Workers Compensation Agency Services

- Introduction to WC
- Reporting a WC case and Obtaining Conditional Payment Information
- **Workers Compensation Medicare Set-aside Arrangements (WCMSAs)**
- Submissions of WCMSAs
- Administering WCMSAs
- WCMSA - Related Topics
- Part D of the Medicare Modernization Act & WCMSAs
- WC Data Match
- WC Agency Outreach
- Workers' Compensation Medicare Set-aside Portal (WCMSAP)

Workers Compensation Medicare Set-aside Arrangements (WCMSAs)

All parties in a Workers' Compensation (WC) case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses. The recommended method to protect Medicare's interests is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate. Once the CMS determined set aside amount is exhausted and accurately accounted for to CMS, Medicare will agree to pay primary for future Medicare covered expenses related to the WC injury.

Settlements Entered Into Prior to the July 23, 2001 ARA Letter Concerning WC Commutation of Future Benefits

(Ref: 7/23/01 Memo)

The CMS will treat WC cases that were settled prior to the issuance of the July 23, 2001 ARA letter concerning WC Commutation of Future Benefits in the same manner as those settled after the review threshold guidelines were established. This will be done regardless of when the settlement actually occurred. However, a reopening of claims (see 42 C.F.R. 405.750 and 405.841) that Medicare previously denied for these individuals will not be granted, nor will the CMS change any decisions already made with respect to settlements which pre-date July 23, 2001.

Additional Information: When the CMS issued the July 23, 2001 ARA letter, it established review thresholds for WC cases settled by injured individuals who are not yet Medicare beneficiaries. This was done in order to organize and prioritize workloads for its ROs and to convey to its ROs that it is not in Medicare's best interests to review WC settlements that do not meet the review thresholds.

CMS Review Threshold

It is not in Medicare's best interest to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. **(Ref: 7/23/01 Memo Q1(c))** A WCMSA is not necessary when resolution of the WC claim leaves the medical aspects of the claim open.

A WCMSA may be submitted to CMS for review in the following situations:

- The claimant is currently a **Medicare beneficiary** and the total settlement amount is **greater than $25,000**; **OR**
- The claimant has a reasonable expectation of Medicare enrollment **within 30 months of the settlement date** and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be **greater than $250,000**.

Computing the Total Settlement Amount

The computation of the total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses (including prescription drugs), and repayment of any Medicare conditional payments. Payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also, any previously settled portion of the WC claim must be included in computing the total settlement amount. **(Ref: 4/25/06 Memo)**

In order to determine the total settlement amount when using an annuity, please be advised that Medicare determines the value of the annuity based on how much the annuity is expected to pay over the life of the settlement, not on the Present Day Value (PDV) or cost of funding that annuity. **(Ref: 4/21/03 Q17)**

Example: A settlement is to pay $15,000 per year for the next 20 years to an individual who has a "reasonable

expectation" of Medicare enrollment within 30 months. This settlement is to be funded with an annuity that will cost $175,000. The RO will review this settlement because the total settlement to be paid is greater than $250,000 ($15,000 per year x 20 years = $300,000). It is immaterial for Medicare's purposes that the PDV or cost ($175,000) to fund this settlement is less than $250,000. **(Ref: 4/21/03 Q17)**

Current Medicare Beneficiaries

Injured individuals who are already Medicare beneficiaries must always consider Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, ALL WC PAYMENTS regardless of amount must be considered for current Medicare beneficiaries.

However, CMS no longer reviews new WCMSA proposals for Medicare beneficiaries where the total settlement amount is **$25,000 or less** (i.e., low dollar threshold Medicare beneficiaries). In order to increase efficiencies in our process, and based on available statistics, CMS instituted this workload review threshold. However, CMS wishes to stress that this is a CMS workload review threshold and not a substantive dollar or safe harbor threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensures that Medicare is secondary to WC in such cases. In other words, if the total settlement amount is **$25,000 or less**, the parties to the settlement are still required to consider Medicare's interests. The recommended method to protect Medicare's interests is to enter into a Medicare Set Aside arrangement to protect Medicare's interests, even though CMS will not review the proposal. **(Ref: 7/11/05 Memo Q1 and 2)**

Settlements Greater than $250,000 where the Claimant is Reasonably Expected to Become a Medicare Beneficiary

(Ref: 4/21/03 Memo Q2)

An individual has a reasonable expectation of Medicare enrollment if any of the following situations apply:

(a) The individual has applied for Social Security Disability Benefits;

(b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;

(c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;

(d) The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or

(e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

To the extent a WC settlement meets both of the criteria (i.e., the settlement is greater than $250,000 AND the claimant is reasonably expected to become a Medicare beneficiary within 30 months of the settlement date), then a CMS-approved Medicare set-aside arrangement is appropriate.

Review Thresholds are Subject to Adjustment

(Ref: 7/11/05 Memo Q2; 4/25/06 Memo)

Both the beneficiary and non-beneficiary review thresholds are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected. Claimants, employers, carriers, and their representatives should regularly monitor this website for changes in policies and procedures.

Group Health Plan (GHP) Insurance, Managed Care Plan, and Veterans' Administration (VA) Coverage

(Ref: 7/11/05 Memo Q8)

In a WC settlement, a WCMSA is recommended where the claimant is covered under a GHP or a managed care plan or has coverage through the VA. A WCMSA is still appropriate because such other health insurance or health service could in the future be canceled or reduced, or the injured individual may elect not to take advantage of such services. It is important to remember that workers' compensation is always primary to Medicare and many other types of health insurance coverage for expenses related to the WC claim or settlement.

When a Medicare Set-Aside is Not Recommended

(Ref: 4/21/03 Memo Q20)

A WCMSA is not recommended if **ALL** of the following apply:

(1) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement);

(2) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and,

(3) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury.

However, if Medicare made any conditional payments for work-related services furnished prior to settlement, then Medicare requires recovery of such payments. Additionally, Medicare will not pay for any services furnished prior to the date of the settlement for which it has not already paid.

The CMS Does Not Provide Verification Letters

(Ref: 5/23/03 Memo Q2)

When an injured individual's WC Settlement does not meet the current review thresholds, the Regional Offices (ROs) will not provide the settling parties with verification letters confirming that approval of a Medicare set-aside arrangement is unnecessary. The ROs will not provide "verification" letters.

Workers' Compensation Medicare Set-aside Arrangements Ethical and Legal Considerations

(Ref: 4/21/03 Memo Q12)

When an attorney's client effectively ignores Medicare's interests in a WC case, the attorney should consult their national, state, and local bar associations for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26.

Downloads
Structured WCMSAs (PDF, 29 KB) [PDF, 13KB]

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