



# **Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide**

**Version 3.0**

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**Confidentiality Statement**

The collection of this information is authorized by Section 1862(b) of the Social Security Act (codified at 42 U.S.C 1395y(b)) (see also 42, C.F.R. 411.24). The information collected will be used to identify and recover past conditional and mistaken Medicare primary payments and to prevent Medicare from making mistaken payments in the future for those Medicare Secondary Payer situations that continue to exist. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of information maintained by the Centers for Medicare & Medicaid Services (CMS) in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the beneficiary provides written consent/proof of representation, CMS will permit authorized parties to access requisite information.

## 1.0 About This Reference Guide

This guide was written to help you understand the process used by the Centers for Medicare & Medicaid Services (CMS) for approving proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amounts and to serve as a reference for those choosing to submit such amounts to CMS for approval. Submitters may include injured workers themselves (claimants), their attorneys, Workers' Compensation (WC) Medicare Set-Aside Arrangement (MSA) agents or consultants, or claimants' other appointed representatives.

This guide reflects information compiled from all WCMSA Regional Office (RO) Memoranda issued by CMS, from information provided on the CMS website, from information provided by the Workers Compensation Review Contractor (WCRC), and from the CMS WCMSA Operating Rules. The intent of this reference guide is to consolidate and supplant all historical memoranda in a single point of reference. Please discontinue the reference of prior documents.

*There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures.*

## 1.1 Changes in This Version of the Guide

Version 3.0 of this guide includes the following changes:

- Addresses have been corrected or clarified for reporting workers' compensation cases; for sending yearly WCSMA account attestations; and for sending WCMSA proposals, final settlements, and re-review requests (Sections 2.2, 17.5, and 17.6).
- "Death of a Claimant" information has been updated and standardized with the Self-Administration Toolkit for WCMSAs (Section 19.2).
- CMS' expectations for competent administration of WCMSA funds when "frequently abused drugs" are prescribed for a claimant have been clarified, with policy and guidance link added (Sections 17.1 and 17.3).
- CMS has clarified how hospital fee schedules are determined (Section 9.4.3).
- Required language for the Consent to Release form now includes indication that the beneficiary understands the intent, process, and administration of WCMSAs (Section 10.2 and Appendix 6: 10 – Consent to Release Note).
- The Life Table link has been updated (Section 10.3).
- This guide has been updated to account for changes in the WCMSAP, which now includes a Professional Administrator role, which can upload account transactions and view account details, and the ability to submit attestations online for all others (Section 17.6; minor changes throughout).
- The time period for submission of amended review requests has been extended to 6 years (Section 16.2).

## **2.0 Introduction to Workers' Compensation and Medicare**

### **2.1 Medicare as Secondary Payer**

“Medicare Secondary Payer” (MSP) is the term used when the Medicare program does not have primary payment responsibility on behalf of its beneficiaries—that is, when another entity has the responsibility for paying for medical care before Medicare. Until 1980, the Medicare program was the primary payer in all cases except those involving WC (including Black Lung benefits) or for care that is the responsibility of another government entity. With the addition of the MSP provisions in 1980 (and subsequent amendments), Medicare is secondary payer to group health plan insurance in specific circumstances, but is also secondary to liability insurance (including self-insurance), no-fault insurance, and WC. An insurer or WC plan cannot, by contract or otherwise, supersede federal law, for instance by alleging its coverage is “supplemental” to Medicare.

WC is a primary payer to the Medicare program for Medicare beneficiaries' work-related illnesses or injuries. Medicare beneficiaries are required to apply for all applicable WC benefits. If a Medicare beneficiary has WC coverage, providers, physicians, and other suppliers must bill WC first.

In order to comply with 42 U.S.C. § 1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment “has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” If responsibility for the WC claim is in dispute and WC will not pay promptly, the provider, physician, or other supplier may bill Medicare as primary payer. If the item or service is reimbursable under Medicare rules, Medicare may pay conditionally, subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. (See 42 C.F.R. § 411.21 for the definition of “promptly” with regard to WC.)

### **2.2 Reporting a WC Case**

All WC occurrences that involve a Medicare beneficiary should be reported to the Benefits Coordination & Recovery Center (BCRC). If you are a Responsible Reporting Entity (RRE) making an initial report of ongoing responsibility, use the Section 111 COB Secure Website for reporting. For the submission of WCMSA information, contact the BCRC by phone or mail. Customer Service Representatives are available Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays. The BCRC's toll free number is 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired.

Written reports of WC occurrences should be addressed to:

Medicare—Medicare Secondary Payer  
Medicare Secondary Payer Claims Investigation Project  
P.O. Box 138897  
Oklahoma City, OK 73113-8897

**NOTE: This mailing address is for reporting a WC occurrence, not for the submission of proposed WCMSA amounts.** See [What Are Workers' Compensation Medicare Set-Aside Arrangements?](#) for an explanation of WCMSAs, or [Paper Copy/CD Submission via the Mail](#) for the WCMSA submission address.

When contacting the BCRC to report a new WC occurrence by phone or by mail, please be sure to have the following information available:

- Injured person's name
- Injured person's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier [MBI]) or Social Security Number (SSN)
- Date of incident
- Nature of illness/injury
- Name and address of the WC insurance carrier
- Name and address of the injured person's legal representatives
- Name of insured
- Policy/claim number

Once this information is received, the BCRC will apply it to the beneficiary's Medicare record and send it to the Commercial Repayment Center (CRC) for processing. The CRC will issue a Conditional Payment Letter (CPL) or Conditional Payment Notice (CPN) to the insurer, copied to the beneficiary, explaining Medicare's recovery rights with respect to conditional payments and outlining next steps in the process. Please note that Medicare's interests cannot be determined until the specifics of the WC occurrence are noted on the beneficiary's record. For inquiries after submission of the WC occurrence, beneficiaries and their representatives should contact the BCRC using the contact information above or in Appendix 1, and non-beneficiaries should contact the CRC at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

## 2.3 Past and Future Medical Services

Generally, the term "past medical services" refers to Medicare-covered and otherwise-reimbursable items and services that the beneficiary receives before he or she obtains a WC settlement, judgment, award, or other payment. The term "future medical services" refers to Medicare-covered and otherwise-reimbursable items and services that the beneficiary receives after he or she obtains a settlement, judgment, award, or other payment.

In situations in which Medicare has paid for WC-claim-related care before the beneficiary has obtained a settlement, judgment, award, or other payment, those Medicare payments are referred to as "conditional payments." They are considered conditional payments because Medicare pays under the condition that it is reimbursed when the beneficiary gets a WC settlement, judgment, award, or other payment.

Medicare is required by statute (42 U.S.C. § 1395y(b)) to seek reimbursement for conditional payments related to the settlement. Further, Medicare is prohibited from making payment where payment has been made (that is, where the beneficiary obtains a settlement, judgment, award, or other payment). Medicare remains the secondary payer until the settlement proceeds are appropriately exhausted. In many situations, the parties to a WC settlement choose to pursue a

CMS-approved WCMSA amount in order to establish certainty with respect to the amount that must be appropriately exhausted before Medicare begins to pay for care related to the WC settlement, judgment, award, or other payment.

**Note:** If Medicare is pursuing recovery directly from the WC insurer, the beneficiary, attorney, or other representative will receive a copy of recovery correspondence sent to the WC insurer. For more information on insurer recovery, see the Non-Group Health Plan Recovery page: <http://go.cms.gov/NGHPR>.

### **3.0 What Are Workers' Compensation Medicare Set-Aside Arrangements?**

A WCMSA allocates a portion of the WC settlement for all future work-injury-related medical expenses that are covered and otherwise reimbursable by Medicare ("Medicare covered"). When a proposed WCMSA amount is submitted to CMS for review and the claimant (who may or may not be a beneficiary) obtains CMS' approval, the CMS-approved WCMSA amount must be appropriately exhausted before Medicare will begin to pay for care related to the beneficiary's settlement, judgment, award, or other payment.

The goal of establishing a WCMSA is to estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-injury-related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost. WCMSAs may be funded by a lump sum or may be structured, with a fixed amount of funds paid each year for a fixed number of years, often using an annuity.

Any claimant who receives a WC settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's interest with respect to future medicals into account. If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received any portion of a third-party payment either directly or indirectly—a right to recover, or take back, that payment. CMS also has a subrogation right with respect to any such third-party payment. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the responsible party (and the responsible party's liability insurance). In this example, Medicare is substituting for the claimant in this situation. Medicare can be a party to any claim by a beneficiary or other entity against a responsible party and/or his/her liability insurance, and can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare.

Medicare may also refuse to pay for future medical expenses related to the WC injury until the entire settlement is exhausted. These arrangements are typically not created until the individual's condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be. CMS prefers this, so that future medical and prescription drug costs can be planned with a reasonable degree of certainty.

Once the CMS-approved set-aside amount is exhausted and accurately accounted for to CMS, Medicare will pay primary for future Medicare-covered expenses related to the WC injury that exceed the approved set-aside amount.

## **4.0 Should I Consider Submitting a WCMSA Proposal?**

### **4.1 Considerations and Guidelines**

An individual or beneficiary may consider seeking CMS approval of a proposed WCMSA amount for a variety of reasons. The primary benefit is the certainty associated with CMS reviewing and approving the proposed amount with respect to the amount that must be appropriately exhausted. It is important to note, however, that CMS approval of a proposed WCMSA amount is not required.

#### **4.1.1 Commutation and Compromise**

WC cases may involve past medical expenses, future medical expenses, or both. When a settlement includes compensation for medical expenses incurred prior to the settlement date, it is referred to as a “WC compromise case.” When a settlement includes compensation for future medical expenses, it is referred to as a “WC commutation case.” A settlement also has a commutation aspect if it does **not** provide for future medical expenses when the facts of the case indicate the need for continued medical care related to the WC illness or injury. A WC settlement can have both compromise and commutation aspects.

#### **4.1.2 Outstanding WC Claims**

If a Medicare beneficiary has outstanding WC-related claims that were not paid by either Medicare or the WC carrier prior to the settlement, the beneficiary is required to pay for related unpaid medicals bills out of his or her WC settlement. Medicare cannot pay because it is secondary to the WC settlement.

#### **4.1.3 Other Health Coverage**

A WCMSA is still recommended when you have coverage through other private health insurance, the Veterans Administration, or Medicare Advantage (Part C). Other coverage could be cancelled or you could elect not to use such a plan. A WCMSA is primary to Medicare Advantage and must be exhausted before using Part C benefits on your WC illness or injury.

#### **4.1.4 Hearing on the Merits of a Case**

Because the CMS prices based upon what is claimed, released, or released in effect, the CMS must have documentation as to why disputed cases settle future medical costs for less than the recommended pricing. As a result, when a state WC judge or other binding party approves a WC settlement after a hearing on the merits, Medicare generally will accept the terms of the settlement, unless the settlement does not adequately address Medicare’s interests. This shall include all denied liability cases, whether in part or in full. If Medicare’s interests were not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the entire dollar amount of the entire WC settlement. Medicare may also assert a recovery claim, if appropriate.

If a court or other adjudicator of the merits (e.g., a state WC board or commission) specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

## 4.2 Indications That Medicare's Interests are Protected

Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare's interests. A WCMSA is not necessary under the following conditions because when all three are true, they indicate that Medicare's interests are already protected:

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

In addition, if a settlement leaves WC carriers with responsibility for ongoing medical and prescription coverage once the settlement funds are fully spent, then a WCMSA is not necessary.

### Notes:

- If Medicare made any conditional payments for WC injury-related services furnished prior to settlement, then Medicare will recover those payments. In addition, Medicare will not pay for any WC injury-related services furnished prior to the date of the settlement for which it has not already paid.
- CMS will not issue "verification letters" stating that a WCMSA is not necessary.
- CMS' voluntary, yet recommended, WCMSA amount review process is the only process that offers both Medicare beneficiaries and Workers' Compensation entities finality, with respect to obligations for medical care required after a settlement, judgment, award, or other payment occurs. When CMS reviews and approves a proposed WCMSA amount, CMS stands behind that amount. Without CMS' approval, Medicare may deny related medical claims, or pursue recovery for related medical claims that Medicare paid up to the full amount of the settlement, judgment, award, or other payment.

## 5.0 WCMSA Funding Structures

There are two kinds of WCMSAs. An individual or a beneficiary may obtain a settlement that provides for a lump-sum WCMSA or a structured WCMSA.

## 5.1 Lump-Sum WCMsAs

A WCMSA can be established as a lump-sum arrangement where the beneficiary accepts a single payment intended to pay for all future medical expenses and disability benefits related to the work injury or disease. When a WCMSA is designated as a lump-sum commutation settlement, Medicare will not make any payments for the claimant's medical expenses (for work-related injuries or diseases) until all the funds within the WCMSA (including any interest earned on the funds in the account) have been completely exhausted. These same basic principles also apply to structured settlements. Generally, WCMsAs that are lump sums are easier to monitor than structured arrangements.

## 5.2 Structured WCMsAs

A WCMSA can also be established as a structured arrangement, where payments are made to the account on a defined schedule to cover expenses projected for future years. In a structured WCMSA, an initial deposit is required to cover the first surgical procedure or replacement and two years of annual payments. The initial deposit ("seed money") is followed by subsequent annual deposits (or a shorter time period if CMS agrees to such), based on the anniversary of the first deposit. If in any given coverage year the deposited funds are not exhausted (i.e., used up, spent), they are carried forward to the next period and added to the next annual deposit. The whole fund, including carry-forwards, must be exhausted before Medicare will pay primary for any WC injury-related medical expenses. If the fund is exhausted appropriately in a given annual period, Medicare will pay primary for further WC injury-related medical expenses during that period. In the next annual period, the replenished WCMSA funds again must be used, until the WCMSA amount is appropriately exhausted.

## 6.0 Who Can Help with the WCMSA Process?

Setting up a WCMSA arrangement, submitting the proposal to CMS for approval, and selecting the best way to administer the arrangement can be complicated. If you are an injured worker who will need future medical treatment, an attorney may be able to explain this process and provide legal help. An attorney can also help you consider whether you should have a separate administrator for your WCMSA. You may also find it useful to seek advice from financial and tax professionals in the planning phases and once the WCMSA is established.

Once a WCMSA is established and funded, it must be administered. This can be done by the claimant, by the claimant's representative payee, appointed guardian, or conservator, or by a professional administrator. The administrator must establish the WCMSA account, pay Medicare-covered services from the WCMSA account, and provide CMS with a reporting of the expenditures from the WCMSA. See the WCMsAP User Guide and the WCMSA Self-Administration Toolkit for more information on administering the account and proper reporting to CMS. The User Guide is located at

<https://www.cob.cms.hhs.gov/WCMSA/assets/wcmsa/userManual/WCMSAUserManual.pdf>, and the Toolkit at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/Self-Administration-Toolkit-for-WCMsAs.pdf>.

## 7.0 How is CMS Approval of a WCMSA Amount Obtained?

Generally there are four steps involved in creating a CMS-approved WCMSA. These steps are explained in more detail in the sections that follow:

1. Analysis of the claim and medical information in order to determine the amount of money required for the fund
2. Negotiation of a tentative settlement and preparation of draft settlement documents to settle the WC case, incorporating terms for creation and administration of the WCMSA (CMS is not a party to the settlement)
3. Obtaining approval from CMS for the amount of the proposed WCMSA
4. Finalizing the settlement and funding the WCMSA

## 8.0 Should CMS Review a WCMSA?

If a proposed WCMSA total settlement amount meets the workload review thresholds outlined below, the proposal can be submitted to CMS for approval. If the parties to a WC settlement stipulate a WCMSA amount but do not receive CMS approval, then CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses related to the WC work-related injury, even if they would ordinarily have been covered by Medicare. However, if CMS approves the WCMSA amount and the account is later appropriately exhausted, Medicare will pay Medicare-covered, WC work-injury-related medical bills for services otherwise covered and reimbursable by Medicare regardless of the amount of care the beneficiary continues to require.

*There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval.*

CMS reviews proposed WCMSA amounts in order to determine if the proposed WCMSA amount is sufficient to cover future claim-related medical expenses related to the WC settlement, judgment, or award. **Note:** A WCMSA amount should not be submitted to CMS when the resolution of the WC claim results in the medical portion of the claim being left open—that is, the resolution does not include medical expenses and the WC plan or carrier maintains ongoing responsibility for medicals (ORM), i.e., the WC plan or carrier will continue to pay for medical expenses related to the WC injury after settlement.

### 8.1 Review Thresholds

CMS will review a proposed WCMSA amount when the following workload review thresholds are met:

- The claimant is a **Medicare beneficiary** and the total settlement amount is **greater than \$25,000.00**; or
- The claimant has a reasonable expectation of Medicare enrollment **within 30 months of the settlement date and** the anticipated total settlement amount for future medical expenses and disability or lost wages over the life or duration of the settlement agreement is expected to be **greater than \$250,000.00**.

**Note:** Please see [Settlement Details](#) in this Reference Guide for more details about what information is included in determining this amount.

A claimant has a reasonable expectation of Medicare enrollment within 30 months if any of the following apply:

- The claimant has applied for Social Security Disability Benefits
- The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision
- The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits
- The claimant is 62 years and 6 months old
- The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD

If a threshold is met, a WCMSA can be submitted to CMS for approval.

These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases.

Also note that both the beneficiary and non-beneficiary workload review thresholds are subject to adjustment. CMS reserves the right to change or remove these thresholds based on Medicare's interests. Claimants, employers, carriers, and their representatives should regularly monitor the CMS website at <https://go.cms.gov/wcmsa> for changes to these thresholds and for other changes in policies and procedures.

Further, note that if a claimant's WC settlement does not meet the current workload review thresholds, CMS will not issue a "verification letter" indicating that the review criteria have not been met, or indicating that a WCMSA is unnecessary. CMS will honor the threshold in effect at the time of settlement.

Example 1: A recent retiree aged 67 and eligible for Medicare benefits under Parts A, B, and D files a WC claim against their former employer for the back injury sustained shortly before retirement that requires future medical care. The claim is offered settlement for a total of \$17,000.00. However, this retiree will require the use of an anti-inflammatory drug for the balance of their life. The settling parties must consider CMS' future interests even though the case would not be eligible for review. Failure to do so could leave settling parties subject to future recoveries for payments related to the injury up to the total value of the settlement (\$17,000.00).

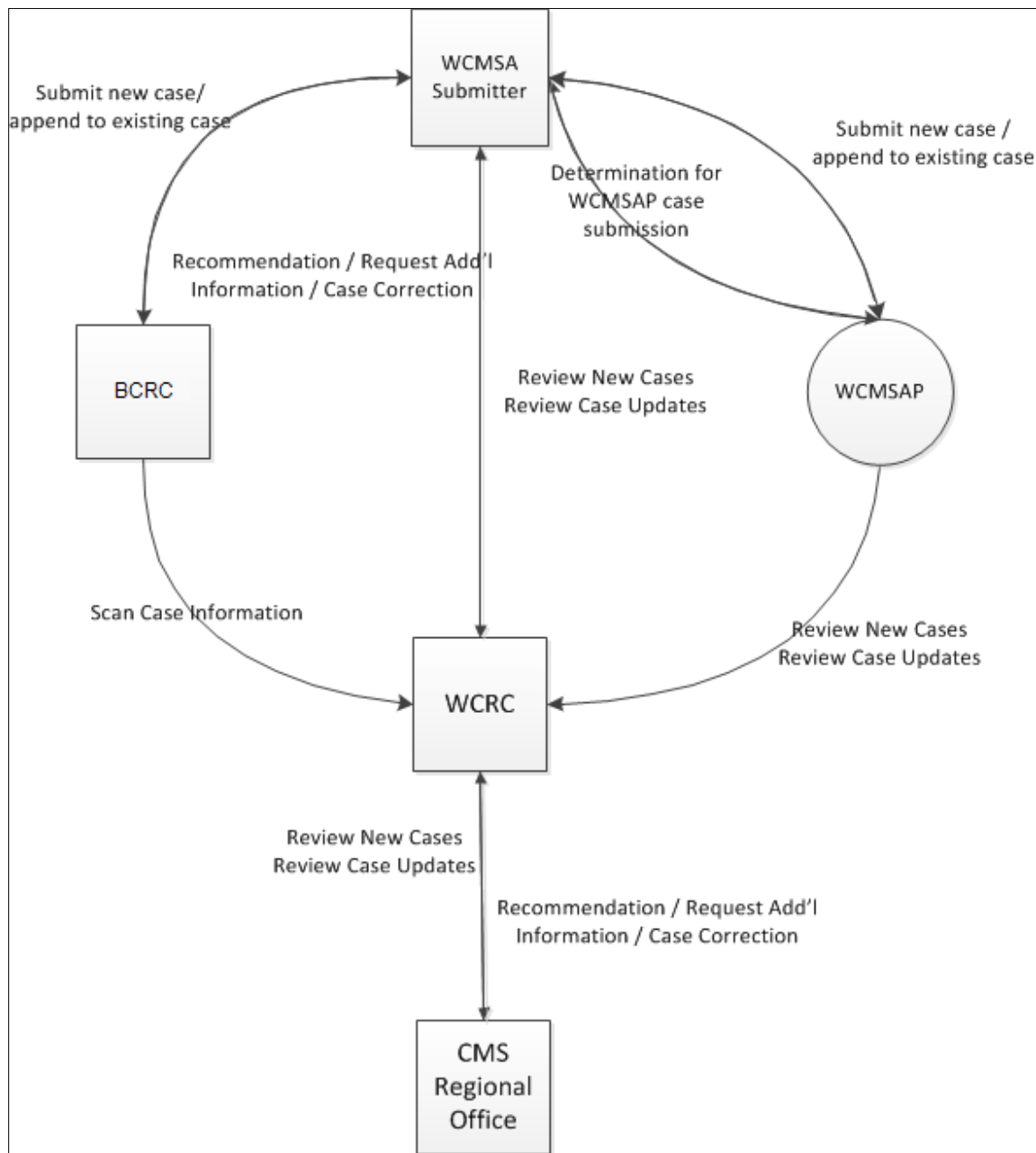
Example 2: A 47 year old steelworker breaks their ankle in such a manner that leaves the individual permanently disabled. As a result, the worker should become eligible for Medicare benefits in the next 30 months based upon eligibility for Social Security Disability benefits. The steelworker is offered a total settlement of \$225,000.00, inclusive of future care. Again, there is a likely need for no less than pain management for this future beneficiary. The case would be ineligible for review under the non-CMS-beneficiary standard requiring a case total settlement to be greater than \$250,000.00 for review. Not establishing some plan for future care places settling parties at risk for recovery from care related to the WC injury up to the full value of the settlement.

## 9.0 WCMSA Submission Process Overview

When a WCMSA proposal is submitted on paper or CD, the Benefits Coordination & Recovery Center (BCRC) transfers it to CMS' computerized system and checks it for completeness. Then it is ready to be reviewed by the Workers' Compensation Review Contractor (WCRC). Proposals submitted online via the WCMSA Portal (WCMSAP) go directly to the WCRC for review. These two submission methods represent the only acceptable delivery methods. Either the BCRC or the WCRC may request more information from the submitter as necessary. The WCRC applies CMS' criteria in reviewing proposals, and forwards the proposals along with a recommendation on the appropriate funding amount to the assigned CMS Regional Office (RO) for a final determination. For more information on the submission process and documentation requirements, please see Section [11.0, How do I submit a WCMSA?](#).

Figure 9-1 illustrates the submission process and all of the entities involved. A single-direction arrow indicates one-way communication. A double-direction arrow indicates two-way communication. More detailed information about this process immediately follows this diagram.

**Figure 9-1: WCMSA Submission Process Overview**



## 9.1 WCMSAP Submissions

When a WCMSA case is submitted online via the WCMSAP, case information is electronically transmitted to the CMS system used to report and track WCMSA cases. The submitter will receive an alert which can only be viewed on the WCMSAP. This alert acknowledges that the case was received.

## 9.2 Paper or CD Submissions

When the BCRC receives a WCMSA proposal via hard copy (paper documents, including faxes) or via CD, it manually prepares, sorts, and scans all eligible WCMSA proposals, including all documentation received, into the CMS system used to report and track WCMSA cases.

## 9.3 Receipt Review

The review process is as follows:

1. **New Case:** If the submitted WCMSA proposal is for a new case and all required documentation has been submitted, it is ready for WCRC review. However, if any required documents are missing, the submitter is asked for the missing information, in a phase called Development.
2. **Existing Case:** If the submitted WCMSA documentation is for an existing case, it is matched with and appended to the existing case. At this point, and if the submitted documentation is complete, the case is ready for WCRC review.
3. **Deceased Beneficiary:** If the WCMSA submission is for a beneficiary who is *possibly* deceased, the submitter is notified that, according to CMS' records, the beneficiary is deceased, and the submitter is requested to submit evidence to the contrary. If supplemental information is not supplied, the case is systematically closed.

The process varies depending on the method of submission. For hard copy submissions, the BCRC performs the checks for completeness, makes requests for additional information, and enters the documents into Medicare's computerized system.

For portal submissions, no document scanning and entry is necessary. The WCMSAP will also check CMS' records for a death date for the beneficiary at the time of submission. Any requests for additional information or for proof that the beneficiary is living will arrive through the portal, with an email notification.

The BCRC's role in this process is limited to preparing and developing the case. Once the case is ready, the WCRC performs the initial review of the proposal.

## 9.4 WCRC Review

### 9.4.1 WCRC Review Process

The WCRC receives submissions from the BCRC and from the portal, and performs an independent review of the adequacy of both the medical and prescription drug costs proposed.

The WCRC first reviews the case in detail for completeness and accuracy. If errors are found in a submitted case, the submitter is notified.

- a) If the case was submitted via the WCMSAP, the submitter will be notified via an e-mail alert to the address provided during the WCMSAP account setup.
- b) If the case was submitted via paper or CD, the submitter will receive a letter via the postal service.

Both types of notification contain the case control number and the type of error found.

The WCRC then reviews and evaluates the adequacy of the proposal submitted. Using some or all of the evaluation tools listed in [Appendix 4](#), the WCRC evaluates the likely need for, and prices medical treatments and prescription medications for, the expected duration of the claimant's life. Based on these findings, the WCRC makes recommendations as to the disposition of the case, the prescription drugs proposed and costs, treatment plans and costs, and the WCMSA amount. In other words, the WCRC ultimately renders an opinion to CMS as to whether the WCMSA amount proposed is adequate to protect Medicare's interests.

During its review, the WCRC may need to develop the case for additional information or documentation. If the submitter does not respond to the development letter within the allotted time frame (i.e., 30 days for cases submitted to the BCRC, 20 business days for cases submitted on the WCMSAP), the case is closed for lack of response. If the submitter does respond, but the response is insufficient, another request may be sent to the submitter. If more than one development request has been sent, the timestamp of the most recent request will be used to calculate the response time frame.

#### **9.4.1.1 Most Frequent Reasons for Development Requests**

The five most frequent reasons for development requests by the WCRC:

1. Insufficient or out-of-date medical records;
2. Insufficient payment histories, usually because the records do not provide a breakdown for medical, indemnity or expenses categories;
3. Failure to address draft or final settlement agreements and court rulings in the cover letter or elsewhere in the submission;
4. Documents that are referenced in the file are not provided – this usually occurs with court rulings or settlement documents;
5. References to state statutes or regulations without providing sufficient documentation (i.e., to which payments the statutes/regulations apply or a copy of the statute or regulation, or notice of which statutes or regulations apply to which payments.)

#### **9.4.2 WCRC Team Background and Resources Used**

All of the WCRC reviewers are licensed healthcare professionals, including registered nurses, physicians, nurse practitioners, and professional counselors. These reviewers also maintain various credentials and certifications, such as Certified Case Managers, Life Care Planners, Certified Coders, Rehabilitation Counselors, and Legal Nurse Consultants. Several are also licensed in the practice of law. The WCRC reviewing staff has knowledge of:

- International Classification of Diseases (ICD)-9, ICD-10, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding practices
- Medicare coverage guidelines
- Anatomy, physiology, and pharmacology
- Clinical practice guidelines
- Utilization review standards and practices

- State-specific workers' compensation guidelines and pricing structure
- Health Insurance Portability and Accountability Act (HIPAA) and related healthcare confidentiality regulations

The WCRC reviewers have many resources to assist them in their daily reviewer responsibilities, including pharmacists, attorneys, the medical director, and certified coders. The reviewers also have access to clinical guidelines, workers' compensation fee schedules, and Medicare coverage guidelines to assist with their reviews. See [Appendix 4](#) for a list of specific resources used in reviews.

### 9.4.3 WCRC Review Considerations

After the WCRC case reviewer validates that the injury has been accepted as a compensable injury, the next step is to project related future medical care. These considerations are key to review accuracy:

Are there previous injuries that affect the resolution of the accepted injury?

Are there underlying medical conditions that will affect the type of future care or the length of care necessary to bring about the best possible outcome?

Are there underlying conditions requiring concurrent medications or treatment, but which are not related specifically to this work injury?

Are non-treating provider reviews and examinations taking precedence over the treating providers' treatment plan?

Are the medical pricing rules used appropriate for the particular region?

The WCRC team reviews all of the submitted records and attempts to determine the future care required for the individual claimant, taking into consideration the claimant's specific condition, other comorbidities, and the claimant's past use of healthcare services. Reviewers use evidence-based rationale for their determinations, taking into account both published guidelines and current peer-reviewed medical literature.

Medical pricing may vary based on injury, age, location, and other factors. Each submission is reviewed independently of other submissions for claimants with the same injury and age. This accounts for any differences in WCMSA amount determination.

For example, a reasonably healthy and active 45-year-old claimant who recently had total knee replacement surgery is likely to require a revision of the surgery (second knee replacement) during his 30-year life expectancy, as the replacement joint wears out. However, another 45-year-old claimant with a recent total knee replacement but who is sedentary and in poor health due to diabetes mellitus and coronary artery disease may not require or be a satisfactory risk for such a revision in the future.

If a claimant might need a revision or replacement surgery in the last 1–3 years of life expectancy, the decision to include this revision in the WCMSA depends on the type of revision and on the claimant's overall condition. For example, a claimant in the last 1–3 years of life expectancy is unlikely to have a revision of a total hip replacement surgery, but a spinal cord stimulator (SCS) for pain management would likely be revised if needed.

The WCRC considers both the claimant's past history of treatment and the recent trending of treatment in determining plans for future treatment frequency. For example, if a claimant was seeing the physician every year initially, but records indicate more frequent visits recently, that will be considered in the determination. There is currently no plan to establish a set of standards for specific conditions.

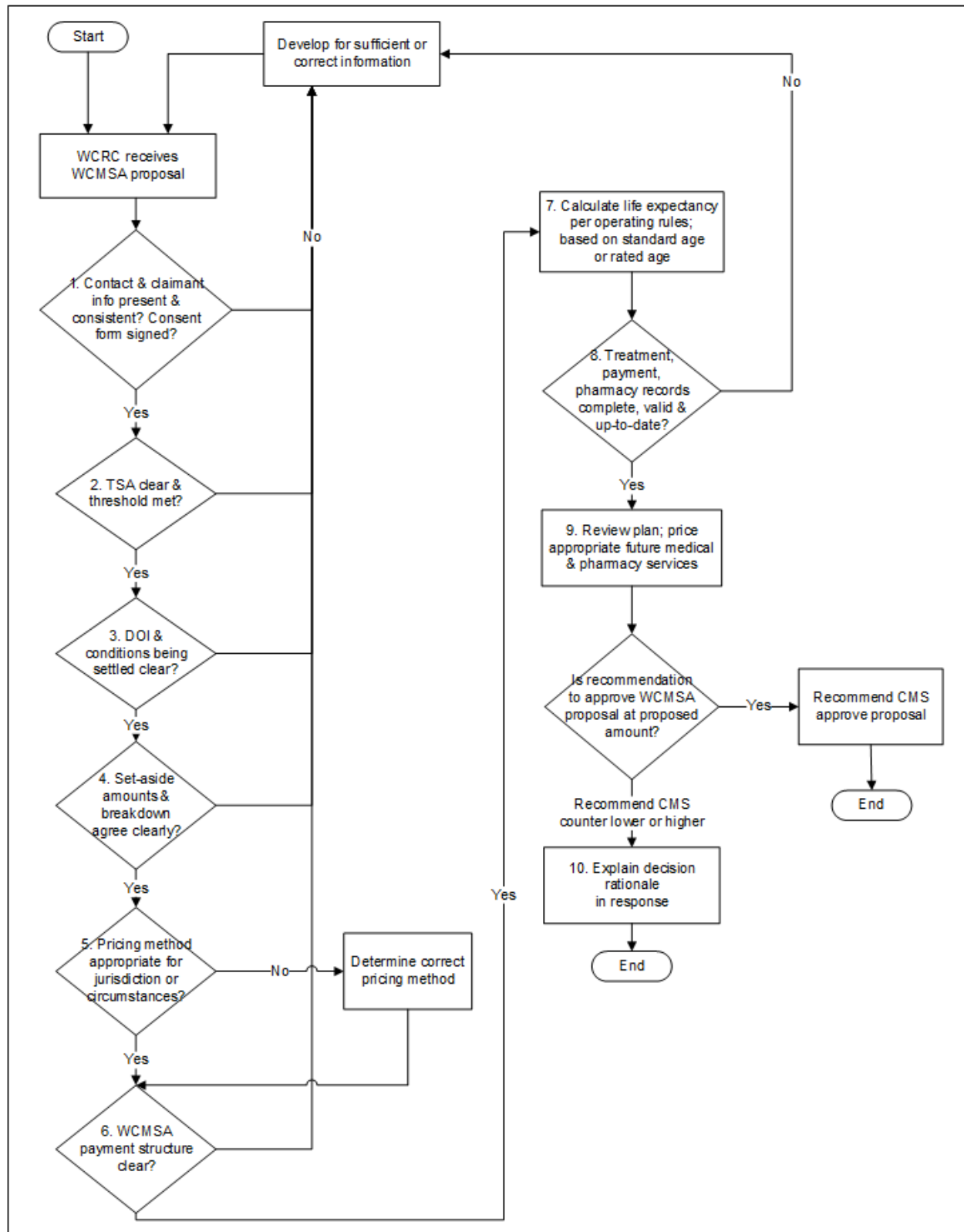
The WCRC relies on evidence-based guidelines for prescription medication and medical treatment allocations; however, these are guidelines, not rules. The final determination is also based on the claimant's past use and future recommended treatment as supported by the medical records and by current peer-reviewed medical literature. See [Appendix 4](#) for a list of resources the WCRC uses.

The WCRC strives to comply with the laws of the state determined to be the appropriate state of venue. The reviewers research the applicable state regulations and fee schedules. In previous years, the WCRC has priced WCMSAs using the highest fee schedule zone possible within any state that uses fee schedules. Currently the WCRC prices WCMSAs according to the correct region for the state of venue. Hospital fee schedules are currently determined using the Diagnosis-Related Groups (DRG) payment for the median Major Medical Center within the appropriate fee jurisdiction for the pricing ZIP code, unless otherwise defined by state law.

### **9.4.4 Medical Review**

The WCRC follows ten steps in its medical review process. For a list of resources used in the process, see [Appendix 4](#). The diagram below shows the steps in order, with decision points. The steps are numbered in the diagram and explained in the text following the diagram.

**Figure 9-2: WCRC Medical Review Steps**



**Step 1: Validate demographics and contact information.**

1. Verify that claimant name, SSN, Medicare ID (HICN or MBI), address, date of birth, and gender are consistent with the submitter letter.
2. Check that contact information is present for claimant's attorney, carrier, employer or carrier attorney submitter, WCMSA administrator, and Social Security Administration (SSA) representative payee (if there is one).
3. If a professional administrator is proposed, verify that the full contact information is available.
4. Check that a consent-to-release note is valid and signed by the claimant, Power of Attorney (POA) holder, or guardian. If there is a POA or guardian, submitted documents must support that relationship.

**Step 2: Verify that the total settlement amount (TSA) is clear and that the review threshold is met.**

If the TSA is not clear in the submitter letter, the case cannot be reviewed until it is clarified through development.

Cases that are clearly under threshold will be closed as ineligible. Cases not clearly meeting the threshold requirements are developed so that the WCRC can determine whether the case is eligible for review.

**Step 3: Verify that dates of injury and conditions being settled are clear.**

Multiple dates of injury that are settling can be included in one WCMSA. Document each date of injury (DOI) with the accepted and alleged body parts for each date of injury. The submitter also has the option to submit separate WCMSA proposals for different DOIs for the same claimant.

It is helpful if the submitter includes the ICD-9 or ICD-10 codes for each condition for each DOI. Do not use both ICD-9 and ICD-10 codes on one submission; use only ICD-10 codes for DOIs on or after 10/1/2015. (ICD-9 codes will continue to be allowed for submissions with a DOI of 9/30/2015 or earlier.)

It is also helpful to include medical records, a payment history, and detailed prescription history for each DOI being settled.

The reviewer will also determine whether parties are settling on all body parts or portions of the claim, or if some portions of the claim will remain open. If the carrier will continue to pay for all WC claim injury-related medical care for the claimant, then the case is ineligible for review. If the proposal involves settling all medical claims for all body parts, the case is eligible for review. Also, if the agreement states that the carrier will continue to pay for some medical services but not others for the same body part, the WCRC considers this as not settling for all treatments for that body part. For example, the WCRC cannot work a case where a submitter wants to settle medical claims for a body part, but leave open prescription drugs for the same body part.

For multiple WC settlements per claimant, the cover letter should be clear on how the submitter expects the cases to be handled. If the cover letter is not clear, the WCRC will discuss with the submitter whether to process the settlements as one WCMSA proposed amount, or as multiple separate amounts. The cases will be closed until the submitter clarifies in writing which is the preferred option, at which point the cases will be reopened.

**Step 4: Verify the proposed set-aside amounts.**

The reviewer will first review a settlement document, signed by all parties and state-approved, for the proposed total settlement amount. If such an amount is not accompanied somewhere in the file by a proposed life expectancy, the reviewer will ignore the amount in the settlement document. If the submitter proposes a different amount, the reviewer will use the settlement documents' amount. If there is no settlement document with a proposed total amount, the reviewer will review the cover letter for proposed WCMSA amounts and the specific breakdown for proposed medical and prescription amounts. The amounts should add up to the total and be identical in both the submitter letter and the proposed future treatment tables provided with the submission. If the submitter letter is not clear as to the proposed set-aside amount or there are any discrepancies, the WCRC will develop the case, which delays review. If there is no specification of how much of the total settlement amount is for medical expenses vs. prescription drug expenses, the reviewer will assume it is all for medical items and services.

**Step 5: Verify jurisdiction and calculation method.**

The jurisdiction for fee schedule selection and pricing depends upon where the WC claim is filed (the state that will control any WC hearing). If the claim is filed in the same state of residence as the claimant, pricing shall be calculated based on the zip code of the claimant. If the claimant resides in a state other than the state of jurisdiction for the WC claim, pricing is calculated based on the zip code associated with the employer's address. If the employer is not located in the state where the WC claim is filed, pricing is calculated based on the zip code of the claimant's attorney. If the claimant is not represented by an attorney, pricing is calculated based on the zip code of the WC carrier. If the carrier is also not located in the state where the WC claim is filed, pricing is calculated based on the zip code of the carrier's attorney.

The order of jurisdictional precedence will follow the charts listed in Table 9-1 and Table 9-2.

**Table 9-1: Verifying Jurisdiction and Calculation Method (Normal Pricing)**

<b>ORDER OF PRECEDENCE</b>	<b>IF...</b>	<b>JURISDICTION USED</b>
1	WC claim is filed in New York and the claimant resides in New York	Pricing is based on claimant's New York ZIP code
2	However, if the claimant resides in Delaware	Pricing is based on the employer's New York ZIP code
3	If the employer also does not have a New York address	Pricing is based on the New York ZIP code of the claimant's attorney
4	If the claimant does not reside in New York and is not represented by an attorney	Pricing is based on the WC carrier's New York ZIP code
5	If the WC carrier does not have a New York address	Pricing is calculated based on the New York ZIP code of the carrier's attorney
6	If the WC carrier's attorney does not have a New York address	Pricing is based on the New York ZIP code of the injury address

**Table 9-2: Verifying Jurisdiction and Calculation Method (Other Pricing)**

ORDER OF PRECEDENCE	IF...	JURISDICTION USED
1	If a case is filed with the U.S. Department of Labor Office of Workers' Compensation Programs (OWCP)	Pricing is based using the OWCP Fee Schedule
2	If submitted documentation indicates that a proposed WCMSA amount is based upon a Longshore Harbor Workers' Compensation Act settlement	Pricing is based on the Office of Workers' Compensation Programs fee schedule for the ZIP code of claimant's residence, unless the submitter specifies actual charges
3	If a state WC fee schedule does not exist based on the jurisdiction evaluation above (Indiana, Iowa, Missouri, New Jersey, Virginia, and Wisconsin)	Pricing is based using actual charges, even if the submitter proposed the use of a fee schedule
4	If a state WC fee schedule exists based on the jurisdiction evaluation above	Pricing is based on the most current version of the fee schedule posted publicly

The pricing will be calculated using the most current version of the state's fee schedule, with the following exceptions:

- If a state institutes or changes a fee schedule, CMS' contractor will apply the new fee schedule immediately upon learning of its official publication, for any case still in process on that date;
- CMS' contractor will default to pricing based on state fee schedule, where applicable, unless the submitter otherwise specifies that the proposal was developed based on actual charges;

#### **Step 6: Verify payout method: lump sum versus annuity.**

If the submission includes settlement documents, the reviewer uses the payout method, if any, listed in such documents. If there are no settlement documents, the reviewer will use the payout method as requested in writing by the claimant or claimant's attorney. If there is no such written request, the reviewer will use the method stated in the submitter cover letter. The default method, should all else fail, is the lump sum payout.

If the cover letter is unclear or if information conflicts with other information in the submission, the case will require development and will take longer to process.

When annuity is selected, the submitter provides a proposed "seed" or initial deposit amount. This amount should include the cost of the first procedure and first replacement, if any. The seed includes the first two years of the annual amount. See [Section 05 – Cover Letter](#) in this Guide for instructions on how to calculate the seed amount, with an example.

The seed includes the cost of the first surgery, including all costs such as prescription drugs, physician fees, anesthesia fees, and facility fees. If the surgery is preceded by an associated trial, i.e., trial SCS or trial intrathecal (IT) pump, the cost of the trial is also included since it is considered part of the same procedure. If there are no surgeries, the first procedure (if any, such as injections) is included. Series of spinal injections are not included but series of knee viscosupplementation is included if three are anticipated to be accomplished as a series of three weekly injections.

The first replacement of Durable Medical Equipment (DME), prosthesis, or orthotics is included in the seed funds if the cost of such items exceeds \$500.

The seed includes the cost of surgeries, procedures, drugs, or replacement items as noted above. It does not include the cost of diagnostic studies, complications, and hospitalizations for non-surgical treatment.

**Step 7: Calculate life expectancy using standard age or median rated age.**

Rated ages (RAs) are optional. For all cases with BCRC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), the submitter must supply a statement that all rated ages obtained on the claimant have been included. If this is missing, the WCRC will use actual age in processing the submission.

If an RA is provided, acceptable proof of the RA is necessary. Rated ages must name the claimant, must be by an insurance company, must be on insurance company or settlement broker letterhead, must be independent, and must give a specific rated age or life expectancy. If there is not at least one RA that meets these criteria, the WCRC will use actual age in processing the submission. Reviewers may drop RAs that are not valid.

If no RAs are provided, if there are no valid rated ages, or if the appropriate RA statement is not provided, actual age is used in calculating the life expectancy.

The reviewer evaluates the issue date of the RA against the proposed settlement date (PSD). This date is the later of the following: BCRC receipt date plus 120 days, or the pricing date plus three months. One year is added to the RA if one year has passed from the issue date to the PSD. If two years have passed from the issue date of the RA, two years are added to the rated age. If three years have passed from the issue date of the RA, the rated age is not used in determining the median rated age.

If there are multiple RAs from the same source, only the most recently issued RA from that issuer is used. When there is more than one valid RA, reviewers will use the median. When calculating the median RA, the reviewer drops decimals and uses the resulting whole number. For example, if the calculated RA is 49.5, the decimal is dropped and the age of 49 is used as the median RA.

If you include a valid RA in a proposal, the reviewer will use that instead of actual age unless you request otherwise in writing.

To determine life expectancy, the reviewer uses the current Centers for Disease Control (CDC) life expectancy table (see [Section 15 – Rated Age Information or Life Expectancy](#) for details). Per CMS memo of May 20, 2008, Table 1 for total population is used.

**Step 8: Verify that treatment records, payment records, and pharmacy records are up-to-date, complete, and valid.**

Submitters should include treatment records for the last two years of treatment of the work injury. Statements from the claimant, carrier, or claimant's attorney are not a substitute for treatment records. Provide all related treatment records, even if the claimant has relocated or begun treatment for the work injury with providers other than the workers' compensation providers, if the treatment is within the last 2 years.

If there are multiple work injuries and the submitter notes that some conditions are resolved or not under active treatment, the submitter should provide the last two years of treatment records for those conditions, even if that treatment did not occur in the last two calendar years. For example, if the claimant's work injuries include a shoulder and cervical spine injury in 2006, but current records of 2011 and 2012 only address the cervical spine, please provide the last two years of treatment records related to the shoulder. If the shoulder was only treated in 2006 and 2007, provide those records. However, if the 2011 and 2012 records sufficiently address the shoulder, the 2006 and 2007 records are not needed. It is helpful to provide the first report of injury and surgical reports related to the work injuries, even if they are not dated in the past two years.

Independent Medical Examination (IME) reports, Qualified Medical Examination (QME) reports, and Agreed Medical Examination (AME) reports are not a substitute for medical records. If the submitter provides an IME report that notes the claimant has not been treated for a work injury since 2008, the reviewer also needs the 2007 and 2008 treatment records.

The WCRC reviewers need carrier payment records (medical and pharmaceutical), printed within six months of the date of submission or date of reopening. This includes a two-year history for all categories: medical, indemnity, and expenses. If the carrier has denied any conditions, submit the entire pay history, not just a two-year history. If the records for denied cases reflect a payment, medical and treatment records may be required to complete the review process.

The information must be sufficient to determine the doses and frequencies of each medication. If the claimant is filling medications for the work injury but the carrier is not currently paying for the medications, the reviewer needs sufficient medical records, prescription records, or a signed treating provider letter stating the medications with doses and frequencies. If physician-dispensed medications do not appear on the carrier prescription history, please submit billing records or other documentation to demonstrate the refill history.

**Step 9: Review records and submitter's proposed plan. Price the appropriate future medical and pharmacy services.**

The WCRC performs an independent review of the adequacy of the medical and prescription drug costs included in the submitted WCMSA proposal, and prepares a recommendation to CMS about the proposal and whether it protects Medicare's interests.

The reviewer considers all evidence provided in the submission. This includes any treatment records, physician-dispensed medication records, payment records, court orders, treatment guidelines, or applicable statutes that were attached to the submission. Please submit any such evidence mentioned in the proposal.

The reviewer must include treatments that are Medicare covered, following local and national coverage guidelines. (National coverage guidelines may be found at this link <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html?DLPage=1&DLSort=0&DLSortDir=ascending> on the CMS website.) Treatments that are not covered by Medicare are not included in the calculated WCMSA amount. If the item is recommended in the medical record and is covered by Medicare, it will be included in the WCMSA, regardless of whether it follows medical association guidelines. The WCRC makes every effort not to include services that have not been recommended in the medical records unless the service is always part of the treatment.

The WCRC reviews proposals on a case-by-case basis. They consider the treatment and usage patterns, the recommendation of the treating providers, life expectancy, functional status, responses to treatment, and effectiveness of therapies as established in the records.

The WCRC references evidence-based guidelines as resources in determining future treatment. Examples include Milliman and the Official Disability Guidelines; see [Appendix 4](#) for further resources and links. For medical expenses, the treating physician opinion carries the greatest weight unless there is a court order to the contrary.

For prescription medications, the reviewers include medications that are Food and Drug Administration (FDA) approved or supported for inclusion in the approved compendia.

Reviewers use the evidence in the records to determine if the proposal accounts for the reasonably probable future prescription drug needs. This includes the prescription drug history, the treatment notes, provider medication lists, and physician dispensing records.

The current Red Book Drug Reference is used to price medications according to Average Wholesale Price (AWP). See Section [9.4.6](#) in this Guide for further details on Pharmacy reviews and special topics.

**Note:** The WCRC will always price the case at 100% of the future costs related to the work injury. CMS does not recognize any apportionment of future medical items and services or prescription drug costs related to the work injury.

### **Step 10: Provide an explanation in the decision rationale for counter higher or counter lower determinations.**

If the recommended WCMSA amount (which is a combined total of medical and prescription costs) is within 5% of the submitter's total proposed WCMSA amount, the WCRC recommendation is approval of the submitter's proposed amount.

In structured cases, the seed amount is separately calculated. If the recommended initial deposit is within 5% of the submitter's initial deposit, the WCRC recommendation is approval of the submitter's proposed seed amount.

The reviewer provides a detailed decision rationale when there is a counter higher or lower determination.

## **9.4.5 Medical Review Guidelines**

### **Diagnostics**

In general, the reviewers include x-rays every 3 to 5 years, but include yearly x-rays if there was or will be a major joint replacement. Magnetic Resonance Imaging (MRI) scans are included every 5 to 7 years. These are guidelines only. Since the determination is made on a case-by-case basis, other factors are considered, such as claimant life expectancy, past surgeries, functional status, age of injury, treatment pattern, and provider recommendations.

In the case of Computerized Tomography (CT) scans and MRIs, if the diagnostic study ordered is specific as to “with or without contrast,” and submitters provide documentation as to which, the WCRC will price them accordingly. To protect Medicare’s interest, if there is no indication as to the testing ordered, the WCRC will allocate for “without followed by with” contrast because the study may be changed due to findings on the “without” study.

### **Intrathecal Pumps**

The WCRC follows the most recent guidance from CMS on intrathecal (IT) pump pricing and frequencies. Permanent placements IT pump devices are included every 7 years: the claimant’s life expectancy is divided by 7, decimals are dropped, and the whole number is used for determining replacement over the life expectancy.

### **Intrathecal Pump Surgery/Procedure Pricing**

Surgery pricing includes physician fees, facility fees, and anesthesia fees, if applicable.

Physician fees: CPT codes are identified and priced per the fee schedule (or usual and customary charges if claimant is in an actual-charges state).

Facility fee: DRG codes for inpatient procedures are priced for a major medical center in that state, unless the fee schedule has pricing for that DRG (such as Illinois). If the procedure is an outpatient procedure, pricing is per the Ambulatory Payment Classification calculator for a facility in that state, unless the fee schedule has a maximum reimbursement amount for that procedure.

Anesthesia fee: anesthesia fee is calculated per fee schedule formula using a reasonable time for the specified procedure for the time-value unit and base value as established by the fee schedule, or Medicare and conversion factors per fee schedule.

Preadmission Testing will be included where appropriate.

Trials: If the surgery is preceded by an associated trial, such as for a spinal cord stimulator, the trial is assumed to be successful and included with the cost of surgery. This does not apply if there is evidence that the trial was performed and was unsuccessful.

If submitters provide a detailed breakdown of their proposed surgery prices, the reviewer will consider the proposed amounts.

### **Spinal Cord Stimulators**

The WCRC follows the most recent guidance from CMS on SCS pricing and frequencies. Permanent placements of SCS devices are included every 7 years for non-rechargeable and every 9 years for rechargeable: the claimant’s life expectancy is divided by the frequency of replacement by type, decimals are dropped, and the whole number is used for determining replacement over the life expectancy. Routine replacement of the neurostimulator pulse

generator includes the lead implantation up to the number of leads related to the associated code. Revision surgeries should only be used where a historical pattern of a need to relocate leads exists.

### **Pricing for Spinal Cord Stimulator (SCS) Surgery**

Surgery pricing may include physician, facility, and anesthesia fees. SCS pricing is based on identification of: 1.) Rechargeable vs. Non-rechargeable and 2.) Single vs. Multiple Arrays (leads). If unknown, CMS will default to non-rechargeable single array.

Physician fees: CPT codes are identified and priced based on the appropriate state fee schedule (or usual and customary charges from a state).

- 63650, number of units equal to the number of lead arrays to be implanted
- 63655, if laminectomy for implantation of electrode is planned
- 63685-51, Insertion or replacement of neurostimulator generator
- 01936, Anesthesia

Facility fee: A DRG, or diagnostic related grouping, is how Medicare and some health insurance companies categorize hospital costs and determine how much to pay for a patient's hospital stay. DRG codes for inpatient procedures are priced for a major medical center in that state, unless the fee schedule has pricing for that DRG (like Illinois). If the procedure is an outpatient procedure, pricing is based on the Ambulatory Payment Classification calculator. This is the amount Medicare pays for facility outpatient services in that state, unless the fee schedule has a maximum reimbursement amount for that procedure.

- The procedure can be inpatient or outpatient, depending on previous surgeries or physician recommendation.
- If inpatient, find out which MS DRG and APR DRG to use as it doesn't vary much.

Consider the number of leads to be used.

Analysis Services: CMS LCDs (L34705 and L35648) can be billed every 30 days and more frequently in the first month. It should be priced four times in the first 30 days, monthly for the first year, and twice a year after the first year.

- **LCD L34705** – SCS (Dorsal Column Stimulation) – “Generally, electronic analysis services (CPT codes 95970, 95971, 95972, and 95973) aren't considered medically necessary when provided more often than once every 30 days. More frequent analysis may be necessary in the first month after implantation.”
- **LCD L35648** – SCS for Chronic Pain – Under Utilization Guidelines: “Generally, electronic analysis services (CPT codes 95970, 95971, 95972 and 95973) aren't considered medically necessary when provided more often than once every 30 days. More frequent analysis may be necessary in the first month after implantation.”

Anesthesia fee: The anesthesia fee is calculated by multiplying the time-value unit by a base value. The time-value unit is the reasonable time for a procedure. The base value is either established by the fee schedule, or by Medicare and conversion factors.

Trials: If an associated trial takes place before the surgery, like for a spinal cord stimulator, the trial is assumed to be successful and included with the cost of surgery. This doesn't apply if there's evidence that the trial was unsuccessful.

If submitters give a detailed breakdown of their proposed surgery prices, the reviewer will consider the proposed amounts.

**Table 9-3: Spinal Cord Stimulator Surgery CPT Codes**

<b>CPT Code</b>	<b>Description</b>
-	<b>Post-placement System Testing:</b>
CPT 95971	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
CPT 95972	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, up to 1 hour
CPT 95973	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)
-	<b>Pre-Placement Psychological Testing:</b>
96101	Psychological testing done prior to the SCS trial (if not already done).
-	<b>Pre-Placement SCS Lead Trial:</b>
63650	Percutaneous implantation of neurostimulator electrode array, (APC 5462)
01936	Anesthesia
-	<b>SCS Permanent Implantation:</b>
63650	Percutaneous implantation of neurostimulator electrode array (one lead), (APC 5462)
63650 + 63650-59	Percutaneous implantation of dual lead system

<b>CPT Code</b>	<b>Description</b>
63655	Laminectomy for implantation of neurostimulator electrode array, (APC 5463)
63685-51	Insertion or replacement of neurostimulator generator (APC 5464)
01936	Anesthesia
-	<b>SCS Replacement:</b>
63663	Revision or replacement of percutaneous neurostimulator electrode array(s), (APC 5462) (When replacing leads only)
63664	Revision or replacement of neurostimulator electrode array, via laminectomy f (APC 5463) (When replacing leads only)
63685-51	Insertion or replacement of neurostimulator generator (APC 5464)(one or two arrays included)
01936	Anesthesia

### **Labs**

The WCRC uses a line item for each lab test included. This allows the submitter to see how they arrived at the lab pricing.

### **Transcutaneous Electrical Nerve Stimulation (TENS)**

CMS proposes coverage for TENS for chronic low back pain (CLBP) only when both of the following conditions are met. For the purposes of this decision, CLBP is defined as:

- a) An episode of low back pain that has persisted for three months or longer; and
- b) Is not the result of certain well-defined diseases that may contribute to low back pain but which are not primarily low-back syndromes.

For example, there are cancers that spread to the spine or pelvis and may elicit pain in the lower back as a symptom. It is important to recognize that this coverage applies only to use of TENS with CLBP and also excludes CLBP which is the result of a well-defined disease as outlined in bullet b.

### **State-Specific Statutes**

The CMS will recognize or honor any state-legislated, non-compensable medical services and will separately evaluate any special situations regarding WC cases. CMS will recognize WC state-specific statutes addressing the limits of future treatment regarding the length or nature of future treatment, provided that the submitter has demonstrated that Medicare's interests have been adequately protected. A submitter requesting that CMS review the applicability of a state WC statute must include a copy of the statute with the submission, and indicate to which section topic in the submission the statute applies.

Submitters requesting alteration to pricing based upon state-legislated time limits must be able to show by finding from a court of competent jurisdiction, or appropriate state entity as assigned by law, that the specific WCMSA proposal does not meet the state's list of exemptions to the legislative mandate. For those states where treatment is varied by some type of state-authorized utilization review board, the submitter shall include the alternative treatment plan showing what treatment has replaced the treatment in question from the beneficiary's treating physician for

those items deemed unnecessary by the utilization review board. Failure to include these items initially will result in pricing at the full life expectancy of the beneficiary or the original value of treatment without regard to the state utilization review board recommendation.

**Note:** Failure to include the required documentation at the time of original submission will not constitute a reason for the request of a re-review.

### **CMS Medical Record Guidelines**

CMS gives specific guidance regarding acceptable formats and requirements for medical record submissions in the CMS manual system; specifically, MLN Matters Article 6698:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>

See also Section [10.4](#) of this guide.

### **Treatment Recommended Outside a Provider's Area of Expertise**

If the provider is a treating provider and there is no recommendation to the contrary, the WCRC will consider the recommendation in assessing the WCMSA, in relation to other treatment and treatment recommendations. This is considered because a licensed physician is not limited to a given specialty within the scope of practice. In the case of chiropractors, the recommendations are considered if related to chiropractic care only and not related to general medical treatment.

## **9.4.6 Pharmacy**

### **9.4.6.1 Prescription Drug Review**

The WCRC reviewer verifies that the prescription drugs included are for the direct treatment of the work injury or injuries by reviewing the submitted clinical documentation.

- Validate that prescription drugs ordered and taken in the past two years were directly for treatment of the injuries.
- Determine if the drug products would be covered under the Part D benefit. This includes assessment of medically accepted indications (drug usage), drug dosage, and drug frequency.
- Determine if the claimant is taking brand or generic drug products.
- Price all drug products using AWP, with generic drugs being priced at the lowest non-repackaged generic AWP.

At any time during the process, if a reviewer is unsure of drug pricing, indication, or allocation amount, those questions are deferred to a pharmacist or pharmacist's designee before the case is finalized.

The WCRC allocates drugs into WCMSAs based on whether the drug is used for a condition related to the WC injury, is considered a Part D or Part B drug, and is used for a medically accepted indication. The WCRC compiles a drug list from medical records and pharmacy records. This list is then used to project future drug costs for the duration of a claimant's life expectancy. The reviewers must see prescription drug and medical treatment payment records/histories dated within 6 months of the date of submission or reopening. Specifically, for pharmacy records, the WCRC prefers the following:

- First, the prescription claim records directly from the WC insurer. This gives a record of exactly what drugs have been used for the work injury. This might come on such a form as the National Council for Prescription Drug Programs (NCPDP) Workers' Compensation/Property and Casualty Claims Form. Many state WC programs use these forms to document drug payments.
- Pharmacy Benefit Manager prescription claim records or third party administrator (TPA) pharmacy records provide a good sense of the totality of drug usage, especially if the claimant goes to multiple pharmacies.
- Individual pharmacy claim records are beneficial, but the WCRC is aware that claimants could go to multiple pharmacies. If at any time in the process the WCRC cannot compile an accurate picture of the claimant's drug needs, they will develop for further records.

When evaluating drug use, the WCRC reviewers assess the drug dosage, frequency, formulation, patents expiring, newer more expensive drugs, and use of brand-name versus generic drugs. Various drug formulations can vary significantly in cost. For example, there are large differences in cost of oxycodone immediate release versus OxyContin (an extended release formulation of oxycodone). It is very important to gain an accurate picture of the specific formulation for an accurate pharmacy allocation.

Both the medical and pharmacy records are used to compile a claimant's drug list. If the medical records are more recent than the prescription records, the WCRC will use the medical records to compile the drug list. However, if there are major discrepancies between the medical and pharmacy records, the WCRC will use the pharmacy records to compile the drug list, favoring actual use over possibly incomplete medical records.

The WCRC continues to price Part D drug products based on AWP and further based on brand or generic drug pricing. AWP pricing is pulled from a proprietary source, Truven Health Analytics' Red Book database. The WCRC uses a program for drug pricing that uses Red Book flat files that are updated monthly. For generic drugs, the WCRC uses the lowest non-repackaged generic drug AWP.

The WCRC prices for generic drugs unless one of the following applies, in which case the WCRC uses brand-name:

- A brand-name drug is in the proposal and there is an indication that the claimant is actually taking the brand-name drug.
- A generic is in the proposal, but no generic exists.
- A generic is in the proposal, but all the evidence indicates that the claimant is taking the brand-name drug.
- The claimant or claimant's attorney insists on a brand-name drug in writing.
- No drugs are indicated in the submitted proposal, but the condition requires certain drugs, or the medical records indicate certain drugs. In this case, the WCRC will default to pricing for brand-name medications.

Where multiple spellings and listings of a drug exist, the WCRC will price using the original manufacturer of the original brand-name drug for brand, and the lowest-price generic drug generic. The reviewer will price drugs based on the lowest price from the manufacturer, ignoring prices from any repackagers or distributors.

The WCRC uses a number of resources when determining drug coverage for WCMSAs. Reviewers consult Part D and Part B guidance documents, current WCRC operating rules, the Part D formulary reference file, and recognized drug compendia to assess drug coverage possibilities.

## **9.4.6.2 Pharmacy Guidelines and Conditions**

### **Recognized Compendia**

Currently, CMS requests that the WCRC use Micromedex's DrugDex database and the American Hospital Formulary Service Drug Information database to validate medically accepted indications. Indications could be in one or both of these databases.

### **Medically Accepted Indications and Off-Label Use**

For a drug to be covered under the Part D Benefit, and thus included in a WCMSA, it must be used for a medically accepted indication. A medically accepted indication is any use for a covered outpatient drug which is approved by the FDA, or a use which is supported by one or more citations included or approved for inclusion in the recognized compendia.

Off-label use is when a drug is prescribed in a manner that is different from the FDA-approved product labeling. According to Medicare IOM 100-02 Chapter 15 Section 50.4.2 - Unlabeled Use of Drug (Rev. 1, 10-01-03) B3-2049.3, "An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice. In the case of drugs used in an anti-cancer chemotherapeutic regimen, unlabeled uses are covered for a medically accepted indication as defined in §50.5." There are many off-label indications that are listed in recognized compendia and peer-reviewed sources; thus, they would be covered under the Part D Benefit, and should also be included in a WCMSA.

Example 1: Lyrica (Pregabalin) is cited in MicroMedEx for an off-label medication use related to neuropathic pain from spinal cord injury, and a number of scientific studies indicate that Pregabalin shows statistically significant positive results for the treatment of radicular pain (a type of neuropathic pain). Spinal cord neuropathy includes injuries directly to the spinal cord or its supporting structures causing nerve impingement that results in neuropathic pain. Lyrica is considered acceptable for pricing as a treatment for WCMSAs that include diagnoses related to radiculopathy because radiculopathy is a type of neuropathy related to peripheral nerve impingement caused by injury to the supporting structures of the spinal cord.

Example 2: Trazodone is approved by the FDA for the treatment of major depressive disorder, but is commonly given off-label to treat insomnia. So the WCRC would include trazodone in a WCMSA if used to treat insomnia, if it is related to the workers' compensation injury.

### **Compounded Drug Products**

Pharmacy compounding is a practice in which a licensed pharmacist combines, mixes, or alters ingredients in response to a prescription, to create a medication tailored to the medical needs of an individual patient. Compounding drugs outside of the FDA-approved labeling is a trend seen in WC cases, especially with pain medications compounded for topical administration. Under the Part D Benefit, compounded prescription drug products can contain all, some, or no Part D drug product components. Only costs associated with those components that satisfy the definition of a

Part D drug are allowable costs under Part D because the compounded products as a whole do not satisfy the definition of a Part D drug. Further, bulk products are not covered under Part D because they are not prescription drug products that are approved under sections 505, 505(j), or 507 of the Federal Food Drug and Cosmetic Act. Overall, many of the compounded drugs the WCRC sees in WCMSAs are formulated from bulk compounds; these are sometimes listed as powders, and would not be considered covered under the Part D benefit, and thus are excluded from WCMSAs. You can also find this guidance in Chapter 6 of the Medicare Prescription Drug Benefit Manual at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html> on the CMS website.

### **Hydrocodone Combination Products**

Hydrocodone combination products were reclassified effective October 2014 from C-III controlled substances to C-II controlled substances. Normally, C-IIIs require a new prescription after five refills or after six months, whichever occurs first. C-IIs require new prescriptions at intervals no greater than 30 days; however, a practitioner may issue up to three consecutive prescriptions in one visit authorizing the patient to receive a total of up to a 90-day supply of a C-II. WCMSA guidelines changed on January 1, 2015 for all new cases submitted after that date to allocate a minimum of 4 healthcare provider visits per year when schedule II controlled substances (including hydrocodone combination products) are used continuously, unless healthcare provider visits are more frequent per medical documentation.

### **Benzodiazepines and Barbiturates**

The WCRC will include benzodiazepines and barbiturates in WCMSAs effective June 1, 2013. Benzodiazepines and barbiturates are new to the Part D Benefit since January 1, 2013. For 2013 and future years, all medically accepted indications for benzodiazepines will be covered. For barbiturates, in 2013, only those used in the treatment of epilepsy, cancer, or a chronic mental health disorder will be covered, but in 2014 all medically accepted indications will be covered. Example: a case submitted on June 1, 2013 includes a barbiturate used for the treatment of headache. This will not be covered in 2013, as this is not being used for the treatment of epilepsy, cancer, or a chronic mental health disorder, but will be covered in 2014. Another example: temazepam for the treatment of insomnia would be covered and should be included in a WCMSA effective June 1, 2013. Cases submitted or reopened on or after June 1, 2013, will need to include benzodiazepines or barbiturates when prescribed. The October 2, 2012, CMS memorandum to Part D Sponsors concerning the transition to Part D coverage of benzodiazepines and barbiturates is available on the CMS website.

### **PRN or As-Needed Drugs**

Many drug products in workers' compensation are used on an as-needed basis. This is rightfully so, as many drug products are used to relieve pain on an as-needed basis. There are drug products that may be used as needed, but there are other drug products that should be used continuously. When allocating as-needed (PRN) drugs, the WCRC first assesses if the drug should or may be used under a PRN designation or if the claimant is just being non-compliant or non-adherent. Note: non-compliance or non-adherence is not a reason to reduce a WCMSA amount.

The WCRC defines PRN drugs as those with a variable usage in a two-month or greater period within the last year of pharmacy claims records, as long as the variability is not related to nonadherence. They also assess the medical records to determine how the PRN drugs are

documented. For example, is the prescription written using a PRN frequency? If so, this signals a possibility that as-needed use may occur in the future.

Reviewers at the WCRC assess the past pharmacy and medical history in these cases to determine a reasonably probable usage of these drugs in the future. For example, some things the WCRC considers are:

- Is the claimant's condition improving?
- Is the claimant's condition getting worse?
- Has the drug usage gone up or down in the past three to six months?
- Has the claimant started on any other medication that may reduce the as-needed drug usage?
- Has the claimant received a medical intervention that has changed their medical situation so as to reduce their drug usage, or has their condition declined that they may need more drug usage in the future?

The WCRC mainly bases as-needed drug usage on past drug history, and makes judgments on what may be reasonably probable in the future based on the claimant's current condition.

### **Physician-Dispensed Drugs**

The WCRC is aware that many physician-dispensed drugs (i.e., dispensed from a physician's office) will be classified as Part D drugs when a claimant uses their Part D Benefit. Physician-dispensed drugs are common in WC cases. For example, in 2010 and 2011, over half (53%) of all prescriptions in the California's Workers' Compensation System were physician dispensed. When this occurs, the WCRC understands that there will be little documentation in carrier records. The WCRC evaluates the medical records in this circumstance. It is very important for the WCRC to receive clear treating physician records. The WCRC may request further records if they are unable to interpret the complete drug regimens in these circumstances.

### **Part B Drugs and Drug Prices**

In general, there are five major categories of Medicare Part B drug spending. (This information can also be found in the introduction to Chapter 6 of the Medicare Prescription Drug Benefit Manual, at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter6.pdf>.)

1. Drugs billed by physicians and typically provided in physicians' offices (such as chemotherapy drugs, or local anesthetic or steroid injections). For example, epidural steroid injections are common in this area.
2. Drugs billed by pharmacy suppliers and administered through DME, such as respiratory drugs given through a nebulizer or IT pain pumps.
3. Drugs billed by pharmacy suppliers and self-administered by the patient (such as immunosuppressive drugs and some oral anti-cancer drugs).
4. Separately billable drugs provided in hospital outpatient departments.
5. Separately billable ESRD drugs such as erythropoietin.

CMS publishes pricing for Part B drugs every quarter in “Payment Allowance Limits for Medicare Part B Drugs.” This is available for download on CMS’ website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html> under “ASP Drug Pricing Files” for the relevant year. The WCRC uses this publication to price Part B Drugs for WCMSAs. Drugs corresponding to a J-code are priced based on Average Sales Price (ASP) plus 6%.

### **Intrathecal (IT) Pain Pump Pricing (Part B)**

Another component of Part B drugs is the IT pain pump. The file “Payment Allowance Limits for Medicare Part B Drugs” on the CMS website also depicts drug pricing for DME infusions, the drugs delivered using the IT pain pump.

When an IT pain pump is needed in a WCMSA case, the WCRC prices the IT pain pump replacement cost and reprogramming office visits per fee schedule. The WCRC assumes a 7-year lifetime per IT pain pump. This is based on historical pain pump failure rates from IT pain pump manufacturers. The Implantable Systems Performance Registry is a prospective, long-term, multi-center registry study that details this information. The WCRC puts separate line items in the approval letters with regard to the reprogramming costs, drug costs, and replacement costs. For drug costs, the WCRC takes into account the IT pain pump volume, concentration, refill frequency, and specific J-code when pricing.

### **Dual-Designation Drugs**

Dual-designation drugs are drugs that are scheduled or approved both over-the-counter (OTC) and in a prescription version. One drug in this category is omeprazole. Omeprazole 20 mg is approved both as an OTC drug and in the prescription format. The WCRC allocates omeprazole when it is used in its prescription format, as it would qualify under the Part D benefit. This could be based on evidence from the medical records, pharmacy records, or both. Some have argued that omeprazole is not a Part D drug, but when dispensed by prescription, it is.

### **Drug Weaning/Tapering**

Drug weaning commonly occurs with pain medications, such as opioids, especially when claimants’ work injuries improve. The WCRC takes all evidence of drug weaning into account, although in most circumstances the WCRC cannot assume that the weaning process will be successful. Usually, the latest weaned dosage is extrapolated for the life expectancy, but again, they assess all records when making these types of determinations. Where a treating physician believes tapering is possible and in the best interests of the claimant, CMS will consider all evidence in making a WCMSA determination, including medical evidence of current actual tapering.

### **Drug Contraindications, Drug Warnings and Precautions, and Drug Interactions**

A drug contraindication is when a drug should not be used at all. This is when the risk of a drug clearly outweighs the benefit. A warning and precaution is intended to identify and describe a discrete set of adverse reactions, or other potential safety hazards that are serious or are otherwise clinically significant, as they have implications for prescribing decisions. These are not contraindications, and in some circumstances the benefit of a drug outweighs its risk even when a warning and precaution is present. Drug interactions can fall into both categories, as a contraindication or as a warning and precaution. Here are some examples to clarify further, starting with a contraindication. For example, a claimant has a paralytic ileus and has been prescribed a fentanyl patch. This is contraindicated for paralytic ileus, so the drug should not be

used. The WCRC rarely sees drugs that are contraindicated within WCMSAs. However, the WCRC commonly sees drugs being used that come under the heading of warnings and precautions. For example, using fentanyl patches again: if a claimant is prescribed erythromycin (an antibiotic) and fentanyl patches at the same time, an interaction occurs increasing the concentration of fentanyl. This is not a contraindication, but is a warning and precaution. The WCRC would still set aside for erythromycin in this case as it is not contraindicated, and if the claimant may have or has tolerated this in the past. Overall, it is very rare that the WCRC would reduce a prescription set-aside allotment due to a drug warning and precaution as defined by the FDA.

If a claimant is tolerating a drug interaction that falls into a warning and precaution, it is important to set aside for these drugs in order to protect Medicare's interests.

## 9.5 Regional Office Receipt

When the WCRC completes its review and recommendation, the case is sent to the RO assigned to the case based on the claimant's state of residence and CMS' state and region logic. Although the RO assignment is based on the state of residence of the beneficiary, a case may be transferred from one RO to another based on the case's legal state of venue, or because the RO that the case was originally assigned to no longer processes WCMSA cases.

When the RO receives the case, they review the WCRC recommendation and make a final determination in the case. The case may not progress to approval for a number of reasons:

- If the RO determines that the case does not qualify as a WCMSA case because it does not meet CMS' workload review threshold for any reason, the RO notifies the submitter.
- If the claimant becomes deceased during the RO review of the WCMSA case submitted, and a date of death with supporting documentation, if requested, is provided, then a date of death is entered into the CMS WCMSA system and the case status is changed to "Deceased."
- If the RO needs additional information or documentation from the submitter in order to continue processing the WCMSA case, the submitter is notified with a development letter. When documentation is received and scanned at the BCRC, the status of the case changes to "Development Received," and the RO begins the review again. If a response is not received within the allotted time frame (i.e., 30 days for cases submitted to the BCRC, 20 business days for cases submitted on the WCMSAP), the case is closed for lack of response. If a response is received after the case is closed, CMS will reopen the case but treat it as a new submission.
- The RO may determine that the case should be closed. This can happen for a number of reasons, including: the parties are no longer settling, the case should be Black Lung instead of WC, the case is a Liability rather than WC case, or the submitter has failed to submit necessary information after repeated development requests. The submitter is notified of the case closure.

## 9.6 Final Determination

If the claimant is living, the case meets workload review thresholds, any needed development has been received, and the case is not closed for other reasons, the RO reviews the WCRC's recommendation and makes a determination as to the final CMS-approved WCMSA amount.

When the final WCMSA amount is determined by the RO, the RO approves the case and the submitter is notified.

After receiving the final settlement agreement, according to the applicable state law, the RO updates Medicare's records with the final settlement date.

**Note:** A case may be re-reviewed once an amount has been approved prior to settlement, but Medicare's records will not change until the new final determination is issued. Only then is the disposition recorded in Medicare's system.

## 10.0 Information Needed for WCMSA Submission

When a WCMSA is submitted for approval, CMS must have certain documentation available to complete a review of the proposal. [Table 10-1](#) lists the documents normally submitted with a WCMSA proposal. It includes the section number, the document name, and whether the document is required. CMS recommends that documents submitted be labeled according to the section number to which they belong. For example, when submitting an electronic Consent to Release note, the first two characters of the file name should correspond to the Consent to Release Section Number (10) e.g., 10AttorneyJonesConsent.PDF.

Cases using this or a similar format are generally processed more quickly with fewer errors and development requests, resulting in faster determinations at lower cost to submitters and the government.

**Table 10-1: WCMSA Document Requirements Checklist**

Section #	Document Name	For more Information Go To
05	Cover Letter	Reference Guide Part <a href="#">10.1</a>
10	Consent To Release Note	Reference Guide Part <a href="#">10.2</a>
15	Rated Age Information or Life Expectancy	Reference Guide Part <a href="#">10.3</a>
20	Life Care / Future Treatment Plan	Reference Guide Part <a href="#">10.4</a>
25	Settlement Agreement or Proposed or Court Order	Reference Guide Part <a href="#">10.5</a>
30	WCMSA Administration Agreement	Reference Guide Part <a href="#">10.6</a>
35	Medical Records	Reference Guide Part <a href="#">10.7</a>
40	Payment History	Reference Guide Part <a href="#">10.8</a>
50	Supplemental or Additional Information	Reference Guide Part <a href="#">10.9</a>

## 10.1 Section 05 – Cover Letter

The cover letter is **required** with your WCMSA submission. It is used to present CMS with a high-level overview of all of the information that is included in the WCMSA proposal. It is important to include as much information as possible in the cover letter rather than simply referring to the different sections that are included in your submission. Include all pertinent names, addresses, phone and fax numbers; all demographic information about the claimant; and all summary numbers and other data for the settlement and the WCMSA. This helps CMS review the proposal more quickly.

Please submit the following information in the format as noted:

### A. Claimant (Injured Party) Information:

1. Name – Claimant first, middle, and last name.
2. Address – Claimant mailing address (street, city, state, & ZIP code).  
**Note:** 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 WCMSA.
3. Phone & Fax Numbers – Telephone number where claimant can be reached (including area code) and fax number, if applicable.
4. Medicare ID (HICN or MBI) or SSN – Claimant’s Medicare ID (Health Insurance Claim Number or Medicare Beneficiary Identifier) as displayed on their Medicare card, or their Social Security Number if the claimant is not yet entitled to Medicare.
5. Gender – Claimant’s sex (male/female).
6. Date of Birth – Claimant’s date of birth (mm/dd/yyyy).
7. Median Rated Age – A rated age is the age of the claimant that has been adjusted to take into consideration the impact of pertinent medical conditions and impairments. 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., 67 is the median where the values are 62, 65, 67, 72, and 77.) If there is an even number of values, the median is the average of the two middle values, rounded down (e.g., 61 is the median for rated ages of 61 and 62 because the life expectancy will be computed using the table for someone who is 61 but not yet 62.)  
 If there are no rated ages, enter “None.” Please see [Section 15 – Rated Age Information or Life Expectancy](#) for additional information.
8. Life Expectancy Used in Proposal – The expected number of years of life remaining at the claimant’s given age. The CMS computes the claimant’s life expectancy as of the date WC carrier or plan responsibility is expected to end and claimant responsibility is expected to begin for medical expenses related to the work injury, using the Centers for Disease Control table (please see [Section 15 – Rated Age Information or Life Expectancy](#) for additional information).

9. Consent to Release note is included in submission – Yes/No.

**Note:** This note is **required** with your WCMSA proposal submission. Although there is no official Consent to Release note, an example of an acceptable note is shown in Figure 10-1.

## **B. Claimant Entitlement Information:**

1. Is the claimant entitled to Medicare? Yes/No.

If the answer to B.1 is *Yes*, do not submit the WCMSA proposal for review unless the total settlement amount exceeds \$25,000.

2. When the claimant is not currently enrolled in Medicare, 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)

If at least one of the answers to B.2 is *Yes*, do not submit the WCMSA proposal for review unless the total settlement amount exceeds \$250,000.

If you should not submit the WCMSA proposal based on the guidelines above, see the [Review Thresholds](#) section of this guide for information on what to do instead.

## **C. Injury Information**

1. Description of Injury – Submit a description of the work-related injuries sustained, which major body part(s) were affected (e.g., head, arm, leg, etc.) and the cause of illness/injury, with diagnosis codes.
2. Date of Injury/Illness (DOI) as defined by CMS – List all date(s) of injury/illness being settled (mm/dd/yyyy). List the oldest first. Show first and last dates of any cumulative traumas. For claims involving cumulative injury, CMS' definition of the DOI is the earlier of the date that treatment for any manifestation of the cumulative injury began, when such treatment preceded formal diagnosis; or the first date that formal diagnosis was made by any medical practitioner.
  - a) For an automobile collision or other type of accident, the date of incident is the date of the accident.
  - b) For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of first exposure.

- c) For claims involving ingestion (for example, a recalled drug), it is the date of first ingestion.
- d) For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).

**Notes:**

- CMS' definition of the DOI generally differs from the definition routinely used by the insurance/WC industry only for claims involving exposure, ingestion, or implants.
- If multiple WC settlements are included in one WCMSA submission, make sure the cover letter addresses how to handle the settlements (one WCMSA, or each settlement in a separate WCMSA).

**D. Contact Information:**

1. Submitter – Name, address, phone & fax of person/entity submitting the WCMSA.
2. MSA Administrator – Identify the person/entity responsible for control and documentation of proper expenditures from the WCMSA. Identify if the administrator is the claimant or a professional administrator.
  - a) If the administrator is the claimant, and they have an SSA Representative Payee (i.e., an individual or organization appointed by the SSA to receive Social Security and/or Supplemental Security Income (SSI) benefits for someone who cannot manage or direct someone else to manage his or her money), provide the name, address, phone, and fax for the SSA Representative Payee.
  - b) If the administrator is a professional administrator, provide their name, address, phone, and fax.
3. Claimant's Attorney – Provide the name address, telephone number, and fax number for the claimant's counsel.
4. Employer – Provide the name address, telephone number, and fax number for the claimant's employer.
5. Employer's Attorney – Provide the name, address, telephone number, and fax number for the employer's attorney if they have prepared documentation for the proposed WCMSA.
6. WC Carrier – Provide the name, address, telephone number, and fax number for the employer's insurance company.
7. WC Carrier's Attorney – Provide the name address, telephone number, and fax number of the carrier's attorney if they have prepared documentation for the proposed WCMSA.

**E. Settlement Details**

1. Total settlement amount – Submit the gross total settlement amount as a single lifetime number and NOT the settlement amount minus attorney fees, expenses, etc.
  - The computation of the total settlement amount includes, but is not limited to, an allocation for future prescription medications of the type normally covered by

Medicare, in addition to allocations for other Medicare covered and non-covered medical expenses, indemnity (lost wages), attorney fees, set-aside amount, non-Medicare medical costs, payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), amounts forgiven by the carrier, prior settlements of the same claim, and liability settlement amounts on the same WC injury (unless apportioned by a court on the merits).

- The total settlement amount excludes prior contested awards by a court on the merits, as well as past payments of indemnity or medical expenses that were not part of settlements, and liens and other amounts that the claimant will pay from the settlement funds. CMS does **not** consider medical malpractice settlements based on alleged mishandling of the WC injury to be part of the WC settlement.
- Use exact amounts, not “under” or “over” a given dollar amount.
- For any cases involving a second injury fund or a “reopener” (common in New Jersey and Oklahoma):
  - Include any prior settlement amounts in the total settlement amount, as well as any second injury fund settlement (in New Jersey) or “3e” settlement (in Oklahoma) being made at the same time the main injury is settling.
  - Do not include in the total settlement amount any estimated amounts for settlements contemplated for the future but not being made at the time of the main injury settlement.
- Where there are no drugs prescribed for the work-related injury or if prescription drugs are excludable under Medicare Part D, the cover letter should contain an explanation.
- If annuities are involved, use the lifetime payout amount in the total instead of annuity purchase price and include the annuity rate sheet to support your calculation. In order to determine the total settlement amount when using an annuity, please be advised that Medicare determines the value of the annuity based on how much the annuity is expected to pay over the life of the settlement, not on the present-day value (PDV) or cost of funding that annuity. The WCMSA does not need to be indexed for inflation.

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

2. Total proposed Medicare set-aside amount – Provide the amount of the medical benefits that you propose to be placed in the WCMSA for future items/services that would otherwise be covered by Medicare (this is 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. Outline future non-Medicare covered expenses not included in the WCMSA, e.g., outpatient prescription medications.

**Note:** Where the WCMSA is to be funded by a structured settlement, the cover letter must disclose whether any portion of the projected prescription drug expenses has been included in the lump sum required to cover the first surgery procedure and/or replacement and the first two years of annual payments.

- a) Provide the portion of set-aside for medical items and services.
- b) Identify the calculation method used to determine the amount for future medical treatment: WC State fee schedule, or full actual charges.

**Note:** Include the method by which prescription drug costs were calculated, in addition to disclosure of the method used to calculate other future medical costs.

- c) Provide the portion of set-aside for prescription drugs. If the WCMSA cover letter fails to include a separate projected amount for future prescription drug costs, one of two results will follow:
  - If the available medical records indicate medications have been or are expected to be prescribed for WC-related injuries, CMS will calculate and price these medications at AWP based on brand-name prices.
  - If the claimant's current treatment records contain no indication that prescription drugs will be needed in the future, CMS will accept that Medicare's interests have been adequately protected with a \$0 projection for future prescription drug expenses. This assumes that the WCMSA provisions regarding other future WC related medical expenses are reasonable.
- d) Identify if the set-aside is paid out as a lump sum or an annuity. If the set-aside is paid out as an annuity, identify the following:
  - Name of the carrier
  - Cost of the annuity
  - Proposed initial deposit (seed money)
  - Minimum annual deposit for the balance of the claimant's life
  - Annuity starting date
  - Length of annuity
  - Annual payout of annuity
  - Annual funding date

See Section 9.4.4, Step 6, for instructions on what amounts to include in the seed money. The following example illustrates how to calculate the seed money:

**Example:**

Total WCMSA = \$301,826.90

Cost of first surgery and the first procedure/replacement = \$10,191.40

Life expectancy of claimant = 28 years:

- Step 1. Identify the total estimated future medical services and prescription drugs covered by Medicare (\$301,826.90)
- Step 2. Identify the cost of the first surgery and the first procedure/replacement (\$10,191.40)
- Step 3. Subtract Step 2 from Step 1 (\$291,635.50)
- Step 4. Divide the result from Step 3 by the life expectancy (28) to get the annual medical costs ( $\$291,635.50 / 28 = \$10,415.55$ )
- Step 5. Multiply the result from Step 4 by 2 ( $\$10,415.55 \times 2 = \$20,831.10$ )
- Step 6. Calculate the seed money to be deposited upon settlement by adding the amount calculated in Step 2 to the amount calculated in Step 5 ( $\$10,191.40 + 20,831.10 = \$31,022.50$ )
- Step 7. Calculate the minimum annual deposit for the balance of the claimant's life by subtracting the seed money (Step 5) from the total WCMSA (Step 1) ( $\$301,826.90 - \$31,022.50 = \$270,804.40$ ) and dividing this by the life expectancy minus one ( $28 - 1 = 27$ ):  $\$270,804.40 / 27 = \$10,029.79$ .

The minimum annual deposit for the balance of this claimant's life is \$10,029.79.

This deposit must be made no later than one year from the date of settlement.

- e) Identify the state of jurisdiction/venue. Identify the state (including Washington, DC, American Samoa, Guam, Puerto Rico, and the US Virgin Islands) where the WC hearing will be held. Show state, District of Columbia, or U.S. protectorate.

**Tips for submission**

- Ensure that the proposed set-aside is a proposed lifetime (not annual) set-aside amount.
- Ensure that it clearly shows how much of the proposed set-aside is for medical services and how much is for prescription drugs.
- Ensure the medical services proposed amount plus the prescription drug proposed amount adds up to the total proposed amount.
- Verify that any pricing charts are consistent with the amounts listed in your cover letter.
- Ensure that the proposed amount is consistent with the court documents, or that any differences are explained.
- If annuities are involved, use lifetime payout amounts instead of annuity purchase prices, and include amount of proposed seed money/initial deposit and annual deposit.

## 10.2 Section 10 – Consent to Release Note

The Consent to Release note is the claimant's signed authorization for CMS, its agents and/or contractors to discuss his or her case/medical condition with the parties identified on the authorization in regard to the WC settlement that includes a WCMSA. When you submit your WCMSA, you are **required** to include the signed consent, plus any applicable court papers if the consent is signed by someone other than the claimant (for example, a guardian, power of attorney, etc.). Do not include unsigned consents or consents to obtain medical records from a provider.

As of April 1, 2020, all consent-to-release notes must include language indicating that the beneficiary reviewed the submission package and understands the WCMSA intent, submission process, and associated administration. This section of the consent form must include at least the beneficiary's initials to indicate their validation.

If there is a change in submitter, please see [Section 19.4](#) for more information.

Please see [Figure 10-1](#), which is a template that can be used to assist you in completing a valid Consent to Release note. Please see [Figure 10-2](#), which is an example of a Consent to Release note with instructions for completing it.

**Figure 10-1: Blank Consent to Release Note**

**CONSENT TO RELEASE**

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 its contractors to disclose, discuss, and release, orally or in writing, information related to my workers' compensation injury and settlement to the individual(s) and firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release will not be necessary unless and until I revoke this consent (which must be in writing). Further, I have had the Workers' Compensation Medicare Set-Aside Arrangement need and process explained to me, and I approve of the contents of the submission.

Beneficiary Initials \_\_\_\_\_

**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 Medicare Number (Health Insurance Claim Number/HICN or Medicare ID)

### Figure 10-2: Example Consent to Release with Instructions

**CONSENT TO RELEASE**

\_\_\_\_\_ 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 its contractors to disclose orally or in writing, information related to my workers' compensation claim to the individual(s) and firm(s) listed below. This consent is on an ongoing basis. An address change and until I revoke this consent (which may be done by a Workers' Compensation Medicare Set-Aside Arrangement need not be made to me, and I approve of the contents of the submission.

Beneficiary Initials \_\_\_\_\_

**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 of Injury

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Social Security Number or Medicare Number (Health Insurance Claim Number/HICN or Medicare ID)

**Claimant name:** Ensure the name matches that used in WCMSA proposal documents.

**Claimant initials:** Ensure the claimant has been informed and agrees to the contents of the submission by initialing.

**Authorized entities:** Check a box for each person or entity who is authorized to receive information on your WC injury and settlement.

**Authorized entities:** For each box checked, enter the name of the person or entity authorized to receive this information.

**Claimant signature:** Ensure the claimant signs and dates the authorization. The CTR is not valid otherwise.

**Claimant information:** Ensure this information matches that used in WCMSA proposal documents

### 10.3 Section 15 – Rated Age Information or Life Expectancy

This section is where you have the option to provide all rated ages obtained on the claimant, even those that appear to have expired or appear not to be independent. If the rated age is not provided, CMS will estimate the claimant's remaining life expectancy using the actual age. If the actual age is being used, do not include any statements or documents in this section.

When submitting one or more rated ages with a request for CMS approval of a WCMSA, the following criteria must be met in order for the rated age to be considered in reviewing the case:

1. Rated age confirmation with original proposal documents. CMS will not accept any variation or substitute wording. As of June 30, 2010, the statement is as follows: “Our organization certifies that all rated ages we have obtained/and or have knowledge of regarding this claimant, and generated at any time on or after the Date of Incident for the alleged accident/illness/injury/incident at issue, have been included as part of this submission of a proposed amount for a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) to the Centers for Medicare & Medicaid Services.” If this specific language is not included as part of the WCMSA proposal, CMS **will not accept** the RA provided. Instead, CMS will estimate the claimant’s remaining life expectancy using Actual Age.
2. A stand-alone statement indicating that all rated ages obtained on the claimant are included.
3. Each rated age is presented on company letterhead for each insurance company (or companies) that made the rating and for each settlement broker that obtained them from the insurance company. **Note:** Letterhead includes the name and address of the insurance company or settlement broker.
4. All rated age sources shall be independent, in fact and appearance, of the submitter, carrier, and claimant.
5. If more than one rated age is submitted, CMS will use the median of all rated ages submitted.
6. When multiple rated ages are provided, the submitter becomes subject to enforcement of the requirement to use the median rated age and must provide all rated ages to CMS.
7. All rated ages shall be accompanied by a written justification on how such age was determined. For example, 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 (CDC) Tables ([https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68\\_04-508.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_04-508.pdf)).

Please see the WCMSA site (<http://go.cms.gov/wcmsa>) for additional information.

**Do not include the following:**

- Actuarial charts or life expectancy charts from the CDC or elsewhere, or statements that there are no rated ages.
- Do not include any documents on rated ages that contain redacted data. They will not be considered.

## **10.4 Section 20 – Life Care / Future Treatment Plan**

For the purpose of evaluating plan proposals, either a Life Care Plan or Future Treatment is **required** for submission.

A Life Care Plan is a dynamic document based on published standards of practice, comprehensive assessment, data analysis, and research that provides an organized concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic health needs. A life care plan is appropriate when the

claimant's injury or disease is extensive and serious, e.g., paraplegia, quadriplegia, brain damage.

Although submission of a life care plan is optional, you are **required** to include drug and dosage lists. Include all pricing charts, cost projections, pricing information, and explanatory narratives and analyses.

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

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

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

A Future Treatment Summary lists all expected care by type, level, frequency, cost per event, and total for all expected future medical and pharmacy care. A Future Treatment Plan is required in the absence of a Life-Care Plan. Future Treatment Summaries do not require the same stringent evaluation as a Life Care Plan; however, they delineate the treatment care pricing expectations by the submitter for the purpose of WCMSA calculation. The Future Treatment Summary gives the WCRC some insight into the pricing methods used by the submitter, and should not be construed to carry the same weight as treatment records or Life Care Plans.

### 10.4.1 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 (or at least is not getting worse). 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). See Section [10.7](#) for details on medical records submission. If the work-related injury occurred less than two years from the date of the WCMSA submission, 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.

### 10.4.2 Future Treatment

Determine the cost of future medical expenses and prescription drugs that are directly related to the injury or illness suffered by the worker. This amount can be determined by reviewing medical records and past medical and prescription expenditures. The WCMSA must show the amount of money that should be invested to provide for the yearly expenses for the worker's life expectancy.

**Note:** In order to protect Medicare's interests, a WCMSA should be funded based on the life expectancy of the claimant unless state law specifically limits the length of time that WC covers work-related conditions. The key is that both the principal amount that is to be set aside and the anticipated interest that it will earn must be sufficient to provide for the worker's future medical treatment and administration fees for the worker's lifetime.

Identify specific types of medical services or items, the frequency and duration of the medical services or items, and the projected costs of the medical services or items related to the work injury or disease that are expected in the future in light of the claimant's condition.

- Include ICD-9 or ICD-10 diagnosis codes if available. Do not use ICD-9 codes for submissions with a DOI on or after 10/1/2015; do not mix ICD-9 and ICD-10 codes in one submission. (ICD-9 codes will continue to be allowed on submissions with a DOI of 9/30/2015 or earlier.)
- 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 affect the medical benefits of the settlement should be noted, such as nursing homes or assisted living facilities.
- Prescription drugs must be included even if the claimant is not yet a Medicare Part D beneficiary, if the current treatment records or future care plan support the use of drugs in treating the claimant's WC injury.

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

1. A physician visit every 6 months with an estimated cost of \$75 per visit.
2. Physical therapy (PT) - 12 sessions per year for only the next 3 years with estimated cost of \$50 per session
3. An x-ray every 3 years with an estimated cost of \$100 per x-ray (including interpretation)
4. An MRI every 5 years with an estimated cost of \$1,500 per MRI (including interpretation)
5. Maintenance dose of prescription pain medication at \$8 per month for 12 months per year
6. Inpatient hospitalization every 10 years with an estimated cost \$10,000 per hospitalization
7. The projected total costs in this case are \$49,180 as listed below.
  - Physician visits @ \$4,500 (\$75 x 2 x 30)
  - PT @ \$1,800 (\$50 x 12 x 3)

- X-rays @ \$1,000 (\$100 x 10)
- MRIs @ \$9,000 (\$1,500 x 6)
- Medication @ \$2,880 (\$8 x 12 x 30)
- Hospitalizations @ \$30,000 (\$10,000 x 3)

## **10.5 Section 25 – Settlement Agreement or Proposed or Court Order**

The parties can 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. However, approval of the WCMSA is not effective until a copy of the final executed WC settlement agreement, which must include the approved WCMSA amount, is received by CMS.

No statement in the settlement of the amount needed to fund the WCMSA is binding on CMS unless and until the parties provide CMS with documentation that the WCMSA has actually been funded for the full amount that adequately protects Medicare's interests as specified by CMS as a result of its review. Include only official documents, such as WC petitions, mediation documents, prior awards and settlements, court orders, draft and final settlement agreements, and annuity rate sheets.

If CMS does not subsequently provide approval of the funded WCMSA amount as specified in the settlement or 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.

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.

### **Reminder:**

- If the case has already settled, please provide the settlement date.
- If there is a proposed settlement date in the future, please provide that date.
- If the settlement date is unknown, CMS will default to using four months from the date of submission as the proposed settlement date.

### **10.5.1 Indicate How Much of the Settlement is for Past v. Future Medical Expenses**

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

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

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

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

### 10.5.2 Use of WC Fee Schedule vs. Actual Charges for WCMSA

CMS uses either the WC fee schedule (for states that have such schedules) or the full actual charges for its review of a proposed WCMSA based on whichever methodology is used by the individual or entity submitting the proposal.

**Note:** The following states do not have a fee schedule: Indiana, Iowa, Missouri, New Hampshire, New Jersey, and Wisconsin. Do not use a fee schedule in a state that does not have a fee schedule.

The CMS reviews WCMSAs on a **case-by-case basis** in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of the WC plan or insurer. Accordingly, in reviewing a WCMSA, CMS must know whether the arrangement is based on WC fee schedule amounts or full actual charge amounts.

### 10.5.3 Total Settlement Amount

The computation of the total settlement amount includes, but is not limited to, an allocation for future prescription medications of the type normally covered by Medicare, in addition to allocations for other Medicare covered and non-covered medical expenses, indemnity (lost wages), attorney fees, set-aside amount, non-Medicare medical costs, payout totals for all annuities rather than cost or present values, settlement advances, lien payments (including repayment of Medicare conditional payments), amounts forgiven by the carrier, prior settlements of the same claim, and liability settlement amounts on the same WC claim (unless apportioned by a court on the merits).

## 10.6 Section 30 – WCMSA Administration Agreement

The WCMSA can be administered either by the claimant (i.e., self-administered, if permitted under state law) or by a third-party trustee, such as a guardian or trust company. (See the [Administrators](#) section of this guide for more information.) When a claimant designates a representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court; the settling parties should include that information in this section. Include any official stand-alone agreement that provides the name and address of the administrator of the WCMSA.

## 10.7 Section 35 – Medical Records

Include the first report of injury, medical records of major surgeries, and medical records for the last two years of treatment, no matter how long ago those last two years were or who paid for the services. Also include depositions from medical providers. Ensure that any “last treatment date” mentioned in the life care plan, carrier letter, or payment history is accompanied by a medical record that matches that date, as well as all medical records for the last two years prior thereto.

Submitters will find guidance on signature requirements for medical records in the following document:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R327PI.pdf>

### Submit the following:

- All medical records from all treating physicians for the last two years of treatment for the work-related injury, even if the WC carrier has not paid for the treatment and even if the treatment was long ago. Remember, CMS needs medical records for the last two years of treatment, which may not be within the last two calendar years.

For example, if the carrier’s records indicate that the last treatment was in February 2006, then treatment records for February 2004–February 2006 should be supplied. A statement indicating that “the claimant has not been treated in the last two years” is not a substitute for medical records for the last two years of treatment. Remember, the information is not for the last two calendar years, but the last two years **of treatment**.

- If the claimant has not been treated by any doctor for any reason within the last two calendar years, CMS generally needs all treating physicians to state when the last two years of treatment for any reason occurred. The treating physicians must also state, in writing, the specific condition/injury the claimant was last treated for, and any related therapy.
- Provide medical documentation (legible recently-dated pharmacy printouts or statements from **all** treating physicians) that specify medication, strength/dosage, **and** frequency.
- Submit medication information, along with any explanations, for those medications that the claimant is taking that are not related to the injury.
- Submit drug, dosage, and frequency information from all pharmacies and treating/prescribing physicians.

### Do not submit:

- Independent medical evaluations. These are not treatment records, nor are invoices or insurance forms. (They may be appropriate to determine future treatment requirements under certain circumstances; they are not appropriate as medical records.)
- Incomplete or insufficient **medical treatment records** for the last two years of treatment or incomplete/insufficient medical records for that period. Some examples of this include:
  - a) A letter from the claimant or his attorney indicating that the claimant has not received treatment for the work-related injury in the last x years
  - b) A letter from the carrier or its attorney indicating that it has not paid for treatment for the last x years

- c) A statement from the carrier or attorney that no treatment is being provided; the claimant is only receiving medications
- d) A letter enclosing recent independent medical evaluations, which indicate that the claimant has not been treated for the work injury in x years
- e) A statement from the carrier or its attorney that the claimant's last treatment date was xx/xx/xx, but the file shows:
  - 1) the claimant is moving and will receive further treatment in the new location,
  - 2) the claimant is currently in severe pain or is scheduled for surgery,
  - 3) the claimant now treats with the Veterans' Administration, or
  - 4) the last medical record received is dated before the last treatment date.
- Incomplete or insufficient **proof of drugs, dosages, and frequencies** for the last two years of treatment. Some examples of this include:
  - a) A letter from the claimant or his attorney indicating that no medications are currently being taken or that no medications have been taken in the last x years
  - b) A letter from the claimant or his attorney indicating no medications for the work injury are currently being taken or that no medications related to the work injury have been taken in the last x years
  - c) A letter from the carrier or its attorney indicating that no payments were made for medications
  - d) Information regarding the names of medications and strength/dosages, but without frequency information

## 10.8 Section 40 – Payment History

Send an all-inclusive payment history (that is, medical, indemnity, and expenses) from all carriers, third-party administrators (TPAs), employers, pharmacies, and prescription drug suppliers dated within the last six months of submission or reopening of the proposal, showing all payments made (including payment date, payee, date of service, and amount).

### Submit the following:

- Any signed statements from carriers or their attorneys with payment information or the last date of treatment. Include billing information where paid claims information is not available, such as for physician-dispensed medications.
- A letter from the carrier or its attorney stating the date the carrier's payment history was generated, if not shown on the history itself.
- A letter from the carrier or its attorney explaining why there is no printable history if the carrier made no payments of medical, indemnity, or expenses, and did not even set up settlement reserves for the claim.
- The entire pay history for all proposals asserting a denial of any condition.

**Do not submit:**

- A payment history with medical payments only, indemnity payments only, or expense payments only, with no explanation.
- A payment history dated more than six months before the case is submitted. Submit as up-to-date a history as possible.
- A statement that there is no payment history attached since the claimant has not been treated in the last two years. Submit a clear explanation if there is no history.

## **10.9 Section 50 – Supplemental or Additional Information**

Use this section to provide miscellaneous documentation that did not fit in one of the other sections, but that has direct bearing on the proposal's requirements. For example, this is where you would include a copy of the claimant's official birth certificate and driver's license where the date of birth is unclear in other documentation; a copy of a state law that the submitter discusses elsewhere, and a photocopy of Social Security or Medicare card or correspondence if needed to verify Social Security or Medicare number or entitlement.

Do not include copies of documents sent by CMS to the WCMSA submitter.

## **11.0 How do I submit a WCMSA?**

A WCMSA can be submitted in one of two ways: electronically through the WCMSA Portal (WCMSAP) on the internet, or by paper submission through the mail. The portal method is preferred. **Note:** WCMSAs are handled in the order they are received regardless of the submission method.

### **11.1 Electronic Submission via the WCMSAP**

A WCMSA can be submitted to CMS electronically through the WCMSAP. This is the preferred method for submission. Each individual or entity that wishes to use or access the portal must complete the WCMSAP registration process.

To get started, go to: <https://www.cob.cms.hhs.gov/WCMSA/> and click [**I Accept**] to agree to the terms for using the site. The *Welcome to the WCMSAP* page displays. Click [**New Registration**] and follow the instructions on the screen. All contact information will be submitted in the New Registration step. Once this step is completed, you will be assigned an Account ID and Personal Identification Number (PIN). You will use this information to complete Step 2 of the process, Account Setup. For more information, refer to the *How to Get Started* help page which is located under the How To menu option on the *Welcome to the WCMSAP* page and the *WCMSAP User Manual* which is located under the Reference Materials option on the *Welcome to the WCMSAP* page, or directly at

<https://www.cob.cms.hhs.gov/WCMSA/assets/wcmsa/userManual/WCMSAUserManual.pdf>.

**Note:** CMS recommends that you read the entire manual before attempting to make a submission via the portal.

### 11.1.1 Benefits of Using the WCMSAP

The WCMSAP was designed to improve the efficiency of the submission process for WCMSAs, including speeding receipt of the proposal by the WCRC, quicker turnaround times for submissions, and case access for the submitter. The WCMSAP allows attorneys, beneficiaries, claimants, insurance carriers, representative payees, and WCMSA vendors to create a work-in-progress case, submit WCMSA cases, perform case lookups, and append documentation to a case. Using the portal to submit a case means the submitter no longer has to burn PDF files to a CD for mailing. Instead, the submitter can gather the WCMSA proposal and its supporting documentation for direct upload to the system. This is easier for the submitter, potentially avoids processing complications, and streamlines the process.

With the WCMSAP, registered participants may upload an unlimited number of cases for review. With instant access, submitters can confirm the status of a case at any point. Submitters may also append additional documentation in response to development requests and submit final, approved settlement documents as a final step to the process.

WCMSA administrators may submit annual attestations on the WCMSAP. Users with a Professional Administrator account may submit detailed transaction records and view summary account information and statuses online. Those who do this may forego submitting the attestation itself.

## 11.2 Paper Copy/CD Submission via the Mail

All WCMSA proposals that are mailed to CMS for review must be sent to the following address:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

### 11.2.1 Paper Copy

When a WCMSA proposal is submitted via hard copy, the submitter must comply with the requirements outlined in the [Information Needed for WCMSA Submission](#) section of this Reference Guide. **Note:** Hard copy submission is not recommended as it is very time consuming to complete the review request. If submission is not possible using the online portal, CD submission is the next best method.

### 11.2.2 CD

When a WCMSA is submitted on a CD, the submitter must comply with the requirements outlined in the [Information Needed for WCMSA Submission](#) section of this Reference Guide, and the additional requirements outlined below.

Additional requirements for CD submissions:

1. Information provided on a CD must be in PDF format. The file extension must be .pdf.
2. All documents submitted on the CD must be listed in the same order as specified in [Table 10-1: WCMSA Document Requirements Checklist](#).
3. Categorize the files based on the following codes and use the associated code as the prefix in the file-naming convention:

- 05 - Submitter Cover Letter
- 10 - Consent to Release Note
- 15 - Rated Age Information or Life Expectancy
- 20 - Life Care / Future Treatment Plan
- 25 - Settlement Agreement or Proposed or Court Order
- 30 - WCMSA Administration Agreement
- 35 - Medical Records
- 40 - Payment History
- 50 - Supplemental or Additional Information

For example, a CD might contain the following files:

10ConsentForm1.pdf  
10ConsentForm2.pdf  
20LifeCarePlan.pdf  
35MedicareRecordsDoc.pdf

4. Medical records must be submitted in chronological order.
5. All documents on the CD must be identified on an index by page number.
6. Place files directly on the CD so that they can be viewed immediately once the CD is opened. Do not save the file in a folder.

## 12.0 What Happens after a WCMSA Has Been Submitted?

Once you have submitted a WCMSA proposal, you will receive an acknowledgement letter. If you do not receive an acknowledgement letter, please contact the BCRC at 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired. Customer Service Representatives are available Monday through Friday, from 8:00 a.m. to 8:00 p.m. Eastern Time, except holidays.

When CMS has reviewed the WCMSA, it will respond in one of several ways. CMS may:

- Ask for additional information (this is called Development);
- Send a written determination approving the WCMSA at the proposed amount or at an amount CMS devises;
- Send notice that your submission was below the threshold necessary for Medicare review; or
- Send a rejection letter.

## 13.0 Sample Submission

A sample submission is included in [Appendix 6](#). This sample is not a required form or format. Each state has unique forms. The intent of the sample document is to aid submitters in organizing the information that is typically sent to CMS with their WCMSA proposals.

Procedures relating to WCMSAs are published on the CMS web site. (Please see the following link: <https://go.cms.gov/wcmsa> on the CMS website.). Where any conflict is perceived between statements or information in this sample and official CMS published procedures, the latter controls.

## 14.0 Tips for Improving Your WCMSA Review Process

1. Do not submit any WCMSA proposal to CMS unless it meets the following workload thresholds for review:
  - The claimant has a “reasonable expectation” of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000, OR
  - The claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000. Please note: **Regardless of the low dollar threshold, Medicare beneficiaries should always consider Medicare’s interest in all WC cases and ensure that Medicare is secondary to WC.**
2. Submit complete case files with your set-aside proposals on the WCMSAP using [Table 10-1: WCMSA Document Requirements Checklist](#) and the [Sample Submission](#) provided in this Reference Guide.
3. If you are planning to submit more than 200 pages of information or more than two years of medical records, it is helpful to contact the WCRC first to discuss if it is all needed.
4. Do not resubmit previously submitted documents unless you have confirmed that they were not received. If you are unsure what is needed, call the WCRC (toll-free at 1-833-295-3773 between 9am-5pm EST, Monday thru Friday) to see if what you are sending will be sufficient.
5. Respond to letters and telephone requests for information in a timely manner and completely, with special attention to request letters printed in ALL CAPS.
6. Check the status of your case via the portal if you submitted on the WCMSAP.  
**Note:** For cases submitted via the WCMSAP, you can review case information any time.
7. Contact the WCRC in regard to the status of a case that was submitted via mail. Please allow 45 business days after the submission of a complete file before contacting the WCRC for a status update.

## 15.0 Review Process and Policies

Please see the [WCMSA Submission Process Overview](#) for more information on the submission and review process.

## 15.1 Time Frame

When you submit a WCMSA for review, CMS tries to review and decide on proposed settlements within 45 to 60 days from the time that all relevant documents are submitted.

Parties to the settlement may settle the indemnity (non-medical-expenses) portion of the claim separately from the WCMSA portion, in order to avoid having indemnity payments continue while CMS is still reviewing the proposal. CMS will still consider the whole claim, including indemnity, in its threshold calculations.

## 15.2 Criteria

The WCRC will consider the following factors in making a decision about your case:

- What is the past medical payment history for this case? Has Medicare or WC paid bills related to the case already? If so, what are they? In particular, bills paid by WC in the first one to two years after the condition is stabilized may indicate likelihood of particular medical expenses; any bills paid by Medicare will be recovered, and may indicate the case has compromise aspects.
- What is the claimant's date of Medicare entitlement?
- What is the basis of Medicare entitlement: disability, ESRD, or age?
- What is the type and severity of the claimant's injury or illness?
  - a) Is full or partial recovery expected?
  - b) If so, in what time frame?
  - c) Is the individual an amputee, paraplegic or quadriplegic as a result of the work injury?
  - d) Is the claimant's condition stable, or might it improve or get worse?
- How old is the claimant? Is the WC injury likely to shorten the claimant's lifespan?
- What is the claimant's WC classification (e.g., permanent partial, permanent total disability, or a combination of both)?
- How much is the settlement, and how is it allocated? Is it based on fee schedules or full actual charges?
- How long is the settlement intended to last: for the claimant's lifetime, or for a specific period?
  - a) If not for a lifetime, how long, and are allocations consistent across the proposed settlement? For example, if the funds for pain and suffering are based on the claimant's lifetime, and the funds for future medical expenses are based on a shorter time period, Medicare will not accept the WCMSA as it stands.
  - b) What is the State law regarding how long WC is obligated to cover the items or services related to the accident or illness?
- If the claimant is living in a nursing home, assisted living facility, or the like, does the settlement consider who should pay for such care? How long will the claimant be living in which situations?
- Does the WCMSA cover appropriate medical items and services for the claimant's condition? Are likely complications included?

All criteria are applied to any WCMSA proposal on a case-by-case basis.

CMS will review your WCMSA using either WC fee schedule charges or full actual charges for medical items and services, whichever one you used in submitting the proposal.

If there are prescription drugs in the future medical expenses in your WCMSA proposal, CMS will price them using the AWP as part of their review. If the future medical care expenses you submitted did not include prescription drugs, but CMS finds that prescription drugs will be necessary, CMS will add them in to their review calculations. If you submit generic drug costs but there are no generics available, CMS will add in brand-name drug costs priced with AWP.

See [WCRC Review](#) in this Guide for further information on this process and considerations.

CMS will **not** evaluate administrative fees or expenses for the set-up and administration of the WCMSA because CMS considers those a separate issue for the settling parties to negotiate. If such fees are included in the proposal, CMS will not allow the fees to be included in the WCMSA amount.

If you do not give CMS all the documents they need to review your case within the requested timeframe (10 days for portal submissions), CMS will close the case and notify you of its status. If you later submit the requested documents, CMS will reopen the case, but consider it a new submission. The review process begins again, and your response should be sent between 45 and 60 days from CMS' receipt of the requested information.

### **15.2.1 Compromise of Future Medical Expenses**

CMS does not compromise or reduce future medical expenses related to a WC injury. 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. In addition, CMS has no process to accept up-front cash payments in lieu of a CMS reviewed WCMSA.

### **15.2.2 No Waivers of Specific Services Related to Future Medicals**

There are no means by which a claimant can permanently waive his or her right to certain specific services related to a WC case and, thereby, reduce the amount of a WCMSA. CMS cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a WCMSA. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the WCMSA.

## **15.3 Case Status and Communications**

You can see your case's status on the WCMSAP, if the case was submitted on the Portal. For cases that were submitted via mail, case status can be obtained by contacting the WCRC.

Any alerts and notifications from CMS will arrive via the same medium in which you submitted your case, either through the Portal or physical mail.

The letters that are currently generated in the WCMSA process and the parties (excluding the submitter) that receive the letters are listed below:

- Acknowledgement (cc to beneficiary/claimant): indicates that the WCMSA has been received and notifies the submitter that it will be prioritized for review in the order in which it was received.
- Below Threshold (cc to beneficiary/claimant, beneficiary's attorney, and BCRC): case did not meet the threshold for review (i.e., the case has a total settlement amount of \$250,000 or less for a non-Medicare-eligible individual with a reasonable expectation of becoming a Medicare beneficiary within 30 months of the settlement date, or is less than \$25,000 for a Medicare beneficiary).
- Development (cc to beneficiary/claimant): case requires additional information in order to be processed.
- Zero Set-Aside (cc to beneficiary/claimant, beneficiary's attorney, and BCRC): indicates that the settlement has been approved with a Medicare Set-Aside Amount of zero dollars.
- Approval including recommendation attachments (cc to beneficiary/claimant, beneficiary's attorney, and BCRC): indicates that CMS has reviewed the WCRC's recommendation for the WCMSA and has made a determination as to the final WCMSA amount. **Note:** The case will not be considered final until CMS receives the final settlement with the appropriate WCMSA amount. CMS may approve a WCMSA for a different amount than originally proposed. See Section [16.0](#) for more information on recourse if you disagree with CMS' assessment.
- Closeout (cc to beneficiary/claimant): supplemental information requested in the development letter was not provided in a timely manner. The case is now closed.

## 16.0 Review Following Conditional Approval

### 16.1 Re-Review

When CMS does not believe that a proposed set-aside adequately protects Medicare's interests, and thus makes a determination of a different amount than originally proposed, there is no formal appeals process. However, there are several other options available. First, the claimant may provide the WCRC with additional documentation in order to justify the original proposal amount. If the additional information does not convince the WCRC to change the originally submitted WCMSA amount and the parties proceed to settle the case despite the lack of change, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until WC settlement funds expended for services otherwise reimbursable by Medicare use up the entire settlement. Thereafter, when Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. Information on applicable appeal rights is provided at the time of each claim denial as part of the explanation of benefits.

A request for re-review may be submitted based one of the following:

1. **Mathematical Error:** Where the appropriately authorized submitter or claimant disagrees with CMS' decision because CMS' determination contains obvious mistakes (e.g., a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, that has already occurred), or
2. **Missing Documentation:** Where the submitter or claimant disagrees with CMS' decision because the submitter has additional evidence, not previously considered by CMS, which was dated prior to the submission date of the original proposal and which warrants a change in CMS' determination.
  - Disagreement surrounding the inclusion or exclusion of specific treatments or medications does not meet the definition of a mathematical error.
  - Re-Review requests based upon failure to properly review already submitted records must include only the specific documentation referenced as a basis for the request.

## 16.2 Amended Review

Where the following criteria are met, CMS will permit a one-time request for re-review in the form of a submission of a new cover letter, all medical documentation related to the settling injury(s)/body part(s) since the previous submission date, the most recent six months of pharmacy records, a consent to release information, and a summary of expected future care.

- CMS has issued a conditional approval/approved amount at least 12 but no more than 72 months prior,
- The case has not yet settled as of the date of the request for re-review.
- Projected care has changed so much that the submitter's new proposed amount would result in a 10% or \$10,000 change (whichever is greater) in CMS' previously approved amount.
- Where a re-review request is reviewed and approved by CMS, the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased.
- This new submission may be delivered in either paper or portal formats. Please see the WCMSAP User Guide for more information on electronic submission.

In order to justify that the projected care would result in a 10% or \$10,000 change (whichever is greater), the submitter must return CMS' Recommendation Sheet that was included in CMS' conditional approval letter and identify the following:

- Line items that were included in the approved amount, but are for care that has already been provided to the beneficiary. Please identify where references to records indicating that the care has already been provided can be found in the updated proposal.
- Line items for care that is no longer required. Please identify where references to replacement treatment can be found in the updated proposal.
- If additional care is required that was not otherwise included in CMS' conditional approved amount, please add line items.

**Notes:**

- In the event that treatment has changed due to a state-specific requirement, a life-care plan showing replacement treatment for denied treatments will be required if medical records do not indicate a change. Requests for changes to treatment plans will not be accepted without supporting medical documentation.
- The approval of a new generic version of a medication by the Food and Drug Administration does not constitute a reason to request an amended review for supposed changes in projected pricing. CMS will deny the request for re-review if submitters fail to provide the above-referenced justifications with the request for re-review. Submitters will not be permitted to supplement the request for re-review, nor will they be developed.
- Re-review and amended review requests may be made electronically or by mail. See the WCMSAP User Guide at <https://www.cob.cms.hhs.gov/WCMSA/assets/wcmsa/userManual/WCMSAUserManual.pdf> for details on electronic submission.

## **16.3 Required Resubmission**

Where a proposed WCMSA amount has been closed due to inactivity for one year or more from the original date of submission, a full-file resubmission will be required.

You may submit the re-review request to WCMSA Proposal/Final Settlement, P.O. Box 138899, Oklahoma City, OK, 73113-8899, or electronically using the WCMSAP. CMS will consider this re-review request in order of receipt as if it were a new WCMSA proposal submission.

## **17.0 Account Set-Up and Administration**

### **17.1 Administrators**

WCMSAs should be administered by a competent administrator (a professional administrator, the representative payee, the claimant, etc.). When a claimant designates a representative payee, appointed guardian/conservator, or has otherwise been declared incompetent by a court, the settling parties must include that information in their WCMSA proposal to CMS. CMS highly recommends professional administration where a claimant is taking controlled substances that CMS determines are “frequently abused drugs” according to CMS’ Part D Drug Utilization Review (DUR) policy. That policy and supporting information are available on the web at <https://cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html>.

Claimants may also administer their own WCMSAs, if State law allows. Claimants should submit annual self-attestations, just as a professional administrator would. This arrangement is subject to the same rules and reporting requirements as any other WCMSA. See Section [17.5](#) for more on this annual attestation. Although beneficiaries may act as their own administrators, it is highly recommended that settlement recipients consider the use of a professional administrator for their funds.

## 17.2 Interest-Bearing Account

You must deposit the total WCMSA amount (future medical treatment and future prescription drug treatment) in an interest-bearing account, separate from any other account such as personal savings or checking.

## 17.3 Use of the Account

WCMSA funds may only be used to pay for medical services and prescription drug expenses related to your work injury. CMS expects that WCMSA funds be competently administered in accordance with all Medicare coverage guidelines, including but not limited to CMS' Part D Drug Utilization Review (DUR) policy. As a result, all WCMSA administration programs should institute Drug Management Programs (DMPs) (as described at <https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf>) for claimants at risk for abuse or misuse of "frequently abused drugs."

WCMSA funds may only be used to pay for those expenses that would normally be paid by Medicare. Examples of some items that Medicare does not pay for are: acupuncture, routine dental care, eyeglasses or hearing aids; therefore, these items cannot be paid from the WCMSA account. For a more extensive list of services not covered by Medicare, get a copy of the booklet "Medicare & You" from your Social Security office or from <https://www.medicare.gov/medicare-and-you/medicare-and-you.html>.

If you have a question regarding Medicare's coverage of a specific item, service, or prescription drug, to determine if you may pay for it from the WCMSA account, please call 1 800-MEDICARE (1-800-633-4227) or visit CMS' website: <https://www.cms.gov/Medicare/Medicare.html>.

**Please note:** If payments from the WCMSA account are used to pay for services other than Medicare-allowable medical expenses related to medically necessary services and prescription drug expenses for the WC settled injury or illness, Medicare will deny all WC-injury-related claims until the WCMSA administrator can demonstrate appropriate use equal to the full amount of the WCMSA.

## 17.4 Medicare Entitlement and WCMSA

Your Medicare entitlement status may change over time. Your use of the WCMSA should not. Use of the WCMSA is limited to services that are related to the WC 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 by non-beneficiaries as well. The CMS will not pay for any expenses related to the WC claim or settlement until a self-attestation document with full accounting of all monies expended from the WCMSA is sent to the BCRC upon Medicare entitlement or re-establishment of Medicare entitlement. At that time, the BCRC will update the records Medicare uses in the claims process. 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 WC claim or settlement until such funds are exhausted. Only then will CMS pay for Medicare-covered services related to the WC claim or settlement.

### **17.4.1 Loss of Medicare Entitlement after CMS Approval of a WCMSA**

Claimants are not entitled to release of WCMSA funds if they lose their Medicare entitlement. However, the funds in the WCMSA may be used for medical expenses specified in the WCMSA until Medicare entitlement is re-established or the WCMSA is exhausted.

### **17.4.2 Use of WC Settlement Funds Prior to Medicare Entitlement**

For claimants who are not yet Medicare beneficiaries and for whom CMS has reviewed a WCMSA, the WCMSA may be used prior to becoming a beneficiary because the accepted amount was priced based on the date of the expected settlement.

## **17.5 Annual Attestation and Record-Keeping**

The administrator of the account will be responsible for keeping accurate records of payments made from the account. These records may be requested by CMS as proof of appropriate payments from the WCMSA account. (For more on Medicare contractors' monitoring accounts, see Section [18.0](#).)

Every year, beginning no later than 30 days after the 1-year anniversary of settlement, the administrator must sign and send a statement that payments from the WCMSA account were made for Medicare-covered medical expenses and Medicare-covered prescription drug expenses related to the work-related injury, illness, or disease. This annual attestation must be submitted no later than thirty days after the end of each year, beginning one year from the establishment of the WCMSA account. Annual self-attestation should continue through depletion of the WCMSA account. A final self-attestation should be forwarded to CMS once the WCMSA account becomes permanently depleted. CMS has the right to demand and receive a complete accounting of payments made from the account at its discretion.

For submitting yearly attestation material:

NGHP

P.O. Box 138832

Oklahoma City, OK 73113

Blank attestation letters with the appropriate identification numbers are included in the approval package sent by CMS. This letter includes the total amount of WCMSA outgoing payments that should separately identify the amounts spent for medical treatment and for prescription drug treatment. For example, if the total WCMSA amount in CMS' written opinion is \$10,000 (\$7,000 identified for future prescription drug treatment and \$3,000 identified for future medical expenses), then the administrator must send an annual attestation that identifies how much of the \$10,000 was spent for medical expenses and how much was spent for prescription drugs. If you use the account funds appropriately on injury-related expenses that might otherwise have been covered by Medicare, you may reallocate the relative amounts for medical expenses vs. prescription drugs. For example, you may have set aside \$7,000 for prescription drugs and \$3,000 for medical expenses, and you may instead spend \$6,000 and \$4,000 respectively. CMS will still consider the \$10,000 appropriately spent.

You may use the WCMSA account to pay for the following costs that are directly related to the account:

- document copying charges
- mailing fees/postage
- any banking fees related to the account
- income tax on interest income from the set-aside account

You may not use the WCMSA account to pay for:

- administrative fees
- expenses for administration of the WCMSA
- attorney costs for establishing the WCMSA

If such administrative funds are part of your settlement, do not combine those funds with the WCMSA, as CMS will not recognize administrative fees as legitimate WCMSA expenses.

Should a WC settlement 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 attestation.

## 17.6 Electronic Attestation

Users with Self and Representative accounts in the portal as well as beneficiaries logging in to the portal through the MyMedicare.gov link can submit yearly or final attestations electronically. These users can upload documentation with their attestation. For more information about how to submit an attestation electronically, please see the WCMSAP User Guide, at <https://www.cob.cms.hhs.gov/WCMSA/assets/wcmsa/userManual/WCMSAUserManual.pdf>.

Users with Professional Administrator accounts in the portal may use a file submission process to submit more detailed account transactions related to WCMSAs they administer. They can also view WCMSA account balance information. For more information on Professional Administrator accounts, please see the WCMSAP User Guide, at <https://www.cob.cms.hhs.gov/WCMSA/assets/wcmsa/userManual/WCMSAUserManual.pdf>.

## 17.7 MyMedicare.gov Link

For convenience of the beneficiary, the CMS has enabled a link under <https://www.mymedicare.gov/> that will allow beneficiaries to review, in a view-only fashion, all documents submitted on their behalf to ensure transparency. Beneficiaries need only apply for a MyMedicare.gov login user identification and password, and the feature will already be populated in that system.

**Note:** If beneficiaries have questions regarding the information in the MSA Cases or Detail Form, they should contact their attorney, submitter, or other representative before contacting Medicare.

When your case settles, please provide Medicare's contractor with a copy of the following at the address listed below:

- The dated settlement agreement signed by all parties showing the total amount of the settlement and WCMSA amount(s).

Your attorney, submitter, or other representative should already be handling these issues for you. Please check your MyMedicare account as updates are made regularly.

For WCMSA Proposals, Final Settlements, and Re-Review Requests:

WCMSA Proposal/Final Settlement

P.O. Box 138899

Oklahoma City, OK 73113-8899

1-855-798-2627

TTY: 1-855-797-2627

## 18.0 CMS' Monitoring

CMS will not monitor the money spent from the WCMSA until the claimant becomes Medicare-eligible (a beneficiary). However, if you have a WCMSA as part of your settlement, the WC-related medical expenses should be paid from the WCMSA even before the claimant becomes a beneficiary. Medicare beneficiaries and claimants who are not yet beneficiaries follow the same reporting rules discussed in Section [17.5](#) above.

When the RO approves a WCMSA, CMS will check the National Medicare Enrollment database regularly to find out when a claimant becomes enrolled in Medicare. Once the claimant is enrolled in Medicare, the BCRC is responsible for monitoring the individual's case.

The WCMSA administrator must send annual attestations summarizing the account transactions to the contractor responsible for monitoring the case. The contractor is then responsible for verifying that the funds from the WCMSA were spent on medical services for Medicare-covered services, or to pay the tax for the interest income from the account.

Additionally, the contractor must ensure that Medicare makes no payments related to the WC injury until the WCMSA has been used up. This is accomplished by placing an electronic marker in CMS' systems used to pay or deny claims. That marker is removed once the beneficiary can demonstrate the appropriate exhaustion of an amount equal to the WCMSA plus any accrued interest from the account. For those with structured settlements, the marker is removed in any period where the beneficiary exhausts their available funds; however, it is replaced once the anniversary fund deposit occurs until the entire value of the WCMSA is demonstrated as entirely exhausted.

## **19.0 What Happens if Circumstances Change?**

### **19.1 WCMSA is Under-Funded**

Medicare does not make any payment until the MSPRC can verify that the funds apportioned to the period, including any carry-forward amount, have been completely exhausted as set forth in the WCMSA.

### **19.2 Death of the Claimant**

If a claimant dies before the WCMSA is completely exhausted, the RO and the BCRC will ensure that all claims have been paid. Then any amount left over in the WCMSA may be disbursed pursuant to state law, once Medicare's interests have been protected. This may involve holding the WCMSA open for some period after the date of death, as providers, physicians, and other suppliers are permitted to submit their initial bill to Medicare for a period of 12 months after the date of service. Often, the settlement itself will dictate the appropriate dispersal of funds upon the death of the claimant and settlement of care-related expenses.

### **19.3 Structured WCMSA Funds Topics**

#### **19.3.1 Funds Left Over/Carried Forward**

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

Example: A structured set-aside is designed to pay \$20,000 per year over the next 10 years for an individual's Medicare-covered services. Medicare would begin paying covered expenses in any given year after this \$20,000 is exhausted. However, in 2012 the injured individual needs only \$15,000 to cover all related expenses. The administrator would need to carry forward the excess \$5,000 into 2013. Therefore, in 2013 a total of \$25,000 of Medicare-covered expenses would need to be spent for services otherwise reimbursable by Medicare before Medicare would begin to cover WC related expenses, but only for the balance of 2013. This carry-forward process continues until the accumulated carry-forward plus the payment for a given year is exhausted.

#### **19.3.2 Funds Used in a Given Period**

If a structured WCMSA proves to be under-funded for a given period because the funds are exhausted by the claimant's medical expenses before the period ends, and if CMS receives verification of exhaustion of both the structured amount for the period and any available roll-over funds, then Medicare will pay for additional medical expenses incurred during the period.

## 19.4 Change of Submitter

If there is a change in submitters, CMS requires a written release from services by the original submitter and a new signed Consent to Release form authorizing the new submitter. Both must be provided in order to continue the WCMSA review process. Submitter changes will not be accepted after settlement, and does not constitute a reason for a re-review (See [Section 16.0](#) for re-review requirements). CMS will not provide copies **of existing documentation to the new submitter. Any documentation must be obtained from** the incumbent submitter.

## **Appendix 1. Contact Information**

### **For general questions not answered by this guide:**

Call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 or TTY/TDD: 1-855-797-2627 for the hearing and speech impaired, Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays.

### **To report a Workers' Compensation incident:**

Call the 800 number above or write:

Medicare—Medicare Secondary Payer  
MSP Claims Investigation Project  
P.O. Box 138899  
Oklahoma City, OK 73113-8897

### **Where to submit a proposed Workers' Compensation Medicare Set-Aside proposal:**

If submitting the proposal electronically, please use the Workers' Compensation Medicare Set-Aside Arrangement Portal (WCMSAP) at <https://www.cob.cms.hhs.gov/WCMSA/>

If submitting the proposal on paper or CD, mail to:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

### **For Workers' Compensation Medicare Set-Aside Portal issues (e.g., password resets, or the status of portal account registration):**

Call the EDI Department at (646) 458-6740.

### **To check the status of a WCMSA proposal submitted online via the portal:**

Log in to the portal at <https://www.cob.cms.hhs.gov/WCMSA/>.

### **To check the status of a WCMSA proposal submitted on paper or CD:**

Please call the WCRC at 833-295-3773.

### **To submit a re-review request:**

For a proposal originally submitted electronically, use the portal at <https://www.cob.cms.hhs.gov/WCMSA/>.

### **Or submit on paper or CD to:**

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

**For questions about Medicare's coverage of a specific item, service, or prescription drug, to determine if you may pay for it from your WCMSA account:**

Please call 1 800-MEDICARE (1-800-633-4227).

**Or visit CMS' website:** <https://www.cms.gov/Medicare/Medicare.html>

**For questions about WCMSA set-up or administration, please contact the Regional Office assigned to you.**

For a list of Regional Offices with contact information, visit CMS' website:

<https://cms.gov/RegionalOffices/>

## Appendix 2. Abbreviations List

AWP	Average wholesale price
BCRC	Benefits Coordination & Recovery Center
CDC	Centers for Disease Control
CLBP	Chronic low back pain
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPT	Current Procedural Terminology
CT	Computerized Tomography
DME	Durable Medical Equipment
DOI	Date of incident or injury
DRG	Diagnosis-Related Groups
ESRD	End-stage renal disease
FDA	Food and Drug Administration
HCPCS	Healthcare Common Procedure Coding System
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
ICD	International Classification of Diseases
IME	Independent medical examination
IT	Intrathecal
MBI	Medicare Beneficiary Identifier
MRI	Magnetic Resonance Imaging
MSP	Medicare Secondary Payer
NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
ORM	Ongoing responsibility for medicals
OTC	Over-the-counter
PDV	Present-day value
POA	Power of Attorney
PRN	Pro re nata, Latin for as-needed
PSD	Proposed settlement date
PT	Physical therapy
RA	Rated age
RO	Regional Office
SCS	Spinal cord stimulator
SSDB	Social Security Disability Benefits
SSA	Social Security Administration
SSI	Supplemental Security Income

## WCMSA Reference Guide

SSN	Social Security Number
TENS	Transcutaneous Electrical Nerve Stimulation
TPA	Third-party administrator
TSA	Total settlement amount
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Arrangement
WCMSAP	WCMSA Portal
WCRC	Workers' Compensation Review Contractor

## **Appendix 3. Glossary**

### **Average wholesale price**

AWP is used to price Medicare Part D drugs included in the calculations for the WCMSA funding amount.

### **Benefits Coordination & Recovery Center**

The BCRC performs a number of functions for CMS, the pertinent one for this guide being the receipt and initial processing of hard copy WCMSA proposals.

### **Centers for Disease Control**

The CDC provides annual life expectancy tables used in the calculations for the WCMSA funding amount.

### **Centers for Medicare & Medicaid Services**

CMS is the government agency responsible for administering Medicare and Medicaid.

### **Claimant**

A person who submits a WC claim. A claim is a request for payment for services and benefits you received.

### **Commutation**

WC commutation cases are settlement awards intended to compensate individuals for future medical expenses required because of a work-related injury or disease. Cases may have both compromise and commutation aspects.

### **Compromise**

WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Cases may have both compromise and commutation aspects.

### **Conditional payment**

A payment made by Medicare for services for which another payer is responsible.

### **Date of incident or injury**

For claims involving cumulative injury, CMS' definition of the DOI is the earlier of: the first date that formal diagnosis was made by any medical practitioner; or the earliest date of treatment for any manifestation of the cumulative injury, when such treatment preceded formal diagnosis.

### **Determination**

CMS' decision about whether the proposed WCMSA includes enough money to cover the claimant's anticipated future medical claims that would otherwise be covered by Medicare. If CMS disagrees with the proposed amount, the determination will include the amount CMS determines is appropriate.

### **Development**

The process of collecting additional information about a case. CMS will issue a development letter to a claimant who provided insufficient information in a WCMSA submission, and the case will be in development until sufficient information is obtained.

**Durable medical equipment**

DME includes oxygen and respiratory therapy equipment, hospital beds, wheelchairs and other walking aids, and other such devices and equipment used in the home or in an institution serving as a home.

**End-stage renal disease**

A person with ESRD may qualify for Medicare benefits.

**Food and Drug Administration**

The US FDA is the governmental body responsible for regulating prescription and over-the-counter medications, as well as medical devices.

**Health Insurance Claim Number**

The HICN is an identification number assigned by the Social Security Administration to Medicare beneficiaries. (See also Medicare Beneficiary Identifier.)

**Independent medical examination**

An IME may be used as part of the supporting documentation in a WCMSA proposal.

**Lump sum settlement**

A settlement in which the agreed-on funds are paid out in one amount.

**Medicare**

The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

**Medicare Beneficiary Identifier**

The MBI is an identification number assigned by the Social Security Administration to Medicare beneficiaries. This number replaces the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

**Medicare Secondary Payer**

MSP is the term used by Medicare when Medicare is not responsible for paying first. With the addition of the MSP provisions to federal law in 1980 (and subsequent amendments), Medicare is secondary payer to group health plan insurance in specific circumstances, but is also secondary to liability insurance (including self-insurance), no-fault insurance, and Workers' Compensation.

**National Drug Code**

The NDC is a unique number assigned to pharmaceuticals.

**Present-Day Value**

PDV is the cost to fund a WCMSA annuity.

**Regional Office**

A CMS RO is assigned to each WCMSA case, and that RO makes the final determination of the appropriate funding level for the WCMSA.

**Social Security Number**

The SSN is an identification number issued by the Social Security Administration, and used instead of a Medicare ID (HICN or MBI) when the Medicare ID is not present.

**Structured settlement**

A settlement in which the agreed-on funds are paid from an initial deposit and subsequent deposits on a regular basis for a given amount of time.

**Submitter**

The person who sends a WCMSA application to CMS. This may be someone acting on the claimant's behalf.

**Third-party administrator**

A TPA may administer a funded WCMSA.

**Threshold**

The minimum qualities needed for CMS to review a WCMSA submission.

**Verification letter**

A letter that confirms a WCMSA does not need to be reviewed. CMS will not issue such letters.

**WCMSA Portal**

The WCMSAP may be used to submit and view WCMSA proposals, to communicate about the review approval process, and to submit re-review requests. It can also be used to submit annual attestations, or for professional administrators, detailed transaction records; and to view the status and balance of an established WCMSA.

**Workers' Compensation**

WC is a government program set up to provide wage replacement and medical benefits to workers injured on the job.

**Workers' Compensation Medicare Set-Aside Arrangement**

A WCMSA is set up to ensure that all future medical and drug or pharmacy expenses for a work-related injury otherwise payable by Medicare are covered by a WC settlement.

**Workers' Compensation Review Contractor**

The WCRC is responsible for reviewing WCMSA proposals and issuing final determinations.

## Appendix 4. WCRC Proposal Review Reference Tools

**Table Appendix 4-1: WCRC Proposal Review Reference Tools**

Tool	Description
Milliman	<a href="https://www.mcg.com/">https://www.mcg.com/</a> Milliman offers various clinical tools and allows search of diagnosis and procedural codes for a code description or search by description to obtain codes. It is helpful for identifying proper procedural code selection for medical services. This source also has care guidelines for various clinical conditions and is a source for evidence-based medicine guidelines.
MediRegs	<a href="https://lrus.wolterskluwer.com/product-family/mediregs">https://lrus.wolterskluwer.com/product-family/mediregs</a> MediRegs provides an extensive database payment tool and is used for pricing inpatient services and outpatient surgery with crosswalk to CPT codes. This tool allows updated access to reimbursement cost per facility in each state. The tool offers additional resources for searching Medicare coverage guidelines (national and local).
PubMed	<a href="https://www.ncbi.nlm.nih.gov/pubmed/">https://www.ncbi.nlm.nih.gov/pubmed/</a> PubMed comprises more than 22 million citations for biomedical literature from MEDLINE, life science journals, and online books. Citations may include links to full-text content.
MicroMedex/ DrugDEX	<a href="http://www.micromedexsolutions.com/">http://www.micromedexsolutions.com/</a> MicroMedex/DrugDEX is the primary resource to access information regarding medications. The DrugDEX profile provides information regarding the Federal Drug Administration (FDA) indications and compendia supported off-label uses of prescription drugs. This resource assists in determining whether a prescription drug that is prescribed for WC condition(s) is appropriate for inclusion in the WCMSA.
Stat!Ref	<a href="http://www.tetondata.com/product-srOnline.cshtml">http://www.tetondata.com/product-srOnline.cshtml</a> Stat!Ref is the secondary resource to access information regarding medications. The profiles are less detailed than DrugDEX profiles. However, there are many useful clinical tools such as a medical dictionary, profiles on clinical conditions and evidence-based medicine references.
Red Book	<a href="http://truvenhealth.com/products/micromedex/product-suites/clinical-knowledge/red-book">http://truvenhealth.com/products/micromedex/product-suites/clinical-knowledge/red-book</a> Red Book is the source for pricing prescription drug products. The database compiles Average Wholesale Prices (AWP) for various drug products.

Tool	Description
DailyMed	<a href="https://dailymed.nlm.nih.gov/dailymed/about.cfm">https://dailymed.nlm.nih.gov/dailymed/about.cfm</a> DailyMed provides information about marketed drugs including FDA labels (package inserts). The website provides a look-up and download resource of medication content and labeling as found in medication package inserts. It is searchable by drug name, National Drug Code number, drug class, SetID, and label type. At present, the site does not contain a complete listing of labels for approved prescription drugs. Drugs marked “unapproved” have not been reviewed by the FDA.
FDA Website: Approved Drugs	<a href="https://www.accessdata.fda.gov/scripts/cder/drugsatfda/">https://www.accessdata.fda.gov/scripts/cder/drugsatfda/</a> Drugs@FDA provides a searchable directory of official information about FDA approved innovator and generic drugs and therapeutic biological products. It allows for location of labels for approved drug products, generic drug products for an innovator drug product, therapeutically equivalent drug products for an innovator or generic drug product, consumer information for drugs approved from 1998 on, all drugs with a specific ingredient, and the approval history of a drug. It is a source for prescription and over-the-counter human drugs and therapeutic biologicals currently approved for sale in the US, discontinued drugs, and Chemical Type 6 approvals.
FDA Website: NDC Directory	<a href="https://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm">https://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm</a> The FDA NDC Directory identifies drug products using a unique, three-segment number called the National Drug Code (NDC). Listing information in the NDC Directory is currently updated every Monday. Search is available by proprietary name, active ingredient, NDC number, application number, or labeler name.
FDA Website: Orange Book Equivalents	<a href="https://www.accessdata.fda.gov/scripts/cder/ob/default.cfm">https://www.accessdata.fda.gov/scripts/cder/ob/default.cfm</a> The FDA Orange Book Equivalents is a directory of approved Drug Products with Therapeutic Equivalence Evaluations and identifies drug products approved on the basis of safety and effectiveness by the FDA. The database contains prescription and OTC medications. Search is available by proprietary name, active ingredient, patent, applicant holder, or application number. Daily Electronic Orange Book updates are provided for product information for new generic drug approvals.

## Appendix 5. Sample Letters

### Approval Letter



<<Date>>

<<Submitter Name>>

<<Address>>

<<City, State, ZIP>>

RE: Workers' Compensation Medicare Set-Aside Arrangement

<<Claimant>>

<<Medicare ID>>

<<Date of Injury>>

<<CMS Case Control Number (CCN)>>

Dear <<Submitter Name>>,

This letter is in response to your submission of a proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount related to the above-named claimant's workers' compensation claim and received on <<insert date received>>.

You proposed a WCMSA amount of \$<<amount>> to pay for future medical items and services that are covered and otherwise reimbursable by Medicare ("Medicare covered") and are related to the claimant's workers' compensation claim. We note that you proposed \$<<amount>> for Medicare-covered prescription drugs.

We have evaluated your proposed WCMSA amount and have determined that \$<<amount>> adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs.

In order to comply with Section 1862(b)(2) of the Social Security Act, Medicare is not permitted to pay for medical items and services, including prescription drug expenses, related to the workers' compensation claim until the approved WCMSA amount is appropriately exhausted ("properly spent") on related medical care. Where a workers' compensation settlement, judgment, award, or other payment is less than the approved WCMSA amount, Medicare is not permitted to pay for related medical care until the whole settlement, judgment, award, or other payment is properly spent on related medical care. The WCMSA funds must be placed in an interest-bearing account. Funds in the account should not be used for any purpose other than

payment for future medical care that is Medicare covered and related to the workers' compensation claim.

**Approval of this WCMSA amount is not effective until the Centers for Medicare & Medicaid Services (CMS) receive a copy of the final executed workers' compensation settlement agreement, which must include this approved WCMSA amount.** Please include the CMS Case Control Number listed at the top of this letter in any correspondence. Submit your settlement agreement via the Portal if your original submission was via the Portal. If you originally submitted outside of the Portal, submit the settlement agreement to the following address:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

If your settlement agreement is 10 pages or less, you may also fax it to (405) 869-3306. **Note:** This number is not for initial submissions, only for additional documentation under 10 pages.

Funds in a WCMSA may not be used to purchase a Medicare supplemental insurance policy or a Medigap policy for a beneficiary, or to pay for the premiums for such policies.

Once the funds in the WCMSA account have been properly spent on Medicare-covered items and services related to the claimant's workers' compensation claim and Medicare has been given proof that the account has been properly spent, Medicare will begin paying for the claimant's Medicare-covered items and services that are related to the workers' compensation claim. Medicare will pay for Medicare-covered items and services that are unrelated to the workers' compensation claim according to Medicare's payment rules.

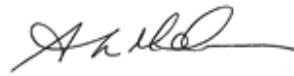
We understand that the claimant will act as administrator of the WCMSA funds. We have enclosed instructions, titled "Administering Your Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)." The WCMSA Self-Administration Toolkit is another resource, available on the CMS website at <http://go.cms.gov/WCMSASelfAdm>. The claimant must send a signed attestation letter to the Benefits Coordination & Recovery Center at the address below every year, no later than 30 days after the end of each reporting period (beginning one year from the date of establishment of the WCMSA account). Annual attestations should continue through final exhaustion of the account.

WCMSA Proposal/Final Settlement  
PO Box 138899  
Oklahoma City, OK 73113-8899

Please note that this decision regarding future medical treatment is independent of any determination regarding Medicare Secondary Payer recovery rights for conditional payments Medicare made for related items and services furnished before the date of the settlement, judgment, award, or other payment. Medicare has the right to recover (or take back) Medicare payments related to any workers' compensation settlement, judgment, award, or other payment. Any payments Medicare may have made that should have been paid from the workers' compensation settlement, judgment, award, or other payment must be repaid to Medicare.

If you have any questions concerning this letter, please call <<contact assigned to case>> at <<contact phone >>.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Sherri McQueen', with a long horizontal flourish extending to the right.

Sherri McQueen  
Director, Financial Services Group  
Office of Financial Management

Enclosure

cc:     <<cc names>>

## Zero Set-Aside Letter



«Date»

«Submitter Name»

«Address»

«City, State, ZIP»

RE: Workers' Compensation Medicare Set-Aside Arrangement

«Claimant»

«SSN or Medicare ID»

«Date of Injury»

«CMS Case Control Number»

Dear Sir or Madam:

This letter is in response to your submission of a proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount, related to the above-named claimant's workers' compensation claim, received on «date».

You proposed that no WCMSA amount is required to pay for future medical items and services, including prescription drugs, that are covered and otherwise reimbursable by Medicare (Medicare covered), related to the claimant's workers' compensation claim.

We have evaluated your proposal along with the supporting medical documentation you submitted and have determined that Medicare's interests have been adequately considered.

**Therefore, no WCMSA amount is deemed necessary in this case.**

Please note that this decision regarding future medical treatment is independent of any determination regarding Medicare Secondary Payer recovery rights for conditional payments Medicare made for related items and services furnished before the date of the settlement, judgment, award, or other payment. Medicare has the right to recover (or take back) Medicare payments related to any workers' compensation settlement, judgment, award, or other payment. Any payments Medicare may have made that should have been paid from the workers' compensation settlement, judgment, award, or other payment must be repaid to Medicare.

**This decision regarding the WCMSA is not effective until CMS receives a copy of the final executed WC settlement agreement.** Please include the CMS Case Control Number listed at the top of this letter in any correspondence. Submit your settlement agreement via the Portal if

your original submission was via the Portal. If you originally submitted outside of the Portal, submit the settlement agreement to the following address:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

If your settlement agreement is 10 pages or less, you may also fax it to (405) 869-3306. **Note:** This number is not for initial submissions, only for additional documentation under 10 pages.

If you have any questions concerning this letter, please call <<RO contact>> at <<RO phone number>>.

Sincerely,



Sherri McQueen  
Director, Financial Services Group  
Office of Financial Management

cc: <<cc names>>

## Below Threshold Letter



«Date»

«Submitter Name»

«Address»

«City, State, ZIP»

RE: Workers' Compensation Medicare Set-Aside Arrangement for:

«Claimant»

«SSN or Medicare ID»

«Date of Injury»

«CMS Case Control Number»

Dear Sir or Madam,

The Centers for Medicare & Medicaid Services (CMS) has received your correspondence regarding the proposed workers' compensation (WC) settlement that includes future medical benefits for the above-named claimant. If the Social Security Number (SSN) above is incorrect, you must provide CMS with the correct SSN or a Health Insurance Claim Number (Medicare number) within «# of days» of the date of this letter. Based on the information you provided, we are unable to identify this claimant as a Medicare beneficiary, and we do not believe the claimant has a reasonable expectation of becoming a beneficiary within 30 months of the anticipated settlement date.

CMS will only review proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amounts from claimants who are not Medicare beneficiaries when the total settlement amount is greater than \$250,000. CMS does not issue "verification" letters confirming that approval of a WCMSA is unnecessary when a WC settlement is \$250,000 or less. This is a CMS workload management tool and not a substantive dollar or "safe harbor" threshold. Therefore, due to resource constraints, CMS will not review this case because the facts presented do not meet the above thresholds. However, WC claimants must still consider Medicare's interest in all cases and ensure that Medicare pays secondary to WC in such cases.

Please visit the Coordination of Benefits & Recovery (COB&R) Workers' Compensation website at <https://go.cms.gov/wcmsa> for more information, including the WCMSA Reference Guide, which contains detailed information for WCMSA submitters.

Please note that this decision regarding future medical treatment is independent of any determination regarding Medicare Secondary Payer recovery rights for conditional payments Medicare made for related items and services furnished before the date of the settlement, judgment, award, or other payment. Medicare has the right to recover (or take back) Medicare payments related to any workers' compensation settlement, judgment, award, or other payment. Any payments Medicare may have made that should have been paid from the workers' compensation settlement, judgment, award, or other payment must be repaid to Medicare.

If you have further questions, please contact <<RO contact>> at <<RO phone number>>.

Sincerely,

<<RO Name>>

cc: <<cc names>>

## Beneficiary Below Threshold Letter



«Date»

«Submitter's Name»

«Address»

«City, State, ZIP»

RE: Workers' Compensation Medicare Set-Aside Arrangement for

«Claimant»

«Medicare ID/SSN»

«Date of Injury»

«CMS Case Control Number»

Dear Sir or Madam:

The Centers for Medicare & Medicaid Services (CMS) has received your correspondence regarding a proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount for the above-named claimant. Based on the information you provided, we have identified the above-named claimant as a Medicare beneficiary. If the Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier) listed above is incorrect, you must provide CMS with the correct Medicare ID within «# of days» of the date of this letter.

CMS will only review proposed WCMSA amounts for Medicare beneficiaries when the total settlement amount is greater than \$25,000.00. CMS does not issue "verification" letters confirming that approval of a WCMSA is unnecessary when the workers' compensation settlement is \$25,000.00 or less. This is a CMS workload management tool and not a substantive dollar or "safe harbor" threshold. Therefore, due to resource constraints, CMS will not review this case because the facts presented do not meet the above thresholds. However, claimants must still consider Medicare's interest in all workers' compensation cases and ensure that Medicare pays secondary to workers' compensation in such cases.

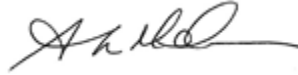
Please visit the Coordination of Benefits & Recovery (COB&R) Workers' Compensation website at <https://go.cms.gov/wcmsa> for more information, including the WCMSA Reference Guide, which contains detailed information for WCMSA submitters.

Please note that this decision regarding future medical treatment is independent of any determination regarding Medicare Secondary Payer recovery rights for conditional payments Medicare made for claim-related items and services furnished before the date of the settlement,

judgment, award, or other payment. Medicare has the right to recover (or take back) Medicare payments related to any workers' compensation settlement, judgment, award, or other payment. Any payments Medicare may have made that should have been paid from the workers' compensation settlement, judgment, award, or other payment must be repaid to Medicare.

If you have any questions concerning this letter, please contact <<contact name>> at <<contact phone number>>.

Sincerely,

A handwritten signature in black ink, appearing to read "Sherri McQueen", written over a horizontal line.

Sherri McQueen  
Director, Financial Services Group  
Office of Financial Management

cc: <<cc names>>

## Development Letter



«Date»

«Submitter Name»

«Address»

«City, State, ZIP»

RE: Workers' Compensation Medicare Set-Aside Arrangement for:

«Claimant»

«Medicare ID or SSN»

«Date of Injury»

«CMS Case Control Number»

Dear Sir or Madam,

The Centers for Medicare & Medicaid Services (CMS) has received your request to review a proposed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount for the above-named claimant. Please note that the items indicated on the enclosure are missing from the above-referenced case and we cannot complete a review of the proposed WCMSA amount without this information. The requested information must include the CMS Case Control Number listed above and should be submitted according to the information provided on the enclosure no later than «# of days» from the date of this letter.

Failure to provide the information requested may result in Medicare denying payment for future medical and prescription drug expenses related to the workers' compensation claim up to the total amount of the settlement.

Once all requested information is received, CMS will complete its review of the proposed WCMSA amount.

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

«Date»

«Claimant»

«Case Number»

Please submit only the item(s) indicated below no later than «# of days» from the date on this document. Please include the CMS Case Control Number listed at the top of this letter in any correspondence. Submit the requested documents via the Portal if your original submission was via the Portal. If you originally submitted outside of the Portal, submit the requested documents to the following address:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

If the requested documents total 10 pages or less, you may also fax them to (405) 869-3306. **Note:** This number is not for initial submissions, only for additional documentation under 10 pages.

For more details on any of the below requests, see the WCMSA Reference Guide, available through <https://go.cms.gov/wcmsa> on the CMS website.

If you have further questions, please contact the Workers' Compensation Review Contractor (WCRC) at (833) 295-3773.

**A cover letter must include the following information for all WCMSA proposals:**

- **Claimant's Name**
- **Claimant's Date of Birth**
- **Claimant's Medicare ID (Health Insurance Claim Number [HICN] or Medicare Beneficiary Identifier) 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 WCMSA account.
- **Claimant's Release** – Claimant's signed authorization for CMS, its agents, and contractors to discuss his or her case and 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 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
- **State of Venue** – Name of state where WC hearing is being held.
- **Attorney Representing Employer or WC Insurer** – Name, address, and phone number if employer's or WC Insurer's attorney has prepared documentation for the WCMSA.
- **Injury/Disease Date** – The date the injury occurred.
- **Type of Injury/Disease** – A brief description of the work-related injury, illness, or disease sustained including the diagnosis codes, if available.
- **Total WC Settlement Amount** – Including the WCMSA amount, plus the amount provided for all other aspects of the settlement. Do NOT provide the settlement amount minus attorney fees, expenses, etc. The total settlement amount is calculated by totaling the following items:
  - a) Amount(s) for wage replacement and disability
  - b) Amount(s) for future medical treatment
  - c) Amount(s) for future prescription drug treatment
  - d) Attorneys' fees
  - e) Amount(s) for repayment of conditional payments
  - f) Payout totals for all annuities to fund the above expenses (**DO NOT** use costs or present values of any annuities)
  - g) Amount of any previously settled portion of the WC claim
- **Proposed Medicare Set-Aside Amount** – Proposed amount to be placed in a WCMSA account for future medical **and** prescription drug expenses that would otherwise be paid by Medicare.

**Documentation that must be available to CMS prior to the approval of a WCMSA amount:**

- **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 or diseases is the method of evaluation, include documentation to support the life expectancy. CMS will project the cost of the claimant's future treatment over the claimant's life expectancy using the most recent table listed on the Centers for Disease Control website ([https://www.cdc.gov/nchs/products/life\\_tables.htm](https://www.cdc.gov/nchs/products/life_tables.htm)).

- **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. For detailed requirements, see the WCMSA Reference Guide on the CMS website at <http://go.cms.gov/wcmsa>.
- **Future Treatment** – Identify specific types of medical services and items, their frequency and duration, and their projected costs related to the workers’ compensation claim that are expected in the future in light of the claimant's condition. For detailed requirements, see the WCMSA Reference Guide on the CMS website at <https://go.cms.gov/wcmsa>.

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

- a) Physician visits @ \$4,500 (\$75 x 2 x 30)
  - b) PT @ \$1,800 (\$50 x 12 x 3)
  - c) X-rays @ \$1,000 (\$100 x 10)
  - d) MRIs @ \$9,000 (\$1,500 x 6)
  - e) Hospitalizations @ \$30,000 (\$10,000 x 3)
- **Prescription Drug Information** – Identify the total amount of the WC settlement that is designated for future prescription drug treatment (separate from the future medical treatment). If no amount is designated for future prescription drug treatment, please provide an explanation.
  - **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).
  - **Amount for Future Medical Treatment** – Identify the total amount of the WC settlement that is designated for future medical benefits (separate from wage or 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 WCMSA 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 WCMSA amount, e.g., fitness center memberships.
- **Administrator** – Designate the administrator responsible for control and documentation of proper expenditures from the WCMSA 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. 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, amount of the initial deposit (seed money), and number of years.
- **Fees** – One-time and recurrent administrative fees and expenses for administration of the WCMSA and attorney costs specifically associated with establishing the WCMSA **cannot** be charged to the WCMSA account. The payment of these costs must come from some other payment source that is completely separate from the WCMSA funds. You **can** use the account to pay for taxes on the interest income earned by the account, and for document copying and banking fees associated with the setup and maintenance of the account.
- **Final WC Settlement Agreement** – Approval of the WCMSA amount is not final until CMS receives an executed copy of the final settlement agreement that has been approved and signed by all parties. Submit a copy of the final settlement agreement using your original method of submission. If you originally mailed your proposal, send your settlement to:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

If the requested documents total 10 pages or less, you may also fax them to (405) 869-3306.

**Note:** This number is not for initial submissions, only for additional documentation under 10 pages.

«FREE TEXT»

## WCMSA Reference Guide

Questions regarding this correspondence may be directed to the WCRC at (833) 295-3773.

Sincerely,

«RO Name»

cc: «cc names»

## Closeout Letter



«Date»

«Submitter Name»

«Address»

«City, State, ZIP»

RE: Workers' Compensation Medicare Set-Aside Arrangement for:

«Claimant»

«Medicare ID»

«SSN»

«Date of Injury»

«CMS Case Control Number»

Dear Sir or Madam:

We recently requested additional information from your office to determine the appropriate Workers' Compensation Medicare Set-Aside amount for the above-named claimant. Since that time, «# of days» have expired without our receiving a reply, or the reply we received did not include all the information we requested.

**We still need:**

«FREE TEXT»

Therefore, we are closing this case due to lack of sufficient information. If the claimant is already a Medicare beneficiary or once he or she becomes a Medicare beneficiary, Medicare may deny medical claims related to the beneficiary's workers' compensation claim.

**Note: The case will automatically reopen when the requested information is received.**

Please include the CMS Case Control Number listed at the top of this letter in any correspondence. Submit your information via the Portal if your original submission was via the Portal. If you originally submitted outside of the Portal, submit your information to the following address:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

## WCMSA Reference Guide

If your information is 10 pages or less, you may also fax it to (405) 869-3306. **Note:** This number is not for initial submissions, only for additional documentation under 10 pages.

If you have any questions regarding our request for additional information, please contact the undersigned toll free at 833-295-3773.

Sincerely,

«RO Contact»

## Appendix 6. Sample Submission

The sample included in this section is not intended to specify a required form or format. Each state has unique forms for processing WC cases, and nothing in this sample is meant to interfere with each state's forms or requirements. Note that the endnotes are for explanation only and are not meant to be part of a suggested submission. The sample submission is intended to be used only as a sample. The intent of the sample document is to aid submitters in organizing the information that is typically sent to CMS with a WCMSA proposal.

Procedures relating to WCMSAs are published on the CMS web site. (Please see <https://go.cms.gov/wcmsa> on the CMS website.) Where any conflict is perceived between statements or information in this sample and official CMS published procedures, the latter controls.

This sample is divided into numbered sections, corresponding to the electronic folders in which CMS scans and files documents for review. Use of these numbered sections by submitters enhances the scanning and review process and reduces errors.

- For cases filed on compact disc, grouping and naming documents by using the numbered folders is preferred, as this will eliminate the need for section dividers.
- For cases submitted on paper, numbered section dividers on single sheets, rather than tabs, are recommended.

This sample assumes a paper filing, and shows the use of numbered section dividers. It also assumes each numbered section is being used, although this practice is not being suggested and rarely is necessary. Note, although the cover letter is very important, it does not need a section divider when paper filing is used because it should always be on top of the submission.

## **Appendix 6: 05 – Cover Letter**

# 05 – Cover Letter

**WCMSA Consultants, LLC**  
**100 Helpful Lane, Suite 300**  
**City, State 11111-2222**  
**Phone: (410) 555-1111, Fax: (240) 555-0000**

January 21, 2009

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-8899

Re: Jane Doe

100 Felldown Lane  
City, State 22222-1111  
Phone: (803) 555-1111  
SSN: 123-45-6789  
Medicare ID: None

Dear Sir/Madam:

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

**A. Claimant Information**

1. Gender: Female
2. Date of Birth: 07/03/49
3. Median Rated Age: 67
4. Life Expectancy Used in Proposal: 17
5. Consent attached (required): YES

**B. Entitlement Information**

1. Is claimant is entitled to Medicare. No  
If the answer to B.1 is Yes, do not submit the WCMSA proposal for review unless the total settlement amount exceeds \$25,000.
2. If above answer is NO, claimant believes he/she will be entitled to Medicare within 30 months of the expected settlement date because (answer YES to one of the following):  
NO - Claimant has applied for Social Security Disability Benefits ("SSDB")  
NO - Claimant has been denied SSDB but anticipates an appeal  
YES - Claimant is in the process of appealing and/or re-filing for SSDB  
NO - Claimant is (or will be) at least 62 years and 6 months old 120 days from today  
NO - Claimant has End Stage Renal Disease ("ESRD") but does not yet qualify for Medicare based on ESRD  
NO - Other (Explain)

### C. Injury Information

1. Description of incident and injury: Claimant was tightening valves and felt her neck burning.
2. All date(s) of injury being settled (list oldest first; show first and last dates of any cumulative traumas):  
01/31/01  
04/13/02
3. ICD-9 diagnosis codes and descriptions for body parts that are settling (list all that apply, in order of priority):  
721.0-Cervical spondylosis without myelopathy  
723.1-Cervicalgia  
723.4-Brachial neuritis or radiculitis NOS
4. ICD-10 diagnosis codes and descriptions for body parts that are settling (list all that apply, in order of priority):  
M47812 - Spondylosis without myelopathy or radiculopathy, cervical region  
M5412 - Radiculopathy, cervical region  
M5413 - Radiculopathy, cervicothoracic region

### D. Contact Information:

1. Submitter  
WCMSA Consultants, LLC  
100 Helpful Lane, Suite 300  
City, State 11111-2222  
Phone: (410) 555-1111, Fax: (240) 555-0000  
Contact: Bea Friend @ (410) 555-1111 x2345
2. MSA Administrator
  - a) Claimant: YES
  - b) SSA Representative Payee: NO (if YES, include name, address, phone, and fax)
  - c) Professional Administrator: NO (if YES, include name, address, phone, and fax)
3. Claimant's Attorney  
Legal Eagle, Esquire  
200 Justice Ct Ste 210  
City, St 33333-4444  
Phone (800) 555-1111  
Fax: (800) 555-0000
4. Employer  
Cool Toys Manufacturing, Inc.  
22 Playful Ln  
City, St 55555-2222

Phone (212) 555-1111

Fax: (212) 555-0000

5. Employer's Attorney

Clarence Darrow & Associates

24 Playful Ln

City, St 55555-2222

Phone (212) 555-2222

Fax: (212) 555-3333

6. WC Carrier

Got U Covered, LLC

100 Carrier Blvd

City, St 66666-3333

Phone (412) 555-1111

Fax: (412) 555-0000

7. WC Carrier's Attorney

Daniel Webster, LLC

102 Carrier Blvd

City, St 66666-3333

Phone (412) 555-2222

Fax: (412) 555-3333

**E. Settlement Details:**

1. Total settlement amount: \$260,000

2. Total proposed Medicare set-aside amount: \$95,891

a) Portion of set-aside for medical items and services: \$17,739

b) Calculated using (check one)

State fee schedule: YES

Full actual charges: NO

c) Portion of set-aside for prescription drugs: \$78,152

3. Set-aside is paid out as

a) Lump sum: NO

b) Annuity: YES

If annuity, proposed initial deposit (seed money): \$12,340

4. State of Jurisdiction/Venue: American Samoa

If you have any questions or require any additional information, please contact me at (410) 555-1111, Extension 11.

## WCMSA Reference Guide

Sincerely,

Signature

Bea Friend  
Benefit Coordination Specialist  
BF/mlf

Enclosures

## **Appendix 6: 10 – Consent to Release Note**

# 10 – Consent to Release Note

CONSENT TO RELEASE

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

Further, I have had the Workers' Compensation Medicare Set-Aside Arrangement need and process explained to me, and I approve of the contents of the submission.

Beneficiary Initials: XX

PLEASE CHECK:

<u>X</u> Claimant's attorney (name and/or firm):	Legal Eagle, Esquire
<u>X</u> Employer's attorney (name and/or firm):	Conrad Courageous, Esquire
<u>X</u> Workers' compensation carrier (name and/or firm):	Got U Covered
<u>X</u> Other (name and/or firm):	WCMSA Consultants
Claimant's Signature:	Signature
Date Signed:	10/18/08
Date(s) of Injury:	01/31/01, 04/13/02
Social Security Number or Medicare Number (Health Insurance Claim Number/HICN or Medicare ID):	123-45-6789

## **Appendix 6: 15 – Rated Age Information or Life Expectancy**

# **15 – Rated Age Information or Life Expectancy**

WCMSA Consultants, LLC  
100 Helpful Lane, Suite 300  
City, State 11111-2222  
Phone: (410) 555-1111, Fax: (240) 555-0000

**Rated Age Statement**

Claimant: Jane Doe

SSN: 123-45-6789

All rated ages obtained on the claimant have been included.

WCMSA Consultants, LLC

Submitter

**VULCAN INSURANCE COMPANY**  
**100 Live Long and Prosper Lane**  
**CITY, STATE 22222-4444**  
**Phone: (302) 555-1111, Fax: (302) 555-0000**

An underwriting assessment for JANE DOE has been completed.

Gender: Female

Date of Birth: July 3, 1949

Actual Age: 59

Rated Age: 67

Issue Date: November 15, 2008

**SUNNY SETTLEMENT BROKER, INC.**  
**200 Sunnyside Lane**  
**CITY, STATE 33333-5555**  
**Phone: (804) 555-1111, Fax: (804) 555-0000**

Name: Jane Doe  
File No.: 00WS458231  
Gender: Female  
DOB: July 3, 1949  
Actual Age: 59

Ratings obtained from:

**A. The Good Life Ins Co, Charles N. Reilly, Phone (410) 555-0000, Fax (410) 555-9999**

Gender: Female  
Date of Birth: July 3, 1949  
Actual Age: 59  
Rated Age: 62  
Issue Date: November 11, 2008

**B. Live Better Ins Co, Inc., Doris Day, Phone (410) 333-0000, Fax (410) 555-8888**

Gender: Female  
Date of Birth: July 3, 1949  
Actual Age: 59  
Rated Age: 65  
Issue Date: November 12, 2008

**C. Fortunate Life Ins Co, LLC, Ruff Day, Phone (410) 777-0000, Fax (410) 555-0000**

Gender: Female  
Date of Birth: July 3, 1949  
Actual Age: 59  
Rated Age: 72  
Issue Date: November 12, 2008

**D. Lively Life Ins. Co., Faye Ray, Phone (410) 444-0000, Fax (410) 555-1111**

Gender: Female  
Date of Birth: July 3, 1949  
Actual Age: 59  
Rated Age: 77  
Issue Date: November 13, 2008

## **Appendix 6: 20 – Life Care/Future Treatment Plan**

# 20 – Life Care/ Future Treatment Plan

**GREATLIFEPLAN, LLC**  
**100 Easylife Way**  
**City, State, 22222**  
**Phone: (888) 555-1111 Fax: (888) 555-0000**

Life Care Plan

Future Medical Care – Medicare Covered Items and Services and Prescription Drugs

Client: Jane Doe  
Date prepared: 10/18/2008  
Prepared by: Rita Reviewer, RN, CCM  
DOB: July 3, 1949  
DOI: 01/31/01, 04/13/02  
Diagnoses: 721.1 Cervical spondylosis without myelopathy  
723.1 Cervicalgia  
723.4 Brachial neuritis or radiculitis NOS  
Median rate age: 67  
Life expectancy: 17 years

**Calculation of WCMSA for medical items and services related to work injury:**

Medical Item or Service, Number, Every x years, # of years, Price per service, Lifetime Total  
Pain management, 4, every 1 year, for 17 years, price \$80.56 per service, \$5,478.08  
Lab work Rx, 1, every 1 year, for 17 years, price \$36.67 per service, \$623.39  
Orthopedist, 1, every 1 year, for 17 years, price \$80.56 per service, \$1,369.52  
X-ray Cervical, 5, every 17 years, for 17 years, price, \$111.31 per service, \$556.55  
MRI/CT Cervical, 3, every 17 yrs, for 17 years, price \$1,386.19 per service, \$4,158.57  
Trigger point injection, 6, every 17 yrs, for 17 yrs, \$80.00 per service, \$480.00  
Physiotherapy, 18, every 17 years, for 17 years, price \$81.83 per service, \$1,472.94  
Epidural injections, 3, every 17 yrs, for 17 yrs, price \$1,200.00 per service, \$3,600.00

**Lifetime total of all medical items and services: \$17,739.05**

**Calculation of WCMSA for prescription drugs related to work injury:**

Drug, National Drug Code, Dosage, Frequency, Length, Price per unit, Lifetime Total  
Zolpidem, 64679-0715-01, 10mg, 30/mo, for 17 yrs price \$3.65 per unit, \$22,338.00  
Tizanidine, 00172-5736-70, 4mg, 90/mo, for 17 yrs price \$1.39 per unit, \$25,520.40  
Hydrocodone/apap, 00591-0540-05, 10/500mg, 90/mo, for 17 yrs, price \$0.18 per, \$3,304.80  
Gabitril, 63459-0404-01, 4mg, 30/mo, for 17 yrs, price \$4.41 per unit, \$26,989.20

**Lifetime total of all prescription drugs: \$78,152.40**

**Appendix 6: 25 – Settlement Agreement or Proposed or Court Order**

# 25 – Settlement Agreement or Proposed or Court Order

**BEFORE THE WORKERS' COMPENSATION COMMISSION  
AMERICAN SAMOA**

Commission File: 000000

Jane Doe  
(Hereinafter called "Employee")

v.

Cool Toys Manufacturing  
(Hereinafter called "Employer")

Got U Covered  
(Hereinafter called "Carrier/TPA")

**\*\*\*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**

The Employee, Jane Doe, for consideration of the sum of \$260,000, 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**

Claimant represents and affirms that all accidents, injuries, and occupational diseases known to have occurred or to 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**

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

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 \$95,891 for future Medicare-covered expenses is intended directly for payment of these expenses. Upon proof that Medicare-covered expenses exceed \$95,891, those expenses will be forwarded to Medicare for payment of covered expenses with proper documentation. It is the responsibility of the claimant/beneficiary to submit bills related to the work-related injury or illness totaling the amount of \$95,891 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 all payments to providers are to be adjusted accordingly, and any monies paid in excess of the fee schedule will not count toward the allocation.

V

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

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

Total WC Settlement Amount: \$260,000 broken down as follows:

Cash to claimant for indemnity	\$115,000
Cash for initial deposit non-Medicare medical needs	\$809
Annuity payout for non-Medicare medical needs (\$100/yr. for life (est. 16 years) starting 08/04/10)	\$1,600
Cash for initial deposit Medicare set-aside	\$12,340
Annuity payout for Medicare set-aside	\$83,551

## WCMSA Reference Guide

(\$5,221.94/yr. for life (est. 16 years) starting 08/04/10)

Attorney fee

\$46,700

\$260,000

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

Employee: Signature

Consented to by: Signature

Legal Eagle, Esq.

Attorney for Employee

State Bar No. 5678

And by: Signature

Conrad Courageous, Esq.

Attorney for Employer/Carrier/TPA

Attest: Signature

NOTARY PUBLIC, American Samoa

My Commission Expires: March 10, 2010

## **Appendix 6: 30 – WCMSA Administration Agreement**

# **30 – WCMSA Administration Agreement**

## **ADMINISTERING YOUR STRUCTURED WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT (WCMSA)**

You have chosen to personally administer the WCMSA account established as part of a Workers' Compensation (WC) settlement, judgment, award, or other payment. It is important that you understand the Centers for Medicare & Medicaid Services' (CMS) policies regarding WCMSA accounts.

By law (Section 1862(b)(2) of the Social Security Act), Medicare is not permitted to pay for medical items or services, including prescription drug expenses, related to the workers' compensation claim until the approved WCMSA amount is appropriately exhausted ("properly spent") on related medical care that is covered and otherwise reimbursable by Medicare ("Medicare covered"). Where a workers' compensation settlement, judgment, award, or other payment is less than the approved WCMSA amount, Medicare is not permitted to pay for related medical care until the whole settlement, judgment, award, or other payment is properly spent on related medical care. The WCMSA funds must be placed in an interest-bearing account. Funds in the account may not be used for any purpose other than payment of future medical care that is Medicare covered and is related to the workers' compensation claim, or for certain allowable expenses. For details on using the account, see the WCMSA Reference Guide and the Self-Administration Toolkit at <https://go.cms.gov/wcmsa> on the CMS website.

Funds in a WCMSA account may not be used to purchase a Medicare supplemental insurance policy or a Medigap policy, or to pay for the premiums for such policies.

When a WCMSA is funded as a structured settlement (settlement monies paid out in yearly installments over a number of years), any WCMSA funds that are not used in a given year must remain in the account to pay for related medical care during later years. If available WCMSA funds for a particular year (the current year's full structured payment plus any prior year's remaining funds plus interest) have been properly spent, Medicare will pay for covered items and services that are related to the workers' compensation claim for the remainder of that year until the scheduled date for the next deposit into the WCMSA account. Bills should be paid in the order they are received to help the Benefits Coordination & Recovery Contractor (BCRC) confirm that the funds have been properly spent for that year. Medicare will pay for items and services covered by Medicare that are unrelated to the workers' compensation claim according to Medicare's payment rules.

Basic instructions for establishing and administering a WCMSA account are listed below; more thorough instructions can be found in the Self-Administration Toolkit mentioned above (<https://go.cms.gov/wcmsa>). If you have any further questions regarding these requirements, please contact the Medicare Regional Office (RO) assigned to you. You can find a list of ROs at <https://cms.gov/regionaloffices/> on the CMS web site; scroll to the Downloads section near the bottom of the page. For questions about annual attestations, contact the BCRC:

WCMSA Proposal/Final Settlement  
P.O. Box 138899  
Oklahoma City, OK 73113-889

### **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.
- WCMSA funds may only be used to pay for medical items and services and prescription drug expenses related to your workers' compensation claim that would **normally be paid by Medicare**, or for certain allowable expenses.
- If you have a question regarding Medicare's coverage of a specific item, service, or prescription drug, please call 1-800-MEDICARE (1-800-633-4227) or visit CMS' website at <https://www.medicare.gov/> where you can search for the item, service, or drug to see if it's covered.

**Note:** If funds from the WCMSA account are used to pay for services other than Medicare-allowable medical expenses related to the workers' compensation claim, Medicare will not pay injury-related claims until these funds are restored to the WCMSA account and then properly spent.

### **Record Keeping**

- You may use the WCMSA account to pay for the following costs that are directly related to the account:
  - a) Document copying charges
  - b) Mailing fees or postage
  - c) Any banking fees related to the account
  - d) Income tax on interest income from the account
- 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 the BCRC as proof of appropriate payments from the WCMSA account.
- Annually, you must sign and submit a copy of the attached attestation letter, which states that all payments from the WCMSA account were made for Medicare-covered medical and prescription drug expenses related to the workers' compensation claim, or for allowable expenses.
- An annual attestation must be submitted to the BCRC at the address listed on the first page of these instructions no later than 30 days after the end of each reporting year, which starts with the date the account is established and ends on that date in the following year.
- Funds remaining in the account at the end of a reporting year must remain in the account for the next year, along with any accrued interest.
- If your WCMSA funds are completely spent but you expect another annual deposit, send the attestation to inform Medicare that the account is temporarily exhausted. Medicare will pay for workers' compensation claim-related medical expenses until the next annual deposit.
- The annual attestation should continue through depletion of the WCMSA account.

**DO NOT SEND YOUR ANNUAL ATTESTATION DIRECTLY TO CMS. Please send your annual attestation to the BCRC.**

## WCMSA Reference Guide

Claimant: Jane Doe  
SSN: 123-45-6789  
DOI: 01/31/01, 04/13/02  
Employer: Cool Toys Manufacturing, Inc.

Claimant: Signature

Date: 11/01/08

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

Counsel Signature

Date: 11/01/08

## **Appendix 6: 35 – Medical Records**

# 35 – Medical Records

**AMERICAN SAMOA BOARD OF WORKER'S COMPENSATION**

**A. EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE**

OSHA File No.:

Carrier/TPA File No.: ABC-987654321

Employer/Address: Cool Toys Manufacturing, Inc., 22 Playful Ln, City, ST 11111

Employer Phone: (684)-555-1111

Employer FEIN: 12-3456789

Employer Location address (If Different):

Nature of Business: Manufacturing

Carrier/TPA & Address: Got U Covered, LLC, 100 Carrier Blvd, City, St 66666-3333

Carrier/TPA Phone: Phone (412) 555-1111

Carrier/TPA FEIN:

Place of Accident or Exposure: Cool Toys Manufacturing, Inc.

Occupation: Construction personnel

Employee Name (Last, First): Doe, Jane

Date of Birth: 07/03/49

Social Security Number: 123-45-6789

Address: 100 Felldown Lane, City, ST 22222-1111

Date of Injury: 01/31/01 & 04/13/02

Home phone number: 803-555-1111

Number of dependents including spouse:

Gender: Female

Time of Injury:

Time workday began:

Date Employer Notified:

Date Hired:

Did Employee work the Next Day?: No

First Date Employee Failed to Work a Full Day:

Did Employee Receive Full Pay for Date of Injury?

Hours Worked Per Day:

Hours Worked Per Week:

Number of Days Worked Per Week: 5

List Normally Scheduled Off Days: Saturday, Sunday

Wage Rate at Time of Injury or Disease:

If employee is paid hourly, on commission or piecework basis, enter average weekly amount:

If board, lodging or other advantages were furnished, enter average weekly amount:

Did Injury/Illness/Exposure Occur on Employer's Premises?: Yes

Type of Injury/Illness: 59-USING TOOL OR MACHINERY

Part of Body Affected: 25- NECK NOC

How Injury or Illness/Abnormal Health Condition Occurred. What was the employee doing just prior to accident?: SHE WAS TIGHTENING DOWN A VALVE AND FELT HER NECK

START BURNING

If Returned to Work, Give Date:

Returned at What Wage per Hour?:

If Fatal, Give Date of Death:

Treating Physician (Name and Address):

Initial Treatment:

Hospital/Treating Facility (Name and Address):

Report Prepared By (Print or Type): Johnny Q. Supervisor

Position:

Telephone Number:

Date of Report : 2/3/01

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO CARRIER/TPA IMMEDIATELY  
MAY RESULT IN PENALTY

**B. FOR USE BY CARRIER/TPA/SELF-INSURER**

Average Weekly Wage: \$700.00

Weekly Benefit: \$

Date of disability:

Date of First payment:

Compensation Paid: \$

Penalty paid: \$

Previous Medical Only: Yes ( ), No ( )

BENEFITS ARE PAYABLE FROM FOR:

( ) Total/temporary total disability

( ) Temporary partial disability

( ) Permanent partial disability of % to for weeks UNTIL WHEN THE EMPLOYEE  
ACTUALLY RETURNED TO WORK ALL OTHER SUSPENSION REQUIRE THE FILING  
OF FORM WC2 WITH THE BOARD OF WORKERS' COMPENSATION AND THE  
EMPLOYEE

By (Carrier/TPA/Self insurer: Type or Print Name of Person Filing Form or Sign): Johnny Q.  
Adjuster

Date: 02/03/01

Phone:

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime  
subject to penalties of up to \$10,000 per violation.

FORM WC-1 (REV. DATE 7/2002) EMPLOYER'S FIRST REPORT of INJURY or  
OCCUPATIONAL DISEASE

**American Samoa Regional Medical Center  
123 South Main Street  
Pago, Pago, American Samoa 54321**

PATIENT: Doe, Jane  
PT DOB: 07/03/1949

DICTATED: 07/26/2002 11:31 A  
TRANSCRIBED: 07/26/2002 14:51 P  
mq/856954

ADMITTED: 07/26/2002  
DISCHARGED:  
Jack G. Skellington, M.D.  
010006879846546/2A 211202  
58-62-48

OPERATIVE NOTE: Jack G. Skellington

DATE OF OPERATION: 07/26/2002

PREOPERATIVE DIAGNOSIS: C5, 6 cervical disk herniation

POSTOPERATIVE DIAGNOSIS: Same

SURGEON: Jack G. Skellington

ASSISTANT: Kathleen Wratchet, R.N., F.A.

OPERATION:

1. C5, 6 cervical discectomy with anterior intrabody fusion (Allograft)2. Codman slim lock anterior cervical plate stabilization

ANESTHESIA: General endotracheal

OPERATIVE INDICATIONS: The patient is a 53-year-old female who presented with cervical myelo-radiculopathy. MRI demonstrated a massive disk herniation at the C5, 6 level with signal changes in the spinal cord.

DESCRIPTION OF OPERATION: The patient was brought to the Operating Room. Preoperatively for one week before this procedure she had been on a high dose of Decadron. Immediately pre-op in the holding area she was started on the Methyl Prednisolone spinal cord injury protocol for additional steroids. She was brought to the Operating Room, underwent an awake fiber optic intubation. The patient was then positioned on the operating room table with a towel beneath her shoulders and her head in a sand bag doughnut in a neutral position exactly the way we were going to be performing the operation. Neurologic examination was documented with the patient moving both her arms and legs. After this was done she was put to sleep. I then prepped and draped the left lateral neck, a transverse incision was then made at approximately the level of the cricoid cartilage. This was carried from the midline to the medial border of the sternocleidomastoid muscle. The wound was deepened, the platysma was identified. It was divided in the direction of its fibers in an intra-fascial dissection technique and finally dividing the superficial, middle and deep cervical fascia sequentially. The pre-vertebral space was then visualized, the anterior cervical spine identified. The intraoperative x-ray localization was obtained confirming that we indeed were at the desired level. The overlaying longus colli muscles were then dissected in a subperiosteal plane along the medial border. The tooth blades of the black belt self-retaining retractor system were then anchored around the C5, 6 disk space. Casper distractor posts were placed in the middle of the C5 and C6 vertebral body. The C5, 6 disk space was then sharply incised. Anterior discectomy was carried out removing all disk

material laterally to the level of the vertebral joints and posteriorly to the level of the annulus. Cartilaginous end plates were then taken down to good bleeding sub-condylar bone. I could actually see a hole in the posterior annulus with a significant amount of disk material in the sub-ligamentous compartment. This was gently teased out with the micro-pituitary rongeur. I could actually see the posterior longitudinal ligaments through the hole now. The Collin knife was used to sharply incise both the posterior annulus and the posterior longitudinal ligament. I insured the epidural space, the ventral cord was identified. Additional disk material was removed. All marginal osteophytes were taken down. The foraminotomy was performed as needed. When I was done I did the depth cage, sized the disk space. I then took tri-cortical and iliac crest bone graft which was reconstituted and cut in the appropriate dimensions. The graft was introduced and slightly counter sunk. Posts were removed, placed in the graft in a compressive mode. Grafts were mainly checked to make sure it was secure. Satisfied, I then moved on to the stabilization portion of the procedure. Unfortunately, this patient's shoulders were in the way and even with retraction I could not get them out of the way, therefore I free handed rather than use an intraoperative x-ray localization to guide pilot hole placement. A Codman anterior cervical plate was selected to expand from C5 to C6. Two pilot holes were drilled at that level using anatomic land marks. The holes were placed in the converging configuration to create a triangulation effect resist pullout. Holes were superficially tapped and because the bone was so hard I used a soft drill to drill in screws. These were 12 mm in length and 4.5 mm in diameter. Two holes were placed at the C5, 6 level. Cams were tightened down completing the construct. It was very clear that we had a rigid construct. The wound was copiously irrigated with Bacitracin containing fluid. Hemostasis was obtained as needed with the bipolar electrocautery and thrombin soaked Gelfoam. The wound was then closed in multiple layers in an anatomic fashion. 3-0 Vicryl was used to approximate the platysma, inverted 3-0 Vicryl for the subcuticular and a running 4-0 subcuticular stitch was used to bring the skin edges together. Benzoin followed by Steri-Strips were applied to the wound edges. Dry sterile compressive dressing followed. The patient was placed in an Aspen hard cervical collar, awakened, extubated and transported to the PACU in stable condition. The Solu-Medrol will be continued postoperatively.

Cc: Jack G. Skellington

**OrthoQuest  
Office Visit**

**Name:** Jane Doe

**Birthdate:** 07/03/49

**SSN:** 123-45-6789

**Date:** 12/02/08

**Subjective:**

The patient returns today for a six-month re-evaluation and medication refill. She continues to have daily and continuous pain; at worst 8/10 and at best 4/10. The pain is severe several times a week and continues to limit her yard work, exercise, hobbies, and sleep. The pain is sharp, aching, and tingling. She has also recently been hospitalized for a myocardial infarction and is on medication. She has fully recovered from her cerebral aneurysm.

**Objective:**

On examination she is pleasant and cooperative but is obviously restricted in her cervical range of motion. Sensation is diminished in the left hand at digits four and five. Grip strength and wrist extension are pain limited. Cervical range of motion is guarded with 10° flexion extension and bilateral rotation.

**Impression:**

1. C5-6 fusion
2. Left C7 radiculopathy

**Recommendations:**

I will recommend continuing with her present medication. She has maintained her functional level with medication which allows her to continue light household chores and social activities. She displays no aberrant behavior. She continues to have significant impairment and disability.

She will follow-up in six months for evaluation.

**John Henry “Doc” Holliday M.D.**

**Board certified PMR**

**Board certified Pain Medicine**

**OrthoQuest  
Office Visit**

**Name:** Jane Doe

**Birthdate:** 07/03/49

**SSN:** 123-45-6789

**Date:** 06/02/08

**Subjective:**

The patient returns today for re-evaluation after six months. She has left arm pain that is unchanged. She has good and bad days. She is unable to tolerate strenuous activity. Medications are still effective and are lasting. She denies any adverse side effects. She is still recovering from her brain aneurysm.

**Objective:**

She still has mild facial droop. The cervical region is extremely guarded. She does have tenderness in the paraspinals. Her left arm strength is 2/5 and guarded secondary to pain.

**Impression:**

C5-6 fusion

Left C7 radiculitis

Left upper extremity paresis

Right brain aneurysm status post craniotomy

**Recommendations:**

Her condition remained stable and unchanged. She is managing on medication without adverse side effects or aberrant behavior. She is still totally disabled from her previous occupation. She will follow-up in six months for medications.

**John Henry “Doc” Holliday M.D.**

**Board certified PMR**

**Board certified Pain Medicine**

**OrthoQuest  
Office Visit**

**Name:** Jane Doe

**Birthdate:** 07/03/49

**SSN:** 123-45-6789

**Date:** 12/04/07

**HISTORY OF PRESENT ILLNESS:**

The patient returns today after her last visit in June with continued left arm pain and weakness. She has been using more Hydrocodone due to more frequent bad days. In the interim, she has had surgery for a ruptured cranial aneurysm on the right. She was in the hospital in October and is still having some arm paresis and facial droop. She is not driving at this time and is still under the surgeon's care. Her weakness in the upper extremity is back to her baseline.

**MUSCULOSKELETAL EXAM:** She has left facial droop. She has a well healed right craniotomy scar. She is ambulating normally. Cervical flexion is still extremely limited in all directions with marked guarding and tenderness. The cervical area appears unchanged.

**SKIN:** Skin is without lesions.

**NEUROLOGIC EXAM:** She still has diminished sensation in digits four and five. Her grip strength is still 5-, but she has more generalized weakness at 4 out of 5 in the more proximal arm and shoulder. Leg strength is 5 out of 5. Spurling Maneuver is still positive on the left.

**IMPRESSION:**

C5-6 fusion

Left C7 radiculitis, unchanged

New left upper extremity paresis

**RECOMMENDATIONS:**

At this time, she is somewhat still concerned about an apparent discrepancy on her disability statement, being sedentary versus total disability. I believe she is still totally disabled from her previous occupation.

**John Henry "Doc" Holliday M.D.**

**Board certified PMR**

**Board certified Pain Medicine**

**OrthoQuest  
Office Visit**

**Name:** Jane Doe

**Birthdate:** 07/03/49

**SSN:** 123-45-6789

**Date:** 06/05/07

**CHIEF COMPLAINT:** Left arm pain, left neck pain

**HISTORY OF PRESENT ILLNESS:** The patient returns today for her six-month follow up evaluation. We increased her medication dosage to the 10-milligram tablet, which has helped. The pain is now at worst an eight on a scale of ten and at best a three. She has good and bad days. She has had flares the last several days, decreased with rest. It is aggravated by over activity. She still gets numbness in the hand. She gets pins and needles and drops things. Her arm feels heavy on the left.

**REVIEW OF SYSTEMS:** She had a knee arthroscopy of the left knee for a torn cartilage.

**SOCIAL HISTORY:** She has applied for, and received, Social Security Disability Insurance.

**PHYSICAL EXAM:**

Height: 5'5"

Weight: 178 pounds

**GENERAL APPEARANCE:** Pleasant, cooperative and in no acute distress.

**CARDIOVASCULAR:** Pulse is two out of four and symmetric in the upper and lower extremities. There is no edema.

**LYMPHATIC:** There is no adenopathy.

**MUSCULOSKELETAL EXAM:** Today she is somewhat antalgic on the left with a single-point cane. Cervical flexion is limited, as is extension and rotation bilaterally. She is very guarded. There is diffuse tenderness predominantly at the left paraspinals.

**SKIN:** Skin is without lesions.

**NEUROLOGIC EXAM:** There is hypoesthesia at digits four through five on the left. Grip strength is 5- on the left. Spurlings Maneuver is positive on the left.

**IMPRESSION:**

1. C5-6 fusion
2. Left C7 radiculitis with both mild sensory and motor loss

**RECOMMENDATIONS:**

At this time, she is stable and managed on her medication. I will see her back in six months for re-evaluation and will continue her current prescriptions of Zanaflex 4 milligrams tid, Lortab 10 milligrams tid, Gabatril 4 milligrams at night and Ambien 10 milligrams at night. We will give her five refills.

**John Henry "Doc" Holliday M.D.**

**Board certified PMR**

**Board certified Pain Medicine**

**OrthoQuest  
Office Visit**

**Name:** Jane Doe

**Birthdate:** 07/03/49

**SSN:** 123-45-6789

**Date:** 12/05/06

**CHIEF COMPLAINT:**

Left arm pain and neck pain

**HISTORY OF PRESENT ILLNESS:**

The patient returns today after her last visit in June. She did well with the last injection. The pain is still daily. The Lortab is not helping as much and the pain is at best a three or four and frequently a seven on a scale of ten. She gets constant pins and needles into the fingers, weakness in the arm, and spasms occasionally at night or during the day with activity.

**SOCIAL HISTORY:**

She is on disability. She has difficulty with driving, especially because she cannot turn her head. She avoids any lifting. She has a reacher.

**PHYSICAL EXAM:**

Height: 5'5"

Weight: 178 pounds

**GENERAL APPEARANCE:** Pleasant, cooperative and in no acute distress.

**CARDIOVASCULAR:** Pulse is two out of four and symmetric in the upper and lower extremities. There is no edema.

**LYMPHATIC:** There is no adenopathy.

**MUSCULOSKELETAL EXAM:** Cervical flexion and extension are very limited at 10° and guarded. Right and left lateral flexion is 10° and guarded. There is tenderness in the paraspinals and particularly in the left C-5 through C-7 region.

**SKIN:** Skin is without lesions.

**NEUROLOGIC EXAM:** There is hypoesthesia at digits four through five on the left. Grip strength is 3- and somewhat pain limited. Coordination is normal. Spurlings Maneuver is positive for radicular symptoms in the left.

**IMPRESSION:**

1. C5-6 fusion
2. Left C7 radiculopathy with primarily sensory and some motor loss

**RECOMMENDATIONS:**

At this time we discuss a spinal cord stimulator as an option for more prolonged pain relief and less dependence on medication. I will, however, give her an opportunity to increase the Lortab 10-milligram strength for now and follow up for prn trigger point injections or epidural steroid injections. We will see her back in six months or sooner if she wants to discuss spinal cord stimulator trial.

**John Henry “Doc” Holliday M.D.**  
**Board certified PMR**  
**Board certified Pain Medicine**

**OrthoQuest  
Office Visit**

**Name:** Jane Doe

**Birthdate:** 07/03/49

**SSN:** 123-45-6789

**Date:** 06/06/06

**CHIEF COMPLAINT:**

Left arm pain and neck pain

**HISTORY OF PRESENT ILLNESS:**

The pain has been worse over the past month, more constant and more severe at an eight out of a scale of ten. She is not getting any relief. It is fairly constant. Her left arm is number. She is getting worsening pins and needles into the upper extremity. She denies any change in strength.

**SOCIAL HISTORY:** She is avoiding most activities at this time, especially since the pain has been worse this month.

**PHYSICAL EXAM:**

Height: 5'5"

Weight: 178 pounds

**GENERAL APPEARANCE:** Pleasant, cooperative and in no acute distress. She displays no abnormal pain behavior. However, she is extremely guarded with any rotation of the neck. She holds her head with a slight list to the left.

**CARDIOVASCULAR:** Pulse is two out of four and symmetric in the upper and lower extremities. There is no edema.

**LYMPHATIC:** There is no adenopathy.

**MUSCULOSKELETAL EXAM:** Gait and station are normal. Cervical flexion is 10° and extension is 15°. Right rotation is 20° and left rotation is zero. Trigger points are noted particularly in the left C-5 though C-7 traps and paraspinals.

**SKIN:** Skin is without lesions.

**NEUROLOGIC EXAM:** There is hypoesthesia at digits four and five. Grip strength is 3+ and pain limited. Reflexes are two out of four and symmetric. Spurlings Maneuver is positive.

**IMPRESSION:**

C5-6 fusion

Left C7 radiculopathy with aggravation

**RECOMMENDATIONS:**

At this time we discussed an epidural steroid injection or possibly a spinal cord stimulator trial since the epidurals haven't helped that much in the past. She opted for trying trigger point injections since that was more expedient. We will refill Lortab, Zanaflex, Neurontin and Ambien today and see her back in six months for refills and re-evaluation.

Trigger point injections were performed at the left C-6/7 paraspinals, trapezius and levator scapula, after sterile preparation of the skin with Betadine. A solution of 6 cc of 0.25 percent Bupivacaine and 40 milligrams Depo-medrol was divided between three trigger point injections. There were no complications and she had moderate relief.

**John Henry “Doc” Holliday M.D.**  
**Board certified PMR**  
**Board certified Pain Medicine**

## **Appendix 6: 40 – Payment History**

# 40 – Payment History

**Affinity Service Group, Inc.**

Claims Payment Request for: Doe, Jane

Claim Number: ABC-987654321

Date Prepared: 1/15/09

Payment Category: All

<b>Check</b>	<b>Type</b>	<b>Check Date</b>	<b>Check Payee</b>	<b>Service Date</b>	<b>Check Amount</b>
259781	Exp	01/10/09	Copy Cat, Inc.	n/a	\$33.60
165487	Exp	01/08/09	C.C & C Law	n/a	\$893.00
548632	Med	01/06/09	Orthoquest	12/02/08-12/02/08	\$72.00
165468	Rx	12/13/08	Prime Rx	n/a	\$4,500.00
876532	Med	11/24/08	Orthoquest	06/02/08-06/02/08	\$80.00
465789	Ind	05/26/08	Doe, Jane	n/a	\$445.00
445646	Ind	04/23/08	Doe, Jane	n/a	\$445.00
879769	Ind	03/27/08	Doe, Jane	n/a	\$445.00
123244	Rx	03/15/08	Prime Rx	n/a	\$3750.00
876921	Ind	02/23/08	Doe, Jane	n/a	\$445.00
346487	Med	02/18/08	Orthoquest	12/04/07-12/04/07	\$72.00
378988	Ind	01/28/08	Doe, Jane	n/a	\$445.00
421321	Rx	01/08/08	Prime Rx	n/a	\$3750.00
898997	Ind	12/23/07	Doe, Jane	n/a	\$445.00
979888	Ind	11/24/07	Doe, Jane	n/a	\$445.00
048777	Exp	11/13/07	Magnum P.I.	n/a	\$278.00
797654	Ind	10/30/07	Doe, Jane	n/a	\$445.00
668376	Ind	09/28/07	Doe, Jane	n/a	\$445.00
735153	Med	09/20/07	Orthoquest	06/05/07-06/05/07	\$80.00
123458	Ind	08/28/07	Doe, Jane	n/a	\$445.00
673677	Ind	07/23/07	Doe, Jane	n/a	\$445.00
879575	Ind	06/24/07	Doe, Jane	n/a	\$445.00
487311	Rx	06/09/07	Prime Rx	n/a	\$3750.00
365768	Ind	05/26/07	Doe, Jane	n/a	\$445.00
778792	Ind	04/29/07	Doe, Jane	n/a	\$445.00
131727	Med	04/18/07	Orthoquest	12/05/06-12/05/06	\$72.00

# WCMSA Reference Guide

Check	Type	Check Date	Check Payee	Service Date	Check Amount
114586	Ind	03/27/07	Doe, Jane	n/a	\$445.00
548763	Ind	02/24/07	Doe, Jane	n/a	\$445.00
965321	Ind	01/30/07	Doe, Jane	n/a	\$445.00
132569	Ind	12/23/06	Doe, Jane	n/a	\$445.00
154351	Med	12/11/06	Orthoquest	06/06/06-06/06/06	\$150.00
456489	Med	12/08/06	Orthoquest	06/06/06-06/06/06	\$150.00
548673	Ind	11/29/06	Doe, Jane	n/a	\$445.00
464593	Ind	10/29/06	Doe, Jane	n/a	\$445.00
356468	Ind	09/27/06	Doe, Jane	n/a	\$445.00
245487	Ind	10/29/06	Doe, Jane	n/a	\$445.00

**PRESCRIPTIONS R US PHARMACY SERVICES****Patient:** Jane Doe**Date Prepared:** 12/31/08

<b>Drug Prescription</b>	<b>Strength</b>	<b>Qty</b>	<b>DS</b>	<b>Service Date</b>	<b>Amount</b>
Zolpidem	10mg	30	30	12/4/2008	\$110.00
Tizanidine	4mg	180	30	12/4/2008	\$250.00
Hydrocodone/APAP	10/325mg	120	30	12/4/2008	\$50.00
Gabitril	4mg	30	30	12/4/2008	\$130.00
Zolpidem	10mg	30	30	11/7/2008	\$110.00
Tizanidine	4mg	180	30	11/7/2008	\$250.00
Hydrocodone/APAP	10/325mg	120	30	11/7/2008	\$50.00
Gabitril	4mg	30	30	11/7/2008	\$125.00
Zolpidem	10mg	30	30	10/2/2008	\$110.00
Tizanidine	4mg	180	30	10/2/2008	\$242.00
Hydrocodone/APAP	10/325mg	120	30	10/2/2008	\$50.00
Gabitril	4mg	30	30	10/2/2008	\$125.00
Zolpidem	10mg	30	30	09/11/2008	\$110.00
Tizanidine	4mg	180	30	09/11/2008	\$242.00
Hydrocodone/APAP	10/325mg	120	30	09/11/2008	\$50.00
Gabitril	4mg	30	30	09/11/2008	\$125.00
Zolpidem	10mg	30	30	08/15/2008	\$103.00
Tizanidine	4mg	180	30	08/15/2008	\$242.00
Hydrocodone/APAP	10/325mg	120	30	08/15/2008	\$50.00
Gabitril	4mg	30	30	08/15/2008	\$125.00

(Account transferred from old computer system on 8/13/08)

## Appendix 7. List of Previous Version Changes

Version 2.9 of this guide includes the following changes:

- To eliminate issues around Development Letter and Alert templates auto populating with individual Regional Office (RO) reviewer names and direct phone numbers, these will now display the generic “Workers’ Compensation Review Contractor (WCRC)” and the WCRC customer service number “(833) 295-3773” (Appendix 5).
- Per CMS’ request, certain references to memoranda on cms.gov have been removed.
- The CDC Life Table has been updated for 2015 (Section 10.3).
- Updates have been provided for spinal cord stimulators and Lyrica (Sections 9.4.5 and 9.4.6.2).

Version 2.8 of this guide includes the following changes:

- As required by Section 501 of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) of 2015, CMS must discontinue all Social Security Number (SSN)-based Medicare identifiers and distribute a new 11-byte Medicare Beneficiary Identifier (MBI)-based card to each Medicare beneficiary by April 2019. All fields formerly labeled as “HICN” have been relabeled as “Medicare ID” and can accept either a HICN or the new MBI.
- The link to the CDC Life Expectancy Table has been updated (Section 10.3).
- The *Verifying Jurisdiction and Calculation Method* for medical reviews has been updated (Table 9-1 and Table 9-2).

Version 2.7 of this guide includes the following changes:

The WCRC contact phone number has been updated (Section 14.0, Appendix 1 and Appendix 5 (Closeout Letter)).

Version 2.6 of this guide includes the following changes:

- Further clarified expectations of Hearings on the Merits (Section 4.1.4)
- Updated defined requirements for Spinal Cord Stimulator pricing (Section 9.4.5)
- Corrected BCRC contact numbers from previous versions
- Expanded state-specific statute guidelines (Section 9.4.5)
- Clarified total settlement calculations guidelines (Section 10.5.3)
- Added ICD-10 examples to Sample Cover Letter
- Clarified jurisdictional verification (Section 9.4.4, Step 5)
- Clarified change of submitter requirements (Sections 9.0, 10.2, and 19.4)
- Updated Re-review policy (Section 16.0)
- Added required resubmission requirements (Section 16.1)
- Updated administration recommendations (Section 17.1)
- Added MyMedicare.gov link (Section 17.6)
- Updated Off Label Medication requirements (Section 9.4.6.2)

Version 2.5 of this guide includes the following changes:

- Updates were made to reflect Non-Group Health Plan (NGHP) Ongoing Responsibility for Medicals (ORM) recovery changes. See Section 2.2.
- Guidelines for use of ICD-9 and ICD-10 codes were updated. See Sections 9.4.4 and 10.4.2.

Version 2.4 of this guide includes the following changes:

- Updates were added to accommodate Non-Group Health Plan (NGHP) Ongoing Responsibility for Medicals (ORM) recovery activities. See Section 2.2.

Version 2.3 of this guide included the following changes:

- Updated language to correspond with recent changes to letters.
- Corrected reference from 42 CFR 411.46 to Section 1862(b)(2) of the Social Security Act.
- Clarified reference to costs related to the workers' compensation claim, rather than the compensable injury.
- Clarified reference to future medical items and services as "Medicare covered and otherwise reimbursable."
- Clarified that CMS approves the WCMSA amount, not the WCMSA, upon submission of a request.
- Correspondingly, clarified language referring to submission of a proposed WCMSA amount, rather than a WCMSA proposal.
- Restated the comparison of fee-schedule vs. full-and-actual-costs pricing as the basis of pricing the proposed amount, rather than the basis of payment from an approved WCMSA account.
- Clarified attestation vs. accounting wording.
- Clarified procedural results when Medicare is not provided with information in response to a development request.
- Removed the word "form" from references to documents that are not forms.
- Added language to address schedule change for hydrocodone compounds from schedule III to schedule II. See Section 9.4.6.2.
- Changed deadline for responding to development requests for submission through the WCMSA Portal to 20 from the previous 10 days. See Sections 9.4.1 and 9.5.

Version 2.2 of this guide included the following changes:

- Added Section 4.1.4, on Hearing on the Merits of the Case
- Clarified initial submission requirements for medical records and payment records
- Miscellaneous modifications:
  - Removed reference to Drug Tables for physician-dispensed drugs
  - Combined sections on Drug Tapering and Drug Weaning
  - Added Wisconsin to the list of states with no WC fee schedules
- Added Appendix 6, List of Previous Version Changes

Version 2.1 of this guide included the following changes:

- Updated references to the Benefits Coordination & Review Contractor (BCRC) and contact information

Version 2.0 of this guide included the following changes:

- Updated web links.
- Section 1.0: Guide source materials updated to include information provided by the Workers Compensation Review Contractor (WCRC), and information from the CMS WCMSA Operating Rules. Added Section 1.1.
- Clarified title of Section 4.2 and wording of situation in which a WCMSA is not necessary because Medicare's interests are manifestly protected.
- Added sections (and subsections of these):
  - 9.4.1.1—Most Frequent Reasons for Development Requests
  - 9.4.2—WCRC Team Background and Resources Used
  - 9.4.3—WCRC Review Considerations
  - 9.4.4—Medical Review
  - 9.4.5—Medical Review Guidelines
  - 9.4.6—Pharmacy
- Added medical records guidelines link in Section 10.7.
- Expanded the acronyms section (Appendix 2); added a glossary definition for DME, and expanded the MSP definition (Appendix 3).
- Section 10.1, 2.e.: corrected jurisdiction list.
- Section 10.8: added to submission list: pay history.
- Removed Operating Rules link from Appendix 4.
- Inserted additional material from the memos per review by CMS.
- Inserted material from the Operating Rules, primarily in Section 9.4, WCRC Review.