Atlas Settlement Group, Inc.

Who's in Your Corner?

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Liability Update: CMS Still Quietly At the Drawing Board

As we have discussed in previous editions of our Report, CMS has actively been contemplating a more formalized process for Medicare Set-Aside (MSA) development and review, including the handling of future medical in the liability arena. The process initially began on June 15, 2012 when CMS published an Advanced Notice of Proposed Rulemaking (ANPRM), which sought public comment on the management of Medicare Set-Asides, most specifically how liability MSAs might be addressed. *Federal Register*, 77 FR 35917 (June 15, 2012).

It was largely anticipated that the ANPRM would result in further guidance regarding handling of future medicals in the liability realm. Subsequently, CMS indicated that a Notice of Proposed Rulemaking (NPRM) would be issued and "would announce CMS' intention regarding the means beneficiaries or their representatives might utilize to protect Medicare's interests with respect to Medicare Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault, and workers' compensation where future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care." *Federal Register*, RIN 0938-AR43, 2013.

However, since June 2012 we have waited for further direction from Medicare, without guidance. No further word followed CMS' call for comment. In the interim, parties have continued to resolve workers' compensation claims utilizing the guidelines prescribed by CMS memorandum, initially set forth in 2001, and confirmed as recently as the current WCMSA Reference Guide. In the more nebulous liability practice, parties attempt to ensure Medicare's interests are best protected under the Medicare Secondary Payer Act, 42 USC §1395y(b)(2), ensuring that future interests are considered where necessary.

In the past several years Medicare has continued to allow each of the ten (10) Regional Offices of CMS to review and approve liability MSAs on a discretionary basis. Several offices have opted to provide review and approval, while others have declined formal review, citing "resource constraints." Each of the offices has been clear to note that regardless of approval status, parties must ensure that Medicare's interests as secondary payer are accounted for upon claim resolution.

CMS has offered one liability memorandum, opining that parties resolving a third party claim in which *no* future medical is anticipated will not need to prepare and submit a MSA plan. Rather, a treating physician may certify, in writing, that treatment for the injury related to the liability settlement has been completed as of the settlement, and that future medical and services will not be required. The certification should be retained for the parties files, rather than submitted to CMS.

CMS memorandum, September 30, 2011, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Future-Medicals.pdf.

In the interim, CMS has continued to verbalize that a MSA should be considered in any "substantial" liability settlement involving a Medicare beneficiary. Yet, until recently, we have heard nothing of the ANPRM. Then, finally, in October 2014, additional word surfaced that CMS has actually continued to address this issue, although behind the scenes. As it turns out, CMS rather quietly submitted proposed regulations to the office of Management and Budget (OMB) for approval, entitled "Medicare Secondary Payer and 'Future Medicals'," but the proposal failed to pass. As of October 8, 2014 the proposal was rescinded.

It seems that CMS is continuing to seek protection of Medicare's interests under the MSP and therefore proposed some form of regulation or guideline. What is unknown at this time is why OMB rejected the proposal, or specifically what CMS' proposal entailed. If our readers will recall, the Advanced Notice of Proposed Rulemaking, set forth in the 2012 Federal Register, proposed a host of "options" for consideration in the handling of liability MSAs. CMS then sought public comment on the same. Claims organizations, attorneys, and insurance organizations alike encouraged Medicare to carefully consider the particular elements of a third party claim in addressing the feasibility of liability regulations and/or submission thresholds. Many objected to formalized "thresholds" for liability MSA. The NPRM that followed and was then submitted to OMB was not published. We are therefore not privy, at this time, as to what suggestions or decisions were made by CMS, and subsequently rejected by OMB.

It is very possible that CMS will go back to OMB with another proposal at which time we will hopefully have a more complete picture of their proposal and any challenges to the same. In the interim, we remain committed to the concept, as CMS has repeatedly stated, that workers' compensation, no-fault, and liability claims all fall under the scope of the Medicare Secondary Payer (MSP) Act, and thus protection should be afforded Medicare as secondary payer. As CMS is clearly still active in this arena and has not adjusted their scope, we suggest continued consideration of future interests in *substantial* liability claims.

Atlas Settlement Group Suggested Liability MSA Recommendations

Scenario A: If Plaintiff is currently a Medicare beneficiary and liability carrier is primary medical payer (i.e. – there is no underlying WC action which will remain open with a WC carrier continuing to cover treatment) and settlement is substantial, we suggest considering a MSA and submission to the appropriate Regional Office of CMS. Not every liability claim will need a MSA. We suggest you look case by case and examine the claim specifics, settlement details, future medicals, etc. Will you be leaving Medicare as the primary payer in a substantial claim with future medicals?

Scenario B: If Plaintiff is not yet a Medicare beneficiary, but following the WC standards has a "reasonable expectation" of Medicare eligibility within 30 months (i.e., on SSDI, but for less than 24 months; has applied for SSDI; 62.5 but not yet 65; renal disease but not yet qualifying for Medicare based upon the same), we suggest that in the parties' reasonable discretion, factoring in settlement value, you consider Medicare's interests, which *may* include a MSA. CMS primarily reviews settlements involving *current* beneficiaries, however we have had offices review significant "reasonable expectation" claims. Regardless of submission you should continue to take Medicare's interests into consideration where necessary. Again, make sure to include the value of the MSA in the settlement documents with all appropriate indemnity language. If in doubt regarding the protection of interests, submission is an option for consideration and discussion.

Scenario C: Where there is both a workers' compensation claim and a liability claim, CMS has issued some guidance (**4/21/03 Memo Q19**). CMS has noted, *"to the extent that a liability settlement is made that relieves a workers' compensation carrier from any future medical expenses, a CMS approved workers' compensation Medicare Set-aside Arrangement is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a WCMSA would be if it can be*

documented that the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted." These dual cases are particularly complicated and should be addressed on an individual basis.

****Scenarios A, B, and C cover many, but not all settlement situations. Scenarios A & B are not legal or CMS guidelines. Please address with your counsel the legal and business ramifications concerning Medicare issues in your individual claims. Please contact us directly to address MSA issues in liability claims and we will be happy to assist.****

Louisiana Workers' Compensation Settlement Vacated

A recurring theme in many of our discussions has been specificity in all settlement negotiations and corresponding release documents. We find ourselves once again learning of a case that addresses how absolute specificity might have assisted the parties in avoiding the minefield of the Medicare process and preventing post settlement headaches. Here, a fairly standard workers' compensation settlement was vacated as it was determined that the parties had no meeting of the minds as to who would pay for medical treatment and, essentially, when the MSA would take effect.

Employee Wendell McCarroll was injured in 2003, while employed with the Livingston Parish Council, insured by the Louisiana Workers' Compensation Corporation (LWCC). LWCC accepted the claim and Mr. McCarroll treated with a variety of providers. Eventually a cervical fusion was recommended, but Mr. McCarroll initially declined surgery.

In November 2008 LWCC began settlement negotiations with the Claimant and in January 2009 initial terms were agreed upon. The parties agreed to a Medicare Set-Aside (MSA) in the total amount of $98,684. Of that total, $21,793 was specifically allocated for surgical intervention. The MSA was to be funded via an annuity and would be approved by the Centers for Medicare and Medicaid Services (CMS).

Around this same time, Mr. McCarroll decided to proceed with surgery. Due to the pending settlement, LWCC denied the requested approval for surgery as unnecessary. The MSA had been submitted to CMS, and was subsequently approved on February 2, 2009, including the cost of the surgery.

Simultaneously, Mr. McCarroll and his counsel had become concerned about the cost of potential surgical expenses. They sought additional funds for the same as a negotiated component of settlement. The parties agreed upon an additional $5,000 as of February 10, 2009. Mr. McCarroll did then proceed with surgery on February 16. He subsequently suffered complications and spent a good deal of time in the ICU, incurring additional medical costs. Finally, the Settlement and Release was executed in March 2009, and approved by OWC on March 9, *after CMS approval, and after surgery had been performed*.

Two years passed and in March 2011 Mr. McCarroll filed a Petition to Enforce Settlement, or in the Alternative, to Nullify Court Approval of the 2009 agreement. Mr. McCarroll's claim argued essentially that his medical expenses had not been paid as he anticipated. Medicare had refused to pay expenses incurred prior to the March 9, 2009 approval of his workers' compensation settlement. LWCC refused to pay for treatment from late January 2009 through the March 9, 2009 OWC approval (including surgery). As such, he sought an order for payment by LWCC, or, in the alternative, nullification of settlement. Essentially, it seems as if the hospital and providers must have simply billed Medicare for the surgery. Though not specifically outlined in the decision, it would not be unusual for Medicare to deny this treatment if a known primary payer were involved (workers' compensation carrier). Here, the settlement was largely up in the air when surgery commenced. OWC had not signed off on the settlement prior to surgery, settlement had not resolved and arguably, the Employer/Insurer remained "on the hook" for surgical costs.

The case proceeded to trial in April 2013 and settlement was subsequently vacated by the Office of Workers' Compensation. Livingston Parish Council and LWCC appealed the decision and on October 27, 2014 the Appellate Court affirmed.

Defendants argue that the cost of Mr. McCarroll's surgery was funded as part of the settlement, specifically as a part of the MSA. $21,793 of the total settlement and MSA was allocated for the fusion.

Mr. McCarroll disagreed, responding in an interesting way. He argued that not only did *he* think that LWCC and Medicare would pay for the costs of his surgery, but that LWCC *also* believed that the surgery would be paid out of the the MSA, with any additional costs to be covered by Medicare. His argument was that OWC correctly vacated the settlement as neither party anticipated that his surgery would not be covered by the MSA and that he would be responsible for the costs of the fusion. He argued there was no meeting of the minds. *McCarroll*, 2014 La. App. LEXIS 2570 at 8.

The trial court put great emphasis on evidence of the parties attesting to great confusion as to who would pay for any excess expenses incurred above and beyond any initial estimated costs of surgery and the testimony of the an LWCC claims examiner who was unsure as to when a Claimant could begin use of a MSA. Her testimony indicated that it was LWCC's intention for Mr. McCarroll to use the MSA to fund the surgery as the MSA accounted for the surgical costs and that no one involved in the case "envisioned that Medicare would deny coverage because the surgery was done before the settlement was signed by the OWC." *McCarroll*, 2014 La. App LEXIS 2570 at 11. Mr. McCarroll testified that he would not have signed the settlement agreement had he known that he would be responsible for any of his medical expenses. The lack of consensus lead OWC to agree that there was a lack of meeting of the minds as to the initial settlement. Specifically OWC felt LWCC misunderstood that the surgery would be covered and that this misunderstanding led to an unintentional misrepresentation to the parties such that the settlement should be vacated. The Appellate Court concurred.

We agree the parties seemed confused and conflicted as to who was to cover the cost of this surgery, when surgery was to occur (if at all), and how and when the MSA was to take effect. However, the decision addressed only the confusion of the parties and whether there was "manifest error" on the part of the lower court, the OWC. What is not addressed by the decision, as not an issue for review, is the use of the MSA and Medicare's denial. Specifically, the Court does not provide us with the details of Medicare' denial of services, whether the Claimant made any appeal of the denial, and critically the authority for the basis that OWC must sign off on the settlement prior to use of the MSA. The parties have determined, based on the denial, that the MSA may not cover any portion of the costs, yet no authority is cited for the same. However, the Claimant had a CMS approved MSA including costs for the surgical intervention. The issue of use of the MSA is not directly before the Court, thus they have not addressed the same.

According to the WCMSA User Guide, Version 2.2, "parties can proceed with the settlement of the medical expenses portion of a WC claim before CMS actually reviews the proposed WCMSA and determines an amount that adequately protects Medicare's interests. However, approval of the WCMSA is not effective until a copy of the final executed WC settlement agreement, which must include the approved WCMSA amount, is received by CMS. *Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide*, May 29, 2014 p. 40. Here, the MSA was approved, but OWC had not approved settlement. Despite Medicare's denial of treatment, if the parties were in agreement, it would seem $21,793 could be put toward costs of the surgical intervention as CMS does not specifically require OWC or Board approval prior to use of the approved MSA. In order to finalize the MSA process, the parties would need to provide CMS with an executed copy of the settlement release, as they would in any case. However, OWC or Board approval of the same does not appear to be a specific requirement of CMS. Note, of course that state law might require approval for final settlement approval.

This decision exemplifies the need for parties to have absolute specificity in settlement negotiation, resolution and documentation. This issue might have be largely be avoided by specificity in the settlement of the claim and drafting of mediation and final settlement documents. The parties must consider any treatment that is to occur prior to CMS or Board approval and note what, if any, approval is necessary prior to final resolution and the party responsible for obtaining the same. Further, parties resolving workers' compensation and liability claims should consider and adjustments CMS might make to the MSA and account for the same. A Claimant such as Mr McCarroll must not only know that a MSA has been prepared, but what is covered, what is excluded, when it is to take effect, how he is to manage the account, and how any excess costs will be addressed.

As we see here, timing of settlement impacts this specificity. Mr. McCarroll was not at maximum medical improvement and was actively treating. He was still contemplating a surgical course of care as settlement approached. This is one of the most challenging scenarios in development of a MSA plan and leaves the Employer/Insurer open to the possibility of potentially paying for surgical intervention twice - both pre-settlement and again in the approved MSA. It is extremely difficult to project a settlement timeline with any accuracy when a party is actively pursuing aggressive care.

Where a claimant is mulling potential surgical intervention upon the threshold of settlement, parties must consider whether to include the surgery in the MSA and postpone treatment, or proceed with surgery pre-settlement and halt settlement negotiations until such time as the claimant has recovered sufficiently to determine a post-surgical course of treatment. As this case exemplifies, Medicare is very unlikely to cover treatment (or excess care) that is clearly claim related and perhaps should have been included under the umbrella of the claim. Given a timeline of the nature of this claim, the matter was certain to face scrutiny and likely, denial. CMS will be very wary of covering care if they have any suspicion that costs are being foisted upon Medicare. *Wendell McCarroll v Livingston Parish Council and Louisiana Workers' Compensation Corporation*, Court of Appeal of Louisiana, First Circuit, 2013 2120 (La. App. 1 Cir. 10/27/14); 2014 La. App. LEXIS 2570.

Termination of a Medicare Set-Aside Account

While this is not a new issue, one question frequently asked is "whether a MSA account may be terminated or modified following initial establishment?" What we find is that parties often cite to outdated information from Medicare regarding termination of an account. This is not surprising as Medicare has completely reversed position on this matter over time. As of 2008, the essential answer is that "no" a MSA account cannot be modified or terminated following initial establishment.

CMS initially held that in cases where the treating physician concluded that a beneficiary's condition had substantially improved, the beneficiary or his/her representative could submit a request to CMS seeking reduction of the MSA. *CMS Memorandum, April 22, 2003, Q11*. In 2005, CMS modified this policy, determining that the beneficiary's treating physician would have to conclude that the individual's condition had substantially improved, and the beneficiary would then need to submit a new MSA justifying at least a 25% reduction. Such an update could not be submitted until at least five years after the initial CMS approval letter. *CMS Memorandum, July 11, 2005*.

This "five-year-rule" is still quoted quite often. However, absent fanfare CMS quietly retracted this rule and procedure in 2008, issuing a statement noting, *"Effective immediately, the July 11, 2005 memorandum at Question and Answer 10, entitled 'Beneficiaries that Request Termination of a WCMSA Account' is rescinded. Section 1862(b)(2) of the Social Security Act (the Act) (42 USC 1395y(b)(2) requires that Medicare payment not be made for any item or service to the extent that payment has been made under a workers' compensation (WC) law or plan. Medicare does not pay for an individual's WC related medical services when that individual received a WC settlement, judgment or award that includes funds for future medical expenses, until all such funds are properly expended. To protect the Medicare Trust Fund, a set-aside arrangement should be funded based on the life expectancy of the individual unless the State law specifically limits the length of time that WC covers work-related conditions...". CMS Memorandum, August 25, 2008*.

Since this time, CMS has not offered to re-visit previously approved files. Most recently, CMS published the *WCMSA Reference Guide, Version 2.3*. Of interest, the User Guide provides MSA guidance for a plan where under funded, provides instruction for funds upon death of the Claimant (all claims are to be paid, with the remainder of the account to be disbursed pursuant to state law), and advises as to how funds are to roll over if not utilized within a given period. However, the User Guide, in accordance with the 2008 memorandum, does not provide any instruction for request for termination of a MSA account *prior to* beneficiary's death, or modification of the plan due to change in condition. Rather, the User Guide remains silent as to the same. For MSA purposes, it is therefore important that the MSA be submitted at a timely juncture and prepared with the understanding that a beneficiary has only one chance at CMS approval and must understand the permanence of the process.

Ten Scenarios In Which to Consider a Structured Settlement

When Atlas settlement Group and our partners provide a Medicare Set-Aside plan, we also provide an annuity quote to supplement the plan. This allows the parties considering settlement to consider how structured funding will impact resolution of a claim. Many are therefore accustomed to seeing annuity quotes for MSA purposes. This is not, however, the only arena in which a structure is applicable. Please find a sample listing of ten potential scenarios in which a structure may be of benefit:

1. Workers' Compensation and/or General Liability Cases.
2. Severe injury, especially shortened life expectancy, and the mentally incompetent.
3. Death cases with surviving spouse and/or children needing monthly/annual income.
4. Guardianship cases, including those involving minors.
5. Temporarily or permanently disabled injured parties.
6. Total or partial wage loss for any period of time.
7. When the settlement is a large portion of the injured party's future medical support.
8. Individuals attempting to retain some portion of their settlement for future use.
9. Deferred payments for college funds, retirement, mortgages or attorney's fees.
10. As an alternative to investing part of the settlement funds.

Workers' Compensation MSA Reference Guide Version 2.3 Published

On January 5, 2015 CMS published Version 2.3 of the recently developed Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide. The initial Reference Guide was released Spring 2013 and was the first consolidated guide to the WCMSA process. The WCMSA Reference Guide provides all basic procedures relating to workers' compensation MSA practice and procedure in one central database:

- Confirms that the review process is a voluntary one. CMS review thresholds are established via memoranda and are not, at this time, statutorily required.
- Walks the user through an outline of the WCMSA process, including submission, with sample plan.
- Provides an overview of administration options, necessary record keeping post approval, and issues that may arise following settlement. (Useful for liability claims as well.)
- Confirms CMS' policy regarding drug weaning and tapering. CMS appears hesitant to allow any weaning or tapering in plans, with the exception of *current* activity - latest weaned dosage and current actual tapering. CMS looks toward what is proven in the records, not what parties indicate might likely occur.

Drug Weaning
Drug weaning commonly occurs with pain medications, such as opioids, especially when claimants' work injuries improve. The WCRC takes all evidence of drug weaning into account, although in most circumstances the WCRC cannot assume that the weaning process will be successful. Usually, the latest weaned dosage is extrapolated for the life expectancy, but again, they assess all records when making these types of determinations.

Drug Tapering
Where a treating physician believes tapering is possible and in the best interests of the claimant, CMS will consider all evidence in making a WCMSA determination, including medical evidence of current actual tapering. WCMSA Reference Guide, Version 2.3, p. 27

Workers' Compensation MSA Threshold Review

Medicare has provided specific thresholds for the review of workers' compensation MSAs. This remains a recommended process, rather than a statutory requirement. A MSA may be submitted to CMS for review in the following situations:

- The claimant is 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 or duration of the settlement agreement is expected to be **greater than $250,000**.

A Claimant has a "reasonable expectation of Medicare enrollment within 30 months if any of the following apply:

- The Claimant has applied for Social Security Disability Benefits
- The Claimant has been denied Social Security Disability Benefits but anticipates appealing that decision
- The Claimant is in the process of appealing and/or re-filing for Social Security Disability Benefits
- The Claimant is 62 years and 6 months old
- The Claimant has an End Stage Renal Disease (ESRD) but does not yet qualify for Medicare based upon ESRD

*These thresholds are created based on CMS' workload, and are not intended to indicate that claimant's may settle below the thresholds with impunity. Claimants must still consider Medicare's interests in all WC cases and ensure that Medicare pays secondary to WC in such cases. *WCMSA Reference Guide, Version 2.3*, p.8.

Section 111 Medicare Medicaid and SCHIP Reporting Act of 2007 (MMSEA) Update

Website: For Section 111 Updates see the current link, http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html.

User Guide: For the most comprehensive reporting information please see the most recent **Section 111 User Guide**, **Version 4.5**, published February 2, 2015. www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html.

What Claims are Reportable Under this Act? Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation, where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgement, award, or other payment has the effect of releasing medicals. (See the reporting thresholds below and in the User Guide.)

Who Must Report? The Responsible Reporting Entity (RRE). The RRE is defined in the User Guide and established via 42 U.S.C. §1395y(b)(8) as the "applicable plan." The liability insurance, no-fault insurance, and/or workers' compensation laws or plans (insurers). The User Guide assists in distinguishing the party who should be considered the RRE - carrier/ self-insured/re-insurance/excess/umbrella, etc. See *User Guide Version 4.5, Chapter III, Policy Guidance, Section 6.1.3*.

When to Report? Responsible Reporting Entities (RREs) are to report **after** there has been a TPOC settlement, judgment or award, or other payment, and/or **after** ORM has been assumed. The User Guide can assist in full outlining reporting obligations, guidelines and timelines.

Health Insurance Marketplace Open Enrollment Period Dates - HealthCare.gov

February 15, 2015 - Last day for enrollment in 2015 coverage before the end of Open Enrollment. After February 15, individuals cannot sign up for a health plan unless they qualify for a Special Enrollment Period. As the enrollment date has passed, parties can visit Healthcare.gov to determine if they qualify for a special enrollment period exemption (marriage, birth of a baby, adoption, divorce, loss of coverage, gaining citizenship, etc.). In the alternative a party may qualify for coverage through Medicaid or the Children's Health Insurance Program (CHIP), both accepting enrollment year round.

Atlas Settlement Group, Inc.

Who's in Your Corner?

Summary: Mandatory Thresholds for Liability Insurance (including self-insurance) Total Payment Obligation to the Claimant (TPOC) Settlements, Judgements, Awards or Other Payments

TPOC Amount:	TPOC Date On or After:	Section 111 Reporting Beginning:
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
TPOCs over $5,000	October 1, 2012	January 1, 2013
TPOCs over $2,000	October 1, 2013	January 1, 2014
TPOCs over $1000	October 1, 2014	January 1, 2015

NGHP User Guide, Version 4.5 Chapter III, Policy Guidance, Table 6-7.

Summary: Mandatory Thresholds for Workers' Compensation Total Payment Obligation to the Claimant (TPOC) Settlements, Judgments, Awards or Other Payments

TPOC Amount:	TPOC Date On or After:	Section 111 Reporting Beginning:
TPOCs over $5,000	October 1, 2010	January 1, 2011
TPOCs over $2,000	October 1, 2013	January 1, 2014
TPOCs over $300	October 1, 2014	January 1, 2015

NGHP User Guide, Version 4.5, Chapter III, Policy Guidance, Table 6-10.

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All information current through January 1, 2015. Information cited is subject to frequent modification by CMS and the Department of Health and Human Services (HHS). Please check back frequently for updates, contact Atlas Settlement Group for assistance with Medicare matters and find frequent updates at www.cms.gov.

Atlas Settlement Group, Inc., offers a full range of Medicare Set-Aside services focused on ensuring compliance with the MSP. On a national scale Atlas Settlement Group can assist in providing services for determining Medicare or SSDI eligibility, preparing Medicare Set-Aside (MSA) allocations and submitting the same for approval to CMS. We also collect and submit the necessary medical records for obtaining rated ages, help prepare settlement language in compliance with the MSP, and our team will provide assistance with securing administration of MSA accounts or annuity quotes to fund the MSAs.

From initial proposed allocation through structure of a settlement and CMS approval, we can assist in your MSA process from start to finish. We pride ourselves on doing so with utmost care and professionalism, while also offering unparalleled efficiency. Our trained professionals have vast experience in workers' compensation as well as liability claims, and are happy to discuss potential cases. In addition to our full stable of Medicare services, Atlas Settlement Group, Inc. is committed to keeping our clients informed as to the myriad of Medicare Secondary Payer issues and Section 111 MMSEA news via "The Atlas Report" and interim bulletins. We are also available for one on one discussions regarding this pertinent field, free educational conferences and seminars for your team (with CLE and CE credit available in many states), and any other questions or concerns that you may have. Please contact us so that we may be of assistance in your settlement.