CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

Introduction to Workers' Compensation Medicare Set-Asides (WCMSAs) Webinar

June 17, 2025

Slide 0: Introduction to Workers' Compensation Medicare Set-Asides (WCMSAs) Webinar

Welcome to the Introduction to Workers' Compensation Medicare Set-Asides Webinar.

Presentation Overview

- Background Information
- Calculations and Funding Basics
- Voluntary Submission
- Review/Approval Overview
- Set Up and Administration
- Final Thoughts
- Additional Resources
- Questions & Answers

Slide 1: Presentation Overview

The intention of this webinar is to serve as a high-level introduction to Workers' Compensation Medicare Set-Asides or WCMSAs. During this presentation we will go over the basics of WCMSAs including what they are, how they are calculated and funded, the voluntary submission and review process as well as offering helpful tips. We will also provide you with additional resources that are available to you to provide more in-depth guidance and then open the call up for questions and answers.

What Is A WCMSA?

A financial agreement to "set aside" some portion of a Workers' Compensation (WC) settlement to cover future medical expenses related to the work injury.

WCMSAs represent anything from a fraction up to the entirety of a financial agreement intended to resolve a WC claim.

Slide 2: What Is A WCMSA?

We want to start today by walking through the basics of a WCMSA. The first big question is what is a WCMSA and what is its purpose?

A WCMSA is a financial agreement to “set aside” some portion of a Workers’ Compensation (WC) settlement to cover future medical expenses including prescription drug costs related to the work injury.

WCMSAs represent anything from a fraction up to the entirety of a financial agreement intended to resolve a WC claim.

The ultimate purpose of any WCMSA is to protect Medicare's interests by ensuring that funds are available to cover future medical costs associated with a work-related injury, when a worker is or is likely to soon become a Medicare beneficiary.

How do WCMSAs fit into the "big picture" of Medicare Secondary Payer?

Under the Medicare Secondary Payer (MSP) statutory provisions found at 42 U.S.C. § 1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made" under WC.

WCMSAs help protect Medicare's interests by ensuring funds are available to cover work related injury medical costs when the worker is or is likely to soon become a Medicare beneficiary.

WCMSAs do not absolve Medicare beneficiaries of their obligation to reimburse Medicare for payments made for care prior to settlement of the claim.

Insurers/ carriers are required by law to report all situations where they are actively paying for care or have made a payment that releases medicals, to facilitate Medicare's coordination of benefits and recovery of payments. As of April 4, 2025, WCMSA information must be included in the reporting.

Slide 3: How do WCMSAs fit into the “big picture” of Medicare Secondary Payer?

Under the Medicare Secondary Payer (MSP) statutory provisions found at 42 U.S.C. § 1395y(b)(2), Medicare may not pay for a beneficiary's medical expenses when payment “has been made or can reasonably be expected to be made” under WC.

WCMSAs help protect Medicare’s interests by ensuring funds are available to cover work related injury medical costs when the worker is or is likely to soon become a Medicare beneficiary.

WCMSAs do not absolve Medicare beneficiaries of their obligation to reimburse Medicare for payments made for care prior to settlement of the claim.

Insurers/ carriers are required by law to report all situations where they are actively paying for care or have made a payment that releases medicals, to facilitate Medicare’s coordination of benefits and recovery of payments. As of April 4, 2025, WCMSA information must be included in the reporting.

A 64-year-old warehouse worker suffers a back injury on the job, resulting in a large workers' compensation settlement. Since the worker is nearing Medicare eligibility, a WCMSA is established, and a portion of the settlement is allocated to a separate account to cover future medical treatments like physical therapy and pain management related to his back injury.

Where may a WCMSA be appropriate?

Slide 4: Where may a WCMSA be appropriate?

Let’s look at a real-life example. A 64-year-old warehouse worker suffers a back injury on the job, resulting in a large workers' compensation settlement. Since the worker is nearing Medicare eligibility, a WCMSA is established, and a portion of the settlement is allocated to a separate account to cover future medical treatments like physical therapy and pain management related to his back injury.

WCMSA Calculation & Funding Basics

WCMSA calculations are based on:

- Severity of injury
- Expected future medical costs
- Worker's age
- Worker's health status

WCMSAs are generally funded in two ways:

- Lump Sum
- Structured Annuity

Slide 5: WCMSA Calculation & Funding Basics

Now that we've looked at an example, let's look at WCMSA calculation and funding basics. WCMSA calculations are handled on a case-by-case basis and the amount of the WCMSA is determined by factors like the severity of the injury, expected future medical costs, and the worker's age and health status.

There are two ways in which a WCMSA is funded: The first is lump sum and the second is a structured annuity WCMSA. We will look at these options in more detail shortly.

What if there are no future medical considerations?

A WCMSA is not necessary under the following conditions because they indicate that Medicare's interests are already protected:

- The injured individual is clearly only being compensated for medical expenses prior to the settlement; and
- There is no evidence that the individual is attempting to maximize any other aspects of the settlement (e.g., lost wages or disability portions of the settlement) to Medicare's detriment.

CMS will not issue "verification letters" stating that a WCMSA is not necessary.

Effective July 17, 2025, CMS will no longer accept or review WCMSA proposals with a zero-dollar ($0) allocation.

Slide 6: What if there are no future medical considerations?

So, what needs to be done if there are no future medical considerations?

It is important to note that a WCMSA is not necessary under the following conditions because they indicate that Medicare's interests are already protected:

- The injured individual is clearly only being compensated for medical expenses prior to the settlement; and
- There is no evidence that the individual is attempting to maximize any other aspects of the settlement (e.g., lost wages or disability portions of the settlement) to Medicare's detriment.

Also note: CMS will not issue "verification letters" stating that a WCMSA is not necessary.

Effective July 17, 2025, CMS will no longer accept or review WCMSA proposals with a zero-dollar ($0) allocation.

Now let's look at funding options in more detail.

Lump Sum WCMSA

Injured party accepts a single payment.

It is intended to pay all future medical expenses related to the work injury.

Medicare will not make any payments for the settled work-related injuries until all the funds have been completely and properly exhausted.

Is easier for beneficiaries and their representatives to monitor than structured arrangements.

Slide 7: Lump Sum WCMSA

There are two types of WCMSA funding. A lump-sum arrangement is when the injured worker accepts a single payment intended to pay for all future medical expenses and disability benefits related to the settled work-related injury.

When a WCMSA is designated as a lump-sum 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 and properly exhausted.

Generally, WCMSAs that are lump sums are easier for beneficiaries and their representatives to monitor than structured arrangements.

Structured WCMSA

- Payments are made on a defined schedule.
- Covers medical costs related to the work injury for future years.
- Initial deposit is required to cover the first surgery or procedure for each body part, and/or the first equipment replacement for each body part plus the first two years of annual payments.
- Non-used funds in a coverage year are carried over.
- If the fund is exhausted in a given annual period, Medicare will pay primary for further WC injury-related medical expenses during that period.

Slide 8: Structured WCMSA

A WCMSA can also be established as a structured arrangement, where payments are made on a defined schedule to cover expenses projected for future years.

In a structured WCMSA, an initial deposit is required to cover the first surgery or procedure for each body part, and/or replacement and the first two years of annual payments. The initial deposit, also known as seed money, is followed by subsequent annual deposits based on the anniversary of the first deposit.

If in any given coverage year, the deposited funds are not used up or exhausted, they are carried forward to the next period and added to the next annual deposit.

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.

Does Medicare need to review and approve a WCMSA?

No, there are no statutory regulations requiring WCMSA submission to Medicare for review and approval. However, submission is recommended.

- The voluntary review process guarantees Medicare will resume payments upon appropriate exhaustion of WCMSA funds. CMS cannot guarantee that non-approved determinations appropriately protect Medicare's interests, and premature exhaustion leaves beneficiaries at risk of Medicare denying claims due to potential payment burden shifting.

There are limitations to the Medicare reviews. When a WCMSA is submitted it will only be reviewed if:

- 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 agreement is expected to be greater than $250,000.00.

Slide 9: Does Medicare need to review and approve a WCMSA?

Someone 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 funded.

While there are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review, submission of a WCMSA proposal is recommended.

The voluntary review process guarantees Medicare will resume payments upon appropriate exhaustion of WCMSA funds. CMS cannot guarantee that non-approved determinations appropriately protect Medicare's interests, and premature exhaustion leaves beneficiaries at risk of Medicare denying claims due to potential payment burden shifting.

There are limitations to the Medicare reviews. When a WCMSA is submitted it will only be reviewed if:

- 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 agreement is expected to be greater than $250,000.00.

For full details on what to consider when submitting an MSA please see section 4 of the WCMSA Reference Guide.

Medicare's Voluntary WCMSA Review Process: Submission

There are two ways to submit a WCMSA for review:

Submit electronically through the Workers Compensation Medicare Set Aside Portal (WCMSAP). This is the recommended approach for efficiency.

Submit by mail

Slide 10: Medicare's Voluntary WCMSA Review Process: Submission

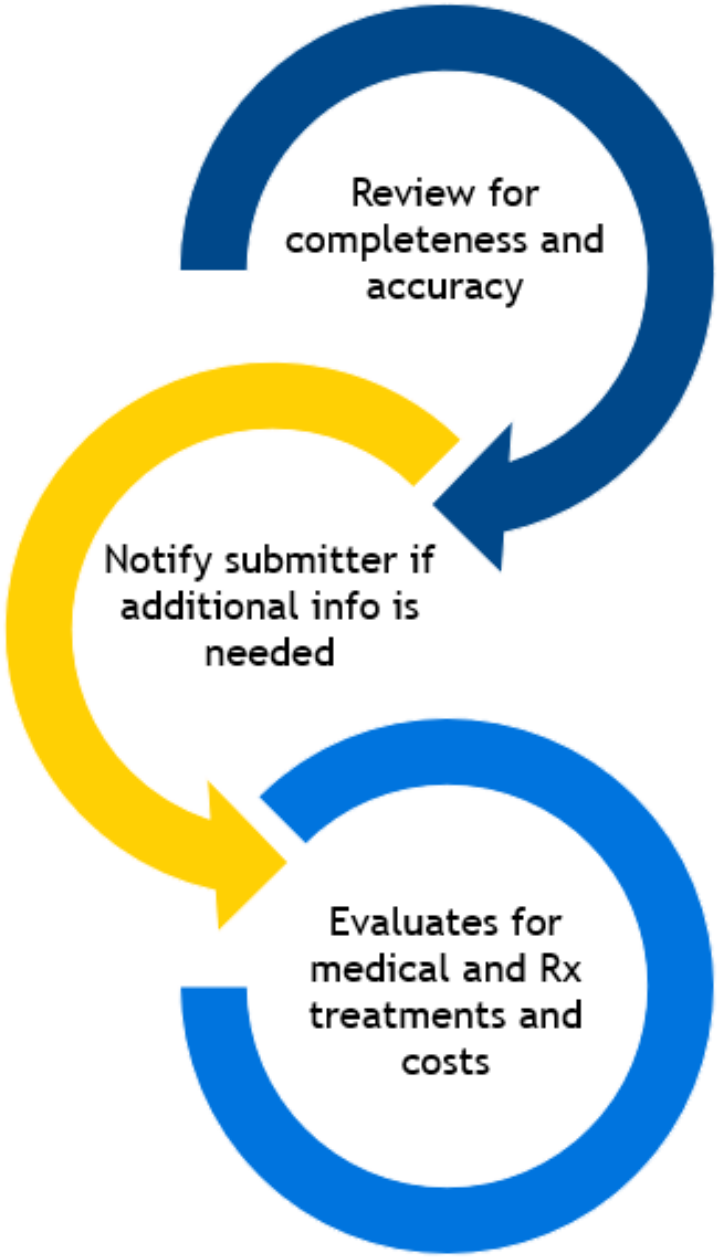
There are two ways that a voluntary WCMSA can be submitted.

The first is electronically through the WCMSA Portal (WCMSAP). 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 on the WCMSAP which acknowledges that the case was received and will receive correspondence via the WCMSAP.

The second is submission by mail, either as paper documents or as a Compact Disc (CD). When CMS (as represented by the Benefits Coordination & Recovery Center or BCRC) receives a WCMSA proposal via hard copy, it electronically scans all eligible WCMSA proposals, including all documentation received, into the CMS system used to report and track WCMSA cases. Correspondence for these cases will be sent via mail.

Using the WCMSAP for your voluntary WCMSA submission is the recommended approach as it is more efficient than mailing this information.

Medicare's Voluntary WCMSA Review Process: Workers' Compensation Review Contractor (WCRC)



Slide 11: Medicare's Voluntary WCMSA Review Process: Workers' Compensation Review Contractor (WCRC)

The Workers Compensation Review Contractor (WCRC) is the CMS contractor that is responsible for performing independent review of voluntary WCMSAs for 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.

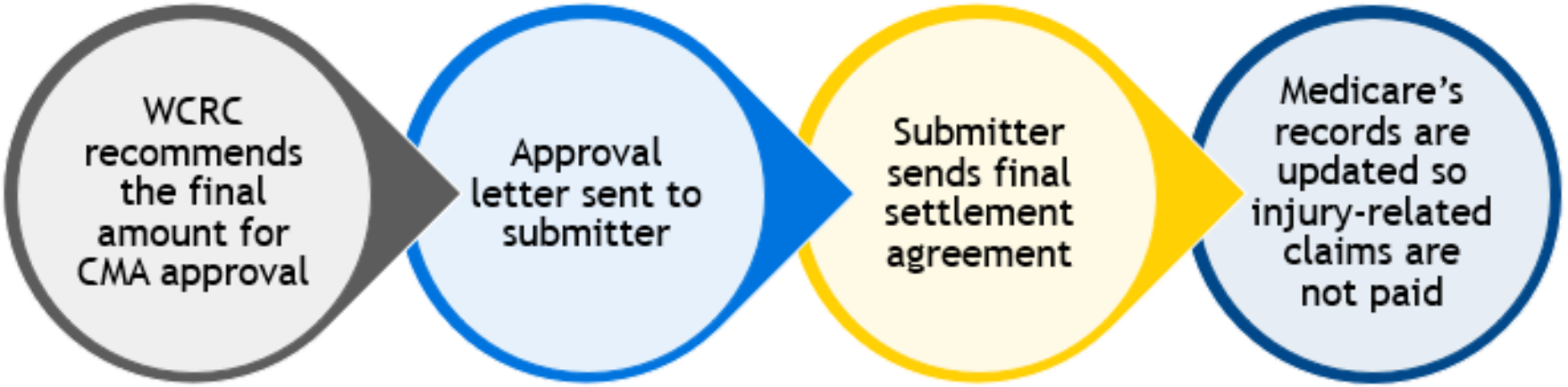
If the case was submitted via the WCMSAP, the submitter will be notified via an email alert to the address provided during the WCMSAP account setup.

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 voluntary proposal submitted. Using various evaluation tools, the WCRC evaluates the likely need for, and prices of medical treatments and prescription medications for the expected duration of the claimant's life. Note that 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 via mail, 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. The response timeframe will be based on the most recent request.

For full details on the WCRC review process please see Section 9.4 of the WCMSA Reference Guide.

Medicare's Voluntary WCMSA Review Process: Case Completion



Slide 12: Medicare's Voluntary WCMSA Review Process: Case Completion

After the WCRC review of a voluntary submission is complete the following will happen:

If the claimant is living, the case met workload review thresholds, any needed development has been received, and the case was not closed for other reasons the WCRC recommends the final WCMSA amount for CMS approval and an approval letter is issued to the submitter.

After receiving the final settlement agreement, according to the applicable jurisdiction's laws, the CMS Regional Office (RO) updates Medicare's records with the final settlement date.

Please note that when a voluntary WCMSA is submitted 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, 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.

Medicare's Voluntary WCMSA Review Process: Request for Re-Review/Amended Review

Re-Review

- Submitter believes the recommended value is the result of a mathematical error, missing documentation or other submission error.
- Limited to no more than one request by type.
- Must be submitted in the same manner the original was submitted (Mail or WCMSAP) if there is no change in submitter.

Amended Review

- Must meet the following criteria:
  - The case has not yet settled as of the date of the request for amended.
  - 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.
  - Must be delivered by mail if originally submitted by mail or via the portal or by mail if submitted originally in the portal.

Slide 13: Medicare's Voluntary WCMSA Review Process: Request for Re-Review/Amended Review

Following conditional approval submitters may, under certain circumstances, request a re-review or an amended review.

If the submitter believes the recommended value is the result of a mathematical error, missing documentation or other submission error, they may be eligible to submit a one-time (per error type) re-review request.

If a case qualifies for a re-review and there is not a change in the submitter the request should be submitted in the same manner as the original submission.

CMS will also permit a one-time request for an amended 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, consent to release information, and a summary of expected future care if certain conditions are met and this is known as an amended review. Criteria for an Amended review are:

- The case has not yet settled as of the date of the request for amended 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.

This new submission must be delivered by mail if originally submitted by mail or via the portal or by mail if submitted originally in the portal.

For more details on this topic, you can reference Section 16 of the WCMSA Reference Guide and Chapter 12 of the WCMSAP User Guide.

Voluntary Process: Helpful Tips

- Don’t 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 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.

Slide 14: Voluntary Process: Helpful Tips

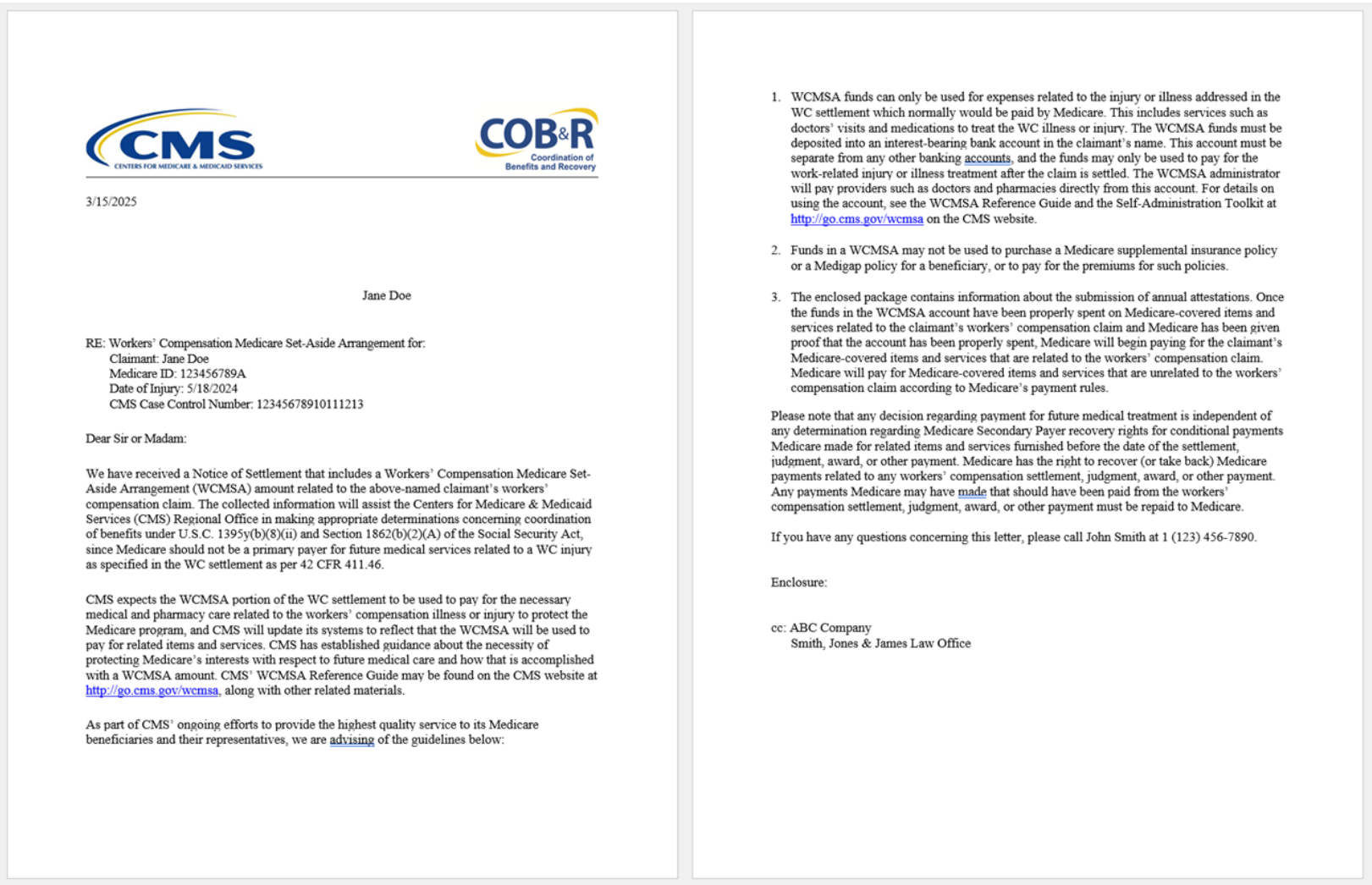
Now that we have looked at all the basics of submitting voluntary WCMSAs we would like to offer some tips to make the process go smoothly.

The number one tip is don't 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. Again, you can find full details on Thresholds in Section 8.1 of the WCMSA Reference Guide.

Notice of Settlement Letter



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

3/15/2025

Jane Doe

RE: Workers' Compensation Medicare Set-Aside Arrangement for:
Claimant: Jane Doe
Medicare ID: 123456789A
Date of Injury: 5/18/2024
CMS Case Control Number: 1234567891011213

Dear Sir or Madam:

We have received a Notice of Settlement that includes a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount related to the above-named claimant's workers' compensation claim. The collected information will assist the Centers for Medicare & Medicaid Services (CMS) Regional Office in making appropriate determinations concerning coordination of benefits under U.S.C. 1395y(b)(8)(ii) and Section 1862(b)(2)(A) of the Social Security Act, since Medicare should not be a primary payer for future medical services related to a WC injury as specified in the WC settlement as per 42 CFR 411.46.

CMS expects the WCMSA portion of the WC settlement to be used to pay for the necessary medical and pharmacy care related to the workers' compensation illness or injury to protect the Medicare program, and CMS will update its systems to reflect that the WCMSA will be used to pay for related items and services. CMS has established guidance about the necessity of protecting Medicare's interests with respect to future medical care and how that is accomplished with a WCMSA amount. CMS' WCMSA Reference Guide may be found on the CMS website at http://go.cms.gov/wcmsa, along with other related materials.

As part of CMS' ongoing efforts to provide the highest quality service to its Medicare beneficiaries and their representatives, we are advising of the guidelines below:

1. WCMSA funds can only be used for expenses related to the injury or illness addressed in the WC settlement which normally would be paid by Medicare. This includes services such as doctors' visits and medications to treat the WC illness or injury. The WCMSA funds must be deposited into an interest-bearing bank account in the claimant's name. This account must be separate from any other banking accounts, and the funds may only be used to pay for the work-related injury or illness treatment after the claim is settled. The WCMSA administrator will pay providers such as doctors and pharmacies directly from this account. For details on using the account, see the WCMSA Reference Guide and the Self-Administration Toolkit at http://go.cms.gov/wcmsa on the CMS website.

2. 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.

3. The enclosed package contains information about the submission of annual attestations. 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.

Please note that any decision regarding payment for 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 John Smith at 1 (123) 456-7890.

Enclosure:

cc: ABC Company
Smith, Jones & James Law Office

Slide 15: Notice of Settlement Letter

Throughout the process several letters may be sent to the claimant and/or submitter. Beginning in April of this year, Workers Compensation Insurance Carriers are required to report WCMSA information on all Workers' Compensation claims involving Medicare beneficiaries that report a settlement. Collection of the information is necessary to assist Medicare in making appropriate determinations concerning coordination of benefits.

This reporting may generate a new letter to claimants/beneficiaries and will CC the attorney and WC administrator if they are known at the time. This letter is known as the Notice of Settlement Letter and since it is new we wanted to mention it specifically, so people are aware of it. The letter lets the claimant know that Medicare received information about a settlement indicating that a WCMSA is present and provides them with a package of important information including information on appropriate use of funds and a blank attestation.

Note that you can find a copy of this and other letters in the WCMSA Reference Guide.

What if the claimant doesn't use Medicare's voluntary process?

As noted previously, participation in Medicare's review and approval process affords the beneficiary certain additional protection but is voluntary.

Medicare will use the information from these non-CMS-approved WCMSAs to coordinate benefits, whether provided by the claimant or the carrier via mandatory insurer reporting.

Medicare expects that these WCMSAs will follow the established procedures for the disposition of funds, including attesting to their use and appropriate exhaustion.

Slide 16: What if the claimant doesn’t use Medicare’s voluntary process?

Now let's talk about what happens if the claimant chooses not to use the voluntary submission process.

As noted previously, participation in Medicare’s review and approval process affords the beneficiary certain additional protection but is voluntary.

Medicare will use the information from these non-CMS-approved WCMSAs to coordinate benefits, whether provided by the claimant or the carrier via mandatory insurer reporting.

Medicare expects that these WCMSAs will follow the established procedures for the disposition of funds, including attesting to their use and appropriate exhaustion.

WCMSA Account Set Up/ Administration

WCMSAs can be administered by a professional WCMSA administrator (recommended) or self-administered.

All WCMSA funds (future medical treatment and future prescription drug treatment) must be deposited in an interest-bearing account.

Must be separate from any other account such as personal savings or checking.

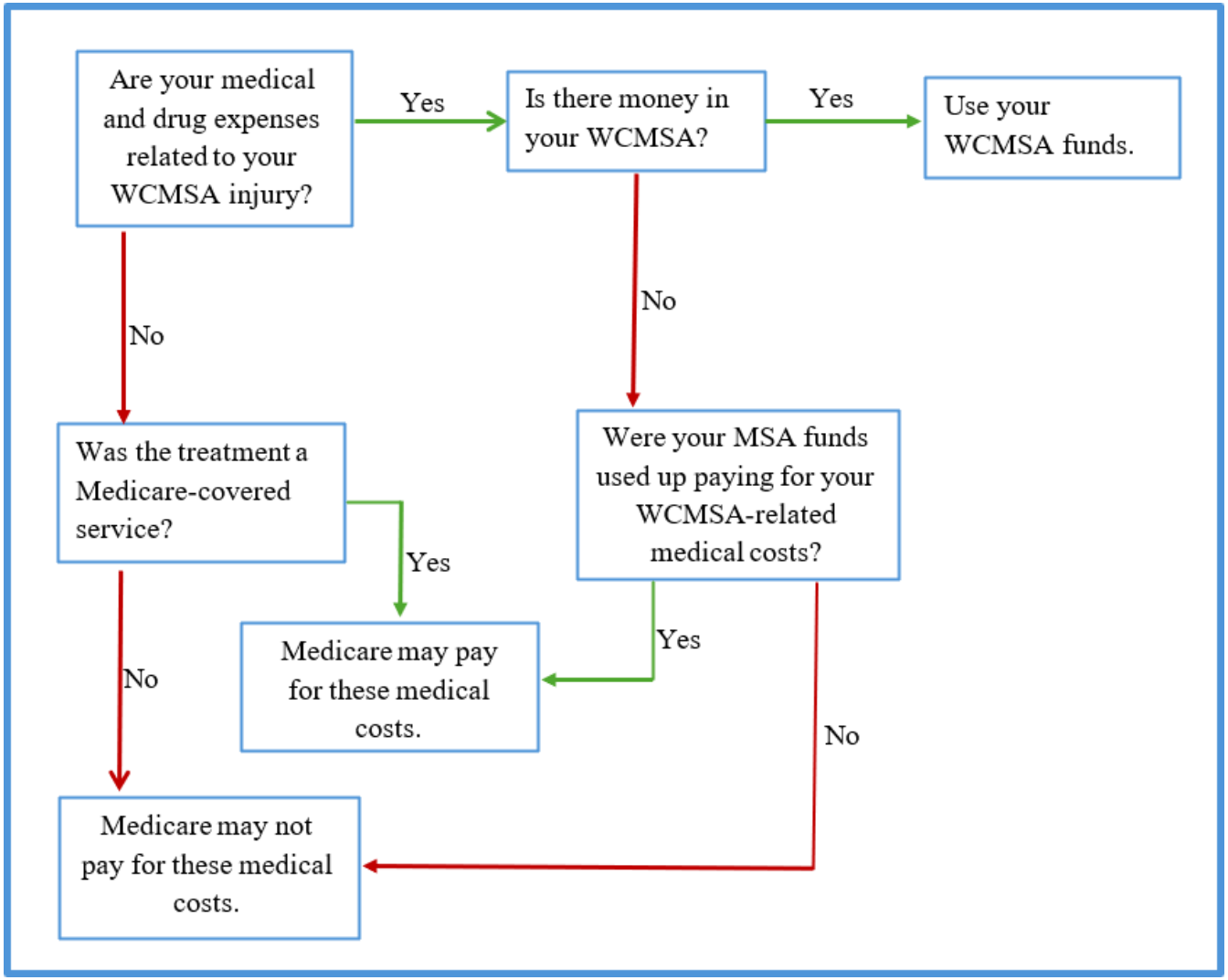
Slide 17: WCMSA Account Set Up/ Administration

WCMSAs can be administered in one of two ways: Medicare beneficiaries can choose to self-administer their CMS-approved WCMSA or have it professionally administered on their behalf.

If a Medicare beneficiary chooses to self-administer their WCMSA, it will be helpful for him/her to review the WCMSA Beneficiary Toolkit for WCMSAs available on CMS.gov. The Toolkit describes the process and guidelines for beneficiaries managing their WCMSA account and walks them through the set-up of their WCMSA through its depletion (exhaustion) and includes helpful sample letters and other documents.

The total WCMSA amount (future medical treatment and future prescription drug treatment) must be deposited in an interest-bearing account, separate from any other account such as personal savings or checking. Regardless of how the account is administered there must be close accounting to be able to demonstrate how the funds are being spent. We talk more about this in the next few slides.

Appropriate Use of WCMSA Funds



Slide 18: Appropriate Use of WCMSA Funds

It is important to understand how WCMSA funds can be used. The flow shown here will help you understand how funds can be used.

WCMSA funds may only be used to pay for medical services and prescription drug expenses related to the work injury. CMS expects that WCMSA funds be competently administered in accordance with all Medicare coverage guidelines.

WCMSA funds may only be used to pay for those expenses that would normally be paid by Medicare. For a more extensive list of services covered and not covered by Medicare, a copy of the booklet "Medicare & You" can be found on Medicare.gov.

Use of Funds Continued

Can be used for:	Cannot be used for:
Cost of copying documents	Fees for trustees, custodians, or other professionals hired to help administer the account
Mailing fees/postage	Attorney costs for establishing the MSA
Any banking fees related to the account	Medicare premiums, co-payments, and deductibles
Income tax on interest income from the account	-

Slide 19: Use of Funds Continued

In some instances, WCMSA funds can also be used for administrative fees.

Funds can be used for:

- Cost of copying related documents
- Mailing Fees/postage
- Bank fees related to the WCMSA account
- Income tax or interest income from the account

The WCMSA funds cannot be used for:

- Trustee, custodian of professional admin fees
- Attorney costs
- Medicare premiums, copays or deductibles

Annual Attestations

Every year 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 must be submitted.

This annual attestation must be submitted no later than thirty days after the end of each year.

Annual attestations should continue through depletion of the WCMSA account.

Attestations must be submitted for both lump sum and structured settlements, for both those approved through the voluntary process and those calculated using other means. If CMS first learns of a WCMSA through insurer reporting, attestation instructions will be mailed to the beneficiary.

Slide 20: Annual Attestations

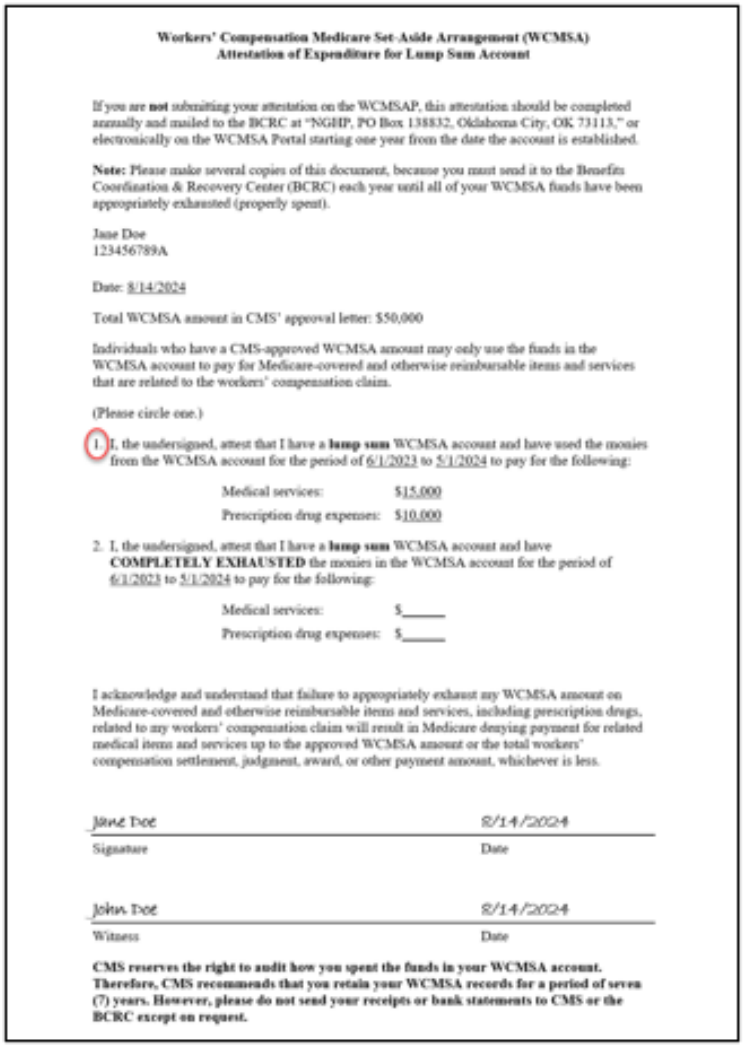
It is also important to understand record keeping and the annual attestation process.

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.

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 attestation should continue through depletion of the WCMSA account. A final attestation should also be forwarded to CMS once the WCMSA account is permanently depleted. Attestations must be submitted for both lump sum and structured settlements.

Attestation Samples



Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)
Attestation of Expenditure for Lump Sum Account

If you are **not** submitting your attestation on the WCMSAP, this attestation should be completed annually and mailed to the BCRC at "NGHP, PO Box 138832, Oklahoma City, OK 73113," or electronically on the WCMSA Portal starting one year from the date the account is established.

Note: Please make several copies of this document, because you must send it to the Benefits Coordination & Recovery Center (BCRC) each year until all of your WCMSA funds have been appropriately exhausted (properly spent).

Jane Doe
123456789A

Date: 8/14/2024

Total WCMSA amount in CMS' approval letter: $50,000

Individuals who have a CMS-approved WCMSA amount may only use the funds in the WCMSA account to pay for Medicare-covered and otherwise reimbursable items and services that are related to the workers' compensation claim.

(Please circle one.)

1. I, the undersigned, attest that I have a **lump sum** WCMSA account and have used the monies from the WCMSA account for the period of 6/1/2023 to 5/1/2024 to pay for the following:

   Medical services: $15,000
   Prescription drug expenses: $10,000

2. I, the undersigned, attest that I have a **lump sum** WCMSA account and have **COMPLETELY EXHAUSTED** the monies in the WCMSA account for the period of 6/1/2023 to 5/1/2024 to pay for the following:

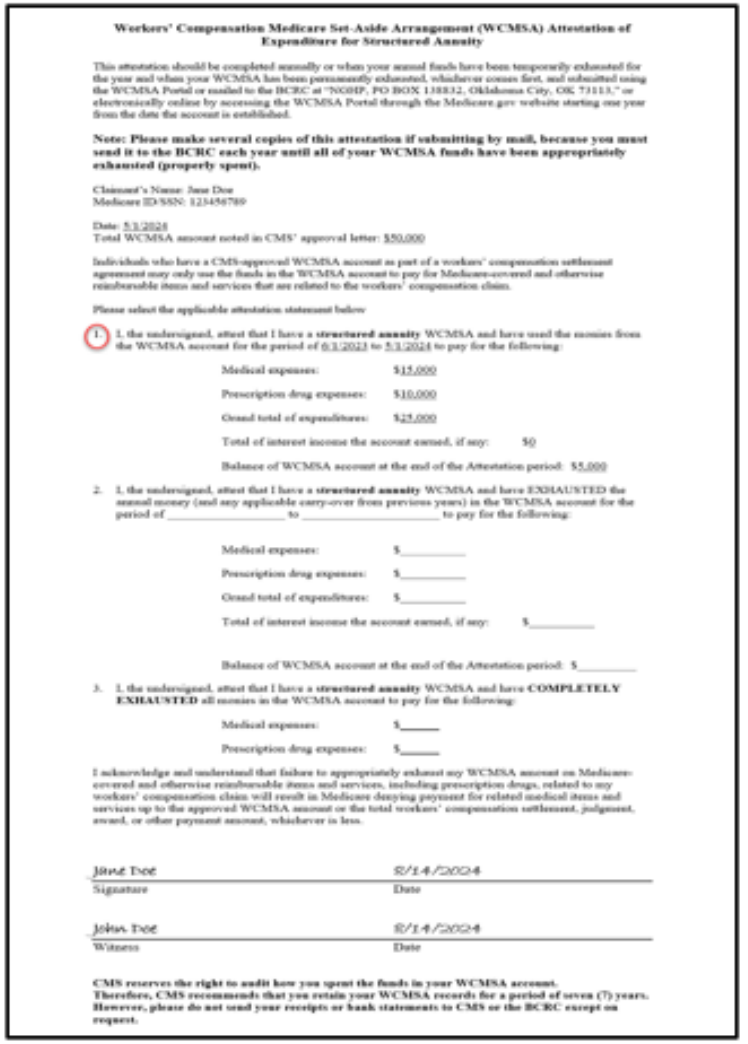
   Medical services: $_____
   Prescription drug expenses: $_____

I acknowledge and understand that failure to appropriately exhaust my WCMSA amount on Medicare-covered and otherwise reimbursable items and services, including prescription drugs, related to my workers' compensation claim will result in Medicare denying payment for related medical items and services up to the approved WCMSA amount or the total workers' compensation settlement, judgment, award, or other payment amount, whichever is less.

Jane Doe — Signature — 8/14/2024 — Date

John Doe — Witness — 8/14/2024 — Date

CMS reserves the right to audit how you spent the funds in your WCMSA account. Therefore, CMS recommends that you retain your WCMSA records for a period of seven (7) years. However, please do not send your receipts or bank statements to CMS or the BCRC except on request.



Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Attestation of Expenditure for Structured Annuity

This attestation should be completed annually or when your annual funds have been temporarily exhausted for the year and when your WCMSA has been permanently exhausted, whichever comes first, and submitted using the WCMSA Portal or mailed to the BCRC at "NGHP, PO BOX 138832, Oklahoma City, OK 73113," or electronically online by accessing the WCMSA Portal through the Medicare.gov website starting one year from the date the account is established.

Note: Please make several copies of this attestation if submitting by mail, because you must send it to the BCRC each year until all of your WCMSA funds have been appropriately exhausted (properly spent).

Claimant's Name: Jane Doe
Medicare ID/SSN: 123456789

Date: 5/1/2024
Total WCMSA amount noted in CMS' approval letter: $50,000

Individuals who have a CMS-approved WCMSA account as part of a workers' compensation settlement agreement may only use the funds in the WCMSA account to pay for Medicare-covered and otherwise reimbursable items and services that are related to the workers' compensation claim.

Please select the applicable attestation statement below:

1. I, the undersigned, attest that I have a **structured annuity** WCMSA and have used the monies from the WCMSA account for the period of 6/1/2023 to 5/1/2024 to pay for the following:

   Medical expenses: $15,000
   Prescription drug expenses: $10,000
   Grand total of expenditures: $25,000
   Total of interest income the account earned, if any: $0
   Balance of WCMSA account at the end of the Attestation period: $5,000

2. I, the undersigned, attest that I have a **structured annuity** WCMSA and have EXHAUSTED the annual money (and any applicable carry-over from previous years) in the WCMSA account for the period of _____ to _____ to pay for the following:

   Medical expenses: $_____
   Prescription drug expenses: $_____
   Grand total of expenditures: $_____
   Total of interest income the account earned, if any: $_____
   Balance of WCMSA account at the end of the Attestation period: $_____

3. I, the undersigned, attest that I have a **structured annuity** WCMSA and have **COMPLETELY EXHAUSTED** all monies in the WCMSA account to pay for the following:

   Medical expenses: $_____
   Prescription drug expenses: $_____

I acknowledge and understand that failure to appropriately exhaust my WCMSA amount on Medicare-covered and otherwise reimbursable items and services, including prescription drugs, related to my workers' compensation claim will result in Medicare denying payment for related medical items and services up to the approved WCMSA amount or the total workers' compensation settlement, judgment, award, or other payment amount, whichever is less.

Jane Doe — Signature — 8/14/2024 — Date

John Doe — Witness — 8/14/2024 — Date

CMS reserves the right to audit how you spent the funds in your WCMSA account. Therefore, CMS recommends that you retain your WCMSA records for a period of seven (7) years. However, please do not send your receipts or bank statements to CMS or the BCRC except on request.

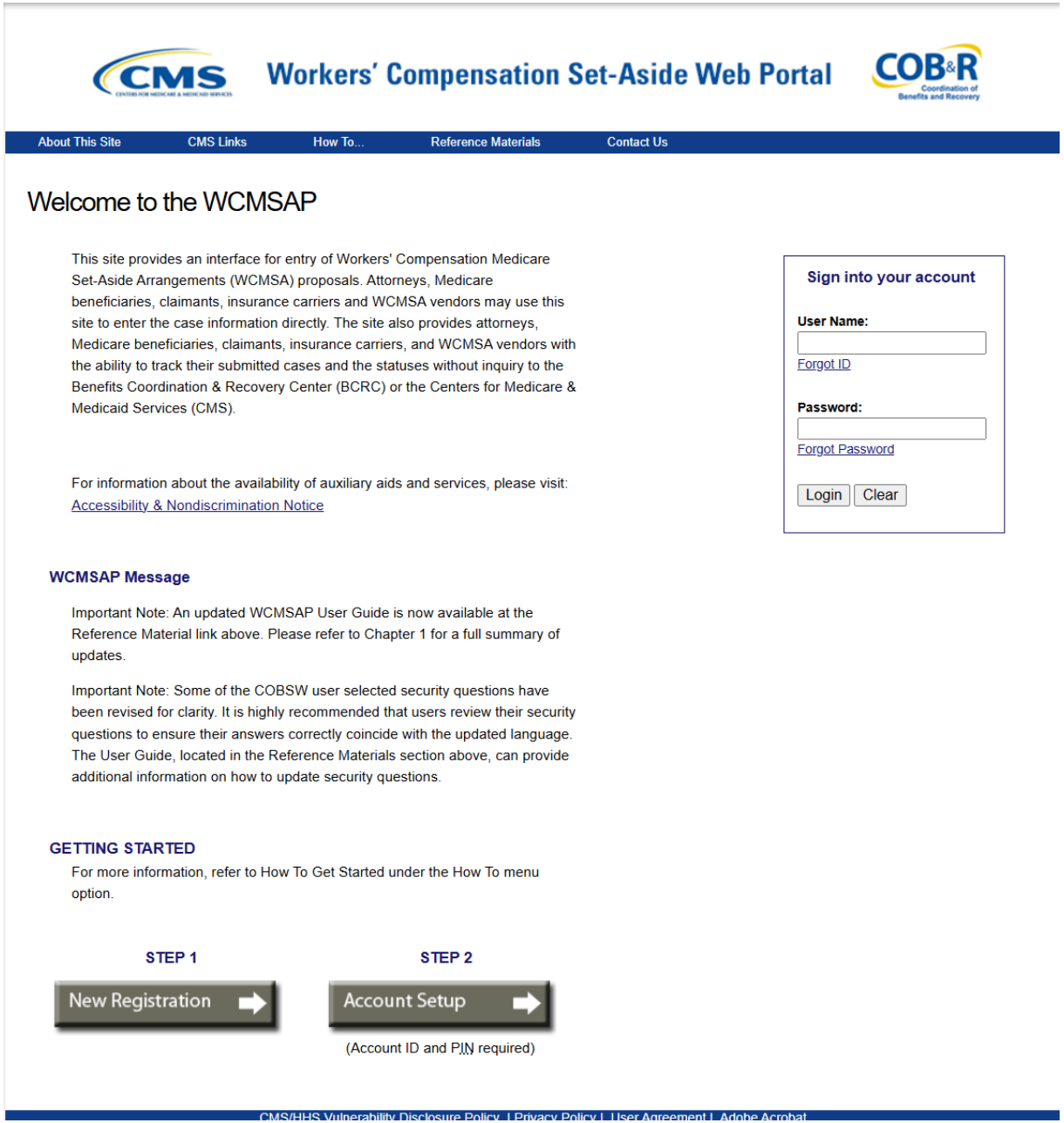
Slide 21: Attestation Samples

These are samples of the annual attestations for both lump sum and structured settlements.

Attestations can be submitted via the WCMSAP or by mail to the Benefits Coordination & Recovery Contractor (BCRC).

Samples of these letters as well as others can be found in the WCMSA Beneficiary Toolkit located on CMS.gov.

Workers' Compensation Medicare Set-Aside Portal (WCMSAP)



Slide 22: Workers' Compensation Medicare Set-Aside Portal (WCMSAP)

Before we start wrapping up, we did want to just give you a bit more information about the WCMSAP.

The WCMSAP allows electronic submission of WCMSAs. The WCMSAP is the recommended method for submitting a voluntary WCMSA for review since it is more efficient than mailing this information.

The WCMSAP provides you with the following features and related benefits:

- Enter WCMSA information and upload relevant documentation.
- Receive immediate confirmation of successful WCMSA submission.
- View WCMSA submission and status.
- Receive notification of submission issues or errors.
- Add or replace missing/incorrect documentation, as requested.
- Upload account transaction files for WCMSAs.
- Download response files for each submitted file.
- Reconcile WCMSA balances with current balance stored on the WCMSAP.
- Submit Annual Attestation information.
- Request a re-review of your WCMSA if you believe the recommended value is the result of an error.

The WCMSAP application can be accessed at: www.cob.cms.hhs.gov/WCMSA/login. For more information on how to register and to use this application, please see the WCMSAP User Manual which is available under the 'Reference Material' menu option of the WCMSAP application.

Please note that beneficiaries do not need to register for a WCMSAP account. They can access the WCMSAP through www.Medicare.gov using their established User ID and Password for that website.

There is also a full training curriculum available for the WCMSAP on CMS.gov.

Final Thoughts

Submit

- If using the voluntary process, make sure to submit complete case files with your proposal and avoid comingling documentation.
- Do not submit more than 200 pages or two years of medical records.
- Don’t resubmit previously submitted documents unless you have confirmed they were not received.

Wait

- Please allow 45 business days after the submission of a complete file before contacting the WCRC for a status update on a WCMSA submitted for approval.

Slide 23: Final Thoughts

Here are some final reminders.

If using the voluntary process be sure to submit complete case files and avoid comingling documentation. If submitting a proposal on the WCMSAP you can always reference Table 10-1 the WCMSA Document Requirements Checklist and Appendix 6: Sample Submissions of the WCMSA Reference Guide to assist you.

You should not submit more than 200 pages of information or more than two years of medical records. And don't resubmit previously submitted documents unless you have confirmed that they were not received. If you are unsure what is needed, call the WCRC.

Also please allow 45 business days after submission of a complete file before contacting the WCRC for an update.

Final Thoughts, Continued

Respond

- Respond to all requests for information regarding the case in a timely manner and with complete information.

Know

- Case statuses may be checked via the WCMSAP if you submitted using the portal, or you can contact the WCRC regarding the status of a case that was submitted via mail.

Coordinate

- Medicare uses WCMSA information to pay claims appropriately, so the claimant and carrier need to be on the same page about the WCMSA to avoid unnecessary interruptions in Medicare payments.

Slide 24: Final Thoughts, Continued

Be sure to respond to all requests for information in a timely manner and completely.

It is important to know that case statuses may be checked via the WCMSAP if you submitted using the portal, or you can contact the WCRC regarding the status of a case that was submitted via mail.

Also be sure you are coordinating with the carrier. Since Medicare uses WCMSA information to pay claims appropriately, the claimant and carrier need to be on the same page about the WCMSA to avoid unnecessary interruptions in Medicare payments.

Additional Resources

Beneficiary & Attorney Information

- Beneficiary Services
- Attorney Services

General WCMSA Information

- WCMSA Page
- Submission Page
- Self-Administration Page

WCMSA Reference Materials

- WCMSA Reference Guide
- WCMSA Beneficiary Toolkit
- WCMSA Top 10 Q&A

WCMSAP

- WCMSAP
- WCMSAP Training

Contacts

- WCRC Customer Service 1-833-295-3773
- BCRC Customer Service 1-855-798-2627

Question & Answer Session

Slide 25: Additional Resources

That concludes the presentation portion of the webinar, but we do want to remind you of other resources available to assist you. All links will be provided when this presentation is posted to CMS.gov.

For more general information for beneficiaries and attorneys you can visit the Beneficiary and Attorney Services sections on CMS.gov

For more information on WCMSA please visit the WCMSA, WCMSA Submission and the WCMSA Self-Administration pages.

Links to the WCMSAP and the training curriculum are available on the WCMSAP page.

Lastly, the WCRC can be reached at 1-833-295-3773 between 9am–5pm EST, Monday through Friday and the BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00am–8:00pm at 1-855-798-2627.