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July 2, 2008

Gerald Walters, Director
Financial Services Group
Office of Financial Management
Center for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: WCRC Non-Medically Indicated/Legal issues in determining MSA Amounts

Dear Mr. Walters:

On behalf of the Board of Directors of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), we ask your consideration of the following.

As you may know, NAMSAP is the only Non-Profit organization devoted to the improvement of the Medicare Set-Aside (MSA) practice. Our organization has approximately 600 members including attorneys, nurses, structured settlement brokers, insurance carriers, and professional administrators. Our members are responsible for the vast majority of submissions received by CMS and include the largest MSA vendors in the country.

Over the past several years, our membership has consistently discussed concerns regarding inappropriate review and inclusion of items in MSAs with your staff, Regional Offices, and the Workers' Compensation Review Center (WCRC). These reoccurring and significant actions violate the law (42 CFR 411 and 42 USC 1395y) and CMS policy memoranda. These actions continue to place inappropriate financial burden on insurers and self-insurers and often result in delays that impede the settlement approval process for all parties.

Many of our members have addressed these concerns with your staff, as your office is best able to comprehend the issues involved in the

often occurring failure of CMS to follow its own rules, policies, coverage guidelines and the consequences of continuing on that course. In addition, we have exhausted our normal review or complaint procedures with no satisfaction. I am certain you are aware that there has been a growing discontent among the various insurers and workers' compensation attorneys (representing claimants, insurers, and employers) with the determination process or handling of MSAs by CMS, which has resulted, and will continue to result, in more proposed legislation to cure certain, undeniable problems.

On behalf of this organization, we ask your attention to the following urgent issues and would strongly encourage you to open the doors of communication with us. We are a resource and we would like to work together to improve this process for everyone involved. Steps taken together to improve this process would prevent the need for and perhaps quiet the current movement demanding legislative changes. We ask that your office assist in arranging a meeting, at your office or other designated location, with senior CMS management, and other counsel as deemed necessary, and NAMSAP Board Members to seriously discuss these problems and explore means to improve the current situation.

1. CMS COVERAGE GUIDELINES: CMS is consistently requiring items or treatments in their determinations which would not be covered by Medicare and treatments for which the carrier would not be responsible under the applicable state workers' compensation laws. The CMS Memoranda and the information on CMS' website suggest that a WC settlement should set aside funds for all future medical services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare. That basic principle underlying MSAs is, obviously, no longer being followed by CMS in their determinations.

As an example of requiring non-Medicare covered items in MSAs, CMS has routinely been requiring the inclusion of any chiropractic care, while CMS guidelines generally only cover chiropractic care when there is a diagnosis of subluxation or, in states where it is permitted, the chiropractor is designated as the claimant's primary health care provider.

2. CMS PRICING: CMS has established standard prices for certain procedures, such as Spinal Cord Stimulators, without regard to the locale of the claimant or the applicable state WC fee schedule for the procedure. This represents a clear violation of the law (above what an insurer would be responsible for paying) and CMS policy allowing the use of workers' compensation fee schedules where available.

3. CMS "UPCODING" of CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES: CMS is "upcoding" treatments to increase the MSA costs, and we have been advised that this "upcoding" is being done to protect CMS from billing fraud. As an example, upcoding 99213 office visits to 99214 office visits, because Medicare reimbursement for 99213 is "too low" and doctors upcode to offset the low Medicare reimbursement. This is ridiculous in an MSA scenario where the funds remain with the claimant post-settlement. Billing fraud is a matter which needs to be resolved and stopped by CMS, but increasing the MSA to account for such fraudulent practices is not acceptable or a proper means to resolve the problem. This upcoding occurs on MRI's (adding with and without contrast codes), x-rays (changing historical 2-3 views to 4 views), and a variety of other diagnostic coding such as labwork being included when there are no medications prescribed. By "upcoding", CMS is clearly not honoring or following the state workers' compensation fee schedule nor is it pricing the MSA pursuant to the amount which Medicare or the insurer would (or should) be covering or reimbursing.

4. DME PRICING: CMS seeks “theoretically” the highest on-line prices available (although this can not be verified since the WCRC refused to disclose its source for DME pricing), not the true or average price at which the equipment can be purchased, and often contrary to the state workers’ compensation fee schedule. In addition, in cases with ambulatory issues, CMS may require coverage for a cane, a walker, a manual wheelchair, and an electric wheelchair. This is directly contrary to CMS coverage guidelines for a Medicare Beneficiary, is unrealistic, and is nothing more than a baseless “padding” of the CMS approved MSA.

5. ACCEPTANCE OF IME/QME REPORTS: CMS will accept the recommendations of the IME or QME if those recommendations require treatments exceeding the recommendations of the treating physician and thereby, increase the MSA. However, CMS will not accept the IME or QME reports if they indicate less treatment than recommended by the treating physician which would reduce or eliminate the need for the MSA.

6. INCONSISTENT WCRC DETERMINATIONS: Identical fact situations will not result in the same determination and will vary depending upon which employee at the WCRC makes the determination. The CMS errors, as outlined in the above five items, are not consistently occurring in all cases. This lack of consistency among the WCRC staff has increased the confusion in the daily attempt to guess what CMS may or may not accept or require. While not desirable, if all of the WCRC employees consistently committed the same errors, there would at least be a standard for preparing MSAs which would be readily approved by CMS.

7. WCRC DETERMINATIONS CONTRARY TO STATE LAW: There is no question that the obligations of the WC employer and insurer are defined by state workers’ compensation law, but this principle is routinely ignored by WCRC. One example, in addition to the Coverage issues raised above, is in cases where prior payments have been made. WCRC routinely views such payments as “admissions of liability” and refuses to recognize a true Compromise Settlement, ignoring the fact that most state workers’ compensation systems allow a workers’ compensation insurer to make payments on part of a case and later controvert the claim. Out and out ignoring state workers’ compensation law denies the employer and insurer due process and deprives them of substantive rights.

Our members have filed thousands of recent reconsiderations based upon sound medical or legal reasons and find that there has been an increasingly obstinate attitude and refusal to even review reconsideration information. Our members reconsiderations are well documented with detailed explanations identifying the CMS errors; to obtain a response to the reconsideration usually requires several months and many follow up inquiries on our part, and even then, our members often only get a form, second determination letter (which usually is nothing more than a restatement of the initial determination letter), which simply provides the amount of the determination without providing any further information supporting that determination or specifically responding to the information provided in our reconsideration. No rationale for CMS’s MSA proposal is provided to substantiate the CMS determination. Clearly, the reconsiderations do not appear, in many cases, to actually receive a proper review and consideration of our reconsideration arguments.

In support of the statements contained herein, NAMSAP members are prepared to provide you supporting data from our membership base to substantiate these claims. These case

documents are only the "tip of the iceberg", and more can easily be provided should the representative cases not fully evidence the problems outlined above.

As indicated, we are trying to assist CMS by reducing the number of reconsiderations, but we, our clients, and all parties requiring CMS approval of MSAs deserve to have a consistent determination process which follows its own rules and guidelines and a process which provides for an adequate review or consideration of any reconsiderations. We fully support CMS' efforts to prevent the shifting of the burden to Medicare, but the current review process has far exceeded a reasonable protection of Medicare's interests.

As always, we thank you for your assistance and await your early response.

Sincerely,

The Board of Directors of The National Alliance of Medicare Set-Aside Professionals

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