In an effort to share more information with the workers' compensation industry and workers' compensation Medicare set-aside arrangement submitters, and to reduce the instance of incomplete set-aside proposals, CMS is posting the "Operating Rules" used by its workers' compensation review contractor and will provide periodic updates when there are changes to these operating rules.

This information was available previously through a Freedom of Information Act request, with certain redactions that are being preserved in this version as well. The reasons for the redactions are: The CMS believes the redacted information would, if released, circumvent agency rules; adversely affect pending litigation; infringe on proprietary information belonging to our contractor; interfere with the performance of the Government contract; and/or violate the privacy of individuals. Information regarding navigating through the Workers' Compensation Case Control System has also been redacted, so as not to cause confusion.

OPERATING RULES (10/27/08)

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1. Incorrect info.
    a. Claimant's first name, middle initial, and last name. Fix only if the claimant is not a Medicare beneficiary.
    b. Claimant's address and submitter's name & address. Always fix.
        i. xxxxx
        ii. xxxxx
        iii. xxxxx
        iv. xxxxx
    c. Gender, birth date, illness/injury date, diagnoses, state of venue. Fix only if the case is eligible.
    d. xxxxx
    e. xxxxx

2. Jurisdiction/Venue/Pricing state. This is the state that will control any WC hearing. In order of priority, use:
    a. State on the settlement documents. If the case is a Longshore and Harbor Workers' Compensation Act ("LHWCA") case, go to 2b.
    b. State the submitter indicates in the submission is the state of jurisdiction.
    c. Call the submitter and ask for the state of jurisdiction. xxxxx
    d. State of the claimant's residence if the submitter fails to give a venue.
    e. xxxxx

3. Proposed settlement date ("PSD"). The PSD is the later of:
    a. COBC receipt date plus 120 days xxxxx OR
    b. xxxxx pricing date plus three months
    c. If there is no pricing (e.g., ineligible, denied liability, no services needed), do not review or change this field.

4. Phone calls.
    a. xxxxx
    b. xxxxx
    c. Submitters/claimants requesting status are entitled to know where the case is in processing and whether documents have been scanned. Do not give recommended amounts or expected completion dates.
    d. If a case is in the RO, check why. If it is for insufficient information, advise what information is still needed. Otherwise, give the RO contact name & phone number.
    e. If a case is at the COBC, give the COBC contact name & number.

5. Medicare set-aside ("MSA") administrator. In order of priority, use:
    a. Blank (only if recommended MSA ("RMSA") is $0)
    b. Professional administrator, if known. This includes claimants who have signed over power of attorney to someone else, or relatives who are handling matters for the claimant but who are not official rep payees.
        i. xxxxx
    c. xxxxx

d. xxxxx

6. Rated age.
    a. Submitter statement. For all cases with COBC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), if the submitter does not supply a statement that all rated ages obtained on the claimant have been included, use actual age and **do not develop**. Instead, explain in the Decision Rationale, "The submitter did not supply a statement that all rated ages obtained on the claimant have been included. Therefore, actual age was used."
    b. Other Criteria. Rated ages must name the claimant, must be from an insurance company, must be on insurance company or settlement broker letterhead, must be independent, and must give a specific rated age or life expectancy.
        i. xxxxx
        ii. xxxxx
        iii. For cases with COBC receipt dates of 10/01/08 or later (or reopened cases where the scan date of the reopening document is 10/01/08 or later), use actual age if there is not at least one rated age in file that meets the criteria and **do not develop**. Instead, explain in the Decision Rationale, "Rated ages were submitted but were not acceptable because xxxxxxx. Therefore, actual age was used."
    c. Median rated ages.
        i. Where there is more than one acceptable rated age, use the median.
        ii. Where there is an even number of acceptable rated ages, average the middle two and drop any decimals. Do not round.
        iii. If you drop a rated age and other acceptable rated ages are left, explain any new median rated age in the Decision Rationale ("The rated age from xxxxxx was not used in computing the median rated age because xxxxxxxx.").
        iv. If a submitter uses the term "median" and only supplies one rated age and it is acceptable, use it as long as Rule 6b (Submitter Statement) is met and **do not develop**. No Decision Rationale statement is necessary.
    d. xxxxx
    e. Unsuccessful development. If the file does not contain an acceptable rated age after the development period expires, use actual age and state in the Decision Rationale, "Although the WCRC developed for an acceptable rated age(s), none was received. Therefore, CMS is pricing this case using the claimant's actual age."
    f. If acceptable rated ages are in file, use them unless the submitter has requested the use of actual age in writing. xxxxx

7. Recommendation letter.
    a. xxxxx

b. xxxxx, use WCMSA rather than MSA, as MSA also means medical savings account.
c. If you disagree with the proposed amount, explain major differences in the Decision Rationale. Use at least the same level of detail as the submitter. For example, if a submitter uses an incorrect CPT code, and correcting the CPT code makes a major difference, explain and state the CPT codes in the Decision Rationale. xxxxx
d. xxxxx.

8. Multiple WC cases for same claimant. If cover letter(s) are not clear on how the submitter(s) want the cases handled, call the submitter(s) and give three options (document the option picked in the Note Log):
    a. We will work the cases as one case, with one injury date (the earliest in file). We will list all injuries and there will be no Medicare payments on any WC injury as of the injury date we use, until the set-aside amount is reached. We will combine the medical items and services proposed Medicare set-aside amounts ("MPMSAs") and prescription drug proposed set-aside amounts ("RxPMSAs") into one; we will combine the total settlement amounts ("TSAs") into one, and we will produce one recommended MSA ("RMSA"). This is the preferred and fastest option.
    b. We will work the case as one case, as in the first option, but in the Decision Rationale, we will do our best to separate the MPMSA, RxPMSA, TSA, and RMSA into the separate injuries and/or injury dates according to the submitter's needs.
    c. The submitter(s) must arrange with COBC to separate the cases into two or more cases, with separate submissions, separate medical records, separate TSA, PMSA, and RxPMSA. We will treat them as two or more independent cases. This option may take additional time, and more than a month is likely. In addition, the overall RMSA may be higher due to duplicate services (e.g., lab costs) in the independently worked cases.

9. Total settlement amount ("TSA").
    a. Include past <u>settlement</u> amounts (including advances), but not past payments of indemnity or medical expenses that were not part of settlements.
    b. Include third party liability settlement amounts for the same injury unless a state court or other administrative body has apportioned liability after a hearing on the merits.
    c. Include amounts forgiven by the carrier or others.
    d. Do not include medical malpractice settlements based on alleged mishandling of the workers' compensation injury, as those have a different date of injury and are not considered by CMS to be part of the workers' compensation case.
    e. xxxxx
    f. "Under" or "over" $X is not acceptable, xxxxx.
    g. xxxxx

h. For any cases involving a second injury fund or a "reopener" (common in New Jersey and Oklahoma):
    i. xxxxx
    ii. Include any prior settlement amounts in the total settlement amount, as well as any second injury fund settlement (NJ) or "3e" settlement (OK) being made at the same time as the main injury is settling even if the submitter requests otherwise.
    iii. Do not include in the total settlement amount any estimated amounts for settlements contemplated for the future but not being made at the time of the main injury settlement.
i. The PMSA and/or RMSA may exceed the TSA. No special language is required in these situations.
j. If the submitter's TSA is $20,000-25,000 for a Medicare beneficiary or $200,000-250,000 for a non-beneficiary AND there is an annuity involved, develop if it is unclear whether the submitter's TSA uses payout amounts ("Send total settlement amount calculated using lifetime payout amount for all annuities, annuity rate sheet, and all settlement papers.").

10. Potential "under threshold" cases:
    a. If there is a HICN, assume current Medicare entitlement and process set-aside, even if there are no entitlement dates. This cannot be an "under threshold" case, unless the TSA is $25,000 or less. (For COBC receipt dates before 4/25/06 that do not involve a reopening, the TSA must be under $10,000 to avoid review).
    b. If there are no HICN and no entitlement dates, assume no current Medicare entitlement. Follow the Threshold Rule, below.
        i. Exception: If the submitter alleges current Medicare entitlement and you are sending a development letter for some other reason, check the "Entitlement Information" box and ask for evidence that the claimant is currently a Medicare beneficiary.
    c. If there is no HICN but there are entitlement dates, xxxxx
    d. Threshold Rule:
        i. First, compute the total settlement amount ("TSA"). See Rule 9.
        ii. If the TSA is greater than $250,000, the case is eligible for review unless there will be no Medicare entitlement within 30 months of the proposed settlement date ("PSD"). xxxxx
        iii. If the TSA is less than $25,000.01 (for COBC receipt dates before 4/25/06 that do not involve a reopening, the figure is $10,000), the case is ineligible for review.
        iv. If the TSA is between these amounts (that is, at least $25,000.01 but not greater than $250,000), the case is eligible for review only if the claimant is entitled to Medicare according to the WCCCS before the PSD.
        v. xxxxx
        vi. xxxxx

11. Ineligible cases. If a case is ineligible for WCRC review (under threshold, death, CMS previously approved, insufficient information xxxxx, Jones Act, FELA, etc.): xxxxx
    a. xxxxx
    b. xxxxx
    c. xxxxx
    d. xxxxx
    e. xxxxx
    f. xxxxx
    g. xxxxx

12. Death cases. You must have something from the submitter in writing with the date of death. (Development letter: No box to check. Say, "Supply date of death.") If a date of death is not supplied in writing, use "Ineligible – Insufficient Information."

13. Development requests.
    a. xxxxx
    b. xxxxx
    c. xxxxx
    d. xxxxx
        i. xxxxx
        ii. xxxxx
        iii. xxxxx
    e. If a submitter calls in response to a Closeout Fax and indicates he/she never received the 30-day letter, confirm that the submitter's address in the WCCCS is correct, make sure the submitter understands what we still need, apologize for the problem, and indicate that the case will reopen when the requested information is received.
    f. xxxxx
    g. xxxxx
    h. If you decide that requested development is no longer needed, advise the submitter xxxxx.

14. xxxxx

15. Calculation method (fee schedule or actual charges). xxxxxx As much as possible, use the calculation method proposed, with prices from the state of jurisdiction. xxxxx Use these rules, in order of priority, to determine the calculation method (and pricing):
    a. For cases involving the Longshore and Harbor Workers' Compensation Act, the only possible fee schedule is the one published by the Office of Workers' Compensation Programs ("OWCP"). Follow rules 15c – 15h in such cases to see if that fee schedule should be used. If so, use the OWCP fee schedule for the zip code of the claimant's residence.

b. If the state does not have a fee schedule, use actual charges. If the submitter wanted fee schedule, add the following sentence to the Decision Rationale, "Although the submitter alleged use of a fee schedule calculation method, the state of jurisdiction has no fee schedule. Therefore, CMS is pricing this case using actual charges."
    i. Note: If any state institutes (or changes) a fee schedule, the WCRC will apply the new fee schedule immediately upon learning of its official publication for any case not yet out the door. The effective date of the new fee schedule does not matter. For example, as soon as the WCRC learned that the Illinois fee schedule was officially published by the state, we applied it immediately for all Illinois fee schedule cases not yet out the door, even if it was published before (or after) the effective date of 2/1/06. Similarly, we began requiring a written statement of fee schedule or actual charge calculation method at the same time for any Illinois case not yet out the door.
    ii. When using actual charges, CMS prefers that we use actual charges from the state of jurisdiction. If not readily available, use actual charges from the state of residence or national prices.
c. If the proposed Medicare set-aside amount ("PMSA") is $0 and the RMSA is not $0, use actual charges unless the submitter stated a preference for fee schedule pricing in the cover letter.
d. If the submitter's method is clearly stated in the cover letter or in a document referenced in the cover letter, use the method noted. If the submitter indicated that he used a mixture of fee schedule and actual charges, check "fee schedule" and use fee schedule as much as possible.
e. If the submitter's method is clearly stated in the settlement documents, and there is no expression in the cover letter or in a document referenced in the cover letter, use the method noted in the settlement documents. The settlement documents do not have to be signed by either party or a judge.
f. If there is no response or an inadequate response from the submitter to the 30-day letter, then process the case using actual charges and include the following sentence in the Decision Rationale, "Although CMS developed for clarification of the submitter's calculation method, no clarification was received. Therefore, CMS is pricing this case using actual charges." Do not close the case as ineligible, insufficient information, because of this missing information.
g. If the submitter states he/she used "Medicare fee schedule," use actual charges and include a Decision Rationale entry, "Although the submitter proposed to use a Medicare fee schedule to calculate the proposed set-aside, CMS uses only state fee schedules or actual charges. Actual charges were used as the default pricing method."

16. Payout method (lump sum or annuity)
    a. If only one payout method is stated in the submitter's cover letter, use it regardless of any other conflicting indication in the file.

b. If there is no payout method in the cover letter, but only one method is stated elsewhere in the file, use it.
c. If neither "a" nor "b" applies and there is conflicting information in file, (e.g., lump sum is stated, but seed money is also stated), develop. If the answer is still confusing, use lump sum and state in the Decision Rationale, "Clarification of the payout method was requested but not received; therefore, lump sum was used."
d. If no payout method is stated in the file, use lump sum.

17. Rounding.
    a. Do not round when computing median rated age. Drop decimals. (50.9 = 50, corresponding to the life expectancy table entry for someone 50 but not yet 51)
    b. xxxxx
    c. xxxxx

18. System problems. Report these xxxxx on the COB Problem Report form, with a screen print if possible. Follow the written instructions for completion of the form.

19. xxxxx

20. xxxxx

21. xxxxx

22. Proposed set-aside amounts. For either the medical services proposed set-aside amount ("MPMSA") or the prescription drug proposed set-aside amount ("RxPMSA"), use these in order of priority:
    a. A settlement document signed by both parties and approved by the state.
        i. If the proposed set aside in that document is the cost of an annuity or an annual amount where the proposed life expectancy is not given anywhere in the file, do not use it.
        ii. If the submitter proposes an amount higher than the set-aside amount in the signed and approved settlement document, that is acceptable, as long as the submitter explains the reason for the change in writing. If there is no explanation, develop in writing.
        iii. If the submitter proposes an amount lower than the set-aside amount in the signed and approved settlement document, use the court-approved amount as the proposed amount and explain in the Decision Rationale: "Although the submitter proposed a different set-aside amount, the WCRC must show the proposed amount from the court approved settlement agreement in file."
    b. The submitter's letter or an attachment referenced in the submitter's letter. xxxxx. If the submitter's letter is not clear, develop in writing.
        i. xxxxx

c. If neither a nor b applies, develop in writing if the MPMSA is not known, but develop for the RxPMSA only if developing for something else.
d. If a submitter proposed a set-aside amount and does not specify how much of it is for medical items and services and how much is for prescription drugs, assume it is all for medical items and services. Do not develop to clarify unless you are developing for something else.

23. Pricing standard. Price all Medicare-covered items and services that are related to the work injury and that are "reasonably probable." The following reasons are <u>not</u> acceptable for reducing a set-aside or approving a $0 set-aside:
    a. The claimant asserts he/she will not purchase Medicare Part B or Part D.
    b. The claimant asserts he/she uses other insurance.
    c. The claimant asserts he/she uses the Veterans' Administration for all health needs.
    d. The claimant asserts he/she is moving out of the country and never coming back.
    e. The claimant promises never to bill Medicare.

    xxxxx.

24. xxxxx

25. xxxxx

26. Consent forms. Consent forms are acceptable if they meet the following:
    a. There should be a reference to the Social Security Administration, Medicare, or the federal government.
    b. The form should contain one of the following words: authorize, release, or consent.
    c. The form should be signed by the claimant or someone authorized to sign on behalf of the claimant (e.g., attorney-in-fact, guardian, etc. – in such cases, obtain proof of such authorization or discuss with a supervisor):
        i. Do not reject any consent form because of an expiration date.
        ii. Claimants may withdraw consent if they do so in writing.
        iii. xxxxx

27. Initial deposit (seed money).
    a. xxxxx
    b. If the entries for 1st surgery procedure and 1st replacement do not exactly match items from the pricing grid, explain in the Decision Rationale.
    c. xxxxx
    d. xxxxx

28. Prescription drugs.
    a. These rules apply to:
        i. New cases with a COBC receipt date on or after 2/1/06.

ii. Reopening cases (whether automatically returned to the WCRC as REOP or manually returned to the WCRC by the regional offices ("ROs")) where the scan date of the document causing the reopening is on or after 2/1/06. xxxxx
    A) Exception: Reopenings that occur because of an obvious error will require prescription drugs only if the case already required prescription drugs before that reopening.
iii. Priority cases where the above rules apply and the WCRC did not screen the case before 3/25/06.

b. xxxxx
c. xxxxx
d. Develop for prescription drug information only if developing for something else.
    i. xxxxx. If developing for something else and there is no discussion of prescription drugs in the submitter's cover letter, then develop for prescription drug information.
    ii. xxxxx. If developing for something else, if the entire file contains no proposal for prescription drugs, and if you determine that prescription drugs should have been included in the proposal, then develop for prescription drug information.
    iii. If development is undertaken for prescription drug information and something else, do not develop for prescription drugs again, even if another 30-day letter is needed for something new.
e. xxxxx.
f. xxxxx.

29. Some body parts not settling medicals
    a. If the carrier will continue to pay for all injury-related medical care for the claimant, the case is ineligible for review. See Operating Rule 11.
    b. If all body parts are settling medicals, the case is eligible. Note, some body parts may be denied liability and others may be compensable and require a set-aside determination.
    c. For pricing purposes, ignore injuries related only to Second Injury Funds and settlement of injuries that have not been alleged.
    d. If the agreement states that the carrier will continue to pay for some medical services but not others for the same body part, contact the submitter xxxxx and advise that CMS considers that body part as not settling for all treatments.
    e. xxxxx

30. xxxxx

31. xxxxx