OPERATING RULES (04/22/10)

xxxxx

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1. Incorrect info.
    a. Claimant's first name, middle initial, last name, and address.
        i. If the claimant has a health insurance claim number ("HICN"), do not change these items.
    b. Gender, birth date, illness/injury date, diagnoses, state of venue. Fix only if the case is eligible. Note, COBC-entered birth date is presumptively correct and should only be changed with strong evidence xxxxx.
    c. xxxxx
    d. xxxxx
    e. Submitter's name, address, and phone. Always fix.
        i. If the submitter is a multi-name firm, use first two names followed by "ET AL."
        ii. xxxxx
    f. xxxxx
        i. xxxxx
        ii. xxxxx
        iii. xxxxx

2. Jurisdiction/Venue/Pricing state. This is the state that will control any WC hearing.
    a. In order of priority:
        i. Find the State on the settlement documents, but if the case is a Longshore and Harbor Workers' Compensation Act ("LHWCA") case, go to 2a.ii.
        ii. Use the State of jurisdictions in the submitter's proposal.
        iii. Develop for the State of jurisdiction, but only if you are developing for something else. If you do develop for this item and do not get the State of venue, make a phone call for this item before sending a closeout letter.
        iv. Make a phone call to the submitter for the State of jurisdiction. If you get voicemail or if the submitter does not know the State of jurisdiction, advise the submitter that we will use the state of the claimant's residence unless we hear from the submitter otherwise, by phone or in writing, before we complete the case. Document the phone call in the Note Log.
        v. Use the state of the claimant's residence if all else fails.
    b. xxxxx
    c. xxxxx

3. Proposed settlement date ("PSD"). The PSD is the later of:
    a. xxxxx
    b. The PSD is the later of:
        i. COBC receipt date plus 120 days xxxxx OR
        ii. xxxxx pricing date plus three months
    c. xxxxx

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

5. Medicare set-aside administrator. In order of priority, use:
    a. Blank, but only if the recommended set-aside is $0
    b. Professional administrator. This includes claimants who have signed over power of attorney to someone else, or relatives who are handling matters for the claimant but who are not official rep payees.
        i. xxxxx
        ii. xxxxx
        iii. An address must be obtained from the submitter and not any other source.
    c. Rep Payee. xxxxx
    d. Self. xxxxx

6. Rated age.
    a. Submitter statement. For all cases with COBC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), if the submitter does not supply a statement that all rated ages obtained on the claimant have been included, use actual age and **do not develop**. xxxxx
    b. Other Criteria. 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.
        i. xxxxx
        ii. xxxxx
        iii. For cases with COBC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), use actual age if there is not at least one rated age in file that meets these criteria and **do not develop**. xxxxx
    c. Median rated ages.
        i. If a submitter uses the term “median” and only supplies one rated age and it is acceptable, use it as long as Rule 6a (Submitter Statement) is met and **do not develop**. No Decision Rationale statement is necessary.
        ii. xxxxx

iii. Where there is more than one acceptable rated age, use the median.
iv. Where there is an even number of acceptable rated ages, list in order, average the middle two, and drop any decimals. Do not round.
v. If you drop a rated age and other acceptable rated ages are left, explain any new median rated age in the Decision Rationale ("The rated age from xxxxxx was not used in computing the median rated age because xxxxxxxx.").
vi. If you drop a rated age and no other acceptable rated ages are left, use actual age and xxxxx.

d. Development. Always verify claimant name, gender, date of birth, and date of issue. If any of these items are missing or wrong, xxxxx **develop** for an acceptable rated age only in these circumstances.
i. xxxxx
ii. xxxxx

e. Unsuccessful development. If the file does not contain an acceptable rated age after the development period expires, use actual age xxxxx

f. If rated ages are in file that meet all CMS requirements, use them unless the submitter has requested the use of actual age in writing. xxxxx

7. Recommendation letter.
a. xxxxx
b. xxxxx
c. xxxxx, use WCMSA rather than MSA, as MSA also means medical savings account.
d. If you disagree with the proposed medical/Rx amount, explain differences if:
i. The medical pricing total is more/less than xxxxx from the proposed medical amount. Suggested language xxxxx: "The medical set-aside should be higher/lower than proposed due to xxxxx."
ii. The Rx pricing total is more/less than xxxxx from the proposed Rx amount. Suggested language xxxxx: "The prescription drug set-aside should be higher/lower than proposed due to xxxxx."

Note: Use at least the same level of detail as the submitter. For example, if a submitter uses an incorrect CPT/NDC code, and correcting the CPT/NDC code makes a major difference, explain and state the CPT/NDC codes xxxxx.

e. xxxxx

8. Multiple WC settlements for same claimant. If the cover letter(s) are not clear on how the submitter(s) want the settlements handled, call the submitter(s) and offer the two options below xxxxx. Advise the submitter(s) that we are closing the case xxxxx until we receive letters from all submitters with a consistent choice.:
a. We will work the settlements as one case, with one injury date (the earliest in file). We will list all injuries and there will be no Medicare payments

on any WC injury as of the injury date we use, until the set-aside amount is reached. We will combine the total settlement amounts ("TSAs"), the proposed Medicare set-aside amounts ("PMSAs"), the medical proposed set-aside amounts ("MPMSAs"), and the prescription drug proposed set-aside amounts ("RxPMSAs"), and we will produce one recommended MSA ("RMSA"). This is the preferred and fastest option.

b. We will ask COBC to separate the settlements into two or more cases, with separate submissions, separate medical records, separate TSA, PMSA, MPMSA, and RxPMSA. We will treat them as two or more independent cases. This option may take additional time, and more than a month is likely. In addition, the overall recommended set-aside amount may be higher due to duplicate services for common body parts or conditions (e.g., surgeries and prescription drugs) in the independently worked cases.

9. Total settlement amount ("TSA").
    a. Include
        i. Payout amounts on all annuities, rather than cost of annuities.
        ii. Past <u>settlement</u> amounts (including advances), but not past payments of indemnity or medical expenses that were not part of settlements.
        iii. Third party liability settlement amounts for the same injury.
        iv. Liens and other amounts paid, forgiven, waived, or "to be negotiated" separately by the carrier or others, but not liens and other amounts that the claimant will pay from his settlement funds.
    b. Do not include medical malpractice settlements based on alleged mishandling of the workers' compensation injury, as those have a different date of injury and are not considered by CMS to be part of the workers' compensation case.
    c. xxxxx
    d. "Under" or "over" $X is not acceptable, xxxxx.
    e. xxxxx
    f. For any cases involving a second injury fund or a "reopener" (common in New Jersey and Oklahoma):
        i. Include any prior settlement amounts in the total settlement amount, as well as any second injury fund settlement (NJ) or "3e" settlement (OK) being made at the same time as the main injury is settling even if the submitter requests otherwise.
        ii. 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.
    g. The PMSA and/or RMSA may exceed the TSA. No special language is required in these situations.
    h. If the submitter's TSA is $20,000-25,000 for a Medicare beneficiary or $200,000-250,000 for a non-beneficiary AND there is an annuity

involved, develop if it is unclear whether the submitter's TSA uses payout amounts. xxxxx.

10. Potential "under threshold" cases:
    a. If there is a HICN, assume current Medicare entitlement and process set-aside, even if there are no entitlement dates. This is an "under threshold" case only if the total settlement amount ("TSA") is less than $25,000.01.
    b. If there are no HICN and no entitlement dates, and you have verified that the SSN is correct, assume no current Medicare entitlement. Follow the Threshold Rule, below.
        i. Exception: If the submitter alleges current Medicare entitlement and you are sending a development letter for some other reason, check the "Entitlement Information" box and ask for evidence that the claimant is currently a Medicare beneficiary.
    c. If there is no HICN but there are entitlement dates, xxxxx
    d. Threshold Rule:
        i. First, compute the TSA to the penny (that is, do not round). See Rule 9.
        ii. If the TSA is greater than $250,000.00, the case is eligible for review unless there will be no Medicare entitlement within 30 months of the proposed settlement date ("PSD"). xxxxx
        iii. If the TSA is less than $25,000.01, the case should be closed as ineligible. See Rule 11.
        iv. If the TSA is between these amounts (that is, at least $25,000.01 but not greater than $250,000.00), the case is eligible for review only if the claimant is entitled to Medicare xxxxx before the PSD.
        v. xxxxx
        vi. xxxxx

11. Ineligible cases.
    a. A case is ineligible for WCRC review for many reasons, such as Black Lung, CMS already approved, death, FELA, insufficient information, Jones Act, no longer settling, xxxxx, lien request, under threshold, withdrawal of proposal, and third-party liability insurance claims including automobile insurance, homeowners' insurance, malpractice insurance, product liability, and general casualty insurance.
        i. Even if a case has one or more of these "ineligible" aspects, it might still be eligible for WCRC review if there are settlement documents from a workers' compensation court, board, or commission in the file or where the evidence otherwise shows that a workers' compensation carrier is settling. xxxxx.
    b. xxxxx

12. Death cases.
    a. You must have the date of death in writing from a responsible party, such as submitter, attorney, carrier, or family member. Develop if death is

alleged but no date is given. xxxxx. Say, "Supply date of death." If a date of death is still not supplied in writing, send Closeout Letter and close the case as Ineligible – Insufficient Information. See Rule 11.

b. If a date of death is supplied in writing, xxxxx and close the case as "Ineligible – Death of Claimant." See Rule 11.

13. Development requests.
    a. xxxxx
    b. xxxxx
    c. xxxxx
    d. xxxxx
        i. xxxxx
        ii. xxxxx
        iii. xxxxx
    e. If a submitter calls in response to a Closeout Letter and indicates he/she never received the development letter, verify the submitter's address xxxxx, make sure the submitter understands what we still need, apologize for the problem, and indicate that the case will reopen when the requested information is received. xxxxx.
    f. Do not have the submitter send information directly to the WCRC unless:
        i. The case is a priority, and
        ii. The submitter is also sending the information to the COBC, and
        iii. xxxxx.
    g. xxxxx
    h. If you decide that requested development is no longer needed, advise the submitter xxxxx.

14. xxxxx

15. Calculation method (fee schedule or actual charges). xxxxxx As much as possible, use the calculation method proposed, with prices from the state of jurisdiction. xxxxx Use these rules, in order of priority, to determine the calculation method (and pricing):
    a. For cases involving the Longshore and Harbor Workers' Compensation Act, the only possible fee schedule is the one published by the Office of Workers' Compensation Programs ("OWCP"). Follow rules 15c – 15g in such cases to see if that fee schedule should be used. If so, use the OWCP fee schedule for the zip code of the claimant's residence.
    b. If the state does not have a fee schedule, use actual charges. xxxxx
        i. Note: If any state institutes (or changes) a fee schedule, the WCRC will apply the new fee schedule immediately upon learning of its official publication for any case not yet out the door. The effective date of the new fee schedule does not matter. For example, as soon as the WCRC learned that the Illinois fee schedule was officially published by the state, we applied it immediately for all Illinois fee schedule cases not yet out the door, even if it was

published before (or after) the effective date of 2/1/06. Similarly, we began requiring a written statement of fee schedule or actual charge calculation method at the same time for any Illinois case not yet out the door.

ii. When using actual charges, CMS prefers that we use actual charges from the state of jurisdiction. If not readily available, use actual charges from the state of residence or national prices.

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

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

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

f. If there is no response or an inadequate response from the submitter to the development letter, then process the case using actual charges xxxxx.

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

16. Payout method (lump sum or annuity). In order of priority, use:

a. The method specified in court-approved settlement documents. If it is different than the submitter's, explain in the Decision Rationale.

b. The method specified in writing by the claimant or the claimant's attorney (even if the claimant's attorney has no consent form). If the method is different than the submitter's, explain in the Decision Rationale.

c. The method stated in the submitter's cover letter, even if a different method is used by the submitter elsewhere in the file.

i. Note: A statement that the <u>type of settlement</u> is lump sum or structured can not be used as a statement of payout method for the <u>set-aside</u>.

d. If there is no payout method in the submitter's cover letter, but only one method is stated elsewhere in the file, use it.

i. "Should an annuity be used…" or "If an annuity is used…" is not a statement of payout method.

e. If a-d do not apply and there is conflicting information in file, (e.g., lump sum is stated, but seed money is also stated), develop. If the answer is still confusing, use lump sum and state in the Decision Rationale, "Clarification of the payout method was requested but not received; therefore, lump sum was used."

i. If the cover letter says lump sum and there is also a statement in file such as "Should an annuity be used…," or "If an annuity is used," then there is no conflict: use lump sum.

f. If no payout method is stated in the file, use lump sum.

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

18. xxxxx

19. xxxxx

20. xxxxx

21. xxxxx

22. Proposed set-aside amounts. For either the total proposed set-aside amount ("PMSA") or the medical services proposed set-aside amount ("MPMSA"), use these in order of priority:
    a. A settlement document signed by both parties and approved by the state.
        i. If the proposed set aside in that document is the cost of an annuity or an annual amount where the proposed life expectancy is not given anywhere in the file, do not use it.
        ii. If the submitter proposes an amount higher or lower than the set-aside amount in the signed and approved settlement document, use the court-approved amount as the proposed amount and explain in the Decision Rationale. "Although the submitter proposed a different set-aside amount, CMS is using the proposed amount from the court approved settlement agreement in file."
    b. The submitter's letter or an attachment referenced in the submitter's letter.
        i. xxxxx. If the submitter's letter is not clear, develop in writing.
        ii. xxxxx
        iii. If the submitter proposes a set-aside amount that is based on an apportionment, use whatever the submitter proposes for Medicare as the PMSA, but price the case at 100% of the future costs related to the work injury. In the Decision Rationale state, "Although the submitter proposed an apportionment in this case, CMS does not recognize any apportionments of the future medical items and services or prescription drug costs related to the work injury."
    c. If neither a nor b applies, develop in writing if the PMSA or MPMSA is not known. Do not develop for the RxPMSA, as it is always the PMSA minus the MPMSA.

d. If the submitter proposed a set-aside amount or the court-approved set-aside amount does not specify how much of the set-aside is for medical items and services and how much is for prescription drugs, assume it is all for medical items and services. Do not develop.

23. Pricing standard. Price all Medicare-covered items and services and prescription drugs that are related to the work injury and that are "reasonably probable." The following reasons are <u>not</u> acceptable for reducing a set-aside or approving a $0 set-aside:
    a. The claimant asserts he/she will not purchase Medicare Part B or Part D.
    b. The claimant asserts he/she uses other insurance.
    c. The claimant asserts he/she uses the Veterans' Administration for all health needs.
    d. The claimant asserts he/she is moving out of the country and never coming back.
    e. The claimant promises never to bill Medicare.
    f. A claimant's prescription drug is not approved by the Food and Drug Administration for a particular use (also known as "off-label use").
    g. The submitter argues that the evidence proves that the claimant has reached maximum medical improvement ("MMI").

    Note: If the claimant asserts he/she will never have a certain surgery, procedure, or drug, this is a relevant fact, which together with the claimant's age, history, and other information, should be taken into account in pricing "reasonably probable" items, services, and drugs.

24. Foreign language documents
    a. If you encounter foreign language documents that are necessary to review the case, send a development letter advising the submitter that the documents must be translated into English by a certified translation service and resubmitted in translated form with the certification.

25. xxxxx

26. xxxxx

27. Prescription drugs.
    a. Prescription drug review applies to:
        i. New cases with a COBC receipt date on or after 6/1/09.
        ii. Reopening cases (whether automatically returned to the WCRC as REOP or manually returned to the WCRC by the regional offices ("ROs")) where the scan date of the document causing the reopening is on or after 6/1/09. xxxxx.
            A) Exception: Reopenings that occur because of an obvious error will require prescription drug review only if the case

already required prescription drug review before that reopening.

iii. Apply the above rules regardless of the date of any court approved settlement documents.

b. xxxxx

c. Development. Develop in the following situations (suggested language: "Send documentation, i.e. pharmacy printout(s) or letter(s) from the treating physician(s), for all prescribed medications taken during the last two years of treatment, including name of medication, dosage, and frequency."):

i. Where there is no medical record or pharmacy printout dated within the last year showing drug use, including drug name and frequency. xxxxx.

ii. Where information on drug use, name, dosage/strength, or frequency is conflicting or unclear

d. Brand or generic. Use generic unless one of the following applies, in which case use brand:

i. No medication is in a submitter cover letter or life care plan.

ii. A brand is in the proposal and there is an indication that the claimant is actually taking the brand name drug.

iii. A generic is in the proposal, but no generic exists.

iv. A generic is in the proposal but all the evidence indicates that the claimant is taking brand.

v. The claimant or his attorney insists on brand in writing.

e. Multiple drug spellings and listings: Where multiple spellings and listings for a drug occur, use the original manufacturer of the original brand name drug where a brand is being priced. Use the lowest priced generic drug from manufacturers where a generic is being priced.

f. Manufacturers v. repackagers and distributors. Do not use any prices from repackagers or distributors. Use the lowest price from manufacturers only.

g. Packaging quantity: This is irrelevant. Use the lowest unit price for the claimant's particular dosage/strength, regardless of packaging quantity.

h. xxxxx

i. xxxxx

j. xxxxx

28. Some body parts not settling medicals

a. If the carrier will continue to pay for all injury-related medical care for the claimant, the case is ineligible for review. See Rule 11.

b. If all body parts are settling medicals, the case is eligible. xxxxxx.

c. For pricing purposes, ignore injuries related only to Second Injury Funds and settlement of injuries that have not been alleged.

d. If the agreement states that the carrier will continue to pay for some medical services but not others for the same body part, contact the submitter xxxxx and advise that CMS considers that body part as not settling for all treatments.

i. For example, we can not work a case where a submitter wants to settle medicals for a body part, but leave open prescription drugs for that same body part.
ii. xxxxx

e. xxxxx
f. xxxxx

29. xxxxx

30. xxxxx

31. Submitter change. If there are set-aside proposals in file from two different submitters, follow these procedures.
    a. If the first submitter withdrew his proposal in writing,
        i. xxxxx
        ii. xxxxx
        iii. xxxxx
        iv. xxxxx
        v. xxxxx
        vi. The case will be considered a new case as of the COBC receipt date of the most recent of:
            A) The new proposal or
            B) The letter permitting a change submitters or the withdrawal of the first submitter.
    b. If there is no withdrawal,
        i. Call both submitters xxxxx we need letter from 1st submitter naming submitter."
        ii. Close the case as "Ineligible – Other" until the first submitter submits the requested letter. xxxxx.