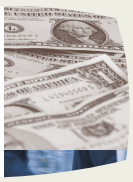

Spring 2013

KKSG focus

OHIO WORKERS' COMPENSATION ADMINISTRATION AND COST CONTROL

Self insurance coverage is a privilege subject to the rules and statutes. Compliance oversight is initiated with audit of the claim payment timing and reporting. The failure to meet performance requirements may result in revocation of self insured coverage and a return to state fund..

Self Insured Employer Reserves

Reserves for Workers' Compensation claims are future costs needed to cover the legal and financial obligations of the insurer arising from the workers' compensation claim. Accurate reserves reflect the experience of the adjuster, the quality of the investigation, an effective claims cost control program, and most of all the impact of the injury on the employee. Reserves represent the estimated full future value based on detailed claim criteria. As a professional cost control organization we must provide financial guidelines that we feel are sufficient in this process. The reserve may need to be modified when additional medical information becomes available or there are other developments within the claim. The Ohio Bureau of Workers' Compensation has recently begun to require reporting of outstanding reserves. This reporting is now included on the SI40 form, Report of Paid Compensation. We have been made aware that the BWC applies 1 to 1.5 times the total of medical and compensation amounts paid for that reporting year to test accuracy. A discrepancy between that figure and the outstanding reserves may lead to further inquiry by the BWC by way of a Self Insured audit or request for explanation of those outstanding reserves. Call us with any questions.

Article by Lori Blaser

FORMS—Recently the Ohio Bureau of Workers' Compensation changed the forms used to certify temporary total disability. Previously, the C84 was a two page form with the first page completed by the injured worker and the second page completed by the doctor of record. The Medco 14 was a supplementary form completed by the Dr. indicating current work abilities. Now the C84 is a one page form completed only by the injured worker to request temporary total compensation. If an injured worker will be off work longer than 7 days, a C84 requesting TT FORMS (continued)

Getting the most from our Self Insured Service

Read about new changes by the BWC in the audit process and how KKSG can help..

This is a very exciting time in regards to the self insured BWC audit process. With the hiring of Paul Flowers as the director of the Bureau of Workers' Compensation, there was a dramatic shift in the focus of the BWC audits. This was a needed change, and to this point, appears to be well received in the SI community. When Mr. Flowers took over this position, there were only three auditors in the state of Ohio. It was not possible to audit an adequate number of employers with the system as it was at that time. One of the biggest changes is that the majority of the audit process can now be done offsite. In most cases, the auditors will be completing the audits by viewing the data electronically and do not need to travel to the employer's place of business. This is important because it limits its costs associated with travel expenses and is a huge time saver. The focus of the BWC audits has shifted towards a review of the reserves and company financials, even though the claim files remain part of the process. In regards to the compliance audit of the claim files, which is by far the most time consuming part of an audit, there is less of a focus on medical bills and general correspondence. This portion of the audit now focuses on accuracy of wage calculation, timely and accurate payment of compensation and reserves. By narrowing the focus to these three categories, auditors are able to complete the audits much faster. Because of these changes, the BWC is now able to audit more employers in a given year with a concentration on the more relevant and important data.

KKSG offers the electronic scan claim file administration which saves our clients time and provides the records needed by the BWC to conduct offsite audits. Call us if you are interested in this service.

Article by Jeff Lodge

FORMS (continued) compensation must be submitted. An updated C84 for each period of disability must be completed by the injured worker. The new Medco 14 completed by the doctor asks if the injured worker's job description has been reviewed to certify disability. We will need to provide this information to the doctor on lost time cases. Therefore please provide a detailed job description with the accident report on obvious lost time injuries. New C84 and Medco 14 forms were sent to your injured workers who were receiving temporary total disability when this change in forms occurred. Since that time, the new forms are consistently being supplied by both the injured workers and their physicians.
As always, do not hesitate to contact your KKSG & Associates account executive with any questions concerning this or any new BWC process.

Article by Sheila Rodgers

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Workers Compensation Medicare Set-aside Arrangements (WCMSAs)

Due to Medicare Secondary Payer laws, employers have significant responsibility when reviewing possible settlement for a workers compensation claim, to protect Medicare's interest with regard to future medical expenses. If Medicare's interest with regard to future medical costs are not considered related to the WC claims, CMS has a priority right of recovery against any entity that received a portion of a third party payment either directly or *indirectly*. There are situations when an employer should look at obtaining a MSA (Medicare Set-Aside) evaluation to determine what amount of a settlement an injured worker would be required to "set-aside" for future medical costs, before Medicare would begin to pay for treatment. There are also specific situations where that MSA evaluation will need to be submitted to CMS/Medicare for approval.

CMS review Threshold for submission of an MSA:

- Claimant is currently a Medicare beneficiary and total settlement is greater than $25,000 or
- Claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated settlement amount is expected to be greater than $250,000

If a claim is being reviewed for settlement and the injured worker is a Medicare beneficiary but the settlement falls outside the above noted submission requirement amount, employers must still consider Medicare's interest in that WC claim. We recommend that an MSA evaluation be obtained and made part of the settlement, with specific language that makes clear what portion of the settlement the injured worker must set aside for future medical costs related directly to the WC claim.

Please keep in mind that employers still have a requirement to report appropriate claims to Medicare under the CMS (Centers for Medicare & Medicaid Services) Section 111 Mandatory Reporting in addition to obtaining an MSA.

Also in addition to obtaining an MSA we recommend making an inquiry to obtain conditional payment information from Medicare prior to settlement for those individuals that are already a Medicare beneficiary. If Medicare has inadvertently made payments for services directly related to the WC claim, CMS could exercise their right of recovery even after that claim has settled and ultimately could come after the employer for payment.

Follow the below link for additional information concerning MSA's and Obtaining Conditional Payment Information:
http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/wcsetaside.html

KKSG & Associates will coordinate the process of obtaining an MSA and conditional payment information from Medicare when necessary.

Article By Karen Stieg

CMS (Centers for Medicare & Medicaid Services) Section 111 Mandatory Reporting

As everyone should already be aware beginning July 1, 2009, CMS requires employers and/or responsible payers of medical, to report specific workers' compensation claims where there is ORM (Ongoing Responsibility for Medical). The main purpose of the CMS Section 111 Mandatory Reporting requirement is for Medicare to monitor and ensure that they are not making medical payments, where they would be considered a secondary payer.

KKSG & Associates has in place the platform, which allows for submission of queries to CMS to determine what injured workers are Medicare eligible, and the platform necessary for the reporting of required claims to CMS for our Self Insured employers. In the case of State Funded employers CMS would consider the BWC (Bureau of Workers Compensation) as the RRE (Responsible Reporting Entity) and the BWC would therefore have the responsibility of reporting claims to CMS.

http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/index.html

Article by Karen Stieg

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