

## **INFORMATION NEEDED TO DETERMINE MEDICARE SET-ASIDE ARRANGEMENTS**

Please submit a written request (via U.S. Mail or fax) to CMS for purpose of determining the Medicare set-aside arrangement. Send this information to: **Juanita Dixon, CMS, 61 Forsyth St., S.W., Suite 4T20, Atlanta, Georgia 30303-8909**. Your request should include the following information. If there is an area that does not apply to the claimant, simply state that it is not applicable.

### **Identifying Information**

- A. Provide the injured individual's name and address, age, telephone number, and Medicare health insurance number, the name, address and telephone number of the injured individual's representative, the name and address of the injured individual's employer, and the name and address of the WC carrier and/or its representative;
- B. Provide a written authorization from the injured individual for Medicare to release his/her personal information to you (Mandatory).

### **Introduction**

- A. Provide the reason(s) for submitting a request to Medicare;

### **Injury and Initial Treatment**

- A. Provide the date of injury or disease;
- B. Describe the injured individual's initial injury or disease;
- C. Describe any recommendations from the physician or health provider, i.e., surgery, physiological care, etc.
- D. **Diagnosis Codes relating to the injury**

### **Present Status of the Injured Individual's Health Condition**

- A. Describe the injured individual's current health condition;
- B. Describe the type of health care that the injured individual is currently receiving, i.e., home care, dialysis, etc.;
- C. Provide the classification of the injured individual's injuries (i.e., permanent, partial, permanent total disability, or a combination of both).

### **Pre-existing Conditions**

- A. Describe any pre-existing conditions before the injured individual's work-related injury or disease;
- B. Describe the current symptoms that the injured individual is experiencing.

**Future Medical Requirements**

- A. Describe any possibility of medical deterioration for the injured individual;
- B. Describe the injured individual's life care plan and provide an estimated annual care plan for the work-related injury or disease, outlining the Medicare covered expenditures and the expenditures not covered by Medicare;
- C. Describe any anticipated treatment for the injured individual including hospital care, skilled nursing facility, etc.;
- D. Provide documentation giving the bases for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

**Life Expectancy Issues**

- A. Provide a copy of the injured individual estimated life care plan including the estimated life span or
- B. Provide "rated age" determination from life insurance companies for injuries/illnesses sustained by others in similar situations.

**Settlement Funds**

- A. Provide a copy of the proposed settlement agreement (including a projected timeframe of the anticipated settlement) or post settlement agreement. Provide an allocation between the injured individual's income, replacement, loss of limb or function, and the medical bills, if not specified in the agreement;
- B. Outline the non-Medicare covered medical expenses;
- C. Outline the Medicare covered expenses for set-aside arrangement or the proposed set-aside arrangement;
- D. Provide the present day value of the settlement;
- E. Provide the attorney's fees and legal costs to be deducted from the settlement;
- F. Specify whether the settlement is based on a WC lump sum settlement with commutations of future benefits or a compromise between the WC carrier and the injured individual.

**Proposed Consideration of Medicare's Interest**

- A. Provide the name, address, and telephone number of the Administrator of Trust for the set-aside arrangement;
- B. Provide the administrative fees to be charged to the Medicare Set-Aside Arrangement (Please specify whether the arrangement is based on the WC fee schedule or the full actual charge amounts.)
- C. Specify if WCSAA is indexed to account for inflation

- Attorneys can get more information regarding their reporting responsibilities on the Coordination Of Benefits (COB) web site  
[http://hcfa.gov/medicare/cob/attorneys/att\\_wc.htm](http://hcfa.gov/medicare/cob/attorneys/att_wc.htm) (exhibit attached)
  
- Attorneys can get more information on what they need to submit to the RO for review of their set aside amounts on CMS web site  
<http://hcfa.gov/medicare/mspmain.htm> (this site provides attorneys with the July 2001 memorandum Q&As (exhibit attached) CMS is preparing to put additional Q&As on this web site

# Medicare Secondary Payer



Please visit our new website at <http://cms.hhs.gov> for the latest, most accurate information from the Centers for Medicare & Medicaid Services

[Search](#)

[Medicare](#) [Medicaid](#) [SCHIP](#) [What's New](#) [Site Index](#)

## Medicare Secondary Payer

- [Workers' Compensation: Commutation of Future Benefits \(Rich Text or Adobe PDF\) July, 2001](#)
- [Frequently Asked Questions \(under development\)](#)

Questions about the information on this page should be directed to [MSPIquiry@cms.hhs.gov](mailto:MSPIquiry@cms.hhs.gov).

*Note:* This page includes links to specialized data and multimedia files. Viewing these files requires the use of a third-party plug-in or viewer. For more information or to test whether your computer can read these files, visit our [File Formats and Plug-Ins](#) page.

HCFA is in the process of updating its website for greater accessibility. If you are unfamiliar with any of the formats we are now using, please view the [File Formats and Plug-Ins](#) page for further information.

[Medicare.gov](#) | [Department of Health and Human Services](#) | [NMEP](#)

[Home](#) | [Privacy & Security](#) | [Feedback](#) | [Help](#) | [Website Accessibility](#)



**§ 411.37 Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.**

(a) *Recovery against the party that received payment*—(1) *General rule.* Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if—

(1) Procurement costs are incurred because the claim is disputed; and

(ii) Those costs are borne by the party against which HCFA seeks to recover.

(2) *Special rule.* If HCFA must file suit because the party that received payment opposes HCFA's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) *Recovery against the third party payer.* If HCFA seeks recovery from the third party payer, in accordance with § 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) *Medicare payments are less than the judgment or settlement amount.* If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) *Medicare payments equal or exceed the judgment or settlement amount.* If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) *HCFA incurs procurement costs because of opposition to its recovery.* If HCFA must bring suit against the party that received payment because that party opposes HCFA's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

**Subpart C—Limitations on Medicare Payment for Services Covered under Workers' Compensation**

**§ 411.40 General provisions.**

(a) *Definition.* "Workers' compensation plan of the United States" includes the workers' compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees' Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

(b) *Limitations on Medicare payment.* (1) Medicare does not pay for any services for which—

(i) Payment has been made, or can reasonably be expected to be made promptly under a workers' compensation law or plan of the United States or a state; or

(ii) Payment could be made under the Federal Black Lung Program, but is precluded solely because the provider of the services has failed to secure, from the Department of Labor, a provider number to include in the claim.

(2) If the payment for a service may not be made under workers' compensation because the service is furnished by a source not authorized to provide that service under the particular workers' compensation program, Medicare pays for the service if it is a covered service.

(3) Medicare makes secondary payments in accordance with § 411.32 and § 411.33.

**§ 411.43 Beneficiary's responsibility with respect to workers' compensation.**

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation.

(b) Except as specified in § 411.45(a), Medicare does not pay until the beneficiary has exhausted his or her remedies under workers' compensation.

(c) Except as specified in § 411.45(b), Medicare does not pay for services that



## Medicare's authority to review

- **The law:** Sec 1862(b)(2) prohibits Medicare payment to the extent WC has paid.
- Sec1862(b)(5)(D) and (b)(6) require that CMS and its providers and suppliers ask beneficiaries about payers that may be primary to Medicare.
- **The regs:** 42 CFR 411.46 prohibits Medicare payment when a WC settlement includes payment for future medical expenses.

Attorney Services - Workers' Compensation

Please visit our new website at <http://cms.hhs.gov> for the latest, most accurate information from the Centers for Medicare & Medicaid Services

Search



Medicare      Medicaid      SCHIP      What's New      Site Index

Beneficiaries  
and  
Advocates

Providers

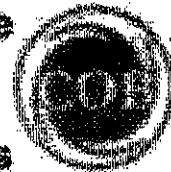
Employers

Attorneys

Medicare  
Secondary  
Payer and  
You

## Workers' Compensation

Medicare  
Coordination  
of  
Benefits



Payment under Medicare may not be made for any item or service when payment has been made or can reasonably be expected to be made for such item or service under a workers' compensation (WC) law or plan of the United States or any state. If it is determined that Medicare has paid for items or services that can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

Newsletters

If payment for services cannot be made by a WC plan because they were furnished by a source not authorized by WC, Medicare can pay for such services.

Fact Sheets

Glossary

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., filing a claim in a timely manner, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

Disclaimer

Contact Us

If it is determined that the liability or no-fault insurer will not pay "promptly" (within 120 days), Medicare may make a conditional payment. However, when the proceeds from the no-fault or liability settlement become available, Medicare has priority right of recovery. Medicare may also make a conditional payment of a claim provided the beneficiary because of incapacity failed to file a proper claim.

If a provider/supplier chooses to bill Medicare after the 120-day period, they must withdraw claims against the insurer and any liens placed on the beneficiary's settlement. If they choose to continue their claim against the insurance settlement, they may not also bill Medicare.

All workers' compensation cases that involve a Medicare beneficiary must be reported to the COB Contractor. When calling to report a new case, please be sure to have the following information available:

Beneficiary's Health Insurance Claim Number

Date of the accident/incident

## Attorney Services - Workers' Compensation

Page 2 of 2

Description of illness/injury

Name, address of the workers' compensation insurance carrier

Name, address of the legal representative

Once this information is received, COB will apply it to your client's Medicare record, assign the case to a Medicare contractor, and inform you and your client of the applicability of the MSP program and Medicare's recovery rights. You will receive a notice advising you of the Medicare contractor assigned to handle the specifics of the case to recovery, Medicare's right of recovery, and a beneficiary consent to release form. Once this process is completed, all further inquiries must be made through the assigned Medicare contractor. Please note that Medicare's interest cannot be determined until the beneficiary's record has been annotated with the specifics of the case.

Medicare regulations make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the workers' compensation carrier and the injured individual. The "Workers' Compensation: Commutation of Future Benefits" letter (in Rich Text or Adobe PDF) will answer some of the questions you may have regarding this policy.

If you would like to report a workers' compensation case or have a general workers' compensation question, please contact the COB Contractor by phone or mail. Customer Service Representatives are available to provide you with quality service Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays. The COB Contractor's toll-free number is 1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired. The mailing address for written inquiries is:

Medicare - Coordination of Benefits  
P.O. Box 5041  
New York, New York 10274-5041

[COB Home](#) | [Top of Page](#) |  
[Attorney Services Welcome](#) | [Attorney Services](#)

[Medicare.gov](#) | [Department of Health and Human Services](#) | [NMEP](#)  
[Home](#) | [Privacy & Security](#) | [Feedback](#) | [Help](#) | [Website Accessibility](#)

