No Medicare Payments for a Claimant's Work-Related Injury or Disease until the WCMSA has been Exhausted

(Ref: 7/23/01 Memo)

The purpose of a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is to pay for all services related to the claimant's work related injury or disease, therefore, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the WCMSA. These arrangements are established in order to pay for **all** medical expenses resulting from work-related injuries or diseases; they are not designated to simply pay portions of medical expenses for work-related injuries or diseases. When WCMSAs are designated as lump sum commutations (i.e., the WCMSA is designated in a manner that the WC settlement is paid into the arrangement all at once), Medicare would not make any payments for the claimant's medical expenses (for work-related injuries or diseases) until all the funds (including interest) within the WCMSA have been completely exhausted. These same basic principles also apply to structured settlements.

Generally, WCMSAs that are lump sums (i.e., the WCMSA is funded by the WC settlement all at once) present less of a problem to monitor than structured arrangements. Medicare would not make any payments for claimants that possess lump sum arrangements until all of the funds within the arrangement have been depleted. For example, if a set-aside arrangement were established for $90,000, Medicare would not make any payments until the entire $90,000 (plus interest, if applicable) were exhausted on the claimant's medical care (for Medicare covered services only).

No Compromise of Future Medical Expenses

(Ref: 7/11/05 Memo Q11)

The CMS does not compromise or reduce future medical expenses related to a WC injury. Some submitters have argued that 42 C.F.R. §411.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a WC injury.

In addition, CMS has no process to accept up-front cash payments in lieu of a CMS reviewed WCMSA.

Treatment of Taxable Interest Income Earned on a WCMSA

(Ref: 7/11/05 Memo Q6)

If a claimant receives a Form 1099-INT for the interest income earned on his or her WCMSA account, the claimant or his/her administrator may withdraw an amount equal to the additional tax as a "cost that is directly related to the account" to cover the additional tax liability. This assumes that there is adequate documentation for the amount of incremental tax that the claimant must pay for the interest earned on this WCMSA. Moreover, such documentation should be submitted along with the annual accounting.

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.

Inflation Adjustment/Discount for Present Value/Change in Policy

(Ref: 10/15/04 Memo Q4)

WCMSAs do not need to be indexed for inflation and may not be discounted to present-day value.

For additional information with regard to the WCMSA submission and review process, please click on our other WCMSA web pages.

No Waivers of Specific Services Related to a WC Case

(Ref: 4/21/03 Memo Q18)

There is no means by which a claimant can permanently waive his or her right to certain specific services related to a WC case and, thereby, reduce the amount of a WCMSA. CMS cannot approve settlements that promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside

arrangement. This is true even if the claimant/beneficiary offers to execute an affidavit or other legal document promising that Medicare will not be billed for certain services if those services are not included in the Medicare set-aside arrangement.

WC Claims Not Covered in the Settlement

(Ref: 4/21/03 Memo Q16)

If a current Medicare beneficiary has outstanding WC related claims that were not paid prior to the settlement and are not covered in the settlement or the WCMSA, Medicare will not pay those claims. Medicare cannot pay because it is secondary to the WC settlement and the Medicare set-aside arrangement cannot pay because it is created solely for future medical expenses related to the WC case. Medical expenses incurred prior to the settlement need to be accounted for in the compromise portion of the settlement. These services should be known to the parties. The provider/supplier will typically have billed Medicare and/or the WC carrier for these services and the beneficiary's representative will have made inquiries about outstanding related claims. In addition, to the extent Medicare has made any conditional payments, Medicare will recover those payments pursuant to 42 CFR 411.47.

Loss of Medicare Entitlement after CMS Approval of a WCMSA

(Ref. 7/11/05 Memo Q9)

Claimants are not entitled to release of Workers' Compensation Medicare Set-aside Arrangement (WCMSA) funds if they lose their Medicare entitlement. However, the funds in the WCMSA may be expended for medical expenses specified in the WCMSA until Medicare entitlement is re-established or the WCMSA is exhausted.

Use of the WCMSA is limited to services that are related to the workers' compensation (WC) claim or settlement and that would be covered by Medicare if the individual were a Medicare beneficiary. The same requirements that Medicare beneficiaries follow for reporting and administration are to be used in the above cases. The CMS will not pay for any expenses related to the WC claim or settlement until a self-attestation document or a full accounting of all monies expended from the WCMSA are sent to the lead contractor upon the re-establishment of Medicare entitlement. At that time, the lead contractor will adjust the WCMSA record to reflect the expenses paid prior to entitlement.

Effect of WCMSA on Medicaid Eligibility

(Ref: 7/11/05 Memo Q13)

Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) are not subject to any special treatment under Medicaid resource rules. WCMSA funds should be evaluated to determine if they meet the legal definition of a resource for Supplemental Security Income (SSI) and, therefore, Medicaid purposes, i.e., “cash or other assets that an individual owns and could convert to cash to be used for his or her support and maintenance.” The funds must be in interest-bearing accounts. These funds may meet the SSI/Medicaid resource definition. There may be cases in which funds in a WCMSA are placed into trusts, possibly trusts that could satisfy the definition of “special needs trusts” under Section 1917 of the Social Security Act. In those cases, the funds might not be a countable resource, however, that result would be based solely on Medicaid, not Medicare rules.

Use of WC Settlement Funds Prior to Medicare Entitlement

(Ref: 7/11/05 Memo Q3)

For claimants who are not yet Medicare beneficiaries and for whom CMS has reviewed a Workers' Compensation Medicare Set-aside Arrangement (WCMSA), the WCMSA may be used prior to becoming a beneficiary because the amount was priced based on the date of the expected settlement. Use of the WCMSA is limited to services that are related to the workers' compensation (WC) claim or settlement and that would be covered by Medicare if the claimant were a Medicare beneficiary. The same three requirements that Medicare beneficiaries follow for reporting and administration are to be used in the above cases. The CMS will not pay for any expenses related to the WC injury, illness/disease until a self-attestation document or a full accounting of all monies expended from the WCMSA are sent to the lead contractor upon Medicare entitlement. At that time, the lead contractor will adjust the WCMSA record to reflect the expenses paid prior to entitlement. Even if there is no CMS-approved WCMSA, any funds from a WC settlement attributable to future medicals that are remaining at the time a claimant becomes a Medicare beneficiary must be used for Medicare-covered services related to the WC claim or settlement until such funds are exhausted. Only then will CMS pay for Medicare-covered services related to the WC claim or settlement.

WCMSAs in Cases Where There are Both a WC Claim and a Third Party Liability Claim

(Ref: 4/21/03 Memo Q19)

Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a Workers' Compensation (WC) carrier from any future medical expenses, a CMS approved Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is

exhausted. The only exception to establishing a WCMSA would be if it can be documented that the claimant does not require any further WC claim related medical services. A WCMSA is also not recommended if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.

For additional information concerning the Workers' Compensation Medicare Set-aside Arrangement (WCMSA) process, please click on the links to our other WCMSA pages

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.

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

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.