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QUICK REFERENCE GUIDE TO MEDICARE SET-ASIDE TRUSTS

TEST 1

1. Is the settlement over $25,000?
    a. If the answer is yes, then go to question 2
    b. If the answer is no, then no Medicare proposal is necessary

2. Is the claimant eligible for Medicare?
    a. Generally a claimant is eligible for Medicare if:
        i. He is 65 years of age or older **or**
        ii. He has been on social security disability for 24 months following the effective date of disability (date of disability is determined by the social security office) **or**
        iii. He is experience the end stages of renal failure
    b. If the answer is yes, then a Medicare proposal is necessary
    c. If the answer is no, then no Medicare proposal is necessary

TEST 2

1. Is the settlement over $250,000?
    a. If the answer is yes, then go to question 2
    b. If the answer is no, then no Medicare proposal is necessary

2. Is there a reasonable expectation of the claimant being eligible for Medicare within 30 months after the date of the settlement?
    a. Examples of reasonable expectation of Medicare eligibility within 30 months:
        1. The claimant is 62½ years old
        2. The claimant is permanently and totally disabled
        3. The claimant has applied for but has not been approved for SSDI
    b. If the answer is yes, then a Medicare proposal is necessary
    c. If the answer is no, then no Medicare proposal is necessary

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You need a Medicare Set-Aside Trust Proposal.

What next?

Contact: McAnany, Van Cleave & Phillips, P.A.
Timothy Gaarder
Ph 913.371.3838
Ph Direct 913.573.3317
E-mail tgaarder@mvplaw.com
707 Minnesota Ave., Fourth Floor
P.O. Box 171300
Kansas City, Kansas 66117

What Information is Needed?

- Claimant's Name
- Claimant's Date of Birth
- Claimant's Entitlement to Medicare (over 65, on SSD over 2 years)
- Claimant's Social Security Number
- Claimant's Address and Phone Number
- Claimant's Attorney Information
- Employer Information
- Injury Date
- Amount of Workers' Compensation Settlement
- Medical Records
- Additional File Materials

What Happens Next?

- Medicare Set-Aside Trust Proposal submission is created and completed by the MVP law office
- Medicare Approval of workers' compensation settlement is obtained
- Establishment of Medicare Set-Aside Trust Account is completed if necessary
- Case is finalized and can be fully and finally closed, including liability for claimant's future medical treatment, within 4-6 months from date of referral

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Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Award

Office of Central Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241-1500
Date: October 10, 2008
Claim Number: 219-72-3179HA

004978 MCSM77 N3 2,300

POMPANO BEACH, FL 33064-6808

You are entitled to monthly disability benefits beginning October 2007.

The Date You Became Disabled

We found that you became disabled under our rules on April 2, 2007.

However, you have to be disabled for 5 full calendar months in a row before you can be entitled to benefits. For these reasons, your first month of entitlement to benefits is October 2007.

What We Will Pay And When

- You will receive $9,998.00 around October 16, 2008.
- This is the money you are due for October 2007 through September 2008.
- Your next payment of $1,347.00, which is for October 2008, will be received on or about the third Wednesday of November 2008.
- After that you will receive $1,347.00 on or about the third Wednesday of each month.
- These and any future payments will go to the financial institution you selected. Please let us know if you change your mailing address, so we can send you letters directly.

The day we make payments on this record is based on your date of birth.

Enclosure(s):
Pub 05-10018
Pub 05-10153
Pub 05-10058

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See Next Page

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rounding. The amount you actually receive(s) may differ from your full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums. We must also round down to the nearest dollar.

Beginning Date		Benefit Amount	Reason
October	2007	$1,316.90	Entitlement began
December	2007	$1,347.10	Cost-of-living adjustment

Other Disability Payments Affect Benefits

We have to consider workers' compensation and/or public disability payments when we figure a Social Security benefit. The following will explain how these payments affect Social Security benefits. For more information, please read the enclosed pamphlet, "How Workers' Compensation and Other Disability Payments May Affect Your Social Security Benefit."

We have to take into account your workers' compensation payment of $1,163.70 when we figure your Social Security benefits. Because you receive this payment, we are reducing the benefits you are due.

We are reducing your monthly Social Security checks beginning October 2007, which is the first month when you were entitled to both Social Security disability benefits and workers' compensation payments.

Your benefit will be $617.60 beginning October 2007.

We do not reduce benefits once workers' compensation payments have stopped. Therefore, we are paying benefits at the full rate beginning July 2008. Please let us know right away if you receive workers' compensation and/or other public disability payments again.

If you had any medical, legal, or other related expenses connected with your claim for workers' compensation payments, you should bring us proof that you paid these expenses. We can exclude these expenses, within the limits set by law, when we figure how much to take out of your Social Security benefits.

Beginning October 2008, we are paying you a Social Security benefit that is not reduced due to workers' compensation payments. This is because of a change caused by the State law which provides for the reduction of these payments to persons who receive Social Security disability benefits.

Other Social Security Benefits

The benefit described in this letter is the only one you can receive from Social Security. If you think that you might qualify for another kind of Social Security benefit in the future, you will have to file another application.

JUL 23 2001

To: All Associate Regional Administrators
Attention: Division of Medicare

From: Deputy Director
Purchasing Policy Group
Center for Medicare Management

SUBJECT: Workers' Compensation: Commutation of Future Benefits

Medicare's regulations (42 CFR 411.46) and manuals (MIM 3407.7&3407.8 and MCM 2370.7 & 2370.8) make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the Workers' Compensation (WC) carrier and the injured individual. This Regional Office letter clarifies the Centers for Medicare & Medicaid Services (CMS) policy regarding a number of questions raised recently by several Regional Offices (RO) concerning how the RO should evaluate and approve WC lump sum settlements to help ensure that Medicare's interests are properly considered.

Regional Office staff may choose to consult with the Regional Office's Office of the General Counsel (OGC) on WC cases because these cases may entail many legal questions. OGC should become involved in WC cases if there are legal issues which need to be evaluated or if there is a request to compromise Medicare's recovery claim or if the Federal Claims Collection Act (FCCA) delegations require such consultation. Because most WC carriers typically dispute liability in WC compromise cases, it is very common that Medicare later finds that it has already made conditional payments. (A conditional payment means a Medicare payment for which another payer is responsible.) If Medicare's conditional payments are more than $100,000 and the beneficiary also wishes Medicare to compromise its recovery under FCCA (31U.S.C.3711), the case must be referred to Central Office and then forwarded to the Department of Justice. It is important to note in all WC compromise cases that all pre-settlement and post-settlement requests to compromise **any** Medicare recovery claim amounts must be submitted to the RO for appropriate action. Regional Offices must comply with general CMS rules regarding collection of debts (please reference the Administrator's March 27, 2000 memo re: New instructions detailing your responsibilities for monies owed to the government).

Medicare is secondary payer to WC, therefore, it is in Medicare's best interests to learn the existence of WC situations as soon as possible in order to avoid making mistaken payments. The use of administrative mechanisms[1] sometimes referred to by attorneys as Medicare Set-

[1] Although 42 CFR 411.46 requires that all WC settlements must adequately consider Medicare's interests, 42 CFR 411.46 does not mandate what particular type of administrative mechanism should be used to set-aside monies for Medicare including a self-administered arrangement (State law permitting). Of course, if an arrangement is self-administered, then the injured individual/beneficiary **must** adhere to

aside Trusts (hereafter referred to as "set-aside arrangements") in WC commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. Medicare learns of the existence of a primary payer (WC) as soon as possible when Medicare reviews a proposed set-aside arrangement at or about the time of WC settlement. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.

One of the distinctions that Medicare's regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump-sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump-sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump-sum settlements should not automatically be considered as commutation

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the same rules/requirements as any other administrator of a set-aside arrangement.

cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.

WC commutation cases are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case.

Generally, parties to WC commutation cases agree on a lump sum amount in exchange for giving up the usual continuing payments by WC for lost wages and for lifetime medical care related to the injuries. Such lump sum amounts are usually requested because the beneficiary wishes to use the funds for some specific purpose. For example, the individual's home may need to be remodeled to accommodate a wheelchair or, more typically, he or she is so disabled that lifetime attendant care is needed. In these latter cases, the injured individual seeks a lump sum payment so that such care can be arranged with certainty in the future. The amount of the lump sum is typically established by using a life care plan[2] and actuarial methods to determine the individual's life expectancy. When WC has accepted full liability in a case prior to the creation of a set-aside arrangement, the likelihood of any Medicare conditional payments being made is reduced.

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living

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[2] If a life care plan is not used to justify the injured individual's future medical expenses, then the injured individual or his/her representative **must** present other alternative evidence that sufficiently justifies the amounts set-aside for Medicare.
expenses may be.

activity. These set-aside arrangements are typically not created until the individual's

condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.

Medicare regulations at 42 CFR 411.46 state that:

> 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.

In addition the Medicare manuals (3407.8 of the MIM, 2370.8 of the MCM) state:

> When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment.

Questions that have been raised are paraphrased below.

Question 1:

(a) Does the Medicare program have a claim against a lump sum WC payment before an individual's Medicare entitlement?
(b) If not, can the Medicare program give a written opinion on the sufficiency of a set-aside arrangement even if the individual is not as yet entitled to Medicare?
(c) In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare's interests be considered before the parties can settle the case?

Answer:

> These questions have been raised by attorneys who wish to devise set-aside arrangements, which represent amounts for medical items, and services that would ordinarily be covered by Medicare and are specified for future medical treatment for work-related illness or injuries. The attorneys are concerned that Medicare will not pay once the individual becomes entitled to Medicare, because the lump-sum included payment for future medical treatment.

The answer to Question 1(a) is no, Medicare cannot make a formal determination until the individual actually becomes entitled to Medicare. However, the attorneys are correct that once the individual becomes entitled, Medicare payment may not be made to the extent of Medicare's interests in the lump sum payment per 42 CFR 411.46 or a set-aside arrangement that adequately considers Medicare's interests in the lump sum payment.

The answer to Question 1(b) is that the RO (with consultation from the Regional OGC, if necessary) can review a proposed settlement including a set-aside arrangement and can give a written opinion on which the potential beneficiary and the attorney can rely, regarding whether the WC settlement has adequately considered Medicare's interests per 42 CFR 411.46. These settlements should all be handled on a case-by-case basis, as each situation is different. If there are several years prior to Medicare entitlement, the RO should use its best judgment regarding what Medicare utilization might be once there is Medicare entitlement. This decision should be based on the documentation obtained as stated in the answer to Question 10. Once the RO has given written assurance that the set-aside arrangement is sufficient to satisfy the requirements at 42 CFR 411.46, when the set-aside arrangement is established and the settlement is approved, the RO, should then set up a procedure to follow the case.

The answer to question 1(c) is, it is not in Medicare's best interests to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests 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.[3]

For example, if the injured individual is designated by WC as a Permanent Total disabled individual, has filed for Social Security disability, and the settlement apportions $25,000 per year (combined for both future medical expenses **and** disability/lost wages) for the next 20 years, then the RO should review that WC settlement because the total settlement amount over the life of the settlement agreement is greater than $250,000 ($25,000 x 20 years = $500,000) and the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date. If the injured individual in this example fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 CFR 411.46 once the injured individual actually becomes entitled to Medicare.

[3] Please note that the review thresholds (i.e., 30 months and $250,000) will be subject to adjustment once CMS has experience reviewing these matters under these instructions.

NOTE: Injured individuals who are already Medicare beneficiaries **must** always consider
Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, **ALL WC PAYMENTS** regardless of amount **must** be considered for current Medicare beneficiaries.

Question 2:

Should a system of records be established for the documentation that the RO and contractors receive/collect concerning these set-aside arrangements?

Answer:

Yes. CMS' Division of Benefit Coordination is in the process of establishing a system of records via the Federal Register process, which will provide legal authority to maintain records on individuals that are not enrolled in Medicare. The RO will be responsible for maintaining or housing the records for every arrangement on which the RO provides a written opinion. Please note that these records are not subject to Freedom of Information Act requests and may not be disseminated to the public.

Question 3:

Once the set-aside arrangement has been approved by the RO (with consultation from the Regional OGC, if necessary), what is the subsequent role of the ROs and contractors?

Answer:

When the RO approves a set-aside arrangement (with consultation from the regional OGC, if necessary), the RO will check on a monthly basis the National Medicare Enrollment database in order to determine when an injured individual actually becomes enrolled in Medicare. Once the RO verifies that the injured individual has actually been enrolled in Medicare, the RO will assign a contractor responsible for monitoring the individual's case. The RO will assign the contractor based on the injured individual's State of residence.

When the injured individual has actually been enrolled in Medicare, the RO **must** provide the Coordination of Benefits Contractor (COBC) with identifying information to add a WC record to Common Working File. The RO must exercise one of the following

options: 1) Fax the information to the COBC; or 2) Submit through an Electronic

Correspondence Referral System (ECRS) inquiry. At a minimum, the RO must indicate that this is a WC set-aside arrangement case, and include the following information:

Beneficiary Name Beneficiary HIC Date of Incident DX code(s): If you do not have dx codes readily available, you must include a description of the illness/injury. **Note:** Do not forward to COB without a dx or description.
Administrator of Trust
Claimant Attorney Information

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for insuring/verifying that the funds allocated to the set-aside arrangement were expended on medical services for Medicare covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

Question 4:

What types of measures should the RO and the contractors take to ensure that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been depleted?

Answer:

Generally, set-aside arrangements that are designed as lump sums (i.e., the arrangement is funded by the WC settlement all at once) present less of a problem to monitor than structured arrangements. Medicare would not make any payments for individuals that possess lump sum arrangements until all of the funds within the arrangement have been depleted. For example, if a set-aside arrangement were established for $90,000, Medicare would not make any payments until the entire $90,000 (plus interest, if applicable) were exhausted on the individual's medical care (for Medicare covered services only).

Structured set-aside arrangements generally apportion settlement monies over fixed or defined periods of time. For example, a structured arrangement may be designed to disburse $20,000 per year over the next ten years for an individual's medical care (for Medicare-covered services only). If the $20,000 allocated on January 1 for Year One were fully exhausted on August 31, Medicare may make payments for the services performed after August 31 once the contractor responsible for monitoring the individual's case can verify that the entire $20,000 (plus interest, if applicable) is exhausted. However, when the structured arrangement allocates money for the start of

Year Two (i.e., on January 1) Medicare would not make any payments for services performed until Year Two's allocation was completely exhausted.

In every set-aside arrangement case the contractor responsible for monitoring the individual's case (with assistance from the RO, if necessary) should ensure that Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the arrangement have truly been exhausted.

NOTE:
Until the individual actually becomes entitled to Medicare, the set-aside arrangement fund must **not** be used to pay the individual's expenses. That is, an individual's medical expenses must be paid from some other source besides the set-aside arrangement when the individual is not a Medicare beneficiary. Once the individual actually becomes entitled to Medicare, then the administrator of the arrangement is permitted to make payments for the individual's medical care (for Medicare-covered services only) from the arrangement.

ADDITIONAL NOTE: THE ABOVE PARAGRAPH OF THIS NOTE HAS BEEN REPLACED BY QUESTION 3 OF THE JULY 11, 2005 ARA MEMORANDUM

If the contractor monitoring the individual's case discovers that payments from the set-aside arrangement have been used to pay for services that are not covered by Medicare or for administrative expenses that exceed those approved by the RO (see Question 11), then the contractor will not pay the Medicare claims. The contractor must provide the evidence of the unauthorized expenditures to the RO for investigation. If the RO determines that the expenditures were contrary to the RO's written opinion on the sufficiency of the arrangement, then the RO will notify the administrator of the arrangement that the RO's informal approval of the arrangement is withdrawn until such time as the funds used for non-Medicare expenses and/or unapproved administrative expenses are restored to the set-aside arrangement.

Question 5:

What are the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken its interests into account?

Answer:

The following criteria should be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the

cost of a work-related injury or illness to Medicare. Specifically, is the amount allocated for future medical expenses reasonable? If Medicare has already made conditional payments their repayment also has to be taken into account.

1. Date of entitlement to Medicare.

2. Basis for Medicare entitlement (disability, ESRD or age)-- If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.

3. Type and severity of injury or illness-- Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?

4. Age of beneficiary-- Acquire an evaluation of whether his/her condition would shorten the life span.

5. WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).

6. Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized-- If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.

7. Amount of lump sum or amount of structured settlement-- Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.

8. Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis?-- Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services

related to the accident or illness?

9. Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.?-- If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.

10. Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition?-- Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost $20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare's interests into account.

The attorney for the individual for whom the arrangement is set-up should be advised that Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of WC.

NOTE:
Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts.

Question 6:

Some attorneys have indicated that a set-aside arrangement should only contemplate three to five years of estimated Medicare covered items or services. Would this be reasonable?

Answer:

No. To protect the Medicare Trust Fund, a set-aside arrangement should be funded based on the expected life expectancy of the individual unless the State law specifically limits the length of time that WC covers work related conditions. If an estimate of the beneficiary's estimated longevity was not submitted, one must be obtained.

Question 7:

What other issues should be considered ?

Answer:

The lump sum amount should be interest bearing and indexed to account for inflation consistent with how Medicare calculates its growth in spending. Provision should also be made in the settlement agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the set-aside arrangement. (For example if outpatient prescription drugs become more widely covered.) If the beneficiary belongs to a Health Maintenance Organization that may not be coordinating benefits based on WC entitlement, the settlement should still set-aside funds for Medicare covered services in case the beneficiary converts to a fee for service plan.

NOTE: THIS ANSWER WAS REPLACED BY QUESTION 4 OF THE OCTOBER 15, 2004 ARA MEMORANDUM AND LATER REPLACED BY QUESTION 15 OF THE JULY 11, 2005 ARA MEMORANDUM.

Question 8:

Is it permissible for Medicare to accept an up-front cash settlement instead of a set-aside arrangement?

Answer:

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when WC did not pay promptly. Thus, when future benefits are included in a WC settlement agreement, Medicare cannot pay until the medical expenses related to the injury or disease equal the amount of the settlement allocated to future medical expenses or the amount included for medical expenses in the set-aside arrangement has been exhausted.

Question 9:

How do providers and suppliers obtain payment for the services covered by the set-aside arrangement?

Answer:

There are two distinct methods for providers, physicians and other suppliers to obtain payment for WC covered services when funds are held in a set-aside arrangement. Determining which distinct payment method applies depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charges or WC fee schedule amounts (i.e., were the injured individual's medical expenses determined based on full actual charge estimates or WC fee schedule estimates).

When a set-aside arrangement's settlement agreement contains specific provisions establishing that the WC carrier will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan, and when the RO reviews and approves the sufficiency of the arrangement based on the WC plan's WC fee schedules, then, providers, physicians and other suppliers will be paid based on what would normally be payable under the WC plan (i.e., under the WC fee schedule). Therefore, providers, physicians and other suppliers would not be permitted to bill the arrangement more than the WC fee schedule rate. For example, if a provider's full charge for a particular service is $100 and the WC carrier normally pays $65 for that particular service, then the arrangement should only pay $65. However, when an arrangement's settlement agreement does **not** contain specific provisions ensuring that the arrangement cannot be charged more than what would normally be payable under the WC plan, then providers, physicians and other suppliers are permitted to bill the arrangement their full charges. It is important to note that when an arrangement's settlement agreement does not contain specific provisions ensuring that providers, physicians and other suppliers cannot bill the arrangement more than the WC fee schedule amounts, then the RO must review the sufficiency of that particular arrangement based upon full actual charge estimates.

Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts. If the arrangement is based upon WC fee schedule amounts, then, the RO cannot provide a written opinion on the sufficiency of an arrangement until the arrangement's settlement agreement contains specific provisions that establish that the WC carrier can and will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan. The WC carrier must require all entities and individuals that accept WC payments to agree not to charge

the arrangement more than what the WC plan would normally pay.

If a WC carrier is unable to enforce the requirement that the arrangement can only be charged the WC fee schedule rates, then the RO will evaluate whether an arrangement reasonably covers/considers Medicare's interest based on whether the future medical expenses billed to the arrangement are enough to cover the actual expenses for the services at issue. If State WC laws do not provide a particular WC carrier with the legal authority to enforce that requirement, then the RO can still provide a written opinion on the sufficiency of the arrangement so long as future medical expenses are evaluated by the RO using full actual charge estimates, not WC fee schedule amounts.
If the arrangement is constructed based upon full actual charge estimates, then the RO must determine whether the proposed amount to be placed in the arrangement for future medical expenses and administrative costs (see Question 11) is sufficient to cover the actual charges for the services at issue (rather than an amount equal to what would have been the Medicare approved amount for a particular service).

Once the arrangement has been depleted because of payments for otherwise Medicare covered services, a complete accounting must be provided to the contractor responsible for monitoring the individual's case and if the payments have been properly made Medicare can then be billed.

NOTE: THIS ANSWER HAS BEEN REPLACED BY QUESTION 1 OF THE OCTOBER 15, 2004 ARA MEMORANDUM

Question 10:

Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a set-aside arrangement?

Answer:

Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:

A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual's estimated life span, then a rated age may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. Also, documentation which gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

The RO may require additional documentation, if necessary and approved by CO.

NOTE: THE ABOVE ANSWER WAS CLARIFIED BY QUESTION 5 OF THE OCTOBER 15, 2004 ARA MEMORANDUM

Question 11:

How does the RO determine whether or not the administrative fees and expenses charged to the arrangement are reasonable?

Answer:

Before a proposed arrangement can be approved, the RO must determine whether the administrative fees and expenses to be charged to the arrangement are reasonable. The RO must be notified (in writing) of all proposed administrative fees prior to the RO providing its written assurance that the set-aside arrangement is sufficient to satisfy the requirements of 42 CFR 411.46. If the administrative fees are determined to be unreasonable, the RO must withhold its approval of the set-aside arrangement. The amount of the approved arrangement must include both the estimated medical expenses plus the amount of administrative fees found to be reasonable.

NOTE: THE ABOVE ANSWER HAS BEEN REPLACED BY THE MAY 7, 2004 ARA MEMORANDUM

Question 12:

What impact will arrangements have on Medicare payment systems and procedures?

Answer:

Because an arrangement's purpose is to pay for all services related to the individual's work-related injury or disease, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the set-aside arrangement. Arrangements are established in order to pay for **all** medical expenses resulting from work- related injuries or diseases; arrangements are not designed to simply pay portions of medical expenses for work-related injuries or diseases.
When arrangements are designed as lump sum commutations (i.e., the arrangement is designed in a manner that the WC settlement is paid into the arrangement all at once, see Question #4 above), Medicare would not make any payments for that individual's

medical expenses (for work-related injuries or diseases) until all the funds (including interest) within the arrangement have been completely exhausted. These same basic principles also apply to structured commutations (see Question #4 above).

When providers, physicians and other suppliers submit claims to Medicare related to the individual’s work-related injury or disease, claims processing contractors should deny those claims and instruct the entity or individual to seek payment from the administrator of the arrangement. Since the injured individual will be a Medicare beneficiary at the time when the provider, physician, or other supplier submits the claim to Medicare, the contractor responsible for monitoring the individual's case will have already updated the Common Working File to indicate that the injured individual's claims should be denied. However, when a provider, physician or other supplier submits any claims that are for injuries or diseases that **are not** work-related, then contractors should process those claims like they would any other claim for Medicare payment.

When the administrator of an arrangement refuses to make payment on a provider’s, physician’s or other supplier’s claim because the administrator of the arrangement asserts the services are for injuries or diseases that are not work-related (or when the administrator of the arrangement denies the claim for any other reason), and the provider, physician or other supplier, subsequent to the administrator’s denial, submits the claim to Medicare, then the contractor should consult the RO in order to determine whether Medicare should pay the claim. If a determination to deny the claim is made, then Medicare’s regular administrative appeals process for claim denials would apply to the claim.

Please note that Central Office is planning to have a contractor assist ROs in monitoring and processing (however, not evaluating) these set-aside arrangement cases as early as possible in Fiscal Year 2002. Further instructions will be issued at that time.

Regional Office staff's questions on these issues should be directed to Fred Grabau at (410) 7860206. We will issue additional guidance as necessary.

/s/

Parashar B. Patel

cc: Regional Administrators Gerry Nicholson, Benefits Operations Group
Liz Richter, Financial Services Group

FARD3/F.Grabau/60206/final 7/11/01 Document: /g:/ppg/dids/araWC2.doc Typist: T. Cox x60750

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicare Management

DATE: APRIL 22, 2003

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer -- Workers' Compensation (WC) Frequently Asked Questions

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1) **What statutory law, regulations, or Federal case law supports/allows CMS to review proposed settlements of injured workers who are not Medicare beneficiaries?**

Answer: Section 1862(b)(2) of the Social Security Act (the Act) (42 USC 1395y(b)(2)) requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation (WC) law or plan. Medicare does not pay for an individual's WC related medical services when that individual received a WC settlement, judgment, or award that includes funds for future medical expenses, until all such funds are properly expended.

Because Medicare does not pay for an individual's WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in that individual's interests to consider Medicare at the time of settlement. Once CMS agrees to a Medicare set-aside amount, the individual can be certain that Medicare's interests have been appropriately considered.

2) **When dealing with a WC case, what is "a reasonable expectation" of Medicare enrollment within 30 months?**

Answer: Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are not limited to:

a) The individual has applied for Social Security Disability Benefits;
b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

3) How does Medicare determine its interests in WC cases when the parties to the settlement do not explicitly state how much of the settlement is for past medical expenses and how much is for future medical expenses?

Answer: A settlement that does not specifically account for past versus future medical expenses will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.

Example: A beneficiary is paid $50,000 by a WC carrier, and the parties to the settlement do not specify what the $50,000 is intended to pay for. If there is no CMS approved Medicare set-aside arrangement, Medicare will consider any amount remaining after recovery of its conditional payments as compensation for future medical expenses.

Additionally, please note that any allocations made for lost wages, pre-settlement medical expenses, future medical expenses, or any other settlement designations that do not consider Medicare's interests, will not be approved by Medicare.

4) What's the difference between commutation and compromise cases? And can a single WC case possess both?

Answer: When a settlement includes compensation for future medical expenses, it is referred to as a "WC commutation case." When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a "WC compromise case." A WC settlement can have both a compromise aspect as well as a commutation aspect.

Additionally, a settlement possesses a commutation aspect if it does not provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury.

Example: The parties to a settlement may attempt to maximize the amount of disability/lost wages paid under WC by releasing the WC carrier from liability for medical expenses. If the facts show that this particular condition is work-related and requires continued treatment, Medicare will not pay for medical services related to the WC injury/illness until the entire settlement has been used to pay for those services.

5) When a state WC judge approves a WC settlement, will Medicare accept the terms of that settlement?

Answer: Medicare will generally honor judicial decisions issued after a hearing on the merits of a WC case by a court of competent jurisdiction. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

However, a distinction must be made where a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. Medicare cannot accept the terms of the settlement as to an allocation of funds of any type if the settlement does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire WC settlement. Medicare will also assert a recovery claim, if appropriate.

6) What is the expected time frame for the regional offices (ROs) to review and make their decisions regarding proposed WC settlements?

Answer: ROs seek to review and make a decision regarding proposed WC settlements within 45 to 60 days, from the time that all necessary/required documentation has been submitted.

7) May administrative fees/expenses for administration of the Medicare set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement be charged to the set-aside arrangement?

Answer: Yes, such fees and costs may be charged to the arrangement if all the following are true:

a) They are related to the Medicare set-aside itself;
b) They are reasonable in amount; and
c) They are included in the proposed Medicare set-aside arrangement submitted to CMS and incorporated into the Medicare set-aside approved by CMS.

It is important to note that all administrative fees and other costs and expenses associated with the disability/lost wages portion of the settlement and/or the portion of the settlement that provides for medical services that are not covered by Medicare cannot be charged to the Medicare set-aside arrangement.

NOTE: THE ABOVE ANSWER WAS REPLACED BY THE MAY 7, 2004 ARA MEMORANDUM

Note: This question and answer does not address attorney fees and costs in connection with procurement of the WC settlement from the WC carrier.

8) May a beneficiary self-administer his or her own Medicare set-aside arrangement?

Answer: Yes, if this is permitted under state law. It should be noted though, that a self-administered arrangement is subject to the same rules/requirements as any other set-aside arrangement.

9) In WC cases that use structured Medicare set-aside arrangements (i.e., settlement monies are apportioned over fixed or defined periods of time), will Medicare agree to cover the beneficiary when it has not been verified whether the funds as apportioned in the arrangement have been exhausted?

Answer: No, Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the Medicare set-aside arrangement.

Additionally, please note that any structured set-aside arrangement agreed to by the parties will not be approved by Medicare if the settlement has not adequately considered Medicare's interests.

10) In a structured Medicare set-aside arrangement where payments are made at regular intervals to cover expenses incurred during those periods, how should an administrator account for unspent funds during a given period?

Answer: If funds are not exhausted during a given period then the excess funds must be carried forward to the next period. The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.

Example: A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2003 the injured individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2004. Therefore, in 2004 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2004. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

NOTE: THE ABOVE ANSWER WAS CLARIFIED BY QUESTION 5 OF THE OCTOBER 15, 2004 ARA MEMORANDUM

11) If a beneficiary or injured individual's physical condition substantially improves, may the administrator of the Medicare set-aside arrangement release or reduce the amounts of the set-aside?

Answer: The administrator of the CMS approved Medicare set-aside arrangement cannot release or reduce the set-aside amounts without approval from CMS. If the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary (or his/her representative) may submit a written request to the appropriate CMS RO asking for a reduction of the Medicare set-aside arrangement. This request must include supporting documentation from the treating physician(s). Once the RO receives all pertinent documentation, the RO will then evaluate the request and make a decision. The RO decision is final and not subject to administrative appeal.

NOTE: THE ABOVE ANSWER WAS REPLACED BY QUESTION 10 OF THE JULY 11, 2005 ARA MEMORANDUM

12) What are an attorney's ethical and legal obligations when his or her client effectively ignores Medicare's interests in a WC case?

Answer: Attorneys should consult their national, state, and local bar associations for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26.

13) From where can CMS recover funds if Medicare's interests are ignored in a WC case?

Answer: The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly. The CMS also has a subrogation right with respect to any such third party payment. See, for example, 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26.

14) If Medicare rejects a proposed Medicare set-aside arrangement, how can the parties to a WC settlement appeal this rejection?

Answer: The CMS has no formal appeals process for rejection of a Medicare set-aside arrangement. However, when CMS does not believe that a proposed set-aside adequately protects Medicare's interests, the parties may provide the RO with additional information/documentation in order to justify their proposal. If the additional information does not convince the RO to approve the set-aside arrangement, and the parties proceed to settle the case despite the ROs objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as WC settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. At this point, when Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. Information on applicable appeal rights is provided at the time of each claim denial.

15) When the parties to a WC settlement present CMS with documentation that is intended to support and justify their proposed Medicare set-aside amounts, will Medicare accept a "life care plan" or similar evaluation prepared by a non-treating physician?

Answer: Yes, Medicare will consider accepting a life care plan or similar evaluation from a non-treating physician, if the physician does all of the following:

a) Examines the WC claimant;
b) Reviews the claimant's medical records;
c) Contacts any of the claimant's treating physicians (if applicable);
d) Is available to answer CMS' questions;
e) Prepares a report that summarizes the above; and
f) Offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury.

Please note that such a life care plan or evaluation is not automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question for some reason, such as contrary evidence, internal conflicts, or if the plan is not credible on its face.

16) If a current Medicare beneficiary has outstanding WC related claims that were not paid prior to the settlement and are not covered in that settlement, will Medicare or the Medicare set-aside arrangement pay those claims?

Answer: No, Medicare cannot pay because it is secondary to the WC settlement and the Medicare set-aside arrangement cannot pay because it is created solely for future medical expenses related to the WC case. Medical expenses incurred prior to the settlement need to be accounted for in the compromise portion of the settlement. These services should be known to the parties. The provider/supplier will typically have billed Medicare and/or the WC carrier for these services and the beneficiary's representative will have made inquiries about outstanding related claims.

In addition, to the extent Medicare has made any conditional payments, Medicare will recover those payments pursuant to 42 CFR 411.47.

17) When an annuity is included in a settlement for an injured individual (who is not yet a Medicare beneficiary), how does Medicare determine whether the value of the annuity meets the $250,000 monetary threshold?

Answer: Medicare determines the value of an annuity based on how much the annuity is expected to pay over the life of the settlement, not on the Present Day Value (PDV) or cost of funding that annuity.

Example: A settlement is to pay $15,000 per year for the next 20 years to an individual who has a "reasonable expectation" of Medicare enrollment within 30 months. This settlement is to be funded with an annuity that will cost $175,000. The RO will review this settlement because the total settlement to be paid is greater than $250,000 ($15,000 per year x 20 years = $300,000). It is immaterial for Medicare's purposes that the PDV or cost ($175,000) to fund this settlement is less than $250,000.

18) Is there a means by which an injured individual can permanently waive his or her right to certain specific services related to a WC case, and thereby reduce the amount of a Medicare set-aside arrangement?

Answer: No, the ROs cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement.

19) Does CMS require that a Medicare set-aside arrangement be established in situations that involve both a WC claim and a third party liability claim?

Answer: Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further WC claim related medical services. A Medicare set-aside arrangement is also unnecessary if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.

20) If the settling parties of a WC case contend that a WC settlement is not intended to compensate an injured individual for future medical expenses, does CMS still require that a Medicare set-aside arrangement be established?

Answer: It is unnecessary for the individual to establish a set-aside arrangement for Medicare if all of the following are true:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);
b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and
c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

However, if Medicare made any conditional payments for work-related services furnished prior to settlement, then Medicare would require recovery of those payments. In addition, Medicare will not pay for any services furnished prior to the date of the settlement for which it has not already paid.

21) If a beneficiary or injured individual dies before the Medicare set-aside arrangement is completely exhausted, what happens to the remaining money?

Answer: Once the RO and the contractor responsible for monitoring the beneficiary's case ensure that all of the beneficiary's claims have been paid, then any amount left over in the beneficiary's Medicare set-aside arrangement may be disbursed pursuant to state law, once Medicare's interests have been protected. This may involve holding the Medicare set-aside arrangement open for some period after the date of death, as providers, physicians, and other suppliers are permitted to submit their initial bill to Medicare for a period ranging from 15-27 months after the date of service.

22) What happens if one of the parties settling a WC case refuses to involve CMS, even though Medicare has an interest in the case?

Answer: In these situations, the "cooperative" settling party should notify the appropriate CMS RO. Where the RO believes it is appropriate, the RO will then send the "uncooperative" party a letter (via certified mail) conveying that Medicare's interests must be considered in the WC settlement.

The ROs should inform the "uncooperative" settling party that: "Pursuant to 42 CFR 411.24(g), CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received a third party payment. Moreover, pursuant to 42 CFR 411.26, CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a third party payer. Therefore, pursuant to 42 CFR 411.24(b), CMS may initiate recovery against the parties listed under 42 CFR 411.26 as soon as it learns that payment has been made or could be made under workers' compensation."

Additionally, if Medicare's interests are not adequately considered in any settlement, then Medicare may refuse to pay for services related to the WC injury until such time as expenses for such services have exhausted the amount of the entire WC settlement.

23) Who should the parties settling a WC case contact in the RO?

Answer: The first report of attorney representation of a Medicare beneficiary for a WC claim should be made to the CMS Coordination of Benefits (COB) Contractor. Attorneys can call the COB Contractor from 8am-8pm, Monday - Friday, Eastern Time; the toll-free number is 1-800-999-1118.

Settling parties should also contact the CMS RO responsible for a particular state (contact information is provided in an attachment to these questions and answers) for approval of a Medicare set-aside arrangement. The inquiry should be directed to the attention of the Regional Office Medicare Secondary Payer Coordinator, who will forward the inquiry to the appropriate RO if a transfer is necessary. (WC set-aside responsibilities are generally, but not always, assigned based upon RO responsibility for contractor oversight over the lead fiscal intermediary for WC recoveries for a particular state. This may or may not be the same RO as the one with general responsibilities for a particular state.)

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

Thomas L. Grissom

Attachment

cc: All ARA's for Financial Management
ARA for DHPP RO VII
All RO MSP Coordinators

bcc: Paul Olenick
Martha Kuespert
Fred Grabau
Eve Fisher
Tina Merritt
Barbara Wright
Betty Noble
Hugh Hill
Joan Fowler
Harry Gamble
Donna Kettish

NOTE: THIS REGIONAL OFFICE CONTACT LIST HAS BEEN UPDATED AND IS AVAILABLE AS A DOWNLOAD UNDER THE WCMSA REVIEW PROCESS WEB PAGE

MEDICARE SECONDARY PAYER REGIONAL OFFICE COORDINATORS
(WORKERS' COMPENSATION CONTACTS)

NAME	REGIONAL OFFICE	PHONE
James Bryant	I--Boston	617-565-1331
Thomas Hatchfield		617-565-1254
Sedric Goutier		617-565-1228
Jerry Kerr	II--New York	212-264-3760
	III--Philadelphia	
Catherine McCoy		215-861-4250
Maria Kuehn		215-861-4306
Juanita Dixon	IV--Atlanta	404-562-7313
Geraldine Taylor		404-562-7311
	V--Chicago	
Janice Edwards		312-886-3256
Barry Thomas	VI--Dallas	214-767-6455
Doug Rundle	VII--Kansas City	816-426-5783
Cindy Christensen	VIII--Denver	303-844-7095
Rosie Sagum	IX--San Francisco	415-744-3655
Tom Bosserman		415-744-4907
Jean Tsutakawa	X--Seattle	206-615-2382
Jonella Windell		206-615-2385

Note: If the caller is simply contacting Medicare for the first time in order to report workers' compensation coverage (as opposed to seeking out RO approval of a proposed Medicare set-aside arrangement), then the caller should contact the Coordination of Benefits Contractor at
1-800-999-1118.

NOTE: THIS LIST HAS BEEN UPDATED

STATES IN EACH REGION

REGION	STATES
REGION I – BOSTON	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
REGION II – NEW YORK	New York Puerto Rico Virgin Islands
REGION III – PHILADELPHIA	Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia
REGION IV – ATLANTA	Alabama North Carolina South Carolina Florida Georgia Kentucky Mississippi Tennessee New Jersey Louisiana
REGION V – CHICAGO	Illinois Indiana Michigan Minnesota Ohio Wisconsin
REGION VI – DALLAS	Arkansas New Mexico Oklahoma Texas
REGION VII – KANSAS CITY	Iowa Kansas Missouri Nebraska

REGION VIII- DENVER	Colorado Montana North Dakota South Dakota Wyoming
REGION IX – SAN FRANCISCO	America Samoa Arizona California Guam Hawaii Nevada
REGION X – SEATTLE	Alaska Idaho Oregon Washington Utah

DATE: MAY 23, 2003

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer -- Workers' Compensation (WC) Additional Frequently Asked Questions

Questions raised are paraphrased below. This memorandum will be posted on the Centers for Medicare & Medicaid Services' (CMS) website.

1.) What are the review thresholds set by the July 23, 2001 All Associate Regional Administrators (ARA) letter concerning WC Commutation of Future Benefits?

Answer: They state that to the extent a WC settlement meets both of the criteria (i.e., the settlement is greater than $250,000 AND the claimant is reasonably expected to become a Medicare beneficiary within 30 months of the settlement date), then a CMS-approved Medicare set-aside arrangement is appropriate. However, if a WC settlement is $250,000 or less OR where the claimant of that settlement is not reasonably expected to become a Medicare beneficiary within 30 months of the settlement date, then a CMS-approved Medicare set-aside arrangement is unnecessary.

Additional Information: Please note that the current review thresholds are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected.

2.) When an injured individual's WC settlement does not meet the current review thresholds, will the Regional Offices (RO) provide the settling parties with "verification" letters confirming that approval of a Medicare set-aside arrangement is unnecessary?

Answer: No, the ROs will not provide "verification" letters. However, the CMS will honor threshold levels that are in effect as of the date of a WC settlement. (See the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits.)

3.) An injured individual, who does not have a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, settles his/her WC case for less than $250,000. Once this individual becomes a Medicare beneficiary, will CMS pay for services that are otherwise reimbursable under Medicare, that are related to the WC injury, even though funds still remain in the individual's settlement?

Answer: Yes. When an individual's settlement does not meet both thresholds Medicare will make payment for WC related services that are otherwise reimbursable under Medicare once the individual enrolls in Medicare.

NOTE: THE ABOVE ANSWER WAS REPLACED BY QUESTION 3 OF THE JULY 11, 2005 ARA MEMORANDUM

Additional Information: The CMS assumes that when a non-Medicare eligible claimant's WC settlement does not meet the 30-month and $250,000 thresholds, typically that individual will completely exhaust his/her settlement by the time Medicare eligibility is reached. Also, according to various members of the WC community, most settlements for these individuals are in the range of $10,000 to $50,000. Therefore, the amount of money in the settlement that is actually being provided for an individual's medical care normally will be appropriately exhausted before the individual becomes a Medicare beneficiary.

Please note that the current review thresholds (see the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits) are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected.

4.) Will CMS treat WC cases that were settled prior to the issuance of the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits in the same manner as those settled after the review threshold guidelines were established?

Answer: Yes. For WC settlements that do not meet the review thresholds, Medicare will make payment for WC related services that are otherwise reimbursable under Medicare, once the individual becomes enrolled in Medicare. This will be done regardless of when the settlement actually occurred. However, a reopening of claims (see 42 C.F.R. 405.750 and 405.841) that Medicare previously denied for these individuals will not be granted, nor will the CMS change any decisions already made with respect to settlements which pre-date July 23, 2001.

Additional Information: When the CMS issued the July 23, 2001 ARA letter, it established review thresholds for WC cases settled by injured individuals who are not yet Medicare beneficiaries. This was done in order to organize and prioritize workloads for its ROs and to convey to its ROs that it is not in Medicare's best interests to review WC settlements that do not meet the review thresholds.

All RO questions on the issues addressed in these "questions and answers" should be directed to Fred Grabau at (410) 786-0206.

Thomas L. Grissom

cc: All ARA's for Financial Management

ARA for DHPP RO VII
All RO MSP Coordinators

bcc: Paul Olenick
Martha Kuespert
Fred Grabau
Eve Fisher
Tina Merritt
Barbara Wright
Betty Noble
Hugh Hill
Joan Fowler
Harry Gamble
Donna Kettish

DATE: May 7, 2004

TO: All Regional Administrators

FROM: Director
Center for Medicare Management

SUBJECT: Medicare Secondary Payer **--** Workers' Compensation (WC)-- INFORMATION

THE PURPOSE OF THIS ALL REGIONAL ADMINISTRATORS MEMORANDUM IS TO REPLACE THE POLICY THAT WAS OUTLINED IN THE ANSWERS TO QUESTIONS IN THE ALL ASSOCIATE REGIONAL ADMINISTRATORS (ARA) MEMORANDUM CONCERNING WORKERS' COMPENSATION COMMUTATION OF FUTURE BENEFITS (ISSUED ON JULY 23, 2001, ATTACHED) AND IN THE ANSWER TO QUESTION SEVEN FROM THE APRIL 21, 2003 FREQUENTLY ASKED QUESTIONS (FAQ). The CMS replaces the policies regarding administrative fee and attorney costs specifically associated with establishing Medicare set-aside arrangements in question eleven of the July 23, 2001 ARA memorandum and question seven of the April 21, 2003 FAQ's with the following policy—

> Administrative fees/expenses for administration of the Medicare set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare set-aside arrangement cannot be charged to the set-aside arrangement. The CMS will no longer be evaluating the reasonableness of any of these costs because the payment of these costs must come from some other payment source that is completely separate from the Medicare set-aside arrangement funds.
>
> For example, if the settling parties submit a Medicare set-aside proposal to CMS that claims that the injured individual will need $50,000 worth of work-related medical expenses that would otherwise be reimbursable under Medicare and the settling parties claim that it will cost $10,000 in administrative and attorney fees in order to both administer and establish the Medicare set-aside arrangement proposal of $50,000, then CMS will only evaluate/judge the reasonableness of the $50,000 figure.
>
> The CMS will not evaluate whether or not the $10,000 in administrative and attorney fees are reasonable nor will CMS permit the settling parties to add that $10,000 amount to the $50,000 Medicare set-aside arrangement amount. Therefore, if CMS approves that proposal for a $50,000 Medicare set-aside arrangement, the settling parties $10,000 in administrative and attorney fees cannot be charged to/against the Medicare set-aside arrangement of $50,000 because CMS considers those costs to be a separate issue for the settling parties to negotiate.
>
> NOTE: This policy will be implemented on a prospective basis.

If you have any questions or concerns contact Fred Grabau at (410) 786-0206.

Herb Kuhn

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop Baltimore, Maryland 21244-1850

OFM/FSG/DMSPPO

DATE: October 15, 2004

TO: All Regional Administrators

FROM: Director
Financial Services Group Office of Financial Management

SUBJECT:

Medicare Secondary Payer (MSP) --Workers' Compensation (WC) Additional Frequently Asked Questions: 1) Use of WC Fee Schedule vs. Full Actual Charges for WC Medicare Set-aside Arrangement (WCMSA); 2) Self-administration of a WCMSA; 3) Up-front Settlement of Future Medicals vs. WCMSA; 4) Inflation Adjustment/Discount to Present Value; 5) Structured WCMSAs; 6) WC Claim Resolution Where Medicals Remain Open.

The above-referenced issues are addressed below. This memorandum will be posted on the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits website.

Q1. Use of WC Fee Schedule vs. Actual Charges for WC Medicare Set-aside Arrangement – What is CMS's policy with respect to reviewing WC Medicare Set-aside Arrangement proposals using either WC fee schedule amounts or full actual charges as the basis for the proposal?

A1. Effective with the issuance of this memorandum, CMS will use either the WC fee schedule (for states that have such schedules) or full actual charges for its review of a proposed WC Medicare Set-aside Arrangement based upon whichever methodology was used by the individual/entity submitting the proposal. The administrator of the WC Medicare Set-aside Arrangement (both professional administrators and self-administrators) should make payments

from the WC Medicare Set-aside Arrangement on the same basis. That is, if the proposal was submitted and approved based upon full actual charges, the administrator should make payment from the WC Medicare Set-aside Arrangement based upon full actual charges; if the proposal was submitted and approved Page 2 – Medicare Secondary – Workers' Compensation Additional Frequently Asked Questions

based upon WC fee schedule amounts, the administrator should make payment from the WC Medicare Set-aside Arrangement based upon WC fee schedule amounts.

NOTE: THE ABOVE ANSWER REPLACES QUESTION 9 ON THE JULY 23, 2001 ARA MEMORANDUM

Q2. Self-administration of a WC Medicare Set-aside Arrangement -- If an individual has a designated representative payee for Social Security purposes pursuant to 20 C.F.R. 404.2010 and 404.2015 (e.g., because the individual is legally incompetent, mentally incapable of managing benefit payments, etc.), has an appointed guardian/conservator, or has otherwise been declared incompetent by a court, may that individual self-administer his/her Medicare set-aside arrangement?

A2. WC Medicare Set-aside Arrangements must be administered by a competent administrator (the representative payee, a professional administrator, etc.). Moreover, when an individual does (in fact) have a designated representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties must include that information in their Medicare set-aside arrangement proposal to CMS.

Q3. Up-front Settlement of Future Medicals vs. WC Medicare Set-aside Arrangement --May Medicare accept an up-front cash settlement for future medicals directly from the settling parties instead of a WC Medicare Set-aside Arrangement?

A3. CMS currently has no process to accept up-front cash payments in lieu of a CMS-approved WC Medicare Set-aside Arrangement.

Q4. Inflation Adjustment/Discount for Present Value/Change in Policy – Must the WC Medicare Set-aside Arrangement include an upward adjustment for inflation? May the WC Medicare Set-aside Arrangement include a downward adjustment as a discount for the present-day value of the total WC Medicare Set-aside Arrangement?

A4. Effective with the issuance of this memorandum, CMS's position is that the WC Medicare Set-aside Arrangement does not need to be indexed for inflation and may not be discounted to present-day value.

NOTE: THIS ANSWER REPLACES QUESTION 7 IN THE JULY 23, 2001 ARA MEMORANDUM

Q5. Can a WC Medicare Set-aside Arrangement be established as a structured arrangement, where payments are made to the arrangement on a defined schedule to cover expenses

projected for future years?
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A5. Yes. However, CMS will approve a payout amount for services that would otherwise be reimbursable by Medicare from the WC Medicare Set-aside Arrangement in the following manner:

The seed money for the WC Medicare Set-aside Arrangement must include an amount equal to the amount of monies calculated to cover the first surgery procedure and/or replacement and two years of annual payments.

The remainder of the approved amount should be divided by the remainder of the claimant's life expectancy (or a shorter defined period of time if CMS has agreed to a shorter time period).

Subsequent annual deposits into the WC Medicare Set-aside Arrangement are to be based upon a set "anniversary date" which cannot be more than one year after the settlement date.

NOTE: THIS ANSWER IS INTENDED TO PROVIDE CLARIFICATION OF QUESTION 10 IN THE APRIL 21, 2003 ARA MEMORANDUM AND FAQ #1903

Q6. WC Claim Resolution Where Medicals Remain Open – Is a WC Medicare Set-aside Arrangement appropriate when resolution of the WC claim leaves the medical aspects of the claim open?

A6. No. However, a WC Medicare Set-aside Arrangement is appropriate where the resolution of the WC claim permanently closes the medical aspects of the claim, and the claimant will require future medical services related to the WC claim that Medicare would otherwise reimburse.

Please direct questions or concerns to Eve Fisher at (410) 786-5641.

/s/ Gerald
Walters

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DATE: July 11, 2005

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer (MSP) – Workers' Compensation (WC)
Additional Frequently Asked Questions

TO: **All Regional Administrators**

Additional Frequently Asked Questions:

1 Clarification of WCMSA Non-beneficiary Threshold;
2 Low Dollar Threshold for Medicare Beneficiaries;
3 Use of WC Settlement Funds Prior to Medicare Entitlement;
4 Avoiding the Continuation of Indemnity Payments While Waiting for CMS to Review a WC Medicare Set-aside Arrangement (WCMSA);
5 Settlement of WC Medical Expenses Prior to Submission to CMS;
6 Treatment of Taxable Interest Income Earned on a WCMSA;
7 Sample Submission of a WCMSA;
8 Group Health Plan (GHP) Insurance and Veteran's Administration (VA) Coverage;
9 Loss of Medicare Entitlement after CMS Approval of a WCMSA;
10 Beneficiaries that Request Termination of WCMSA Funds;
11 Compromising of Future Medical Expenses;
12 Additional Information Submission after WCMSA Case is Closed;
13 Effect of WCMSA on Medicaid Eligibility;
14 CMS Recognition of State Specific Statutes;
15 Transfer Mechanism for Items and Services Not Covered by Medicare.

The above-referenced issues are addressed below. This memorandum will be posted on the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits website @ www.cms.hhs.gov/medicare/cob/attorneys/att_wc.asp.

Q1. Clarification of WCMSA Review Thresholds – Should I establish a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) even if I am not yet a Medicare beneficiary and/or even if I do not meet the CMS thresholds for review of a WCMSA proposal?

A1. The thresholds for review of a WCMSA proposal are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered.

Q2. Low Dollar Threshold for Medicare Beneficiaries – Has Medicare considered a low dollar threshold for review of WCMSA proposals for Medicare beneficiaries?

A2. Effective with the issuance of this memorandum, CMS will no longer review new WCMSA proposals for Medicare beneficiaries where the total settlement amount is less than $10,000. In order to increase efficiencies in our process, and based on available statistics, CMS is instituting this workload review threshold. However, CMS wishes to stress that this is a CMS workload review threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases.

Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

Also note that both the beneficiary and non-beneficiary review thresholds are subject to adjustment. Claimants, employers, carriers, and their representatives should regularly monitor the CMS website at www.cms.hhs.gov/medicare/cob/attorneys/att_wc.asp for changes to these thresholds and for other changes in policies and procedures.

Q3. Use of WC Settlement Funds Prior to Medicare Entitlement – May workers' compensation settlement funds attributable to future medicals be used prior to Medicare entitlement?

A3. For claimants who are not yet Medicare beneficiaries and for whom CMS has approved a WCMSA, the WCMSA may be used prior to becoming a beneficiary because the amount was priced based on the date of the expected settlement. Use of the WCMSA is limited to services that are related to the workers' compensation claim or settlement and that would be covered by Medicare if the individual were a Medicare beneficiary. The same requirements that Medicare beneficiaries follow for reporting and administration are to be used in the

above cases. The CMS will not pay for any expenses related to the workers' compensation illness or injury until a self-attestation document or a full accounting of all monies expended from the WCMSA are sent to the lead contractor upon Medicare entitlement. At that time, the lead contractor will adjust the WCMSA record to reflect the expenses paid prior to entitlement.

Even if there is no CMS-approved WCMSA, any funds from a WC settlement attributable to future medicals that are remaining at the time a claimant becomes a Medicare beneficiary must be used for Medicare-covered services related to the workers' compensation claim or settlement until such funds are exhausted. Only then will CMS pay for Medicare-covered services related to the workers' compensation claim or settlement.

NOTE: THE ABOVE ANSWER REPLACES THE FIRST PARAGRAPH OF THE NOTE AT THE END OF ANSWER NUMBER FOUR IN THE JULY 23, 2001 ARA WC MEMORANDUM AND QUESTION NUMBER THREE IN THE MAY 23, 2003 ARA WC MEMORANDUM.

Q4. Avoiding the Continuation of Indemnity Payments While Waiting for CMS to Review a WCMSA – Is there a way to avoid the continuation of indemnity payments while awaiting a CMS determination on a proposed WCMSA?

A4. Yes. To avoid this situation, CMS recommends that the claimant (or the claimant's representative) close out the indemnity portion of the settlement and leave the settlement of medical expenses open pending a determination by CMS on the proposed WCMSA. In determining the review thresholds, the total settlement amount, including indemnity and medicals, shall be used.

Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

Q5. Settlement of WC Medical Expenses Prior to Submission to CMS – Can the parties proceed with the settlement of the medical expenses portion of a WC claim before CMS actually reviews the proposed WCMSA and determines an amount that adequately protects Medicare's interests?

A5. The parties may proceed with the settlement, but any statement in the settlement of the amount needed to fund the WCMSA is not binding upon CMS unless/until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount as specified by CMS that adequately protects Medicare's interests as a result of its review.

If CMS does not subsequently provide approval of the funded WCMSA amount as specified in the settlement and proof is not provided to CMS that the CMS-approved amount has been fully funded, CMS may deny payment for services related to the WC claim up to the full

amount of the settlement. Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA. This shall be demonstrated by submitting a copy of the final, signed settlement documents indicating the WCMSA is the same amount as that recommended by CMS.

As a reminder, the claimant may be at risk if the WCMSA is funded for less than the amount that CMS determines to be adequate to protect Medicare's interests.

Q6. Treatment of Taxable Interest Income Earned on a WCMSA – If I receive a Form 1099-INT for the interest income earned on my WCMSA account, may I charge the income tax on that amount against the WCMSA?

A6. Assuming that there is adequate documentation for the amount of incremental tax that the claimant must pay for the interest earned on this set-aside account, the claimant or his/her administrator may withdraw an amount equal to the additional tax as a "cost that is directly related to the account" to cover the additional tax liability. Such documentation should be submitted along with the annual accounting.

Q7. Sample Submission of a WCMSA – Does CMS provide an example of what a proper WCMSA looks like?

A7. Yes, at http://www.cms.hhs.gov/medicare/cob/pdf/attwc_sample.pdf**,** CMS has posted a sample WCMSA proposal. Any comments or questions regarding this sample submission should be directed to mspcentral@cms.hhs.gov.

Q8. Group Health Plan (GHP) Insurance, Managed Care Plan, and Veterans' Administration (VA) Coverage – In a WC settlement, is a WCMSA recommended where the claimant is covered under a GHP or a managed care plan, or has coverage through the VA?

A8. Yes, a WCMSA is still appropriate because such other health insurance or health service could in the future be canceled or reduced, or the injured individual may elect not to take advantage of such services. It is important to remember that workers' compensation is always primary to Medicare and many other types of health insurance coverage for expenses related to the WC claim or settlement.

Q9. Loss of Medicare Entitlement after CMS Approval of a WCMSA – Am I entitled to a release of my WCMSA funds if I lose my Medicare entitlement?

A9. No. However, the funds in the WCMSA may be expended for medical expenses specified in the WCMSA until Medicare entitlement is re-established or the WCMSA is exhausted. Use of the WCMSA is limited to services that are related to the workers' compensation claim or settlement and that would be covered by Medicare if the individual were a Medicare beneficiary. The same requirements that Medicare beneficiaries follow for reporting and administration are to be used in the above cases. The CMS will not pay for any expenses related to the workers' compensation claim or settlement until a self-attestation document or a full accounting of all monies expended from the WCMSA are sent to the lead contractor

upon the re-establishment of Medicare entitlement. At that time, the lead contractor will adjust the WCMSA record to reflect the expenses paid prior to entitlement.

Q10. Beneficiaries that Request Termination of a WCMSA Account – May a claimant have any or all of a WCMSA released for personal purposes under any circumstances?

A10. The administrator of the CMS-approved WCMSA should not release set-aside funds for any purpose other than the purpose for which the WCMSA was established without approval from CMS. However, if the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary (or the beneficiary's representative) may submit a new WCMSA proposal covering future expected medical expenses. Such proposals must justify at least a 25% reduction in the outstanding WCMSA funds. In addition, such proposal may not be submitted until at least five years after a previous CMS approval letter and should be accompanied by all supporting documentation not previously submitted with the original WCMSA proposal. The CMS decision on the new proposal is final and not subject to administrative appeal.

The above proposals shall be submitted to CMS c/o COBC. If CMS determines that a 25% or greater reduction is justified, CMS will issue a new approval letter. After CMS issues a new approval letter, any funds in the current WCMSA in excess of the newly calculated amount may be released to the claimant.

NOTE: THE ABOVE ANSWER REPLACES QUESTION NUMBER ELEVEN IN THE APRIL 21, 2003 ARA WC MEMORANDUM.

Q11. Compromising of Future Medical Expenses – Does CMS compromise or reduce future medical expenses related to a WC injury?

A11. No. Some submitters have argued that 42 C.F.R. §411.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a WC injury.

Q12. Additional Information Submission after WCMSA Case Is Closed – If I disagree with the amount that CMS has determined for my WCMSA, do I have any recourse?

A12. There are no appeal rights stemming from a CMS determination of the appropriate amount of a WCMSA; however, claimants and submitters have several other options available to them. First, a claimant or submitter may always contact the Regional Office that issued the CMS determination for a clarification. Also, if the claimant or submitter believes that a CMS determination contains obvious mistakes, such as mathematical errors or failure to recognize that medical records already submitted show that a surgery that CMS priced has already occurred, then the claimant or submitter should contact the CMS Regional Office that issued the CMS determination for a correction of the errors.

Where the claimant or submitter believes that CMS has misinterpreted the evidence or disagrees with the CMS determination for some other reason, there are two choices available. If the claimant or submitter believes that there is additional evidence not previously

considered by CMS that would warrant a change in the CMS determination, the claimant or submitter may resubmit the case with the additional evidence and request a re-evaluation. The re-evaluation request should be clearly marked as such, submitted to the Coordination of Benefits Contractor (COBC), P.O. Box 660, New York, New York 10274-660, and must be accompanied by additional evidence not available at the time of the original submission. It will then be considered a new submission and shall be processed in order of receipt. Although a claimant has no formal appeal rights with respect to the WCMSA process, beneficiaries do have appeal rights with respect to specific denied claims. If CMS denies a submitted claim for a service on the basis that CMS determined the WCMSA amount has not been exhausted, the beneficiary may appeal that specific claim denial through the administrative appeal process.

Q13. Effect of WCMSA on Medicaid Eligibility – Does a WCMSA have an effect on Medicaid resources for purposes of eligibility to Medicaid?

A13. Medicare set-aside arrangements are not subject to any special treatment under Medicaid resource rules. These funds should be evaluated to determine if they meet the legal definition of a resource for Supplemental Security Income (SSI), and therefore Medicaid, purposes, i.e., "cash or other assets that an individual owns and could convert to cash to be used for his or her support and maintenance." The funds must be in interest-bearing accounts. These funds may meet the SSI/Medicaid resource definition.

There may be cases in which funds in a Medicare set-aside arrangement are placed into trusts, possibly trusts that would satisfy the definition of "special needs trusts" under Section 1917 of the Social Security Act. In those cases, the funds might not be a countable resource, but that result would be solely on the basis of Medicaid, not Medicare, rules.

Q14. State Specific Statutes - Does CMS recognize or honor any State-specific statutes that conflict with CMS policy?

A14. The CMS will recognize or honor any non-compensable medical services and CMS will separately evaluate any special situations regarding workers' compensation cases. This is subject to a copy of the applicable statute being forwarded to the COBC, P.O. Box 660, New York, New York 10274-660, as part of the case file.

Q15. Transfer Mechanism for Items and Services Not Covered by Medicare –Is a mechanism for items and services not covered by Medicare that may later become covered necessary?

A15. Should the settlement agreement provide for items and services that are not covered by Medicare but later become covered, those funds should then be considered part of the set-aside and treated accordingly, i.e., used to pay for any services as they were designated in the non-Medicare portion of the set-aside included in the WC settlement. These funds do not have to be transferred to a separate WCMSA bank account or be included in the annual WCMSA accounting.

NOTE: THE ABOVE ANSWER REPLACES THE ANSWER TO QUESTION 7 OF THE JULY 23, 2001 ARA MEMORANDUM.

Please direct questions or concerns to Eve Fisher at (410)-786-5641.

/s/
Gerald Walters

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MEMORANDUM

DATE: **December 30, 2005**

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) Questions and Answers

TO: All Regional Administrators

Beginning January 1, 2006, Medicare will begin its Part D prescription drug coverage as a result of the implementation of the Medicare Modernization Act of 2003 (MMA). This memorandum includes policy regarding the inclusion of prescription drugs that Medicare will cover as of January 1, 2006, in Workers' Compensation Medicare Set-aside Arrangements (WCMSAs).

NOTE: References to prescription drugs in this document are limited to those prescription drugs that are for the treatment of the Workers' Compensation (WC) related injury(ies) and/or illness(es)/disease(s), (hereinafter referred to as "WC injury") and those where Medicare provides coverage.

Question 1: What is the Centers for Medicare & Medicaid Services' (CMS) policy regarding the inclusion of prescription drugs in WCMSAs with the implementation of the MMA?

Answer 1: All WC settlements that occur on or after January 1, 2006, must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare. The recommended method to protect Medicare's interests is to include a WCMSA as part of the WC settlement.

Question 2: Will the submission of WCMSA proposals change with the implementation of the MMA on January 1, 2006?

Answer 2: Yes, the submission of WCMSA proposals will change with the implementation of the MMA on January 1, 2006. For WCMSA proposals received by CMS' Coordination of Benefits Contractor (COBC) on or after January 1, 2006, the cover letter must include separate amounts for: (1) future medical treatment, and (2) future prescription drug treatment. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount (*i.e.,* actual costs, average wholesale price, etc.).

Question 3: What happens if a WCMSA proposal received on or after January 1, 2006, does not include an amount for future prescription drug treatment?

Answer 3: If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, the submitter did not adequately consider Medicare's interests. In such a case, CMS will advise the submitter in its written opinion that the parties to the WC settlement may not have protected Medicare's interests.

If the cover letter does not include an amount for future prescription drug treatment, and there is no indication in the current treatment records that the claimant will need future treatment with prescription drugs related to the WC injury, then CMS will accept that Medicare's interests have been adequately protected. Medicare will then pay primary for future prescription drugs if the beneficiary has enrolled in a Medicare prescription drug plan and does not have any other coverage that is primary to Medicare.

Question 4: Will CMS' review of WCMSA proposals change with the implementation of the MMA on January 1, 2006?

Answer 4: The CMS' review of WCMSA proposals will not change until it begins to independently price for future prescription drug treatment for WCMSAs received by the COBC on or after January 1, 2007. Until the review of future prescription drug treatment begins on January 1, 2007, CMS will continue to review and independently price for future Medicare-covered medical expenses in WCMSAs in accordance with CMS' published policy memoranda dated: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; and July 11, 2005.

For a WCMSA proposal received by COBC on or after January 1, 2006, CMS will provide in its written opinion the total WCMSA amount that adequately protects Medicare's interests with regard to the claimant's future medical treatment. In addition, CMS' written opinion will note the submitted prescription drug amount. The CMS' written opinion will provide the total WCMSA amount, which is a combination of the future medical treatment reviewed by CMS and the future prescription drug costs noted in the submitter's cover letter. The parties to the WC settlement must note the total WCMSA amount in the final settlement agreement. Once the final settlement agreement is submitted to CMS' COBC, the claimant and all other parties to the WC settlement can rely on CMS' written opinion regarding whether the WC settlement adequately protects Medicare's interests.

The total WCMSA amount (future medical treatment and future prescription drug treatment) must be deposited in an interest bearing account. The administrator of the WCMSA must forward an annual accounting, separately identifying the expenditures for the medical treatment and prescription drug treatment to the Medicare contractor responsible for monitoring the claimant's case. For example, if the total WCMSA amount in CMS' written opinion is $10,000 ($7,000 identified for future prescription drug treatment and $3,000 identified for future medical expenses), then the administrator must forward an annual accounting that separately identifies how much of the $10,000 was spent for medical expenses and prescription drugs. Exhaustion of the total WCMSA amount is not limited to the separate amounts set-aside for future medical expenses and future prescription drug treatment. As long as the annual accounting shows bona fide payments were made from the total WCMSA account, CMS will consider the account appropriately exhausted. For example, final actual expenditures may be $6,000 for future prescription drug treatment and $4,000 for the future medical expenses that may appropriately exhaust the $10,000 WCMSA.

Question 5: Will the submission of WCMSA proposals change when CMS begins to review and independently price for future prescription drug treatment on January 1, 2007?

Answer 5: When CMS begins to review and independently price for future prescription drug treatment on January 1, 2007, the submitter must include in the cover letter separate amounts for: (1) future medical treatment, and (2) future prescription drug treatment. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount (*i.e.,* actual costs, average wholesale price, etc.). Moreover, the submitter must include with the submission a payment history of the prescription drugs paid by the WC carrier, as follows:

- If the injury occurred less than 2 years from the date of the submission, a payment history should include those prescription drugs paid from the injury date through the date of submission.

- If the injury occurred more than 2 years from the date of the submission, a payment history should include the last 2 years of payments for prescription drugs.

The CMS will review WCMSAs that include an allocation for future treatment with prescription drugs based on the required payment history, anticipated future prescription drug treatment information, and Medicare Part D data. If the submitter fails to provide a payment history or the payment history reflects that the WC carrier did not previously pay for prescription drugs indicated for the claimant's future treatment, CMS will independently price the Medicare-covered prescription drugs using CMS information available from current Medicare Part D data.

Question 6: Should funds for future prescription drug treatment be included in the calculation of the total settlement amount to determine if the WCMSA proposal should be reviewed by CMS?

Answer 6: Yes, the total settlement amount calculation should include an amount for prescription drugs if the future treatment indicates that the claimant has been prescribed drugs and/or may need drugs in the future. As stated in the July 11, 2005 memorandum, the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, ***all*** future medical expenses, and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously *settled* portion of the WC claim must be included in computing the total settlement amount.

Current review thresholds for Medicare beneficiary and non-beneficiary WCMSA proposals will remain in effect as stated in the following policy memoranda: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; and July 11, 2005.

Note: Question/Answer #6 is not a change in CMS' policy for determining whether a WC settlement that includes a WCMSA meets CMS' review thresholds.

Question 7: Do claimants have to resubmit their WCMSA proposals if CMS already issued a written opinion as to the total WCMSA amount?

Answer 7: No, claimants do not have to resubmit their WCMSA proposals, if CMS has already issued a written opinion as to the total WCMSA amount for settlements occurring prior to January 1, 2006, or where the WCMSA review occurred prior to January 1, 2006, the MMA implementation date.

Note: If the WC settlement occurred prior to January 1, 2006, and the WC settlement included an allocation for future prescription drug treatment, then the claimant must exhaust those funds prior to billing Medicare for those future prescription drugs. For example, if the WC settlement allocates $5,000 for prescription drugs related to the WC injury, then the claimant must exhaust that amount from the settlement funds before billing Medicare for prescription drug costs incurred on or after January 1, 2006. However, the claimant does not have to transfer these funds to the existing WCMSA account or include them in the annual WCMSA accounting.

THE ABOVE NOTE CLARIFIES Q/A #15 OF THE JULY 11, 2005 MEMORANDUM.

/s/

Gerald Walters
Director, Financial Services Group
Office of Financial Management

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

MEMORANDUM

DATE: **April 25, 2006**

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries

TO: All Regional Administrators

The purpose of this memorandum is to replace Q/A #2 of the July 11, 2005 Memorandum with regard to the Centers for Medicare & Medicaid Services' (CMS') low dollar WCMSA threshold for Medicare beneficiaries. Effective with the issuance of this memorandum, CMS will only review new WCMSA proposals for Medicare beneficiaries where the total settlement amount is greater than $25,000.00. The CMS wishes to stress that this is a CMS **workload review** threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases.

Note that the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

Also note that both the beneficiary and non-beneficiary review thresholds are subject to adjustment. Claimants, employers, carriers and their representatives should regularly monitor the CMS website at www.cms.hhs.gov/WorkersCompAgencyServices for changes to these thresholds and for other changes in policies and procedures.

/s/

Gerald Walters

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Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: **July 24, 2006**

FROM: **Director**
Financial Services Group
Office of Financial Management

SUBJECT: **Questions and Answers for Part D and Workers' Compensation Medicare Set-aside Arrangements**

TO: **All Regional Administrators**

This memorandum **supersedes** the Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSA) memorandum that was published on December 30, 2005. It includes policy regarding the inclusion of future prescription drug treatment costs/expenses in WCMSAs.

> **NOTE:** References to prescription drugs in this document are limited to those prescription drugs that are for the treatment of the Workers' Compensation (WC) related injury(ies) and/or illness(es)/disease(s), (hereinafter referred to as "WC injury") and those where Medicare provides coverage.

Question 1: What is the Centers for Medicare & Medicaid Services' (CMS) policy regarding the inclusion of prescription drugs in WCMSAs with the implementation of the MMA?

Answer 1: All WC settlements that occur on or after January 1, 2006 must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare. The recommended method to protect Medicare's interests is to include a WCMSA as part of the WC settlement. However, if the WC claim settled prior to January 1, 2006, the WCMSA proposal does not need to include an amount for future prescription drug treatment.

Question 2: How does CMS define a WC "settlement"?

Answer 2: A WC "settlement" is an executed settlement agreement that is approved by the court of competent jurisdiction for the applicable state.

Question 3: What are CMS' submission requirements if the WC claim did not "settle" (as defined in Answer 2 above) prior to January 1, 2006?

Answer 3: If the WC case did not "settle" (as defined in Answer 2 above) prior to January 1, 2006 and the WCMSA proposal is received by CMS' Coordination of Benefits Contractor (COBC) on or after January 1, 2006, then the submitter must include separate amounts for future medical treatment and future prescription drug treatment in the cover letter. In addition, the cover letter must include an explanation as to how the submitter calculated the future prescription drug treatment amount (*i.e.,* actual costs, average wholesale price, etc.).

For structured WCMSA proposals, the submitter must also indicate whether any portion of the future prescription drug treatment amount has been included in the initial deposit (i.e., seed money). Per Question and Answer Number 5 of the October 15, 2004 memorandum, the seed money for a structured WCMSA must include a sum equal to the amount of monies calculated to cover the first surgery procedure and/or replacement and two years of annual payments (which must include prescription drug treatment). The remainder of the approved amount should be divided by the remainder of the claimant's life expectancy (or a shorter defined period of time if CMS has agreed to a shorter time period).

> **NOTE:** The amount for future prescription drug treatment should **not** be a separate annuity from the future medical portion of the WCMSA.

Question 4: What happens if CMS closes its case because the submitter failed to provide requested information in a timely manner?

Answer 4: If the WC case did not "settle" (as defined in Answer 2 above) prior to January 1, 2006, and the submitter provides additional documentation with regard to the closed case on or after January 1, 2006, the case is considered a new WCMSA submission and the requirements included in this memorandum related to: (1) future medical treatment; and, (2) future prescription drug treatment will be applied to the new WCMSA submission.

If the WC claim settled prior to January 1, 2006 and the submitter provides additional documentation with regard to a closed case, the case is considered a new WCMSA submission; however, the WCMSA proposal **does not** need to include an amount for future prescription drug treatment.

Question 5: Should submitters provide an explanation in the cover letter when the claimant has not been prescribed drugs for the work-related injury, illness/disease or if the drugs prescribed are excludable under the MMA?

Answer 5: Yes. Submitters should provide such an explanation in the cover letter when submitting their WCMSA proposals to CMS.

Question 6: Where a WC claim settled prior to January 1, 2006, can the claimant use the WCMSA funds to pay for prescription drug expenses related to the WC injury?

Answer 6: No, the claimant cannot use the WCMSA funds to pay for prescription drug expenses related to the WC injury. If the WC settlement included an allocation for non-Medicare covered medical and/or prescription drug expenses, the claimant must exhaust those funds prior to billing Medicare for prescription drugs. However, the claimant does not have to transfer these funds to the existing WCMSA account or include them in the annual WCMSA accounting. After exhausting these funds, if the claimant enrolls in a Part D plan, Medicare may be billed for prescription drug expenses related to the WC injury, assuming that the claimant does not have any other coverage primary to Medicare.

> **NOTE:** The above questions clarify Question and Answer Number 5 of the July 11, 2005 memorandum.

Question 7: Should submitters include an amount for future prescription drug expenses if the claimant has not enrolled in a Part D plan?

Answer 7: Yes. Claimants who have not enrolled in a Part D plan need to include future prescription drug expenses in their WCMSA proposals if the current treatment records indicate that the claimant has been prescribed drugs and/or may need future prescription drug treatment related to the WC injury.

Question 8: Has CMS' review of WCMSA proposals changed with the implementation of the MMA on January 1, 2006?

Answer 8: The CMS' review of WCMSA proposals has not changed with the implementation of the MMA. The CMS continues to review and independently price for future Medicare-covered medical expenses in WCMSAs in accordance with CMS' published policy memoranda dated: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; July 11, 2005; and April 25, 2006.

For a WCMSA proposal received by COBC on or after January 1, 2006, CMS will provide in its written opinion the total WCMSA amount that adequately protects Medicare's interests with regard to the claimant's future medical treatment. However, CMS' written opinion will also note the submitted prescription drug amount. The CMS' written opinion will provide the total WCMSA amount, which is a combination of the future medical treatment reviewed by CMS and the future prescription drug costs noted in the submitter's cover letter. The parties to the WC settlement must note the total WCMSA amount in the

final settlement agreement. Once the final settlement agreement is submitted to CMS' COBC, the claimant and all other parties to the WC settlement can rely on CMS' written opinion regarding whether the WC settlement adequately protects Medicare's interests.

The total WCMSA amount (future medical treatment and future prescription drug treatment) must be deposited in an interest-bearing account. The administrator of the WCMSA must forward an annual accounting, separately identifying the expenditures for the medical treatment and prescription drug treatment, to the Medicare contractor responsible for monitoring the claimant's case. For example, if the total WCMSA amount in CMS' written opinion is $10,000 ($7,000 identified for future prescription drug treatment and $3,000 identified for future medical expenses), then the administrator must forward an annual accounting that separately identifies how much of the $10,000 was spent for medical expenses and prescription drugs. Exhaustion of the total WCMSA amount is not limited to the separate amounts set-aside for future medical expenses and future prescription drug treatment. As long as the annual accounting shows bona fide payments were made from the total WCMSA account, CMS will consider the account appropriately exhausted. For example, final actual expenditures may be $6,000 for future prescription drug treatment and $4,000 for the future medical expenses that may appropriately exhaust the $10,000 WCMSA.

Question 9: What happens if a WCMSA proposal received by the COBC on or after January 1, 2006, does not include an amount for future prescription drug treatment?

Answer 9: If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future*,* the submitter did not adequately consider Medicare's interests. In such a case, CMS, in its written opinion, will advise the submitter that the parties to the WC settlement have not protected Medicare's interests.

If the cover letter does not include an amount for future prescription drug treatment, and there is no indication in the current treatment records that the claimant will need future treatment with prescription drugs related to the WC injury, then CMS will accept that Medicare's interests have been adequately protected. Medicare will then pay primary for future prescription drugs if the beneficiary has enrolled in a Medicare prescription drug plan and does not have any other coverage that is primary to Medicare.

Question 10: Has CMS published any guidelines about how to price for future prescription drug expenses in WCMSAs?

Answer 10: No. The CMS has not published any guidelines regarding the pricing for future prescription drug expenses in WCMSAs.

Question 11: Should funds for future prescription drug treatment be included in the calculation of the total settlement amount to determine if the WCMSA proposal should be reviewed by CMS?

Answer 11: Yes, the total settlement amount calculation should include an amount for prescription drugs if the future treatment indicates that the claimant has been prescribed drugs and/or may need drugs in the future. As stated in the July 11, 2005 memorandum, the computation of the total settlement amount includes, but is not limited to, wages, attorney fees, ***all*** future medical expenses, and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously ***settled*** portion of the WC claim must be included in computing the total settlement amount.

Current review thresholds for Medicare beneficiary and non-beneficiary WCMSA proposals will remain in effect as stated in the following policy memoranda: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; July 11, 2005; and April 25, 2006.

> **NOTE**: Question and Answer Number 11 is not a change in CMS' policy for determining whether a WC settlement that includes a WCMSA meets CMS' review thresholds.

Question 12: Do claimants have to resubmit their WCMSA proposals if CMS already issued a written opinion as to the total WCMSA amount?

Answer 12: No, claimants do not have to resubmit their WCMSA proposals if CMS has already issued a written opinion as to the total WCMSA amount.

> **NOTE:** If the WC settlement occurred prior to January 1, 2006, and the WC settlement included an allocation for future prescription drug treatment, then the claimant must exhaust those funds before Medicare can be billed for those future prescription drugs. For example, if the WC settlement allocates $5,000 for prescription drugs related to the WC injury, then the claimant must exhaust that amount from the settlement funds before Medicare can be billed for prescription drug costs incurred on or after January 1, 2006. However, the claimant does not have to transfer these funds to the existing WCMSA account or include them in the annual WCMSA accounting.
>
> **NOTE:** The above note clarifies Question and Answer Number 15 of the July 11, 2005 memorandum.

Question 13: Will CMS begin to independently price for future prescription drug treatment in WCMSAs beginning on January 1, 2007?

Answer 13: No. Beginning January 1, 2007, CMS will not change its current procedures and will not independently price for future prescription drug treatment in WCMSA

proposals. The CMS will provide advanced notification when it plans to begin to independently price for future prescription drug treatment in WCMSAs. The CMS will continue to review and independently price for future Medicare-covered medical expenses in WCMSAs in accordance with CMS' published policy memoranda dated: July 23, 2001; April 21, 2003; May 23, 2003; May 7, 2004; October 15, 2004; July 11, 2005; and April 25, 2006.

/s/

Gerald Walters

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-14-00
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: May 20, 2008

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer **--** Workers' Compensation -- INFORMATION

TO: Consortium Administrators for Financial Management and Fee-for-Service Operations

The purpose of this memorandum is to include policy regarding the exclusive use of the Centers for Disease Control (CDC) Table 1 (All American Table) when determining life expectancy in Workers' Compensation Medicare Set-Asides (WCMSA) proposals. The Centers for Medicare & Medicaid Services (CMS) will only accept life expectancies obtained from the CDC Table 1, "Life table for the total population."

Effective with WCMSA submissions received by CMS' Coordination of Benefits Contract on or after July 1, 2008, CMS will only accept life expectancies obtained from the CDC Table 1, "Life table for the total population." The CMS will only use the CDC Table 1 in its WCMSA review process.

Please direct questions or concerns to Frank Johnson of my staff at (410) 786-2892.

Gerald Walters

Gerald Walters

cc:
Charlotte Foster, ARA, DFMFFSO

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-14-00
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: **August 25, 2008**

FROM: Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer **--** Workers' Compensation -- INFORMATION

TO: Consortium Administrator for Financial Management and Fee-for-Service Operations

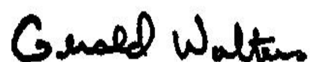
The purpose of this memorandum is to include policy regarding the pricing of Implantable Devices and to replace the policies regarding "Beneficiaries that Request Termination of a Workers' Compensation Medicare Set-Aside (WCMSA) Account" in Question and Answer 10 of the July 11, 2005 Associate Regional Administrator memorandum.

Effective with WCMSA submissions received by the Centers for Medicare & Medicaid Services' (CMS') Coordination of Benefits Contractor on or after September 1, 2008, if the WCMSA proposal includes the pricing for any Implantable Device(s) and does not include enough information as illustrated on the sample, "Pricing for a Spinal Cord Stimulator," or if the WCMSA proposal does not include pricing for any Implantable Device(s), and it is determined upon review of the WCMSA proposal, an Implantable Device(s) is recommended for the claimant and CMS will then utilize its own cost-finding methodology.

Effective immediately, the July 11, 2005 memorandum at Question and Answer 10, entitled "Beneficiaries that Request Termination of a WCMSA Account," is rescinded. Section 1862(b)(2) of the Social Security Act (the Act) (42 USC 1395y(b)(2)) requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation (WC) law or plan. Medicare does not pay for an individual's WC related medical services when that individual received a WC settlement, judgment or award that includes funds for future medical expenses, until all such funds are properly expended. To protect the Medicare Trust Fund, a set-aside arrangement should be funded based on the life expectancy of the individual unless the State law specifically limits the length of time that WC covers work-related conditions. Unless a submitter furnishes acceptable proof of a

Rated Age for a claimant, CMS will estimate the claimant's remaining life expectancy using Actual Age. Acceptable proof of Rated Ages includes independent rated ages on the letterhead of an insurance carrier or settlement broker and a statement from the submitter that all rated ages obtained on the claimant have been included.

Please direct questions or concerns to Frank Johnson of my staff at (410) 786-2892.



Gerald Walters

Attachment

cc:
Charlotte Foster, ARA, DFMFFSO

SAMPLE

Pricing for an implantable device							
Claimant:							
	Manufacturer	Model # or type	Useful life of item	Describe evidence to support useful life (and give exhibit reference, if any)	Cost (including tax, freight, and handling)	Describe evidence to support cost (and give exhibit reference, if any)	State evidence to support suitability of this particular item for this claimant (and give exhibit reference, if any)
A. Device							
B. Electrodes							
C. Receiver							
D. Other							
	Facility type	Inpatient or outpatient?	Procedure code(s)	If fee schedule, State and region	Cost	Describe evidence to support cost (and give exhibit reference, if any)	DRG or OPPPS code
E. Facility fee							
	Facility type	Inpatient or outpatient?	Procedure code(s)	If fee schedule, State and region	Cost	Describe evidence to support cost (and give exhibit reference, if any)	
F. Surgeon							
G. Anesthesiologist							
H. Programming services							
Total Cost (A thru H)							

Commutation vs. compromise

Ref: 7/23/01 Memo

One of the distinctions that Medicare regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump-sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump-sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.

WC commutation cases are settlement awards intended to compensate individuals for future medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. Conversely, a compromise case may posses a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump-sum settlement agreement to be both a WC compromise and a WC commutation case.

Generally, parties to WC commutation cases agree on a lump sum amount in exchange for giving up the usual continuing payments by WC for lost wages and for lifetime medical care related to the injuries. Such lump sum amounts are usually requested because the beneficiary wishes to use the funds for some specific purpose. For example, the individual's home may need to be remodeled to accommodate a wheelchair or, more typically, he or she is so disabled that lifetime attendant care is needed. In these latter cases, the injured individual seeks a lump-sum payment so that such care can be arranged with certainly in the future. The amount of the lump sum is typically established by using a life

care plan[1] and actuarial methods to determine the individual's life expectancy. When WC has accepted full liability in a case prior to the creation of a WCMSA, the likelihood of any Medicare conditional payments being made is reduced. However, a WCMSA may only be used to pay for future medical services related to the WC injury or illness that would otherwise be reimbursable by Medicare.

WCMSAs are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. WCMSAs are typically not created until the individual's condition has stabilized so that it can be determined based on past experience, what the future medical expenses may be.

[1] If a life care plan is not used to justify the injured individual's future medical expenses, then the injured individual or his/her representative must present other alternative evidence that sufficiently justifies the amounts set-aside for Medicare.

Structured Set-Aside Arrangements

(Ref: 4/21/03 Memo Q10 & 10/15/04 Memo Q5)

A WC Medicare Set-aside Arrangement can be established as a structured arrangement, where payments are made to the arrangement on a defined schedule to cover expenses projected for future years. In a structured Medicare set-aside arrangement, monies are apportioned over fixed or definite periods of time. In such cases, Medicare will not agree to cover the beneficiary if there is no verification that the funds apportioned in the arrangement have been exhausted. Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the Medicare set-aside arrangement.

However, CMS will approve a payout amount for services that would otherwise be reimbursable by Medicare from the WC Medicare Set-aside Arrangement in the following manner:

(1) The seed money for the WC Medicare Set-aside Arrangement must include an amount equal to the amount of monies calculated to cover the first surgery procedure and/or replacement and two years of annual payments.

(2) The remainder of the approved amount should be divided by the remainder of the claimant's life expectancy (or a shorter defined period of time if CMS has agreed to a shorter time period).

(3) Subsequent annual deposits into the WC Medicare Set-aside Arrangement are to be based upon a set "anniversary date" which cannot be more than one year after the settlement date.

In a structured Medicare set-aside arrangement, if funds are not exhausted during a given period, then the excess funds must be carried forward to the next period. The threshold after which Medicare would begin to pay claims related to the injury would then be increased in any subsequent period by the amount of the carry-forward.

Example: A structured set-aside is designed to pay $20,000 per year over the next 10 years for an individual's Medicare covered services. Medicare would begin paying covered expenses in any given year after this $20,000 is exhausted. However, in 2003 the injured individual needs only $15,000 to cover all related expenses. The administrator would need to carry-forward the excess $5,000 into 2004. Therefore, in 2004 a total of $25,000 of Medicare covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2004. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

Please note that any structured set-aside arrangement agreed to by the parties will not be approved by Medicare if the settlement has not adequately considered Medicare’s interests.

Criteria for Determining Whether a Lump Sum or Structured Settlement Sufficiently Takes into Account Medicare's Interests

(Ref: 7/23/01 Memo Q5)

The CMS considers whether the amount allocated for future medical expenses is reasonable. In addition, the repayment of conditional payments made by Medicare should be taken into account. Consequently, CMS considers the following criteria when reviewing Workers' Compensation Medicare Set-aside Arrangement (WCMSA):

1. Date of entitlement to Medicare.

2. Basis for Medicare entitlement [disability, End-stage Renal Disease (ESRD) or age] -- If the claimant has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for claimants who are over 65, but had been entitled prior to attaining that age.

3. Type and severity of the injury or illness-- Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the claimant an amputee, paraplegic or quadriplegic? Is the claimant's condition stable or is there a possibility of medical deterioration?

4. Age of the claimant-- Acquire an evaluation of whether his/her condition would shorten the life span.

5. Workers' Compensation (WC) classification of the claimant (e.g., permanent partial, permanent total disability, or a combination of both).

6. Prior medical expenses paid by WC due to the injury or illness in the one or two year period after the condition has stabilized—Any conditional payments made by Medicare must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.

7. Amount of the lump sum or structured settlement-- Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.

8. Whether the commutation is for the claimant's lifetime or for a specific time period? If not for lifetime, please provide basis.

9. Whether the claimant is living at home, in a nursing home, or receiving assisted living care, etc. If the claimant is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such

care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.

10. Whether the expected expenses for Medicare covered items and services are appropriate in light of the claimant's condition?-- Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost $20,000). For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently taken Medicare's interests into account.

Life Care Plans or Similar Evaluations Prepared by Non-Treating Physicians

(Ref: 4/22/03 Memo Q15)

When the parties to a Workers' Compensation (WC) settlement present CMS with "life care plans" or similar evaluations prepared by non-treating physicians to support and justify their proposed Workers' Compensation Medicare Set-aside Arrangements (WCMSA), Medicare will consider accepting such evaluations if the physician does all of the following:

a) Examines the claimant;
b) Reviews the claimant's medical records;
c) Contacts any of the claimant's treating physicians (if applicable);
d) Is available to answer CMS' questions;
e) Prepares a report that summarizes the above; and
f) Offers a written medical opinion as to all of the reasonably anticipated future medical needs of the claimant related to the claimant's work injury or illness/disease.

Please note that such a life care plan or evaluation is not automatically conclusive. The CMS may not credit the report if there is information that calls the evaluation or plan into question for some reason, such as contrary evidence, internal conflicts, or if the plan is not credible on its face.

Centers for Medicare & Medicaid Services (CMS)
Workers' Compensation (WC)
Medicare Set-aside Proposal
Requirements Checklist

Please mail or fax **only** the item(s) indicated below no later than 30 days from the date of this document. Information provided on a CD-ROM must be in PDF format and in the same order as requested below. All documents on the CD-ROM must be identified on an index. Medical records must be submitted in a logical order. Requested information may be mailed to:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 33849
Detroit, MI 48232-5849
Attention: WCMSA Proposal

The requested information may also be faxed to **646-458-6745**, however, the fax is limited to **10 pages maximum**. If you are faxing the documentation, please include the CMS Case Control Number on the bottom of each page. Please keep in mind this fax number is **NOT** for initial WCMSA submissions, only for additional documentation.

1. A cover letter must include the following information for all Medicare Set-aside arrangement proposals.

__ Claimant's Name

__ Claimant's Date of Birth

__ Claimant's Health Insurance Claim Number (HICN) or Social Security Number (SSN) if claimant is not yet entitled to Medicare

__ Claimant's Address and Phone Number – The address is used primarily for (1) mailing copies of CMS correspondence and (2) for information purposes when the claimant is also the Administrator of the set-aside account

__ Claimant's Release – claimant's signed authorization for CMS, its agents and/or contractors to discuss his or her case/medical condition with parties to a WC settlement that includes a Medicare Set-aside arrangement (sample format attached)

__ Claimant's Counsel: Name, address and telephone number

__ Entitlement Information – Indicate if the claimant is currently enrolled in Part "A" and Part "B" of Medicare or in Part "A" only
When the claimant is not currently enrolled in Medicare Part A or Part B, indicate

if any of the following situations apply to the claimant or if another situation will result in the claimant being enrolled in Medicare within 30 months of the date of settlement.

___ Individual has applied for Social Security Disability Benefits (SSDB)
___ Individual has been denied SSDB but anticipates an appeal
___ Individual is in process of appealing and/or re-filing for SSDB
___ Individual is 62 years and 6 months old
___ Individual has End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD
___ Other (explain)

__ <u>Employer's Information</u> – name, address and phone number

__ <u>WC Insurer</u> – name, address and phone number of employer's insurance company

__ <u>State of Venue</u>—name of state where WC hearing is being held.

__ <u>Attorney Representing Employer or WC Insurer</u> -name, address and phone number if employer's or WC Insurer's attorney has prepared documentation for the Medicare Set-aside arrangement.

__ <u>Injury/Disease Date</u> – the date the injury (ies) occurred.

__ <u>Type of Injury/Disease</u> – a brief description of the work-related injuries sustained including the ICD-9 diagnosis codes, if available.

__ <u>Total WC Settlement Amount</u> -including the Medicare Set-aside amount plus the amount provided for all other aspects of the settlement.

__ <u>Proposed Medicare Set-aside Amount</u> -proposed amount to be placed in a Set-aside arrangement for future items/services that would otherwise be paid by Medicare.

2. Documentation that must be available to CMS prior to the approval of a Medicare set-aside arrangement

__ <u>Life Expectancy</u> – Provide an evaluation of whether the claimant's condition would shorten the life span or a copy of State law that specifically limits the length of time that WC covers work-related conditions. If a rated age obtained from life insurance companies for like injuries/illnesses is the method of evaluation, include documentation to support the life expectancy. CMS will project the cost of the claimant's future treatment over the claimant's life expectancy using the most recent table listed on the Centers for Disease Control website (http://www.cdc.gov/nchs/products/pubs/pubd/lftbls/life/1966.htm), unless documentation from a medical professional provides justification for an alternative projection.

__ <u>Life Care Plan</u> – A life care plan is appropriate when the claimant's injury/disease is

extensive/serious, e.g., paraplegia, quadriplegia, brain damage.

__ Proposed WC Settlement Agreement -Provide a copy of the proposed settlement agreement.

__ Current Treatment – Provide the treatment/services that the claimant regularly receives. The current treatment should give an indication that the work-related condition is stable. The summary of current treatment should be supported by a minimum of two years of medical documentation and a comprehensive payment history from the WC Carrier (including indemnity payments). If the work-related injury occurred less than two years from the date of submission of the WC Medicare Set-aside arrangement, supporting medical documentation should date back to the date of the work-related injury. Also note any relevant past treatment, such as surgery that the claimant may have undergone.

In addition, the summary of current treatment should be supported by a minimum of two years of prescription drug information that is related to the WC injury and/or illness/disease. Include the name of the drug, dosage, and intake regimen (i.e. 3 times a day, once a month etc.) for each drug listed.

Also, provide a comprehensive payment history from the WC Carrier as follows:

- If the injury occurred less than 2 years from the date of the submission, the prescription drug payment history should include those payments that were paid from the injury date through the date of submission.

- If the injury occurred more than 2 years from the date of the submission, the prescription drug payment history should include the last 2 years of payments for prescription drugs.

__ Future Treatment – Identify specific types of medical services/items, the frequency/duration of the medical services/items and the projected costs of the medical services/items related to the work injury/disease that are expected in the future in light of the claimant's condition. Include ICD-9 diagnosis codes if available. Appropriately identify the information by both Medicare covered services and services not covered by Medicare. Future treatment must be based on the evaluation and recommendation of a physician(s), e.g., the primary care physician, orthopedic surgeon or other specialist (if applicable). An Independent Medical Examination (IME) may be sufficient under certain circumstances, e.g., claimant has not received treatment in several years and there is no primary care physician. The claimant's condition and medical care required in the future must be documented in written evaluations, reports and/or letters from a physician(s). Living arrangements that impact the medical benefits of the settlement should be noted.

Example: The primary care physician states that during the claimant's life expectancy of 30 years, it is estimated that he/she will need the following Medicare covered services.

- A physician visit every 6 months with an estimated cost of $75 per visit.
- Physical therapy (PT) -12 sessions per year for only the next 3 years with estimated cost of $50 per session
- An x-ray every 3 years with an estimated cost of $100 per x-ray (including interpretation)
- An MRI every 5 years with an estimated cost of $1,500 per MRI (including interpretation)
- Inpatient hospitalization every 10 years with an estimated cost $10,000 per hospitalization

The projected total costs in this case are $46,300 as listed below.

- Physician visits @ $4,500 ($75 x 2 x 30)
- PT @ $1,800 ($50 x 12 x 3)
- X-rays @ $1,000 ($100 x 10)
- MRIs @ $9,000 ($1,500 x 6)
- Hospitalizations @ $30,000 ($10,000 x 3)

__ <u>Future Prescription Drug Information</u> – Provide a list of prescription drugs related to the WC injury and/or illness/disease that the claimant will need to take in the future. Include the name of the drug, dosage, and intake regimen (i.e. 3 times a day, once a month etc.) for each drug listed that is covered by Medicare.

__ <u>Patient Medical Recovery Prognosis</u> – Describe the expected recovery, e.g., full or partial. Describe the projected recovery period. Identify the date at which the patient achieved maximum medical improvement (when relevant).

__ <u>Total Settlement Amount</u> – Provide the total WC settlement amount and NOT the settlement amount minus attorney fees, expenses, etc. Identify all categories of the settlement.

__ <u>Amount for Future Medical Treatment</u> – Identify the total amount of the WC settlement that is designated for future medical benefits (separate from wage/indemnity benefits). If the settlement does not specify a total amount for future medical treatment, explain why it does not. Identify separately the appropriate future expenses that might otherwise be paid by Medicare.

__ <u>Identify the calculation method</u> used to determine the amount for future medical treatment, WC fee schedule or full actual charges. Identify if the amount is for the claimant's lifetime or for a specified time period.

__ <u>Medicare Set-aside Amount</u> – State the amount of the medical benefits that you propose to be placed in the Medicare Set-aside arrangement for future items/services that would otherwise be covered by Medicare. Include a payout schedule for each year if a structured settlement is applicable. Outline future non-Medicare covered expenses not included in the Medicare Set-aside. amount, e.g., fitness center memberships.

__ Administrator – Designate the administrator responsible for control and documentation of proper expenditures from the Medicare Set-aside account. Include the address of the administrator if it is not the claimant.

__ Medicare Set-aside Arrangement Account -The arrangement may be funded with a lump-sum amount or a structured annual amount or a combination of both. Funds must be placed in an interest-bearing account. If an account is structured and funded by an annual annuity, identify the source of the annuity and include the annual payment amount, annual funding date, and the amount of the initial lump sum deposit.

__ Fees -One-time and recurrent administrative fees/expenses for administration of the Medicare Set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare Set-aside arrangement cannot be charged to the set-aside arrangement. The payment of these costs must come from some other payment source that is completely separate from the Medicare Set-aside arrangement funds.

__ Final WC Settlement Agreement -Approval of the WC Medicare Set-aside arrangement is not final until CMS receives an executed copy of the final settlement agreement that has been approved and signed by all parties. Forward a copy of the final settlement agreement to:

CMS
c/o Coordination of Benefits Contractor

P.O. Box 33849
Detroit, MI 48232-5849
Attention: WCMSA

SAMPLE

CONSENT TO RELEASE FORM

CMS Case Control Number: CASENUM

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, ______________________________, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my workers' compensation injury and/or settlement to the individual(s) and/or firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

__ Claimant's attorney ______________________________________
(name and/or firm)

__ Employer's attorney ______________________________________
(name and/or firm)

__ Workers' compensation carrier ______________________________________
(name and/or firm)

__ Other ______________________________________
(name and/or firm)

____
Claimant's Signature

____
Date Signed

____
Date of Injury

____
Social Security Number Or
Health Insurance Claim Number

As-of-July 14, 2008

New Regional Offices Point-of-Contact Effective September 1, 2008

If your workers' compensation claim is pending in:	Regional Office (RO)	RO Point-of-Contact
Connecticut	**Boston Region**	**Hotline (617) 565-1318**
Maine		
Massachusetts		
New Hampshire		
New York		
Puerto Rico		
Rhode Island		
Vermont		
Virgin Islands		
Delaware	**Philadelphia Region**	**Sean Emberson or Richard Meehl (215) 861-4178**
District of Columbia		
Florida		
Maryland		
New Jersey		
Pennsylvania		
Tennessee		
Virginia		
West Virginia		
Georgia	**Chicago Region**	**Carol Hanson or Okla White (312) 353-1801**
Kentucky		
Illinois		
Indiana		
Michigan		
Minnesota		
Ohio		
Wisconsin		
Alabama	**Dallas Region**	**Hotline (214) 767-6402**
Arkansas		
Louisiana		
Mississippi		
New Mexico		
North Carolina		
Oklahoma		
South Carolina		
Texas		
American Samoa	**San Francisco Region**	**Tom Bosserman (415) 744-4907**
Arizona		
California		
Colorado		**Ian Fraser (415) 744-3665**
Guam		
Hawaii		
Montana		**Tina Lim (415) 744-3673**
Nevada		
North Dakota		
Northern Marianas Islands		**Irene Cheng (415) 744-3582**
South Dakota		
Utah		
Wyoming		
Alaska	**Seattle Region**	**Jonella Windell (206) 615-2385**
Idaho		
Iowa		
Kansas		
Missouri		**Bert Vance (206) 615-2329**
Nebraska		
Oregon		
Washington		

In an effort to share more information with the workers' compensation industry and workers' compensation Medicare set-aside arrangement submitters, and to reduce the instance of incomplete set-aside proposals, CMS is posting the "Operating Rules" used by its workers' compensation review contractor and will provide periodic updates when there are changes to these operating rules.

This information was available previously through a Freedom of Information Act request, with certain redactions that are being preserved in this version as well. The reasons for the redactions are: The CMS believes the redacted information would, if released, circumvent agency rules; adversely affect pending litigation; infringe on proprietary information belonging to our contractor; interfere with the performance of the Government contract; and/or violate the privacy of individuals. Information regarding navigating through the Workers' Compensation Case Control System has also been redacted, so as not to cause confusion.

<u>OPERATING RULES</u> (10/27/08)

xxxxx

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1. Incorrect info.
    a. Claimant's first name, middle initial, and last name. Fix only if the claimant is not a Medicare beneficiary.
    b. Claimant's address and submitter's name & address. Always fix.
        i. xxxxx
        ii. xxxxx
        iii. xxxxx
        iv. xxxxx
    c. Gender, birth date, illness/injury date, diagnoses, state of venue. Fix only if the case is eligible.
    d. xxxxx
    e. xxxxx

2. Jurisdiction/Venue/Pricing state. This is the state that will control any WC hearing. In order of priority, use:
    a. State on the settlement documents. If the case is a Longshore and Harbor Workers' Compensation Act ("LHWCA") case, go to 2b.
    b. State the submitter indicates in the submission is the state of jurisdiction.
    c. Call the submitter and ask for the state of jurisdiction. xxxxx
    d. State of the claimant's residence if the submitter fails to give a venue.
    e. xxxxx

3. Proposed settlement date ("PSD"). The PSD is the later of:
    a. COBC receipt date plus 120 days xxxxx OR
    b. xxxxx pricing date plus three months
    c. If there is no pricing (e.g., ineligible, denied liability, no services needed), do not review or change this field.

4. Phone calls.
    a. xxxxx
    b. xxxxx
    c. Submitters/claimants requesting status are entitled to know where the case is in processing and whether documents have been scanned. Do not give recommended amounts or expected completion dates.
    d. If a case is in the RO, check why. If it is for insufficient information, advise what information is still needed. Otherwise, give the RO contact name & phone number.
    e. If a case is at the COBC, give the COBC contact name & number.

5. Medicare set-aside ("MSA") administrator. In order of priority, use:
    a. Blank (only if recommended MSA ("RMSA") is $0)
    b. Professional administrator, if known. This includes claimants who have signed over power of attorney to someone else, or relatives who are handling matters for the claimant but who are not official rep payees.
        i. xxxxx
    c. xxxxx

d. xxxxx

6. Rated age.
   a. Submitter statement. For all cases with COBC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), if the submitter does not supply a statement that all rated ages obtained on the claimant have been included, use actual age and **do not develop**. Instead, explain in the Decision Rationale, "The submitter did not supply a statement that all rated ages obtained on the claimant have been included. Therefore, actual age was used."
   b. Other Criteria. Rated ages must name the claimant, must be from an insurance company, must be on insurance company or settlement broker letterhead, must be independent, and must give a specific rated age or life expectancy.
      i. xxxxx
      ii. xxxxx
      iii. For cases with COBC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), use actual age if there is not at least one rated age in file that meets the criteria and **do not develop**. Instead, explain in the Decision Rationale, "Rated ages were submitted but were not acceptable because xxxxxxx. Therefore, actual age was used."
   c. Median rated ages.
      i. Where there is more than one acceptable rated age, use the median.
      ii. Where there is an even number of acceptable rated ages, average the middle two and drop any decimals. Do not round.
      iii. If you drop a rated age and other acceptable rated ages are left, explain any new median rated age in the Decision Rationale ("The rated age from xxxxxx was not used in computing the median rated age because xxxxxxxx.").
      iv. If a submitter uses the term "median" and only supplies one rated age and it is acceptable, use it as long as Rule 6b (Submitter Statement) is met and **do not develop**. No Decision Rationale statement is necessary.
   d. xxxxx
   e. Unsuccessful development. If the file does not contain an acceptable rated age after the development period expires, use actual age and state in the Decision Rationale, "Although the WCRC developed for an acceptable rated age(s), none was received. Therefore, CMS is pricing this case using the claimant's actual age."
   f. If acceptable rated ages are in file, use them unless the submitter has requested the use of actual age in writing. xxxxx

7. Recommendation letter.
   a. xxxxx

b. xxxxx, use WCMSA rather than MSA, as MSA also means medical savings account.
c. If you disagree with the proposed amount, explain major differences in the Decision Rationale. Use at least the same level of detail as the submitter. For example, if a submitter uses an incorrect CPT code, and correcting the CPT code makes a major difference, explain and state the CPT codes in the Decision Rationale. xxxxx
d. xxxxx.

8. Multiple WC cases for same claimant. If cover letter(s) are not clear on how the submitter(s) want the cases handled, call the submitter(s) and give three options (document the option picked in the Note Log):
    a. We will work the cases as one case, with one injury date (the earliest in file). We will list all injuries and there will be no Medicare payments on any WC injury as of the injury date we use, until the set-aside amount is reached. We will combine the medical items and services proposed Medicare set-aside amounts ("MPMSAs") and prescription drug proposed set-aside amounts ("RxPMSAs") into one; we will combine the total settlement amounts ("TSAs") into one, and we will produce one recommended MSA ("RMSA"). This is the preferred and fastest option.
    b. We will work the case as one case, as in the first option, but in the Decision Rationale, we will do our best to separate the MPMSA, RxPMSA, TSA, and RMSA into the separate injuries and/or injury dates according to the submitter's needs.
    c. The submitter(s) must arrange with COBC to separate the cases into two or more cases, with separate submissions, separate medical records, separate TSA, PMSA, and RxPMSA. We will treat them as two or more independent cases. This option may take additional time, and more than a month is likely. In addition, the overall RMSA may be higher due to duplicate services (e.g., lab costs) in the independently worked cases.

9. Total settlement amount ("TSA").
    a. Include past <u>settlement</u> amounts (including advances), but not past payments of indemnity or medical expenses that were not part of settlements.
    b. Include third party liability settlement amounts for the same injury unless a state court or other administrative body has apportioned liability after a hearing on the merits.
    c. Include amounts forgiven by the carrier or others.
    d. Do not include medical malpractice settlements based on alleged mishandling of the workers' compensation injury, as those have a different date of injury and are not considered by CMS to be part of the workers' compensation case.
    e. xxxxx
    f. "Under" or "over" $X is not acceptable, xxxxx.
    g. xxxxx

h. For any cases involving a second injury fund or a "reopener" (common in New Jersey and Oklahoma):
    i. xxxxx
    ii. Include any prior settlement amounts in the total settlement amount, as well as any second injury fund settlement (NJ) or "3e" settlement (OK) being made at the same time as the main injury is settling even if the submitter requests otherwise.
    iii. Do not include in the total settlement amount any estimated amounts for settlements contemplated for the future but not being made at the time of the main injury settlement.

i. The PMSA and/or RMSA may exceed the TSA. No special language is required in these situations.

j. If the submitter's TSA is $20,000-25,000 for a Medicare beneficiary or $200,000-250,000 for a non-beneficiary AND there is an annuity involved, develop if it is unclear whether the submitter's TSA uses payout amounts ("Send total settlement amount calculated using lifetime payout amount for all annuities, annuity rate sheet, and all settlement papers.").

10. Potential "under threshold" cases:
    a. If there is a HICN, assume current Medicare entitlement and process set-aside, even if there are no entitlement dates. This cannot be an "under threshold" case, unless the TSA is $25,000 or less. (For COBC receipt dates before 4/25/06 that do not involve a reopening, the TSA must be under $10,000 to avoid review).
    b. If there are no HICN and no entitlement dates, assume no current Medicare entitlement. Follow the Threshold Rule, below.
        i. Exception: If the submitter alleges current Medicare entitlement and you are sending a development letter for some other reason, check the "Entitlement Information" box and ask for evidence that the claimant is currently a Medicare beneficiary.
    c. If there is no HICN but there are entitlement dates, xxxxx
    d. Threshold Rule:
        i. First, compute the total settlement amount ("TSA"). See Rule 9.
        ii. If the TSA is greater than $250,000, the case is eligible for review unless there will be no Medicare entitlement within 30 months of the proposed settlement date ("PSD"). xxxxx
        iii. If the TSA is less than $25,000.01 (for COBC receipt dates before 4/25/06 that do not involve a reopening, the figure is $10,000), the case is ineligible for review.
        iv. If the TSA is between these amounts (that is, at least $25,000.01 but not greater than $250,000), the case is eligible for review only if the claimant is entitled to Medicare according to the WCCCS before the PSD.
        v. xxxxx
        vi. xxxxx

11. Ineligible cases. If a case is ineligible for WCRC review (under threshold, death, CMS previously approved, insufficient information xxxxx, Jones Act, FELA, etc.): xxxxx
    a. xxxxx
    b. xxxxx
    c. xxxxx
    d. xxxxx
    e. xxxxx
    f. xxxxx
    g. xxxxx

12. Death cases. You must have something from the submitter in writing with the date of death. (Development letter: No box to check. Say, "Supply date of death.") If a date of death is not supplied in writing, use "Ineligible – Insufficient Information."

13. Development requests.
    a. xxxxx
    b. xxxxx
    c. xxxxx
    d. xxxxx
        i. xxxxx
        ii. xxxxx
        iii. xxxxx
    e. If a submitter calls in response to a Closeout Fax and indicates he/she never received the 30-day letter, confirm that the submitter's address in the WCCCS is correct, make sure the submitter understands what we still need, apologize for the problem, and indicate that the case will reopen when the requested information is received.
    f. xxxxx
    g. xxxxx
    h. If you decide that requested development is no longer needed, advise the submitter xxxxx.

14. xxxxx

15. Calculation method (fee schedule or actual charges). xxxxxx As much as possible, use the calculation method proposed, with prices from the state of jurisdiction. xxxxx Use these rules, in order of priority, to determine the calculation method (and pricing):
    a. For cases involving the Longshore and Harbor Workers' Compensation Act, the only possible fee schedule is the one published by the Office of Workers' Compensation Programs ("OWCP"). Follow rules 15c – 15h in such cases to see if that fee schedule should be used. If so, use the OWCP fee schedule for the zip code of the claimant's residence.

b. If the state does not have a fee schedule, use actual charges. If the submitter wanted fee schedule, add the following sentence to the Decision Rationale, "Although the submitter alleged use of a fee schedule calculation method, the state of jurisdiction has no fee schedule. Therefore, CMS is pricing this case using actual charges."
    i. Note: If any state institutes (or changes) a fee schedule, the WCRC will apply the new fee schedule immediately upon learning of its official publication for any case not yet out the door. The effective date of the new fee schedule does not matter. For example, as soon as the WCRC learned that the Illinois fee schedule was officially published by the state, we applied it immediately for all Illinois fee schedule cases not yet out the door, even if it was published before (or after) the effective date of 2/1/06. Similarly, we began requiring a written statement of fee schedule or actual charge calculation method at the same time for any Illinois case not yet out the door.
    ii. When using actual charges, CMS prefers that we use actual charges from the state of jurisdiction. If not readily available, use actual charges from the state of residence or national prices.

c. If the proposed Medicare set-aside amount ("PMSA") is $0 and the RMSA is not $0, use actual charges unless the submitter stated a preference for fee schedule pricing in the cover letter.

d. If the submitter's method is clearly stated in the cover letter or in a document referenced in the cover letter, use the method noted. If the submitter indicated that he used a mixture of fee schedule and actual charges, check "fee schedule" and use fee schedule as much as possible.

e. If the submitter's method is clearly stated in the settlement documents, and there is no expression in the cover letter or in a document referenced in the cover letter, use the method noted in the settlement documents. The settlement documents do not have to be signed by either party or a judge.

f. If there is no response or an inadequate response from the submitter to the 30-day letter, then process the case using actual charges and include the following sentence in the Decision Rationale, "Although CMS developed for clarification of the submitter's calculation method, no clarification was received. Therefore, CMS is pricing this case using actual charges." Do not close the case as ineligible, insufficient information, because of this missing information.

g. If the submitter states he/she used "Medicare fee schedule," use actual charges and include a Decision Rationale entry, "Although the submitter proposed to use a Medicare fee schedule to calculate the proposed set-aside, CMS uses only state fee schedules or actual charges. Actual charges were used as the default pricing method."

16. Payout method (lump sum or annuity)
    a. If only one payout method is stated in the submitter's cover letter, use it regardless of any other conflicting indication in the file.

   b. If there is no payout method in the cover letter, but only one method is stated elsewhere in the file, use it.
   c. If neither "a" nor "b" applies and there is conflicting information in file, (e.g., lump sum is stated, but seed money is also stated), develop. If the answer is still confusing, use lump sum and state in the Decision Rationale, "Clarification of the payout method was requested but not received; therefore, lump sum was used."
   d. If no payout method is stated in the file, use lump sum.

17. Rounding.
   a. Do not round when computing median rated age. Drop decimals. (50.9 = 50, corresponding to the life expectancy table entry for someone 50 but not yet 51)
   b. xxxxx
   c. xxxxx

18. System problems. Report these xxxxx on the COB Problem Report form, with a screen print if possible. Follow the written instructions for completion of the form.

19. xxxxx

20. xxxxx

21. xxxxx

22. Proposed set-aside amounts. For either the medical services proposed set-aside amount ("MPMSA") or the prescription drug proposed set-aside amount ("RxPMSA"), use these in order of priority:
   a. A settlement document signed by both parties and approved by the state.
      i. If the proposed set aside in that document is the cost of an annuity or an annual amount where the proposed life expectancy is not given anywhere in the file, do not use it.
      ii. If the submitter proposes an amount higher than the set-aside amount in the signed and approved settlement document, that is acceptable, as long as the submitter explains the reason for the change in writing. If there is no explanation, develop in writing.
      iii. If the submitter proposes an amount lower than the set-aside amount in the signed and approved settlement document, use the court-approved amount as the proposed amount and explain in the Decision Rationale: "Although the submitter proposed a different set-aside amount, the WCRC must show the proposed amount from the court approved settlement agreement in file."
   b. The submitter's letter or an attachment referenced in the submitter's letter. xxxxx. If the submitter's letter is not clear, develop in writing.
      i. xxxxx

c. If neither a nor b applies, develop in writing if the MPMSA is not known, but develop for the RxPMSA only if developing for something else.
d. If a submitter proposed a set-aside amount and does not specify how much of it is for medical items and services and how much is for prescription drugs, assume it is all for medical items and services. Do not develop to clarify unless you are developing for something else.

23. Pricing standard. Price all Medicare-covered items and services that are related to the work injury and that are "reasonably probable." The following reasons are not acceptable for reducing a set-aside or approving a $0 set-aside:
    a. The claimant asserts he/she will not purchase Medicare Part B or Part D.
    b. The claimant asserts he/she uses other insurance.
    c. The claimant asserts he/she uses the Veterans' Administration for all health needs.
    d. The claimant asserts he/she is moving out of the country and never coming back.
    e. The claimant promises never to bill Medicare.

    xxxxx.

24. xxxxx

25. xxxxx

26. Consent forms. Consent forms are acceptable if they meet the following:
    a. There should be a reference to the Social Security Administration, Medicare, or the federal government.
    b. The form should contain one of the following words: authorize, release, or consent.
    c. The form should be signed by the claimant or someone authorized to sign on behalf of the claimant (e.g., attorney-in-fact, guardian, etc. – in such cases, obtain proof of such authorization or discuss with a supervisor):
        i. Do not reject any consent form because of an expiration date.
        ii. Claimants may withdraw consent if they do so in writing.
        iii. xxxxx

27. Initial deposit (seed money).
    a. xxxxx
    b. If the entries for 1st surgery procedure and 1st replacement do not exactly match items from the pricing grid, explain in the Decision Rationale.
    c. xxxxx
    d. xxxxx

28. Prescription drugs.
    a. These rules apply to:
        i. New cases with a COBC receipt date on or after 2/1/06.

ii. Reopening cases (whether automatically returned to the WCRC as REOP or manually returned to the WCRC by the regional offices ("ROs")) where the scan date of the document causing the reopening is on or after 2/1/06. xxxxx
    A) Exception: Reopenings that occur because of an obvious error will require prescription drugs only if the case already required prescription drugs before that reopening.
iii. Priority cases where the above rules apply and the WCRC did not screen the case before 3/25/06.

b. xxxxx
c. xxxxx
d. Develop for prescription drug information only if developing for something else.
    i. xxxxx. If developing for something else and there is no discussion of prescription drugs in the submitter's cover letter, then develop for prescription drug information.
    ii. xxxxx. If developing for something else, if the entire file contains no proposal for prescription drugs, and if you determine that prescription drugs should have been included in the proposal, then develop for prescription drug information.
    iii. If development is undertaken for prescription drug information and something else, do not develop for prescription drugs again, even if another 30-day letter is needed for something new.
e. xxxxx.
f. xxxxx.

29. Some body parts not settling medicals
    a. If the carrier will continue to pay for all injury-related medical care for the claimant, the case is ineligible for review. See Operating Rule 11.
    b. If all body parts are settling medicals, the case is eligible. Note, some body parts may be denied liability and others may be compensable and require a set-aside determination.
    c. For pricing purposes, ignore injuries related only to Second Injury Funds and settlement of injuries that have not been alleged.
    d. If the agreement states that the carrier will continue to pay for some medical services but not others for the same body part, contact the submitter xxxxx and advise that CMS considers that body part as not settling for all treatments.
    e. xxxxx

30. xxxxx

31. xxxxx

LAURA IVESTER, Appellant,
v.
PARKWAY REGIONAL & SPECIALTY RISK, Appellees.
Case No. 1D08-1520.
District Court of Appeal of Florida, First District.
Opinion filed November 26, 2008.

An appeal from the Judge of Compensation Claims, Alan M. Kuker, Judge, Date of Accident: November 21, 2003.

Mark L. Zientz of Law Offices of Mark L. Zientz, P.A., Miami, for Appellant.

Jack R. Simmons of Barnes & Simmons, P.A., Miami Lakes, for Appellees.

PER CURIAM.

Claimant appeals an order of the Judge of Compensation Claims (JCC) enforcing a mediation settlement agreement. Claimant argues that the agreement was contingent on approval of a Medicare Set-Aside Agreement (MSA) by the

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Centers for Medicare & Medicaid Services (CMS), and because no such approval occurred, Claimant could void the settlement. For the reasons explained below, we agree, and reverse.

The parties entered into a mediation agreement on March 26, 2007. At that time, Claimant was receiving social security disability benefits (SSD). A provision in the agreement stated:

This Agreement is contingent on CMS Approval of the MSA amount recommended by Gould & Lamb, as attached. If such MSA is not approved by CMS, then either Claimant or E/C can void this agreement.

Shortly after the agreement was signed, the Employer/Carrier (E/C) was advised by Gould & Lamb that, although Claimant was receiving SSD, she was not yet a Medicare beneficiary, and was not expected to be within thirty months. Gould & Lamb further advised that, under these circumstances, because the settlement was for less than $250,000.00, CMS approval of the MSA was unnecessary and the agency would not consider the matter at all. Based on this information, the E/C declined to submit the MSA for approval, informed Claimant's attorney of this development, and forwarded the final settlement and release documents for Claimant's signature.

Claimant refused to sign the documents because the contingency was not satisfied, and the E/C moved to enforce the settlement agreement. A final hearing

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was held on March 5, 2008, nearly one year after the mediation agreement was signed. Claimant's attorney represented to the JCC that her client was approximately one month away from becoming a Medicare beneficiary, and she was concerned that she would need approval of the MSA at that time, thus, underscoring the importance of the contingency.

Ultimately, the JCC agreed with the E/C's argument, and found the parties' intent concerning CMS approval of the MSA "was to avoid [C]laimant being responsible for an additional amount." The JCC found no set aside was necessary because the settlement didn't meet the $250,000.00 threshold. Based on these findings, the JCC found the parties' intent was satisfied and entered an order enforcing the agreement.

The only evidence on the issue of the parties' intent is the settlement agreement itself, which we review de novo. See Munroe v. U.S. Food Serv., 985 So. 2d 654 (Fla. 1st DCA 2008). A court may look beyond the language of a contract only when the document's terms are ambiguous. See Churchville v. GACS, Inc., 973 So. 2d 1212, 1215 (Fla. 1st DCA 2008). Whether an agreement is ambiguous is a question of law, reviewed de novo. Id.

Here, there is nothing ambiguous about the contingency provision: If there is no CMS approval, whatever the reason, Claimant can void the agreement. See

also Quinlan v. Ross Stores, 932 So. 2d 428, 429 (Fla. 1st DCA 2006) (upholding the JCC's finding that a final and enforceable agreement was never made where the parties intended finality of their settlement agreement to hinge, in part, on approval of the set-aside amount by CMS, and, because claimant died before this could happen, the contingency was not satisfied); Munroe, 985 So. 2d at 655 (holding that conditioning a contract upon a party's approval shows a binding contract has not yet been formed).

Based on the plain language of the agreement, Claimant could void the settlement because the contingency of CMS approval of the MSA did not occur. The JCC's order enforcing the agreement is REVERSED and REMANDED for proceedings consistent with this opinion.

BARFIELD, DAVIS, and HAWKES, JJ., CONCUR.

NOT FINAL UNTIL TIME EXPIRES TO FILE MOTION FOR REHEARING AND DISPOSITION THEREOF IF FILED.