

The Ghost of Settlement Past  
Medicare Set-Aside Allocation  
Questions/Answers

MWCEA

MSIECA

September 20, 2005

Ocean City, Maryland

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Budow and Noble  
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Mr. Szczesny has been a defense attorney since 1991. He is a partner in the law firm of Budow and Noble, P.C., with offices in Montgomery County and Howard County, Maryland. Mr. Szczesny is the founder and current Chairman of the firm's Workers' Compensation Defense Practice Group. His practice includes workers' compensation defense in Maryland and the District of Columbia, as well as a wide variety of insurance-related litigation and medical issues, and he has extensive trial practice experience in these areas.

Mr. Szczesny is a member of many Bar Associations, he is active in the leadership of a number of professional associations, and he has been a frequent speaker in the field of workers' compensation law. Mr. Szczesny is a member of the Baltimore Claims Association, and is on the Board of Directors of the Maryland Self-Insurers' and Employers' Compensation Association (MSIECA), where he serves as the Chairman of the Program Committee and is active on the Membership Committee. He is also on the Board of the Washington Claims Association, and is the current Chairman of the Workers' Compensation Committee of that organization.

Mr. Szczesny practices law in Maryland and the District of Columbia and is a trained and certified civil mediator. He serves as a volunteer Settlement Conference Officer in the Circuit Court for Anne Arundel County, where he was approved by the Judges of that court to assist in the mediation and settlement of workers' compensation claims.

# Frank L. Lipshultz

**Lipshultz and Miller P.A.**  
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Admitted to the Maryland State Bar in 1972 and the District of Columbia Bar in 1977. In January 2004 he joined Jeffrey R. Miller and currently practices with the law firm of Lipshultz and Miller P.A. in Columbia, Maryland. Mr. Lipshultz began practicing law following his graduation from the University of Baltimore in 1972. He received his B.A. from the University of Maryland, Baltimore County in 1970. Mr. Lipshultz gained his experience starting with the law firm of Friedman & Lipshultz in 1971 and became a principal in the law firm of Lipshultz and Hone in 1972.

Mr. Lipshultz is a member of the American Bar Association, the Maryland State Bar Association, and The District of Columbia Bar Association.

Mr. Lipshultz is a member of the Maryland Association of Defense Trial Counsel, as well as the Defense Research Institute, he has published an article for DRI Workers Compensation Newsletter on Medicare Set Aside "A Necessary Component of Your Workers' Compensation Settlements".

Mr. Lipshultz has also lectured for MICPEL in their presentation of Hot Tips in Workers Compensation with subject's occupational disease, Subsequent Injury Fund, Dealing with the Digits and Medicare Set Aside. He has lectured at Maryland State Bar Association and Maryland Workers Compensation Educational Association and the Maryland Trial Lawyers Association on the aspect of Medicare Secondary Payer and Medicare Set Aside Trusts. He has served as a panel member for ABA Teleconference Medicare Liens in Workers' Compensation Cases A Minefield for the Defense and Plaintiff's Bar September 17, 2002. He has also lectured for Lorman Educational Service Seminars.

He is Immediate Past Chair of the Maryland State Bar Association's Negligence Insurance and Worker's Compensation Section Council

Having gained admittance to all State and Federal Trial and Appellate Courts in Maryland and the District of Columbia, as well as the Court of Appeals for the 4th Circuit, Mr. Lipshultz is actively engaged in the preparation and trial of all types of casualty as well as appeals. He handles all aspects of workers' compensation cases from hearings and trials to appeals.

## Robert H. Clark

Bob was born and raised in Philadelphia, Pennsylvania, graduating Northeast High School in 1967 and Ursinus College in 1971. He joined the U.S. Department of Health, Education & Welfare in 1972, and spent 5 years in West Virginia combating AFDC Welfare fraud.

Bob returned to Philadelphia in 1978 and moved over to the newly-formed Health Care Financing Administration (HCFA), turning his attention to Medicaid fraud and abuse. HCFA was able to address many of the needs expressed by our State partners. These included an Internet Website that compiled the language of all 50 States' anti-fraud statutes, another Website that lists the types of software that each State uses to identify inappropriate service patterns, and a third Website that recommends strategies for combating fraud and abuse in the ever-expanding world of Medicaid Managed Care.

Bob switched from the Medicaid side of HCFA's successor-CMS (Centers for Medicare & Medicaid Services) specifically to work with the newly-promoted Medicare Set-Aside Approval process for Workers' Compensation cases. He was recently selected to perform outreach functions in the six States under the auspices of the Philadelphia Regional Office. This is his first visit to Maryland.

Robin L. Karns, B.S.N., R.N., C., CCM, CNLCP, RN-WCCM

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Robin Karns is a Nurse Life Care Planner at M Hayes and Associates, LLC, providing life care planning services for plaintiff and defense in a variety of settings, including Workers Compensation, liability, personal injury, and medical malpractice. Attaining certification in 1995, Ms. Karns was one of the first one hundred Certified Nurse Life Care Planners (CNLCP) in the country. Additionally, Ms. Karns holds two national certifications in case management, Certified Case Manager (CCM) from the Commission for Case Manager Certification, and Registered Nurse, Certified (R.N., C.) from the American Credentialing Center for the American Nurses Association. Graduating summa cum laude with a Bachelor of Science in Nursing (B.S.N.) from Marquette University, Ms. Karns has 27 years of nursing experience, with the last ten years in case management and life care planning. Ms. Karns earned a certificate of Professional Training in Medicare Set-Aside Allocations per the University of Florida/Medipro Seminars in 2004, a CMS-approved program.

## **John S. Tiedemann, AIC, ARM**

John was born and raised in Washington, D.C. In 1987 he graduated from Shenandoah College with a Bachelors of Science in Business Administration. John has earned the Associate in Claims and Associate in Risk Management designations through the Insurance Institute of America and received the Marriott Service Award. John is currently the Claims Unit Manager for Marriott Claims Services managing the Maryland Worker's Compensation team. John's team also manages general liability claims for the state of New York. With almost 20 years of casualty claims experience, John has managed claims in the jurisdictions of Maryland, New York, Virginia, West Virginia, Delaware, New Jersey, Pennsylvania and Washington, D. C. Before joining Marriott in 1992, John worked for Federal Kemper Insurance Company and The Netherlands-Excelsior Insurance Company adjusting casualty claims. John currently resides in the beautiful Shenandoah Valley with his wife and son.

**W**elcome to the confusing world of Medicare Set Asides (MSA). Every year something new comes out to “clarify” and make the procedures easier and every year we have more unanswered questions. Remember we are dealing with the Federal Government and the Center for Medicare and Medicaid Services (CMS) or at least we think that is who is supposed to be helping us out.

**I**t was up to May 2004 that we were being successful in getting approvals of the MSA’s within 30-60 days out of Philadelphia. Then CMS in their infinite wisdom decided that in order to streamline the procedures nationwide and to have them more uniform and allegedly to speed up the process they chose to have the MSA proposals sent to one address to be a clearing house for these.

**S**o here we are over a year later and instead of being two months they are now taking as long as six months if not longer. This clearing house is supposed to be checking the documentation that is being submitted and if anything is missing they are supposed to be following up and requesting the missing documentation. If your documentation is in order and you have dotted your I’ and crossed those T’s then you can assist in getting this done quicker. The information provided in this presentation today and the documentation provided can assist you in this process.

## **HISTORY OF MSA**

**T**he Medicare Act indicating the need for a set aside or at least a consideration of future needs of Medicare recipients started back in the early 1980’s. Very little attention was given to this issue and it was not until the late 1990’s when HCFA (Health Care Financing Administration) started looking into why Medicare recipients who were otherwise supposed to have medicals paid for by a primary provider were paying for these benefits. HCFA started out by doing a cross check of workers compensation claims that were closed out, whether it was a result of a compromise (which is a settlement of the claimant’s current or past medical expenses which are incurred as a result of an accidental injury or occupational disease) or a commutation (which is a settlement intended to compensate the claimant for future medical expenses because of the accidental injury or occupational disease). See July 23, 2001 “Patel Memo”.

The Government, sensing that there is going to be a significant shortfall of money to continue with the funding of Medicare, is going to look very carefully at workers compensation cases to see if their interests are being protected. Recently there has been a program of data sharing with the workers compensation agencies in several states that allows CMS (or its contractors) to gather data which they used to identify Medicare recipients and place them, their attorneys (claimants attorneys) and the carriers on notice of the involvement of CMS and that there is a need to make sure that the interests of Medicare have been protected.

## THE BASIC RULE

Regardless of whom you represent you will need to know the very basics of MSA and these rules are fairly simple. If the claimant is a Medicare recipient<sup>1</sup> or your settlement is over \$250,000 and the claimant has a reasonable expectation of being on Medicare within 30 months **and your are closing out medicals in your settlement** you must get written approval of CMS of your settlement and the MSA. Failure to secure this approval places the claimant at a risk of having his Medicare medicals denied or CMS may come back to the carrier, employer, and self insured for these payments.

## WHAT DO I NEED TO DO

There is no set order in which you gather the needed documentation and information for the Agreement of Final Compromise and Settlement (AFCS), as well as what you will be need in order to submit a complete settlement package for CMS. The following is should be considered when accomplishing this task.

1. Each party to a settlement regardless of who you represent should identify if the claimant falls into the class of persons who need to have their settlements approved. You should check the claimant's age/ date of

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<sup>1</sup> Some slight modification to this hard and fast rule has been changed by the July 11, 2005 CMS Frequently Asked Questions (FAQ)

birth. You should inquire if the claimant is on SSDI (Social Security Disability Insurance). Note that if the claimant has been out for a long period of time and they are not likely to return to work they may be a candidate even though they may not have applied. Remember also that a person on SSDI who has received benefits totaling 24 months (the 30 month time frame appears to have a 6 month “waiting period” and thus is the basis for the 30 month timeframe referred to by CMS) will be a Medicare recipient.<sup>2</sup> You should ask to see their Medicare Card.

2. As a claimant’s counsel you should not put on the claim form or make a claim for body parts that are not causally related to the accidental injury. (see 3 )
3. As a carrier if the body part is not one that was injured in the accidental injury (or occupational disease) you should file issues contesting that body part. Why? Because the way that CMS is looking at cases is that they are coding the body parts allegedly injured and when there is a requested medical treatment for that part they will cross check it with the employees claim. This may cause a problem with the MSA if it does not protect CMS’s interest and thus either additional delays and/or refusal to approve the MSA.
4. The carrier should provide to whoever is preparing the amount for the set aside, the medical reports on the claimant including the carrier’s medical evaluation (and the claimant must have been seen by these doctors). They should also provide a comprehensive payment history of the medicals and indemnity payments with the inclusion of CPT codes if possible and the bills. (refer to the checklist from CMS).
5. If you have secured a rated age for the claimant provide that as well. Document the rated age with a letter from an established company.
6. If the claimant has had surgery, then all operative reports will be necessary.
7. If the claimant has a subsequent accident whether it is of the same body part(s) or not or a medical condition that

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<sup>2</sup> Please see FAQ’s dated April 22, 2003 Question number 2

will have an affect on the rated age then those documents would also be necessary and in some cases cut down the amount needed for the MSA.

8. If the WCC has entered an Order on a causal relationship issue or future medical treatment then those should also be provided.
9. You will also need to provide documentation about the claimant's AFCS<sup>3</sup> with the amounts set forth.
10. You will also need to have the claimant's consent form for CMS and list all persons on the form including the attorneys, insurance company and the claimant so that CMS has permission to talk to these parties.

## **DO I REALLY NEED AN MSA**

**S**ome carriers, self-insurers and claimant's counsel say that they do not need and MSA because the claimant is not on Medicare or that the claimant will not make an claim for future medicals or that they know that the claimant will need no further treatment for the claim. If they want to take that chance they do so at their own risk. Remember in settling a workers compensation claim if the settlement appears to represent an attempt to shift to Medicare the responsibility for making future medical payments away from the responsible party CMS does not have to honor the agreement and the following can occur.

1. CMS may not honor the agreement and secure payment from any party to the claim.
2. If there is a deliberate attempt at circumventing CMS then the penalty may double.
3. The claimant's medical expenses may not be paid by Medicare and they could have a deductible for the medicals as much as the entire settlement.
4. There are people who believe that CMS could have the AFCS revisited and have the agreement set aside as to the aspect of medical expenses.

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<sup>3</sup> Agreement of Final Compromise and Settlement is the name given for settlements in Maryland

**I**n a disputed claim and if a MSA is needed then there will be a need for a hearing before a Commissioner who will have to make a decision about the claim, whether it be to determine a causal relationship issue, an accidental injury issue or whether it be for a determination if there is a compensable occupational disease to protect the AFCS.

**T**he following pages have been provided to give you some guidance in the maze of MSAs. There is a vast amount of knowledge out on the internet. This writer has spent numerous hours gathering helpful information. Besides the materials that are provided herein the MWCEA and MSIECA will be setting up links to additional information documents and internet sources.

**T**his is the fourth revision of this paper which was started in March 2005 and was changed several times with additional up to date information. This latest revision came about because of the most recent Frequently Asked Questions that were issued on July 11, 2005 which changed some of the material as well as confirming this writer's position about allocations of medicals in a settlement. These FAQ are added to this material for review **but** all practioners should read the previous FAQ from July 23, 2001 for links to all of the FAQ see:

[http://www.cms.hhs.gov/medicare/cob/attorneys/att\\_wc.asp](http://www.cms.hhs.gov/medicare/cob/attorneys/att_wc.asp)

For further information see links to MWCEA and MSIECA

<http://www.msieca.org/>

<http://www.mwcea.com/>

Frank L. Lipshultz  
Lipshultz and Miller P.A.  
Wednesday, August 24, 2005

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

When a WC settlement includes a proposal for a WC Medicare Set-aside Arrangement, the CMS Regional Office must have the following documentation available to complete a review of the proposal. Information provided on a CD-ROM must be in PDF format and in the same order as this requirements checklist. All documents on the CD-ROM must be identified on an index. Medical records must be submitted in chronological order.

**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)

- Employer's Information – name, address and phone number
- WC Insurer – name, address and phone number of employer's insurance company
- Attorney Representing Employer or WC Insurer - name, address and phone number if employer's or WC Insurer's attorney has prepared documentation for the Medicare Set-aside arrangement
- Injury/Disease Date – the date the injury(ies) occurred
- Type of Injury/Disease – a brief description of the work-related injuries sustained including the ICD-9 diagnosis codes, if available
- Total WC Settlement Amount - including the Medicare Set-aside amount plus the amount provided for all other aspects of the settlement
- Proposed Medicare Set-aside Amount - 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**

- Life Expectancy – 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 Centers for Disease Control website ([http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51\\_03.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_03.pdf)), unless documentation from a medical professional provides justification for an alternative projection.
- Life Care Plan – 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.
- 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 ( $\$75 \times 2 \times 30$ )
  - PT @ \$1,800 ( $\$50 \times 12 \times 3$ )
  - X-rays @ \$1,000 ( $\$100 \times 10$ )
  - MRIs @ \$9,000 ( $\$1,500 \times 6$ )
  - Hospitalizations @ \$30,000 ( $\$10,000 \times 3$ )
- Patient Medical Recovery Prognosis – 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).
  - Total Settlement Amount – Provide the total WC settlement amount and NOT the settlement amount minus attorney fees, expenses, etc. Identify all categories of the settlement.
  - Amount for Future Medical Treatment – 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. Identify the calculation method 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.
  - Medicare Set-aside Amount – 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., outpatient prescription medications.

- 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 660  
New York, NY 10274-0660

Attention: WCMSA

## CONSENT TO RELEASE FORM

CMS Case Control Number: \_\_\_\_\_

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 worker's 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

## WHAT YOUR ALLOCATOR NEEDS FROM YOU TO PREPARE YOUR MEDICARE SET-ASIDE ALLOCATION

*The Allocator's goal is to prepare a concise yet complete Medicare Set-Aside Allocation, based upon current medical records, appropriately outlining the future treatment plan, ensuring accuracy of costs and projections, and incorporating knowledge of Medicare coverage issues. To facilitate timely completion of this document, the following information is requested upon referral.*

- ◆ Case demographics/identifying information
- ◆ Medical records, most recent 2 to 3 years
- ◆ Payment records, most recent 2 to 3 years  
(Payment History & copies of recent invoices)
- ◆ Rated Age documentation (if applicable)
- ◆ Copies of consents (if available)  
(General; Social Security; Medicare/CMS)
- ◆ Discussion of your individual case  
(Causal relationship issues; guidelines for communication with physicians, etc.)
- ◆ Your target date/deadline



Robin Karns, B.S.N., R.N., C., CCM, CNLCP, RN-WCCM  
Certified Nurse Life Care Planner  
M HAYES AND ASSOCIATES, LLC



# **SUBMITTER COVER LETTER AND OTHER SUMMARY DOCUMENTATION**

**NOTE: THIS DOCUMENT IS INTENDED TO BE USED AS A SAMPLE, EACH STATE HAS UNIQUE FORMS. THE MORE INFORMATION THAT IS INCLUDED IN THE SUBMITTER LETTER RATHER THAN SIMPLY REFERENCED TO THE ATTACHMENTS, THE QUICKER THE PROPOSAL CAN BE REVIEWED.**

MSA Consultants, LLC  
100 Correct Lane, Suite 300  
City, State 11111-2222  
Phone: (410) 555-1111, Fax: (240) 555-0000  
E-mail: perfectmsaproposal@hmc.com

March 15, 2005

CMS  
Coordination of Benefits Contractor  
Attn: WCMSA Proposal  
P.O. Box 660  
New York, NY 10274-0660

Re: Claimant: Wendy Storm  
100 Careful Lane  
City, State 22222-1111  
Phone: (803) 555-1111, Fax: (803) 555-0000  
email: wendystorm@wclaimant.com  
SSN: 123-45-6789  
HICN: 123-45-6789A

Dear Sir/Madam:

We represent Wendy Storm and have been asked by the parties to refer the above case to your office for review and approval of the Workers' Compensation Medicare Set-aside Arrangement ("WCMSA") outlined in the attached settlement documents. The following is the pertinent information in regard to the above-captioned claimant:

**Claimant Information:**

- A. Gender: Female
- B. Date of Birth: 12/25/1978
- C. Proposed Settlement Date (PSD): 07/15/2005 (1)
- D. Age at PSD: 26
- E. Median Rated Age: 47 (2)
- F. Life Expectancy: 35 (3)

(1) *The proposed settlement date (PSD):*

*If the case has already settled, please provide the settlement date. Also, if there is a proposed settlement date in the future, please provide that date. Otherwise, if the settlement date is unknown, CMS will default to four months from the date of submission for the PSD.*

- (2) *The median (not mean) rated age shall be used where more than one rated age is obtained. The median is the value at the center of an ordered range of numbers. (E.g., 47 is the median where the values are 42, 45, 47, 62, and 67.) If there is an even number of values, the median is the average of the two middle values. Where there is an even number of rated ages, compute the median to one decimal, then drop the decimal, i.e., do not round. (E.g., 50.9 becomes 50, because the life expectancy will be computed using the table for someone who is 50 but not yet 51.) All rated age sources shall be independent of the submitter and carrier and proof of all rated ages shall be included in the WCMSA proposal, i.e., name and phone number of source on insurance company or settlement broker letterhead. (See examples following.)*
- (3) *Life expectancy is computed using 2001 CDC table 2 or 3, based on the higher of the age or rated age, then rounded to the nearest whole number. On July 1<sup>st</sup> of each subsequent year, the updated tables for the following year should be used, e.g., as of July 1, 2005, submissions should be based on the 2002 CDC tables. These tables can be found at <http://www.cdc.gov/nchs/products/pubs/pubd/lftbls/life/1966.htm>.*

**Entitlement Information:**

(X) Claimant is entitled to Medicare Part A X  
 Part B X

If above box is not checked, claimant believes he/she will be entitled to Medicare within 30 months of the proposed settlement date (defined above) because:

- ( ) Claimant has applied for Social Security Disability Benefits
- ( ) Claimant has been denied SSDB but anticipates an appeal
- ( ) Claimant is in the process of appealing and/or re-filing for SSDB
- ( ) Claimant is (or will be) at least 62 years and 6 months old 120 days from today
- ( ) Claimant has End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based on ESRD
- ( ) Other: \_\_\_\_\_

**Injury Information**

A. Description of injury: Toy robot fell on claimant’s right foot  
 B. Date of Injury: 12/31/1997  
 (oldest if more than 1)  
 C. ICD-9 Diagnosis Codes and Descriptions (up to five, in order of priority)

825.30	Compound fracture of right foot
728.71	Plantar fasciitis
311	Depressive disorder
300.00	Anxiety disorder

**Release Attached:** Yes (required)

**MSA Administrator:** Claimant   
SSA Representative Payee \_\_\_\_\_, or  
Professional Payment, LLC  
100 Payment Way  
City, State 33333-2222  
Phone: (985) 555-1111, Fax: (985) 555-0000  
E-mail: [keepitstraightforyou@ppllc.com](mailto:keepitstraightforyou@ppllc.com)

**Claimant's Attorney:** Legal Eagle, Esquire  
Legal Law Way  
City, State 33333-4444  
Phone: (800) 555-1111, Fax: (800) 555-0000  
E-mail: [legaleagle@lawway.com](mailto:legaleagle@lawway.com)

**Employer:** Cool Toys Manufacturing, Inc.  
22 Playful Lane  
City, State 55555-2222  
Phone: (212) 555-1111, Fax: (212) 555-0000  
E-mail: [coolplaytime@toysforfun.com](mailto:coolplaytime@toysforfun.com)

**Employer Attorney:** The same information as displayed in claimant's attorney field is required if employer's attorney is the submitter.

**WC Insurance Carrier:** Got U Covered, LLC  
100 Carrier Blvd.  
City, State 66666-3333  
Phone: (412) 555-1111, Fax: (412) 555-0000  
E-mail: [Uarecovered@blanket.com](mailto:Uarecovered@blanket.com)

**WC Insurance Carrier Attorney:** The same information as displayed in claimant's attorney field is required if WC insurance carrier's attorney is the submitter.

**State of Jurisdiction/Venue:** This is the State where the workers' compensation hearing will be held.

**Total WC Settlement Amount:** \$1,530,684.05, including but 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 provided rather than cost or present values of any annuities).

**Type of Settlement:**                         Lump Sum  
      X   Structured

**Proposed Medicare Set-aside Amount, exclusive of all administrative fees:**

\$ 174,775.81 Total (If lump sum, stop here and go to MSA calculation method)  
- 20,240.03 Seed money or initial deposit (if annuity) (4)  
\$ 154,535.78 Annuity **payout** over life expectancy remaining at annuity starting date (assumed to be one year from the PSD)

Proposed settlement date: 07/15/2005 (repeat from page 1)

Life expectancy: 35 (repeat from page 1)

Annuity starting date: 07/15/2006 (assumed to be one year from PSD)

Length of annuity:      Life (treated same as life expectancy minus one year)

  34   Fixed years (provide number)

Annual amount: \$4,537.07 (= 154,260.31 / 34 years)

**MSA calculation method:**   X   WC fee schedule

     Full actual charges

*(4) The seed money for the WCMSA shall include an amount equal to the cost of the first surgery and the cost of the first procedure/replacement, plus two years of the remainder of the set-aside. See example below:*

*Step 1 – Total estimated future medical services covered by Medicare \$174,775.81*

**SAMPLE**

- Step 2 - Identify cost of first surgery and first procedure/replacement*      \$10,874.23
- Step 3 – Subtract Step 2 from Step 1*      \$163,901.58
- Step 4 - Divide above by life expectancy (35) to get annual  
medical costs and multiply the amount by two. (\$163,901.58/35)  
= \$4,682.90 x 2 = \$9,365.80*      \$9,365.80
- Step 5 – Seed money to be deposited upon settlement is equal to  
the sum of the amounts calculated in Steps 2 and 4 above.  
(10,874.23 + 9365.80)*      \$20,240.03
- Step 6 – Subtract seed money from total WCMSA (Step 1) and divide  
by life expectancy minus one (35-1) to calculate minimum annual  
deposit for the balance of claimant’s life. Deposit must be made  
no later than one (1) year from date of settlement. (174,775.81-  
20,240.03/34)*      \$4,545.17

**Calculation of MSA figures:**

<b>Service</b>	<b>Frequency</b>	<b>Every x years</b>	<b># of years</b>	<b>Price per service</b>	<b>Total</b>
<b>Periodic Items and Services</b>					
<i>Physical therapy</i>	30.00	3.00	35.0	\$76.50	\$26,775.00
<i>Laboratory</i>	3.00	1.00	35.0	\$125.00	\$13,125.00
<i>Physiatrist</i>	1.00	1.00	35.0	\$120.00	\$4,200.00
<i>Podiatrist</i>	1.00	1.00	35.0	\$140.00	\$4,900.00
<i>Doppler ultrasound</i>	4.00	35.00	35.0	\$164.00	\$656.00
<i>Psychologist</i>	24.00	1.00	6.0	\$180.00	\$25,920.00
<i>Psychiatrist</i>	4.00	1.00	3.0	\$180.00	\$2,160.00
<i>X-ray foot</i>	4.00	10.00	35.0	\$120.00	\$1,680.00
<i>Electro convulsive therapy</i>	3.00	1.00	3.0	\$5,900.00	\$53,100.00
<i>X-ray head</i>	1.00	5.00	35.0	\$120.00	\$840.00
<i>Foot treatments</i>	1.00	5.00	35.0	\$980.00	\$6,860.00
<b>Sub Total</b>					\$140,216.00
<b>Surgeries, Replacements, and Procedures</b>					
<i>Replacement foot including physician fee, anesthesia, and hospitalization</i>	1.00	10.00	35.0	\$8,874.23	\$31,059.81
<i>Foot surgery</i>	1.00	20.00	35.0	\$2,000.00	\$3,500.00
<b>Sub Total</b>				\$10,874.23	\$34,559.81
<b>Total:</b>					\$174,775.81

**Examples of Surgical Procedures and/or Replacements**

**Surgical Procedures**

- Back Surgery
- Rotator Cuff Surgery
- Arthroscopic Surgery
- Carpal Tunnel Surgery

**Replacements**

- SCS Battery Replacement
- Electric Wheelchair Replacement
- Hip Replacement
- Knee Replacement
- Other Prosthesis Replacement

If you have any questions or require any additional information, please contact me at (803) 555-1111, Extension 11.

Sincerely,

Ima Friend

Ima Friend  
Benefit Coordination Specialist

# CONSENT FORM

**(The attached example is not a required format, it is only an example of an acceptable form)**

**CONSENT TO RELEASE FORM**

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, Wendy Storm, 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 worker's 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:

(X) Claimant's attorney Legal Eagle, Esquire  
(name and/or firm)

(X) Employer's attorney Dennis Defender, Esquire  
(name and/or firm)

(X) Workers' compensation carrier Got U Covered  
(name and/or firm)

( ) Other \_\_\_\_\_  
(name and/or firm)

Wendy Storm  
Claimant's Signature

10/18/04  
Date Signed

12/31/1997  
Date of Injury

123-45-6789A  
Social Security Number Or  
Health Insurance Claim Number

**RATED AGE  
INFORMATION  
or  
LIFE  
EXPECTANCY**

**(Proof of all rated ages obtained on the case should be on documents independent (no relationship) of the submitter or carrier, and on insurance company or settlement broker letterhead).**

**If there is no information on rated age(s), the review will be based on the CDC tables referenced in the submitter cover letter.**

**PREMIUM INSURANCE COMPANY**  
**100 Ageless Lane**  
**CITY, STATE 22222-4444**  
**Phone: (302) 555-1111, Fax: (302) 555-0000**  
**E-mail: iamins@pic.com**

February 5, 2005

Life expectancy calculation for the following claimant:

Wendy Storm  
100 Careful Lane  
City, State 22222-1111  
Phone: (410) 555-8989, Fax: (410) 555-4545  
E-mail: stormywind@lil.com  
SSN : 123-45-6789  
HICN : 123-45-6789A  
DOB : 12/25/1978  
DOI : 12/31/1997

Actual Age: 25

Rated Age: 47 (Expires in 1 Year)

**Note: Several rated ages obtained in the above manner may be included with the submission and presented in a chart format as shown below:**

**Workers' Compensation Settlement Broker, LLC**  
**200 Sunny Lane**  
**CITY, STATE 33333-5555**  
**Phone: (804) 555-1111, Fax: (804) 555-0000**  
**E-mail: sunny@msa.com**

File Name: Wendy Storm File No.: 00WS458231 DOB: 12/25/1978 Age: 25

Ratings Used:

<b>Date Sent</b>	<b>Life Co. Fax Number</b>	<b>Contact &amp; Phone Number</b>	<b>Date Received</b>	<b>Rated Age</b>	<b>Expires In</b>
2/11/05	Best Life Ins. (410) 222-0000	Ruff Dogg (410) 555-9999	2/12/05	44	1 Year
2/11/05	Live Better, Inc. (410) 333-0000	Doris Day (410) 555-8888	2/12/05	46	1 Year
2/11/05	Premium Insurance Co. (410) 777-0000	Fay Ray (410) 555-0000	2/12/05	47	1 Year
2/11/05	Lively Life, Inc. (410) 444-0000	Connie Can (410) 555-1111	2/12/05	48	1 Year
2/11/05	Jumpstart Life, Inc. (410) 555-0000	Jack Jump (410) 555-7777	2/12/05	49	1 Year

**NOTE: The above formats are the only acceptable formats. CMS will only accept rated ages presented on a settlement broker or insurer letterhead, and only rated ages independent (no relationship) of the submitter and carrier.**

# Life Care Plan

**Note: A life care plan is not required on all WCMSAs. It is appropriate to include one when the claimant's injury/disease is extensive/serious, e.g., paraplegia, quadriplegia, brain damage, etc.**

**SAMPLE**

Client: Wendy Storm Date prepared: 02/18/2005  
 Prepared by: Rita Reviewer, RN, CCM  
 DOB: December 25, 1978 DOI: 12/31/1997  
 Diagnoses 825.30 Compound fracture of right foot  
 728.71 Plantar fasciitis  
 311 Depressed  
 300.00 Anxiety disorder

Life expectancy: 35 years Costs based on year: 2004

Life Care Plan  
 Future Medical Care – Medicare Covered Items and Services

Service	Frequency	Every x years	# of years	Price per service	Total
<b>Periodic Items and Services</b>					
<i>Physical therapy</i>	30.00	3.00	35.0	\$76.50	\$26,775.00
<i>Laboratory</i>	3.00	1.00	35.0	\$125.00	\$13,125.00
<i>Physiatrist</i>	1.00	1.00	35.0	\$120.00	\$4,200.00
<i>Podiatrist</i>	1.00	1.00	35.0	\$140.00	\$4,900.00
<i>Doppler ultrasound</i>	4.00	35.00	35.0	\$164.00	\$656.00
<i>Psychologist</i>	24.00	1.00	6.0	\$180.00	\$25,920.00
<i>Psychiatrist</i>	4.00	1.00	3.0	\$180.00	\$2,160.00
<i>X-ray foot</i>	4.00	10.00	35.0	\$120.00	\$1,680.00
<i>Electro convulsive therapy</i>	3.00	1.00	3.0	\$5,900.00	\$53,100.00
<i>X-ray head</i>	1.00	5.00	35.0	\$120.00	\$840.00
<i>Foot treatments</i>	1.00	5.00	35.0	\$980.00	\$6,860.00
<b>Sub Total</b>					\$140,216.00
<b>Surgeries, Replacements, and Procedures</b>					
<i>Replacement foot including physician fee, anesthesia, and hospitalization</i>	1.00	10.00	35.0	\$8,874.23	\$31,059.81
<i>Foot surgery</i>	1.00	20.00	35.0	\$2,000.00	\$3,500.00
<b>Sub Total</b>				\$10,874.23	\$34,559.81
<b>Total:</b>					\$174,775.81

CREATELIFEPLAN, LLC  
 100 Easylife Way  
 City, State, 22222  
 Phone: (888) 555-1111 Fax: (888) 555-0000  
 E-mail: jbc@create.com

# **Settlement Agreement or Proposed Court Order**

**(The attached is only an example. Each state has its own format.)**

**BEFORE THE COURT COMMISSION  
STATE OF \_\_\_\_\_**

Commission File: 000000

Wendy Storm  
(Hereinafter called "Employee")

vs.

Cool Toys Manufacturing  
(Hereinafter called "Employer")

Got U Covered  
(Hereinafter called "Insurer")

**\*\*\*AGREEMENT OF FINAL SETTLEMENT AND RELEASE\*\*\***

THIS AGREEMENT OF FINAL SETTLEMENT AND RELEASE was made and entered into on the \_\_\_\_ day of \_\_\_\_\_ by and between Employee, Employer, and Insurer.

**I**

**(This is intended only as sample language)**

The Employee, Wendy Storm, for consideration of the sum of \$1,530,684.05, paid by or on behalf of the above captioned Employer/Carrier/TPA, shall release Employer/Carrier/TPA, from its obligation or liability to pay all benefits of whatever kind or classification available under the \_\_\_\_\_ State Workers' Compensation Law on account of the above captioned manufacturing accident and any other known or unknown (discussed below) work related injury that the Claimant may have sustained while employed by the Employer and/or their successors, assigns, interests, officers, directors, employees, agents, shareholders or any other person or entity who may be responsible or liable for actions of the Employer.

**II**

**(This is intended only as sample language)**

Claimant represents and affirms that all accidents, injuries, and occupational diseases known to have occurred or have been sustained while employed by the Employer have been revealed but in any event, this Settlement Agreement and release releases the Employer/Carrier/TPA from all Workers' Compensation liability and as such, Claimant bears the risk of arguably related conditions not yet manifested. It is the intention of the parties to resolve all claims actual or potential for any and all accidents and/or injuries, arising out of and in the course and scope of employment, in exchange for the monetary consideration outlined herein.

**III**

**(This is intended only as sample language)**

The Claimant specifically acknowledges that on finality of this Settlement Agreement and release, rights to all future medical care and treatment related or arguably related to the workers' compensation claim, whether remedial or palliative in nature, are forever and fully relinquished whether or not the Claimant's condition has been brought to a state of maximum medical improvement and regardless of whether the Claimant's condition(s) improves or seriously deteriorates for any reason whatsoever. On finality of this Settlement Agreement and Release, except as specifically provided and limited below, the Employer/Carrier/TPA shall not be responsible for either the provision or payment of any medical benefits. Any future medical care treatment or expense that may arise in the future, regardless of the cause thereof, will be the responsibility of the Claimant. Claimant understands only authorized medical providers will be paid for authorized services rendered prior to the finality of this Settlement Agreement and Release. Any medical bills from authorized providers for authorized services rendered to the finality of this Settlement Agreement and Release shall be submitted for payment by the Employer/Carrier/TPA. All medical bills from unauthorized providers are the responsibility of the Claimant, not the Employer/Carrier/TPA. Medical bills from authorized providers for services rendered after the date of finality become the responsibility of the Claimant.

**IV**

**(This is intended only as sample language)**

The Medicare Set Aside funds in this case are to be self administered by the claimant. Claimant has been provided directives issued by CMS regarding her rights and responsibilities in this regard. Claimant understands that until she becomes entitled to Medicare, the MSA funds must not be used to pay the claimant's expenses. Claimant understands that the MSA funds must be placed in an interest bearing account, and this account must be separate from the individual's personal savings and checking accounts. The funds in this account may only be used for payment of medical services related to the work injury that would normally be paid by Medicare.

It is not the intention of the Workers' Compensation Carrier to shift responsibility of future medical benefits to the Federal government. The sum of \$174,775.81 for future Medicare-covered expenses is intended directly for payment of these expenses. Upon proof that Medicare-covered expenses exceed \$174,775.81, those expenses will be forwarded to Medicare for payment of covered expenses with proper documentation. It is the responsibility of the claimant/beneficiary to maintain records, including bills for services Medicare would normally cover, related to the work-related injury or illness totaling the amount of \$174,775.81 before Medicare will make payment on any covered expenses related to the work injury or illness.

This allocation is based on the workers' compensation fee schedule. The injured worker should be advised that they should make their best effort to obtain services from providers that accept this fee schedule.

V

**(This is intended only as sample language)**

Claimant and her family agree not to discuss the existence of this settlement or any of the terms to any persons in the employment of Cool Toys Manufacturing, Inc. or any former employees of Cool Toys manufacturing. The Claimant specifically agrees to keep the existence of and the terms of this settlement strictly confidential.

VI

**(This is intended only as sample language)**

The Employee accepts the following settlement as full and final compensation from her former employer:

Total WC Settlement Amount:            \$1,530,684.05 broken down as follows:

\$ 1,000,000.00 Cash to claimant  
\$ 300,000.00 Cash attorney fee  
\$ 55,908.24 Non-Medicare medical annuity payout (\$1,597.38/year for life, life expectancy 35 years, starting 07/15/2005)  
\$ 20,240.03 MSA initial deposit (seed money), includes 1st surgery and 1<sup>st</sup> procedure/replacement and 2 years of remaining medical services.  
\$ + 154,535.78 MSA annuity payout (\$4,545.17/year for remaining life, 34 years, starting 07/15/2006)  
\$ 1,530,684.05

In testimony whereof, the parties have hereunto set their hands and affixed their seals the day and year first above herein.

\_\_\_\_\_  
Employee

Consented To:

\_\_\_\_\_  
Legal Eagle  
Attorney for Employee  
State Bar No. 5678

\_\_\_\_\_  
Attorney for Employer/Carrier/TPA

\_\_\_\_\_  
NOTARY PUBLIC, State of \_\_\_\_\_  
My Commission Expires: March 10, 2006  
 The Employee is personally known to me  
 Has produced ID: Valid driver's license

# **SET-ASIDE ADMINISTRATOR/COPY OF AGREEMENT**

**(The attached is an example for a self-administered WCMSA, there are different criteria for a professionally-administered WCMSA)**

**TERMS AND CONDITIONS FOR BENEFICIARY ADMINISTERED  
WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT  
(WCMSA)**

Medicare Beneficiary: Wendy Storm  
HICN: 123-45-6789A  
DOI: 12/31/1997  
Employer: Cool Toys Manufacturing, Inc.

Medicare regulations found in Title 42 of the Code of Federal Regulations §411.46, state that Medicare will not pay for services related to this work-related injury until the WCMSA funds have been exhausted. Your WCMSA funds must be used to pay for all Medicare-covered medical services related to the work injury. A CMS lead Medicare contractor will monitor your expenditures from the WCMSA account by reviewing annual accounting statements that you are required to submit. Once the lead contractor has confirmed that the WCMSA funds have been exhausted appropriately, Medicare will begin paying for covered-services related to the work-related injury.

The terms and conditions for establishing and administering a WCMSA account are listed below. If you have any questions regarding these requirements, please contact the CMS lead Medicare contractor at the following address.

[insert]            **CONTRACTOR NAME**  
                         **ADDRESS**  
                         Attention: MSP – Medicare Set-aside Reconciliation

**Establishing and Using your Medicare Set-Aside Account**

- WCMSA funds must be placed in an interest-bearing account, separate from your personal savings or checking account. A copy of the documents establishing this account shall be sent to the CMS RO that has been handling your case within 30 days of the workers' compensation settlement award being disbursed. All interest earned on this account shall be allowed to accrue in the account and will be used solely for the purposes described below.
- If you are not currently entitled to Medicare benefits, the WCMSA funds must not be used to pay for any medical expenses. WCMSA funds must be held until you become a Medicare beneficiary.
- WCMSA funds may only be used to pay for medical services related to your work injury that would normally be paid by Medicare. Examples of some items that Medicare does not pay for are: prescription drugs, acupuncture, routine dental care, eyeglasses or hearing aids and therefore, these items can not be paid from the WCMSA account. You can obtain a copy of the booklet "Medicare & You" from

your Social Security office for a list of services not covered by Medicare. If you have a question regarding Medicare's coverage of a specific item or service, call 1-800-MEDICARE (1-800-633-4227) or visit the [www.medicare.gov](http://www.medicare.gov) website. If Medicare does cover the item or service and it is related to your work injury, you may pay for it from your WCMSA account.

*Please note: If payments from the WCMSA account are used to pay for services that are not covered by Medicare, Medicare will not pay injury related claims until these funds are restored to the WCMSA account and then properly exhausted.*

### **Record Keeping**

- As administrator of the account, you will be responsible for keeping accurate records of payments made from the account. These records may be requested by CMS' lead Medicare contractor as proof of appropriate payments from the WCMSA account.
- You may use the WCMSA account to pay for the following costs that are directly related to the account:
  - Document copying charges
  - Mailing fees
  - Any banking fees related to the account

Annually, you must sign and forward a copy of the attached form providing self-attestation that payment from the WCMSA account was made appropriately for work-related injuries that would otherwise be reimbursable by Medicare. The self-attestation form shall be submitted no later than 30 days after the end of each year (beginning with one year from establishment of the WCMSA account). Annual self-attestations should continue through depletion of the WCMSA account.

I, Wendy Storm, have read and understood the above-listed terms and conditions. I agree to abide by these terms and conditions in order to protect my ability to obtain Medicare coverage for my work-related injury medical expenses once the Workers' Compensation Medicare Set-aside Arrangement (WCMSA) account is depleted. I understand that if I fail to abide by the above listed terms and conditions, I may not be eligible for Medicare coverage for my work-related injury medical expenses.

Wendy Storm  
Wendy Storm  
Claimant

3/01/2005  
Date

I, Legal Eagle, counsel for Wendy Storm, have reviewed the above agreement with the Claimant and have explained it, in detail. I believe that Ms. Storm fully understands the complete contents of the document and the duties she is undertaking to administer her WCMSA.

Legal Eagle  
LEGAL EAGLE  
Counsel for Wendy Storm

03/01/2005  
Date

# Medical Records

Doc Holliday  
100 OK Corral Lane  
City, State 77777-2222  
Phone: (410) 555-1111, Fax: (410) 555-0000  
E-mail: doc@okcorral.com

February 1, 2005

Ima Friend  
Benefit Coordination Specialist  
MSA Consultants, LLC  
100 Correct Lane, Suite 300  
City, State 11111-2222

RE: Wendy Storm  
DOI: 12/31/1997

Dear Ima:

Pursuant to your request for a report regarding Ms. Wendy Storm's medical treatment, please find same below in the format you indicated.

Current Treatment Status (including past medical treatment):

I have been Ms. Storm's primary care physician for the past twelve years. Ms. Storm is a 26 year old white female with a prosthetic right foot. She sustained an injury at her place of employment on 12/31/1997, resulting in a fracture to the right foot. Subsequently, the foot became severely infected causing the need for amputation and replacement with a prosthetic foot. The incident occurred while Ms. Storm was working on a remote control robot for Cool Toys Manufacturing, Inc. The robot fell from a worktable and landed on her right foot, causing her to fall backward, landing on her head. She was transported via ambulance to the nearest hospital.

Upon initial examination, there appeared to be no apparent trauma to Ms. Storm's head. A series of x-rays indicated a compound fracture to the right foot, along with pieces of metal from the robot imbedded in the foot, causing infection. She did not respond to aggressive antibiotic treatment and amputation of the foot was indicated. A surgical team led by an orthopedic specialist performed the procedure and replaced the damaged foot with a prosthetic device. Post surgery, she was discharged to home, with an order for home health assistance five times a week and an appointment for follow-up evaluation in six weeks.

During this recuperative period, the home health staff notified me that Ms. Storm was beginning to exhibit some unusual behavior. I made a home visit to see her and immediately noticed that she showed signs of depression and anxiety. I referred her to

Dr. Head for a psychiatric evaluation. He diagnosed her with severe depression and anxiety, along with mild to moderate paranoia. He prescribed moderate doses of psychotropic medications including xanax and zoloft and recommended electro-convulsive therapy for the depression.

From 1998 to the present, she continues to see Dr. Head for medication monitoring and a psychologist in his group for individual therapy. She recently began participating in group therapy with other individuals injured at the workplace and unable to return to work or sustain gainful employment.

Past Medical Treatment Unrelated to WC Injury/Co-Morbid Conditions:

Ms. Storm's past medical history was positive for smoking. She also has a family history (paternal grandmother) of Adult-onset Type II Diabetes.

Future Treatment (for Medicare covered items and services for the WC injury only):

Future treatment should include physiatrist visits with her primary care physician, physical therapy treatments, podiatrist visits for foot evaluation, x-rays of foot and head and periodic prosthetic foot replacements and adjustments. Ms. Storm should also continue with the mental health services and associated treatments, medications and lab work indicated in her life care plan.

If there are any further questions, please do not hesitate to contact me.

Sincerely, yours,

Doc Holiday, M.D.  
Doc Holiday, M.D.

cc: Virgil Earp, RN

**NOTE: PLEASE SUBMIT ALL ACTUAL MEDICAL RECORDS FOR THE LAST TWO YEARS IN ADDITION TO TREATING PHYSICIAN'S SUMMARY. IT IS RECOMMENDED THAT MEDICAL RECORDS BE SORTED BY PROVIDER OR BY CALENDAR YEAR.**

# PAYMENT HISTORY

(Include claims payment history for medical and indemnity payments for the last 2 years)

Detail Claim Activity 11/01/04

Claim Number: 00DC4563210DC

Coverage Type: Indemnity  
Deductible: None

Employee: 123-45-6789  
Wendy Storm  
100 Carefree Lane  
City, State 22222-1111

Insured Company  
Cool Toys Manufacturing, Inc.  
22 Playful Lane  
City, State 55555-2222

Account # 00912345

Policy # 00ACDR

Employer Tax ID# 7776655

Date/Time of Loss: 12/31/1997

Date First Report Entered: 01/04/1998

Adjuster: 007 / James Bond  
Agent: 086 / Maxwell Smart

Injury Code: 28 / Fracture  
Catastrophe ID:  
Supervisor

A.I. Loss Code: 0731 / Work Station  
NCCI Accident Code: 47 / falling object  
Job Class: 2274 /

Injury/Acc Desc: Fracture/Rt foot, Depression

Open: 01/04/1998 Subro: N 2<sup>nd</sup> Inj: N Med Open: N Employed: 01/01/1997 DOB: 12/25/1978

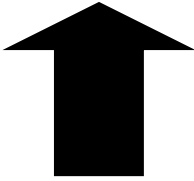
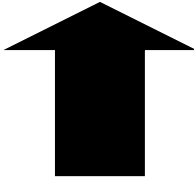
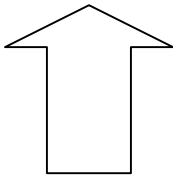
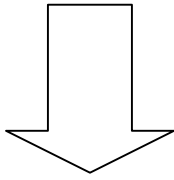
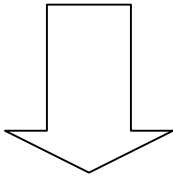
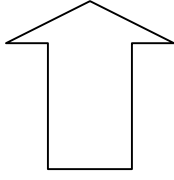
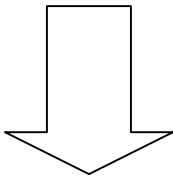
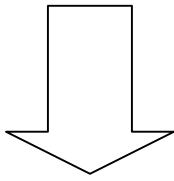
Payments (All)

<u>Date</u>	<u>Type</u>	<u>Check #</u>	<u>Amount</u>	<u>Payee</u>	<u>Period/Service Date</u>
02/04/2005	Indemnity	0001112255	\$ 623.00	01 Wendy Storm	02/03/05-02/03/05
01/04/2005	Indemnity	0001112255	\$ 623.00	01 Wendy Storm	01/03/05-01/03/05
12/04/2004	Indemnity	0001112255	\$ 623.00	01 Wendy Storm	12/03/04-12/03/04
11/04/2004	Indemnity	0001112254	\$ 623.00	01 Wendy Storm	11/03/04-11/03/04
10/31/2004	Medical	0001112233	\$ 230.00	41 Clinicure, Inc.	10/15/04-10/15/04
10/31/2004	Medical	0001112234	\$ 330.00	41 Clinicare, Inc.	10/05/04-10/05/04
10/3120/04	Medical	0001112236	\$ 101.00	41 Clinicare, Inc.	09/06/04-09/06/04
10/04/2004	Indemnity	0001112253	\$ 623.00	01 Wendy Storm	10/03/04-10/03/04
09/04/2004	Indemnity	0001112237	\$ 623.00	01 Wendy Storm	08/12/04-08/12/04
08/04/2004	Indemnity	0001112252	\$ 623.00	01 Wendy Storm	08/03/04-08/03/04
07/10/2004	Medical	0001112238	\$ 462.20	41 Clinicare, Inc.	06/12/04-06/12/04
07/04/2004	Indemnity	0001112251	\$ 623.00	01 Wendy Storm	07/03/04-07/03/04

**SAMPLE**

06/10/2004	Medical	0001112239	\$1,200.00	41	Clinicare, Inc.	05/12/04-05/12/04
06/04/2004	Indemnity	0001112250	\$ 623.00	01	Wendy Storm	06/03/04-06/03/04
05/10/2004	Medical	0001112240	\$1,200.00	41	Clinicare, Inc.	04/10/04-04/10/04
05/04/2004	Indemnity	0001112249	\$ 623.00	01	Wendy Storm	05/03/04-05/03/04
04/04/2004	Indemnity	0001112241	\$ 623.00	01	Wendy Storm	04/03/04-04/03/04
03/10/2004	Medical	0001112242	\$4,200.00	41	Clinicare, Inc.	02/03/04-02/03/04
03/04/2004	Indemnity	0001112248	\$ 623.00	01	Wendy Storm	03/03/04-03/03/04
02/10/2004	Medical	0001112243	\$ 500.00	41	Clinicare, Inc.	01/04/04-01/04/04
02/04/2004	Indemnity	0001112247	\$ 623.00	01	Wendy Storm	02/03/04-02/03/04
01/10/2004	Medical	0001112244	\$ 600.00	41	Clinicare, Inc.	12/01/03-12/31/03
01/04/2004	Indemnity	0001112246	\$ 623.00	01	Wendy Storm	01/03/04-01/03/04
12/01/2003	Medical	0001112245	\$4,200.00	41	Clinicare, Inc.	02/31/03-11/30/03

## Under Threshold Criteria For Submission of a WCMSA

Over \$250,000	30 Month Expectation*	Action to be Taken
		<b>CMS Should Review</b>
<b>YES</b>	<b>YES</b>	
		<b>CMS Should NOT Review</b>
<b>YES</b>	<b>NO</b>	
		<b>CMS Should NOT Review</b>
<b>NO</b>	<b>YES</b>	
		<b>CMS Should NOT Review</b>
<b>NO</b>	<b>NO</b>	

\*Reasonable expectation of Medicare enrollment within 30 months of settlement date.

Note: The above threshold criteria are only a **review** threshold due to the high volume of cases submitted to CMS for review. Section 1862 of Social Security Act of 1966 states a Workers Compensation Case is always primary to Medicare. In addition, if the claimant is a Medicare beneficiary at the time of settlement, then CMS should review the proposed WCMSA, irrespective of the dollar amount.

The following form has been recommended by at least one CMS regional office.

**TERMS AND CONDITIONS FOR BENEFICIARY ADMINISTERED  
MEDICARE SET-ASIDE ACCOUNT**

Medicare beneficiary, [Claimant] (Claimant), HIC # [Number] , sustained a [describe work related condition(s)] at work on [Date(s) of injury] . As a result of the accident, Claimant filed a Michigan workers' compensation claim. Claimant has negotiated a settlement of [his/her] workers' compensation claim. It is anticipated that Claimant will require future medical treatment for the [describe work related condition(s)] sustained at work.

Federal regulations provide that the liability for work-related injury lifetime medical expenses should not be shifted to Medicare from the responsible party. Accordingly, a portion of a Medicare beneficiary's workers' compensation settlement must be set aside to pay for the beneficiary's future work-related injury or illness medical expenses. 42 C.F.R. § 411.46. Federal regulations also provide that Medicare will not pay for any medical expenses for the work-related injury or illness, after a workers' compensation settlement is received, until the amount of the lump sum settlement allocated to future medical expenses is exhausted. Id.

Consequently, in order to comply with the applicable federal regulations and to reasonably recognize Medicare's interest, Claimant will use \$[Amount] from [his/her] workers' compensation settlement award to fund a Medicare Set-Aside Account. This account will be known as the "[Claimant] Medicare Set-Aside Account." If Claimant adheres to the following terms and conditions in administering the [Claimant] Medicare Set-Aside Account, then, when the set-aside funds are depleted and a satisfactory final accounting has been provided to the Centers for Medicare & Medicaid Services, (CMS), Medicare will pay for any Medicare covered medical treatment Claimant receives as a result of the [describe work related condition(s)] [he/she] sustained at work. However, in the event Claimant fails to adhere to any of the following terms and conditions, CMS may regard such a default as a failure to reasonably recognize Medicare's interests and may deny Medicare coverage for all medical treatments due to Claimant's work related [describe condition(s)] injury. The terms and conditions are as follows.

1. **Work-Related Injury Defined** - Claimant's "work-related injury" is defined as [describe work related condition(s), DOI & how it occurred] .
2. **Initial Set-Aside Account Funding** - The [Claimant] Medicare Set-Aside Account shall initially be funded with \$[Amount set aside for Medicare] from the proceeds of the \$[Redemption amount] settlement award Claimant received in [his/her] workers' compensation lawsuit.
3. **Set-Aside Account Interest Income** - The Medicare Set-Aside funds shall be placed in an interest bearing account, denominated "[Claimant] Medicare Set-Aside Account," that is insured by the Federal Deposit Insurance Corporation. A copy of the documents establishing the [Claimant] Medicare Set-Aside Account shall be sent to CMS within 30 days of the workers' compensation settlement award being disbursed to Claimant.
4. **Distribution of the Set-Aside Account Funds** - The funds in the [Claimant] Medicare Set-Aside Account shall be used solely for medical expenses incurred by Claimant for those medical needs related to or resulting from [his/her] work-related injury, which would otherwise be reimbursable or paid for by Medicare. Funds in the [Claimant] Medicare Set-Aside Account shall not be used to pay for medical services not covered by Medicare. Federal statutes and regulations set forth the medical services and equipment that are covered by Medicare. For a reference aide, Claimant should obtain a



11. **Misappropriated Set-Aside Account Funds** - If, after the [Claimant] Medicare Set-Aside Account is depleted, the final accounting reveals that funds in the account were used to pay for items other than medical expenses for medical needs related to or resulting from Claimant's work related injury, which would otherwise be covered by Medicare, CMS will withhold Medicare coverage for work-related injury medical expenses in an amount equal to the misappropriated funds.

I, [Claimant] , have read and understand the above-listed terms and conditions. I agree to abide by these terms and conditions in order to protect my ability to obtain Medicare coverage for my work-related injury medical expenses once the [Claimant] Medicare Set-Aside Account is depleted. I understand that if I fail to abide by the above-listed terms and conditions, I may not be eligible for Medicare coverage for my work-related injury medical expenses.

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[Claimant]

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Date

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MEMORANDUM

**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](http://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](http://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](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](mailto: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.

Gerald Walters



If a settlement has been reached or benefits have been exhausted, or if you issued a denial of liability notice, please provide the following information to the Medicare contractor listed in the preceding paragraph, as applicable:

1. Authorization from your insured/claimant to release Medicare specific paid claims data. If you do not have a release on file, the enclosed release form must be signed by both you and your insured/claimant and returned to the above Medicare contractor. (A release must be signed, even if the case has not yet been settled or arbitrated.)
2. A copy of the settlement agreement indicating the settlement date and total amount of the award.
3. If monies were available through personal injury/med-pay, or another form of coverage, indicate the total coverage amount, itemization of benefits paid, and the date that benefits were exhausted.
4. If monies were disbursed to your client/claimant furnish a copy of the check indicating date of issuance.
5. If you have denied liability, a copy of your denial notice.

If you have any questions regarding Medicare's right of recovery as outlined, please contact:

TCLNAME  
TCLADD1  
TCLADD2  
TCLCITY TCLSTATE TCLZIP  
Phone: TCLPHONE

Enclosure:  
Consent to Release form

CC: BENENAME,  
TCLNAME

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**NOTICE TO PATIENT ABOUT THE COLLECTION  
AND USE OF MEDICARE INFORMATION  
(PRIVACY ACT STATEMENT)**

The Social Security Act mandates the collection of this information. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information collected may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of title XVIII; and to an individual or organization for a research evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

The identification number we are using is your Medicare Health Insurance Number. While furnishing the information on this form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records.

Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988 permits the government to verify information by way of computer matches. Anyone who knowingly and willfully makes or causes to be made a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0214. The time required to complete this information collection is estimated to average 5 minutes per responder, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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