a) Overview of EB-MSAs
      i) Use of scientific evidence and clinical guidelines.
      ii) Optimization of treatment for better patient outcomes.
   b) Overview of Non-Submit MSAs
      i) Types: Liability MSAs, zero MSAs, and medical cost projections.
      ii) Differences from WCMSAs.

2) Evidence-Based Guidelines in MSAs
   a) Nationally Accepted and State-Specific Guidelines
      i) Examples: ODG, ACOEM, and state-specific rules.
      ii) Importance of keeping up with changing guidelines.
   b) Application to Treatment
      i) Examples of supported and excluded treatments.
      ii) Adjustments to medication dosages and frequencies.

3) Documentation and Evidence Requirements
   a) Supporting Evidence for EB-MSAs
      i) UR determinations, IMEs, and medical records.
      ii) Exclusion of unsupported treatments based on guidelines.
   b) Requirements for Non-Submit MSAs
      i) Last two years of medical and payment records.
      ii) Accurate tracking of treatment dates and outcomes.

4) Reducing Costs with Evidence-Based MSAs
   a) Tapering Medications
      i) Application of weaning schedules.
      ii) Adjustments to life expectancy projections.

b) Treatment Exclusions
   i) Excluding unsupported or non-beneficial treatments.
   ii) Examples: Pain pumps, corticosteroid injections.

5) Identifying Challenges and Implementing Best Practices
   a) Addressing Discrepancies
      i) Aligning pharmacy histories with medical records.
      ii) Resolving unsupported claims through documentation.
   b) Leveraging Evidence-Based Strategies
      i) Applying guidelines to future allocations.
      ii) Balancing cost savings with patient care quality.

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