ADDRESSING THE SOCIAL SECURITY DISABILITY AND MEDICARE CONCERNS IN RESOLVING A PENNSYLVANIA WORKERS' COMPENSATION INJURY CLAIM

By: Thomas C. Lowry, Esquire

If a worker in PA is injured in the course of his/her employment, he/she is entitled to reasonable medical care for the treatment of the work injury as long as necessary and, if disabled from work, he/she may also be entitled to wage loss/indemnity benefits. Following the occurrence of a work injury, a workers' compensation carrier/self-insurer in PA establishes indemnity and medical treatment financial reserves based upon statistical data as to the type of injury and wage loss sustained by the injured worker/Claimant. The ultimate goal of a carrier/self-insurer is cost containment, i.e., an end to future wage loss and an end to future medical expenses. Oftentimes, this cost containment goal can be achieved through negotiations and is implemented under a Compromise and Release Agreement as provided for by Section 449 of the PA Workers' Compensation Act, as amended. This article attempts to explore how a seriously injured, workers' compensation Claimant's receipt of Social Security Disability benefits and Medicare coverage impacts upon any negotiated resolution implemented by means of a Compromise and Release Agreement, which must be approved by a Workers' Compensation Judge after a hearing.

If a workers' compensation Claimant is seriously injured, his/her attorney must be prepared to address Social Security Disability, as well as Medicare issues that may arise in any workers' compensation resolution. Therefore, it is helpful to review basic concepts to explain how they are interrelated.

Social Security Disability

Initially, it should be noted that workers' compensation disability differs from the criteria used by Social Security:

> (a). Workers' compensation disability is synonymous with a loss of earning power which results from a medical condition/injury related to a workers' employment. Davis v. WCAB (USX Corp), 567 a.2d 782 (Pa. Cmwlth. 1989);
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> (b). Social Security Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last continuous periods of not less than 12 months. See 20 CFR 404.1520 and 20 CFR 416.920 for sequential analysis (for SSD information or to apply 1-800-772-1213).

Once applied for and awarded, a workers' compensation Claimant's SSD benefits may be reduced so that the combined amount of the SSD benefits that a Claimant and his/her family receive plus workers' compensation benefits and/or public disability benefits do not exceed 80% of the average current earnings (ACE). ACE is calculated by either averaging Claimant's five highest gross earning years, or, more commonly, by taking the highest earning year and multiplying the net result by a factor

of .8 (80%). The easiest method for determining Claimant's ACE number is to find it in the lower left hand corner of the Claimant's earning statement from the Social Security Administration. Once you calculate 80% of the ACE number, subtract the monthly SSD benefits, the remaining amount is how much the disabled worker/Claimant can receive in monthly workers' compensation benefits before the offset rule is triggered. [1] Any reduction will last until age 65 (Social Security Retirement conversion) or the month that the workers' compensation benefits stop, whichever comes first.

The practical consequences of a workers' compensation resolution ending future wage loss claims/indemnity benefits is a Win:Win situation for the disabled worker/Claimant. He/she receives a lump sum amount and the monthly SSD benefits will likely increase as well. This is accomplished by prorating the lump sum over the number of months the workers' compensation would have normally been payable had the lump sum not been paid. Therefore, it is recommended that Claimant's life expectancy be utilized for proration purposes by including the appropriate language in the Compromise and Release Agreement. As the lump sum is prorated, the monthly amount subject to the potential offset is reduced thereby most likely increasing the monthly SSD benefit.

It is important to note that the net amount paid to the Claimant is used in the proration language because amounts allocated to current or future medical, legal fees or related expenses incurred are excluded from the offset calculation. This means allocating a sum for the payment of future medical (in consideration of Medicare's interest) in connection with a lump sum compensation resolution will have the favorable effect of reducing the sum prorated over Claimant's life expectancy which is subject to the offset of SSD, thereby likely increasing the amount of the SSD benefit to an injured worker/Claimant.

Medicare and Considering Medicare's Interest in a Workers' Compensation Settlement

The Medicare program was enacted into law in 1965, as a Federal Health Insurance Program designed to provide medical benefits to individuals age 65 or older. In 1972, the program was expanded to provide coverage for individuals under 65 who were awarded Social Security Disability (SSD) benefits. Immediate Medicare coverage is provided for individuals with end stage renal disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS). The Medicare secondary payer statute (MSP) is codified at 42 USC Section 1395Y, et. Seq. In addition, pertinent provisions are contained in subparts (B, C & D) are titled 42 of the code of Federal Regulations (42 C.F.R. Sections 411.20 through 411.50, et.).

The interaction of Medicare has become an increasingly important issue that must be addressed. Essentially, the underlying concept is that it is improper to cost shift the treatment of the work injury from the workers' compensation carrier/self insurer to Medicare. MSP, 42 USC Section 1394Y(b). All parties to such a transaction that improperly cost shifts future medical treatment for a work injury to Medicare are potentially liable, including the disabled worker/Claimant, his/her attorney, the carrier/self-insurer and their attorney.

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[1] Generally, workers' compensation benefits are not taxable. 26 USC Section 104 (a)(1). However, when the injured worker is receiving workers' compensation benefits and his/her Social Security Disability benefits are offset, then this offset amount (workers' compensation) becomes taxable.

The requisite starting point for any analysis is to determine when the interests of Medicare must be considered. First, if the Claimant is a current Medicare beneficiary either because of age 65 retirement or an SSD award, pre-approval must be obtained from the Center for Medicare Services (CMS) before any workers' compensation resolution is approved by a Workers' Compensation Judge. This creates an important safety net to ensure future medical coverage by Medicare for a Claimant once the Medicare set aside funds are depleted for the treatment of the work injury. It is suggested that the injured worker/Claimant be asked if he/she possesses a red, white and blue Medicare beneficiary card at the start of any negotiations.

After a disabled worker/Claimant receives SSD benefits for 24 months, he/she becomes automatically enrolled for Medicare A and eligible for B coverage. Certain disabilities such as chronic kidney disease requiring regular dialysis or transplant may qualify for Medicare immediately. The SSD decision should be reviewed to ascertain the "onset date" then count an additional 29 months (5 full months SSD waiting period plus the additional 24 months) to determine Medicare's enrollment date. Because the processing of an SSD application is time consuming and may require a hearing and decision from an Administrative Law Judge, it is important to track the time sequence based upon the alleged "onset of disability". As a practice tip to Claimant's counsel, the timing of the SSD application as well as the choice of the disability dates therein and the potential amendment of the disability date are important considerations that may afford much needed flexibility.

Secondly, even if the Claimant is not a Medicare beneficiary, pre-approval must be obtained from CMS if it is reasonably anticipated that the Claimant will become a Medicare beneficiary within 30 months **and** the total settlement exceeds $250,000.00. Pre-approval by CMS is not required if the Claimant is currently a Medicare beneficiary but the total settlement amount is less than $25,000.00. However, the parties are still obligated to consider the interest of Medicare in any resolution. (See advisory memos 4/25/2006 and 5/11/2011). In recognition of the Federal mandate contained in the Medicare Secondary Payer Act (MSP) as of January 2011, the PA Bureau of Workers' Compensation has revised its Compromise and Release Agreement not only to specifically inquire into all benefits received or available to a Claimant including Social Security (Disability or Retirement) and Medicare but also to address the interest of Medicare as follows:

No. 14	(a)	Matter in which Medicare interests have been addressed;
	(b).	Amount allocated: $_____
	(c).	Matter in which conditional payments have been addressed;

In order to successfully implement a negotiated resolution by Compromise and Release Agreement reached through an arms length negotiation between the parties, there must be a promise to cooperate and exchange important information in working towards the mutual goal of achieving a Medicare compliant Compromise and Release Agreement.

Conditional Medical Payment Inquiry

Once the attorney has ascertained that his/her client (a Medicare beneficiary) must obtain pre-approval from CMS of their Compromise and Release Agreement which will end or limit the future medical obligations of the workers' compensation carrier/self insurer, then steps must be undertaken with the joint cooperation of defense counsel which are not only time consuming but filled with pitfalls. First, an attorney must determine if past "conditional" medical payments have been made by Medicare for the treatment of the work injury that is the subject of the Compromise and Release Agreement.

A "conditional" payment is a Medicare payment for services where another payer may be responsible. These situations usually arise where the workers' compensation carrier initially denies the injury claim and does not pay for the incurred medical services but later accepts responsibility or conversely the medical provider mistakenly bills Medicare instead of the responsible workers' compensation carrier. It is advisable for an attorney to recommend to his injured worker/client to segregate, if possible, his/her work related medical treatment with specific providers separate from other physicians, such as a family physician who may treat their other non work related ailments. Essentially, Medicare has a statutory right for a "conditional payment reimbursement when a settlement or an award is made". 42 USC §1395(y)(b)(2)(b)(ii). Obtaining conditional payment information can be a time consuming process. In general, this process is initiated by notifying the coordination of benefits contractor (COBC) and providing this COBC with identifying information related to the injured worker/Claimant and the injury claim (CMS c/o Coordination of Benefits Contractor, P.O. Box 33847, Detroit, MI 48232, 1-800-999-1118, http://www.cms.hhs.gov/cobgeneralinformation/).

Once the COBC is placed on notice it in turn notifies another contractor, the Medicare Secondary Payer Recovery Contractor (MSPRC, WC, P.O. Box 33831, Detroit, MI 48232-3831, 1-866-MSPRC-20) which in turn issues a "rights and responsibilities" letter to the parties advising of Medicare's reimbursement rights. Within 65 days, a conditional payment letter (CPL) will be issued. Since a conditional payment may continue to accrue, it is often necessary to request updated information. Often times in practice the parties cannot obtain the exact reimbursable conditional payment amount until after the injury claim settles and the Compromise and Release Agreement is sent to the MSPRC which then issues CMS's "final demand" letter requesting reimbursement within 60 days. [2]

Notice and Reporting Statute

The tracking of conditional Medicare payments is also monitored by a separate means by CMS. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42 USC Section 1395(y)(b)(8). "This notice and reporting statute" directs a workers' compensation carrier/self insurer (also liability and no fault carriers) classified as a "responsible reporting entity (RREs) to determine when an injury claim involving a Medicare beneficiary needs to be reported to CMS via an Internet reporting system. There are two "reporting triggers" referred to as total payment obligations to the

[2] On June 27, 2011 CMS has issued a new revised conditional payment final demand letters presumably in response to the recent case of Haro v. Sebelius, No. CV 09-134, TCU DCV, 2011 WL 2046219 (D.Ariz., May 9, 2011.

Claimant (TPOC) and/or ongoing responsibility for medicals (ORM). Essentially, reporting is triggered when an RRE either accepts responsibility for medical payments, or settles or concludes a disputed claim such that there is an award involving a Claimant entitled to Medicare. When a trigger is met, the RRE must report the claim electronically to Medicare and submit certain required claim data information. This is a road map to track and monitor the settlement and awards to a Medicare eligible Claimant. CMS has released its mandatory insurer reporting (MIR) guidelines to implement Section 111 "Notice and Reporting" mandates. The clear threat of a civil penalty of $1,000.00 for each day of non compliance has heightened the insurance industry's awareness to scrutinize their work injury claims and to ensure that all Compromise and Release Agreements must be Medicare compliant. [3]

Medicare Set Aside Arrangement Proposal

In addition to addressing the "conditional medical payments" made by Medicare that may be reimbursable at the time of a Compromise and Release Agreement the parties through joint cooperation must submit a proposed workers' compensation Medicare set aside arrangement (MSA) to CMS for review and pre-approval. This MSA is a mechanism for recognizing Medicare's interest with respect to anticipated future Medicare covered expenses. All Medicare set aside arrangements proposals must be submitted for review and sent to CMS c/o Coordination of Benefits Contractor, P.O. Box 33849, Detroit, MI 48232-5849, Attention: WCMSA Proposal. The COBC's contractor's recommendation is then transmitted to CMS which pre-approves the requisite set aside amount. It is important to understand the purpose of the Medicare set aside amount (MSA) is to require sufficient funds be available for the payment of those future medical expenses (possibly for an injured worker/Claimant's lifetime) that would otherwise be covered by Medicare. Once such a fund is depleted, the safety net of Medicare becomes available to the Claimant who can look to Medicare to pay future work injury treatment. CMS ultimately decides what sum is adequate for the MSA. This includes deciding what medical conditions are causally related to the injury claim unless there is a judicial decision on the subject. (CMS policy memo, April 22, 2003, question 5). The creation and submission of a proposed MSA can be a daunting task especially in a litigated case where the outcome is uncertain and which may reduce or possibly end a Claimant's workers' compensation entitlement for wage loss and future medicals. It is important to realize that CMS relies heavily upon the opinions of the treating physician regardless of qualifications. Therefore, as a practice tip it is helpful for Claimant's counsel to obtain a medical note from the treating physician providing a prognosis and commenting on the need for future medical care as part of any submission of a proposed MSA. The approval by CMS provides a "safe harbor" for all parties who will not be subject to further claims for non compliance. Common medical treatment covered by Medicare includes: doctors visits; diagnostic tests; steroid injections; hospitalization; surgeries; morphine pumps; tens unit; physical therapy and prescription drugs. Common medical services not currently covered by Medicare includes: dentures; glasses; hearing aides; travel to medical appointments; custodial care; "alternative medicine" (i.e. acupuncture, aqua therapy, biofeedback, etc.).

[3] Many insurers, TPA's and self insurers are in fact utilizing the software/services of vendors who typically perform Medicare set aside analysis and obtain pre-approvals from CMS of worker's compensation settlements.

Once approval from CMS is obtained in writing (often used as an exhibit and attached to a C & R Agreement) the parties can proceed to a hearing before a workers' compensation Judge for approval of a Compromise and Release Agreement that specifies a Medicare set aside arrangement and ends future medical treatment of a work injury. Often times a Compromise and Release Agreement will provide for the injured worker/Claimant to self administer the Medicare set aside funds. Written guidelines for the self administration of a approved MSA is contained in CMS's approval letter. Essentially, Claimant may utilize a "poor man's trust" by establishing a separate interest earning checking account from which he/she will pay only for those work injuries/Medicare covered medical bills. [4]

Current and Future Trends

Because of the increasing complexity and delays in obtaining CMS's pre-approval for a workers' compensation resolution to be implemented with a Compromise and Release where the injured worker/Claimant is also a Medicare beneficiary, it is anticipated the carrier/self insurer's wishing to ensure the certainty of the transaction will more and more insist on undertaking the Medicare set aside approval process with the consent of the injured worker/Claimant. A number of vendor/organizations are actively marketing such services to the insurance industry as well as to Claimant's attorneys. Naturally, if the carrier/self insurer insist on handling the Medicare set aside pre-approval process then it is advisable that Claimant's counsel request this written analysis before agreeing to the Compromise and Release of future medical treatment. To do otherwise is to risk disappointing your client/Claimant who may envision a significant amount of the C & R settlement going into his/her pocket, only to become dissatisfied upon learning of the strings attached by a Medicare set aside proposal. Often times during active negotiations the parties will find themselves conducting an arms length negotiation where a Claimant's attorney will endeavor to inflate the value of the claim with the prospect of future medical costs only to in turn seek to cooperate in obtaining pre-approval of a proposed MSA that is both reasonable and defensible but at a lower amount. Over funding by CMS of MSAs remains a legitimate concern. For instance, CMS will likely require an MSA allocation for future surgery if surgery is mentioned in the treating physicians records, even if the injured worker/Claimant does not desire such an operation. CMS focuses its review on medical records for the last two years of treatment before the submission date of the MSA and on the cost of the treatment in that interval in making its approval decisions.

This has lead to two divergent trends, "two step shuffle" and the "one and done" approaches to Compromise and Release Agreements. First the developing trend is to negotiate a two step compromise and release process with the first compromise and release agreement ending the wage loss indemnity benefits with the Claimant, who then receives the bulk of the settlement, while the second compromise and release is held in abeyance pending CMS pre-approval. Once again, timing is important since the "curative effect" of a large sum of money paid at the time of the indemnity benefit Compromise and Release Agreement may reduce the frequency of future medical treatment since the prospect of litigation has ended. By delaying the attempt to end the future medical treatment for such an injured worker/Claimant, the carrier may ultimately benefit by approaching the Claimant for a second

[4] A helpful requirement checklist for a proposed MSA is attached hereto.

Compromise and Release of its future medical obligations, several years later when a pattern of less frequent treatment can be used as a basis to seek a lower proposed MSA. It is important for both parties to retain sufficient funds for the second Compromise and Release Agreement to offset the escalating CMS set aside amount. To avoid future misunderstandings it is important that the parties, as part of their negotiations, predetermine what occurs in the event that the CMS Medicare set aside amounts is higher than anticipated. It may also be possible that the workers' compensation carrier/self insurer will agree to cover any additional funds required by CMS for it's Medicare set aside amount.

The second approach of "one and done" involves a single full Compromise and Release Agreement with contingency language designed to provide greater flexibility in the future. This "one and done" approach involves a Compromise and Release Agreement in which the indemnity/wage loss portion of the injury claim is resolved by a specific amount and in the same document the Claimant agrees to compromise and release future medical based on contingencies. Additional language is provided so that all the parties to the Compromise and Release Agreement acknowledge that in cases where CMS approved MSA allocation is significantly higher than the allocation recommended by an MSA vendor, the carrier may have the right to negotiate with CMS on the final allocation amount before the medical portion becomes final or in the alternative, the carrier has the sole elective right to rescind the medical portion of the Compromise and Release since the CMS approved allocation amount was significantly higher than what the parties had contemplated, while acknowledging the carrier's responsibility to continue to pay for causally related medical treatment for the injured worker/Claimant's work injury. In the latter event, the interest of Medicare would be protected since the resolution of the indemnity/wage loss injury claim has the legal effect of keeping the medical portion of the injury claim left open. The attempt to resolve the future medical portion of the injury claim can be revisited at some future time. If so, it is important to also include language that both parties retain their respective rights under the PA Workers' Compensation Act so as not to preclude the filing of a Termination Petition or seeking to attain cost containment through Utilization Review challenges. It is advisable that at the time of the Compromise and Release hearing that a record be made establishing Claimant's knowledge and understanding and ultimate agreement to these possible scenarios.

This area of law remains a fast evolving and challenging one with periodic advisory memos and updates from CMS that has placed the workers' compensation practitioner in the vanguard of implementing complex settlements now that CMS has actively sought to protect Medicare's interest in liability cases and no fault motor vehicle accident claims.

Respectfully submitted,

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

Please mail or fax **only** the item(s) indicated below no later than 30 days from the date of this document. Information provided on a CD-ROM must be in PDF format and in the same order as requested below. All documents on the CD-ROM must be identified on an index. Medical records must be submitted in a logical order. Requested information may be mailed to:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 33849
Detroit, MI 48232-5849
Attention: WCMSA Proposal

The requested information may also be faxed to **646-458-6745**, however, the fax is limited to **10 pages maximum**. If you are faxing the documentation, please include the CMS Case Control Number on the bottom of each page. Please keep in mind this fax number is **NOT** for initial WCMSA submissions, only for additional documentation.

1. A cover letter must include the following information for all Medicare Set-aside arrangement proposals.

__ Claimant's Name

__ Claimant's Date of Birth

__ Claimant's Health Insurance Claim Number (HICN) 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 set-aside account

__ Claimant's Release – claimant's signed authorization for CMS, its agents and/or contractors to discuss his or her case/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 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)

__ 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 Medicare Set-aside arrangement.

__ Injury/Disease Date – the date the injury (ies) occurred.

__ Type of Injury/Disease – a brief description of the work-related injuries sustained including the ICD-9 diagnosis codes, if available.

__ Total WC Settlement Amount -including the Medicare Set-aside amount plus the amount provided for all other aspects of the settlement.

__ Proposed Medicare Set-aside Amount -proposed amount to be placed in a Set-aside arrangement for future items/services that would otherwise be paid by Medicare.

2. Documentation that must be available to CMS prior to the approval of a Medicare set-aside arrangement

__ 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/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 most recent table listed on the Centers for Disease Control website (http://www.cdc.gov/nchs/products/pubs/pubd/lftbls/life/1966.htm), unless documentation from a medical professional provides justification for an alternative projection.

__ 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. The current treatment should give an indication that the work-related condition is stable. 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). If the work-related injury occurred less than two years from the date of submission of the WC Medicare Set-aside arrangement, 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.

In addition, the summary of current treatment should be supported by a minimum of two years of prescription drug information that is related to the WC injury and/or illness/disease. Include the name of the drug, dosage, and intake regimen (i.e. 3 times a day, once a month etc.) for each drug listed.

Also, provide a comprehensive payment history from the WC Carrier as follows:

- If the injury occurred less than 2 years from the date of the submission, the prescription drug payment history should include those payments that were paid from the injury date through the date of submission.

- If the injury occurred more than 2 years from the date of the submission, the prescription drug payment history should include the last 2 years of payments for prescription drugs.

__ Future Treatment – Identify specific types of medical services/items, the frequency/duration of the medical services/items and the projected costs of the medical services/items related to the work injury/disease that are expected in the future in light of the claimant's condition. Include ICD-9 diagnosis codes if available. 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 impact the medical benefits of the settlement should be noted.

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 physician visit every 6 months with an estimated cost of $75 per visit.
- Physical therapy (PT) -12 sessions per year for only the next 3 years with estimated cost of $50 per session
- An x-ray every 3 years with an estimated cost of $100 per x-ray (including interpretation)
- An MRI every 5 years with an estimated cost of $1,500 per MRI (including interpretation)
- 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.
- 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)
- Hospitalizations @ $30,000 ($10,000 x 3)

__ Future Prescription Drug Information – Provide a list of prescription drugs related to the WC injury and/or illness/disease that the claimant will need to take in the future. Include the name of the drug, dosage, and intake regimen (i.e. 3 times a day, once a month etc.) for each drug listed that is covered by Medicare.

__ 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).

__ Total Settlement Amount – Provide the total WC settlement amount and NOT the settlement amount minus attorney fees, expenses, etc. Identify all categories of the settlement.

__ Amount for Future Medical Treatment – Identify the total amount of the WC settlement that is designated for future medical benefits (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.

__ 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 Medicare Set-aside arrangement 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 Medicare Set-aside. amount, e.g., fitness center memberships.

__ Administrator – Designate the administrator responsible for control and documentation of proper expenditures from the Medicare Set-aside 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 or a combination of both. 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, and the amount of the initial lump sum deposit.

__ Fees -One-time and recurrent administrative fees/expenses for administration of the Medicare Set-aside arrangement and/or attorney costs specifically associated with establishing the Medicare Set-aside arrangement cannot be charged to the set-aside arrangement. The payment of these costs must come from some other payment source that is completely separate from the Medicare Set-aside arrangement funds.

__ Final WC Settlement Agreement -Approval of the WC Medicare Set-aside arrangement is not final until CMS receives an executed copy of the final settlement agreement that has been approved and signed by all parties. Forward a copy of the final settlement agreement to:

CMS
c/o Coordination of Benefits Contractor

P.O. Box 33849
Detroit, MI 48232-5849
Attention: WCMSA