Top Ten WCMSA Submitter Errors and Helpful Hints to Avoid Them (February 2010)	
Error	**Helpful Hints**
1. Incomplete or insufficient **medical treatment records** for the last two years of treatment or incomplete/insufficient medical records for that period. Some examples: 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 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 xx state, 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 before that date	A. Always send all medical records from all treating physicians for the last two years of treatment for the work-related injury, even if the carrier has not paid for the treatment and even if the treatment was long ago. Remember, we need medical records for the last two years of treatment, which may not be within the last two calendar years. B**.** Independent medical evaluations are not treatment records, nor are invoices or insurance forms. C. If you believe the last two years of treatment are unrelated to the work injury, send those medical records in addition to those related to the work injury, along with any explanation you believe is necessary. D. If the claimant has not treated with any doctor for any reason within the last two calendar years, we generally need a treating physician to state when the last two years of treatment for any reason occurred, and we need those medical records, too. E. Finally, make sure 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.
2. Insufficient proof of **drugs, dosages, and frequencies** for the last two years of treatment. Some examples: 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	A. We need medical documentation (that is, legible recently-dated pharmacy printouts or statements from <u>all</u> treating physicians) that specify medication, strength/dosage, <u>and</u> frequency. B. If you believe the medications the claimant is taking are not related to the injury, send the medication information, along with any explanation you believe is necessary. C. If the claimant has used more than one pharmacy or has had more than one treating/prescribing physician, make sure all sources have been tapped for the information.

3. **Payment history** missing, undated, old, or incomplete. Some examples: a) A payment history with medical payments only, indemnity payments only, or expense payments only, with no explanation b) A payment history dated more than six months before the case is submitted or reopened c) A statement that there is no payment history attached since the claimant has not treated in the last two years	A. Send an all-inclusive payment history (that is, medical, indemnity, and expenses) dated within the last six months of submission or re-opening, showing all payments made (including payment date, payee, date of service, and amount) for at least the last two years of treatment. B. If the carrier's payment history typically does not show the run date, then a letter from the carrier or its attorney stating the run date will be needed. C. If the carrier made no payments of medical, indemnity, or expenses, and did not even set up settlement reserves for the claim, a letter from the carrier or its attorney explaining why there is no printable history will be needed.
4. **Total settlement amount** missing, unclear, or improperly computed.	A. Submit gross total settlement amount as a single lifetime number. If annuities are involved, use the lifetime payout amounts in the total instead of annuity purchase prices and include the annuity rate sheet to support your calculation. Include in the total all attorney fees, proposed set-aside amounts for medical services and/or prescription drugs, settlement payments of past medical expenses/liens, amounts for non-Medicare medicals, settlement payment of any Medicare conditional payments, amounts of previous settlements, any third party liability settlements, and amounts of any waived or forgiven liens/expenses at settlement. B. References to attachments without stating a number generally result in a development request. If you are unsure, call the Workers' Compensation Review Contractor (WCRC) for assistance in computing the number.
5. No response or insufficient response to **development requests.**	A. Make sure each item on the CMS request letter is addressed timely, especially the items printed in ALL CAPS. Specific reply language may be necessary. B. Do not resubmit prior documents unless you have confirmed that they were not received. If you are unsure what is needed, call the WCRC to see if what you are sending will be sufficient. C. Call the WCRC 2-3 weeks after sending information to make sure your document was received and is sufficient.

6. **Proposed set-aside** not clearly divided between medical and prescription drugs	A. The submitter must give a proposed lifetime (not annual) set-aside amount and should clearly show how much of that is for medical services and how much is for prescription drugs. The sample case, elsewhere on this website, gives a helpful format. B. Make sure the medical services proposed amount plus the prescription drug proposed amount adds up to the total proposed amount. C. Make sure that any pricing charts are consistent with the amounts shown in the cover letter. D. Make sure that the proposed amount is consistent with the court documents, or that any differences are explained. E. If annuities are involved, use lifetime payout amounts instead of annuity purchase prices, and include amount of proposed seed money/initial deposit.
7. **Flooding** (voluminous unnecessary/unrelated/duplicate records and documents). Some examples: a) Copies of CMS development letters and other CMS letters b) Correspondence between the claimant's medical provider and the attorney showing the effort expended to get the documents c) Invoices or subpoenas for medical records d) Notices concerning medical appointments e) Medical records of monthly visits during each of the last 15 years f) Additional copies of the same documents that were already found to be insufficient g) Court scheduling orders	A. We need the items noted in the Sample Case. You are always free to send in whatever you believe is necessary and helpful – and it will all be reviewed – but usually the initial report of injury, records relating to major surgeries, and medical records for the last two years of treatment for the work injury are the only medical records we need. B. If you are planning to send in more than 200 pages of information or more than two years of medical records, it might be helpful to call the WCRC to discuss whether it will all be needed. C. Do not resubmit prior documents unless you have confirmed that they were not received. If you are unsure what is needed, call the WCRC to see if what you are sending will be sufficient.
8. **Fee schedule** incorrectly referenced for state that does not have one	The following states do not have a fee schedule: Indiana, Iowa, Missouri, New Hampshire, New Jersey, Virginia, and Wisconsin.
9. No **rated age statement** from submitter confirming "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."	Submit rated age confirmation with original proposal documents as outlined in current procedure memorandums. The CMS will not accept any variation or substitute wording.

10. Incorrect **pricing of drugs**, e.g., using repackagers or expected tapering	Please review current procedure memorandums for further guidance on prescription drug pricing.