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August 7, 2008

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RE: Workers' Compensation Review Contractor (WCRC) Request for Information (RFI) industry comments

Dear Mr. Fredericks:

On behalf of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), we ask your consideration of the following industry comments in regard to the RFI notice for the WCRC function.

NAMSAP is a non-profit professional organization formed to address issues and challenges related to Medicare Secondary Payer (MSP) compliance. Our organization is comprised of approximately 600 members including attorneys, nurses, structured settlement brokers, insurance carriers, and professional administrators who work actively within the MSP compliance industry.

Our membership desires to share concerns regarding what it considers inappropriate and/or inefficient review practices by the WCRC in order to assist CMS in making an informed decision regarding Scope of Work issues. The following represents a compilation of experiences submitted by our members.

#### **Methodology for Calculation of Costs Contrary to CMS Policy:**

CMS policy indicates that MSA arrangements may be calculated at the WC reimbursement rate in the state of claim jurisdiction. The WCRC consistently recalculates MSA care costs at a rate other than the WC reimbursement rate. The establishment of standard pricing for certain procedures or "flat rate" pricing by the WCRC for services

without regard to the applicable state of jurisdiction has become commonplace. This is a clear violation of CMS policy. In addition, the WCRC will not disclose the rationale or source of the required flat rate pricing amount in most cases.

### **Failure to Consider Individual Case Circumstances:**

The WCRC often utilizes a “cookie cutter” approach when reviewing MSA arrangements. Requirements for the type, frequency and duration of care are often determined without consideration of the individual case circumstances. Although the WCRC verbalizes that it reviews cases on an individual basis, analysis of WCRC review decisions does not support this claim

Resources are being utilized by the WCRC to obtain statistics for average utilization of supplies or services based on diagnoses rather than considering the actual usage or recommendations of the specific case being submitted.

Example: The WCRC requires a minimum of \$660 per year for catheter supplies in cases involving intermittent catheterization. In cases where there is no history of chronic urinary tract infections and clean catheterization techniques are being utilized and are appropriate, the cost is significantly less and therefore the \$660 minimum charge is not appropriate. The WCRC indicates that it utilizes decision making tools such as the “National Spinal Cord Injury Data Base” to obtain statistics of average expenditures in spinal cord injury cases. WC law requires that the primary payer is obligated to pay the injury related expenses at WC reimbursement rates that are applicable to the individual injured worker’s needs, not average national cost of care statistics.

Example: Medical records documented historic utilization of lumbar CT scans (not MRI) and the MSA therefore allocated future CT scans. WCRC changed the allocated CT scans to MRIs with no justification or physician recommendation. The MRI’s were more expensive than the CT scans.

Example: The WCRC requires the inclusion of psychiatric physician visits whenever the claimant is taking psychotropic medications even when there are no current or future recommendations for psychiatric care. Psychotropic medications are commonly prescribed by a pain management physician or the primary treating physician for pain control and not for treatment of a psychiatric disorder.

### **CPT Upcoding**

The WCRC regularly requires a higher level of service than recommended by the physician or historically utilized.

Example: An MRI may be ordered by the physician either with or without contrast based on clinical indications. MRI with contrast is more expensive than without. The WCRC requires all MRIs be priced to include contrast regardless of clinical indicators, historic utilization or future recommendations. In cases where all previous MRIs have been completed without contrast and there is no future recommendation for surgery or other procedure that would justify future MRIs with contrast, MRIs with contrast are still required to be included.

Example: X-rays increased to a higher number of views than historically utilized or indicated.

Example: Physician office visits routinely increased to a higher (more expensive) complexity level than utilized historically. In addition to complexity upcoding, the WCRC routinely upcodes to the highest locality for the state of jurisdiction regardless of the claimant's actual locality.

### **Increased Frequency of Service**

The WCRC regularly increases the frequency of service or equipment replacement without justification.

Example: WCRC requires that physician visits be no less than 4 times per year for chronic pain cases and/or cases where the claimant is taking a narcotic medication regardless of historic treatment patterns or recommendations. Even in cases of claimants with documented physician visits of 2 times a year for several years, the physician visits were increased by the WCRC to 4 times a year.

Example: The WCRC requires costs be added to the MSA for yearly maintenance/repair of wheelchairs even in the year that costs were included for a new wheelchair. It is a nationally accepted standard of practice by Life Care Planners that maintenance/repair costs are not included in the care projection in the year of replacement.

### **Inappropriate Requirements for Services not Covered by Medicare:**

Per CMS Policy, the MSA should contain future medical and prescription drug services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare. The WCRC continues to require care costs not otherwise reimbursable by Medicare under the Medicare coverage guidelines based on the individual case criteria.

Example: The WCRC has required the inclusion of any chiropractic care. 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.

### **Annuity Calculation Inconsistencies:**

The WCRC is inconsistent in regard to the calculation of seed funds for annuitized MSAs. The current CMS policy is to allocate for the first surgical procedure and/or first replacement. If multiple surgical procedures are allocated, the one which will be performed first should be included (if this can be clearly distinguished).

Example: This example involves a future spinal cord stimulation (SCS) trial and implantation. In one case the WCRC required only the trial SCS in the seed. In another case the WCRC required only the first permanent implant in the seed. In yet another case, the WCRC required both the trial SCS and the permanent implant in the seed. When questioned about the WCRC's current procedure, the WCRC confirmed that under current CMS policy only the first surgical procedure should be included which is the trial SCS.

### **Inappropriate Utilization of a Proposed Settlement Date:**

The CMS simple submission document indicates a proposed settlement date (PSD) should be used when there is no known settlement date. The PSD is a default date of 4 months from the date the submission is received. In cases that were settled prior to CMS submission, the actual settlement date is known. The WCRC has indicated that a PSD will be used in all cases even when the actual settlement date is known. If the rated age utilized to calculate the life expectancy (LE) expires within the PSD time frame, even if the rated age was not expired on the settlement date or even on the date the MSA was reviewed, the WCRC will change the LE to reflect the actual age, not the rated age and change the annuity payments accordingly. Since these cases have already been settled, the seed money already disbursed and the annuity already been purchased, this creates an impossible situation for the settling parties without justification.

### **Inflexible Stance on Re-Reviews and “New” Evidence:**

There is currently no formal appeals process in place to dispute CMS’ determinations in regard to a MSA review. At present, the only remedy is to present “new” evidence to CMS and request re-consideration. CMS Regional Offices are increasingly resistant to override the findings of the WCRC even in the presence of inappropriate application of CMS policy. Examples include limitations of state law, cost requirements over the state WC fee schedule and inclusion of costs for non-Medicare allowable services. CMS and/or the WCRC have begun to impose strict guidelines on what constitutes “new” evidence, making it extremely difficult to dispute cases where the WCRC may have made an error.

Example: A claimant treated for a blood clot in the lower extremity due to a work injury with anticoagulant therapy for approximately 1 year. The injury was resolved and there was no treatment for approximately 7 years; therefore, no subsequent medical records exist. The WCRC required costs be added to the MSA for anticoagulant therapy and related lab work. When questioned regarding the logic supporting this decision, the WCRC’s position was that the review must be based on the last treatment recommendations presented for review (no matter how old). CMS would not override the WCRC’s position.

### **Inconsistent Weight of IME/QME Recommendations:**

CMS will accept the recommendations of the IME or QME if those recommendations require treatments exceeding the recommendations of the treating physician and thereby, increasing 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.

Example: The treating physician recommended lumbar surgery in 2005. The surgery was not performed. This surgery was not included on the MSA as two IME opinions provided after the treating physicians’ recommendation, 3 years prior, indicated that the surgery was not medically necessary. The WCRC required the cost of the lumbar surgery be included in the MSA.

## **Requirements Contrary to Limitations of 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.

Example: The claimant's WC injury did not justify, nor did any WC treating physician prescribe, a wheelchair. A wheelchair was never purchased by the WC carrier per the pay history. Claimant had co morbidities not related to the WC injury that would support the use of a wheelchair. Since the claimant utilized a wheelchair to attend a physician appointment, the physician noted in the medical record that the "claimant presented in his wheelchair". As a result, the WCRC added a wheelchair replacement every 5 years for life expectancy. The wheelchair is not covered under WC state law as it is not related to the WC injury.

Example: The WCRC's pricing of surgical procedures is inconsistent with WC reimbursement rates in the state of jurisdiction. When contacted for information on how they arrive at surgical pricing, the WCRC indicated they have a price range from which each reviewer can choose from and would not disclose the pricing source.

Example: The Colorado WC statute limits prosthesis replacements. Prosthetic replacements for an above the knee amputation was limited in the MSA submitted for review. A copy of the statute was submitted with the MSA. The WCRC required the prosthetic replacements be added to the MSA therefore overriding the state WC statutory limitations.

## **Lack of Communication with the Industry**

The WCRC changes their review procedures and MSA requirements regularly and without notice to the industry. Changes in the requirements for the WCRC's flat rate pricing, level of service and frequency of service occur without notice or justification. Since the industry must wait until it starts receiving counter proposals on previously submitted MSAs to become aware of new WCRC requirements, it may have 45 to 90 days of MSAs in the review pipeline that will be impacted. The industry is in the position of constantly trying to hit a moving target. In addition, when questioned about changes, the WCRC is unable to provide adequate justification for the new requirements.

Example: The WCRC required flat rate pricing for Spinal Cord Stimulator (SCS) implantation and related procedures. Although flat rate pricing was considered inappropriate by the industry because the required pricing failed to consider jurisdictional WC reimbursement rates, the industry often conceded the required price in order to obtain CMS approval. Without notice, the WCRC raised the required flat price significantly and submitters were unaware of the new requirements until MSA arrangements began coming back unapproved and recalculated at the new flat rate. Since SCS implantation commonly occurs in WC injury care, this created significant unnecessary expenditure of industry resources to renegotiate settlement amounts, restructure annuities, rework settlement documents, etc. and delayed settlement finalization.

NAMSAP believes that it is in the best interest of the industry, and the WCRC, to improve the review practices and communication by the WCRC based on the above examples.

We appreciate your consideration of the concerns of our membership. If you would like additional information or case examples, please contact NAMSAP at 407-647-8839.

Sincerely,

The NAMSAP Board of Directors

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