DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS for MEDICARE & MEDICAID SERVICES

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.

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.

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