Case Management Society of America Presents:

MSA & STRUCTURED SETTLEMENTS: IDENTIFYING THE ROLE OF THE CASE MANAGER

February 17, 2022
Presented by
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Medicare Set-Aside (MSA) Overview

- The MSA is the vehicle created to comply with the Medicare Secondary Payer (MSP) Statute
- The MSA is a portion of the WC settlement. It is calculated to cover the amount of the future medical expenses related to the industrial injury that would otherwise be paid for by Medicare.
- Only appropriate when settling future medical

Medicare Set-Aside (MSA) Overview

- 1980: Medicare Secondary Payer Statute
  - 42 U.S.C. § 1395y(b)2
  - Workers' Compensation is a Primary Payer
  - Enacted to prevent the burden of medical expenses for industrial injuries from being shifted to Medicare.
  - Addressed the Situation where a Medicare Beneficiary (or soon to be) settled a Work Comp claim that included future medical expenses – Medicare only pays second

MSA Goal

- From WCMSA Reference Guide:
- "The goal of establishing a WCMSA is to estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-injury- related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost. WCMSAs may be funded by a lump sum or may be structured, with a fixed amount of funds paid each year for a fixed number of years, often using an annuity."

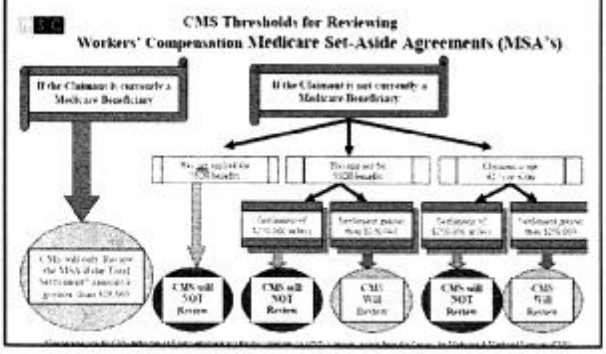
What is Included in the MSA

- All Medicare-covered items and services that are related to the work injury and that are "reasonably probable". Includes:
  - Hospitalizations – Medicare Part A
  - Doctor's Services – Medicare Part B
  - Certain Durable Medical Equipment
  - Prescription Medication – Medicare Part D

MSA Account Funding Options

- Funding the MSA using a Structured Annuity
  - Structured Settlement Broker–Free valuable resource
  - Rated Age – Reduces the amount of the MSA
  - Provides more money for claimant's use
  - Lessens the chance of misuse of MSA funds
  - Seed Money + annual payment
- Funding the MSA with a lump sum
  - Entire MSA amount is deposited into account upon settlement of claim

CMS Submission Thresholds



CMS Approval: Requirements for MSA Submission

- Medical Records
  - All medical records from all treating physicians for the last two years of treatment
- Payment History
  - All inclusive (medical & indemnity) from all carriers, TPAs, employers, pharmacies dated with in the last 6 months of submission for at least the last two years of treatment.
- Self or Professional Administration of the MSA

MSAs Submitted to CMS Follow Strict Guidelines

- Prescription Cost based on Average Wholesale Price (AWP) and priced out for the applicant's life expectancy typically.
- Medical services pricing based on CA Work Comp Fee Schedule.
- Based on medical records for last 2 years
  - All Procedures included
  - IME's not considered
- Payment histories dated within last 6 mo.

What is Professional Administration?

- Professional administration services provide access to discounted drug, provider, and medical equipment pricing, technology that provides a hassle-free experience with medical care, and a dedicated team of representatives to answer questions and help you navigate your medical care. The service also protects the injured person's Medicare benefits in the case of a Medicare Set Aside (MSA).

Structured Settlements "The Basics"

1. Alternative Form of a Lump Sum C & R
2. Contains Some Cash for:
   a) Applicant
   b) Attorney's Fees
   c) MSA Seed Money
3. Then a Series of Future Periodic Payments

<u>These Payments are TAX FREE</u>

Payments Are TAX FREE Because:

1. Specific Language included in the C & R, Usually Through an <u>ADDENDUM</u>
2. The Defense Purchases the Annuity or Reinsurance Agreement

Why are Structures Beneficial?

1. Allows for Creative Solutions
2. Provides Tremendous Flexibility
3. Can Customize Payment Schedule

Why Are Structures Beneficial?

4. Bridges the Gap between Demand and Offer. CAN SAVE THE SETTLEMENT

Example: Case Settled for $115,000 Contingent upon CMS approval of $22,773 MSA.

However, CMS comes back with $110,959. Deal was DEAD!

However, the Deal was revived by Structuring the MSA

The Structured MSA freed up enough cash to cover Atty's Fees and provide the Applicant with $35,000 cash up front

D.O.B.: 7/16/1964
Package C

Payment Description	Costs	Guaranteed Payout	Expected Payout
CASH AT SETTLEMENT	$35,015	$35,015	$35,015
ATTORNEY FEES	$17,250	$17,250	$17,250
MSA SEED	$6,341	$6,341	$6,341
ANNUAL CONTRIBUTION TO MSA ACCT FOR 34 YRS CERTAIN $3,077 payable annually, beginning 2/4/2018 for 34 years certain only.	$56,394	$104,618	$104,618
TOTAL	$115,000	$163,324	$163,324

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

[redacted]
Case Number 1

Case Number 4

Case Number 2

Case Number 5

Case Number 3

[redacted]
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☒ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VNO
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee (Completion of this section is required)

[redacted]
First Name

MI

[redacted]
Last Name

[redacted]
Address/PO Box (Please leave blank spaces between numbers, names or words)

[redacted]
City

[redacted]
State

[redacted]
Zip Code

Employer Information (Completion of this section is required)

☒ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

[redacted]
Employer Name (Please leave blank spaces between numbers, names or words)

[redacted]
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

[redacted]
City

[redacted]
State

[redacted]
Zip Code

Applicant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

[redacted]
First Name

[redacted]
Last Name

[redacted]
Law Firm Number

[redacted]
Law Firm Name

[redacted]
Address/PO Box (Please leave blank spaces between numbers, names or words)

[redacted] [redacted] [redacted]
City State Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

[redacted]
First Name

[redacted]
Last Name

[redacted]
Law Firm Number

[redacted]
Law Firm Name

[redacted]
Address/PO Box (Please leave blank spaces between numbers, names or words)

[redacted] [redacted] [redacted]
City State Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

[redacted]
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

[redacted]
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

[redacted] [redacted] [redacted]
City State Zip Code

Claims Administrator Information (If known and if applicable)

[redacted]
Name (Please leave blank spaces between numbers, names or words)

[redacted]
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

[redacted] [redacted] [redacted]
City State Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 08/28/1963 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

INSTRUCTIONAL AIDE (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

☒ Specific Injury

[redacted]
Case Number 1

☐ Cumulative Injury

09/01/2015 (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 420 BACK Body Part 2: 200 NECK Body Part 3: 310 BIL ARMS

Body Part 4: 802 CIRC SYSTEM Other Body Parts: 841 PSYCHE; 110 CEREBRAL INFARCTION; 119 BRAIN; 401 HEART 999 INTERNAL BLEEDING; 800 STOMACH; 410 RIGHT GROIN; 200 THORACIC 800 RESPIRATORY FAILURE; 803 STREPTOCOCCAL INFECTION; 880 THROAT 800 ENCEPHALOPATHY; 890 HYPERGLYCEMIA 800 PNEUMONIA 800 PULMONARY EDEMA, 800 VOCAL CORD PARALYSIS

The injury occurred at [redacted]
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

[redacted] [redacted] [redacted]
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The Injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 996.97 per week

TEMPORARY DISABILITY INDEMNITY PAID 63,521.55 Weekly Rate $ 664.65

Period(s) Paid 09/01/2015 (Start Date: MM/DD/YYYY) 06/30/2017 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 141,066.68 Weekly Rate $ 664.65

Period(s) Paid 07/01/2017 (Start Date: MM/DD/YYYY) End date 12/03/2021 (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 78,921.92 Total Unpaid Medical Expense to be Paid By: BY DEF ~~PER PAR 9~~

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 1,400,000.00* (*per structure settlement included herein)
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ 141,066.68 for permanent disability advances through 12/03/2021 AND CONTINUING

$ _____ for temporary disability indemnity overpayment, if any.

$ 48,980.21 payable to [redacted]

$ 249,765.00 payable to [redacted]

$ 625,188.11 payable to [redacted]

$ _____ payable to _____

$ 210,000.00** requested as applicant's attorney's fee. ** to be held in trust by defendant pending agreement of fee division with previous attorneys or court order

LEAVING A BALANCE OF $ 125,000.00*** , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

*** represents initial payment to applicant per structure settlement included herein.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

DEFENDANT HAS MADE GOOD FAITH EFFORTS TO RESOLVE THE UNPAID LIENS IN THIS CASE. DEFENDANT IS UNAWARE OF ANY UNRESOLVED LIENS OTHER THAN LIENS MENTIONED IN THE ATTACHED AFFIDAVIT. DEFENDANT SHALL NEGOTIATE AND/OR LITIGATE THE REMAINING LIENS, LESS CREDIT FOR PAYMENTS PREVIOUSLY PAID, WITH THE WCAB TO RETAIN JURISDICTION THEREOF.

[redacted]
D.O.B.: 08/28/1963 (Age: 58.3)

PACKAGE J

Payment Description	Costs	Guaranteed Payout	Expected Payout
CASH AT SETTLEMENT	$125,000.00	$125,000.00	$125,000.00
ATTORNEY'S FEES	$210,000.00	$210,000.00	$210,000.00
CREDIT FOR PDAS	$141,066.68	$141,066.68	$141,066.68
MSA SEED $48,980.21	$48,980.21	$48,980.21	$48,980.21
ANNUAL CONTRIBUTION TO MSA ACCT FOR 18 YRS, IF LIVING $19,587.88 payable annually, beginning 02/01/2023	$250,515.00		$352,581.84
TAX FREE MONTHLY PAYMENTS FOR 10 YRS $5,477.44 payable monthly, beginning 03/01/2022 for 10 years certain only. Last guaranteed payment is due 02/01/2032.	$624,438.11	$657,292.80	$657,292.80
Totals:	$1,400,000.00	$1,182,339.69	$1,534,921.53

This quote is only valid until EOB December 03, 2021

THIS SETTLEMENT IS CONTINGENT UPON VERIFICATION OF DATE OF BIRTH

ALLAN KOBA
COMPLIANCE SOLUTIONS

WCMSA Report

REC'D 9/13/21 @ JACOBS & ASSOCIATES

Applicant's Name: [redacted]

MSA Report Date: 08/19/2021
Medicare ID/ [redacted]
Applicant's Address: [redacted]
Jurisdiction: [redacted]
Date of Injury: 09/01/2015
Claim Number: 33068160
Date of Birth: 08/28/1963
Actual Age: 58 years
Rated Age: 66 years
Life Expectancy: 18.7 years

Total Proposed WCMSA Amount: $401,562
Proposed Future Medical WCMSA Amount: $368,989
Proposed Future Rx WCMSA Amount: $32,573

Most Recent Medical Record Reviewed: 05/07/2021
Claims Payment History Date: 04/15/2021
Rx History Date: N/A

ALLAN KOBA
COMPLIANCE SOLUTIONS

WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT REVIEW

Injury Description:

Applicant, Agustin Gonzalez, sustained work-related cervical spine, thoracic spine, right groin, left upper extremity, and hypertension injuries; subsequently resulting in an aneurysm requiring tracheostomy care on September 1, 2015, while working as a Special Needs Attendant for No Ordinary Moments, Inc. Applicant was restraining a combative consumer on the floor and the consumer kicked him in the back.

Applicant underwent tracheostomy placement in September 2015, an IVC filter placement in 2015, gastrotomy tube placement with subsequent removal, and a thoracic endovascular aortic aneurysm repair with right carotid subclavian artery bypass on June 6, 2018.

Included Injuries & ICD-10 Codes

Stroke [ICD-10: I69.30]
Hyperreflexia and spasticity left upper extremity [ICD-10: R29.2]
Hyperreflexia and spasticity left lower extremity [ICD-10: R29.2]
Hypertension [ICD-10: I10]
Left hemiplegia [ICD-10: G81.92]
Tracheostomy [ICD-10: Z93.0]
Paralysis of vocal cords and larynx, unspecified [ICD-10: J38.00]
Thoracic aortic dissection [ICD-10: I71.01]
Aneurysm of other specified arteries [ICD-10: I72.8]
GERD [ICD-10: K21.9]
Diverticulum of Kommerell [ICD-10: Q25.49]
Dizziness [ICD-10: R42]
Aberrant right subclavian artery [ICD-10: Q27.8]
Hyperlipidemia, unspecified [ICD-10: E78.5]
Chest pain, resolved [ICD-10: R07.89]
Post-procedural headache, resolved [ICD-10: R51]
Pneumonia, resolved [ICD-10: J15.6]
Transient postprocedural hyperglycemia, resolved [ICD-10: R73.9]
UTI, resolved [ICD-10: N39.0]

Pre-existing and Unrelated Conditions

Prostate issue
Left hip pain

Presbyopia
Bilateral knee pain
Headaches
SOB
Bilateral eye surgery
Vertigo
Bilateral shoulder pain
Blurred vision
Elevated PSA
Chronic prostatitis
Inflammatory disease of prostate
Eye disorder
Eye pain
Eye infection
BPH

Rated Ages and Life Expectancy

Chronological Age: 58 years
Rated Age: KP Underwriting – 66 years
Life Expectancy: *18.7 years*

(National Vital Statistics Report, United States Life Tables, 2018, Volume 69, No. 12, Table 1, Life Table for the Total Population)

Annuity Funding Breakdown

Recommended Initial Seed Amount: $48,980.21
Annual Annuity Payments for Eighteen (18) years: $19,587.88

**Please note that the total set-aside amount includes the seed amount. The seed amount is comprised of two (2) years of the anticipated average annual Medicare-Covered medical expenses.*

WCMSA Preparation by:

Logan Pry, Esquire
Caitlin Brown, MSN, RN, CPC

ALLAN KOBA
COMPLIANCE SOLUTIONS

CURRENT TREATMENT STATUS FOR WC INJURIES OR DISEASE INCLUDING PAST MEDICAL TREATMENT

Applicant, Agustin Gonzalez, sustained work-related cervical spine, thoracic spine, right groin, left upper extremity, and hypertension injuries; subsequently resulting in an aneurysm requiring tracheostomy care on September 1, 2015, while working as a Special Needs Attendant for No Ordinary Moments, Inc. Applicant was restraining a combative consumer on the floor and the consumer kicked him in the back.

Applicant's past medical treatment for his work-related injury has included visits to his treating physician, surgical intervention, diagnostic testing, DME replacement, prescriptions, physical therapy, and laboratory work. Applicant underwent tracheostomy placement in September 2015, an IVC filter placement in 2015, gastrotomy tube placement with subsequent removal, and a thoracic endovascular aortic aneurysm repair with right carotid subclavian artery bypass on June 6, 2018.

Applicant's future treatment for his work-related injury will likely include visits to his treating physician, diagnostic testing, prescription medications, physical therapy, occupational therapy, DME replacement, and laboratory work.

Recent medical records and the itemized prescription payment history also indicate that Applicant is currently treating with prescription medications: Metoprolol ER, Hydralazine, Famotidine, Ciprofloxacin, Albuterol Sulfate (Proair HFA), Amlodipine, Atorvastatin and Sertraline HCL.

ALLAN KOBA
COMPLIANCE SOLUTIONS

FUTURE MEDICAL TREATMENT

(For Medicare-covered items and reimbursable services for the WC injury only)

Claimant's Name: Agustin Gonzalez
Date of Injury: 9/1/2015
Jurisdiction: California
Life Expectancy: 18.7

Medical Treatment	Cost/Unit	Units/Year	Annual Cost	# of Years	Total
Neurology (99213)	$133.34	1	$133.34	19	$2,533.46
Cardiovascular surgery (99213)	$133.34	1	$133.34	19	$2,533.46
Primary care (99213)	$133.34	4	$533.36	19	$10,133.84
ENT/Pulmonology (99213)	$133.34	1	$133.34	19	$2,533.46
Psychiatrist (99213)	$133.34	1	$133.34	19	$2,533.46
Emergency room visits	$1,200.00	1	$1,200.00	6	$7,200.00
Acute hospitalization	$7,500.00	1	$7,500.00	2	$15,000.00
Physical therapy (97110)	$131.67	24	$3,160.08	1	$3,160.08
Occupational therapy (97530)	$173.88	24	$4,173.12	1	$4,173.12
X-ray chest (71045)	$38.99	1	$38.99	19	$740.81
CT chest w/o contrast (71250)	$217.85	1	$217.85	19	$4,139.15
CTA abd/pelvis w/ & w/o contrast (74174)	$630.54	1	$630.54	3	$1,891.62
CTA chest/aorta w/ & w/o contrast (71275)	$463.74	1	$463.74	3	$1,391.22
Aortic angiogram (75630)	$244.99	1	$244.99	2	$489.98
CT abd/pelvis w/o contrast (74176)	$297.86	1	$297.86	19	$5,659.34
CT neck w/ & w/o contrast (70498)	$453.91	1	$453.91	2	$907.82
CT head w/o contrast (70450)	$173.57	1	$173.57	2	$347.14
X-ray cervical spine (72050)	$81.50	1	$81.50	6	$489.00
MRI cervical spine w/ & w/o contrast (72156)	$549.55	1	$549.55	2	$1,099.10
X-ray thoracic spine (72074)	$68.23	1	$68.23	6	$409.38
MRI thoracic spine w/ & w/o contrast (72157)	$550.63	1	$550.63	2	$1,101.26
Abdominal aortic ultrasound (76706)	$169.39	1	$169.39	2	$338.78
Carotid duplex bilateral (93880)	$309.10	1	$309.10	3	$927.30
Transthoracic ECHO (93350)	$294.13	1	$294.13	6	$1,764.78
ECG (93000)	$21.80	1	$21.80	6	$130.80
Magnesium (83735)	$8.04	1	$8.04	19	$152.76
Phosphorus (84100)	$5.69	1	$5.69	19	$108.11
BMP (80048)	$10.15	1	$10.15	19	$192.85
GFR (82565)	$6.14	1	$6.14	19	$116.66
PT/INR (85610)	$5.15	4	$20.60	19	$391.40
Creatine (82540)	$5.57	1	$5.57	19	$105.83
Troponin (84484)	$14.96	4	$59.84	19	$1,136.96
UA/UC (81001/87088)	$13.51	1	$13.51	19	$256.69
Lubricant per oz (A4402)	$2.23	48	$107.04	19	$2,033.76
Tracheostomy filter (A4481)	$0.52	744	$386.88	19	$7,350.72
Inner cannula (A4623)	$7.79	744	$5,795.76	19	$110,119.44
Tracheostomy Care Kit (A4629)	$6.47	372	$2,406.84	19	$45,729.96
Skin barrier wipes/swabs (A5120)	$0.34	1800	$612.00	19	$11,628.00
Tracheotomy faceplate (A7502)	$69.74	12	$836.88	19	$15,900.72
Tracheostomy tube cuffed (A7521)	$65.71	4	$262.84	19	$4,993.96
Tracheostomy tube collar/holder (A7526)	$4.74	372	$1,763.28	19	$33,502.32
Tracheostomy adapter for inhaler (A4627)	$26.40	6	$158.40	19	$3,009.60
Saline (A4217)	$3.72	48	$178.56	19	$3,392.64
Passy Muir valve (L8501)	$144.96	6	$869.76	19	$16,525.44
Suction machine (E0600)	$831.48	1	$831.48	2	$1,662.96
Sterile water/saline (A4217)	$3.72	48	$178.56	19	$3,392.64
Suction canister (A7001)	$46.21	6	$277.26	19	$5,267.94
Tubing (A7002)	$5.35	6	$32.10	19	$609.90
Tracheal suction catheters (A4624)	$3.68	365	$1,343.20	19	$25,520.80
Lipid panel (80061)	$16.07	1	$16.07	19	$305.33
Cane (E0100)	$27.92	1	$27.92	6	$167.52
Wheelchair (K0001)	$678.86	1	$678.86	1	$678.86
Wheelchair maintenance	$67.88	1	$67.88	18	$1,221.84
Wheelchair cushion (E2601)	$73.63	1	$73.63	19	$1,398.97
Venipuncture (36415)	$3.60	1	$3.60	19	$68.40
CBC (85025)	$9.32	1	$9.32	19	$177.08
CMP (80053)	$12.67	1	$12.67	19	$240.73
				Total Medical Treatment:	**$368,989.15**

ALLAN KOBA
COMPLIANCE SOLUTIONS

FUTURE PRESCRIPTION DRUGS TREATMENT

(For Medicare-covered items and reimbursable drugs for the WC injury only)

Drug Name	NDC	Dosage	Frequency	Units per Month	Months per year	Price Per Unit	Total # of Years	Total
Metoprolol Succinate ER	64679-0847-10	50mg TER	QD	30	12	$0.08	19	$547.20
Hydralazine	00904-6441-61	25mg	QD	30	12	$0.14	19	$957.60
Famotidine	36800-0194-71	20mg	1/2 tab QD (10mg)	15	12	$0.08	19	$273.60
Sertraline HCL	00904-6924-61	25mg	QD	30	12	$0.41	19	$2,804.40
Ciprofloxacin*	61442-0224-50	750	q12h/14 days	28	1	$5.17	19	$2,750.44
Albuterol Sulfate (Proair HFA)	00173-0682-24	0.09 mg/1 actuation	2 puffs QID	240	12	$0.44	19	$24,076.80
Amlodipine besylate	76282-0239-10	10mg	QD	30	12	$0.08	19	$547.20
Atorvastatin	10135-0650-05	20mg	QD	30	12	$0.09	19	$615.60
							Total Prescription Drugs:	**$32,572.84**

[redacted]

D.O.B.: 07/27/1970 (Age: 50.7)

PACKAGE L

Payment Description	Costs	Guaranteed Payout	Expected Payout
CASH AT SETTLEMENT	$180,000.00	$180,000.00	$180,000.00
ATTORNEY'S FEES	$732,000.00	$732,000.00	$732,000.00
MSA SEED	$149,508.00	$149,508.00	$149,508.00
ANNUAL CONTRIBUTION TO MSA ACCT FOR 19 YEARS IF LIVING $47,794.00 payable annually, beginning 05/29/2022	$638,671.00		$908,086.00
TAX FREE LIFETIME MONTHLY PAYMENTS $21,493.62 payable monthly, beginning 06/29/2021 for life.	$4,399,821.00		$8,210,562.84
Totals:	$6,100,000.00	$1,061,508.00	$10,180,156.84

This quote prepared on April 08, 2021

THIS SETTLEMENT IS CONTINGENT UPON VERIFICATION OF DATE OF BIRTH

NATIONAL SETTLEMENT CONSULTANT

800-845-2969

Gregg M. Chapman

ADDENDUM E TO COMPROMISE AND RELEASE

March 06, 2020

[redacted]
Tampa, FL 33619

RE: Workers' Compensation Medicare Set-Aside Arrangement
Claimant: [redacted]
Medicare [redacted]
Date of Injury: 01/27/2014
CMS Case Control Number(CCN): WC1932302221442

Dear Sir or Madam,

This letter is in response to your submission of a proposed Workers' Compensation Medicare Set Aside Arrangement (WCMSA) amount related to the above named claimant's workers' compensation claim and received on 11/19/2019.

You proposed a WCMSA amount of $821,492.00 to pay for future medical items and services that are covered and otherwise reimbursable by Medicare ("Medicare covered") and are related to the claimant's workers' compensation claim. We note that you proposed $174,384.00 for Medicare covered prescription drugs.

We have evaluated your proposal and have determined that $1,057,602.00 adequately considers Medicare's interests with respect to Medicare covered future medical items and services, including prescription drugs.

In order to comply with Section 1862(b)(2) of the Social Security Act, Medicare is not permitted to pay for medical items or services, including prescription drug expenses, related to the workers' compensation claim until the approved WCMSA amount is appropriately exhausted ("properly spent") on related medical care. Where a workers' compensation settlement, judgment, award, or other payment is less than the approved WCMSA amount, Medicare is not permitted to pay for related medical care until the whole settlement, judgment, award, or other payment is properly spent on related medical care. The WCMSA funds must be placed in an interest bearing account. Funds in the account should not be used for any purpose other than payment of future medical care that is Medicare covered and is related to the workers' compensation claim.

The account must be funded by an initial deposit of $149,508.00 and subsequent equal payments of $47,794.00 over 19 year(s).

When a WCMSA is funded as a structured settlement (settlement monies paid out in yearly installments over a number of years), any WCMSA funds that are not used in a given year must remain in the account to pay for related medical care during following years. If available WCMSA funds for a particular year (including the current year's full structured payment plus any prior year's remaining funds plus interest) have been properly spent, Medicare will pay for covered items and services that are related to the workers' compensation claim for the remainder of that year until the scheduled date for the next year's deposit into the WCMSA account. Bills should be paid in the order they are received to help the Benefits Coordination & Recovery Contractor (BCRC) confirm that the funds have been temporarily exhausted (properly spent for that year).

Approval of this WCMSA amount is not effective until the Centers for Medicare & Medicaid Services (CMS) receive a copy of the final executed workers' compensation settlement agreement, which must include this approved WCMSA amount. Please include the CMS Case Control Number listed at the top of this letter in any correspondence. Submit your settlement agreement via the Portal if your original submission was via the Portal. If you originally submitted outside of the Portal, submit the settlement agreement to the following address:

WCMSA Proposal/Final Settlement
P.O. Box 138899
Oklahoma City, OK 73113-8899

If your settlement agreement is 10 pages or less, you may also fax it to (405) 869-3306. **Note:** This number is not for initial submissions, only for additional documentation under 10 pages.

The proposed WCMSA amount was calculated based on the workers' compensation fee schedule for the State of CALIFORNIA.

Funds in a WCMSA may not be used to purchase a Medicare supplemental insurance policy or a Medigap policy for a beneficiary, or to pay for the premiums for such policies.

Once the funds in the WCMSA account have been properly spent on Medicare-covered items and services related to the claimant's workers' compensation claim and Medicare has been given proof that the account has been properly spent, Medicare will begin paying for the claimant's Medicare covered items and services that are related to the workers' compensation claim. Medicare will pay for Medicare covered items and services that are unrelated to the workers' compensation claim according to Medicare's payment rules.

We understand that the claimant will act as administrator of the WCMSA funds. We have enclosed instructions, titled "Administering Your Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)." The WCMSA Self-Administration Toolkit is another resource, available on the CMS website at http://go.cms.gov/WCMSASelfAdm. The claimant must send a signed attestation letter to the Benefits Coordination & Recovery Center at the address below every year, no later than 30 days after the end of each reporting period (beginning one year from the date of establishment of the WCMSA account). Annual attestations should continue through final exhaustion of the account.

NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113

Please note that this decision regarding future medical treatment is independent of any determination regarding Medicare Secondary Payer recovery rights for conditional payments Medicare made for related items and services furnished before the date of the settlement, judgment, award, or other payment. Medicare has the right to recover (or take back) Medicare payments related to any workers' compensation settlement, judgment, award, or other payment. Any payments Medicare may have made that should have been paid from the workers' compensation settlement, judgment, award, or other payment must be repaid to Medicare.

If you have any questions concerning this letter, please call IAN FRASER at (415) 744-3658.

Sincerely,

Sherri McQueen
Director, Financial Services Group
Office of Financial Management

Enclosure

CC: [redacted]
NGHP
NEIL BERMAN, ESQUIRE

WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT (WCMSA) REVIEW

Case Control #: [redacted] **Medicare** [redacted]

Claimant's Name: [redacted]

Date of Injury: 01/27/2014

Diagnosis Code:

Dx Code	Dx Ind.	Dx Description
B351	ICD-10	Tinea unguium
D7582	ICD-10	Heparin induced thrombocytopenia (HIT)
G3184	ICD-10	Mild cognitive impairment, so stated
G8252	ICD-10	Quadriplegia, C1-C4 incomplete
G8254	ICD-10	Quadriplegia, C5-C7 incomplete
I82409	ICD-10	Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
K592	ICD-10	Neurogenic bowel, not elsewhere classified
L739	ICD-10	Follicular disorder, unspecified
M21379	ICD-10	Foot drop, unspecified foot
M545	ICD-10	Low back pain
N111	ICD-10	Chronic obstructive pyelonephritis
N319	ICD-10	Neuromuscular dysfunction of bladder, unspecified
S020XXA	ICD-10	Fracture of vault of skull, initial encounter for closed fracture
S062X1A	ICD-10	Diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, initial encounter
S2249XA	ICD-10	Multiple fractures of ribs, unspecified side, initial encounter for closed fracture
S52509A	ICD-10	Unspecified fracture of the lower end of unspecified radius, initial encounter for closed fracture
S52609A	ICD-10	Unspecified fracture of lower end of unspecified ulna, initial encounter for closed fracture
Z79891	ICD-10	Long term (current) use of opiate analgesic
Z87440	ICD-10	Personal history of urinary (tract) infections

Proposed Settlement Date (PSD): 06/03/2020 **Date of Birth:** 07/27/1970
Age at PSD: 49 **Rated Age at PSD:** 64 **Life Expectancy:** 20 yrs.

Submitter:
(813) 612-5507
PMSI SETTLEMENT SOLUTIONS
175 Kelsey Lane
Tampa, FL 33619

Claimant:
[redacted]

[] SSA's record shows Representative Payee

Proposed Future Medical WCMSA Amount: $821,492.00
Proposed Future Rx WCMSA Amount: $174,384.00
Total Proposed WCMSA: $995,876.00
Proposed Initial Deposit: $127,401.00
Total Settlement Amount: $3,495,876.00

Recommended WCMSA: $1,057,602.00 **Pricing Method:** Fee **WC State:** CALIFORNIA
Recommended WCMSA Lump Sum [] or
Recommended WCMSA Structured Payments: [X]
Recommended Initial Deposit: $149,508.00
Annual Amount: $47,794.00 x 19 yrs.
Anniversary Date: 06/03/2021
Type of Recommendation: Counter-Higher
If not eligible for WCMSA, reason:

Current Treatment Status for WC Injury or Disease (including past medical treatment):

THE CLAIMANT SUSTAINED AN INJURY ON 1/27/2014, AS A RESULT OF A FALL FROM A TWO-STORY PLATFORM. DIAGNOSES INCLUDED ASIA D C4-5 LEVEL TETRAPARESIS, TRAUMATIC BRAIN INJURY, MULTIPLE FRACTURES, INCLUDING TO THE RIGHT WRIST, RIBS, LEFT SKULL FRACTURE, AND LEFT ORBIT, NEUROGENIC BLADDER WITH URINARY TRACT INFECTIONS, PYELONEPHRITIS, ACUTE EMBOLISM, DEEP VEIN THROMBOSIS, NEUROGENIC BOWEL, LUMBAGO, TINEA UNGUIUM, AND FOOT DROP. THE SUBMITTER'S PROPOSAL ALLEGED THE PULMONARY, PSYCHOLOGICALCONDITION, AND SLEEP APNEA WERE DENIED BY THE CARRIER. AS THE SUBMITTER HAS FURNISHED PROOF THAT THESE MEET CRITERIA FOR DENIAL, FUTURE TREATMENT FOR THESE WERE EXCLUDED FROM THE WCMSA. THE CLAIMANT REQUIRED EMERGENT CARE FOR CONDITION ASSESSMENT AND HOSPITAL ADMISSION. INITIAL TREATMENT INCLUDED A CERVICAL SPINE FUSION SURGERY FOR STABILIZATION. SUBSEQUENT TO DISCHARGE, THE CLAIMANT PARTICIPATED IN A COMPREHENSIVE IN PATIENT PROGRAM FOR FUNCTIONAL IMPROVEMENT. ADDITIONAL TREATMENT CONSISTED OF SPECIALTY PHYSICIAN VISITS, DIAGNOSTIC STUDIES, THERAPIES, AND MEDICATION. THE CLAIMANT REQUIRED DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES FOR ACTIVITIES OF DAILY LIVING, AND A BLADDER AND BOWEL PROGRAM INCLUDING INTERMITTENT CATHETERIZATION. HOME SKILLED NURSING WAS PROVIDED. BY SEPTEMBER 2019, THE CLAIMANT UTILIZED A POWER CHAIR, AND COULD AMBULATE SHORT DISTANCES WITHIN THE HOME WITH A WALKER. SURGERY IS ANTICIPATED FOR THE BLADDER STOMA. CURRENT TREATMENT INCLUDES PHYSICIAN FOLLOW UP FOR SYMPTOM AND MEDICATION MANAGEMENT, WITH PERIODIC URINE DRUG TESTING, VARIOUS MEDICAL SUPPLIES AND EQUIPMENT, AND PRESCRIBED MEDICATIONS.

Past Medical Treatment Unrelated to WC Injury or Its Co-Morbid Conditions:

PULMONARY CONDITION, SLEEP APNEA, PSYCHOLOGICAL CONDITION.

Future Treatment (for Medicare-covered items and reimbursable services for the WC injury only):

THE FOLLOWING SERVICES ARE INDICATED FOR THE INDUSTRIAL INJURY:

The following chart summarizes the future medical treatment costs (exclusive of pharmacy items) that

adequately protect Medicare's interests:

Service	Freq	Every X Yrs	# of Years	Price Per Service	Total
INTERNIST/PRIMARY CA	12.00	1.00	20.0	$102.65	$24,636.00
PHYSICAL MEDICINE AN	8.00	1.00	20.0	$148.73	$23,796.80
NEUROSURGEON	1.00	1.00	20.0	$148.73	$2,974.60
PHYSIATRIST	4.00	1.00	20.0	$102.65	$8,212.00
ORTHOPEDIC PHYSICIAN	1.00	1.00	20.0	$148.73	$2,974.60
INFECTIOUS DISEASE P	1.00	1.00	20.0	$148.73	$2,974.60
UROLOGIST	2.00	1.00	20.0	$148.73	$5,949.20
PODIATRIST CONSULTAT	1.00	20.00	20.0	$224.09	$224.09
PSYCHIATRIC CONSULTA	1.00	20.00	20.0	$224.09	$224.09
SURGERY, BLADDER TO	1.00	20.00	20.0	$3,830.69	$3,830.69
PHYSICAL THERAPY	72.00	20.00	20.0	$127.08	$9,149.76
OCCUPATIONAL THERAPY	24.00	20.00	20.0	$127.08	$3,049.92
SPEECH THERAPY	24.00	20.00	20.0	$136.00	$3,264.00
INTERMITTENT SELF CA	12.00	1.00	20.0	$1,464.00	$351,360.00
URINARY DRAIN BAG/LE	12.00	1.00	20.0	$48.26	$11,582.40
ANKLE-FOOT ORTHOSIS	6.00	20.00	20.0	$1,697.81	$10,186.86
RIGHT LEG KNEE-ANKLE	6.00	20.00	20.0	$4,024.28	$24,145.68
SPLINT, RIGHT WRIST	6.00	20.00	20.0	$481.34	$2,888.04
WRIST-HAND-FINGER OR	6.00	20.00	20.0	$1,727.05	$10,362.30
BRACE, BACK	6.00	20.00	20.0	$190.03	$1,140.18
HOSPITAL BED WITH PR	2.00	20.00	20.0	$2,707.47	$5,414.94
HOYER LIFT WITH SLIN	2.00	20.00	20.0	$1,891.52	$3,783.04
TRANSFER BOARD	4.00	20.00	20.0	$51.55	$206.20
BEDSIDE COMMODE	4.00	20.00	20.0	$131.09	$524.36
CUSTOMIZED POWER WHE	4.00	20.00	20.0	$32,730.26	$130,921.04
POWER WHEELCHAIR MAI	1.00	1.00	20.0	$3,273.03	$65,460.60
POWER WHEELCHAIR BAT	1.00	1.00	20.0	$168.11	$3,362.20
POWER WHEELCHAIR CU	10.00	20.00	20.0	$364.30	$3,643.00
MANUAL WHEELCHAIR (B	2.00	20.00	20.0	$3,133.91	$6,267.82
MANUAL WHEELCHAIR MA	1.00	1.00	20.0	$313.39	$6,267.80
WALKER	6.00	20.00	20.0	$55.45	$332.70
BONE DENSITY	1.00	20.00	20.0	$428.57	$428.57
CT, HEAD	4.00	20.00	20.0	$160.20	$640.80
CT, CERVICAL SPINE	4.00	20.00	20.0	$216.45	$865.80
X-RAYS, CERVICAL	6.00	20.00	20.0	$70.28	$421.68
MRI, LUMBAR	4.00	20.00	20.0	$510.76	$2,043.04
X-RAYS, LUMBAR	6.00	20.00	20.0	$67.30	$403.80
X-RAYS, CHEST	1.00	1.00	20.0	$50.72	$1,014.40
CT, ABDOMEN/PELVIS	4.00	20.00	20.0	$276.99	$1,107.96
X-RAYS, ABDOMINAL	6.00	20.00	20.0	$67.17	$403.02
CYSTOGRAPHY	6.00	20.00	20.0	$55.66	$333.96
URODYNAMIC TESTING	6.00	20.00	20.0	$1,441.23	$8,647.38
EMG, URETHRAL SPHINC	1.00	20.00	20.0	$93.50	$93.50
VOIDING PRESSURE	1.00	20.00	20.0	$228.17	$228.17
CYSTOURETHROGRAM	1.00	20.00	20.0	$136.24	$136.24

ULTRASOUND, RENAL	1.00	1.00	20.0	$157.66	$3,153.20
VENOUS DOPPLER, BILA	6.00	20.00	20.0	$356.22	$2,137.32
COMPLETE BLOOD COUNT	1.00	1.00	20.0	$9.32	$186.40
COMPREHENSIVE METABO	1.00	1.00	20.0	$12.67	$253.40
VENIPUNCTURE	1.00	1.00	20.0	$3.60	$72.00
VITAMIN D LEVELS	1.00	1.00	20.0	$35.52	$710.40
URINE DRUG SCREEN	4.00	1.00	20.0	$137.32	$10,985.60
URINALYSIS	2.00	1.00	20.0	$4.22	$168.80
URINE CULTURES	2.00	1.00	20.0	$10.79	$431.60
FLU VACCINE	1.00	1.00	20.0	$26.05	$521.00
PNEUMOVAX	4.00	20.00	20.0	$114.21	$456.84
SKILLED NURSE	12.00	1.00	20.0	$501.60	$120,384.00
EMERGENCY DEPARTMENT	10.00	20.00	20.0	$625.45	$6,254.50
HOSPITAL BED MAINTEN	18.00	20.00	20.0	$270.75	$4,873.50
Total:					$896,466.39

Prescription Drugs (for Medicare-covered and reimbursable drugs for the WC injury only):

THE FOLLOWING MEDICATIONS ARE INDICATED FOR THE INDUSTRIAL INJURY:

According to available documentation, this claimant is currently receiving the following drugs: ACETAMINOPHEN/HYDROCODONE BITARTRAT, BACLOFEN, DULOXETINE HYDROCHLORIDE, MYRBETRIQ, OXYBUTYNIN CHLORIDE, GABAPENTIN,

The following chart summarizes the future prescription drug costs that adequately protect Medicare's interests:

Drug	National Drug Code	Amount Per Unit (Dosage)	Per Day	Per Week	Per Month	# of Years	Price Per Units	Total
BACLOFEN	71930-0007-12	20 MG	0.00	0.00	120.00	20	$0.55	$15,840.00
ACETAMINOPH	71930-0019-52	325 MG-5 MG	0.00	0.00	30.00	20	$0.33	$2,376.00
GABAPENTIN	52343-0031-99	300 MG	0.00	0.00	180.00	20	$0.03	$1,296.00
DULOXETINE	47335-0382-83	30 MG	0.00	0.00	30.00	20	$1.92	$13,824.00
MYRBETRIQ	00469-2602-90	50 MG	0.00	0.00	30.00	20	$15.37	$110,664.00
OXYBUTYNIN	10135-0611-01	15 MG	0.00	0.00	30.00	20	$2.38	$17,136.00
							Total:	$161,136.00

Rationale for Decision:

INSTEAD OF THE SUBMITTER'S PROPOSED SET-ASIDE, CMS HAS DETERMINED THAT A DIFFERENT SET-ASIDE AMOUNT IS NECESSARY TO PROTECT MEDICARE'S INTEREST FOR THE FOLLOWING REASONS: MEDICAL SERVICES PRICING WAS HIGHER THAN THE SUBMITTED PROPOSAL. THIS RESULTEDIN A COUNTER HIGHER. THE SUBMITTER'S PROPOSAL ALLEGED THE PULMONARY, PSYCHOLOGICAL CONDITION, AND SLEEP APNEA WERE DENIED BY THE CARRIER. AS THE SUBMITTER HAS FURNISHED PROOF THAT THESE MEET CRITERIA FOR DENIAL, FUTURE TREATMENT FOR THESE WERE EXCLUDED FROM THE WCMSA. REVIEWED 3/3/2020. AN INITIAL DEPOSIT OF $149,508 INSTEAD OF THE SUBMITTER'S PROPOSED INITIAL DEPOSIT OF $127,401 WILL ADEQUATELY PROTECT MEDICARE'S INTEREST. 1,057,602 RECOMMENDED MSA, MINUS 3,831 A. COST OF 1ST SURG PROC (INCL

PREP) 44,778 B. COST OF 1ST REPLACEMENT 0 C. RX INITIAL DEPOSIT 1,008,993 EQUALS REMAINING LIFE NEEDS 20 LIFE EXPECTANCY 50,450 REMAINING NEEDS/LE= ANNUAL NEEDS 2 TIMES TWO YEARS 100,899 D. EQUALS TWO YRS OF REMAINING NEEDS 149,508 CALCULATED INITIAL DEPOSIT = A+B+C+D

The following chart summarizes the services and costs that adequately protect Medicare's interests:

Subtotal Future Treatment: $896,466.00
Subtotal Prescription Drugs: $161,136.00
Grand Total: $1,057,602.00

ADMINISTERING YOUR STRUCTURED WORKERS' COMPENSATION MEDICARE SET ASIDE ARRANGEMENT (WCMSA)

You have chosen to personally administer the WCMSA account established as part of a Workers' Compensation (WC) settlement, judgment, award, or other payment. It is important that you understand the Centers for Medicare & Medicaid Services' (CMS) policies regarding WCMSA accounts.

In order to comply with Section 1862(b)(2) of the Social Security Act, Medicare is not permitted to pay for medical items or services, including prescription drug expenses, related to the workers' compensation claim until the approved WCMSA amount is appropriately exhausted ("properly spent") on related medical care that is covered and otherwise reimbursable by Medicare ("Medicare covered"). Where a workers' compensation settlement, judgment, award, or other payment is less than the approved WCMSA amount, Medicare is not permitted to pay for related medical care until the whole settlement, judgment, award, or other payment is properly spent on related medical care. The WCMSA funds must be placed in an interest bearing account. Funds in the account may not be used for any purpose other than payment of future medical care that is Medicare covered and is related to the workers' compensation claim, or for certain allowable expenses. For details on using the account, see the WCMSA Reference Guide and the Self Administration Toolkit at http://go.cms.gov/wcmsa on the CMS website.

Funds in a WCMSA account may not be used to purchase a Medicare supplemental insurance policy or a Medigap policy, or to pay for the premiums for such policies.

When a WCMSA is funded as a structured settlement (settlement monies paid out in yearly installments over a number of years), any WCMSA funds that are not used in a given year must remain in the account to pay for related medical care during later years. If available WCMSA funds for a particular year (the current year's full structured payment plus any prior year's remaining funds plus interest) have been properly spent, Medicare will pay for covered items and services that are related to the workers' compensation claim for the remainder of that year until the scheduled date for the next deposit into the WCMSA account. Bills should be paid in the order they are received to help the Benefits Coordination & Recovery Contractor (BCRC) confirm that the funds have been properly spent for that year. Medicare will pay for items and services covered by Medicare that are unrelated to the workers' compensation claim according to Medicare's payment rules.

Basic instructions for establishing and administering a WCMSA account are listed below; more thorough instructions can be found in the Self Administration Toolkit mentioned above (http://go.cms.gov/wcmsa). If you have any further questions regarding these requirements, please contact the Medicare Regional Office (RO) assigned to you. You can find a list of ROs at http://cms.gov/regionaloffices/ on the CMS web site; scroll to the Downloads section near the bottom of the page. For questions about annual attestations or annual accountings, contact the BCRC:

NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113

Establishing and Using Your Medicare Set Aside Account

- WCMSA funds must be placed in an interest-bearing account, separate from your personal savings or checking account.
- WCMSA funds may only be used to pay for medical items and services and prescription drug expenses related to your workers' compensation claim that would **normally be paid by Medicare**, or for certain allowable expenses.
- If you have a question regarding Medicare's coverage of a specific item, service, or prescription drug, please call 1-800-MEDICARE (1-800-633-4227) or visit CMS' website at http://www.medicare.gov/ where you can search for the item, service, or drug to see if it's covered.

  Note: If funds from the WCMSA account are used to pay for services other than Medicare allowable medical expenses related to the workers' compensation claim, Medicare will not pay injury related claims until these funds are restored to the WCMSA account and then properly spent.

Record Keeping

- You may use the WCMSA account to pay for the following costs that are directly related to the account:
  - Document copying charges
  - Mailing fees or postage
  - Any banking fees related to the account
  - Income tax on interest income from the account
- As administrator of the account, you will be responsible for keeping accurate records of payments made from the account. These records may be requested by the BCRC as proof of appropriate payments from the WCMSA account.
- Annually, you must sign and submit a copy of the attached attestation letter, which states that all payments from the WCMSA account were made for Medicare covered medical and prescription drug expenses related to the workers' compensation claim, or for allowable expenses.
- You may optionally submit your annual attestation electronically using WCMSA Portal. An attestation submitted on WCMSA Portal will be immediately processed. For more information on using the WCMSA Portal, see the resources list at http://go.cms.gov/wcmsa
- The annual attestation must be submitted online in the WCMSA Portal or by mail to the BCRC at the address listed on the first page of these instruction no later than 30 days after the end of each reporting year, which starts with date the account is established and ends on that date in the following year.
- Funds remaining in the account at the end of a reporting year must remain in the account for the next year, along with any accrued interest.
- If your WCMSA funds are completely spent but you expect another annual deposit, send the attestation to inform Medicare that the account is temporarily exhausted. Medicare will pay for workers' compensation claim related medical expenses until the next annual deposit.
- The annual attestation should continue through depletion of the WCMSA account.
- In the event that you die before the funds in the WCMSA account are depleted, the account

will continue to exist for payment of any outstanding bills for work-related injury medical expenses and prescription drug expenses that would otherwise be covered by Medicare. For instructions related to the disbursement of remaining funds, please follow the instructions under Section 19.2 in the most recent version of the WCMSA Reference Guide at http://go.cms.gov/wcmsa.

DO NOT SEND YOUR ANNUAL ATTESTATION DIRECTLY TO CMS. Please send your annual attestation to the BCRC or submit electronically on the WCMSA Portal.

Workers' Compensation Medicare Set Aside Arrangement (WCMSA) Attestation of Expenditure for Structured Annuity

This attestation should be completed annually or when your annual funds run out, whichever comes first, and submitted using the WCMSA Portal or mailed to the BCRC at "NGHP, PO BOX 138832, Oklahoma City, OK 73113," starting one year from the date the account is established. **Note:** Please make several copies of this attestation if submitting by mail, because you must send it to the BCRC each year until all of your WCMSA funds have been appropriately exhausted (properly spent).

ARMANDO MARTINEZ
*****65QT76

Date:

Total WCMSA amount in CMS' approval letter: $1,057,602.00

Individuals who have a CMS-approved WCMSA account as part of a workers' compensation settlement agreement may only use the funds in the WCMSA account to pay for Medicare covered and otherwise reimbursable items and services that are related to the workers' compensation claim.

(Please circle one.)

1. I, the undersigned, attest that I have a **structured annuity** WCMSA and have used the monies from the WCMSA account for the period of to to pay for the following:

   Medical services: $
   Prescription drug expenses: $

2. I, the undersigned, attest that I have a **structured annuity** WCMSA and have EXHAUSTED the annual money (and any applicable carry over from previous years) in the WCMSA account for the period of to to pay for the following:

   Medical services: $
   Prescription drug expenses: $

3. I, the undersigned, attest that I have a **structured annuity** WCMSA and have COMPLETELY EXHAUSTED all monies in the WCMSA account to pay for the following:

   Medical services: $

Prescription drug expenses: $

I acknowledge and understand that failure to appropriately exhaust my WCMSA amount on Medicare-covered and otherwise reimbursable items and services, including prescription drugs, related to my workers' compensation claim will result in Medicare denying payment for related medical items and services up to the approved WCMSA amount or the total workers' compensation settlement, judgment, award, or other payment amount, whichever is less.

Signature Date

Witness Date

CMS reserves the right to audit how you spent the funds in your WCMSA account. Therefore, CMS recommends that you retain your WCMSA records for a period of seven (7) years. However, please do not send your receipts or bank statements to CMS or the BCRC except on request.

"There is More to Future Medical than just the MSA"

Common Services/Supplies Not Covered By Medicare Parts A & B

It is Important to Incorporate Non-Medicare Medical Costs into your Settlement Demand

Not Covered	Exceptions/Explanations
Acupuncture	Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain. Medicare covers an additional 8 sessions if you show improvement. If your doctor decides your chronic low back pain isn't improving or is getting worse, then Medicare won't cover your additional treatments. No more than 20 acupuncture treatments can be given yearly.
Alternative Therapies	Including massage therapy, chelation therapy and holistic medicine
Blood - limited	The first three pints are not covered. After the first three pints, beneficiary pay 20% coinsurance of the Medicare approved amount
Chiropractic Services - very limited	Medicare covers manipulation of the spine if medically necessary to correct a subluxation. Beneficiary pays 20% coinsurance. You pay all costs for any other services or tests ordered by a chiropractor (including x-rays and massage therapy)
Common Medical Supplies - Like Bandages and Gauze	
Concierge Care	Also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice or direct care.
Cosmetic Surgery	Unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction covered for a mastectomy because of breast cancer.
Custodial Care	Not covered when that is the only kind of care needed. Defined as assistance with activities of daily living such as bathing and eating when provided by unskilled individuals. Most nursing home care is custodial care.
Deductibles, Coinsurance & Copayments	Deductible-the amount that must be paid before Medicare begins to pay. Coinsurance-your percentage share of the costs. Copayment-your fixed share of the costs
Dental Service	Medicare does not cover routine dental care, dentures or most dental procedures
Durable Medical Equipment - limited	Provided under Part B but there is no coverage if the beneficiary's doctor or supplier is not enrolled in Medicare. If covered, beneficiary pays 20% coinsurance.
Emergency Services	Medicare Part "B" only pays for an injury or illness that requires immediate medical attention to prevent a disability or death. There is a set copay for the emergency room visit, 20% for the doctor's services and the Part B deductible applies.
Eye Exams, Eyeglasses and Contact Lenses	Medicare does not cover routine eye exams. Some eye tests and screenings are covered. One pair of eyeglasses with standard frames (or contact lenses) only after cataract surgery that implants an intraocular lens.
Foot Care	Routine foot care is not covered
Gym Memberships	
Health Care While Traveling Outside the U.S.	Rare exception for hospital care in Canada or Mexico
Hearing Aids & Exams	Medicare does not cover routine hearing exams or hearing aids
Home Modifications	
Home Repairs/Maintenance	

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"There is More to Future Medical than just the MSA"

Common Services/Supplies Not Covered By Medicare Parts A & B

(Continued From Front)

Not Covered	Exceptions/Explanations
Incontinence Supplies & Adult Diapers	
Long Term Hospital Care	Beneficiary pays: $1,556 yearly deductible; Coinsurance of $389/day for days 61-90; $778/day for days 91-150; all costs for each day beyond lifetime reserve days
Long Term Inpatient Mental Health Care	Not covered after a total of 190 days in a specialty psychiatric hospital during beneficiary's lifetime
Long Term Skilled Nursing Facility Care	Beneficiary pays coinsurance of $194.50 per day for days 21 – 100 per benefit period. Not covered beyond 100 days per benefit period
Over - The - Counter Medications	
Prescription Drugs - limited	Most prescription drugs, as well as off-label uses, are not covered under original Medicare. Beneficiary must buy Part D for coverage
Psychiatric Care – limited	One depression screening per year. Beneficiary pays 20% coinsurance for outpatient treatment (such as counseling or psychotherapy) in a doctor's office setting
Routine Physical Exams	
Routine Screening Tests	Most screening tests like checking your hearing are not covered
Transportation (routine)	

"Even if Medicare covers a service or item, you generally have to pay your deductible, coinsurance and copayment"*

Medicare premiums, deductibles and coinsurance rates for 2022:

- Part A (Hospital Ins.) No Monthly Premium if Medicare taxes paid while working (some exceptions)
- Part B (Medical Ins.) The Standard Premium amount is $170.10/mo. or higher depending on income

- Part A Deductible: $1,556 Paid by beneficiary for each benefit period.
- Part B Deductible: $ 233 per year. After the deductible is met, beneficiary typically pays 20% coinsurance of the Medicare-approved amount of the service

Above information is based on Original Medicare.

- A Medigap (Medicare Supplemental Insurance) policy, sold by private insurance companies, can help pay some of the health care costs ("gaps") that original Medicare doesn't cover, like copayments, coinsurance and deductibles

- Sources: Medicare.gov, Medicare publications: "Medicare & You 2022"*, "Medicare 2022 Costs"

Please contact us to assist you in determining the present value of the above items

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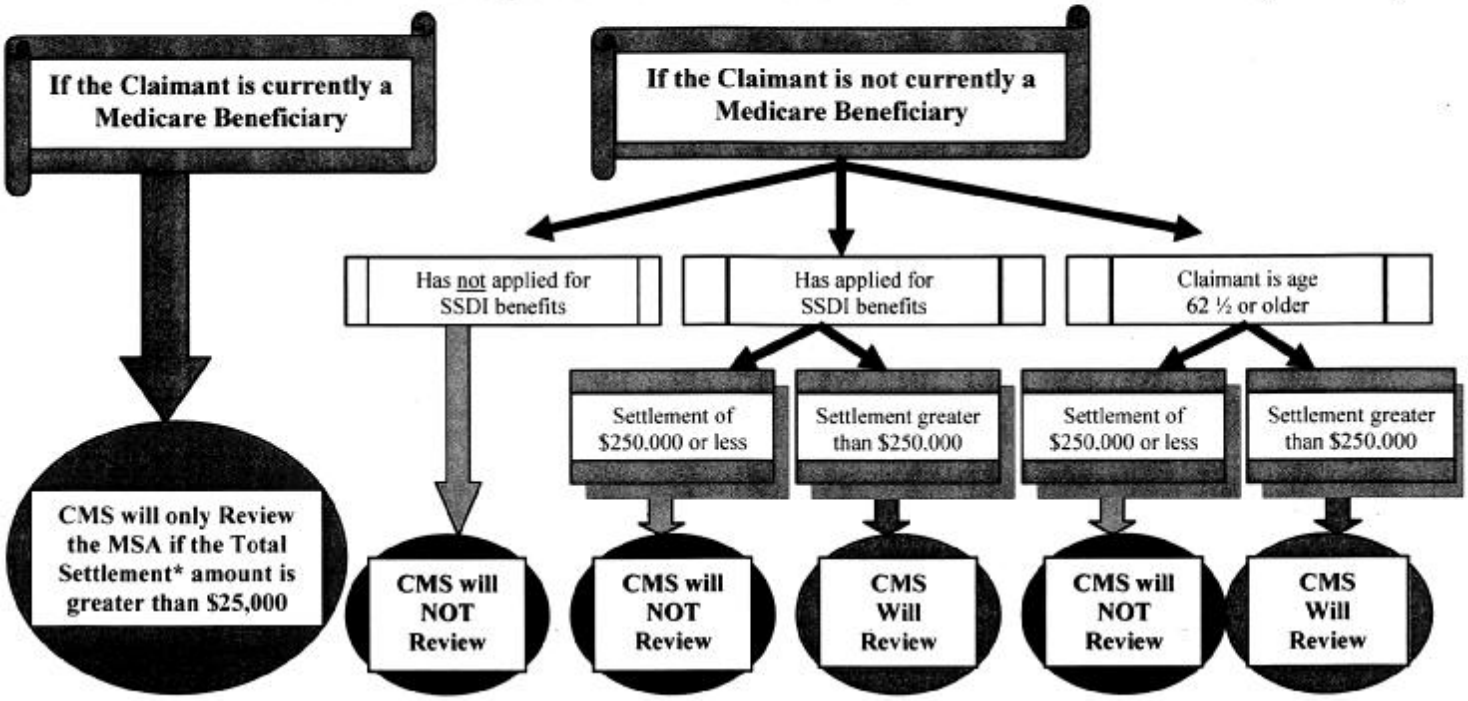
CMS Thresholds for Reviewing Workers' Compensation Medicare Set-Aside Agreements (MSA's)



*See below for CMS definition of Total Settlement and for the complete list of MSA review criteria from the Centers for Medicare & Medicaid Services (CMS).

*A MSA meets CMS' criteria for review when the following thresholds are met:

- 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 of duration of the settlement agreement is expected to be greater than $250,000

Situations where an individual has a reasonable expectation of Medicare enrollment within 30 months include but are not limited to:

1. The individual has applied for Social Security Disability Insurance (SSDI) benefits.
2. The individual has been denied SSDI but anticipates appealing that decision
3. The individual is in the process of appealing and/or re-filing for SSDI
4. The individual is 62 ½ years old (i.e. may be eligible for Medicare based upon his/age within 30 months)
5. The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD. (Sec. 8.1)

Total settlement amount includes, but is not limited to, wages, attorney fees, all future medical expenses and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the WC claim must be included in computing the total settlement amount.

These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases.

CMS Guidance Regarding Submitting a WCMSA for Review

Per Sec. 8 of the CMS Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide v. 3.5 dated 1/10/2022: "There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review". Per Sec. 4.3: ".42 C.F.R. 411.46 specifically allows CMS to deny payment for treatment of work-related conditions if a settlement does not adequately protect the Medicare program's interest. Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program's interests are adequately protected. As such, CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement. As a matter of policy and practice, CMS will deny payment for medical services related to the WC injuries or illness requiring attestation of appropriate exhaustion equal to the total settlement less procurement costs before CMS will resume primary payment obligation for settled injuries or illnesses. This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount."

Please contact STEVEN F. CHAPMAN, STEFANIE V. PLOTKIN or GREGG M. CHAPMAN for all your Structured Settlement needs: 800-845-2969 www.workcompsettlementconsultants.com

NSSTA National Structured Settlements Trade Association Member

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Structured Settlement Specialist

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Why You Want to Structure the Medicare Set-Aside (MSA)

Using a Structure to Fund the MSA:

< Maximizes Settlement Dollars >
< Frees up Additional Funds for the Applicant >
< Bridges the Gap between Demand and Offer >
< Provides Flexibility to the Settlement Process >

High MSA totals run the risk of preventing any further C & R discussions. Through the use of a structured settlement, you may be able to keep the cost of your MSA within reason, allowing for the settlement of your case.

Example

- 34 year old male applicant suffered a lower back injury during the course of his employment
- Medical records were submitted to Underwriting and a rated age of 43 was obtained
- The MSA report from the vendor provided the following:
  - **$262,888.00** Total MSA Allocation (lump sum)
    As well as
  - $22,616.00 Seed Amount
  - $7,025.50 Annual Payments

The Annuity Cost to provide the Annual Payments was $106,371.00
Structuring the MSA thus costs:
$22,616.00 Seed +$106,371.00 Annuity = **$128,987.00**

Structuring the MSA provides a savings of $133,901.00
This savings made the difference and led to a settlement!