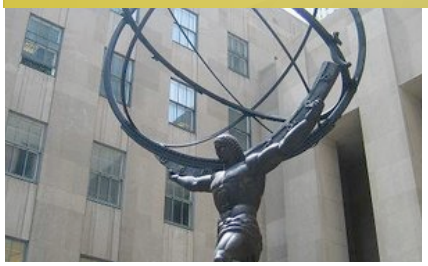
Atlas Settlement Group, Inc.

Who's in Your Corner?



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Medicare Secondary Payer Recovery Portal is LIVE!

One of the key components of the Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART ACT), required that by January 2016 the Medicare Secondary Payer Recovery Portal (MSPRP) must be "live" for general use. This has now been accomplished and the portal, found at www.cob.cms.hhs.gov/MSPRP now includes the general anticipated functions for obtaining final conditional payment demands.

While not beneficial in all circumstances, and not designed for immediate access and use by all parties, the portal should allow for early resolution of conditional payment lien issues *when used according to Medicare's guidelines and by the allowable parties*.

Prior to the January 2016 implementation date of this component of the SMART Act, Medicare did not issue a *final demand* for reimbursement, in any case, until final settlement, judgment, award or payment of a claim and the subsequent receipt by Medicare of notice of the same. This aspect of the Act was designed to address the obvious issues created when parties must settle or resolve claims without having the ability to obtain a concrete Medicare demand prior to final claim resolution. In order to alleviate this dilemma, this new program was created to assist in providing a reimbursement sum *prior to* settlement. That being said, there are significant limits on the functionality of the MSPRP portal.

The new "functionality," as noted on the CMS website, allows for authorized MSPRP users, typically Plaintiffs and their representatives, to notify CMS that a case is 120 days (or less) from anticipated settlement, and subsequently request that the recovery case be part of the final conditional payment process through the MSPRP system. Medicare will then still have a standard inquiry period in which to review, investigate, and post notice of any conditional payments on the portal.

When a final conditional payment is requested, and Medicare provides notice of the conditional payments, the parties have the right to dispute any unrelated sums. Under the new system, any dispute of conditional payments submitted through the MSPRP should be resolved by Medicare within 11 business days of receipt of the dispute - a clear benefit to the parties resolving the claim. Once all disputes have been resolved, *and the case is within 3 days of settling*, the Medicare beneficiary or his/her representative, can then request a final conditional payment amount (demand) on the MSPRP site. Once calculated, this final settlement amount will remain the final conditional payment sum as long as 1) the case resolves and settles within 3 calendar days of the request for the final conditional payment amount, and 2) settlement information is submitted through the MSPRP website within 30 calendar days of request.

The parties must therefore be cognizant of WHEN the request for a final lien is made. They must be careful to request the final conditional payment amount in a timely manner in consideration of the not only the settlement, but also document execution and and a reasonable timeline for funding. The catch is that the request for the final conditional payment, via the MSPRP, can only be made one time. If the case does not settle within the three day period, or if final settlement documents are not received within the thirty days, additional sums may be added to the conditional lien demand, as it is no longer final.

The other significant caveats are WHO may request the demand and on WHAT kind of case. Please see the following "*Important Note from CMS:"*

> *"An insurer and their authorized representative can initiate the Final CP process on their insurer-debtor case as long as settlement is pending on the case and no outstanding Ongoing Responsibility for Medicals (ORM) exists. Once the Final CP process has been started on an insurer-debtor case, the following events will occur:*
> *The insurer-debtor case will be closed and the debt will be transferred to a new case where the beneficiary is the identified debtor.*
> *-The insurer and their authorized representatives will not be able to work the new beneficiary-debtor case or receive copies of any recovery related correspondence related to the new beneficiary-debtor case until they obtain and submit an authorization signed by the beneficiary."*

www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery-Overview/Whats-New.html

The key, above, is that this option cannot be utilized where "outstanding responsibility for medicals" (ORM) exists. If the file includes an existing ORM component, which is the case in most workers' compensation matters, this is not a valid option and the "traditional" conditional payment process appears the best option. Thus, the MSPRP portal is primarily being utilized in third party claims, with the beneficiary and his/her representative taking the lead in obtaining information from the portal, unless authorizations can be obtained allowing for third parties to secure portal access. As such, while this certainly can speed up the recovery process, arguably, it may have somewhat limited application.

Workload Transition to the CRC - Continued Efforts to Speed up the Recovery Process

In a February 9, 2016 post on the CMS Coordination of Benefits website (www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery-Overview/Overview.html, CMS outlined the efforts Medicare has made to increase efficiency in the Coordination of Benefits & Recovery (COB&R) program. The COB&R is tasked with the oversight of all Medicare conditional payment "lien" reimbursement matters.

In an effort to increase output, CMS, as of October 2015, has transitioned a portion of the COB&R Non-Group Health Plan (NGHP) recovery workload, from the Benefits Coordination & Recovery Center (BCRC), to the Commercial Repayment Center (CRC). Together, these contractor agencies are charged with Medicare's recovery efforts.

The BCRC will continue to handle reimbursement matters where Medicare is pursuing recovery directly from the beneficiary, which is typically the case in third party liability claims. The CRC, on the other hand, will "assume responsibility" for *new claims* in which Medicare is pursuing recovery for conditional payments directly against the insurer (including a self-insured entity), no-fault insurer or workers' compensation entity.

While this plan may sound a bit confusing, parties basically can work with the contractor unit from which they receive correspondence. Beneficiaries and their attorneys seeking lien verification will continue to work with the BCRC, as before, as the BCRC will continue to pursue claims in which recovery is directly against the beneficiary. Essentially the significant change relates to cases where recovery is directed against the insurer (largely workers' compensation matters). In such matters the CRC has been tasked with recovery, in an effort to split the burden and speed up a backlogged system.

The initial transition has slowed the system down a bit, especially in workers' compensation claims, with lien statements running a bit longer than anticipated. We are hopeful that the division of labor will eventually serve to increase efficiency

once all initial transitional "bugs" are worked out. In the interim, please be cognizant of the split and make sure that you have the proper conditional payment lien verification materials for your claim.

CMS has issued a series of Frequently Asked Questions regarding the CRC Non-Group Health Plan workload transition. For your review, please find questions 1-3 set forth, below, as these inquiries may be of assistance in determining which entity will handle a particular matter, BCRC or CRC:

Q1. When should I talk to the Benefits Coordination and Recovery Center?
A1. Please contact the Benefits Coordination and Recovery Center (BCRC) for all of the following:

- When you are reporting or updating an MSP occurrence.
- When Medicare is pursuing recovery from the beneficiary as the identified debtor. Medicare beneficiaries and their representatives should always contact the BCRC.
- When you are an applicable plan that is already working with the BCRC on a recovery case, you should continue to do so until the case is resolved.

Q2. When should I talk to the Commercial Repayment Center?
A2. Please contact the Commercial Repayment Center (CRC) if you are an applicable plan or recovery agent for an applicable plan and you have questions about recovery cases initiated by the CRC (that is, you have received correspondence from the CRC).

Q3. When is CMS pursuing recovery from a beneficiary versus recovery from the applicable plan?
A3. The CMS may recover from the primary payer, the beneficiary, or any other entity receiving payments from the primary payer when there is a settlement, judgment, award, or other payment.

- In general, CMS pursues recovery directly from an applicable plan as the identified debtor when an applicable plan reports that it has ongoing responsibility for medicals (ORM) or otherwise notifies CMS of its primary payment responsibility, as the assumption is that the applicable plan's responsibility is not in dispute. This situation most frequently occurs in no-fault insurance and workers' compensation.
- In general, CMS pursues recovery from the beneficiary when the applicable plan has not reported ORM and has not otherwise notified CMS of primary payment responsibility. Typically, this is when the beneficiary obtains a lump sum settlement, judgment, award, or other payment. This situation most frequently occurs with liability insurance, including self-insurance.

For the Full FAQ Memorandum, with additional questions, please see: www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/Frequently-Asked-Questions-about-the-Commercial-Repayment-Center-Non-Group-Health-Plan-Recovery-Workload-Transition.pdf

MEDICARE ADVANTAGE RECOVERY RIGHTS EXPANDING

While the Medicare compliance waters may at times be murky, the one thing that has remained crystal clear has been the ability of Medicare to recover for pre-settlement, claim-related, conditional payments. Under the Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)(2) and pursuant to 42 CFR §411.24, CMS may initiate recovery as soon as it learns that payment has been made or could be made under a workers' compensation, liability or no-fault insurance plan. Further, CMS may recover from the beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment, OR the primary payer. If CMS has to take legal action to recover from the primary payer, double damages may be sought. See, 42 CFR §411.24(c)(2).

The ability for Medicare to recover for pre-settlement conditional payments is well-settled. As such, parties engaging in the settlement process are aware that they must verify and reimburse such "liens" upon resolution of a claim involving a

Medicare beneficiary. In the past this has primarily meant working to negotiate and reimburse pre-settlement conditional payments owed to Medicare. However, with increasing frequency we are seeing that Medicare beneficiaries do not simply have "original" Medicare coverage through the federal government, but rather many have coverage supplied through a Medicare Advantage organization, (referred to frequently as a MAO or MA plan).

In the simplest of terms, a Medicare Advantage plan is a Part "C" health plan, offered to Medicare beneficiaries by a private health company in lieu of traditional or "original" Medicare. The private health company contracts with Medicare to provide Part A (Hospital Insurance) and B (Medical Insurance) Medicare benefits. The providers offer most standard Medicare services and most also provide prescription drug coverage (Part D). Many plans also offer additional services, for a premium, that the beneficiary might not otherwise have access to through original Medicare (vision, dental, hearing care, etc.) The MA plan benefits the individual through expanded care and coverage, and benefits Medicare in that these private health companies, for a fee, are covering a portion of the Medicare eligible population. According to 2015 Kaiser Family Foundation statistics, 31% of the total Medicare enrollee population is utilizing a Medicare Advantage plan. http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/

The question that has arisen over the past several years is whether these MA plans have the same rights of reimbursement as "original" Medicare? In the past, MA plans sought reimbursement primarily against the beneficiaries with whom they had contracted for care. In the last few years, however, MA plan recovery effort has shifted, with MA plans asserting virtually the same recovery rights as "original" Medicare. Critically, in some cases, MA plans have sought recovery not only against the beneficiaries with whom they have a contractual agreement, but also against primary payers. Several recent cases appear to expand these recovery rights.

To date, the pre-eminent case establishing the concept of MA plan recovery rights is *In re Avandia Mktg., Sales Practices & Products Liab. Litigation*, 685 F.3d. (3d Cir. 2012). Here, in a multi-party action, the Medicare Advantage carrier, Humana, filed suit seeking to assert a claim as secondary payer under the Medicare Secondary Payer Act. Humana specifically alleged a private cause of action for double damages pursuant to §1395y(b)(3)(A). In a decision overturning the lower court, the *Avandia* appellate court held that the very broad language of the MSP encompasses MA plans.

The *Avandia* court also gave deference to the Medicare regulations. The *Avandia* court determined the Medicare regulations, which are the guiding force in most Medicare decisions, included MA plans. CMS first addressed such plans December 5, 2011, via memoranda, in which the Agency published a statement supporting the rights of Medicare Advantage plans to seek the same recovery as "traditional" Medicare, citing the Medicare Secondary Payer Act as authority and referring to the Medicare Advantage plan reimbursement "rights" under the MSP. CMS stated "support for our regulations giving Medicare Advantage organizations (MAOs) and Prescription Drug Plan (PDP) sponsors the right, under existing Federal law, to collect for services for which Medicare is not the primary payer." *CMS Memorandum, December 5, 2011, Medicare Secondary Payment Subrogation Rights.*

Following the decision of the *Avandia* court, it became critical for *all parties* in the 3rd circuit to consider both conditional payment reimbursement obligations to "original" Medicare and any potential Medicare Advantage reimbursement obligations. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3rd. Cir. 2012)

Recently other jurisdictions have followed the lead of the 3rd Circuit, with district court cases following suit. We anticipate Appellate decisions to follow shortly as appeals are pending.

Recently, the Southern District of Florida had the opportunity to address the MA reimbursement issue in *Humana v. Western Heritage Insurance Co*. Humana Medical Plan, a MA provider, filed suit against Defendant Western Heritage Insurance company seeking recovery of conditional payments it made for medical expenses related to Mary Reale, a Medicare beneficiary/Humana enrollee. Mrs. Reale suffered a slip-and-fall and obtained treatment covered by Humana. She then brought a claim against the condominium complex in which she was injured, entered into settlement and resolved her claim. She attested that she owed no Medicare liens and obtained a Conditional Payment Letter (CPL) from "original" Medicare

showing that no lien was owed the federal government. (A note: Should a party have a MA plan, "original" Medicare will issue a conditional payment letter indicating $0 or "no payments have been made to date". The CPL will not indicate whether or not a MA plan is in use. It is up to the Plaintiff to disclose the involvement of the MA plan and the parties to make inquiries of the same.)

During the course of the matter, Western Heritage became aware of the Humana lien and attempted to include Humana as a payee in the settlement, but Mrs. Reale opposed the same, disputing the lien. The state court ordered payment to Mrs. Reale and the withholding of sufficient funds in trust to address the rights of reimbursement. Settlement funds were disbursed with the understanding that Mrs. Reale and her attorney would address and reimburse the Humana lien. However, Humana and Mrs. Reale failed to reach an agreement.

Dismissing Mrs. Reale, Humana filed suit against Western Heritage seeking reimbursement, alleging Western Heritage was responsible as primary payer. Humana alleged that Western Heritage remained liable under the Medicare Secondary Payer Act, even though all claims had been settled directly with Mrs. Reale. Double damages were sought under the MSP private cause of action provision.

The Court granted Humana's Motion for Summary Judgement finding the text of the Medicare Secondary Payer Act indicates that MA plans are "included within the purview of parties who may bring a private cause of action." *Humana Medical Plan, Inc. v. Western Heritage Insurance Company*, 2015 U.S. Dist. LEXIS 31875 (March 16, 2015). The Court determined that Western Heritage, as the insurer of the condominium complex, entered into a settlement agreement with Mrs. Reale to resolve all personal injury claims. That agreement, in which they reimbursed Mrs. Reale for medical expenses, demonstrated Western Heritage's responsibility under the MSP to reimburse Humana for the Medicare benefits it paid on behalf of Mrs. Reale. The Court found Western Heritage to be primary payer under the MSP and responsible for reimbursement. The Court further found that double damages attached, thus increasing the reimbursement amount to $38,310.82 (in lieu of the $19,155 Humana initially sought in reimbursement). 2015 U.S. Dist. LEXIS 31875 at 15-19. (Western Heritage has filed an appeal with the U.S. Court of Appeals for the Eleventh Circuit which will hopefully provide much greater insight, in this circuit, as there are other similar cases pending in the jurisdiction.)

In the interim, it seems the tide is potentially turning in other jurisdictions as well. The United States District Court for the Eastern District of Tennessee (6th Circuit) also found *Avandia* persuasive. *Cariten Health Plan, Inc. v. Mid-Century Ins. Co*., No. 3:14-CV-476-TAV-CCS, 2015 WL 5449221, 2015 Dist. LEXIS 126887 (E.D. Tenn, Sept. 1, 2015).

The MA carrier, Cariten Health Plan, paid for treatment for a beneficiary injured in a motorcycle accident. However, the beneficiary also had coverage through Defendant Mid-Century Insurance Company. Upon learning of the Mid-Century no-fault policy, Cariten demanded reimbursement. Mid-Century denied the same, prompting a suit by Cariten, claiming both a private cause of action under the Medicare Secondary Payer Act at 1395y(b)(3)(A), and a claim in federal common law.

In reviewing this matter, the district court found the Third Circuit's reasoning in *Avandia* compelling and relied on the same in finding a private cause of action. The Court determined this reasoning applied specifically to Medicare Advantage organizations. Finding that §1395y(b)(3)(A) provides a private cause of action, the court held for Cariten, finding Mid-Century to be primary payer.

Similarly, very recently on May 10, 2016 in the 4th Circuit, a district court judge in Virginia signed an Order holding that Part C, "commonly referred to as Medicare Advantage, provides an alternative option for Medicare beneficiaries by allowing for those individuals to obtain health care benefits from private companies known as Medicare Advantage Organizations ("MAO"). Funded by the Medicare Trust Funds, Medicare Advantage operates as a federal program under federal rules." *Humana Insurance Co. v. Paris Blank LLP*, et al. Civil Action No. 3:16CV79-HEH

The Judge noted that the statute §1395y(b)(3)(A) creates a private right of action for the pursuit of reimbursement and that *Avandia* found the plain language of the statute to be "broad and unambiguous, placing no limitations upon which private (i.e. non-governmental) actors can bring suit for double damages when a primary plan fails to appropriately reimburse any secondary payer". *In re Avandia*, 685 F.3d at 358. The Virginia district court held that although Avandia is not binding precedent, it is persuasive and that there is, in fact, a private cause of action for potential double damages.

There are now multiple circuits, albeit several at the district court level (appellate decisions pending in multiple jurisdictions), which have held that MA organizations have the same rights of reimbursement and recovery as "original" Medicare. These courts are largely upholding the tenets of *Avandia*. At one point we were able to simply caution that parties resolving claims in the Third Circuit should be cognizant of MA plan reimbursement. Now it is becoming clear that the reach of MA plan recovery is expanding and all parties resolving claims involving MA beneficiaries should be aware that these liens may very likely be treated in much the same way as "original" Medicare. Parties may wish to err on the side of caution considering the potential double damages associated with the failure to reimburse. While not all courts are in agreement (see, *Parra v. PacifiCare of Arizona*, Inc. 2013 WL 1693713 (9th Cir., April 19, 2013)) it is certainly a factor to now consider in the claim resolution process.

A conditional payment "lien" statement from "original" Medicare will not disclose any information about a Medicare Advantage lien. We do suggest obtaining a conditional payment verification and demand from "original" Medicare in any claim involving a Medicare beneficiary, but would note that if a MA plan is in existence the parties may receive a $0 lien statement from CMS/Medicare as "original" Medicare is not handling the beneficiary's treatment. MA demands are issued only from the MA carrier directly. As such, it would then become necessary for the primary payer to require the beneficiary/plaintiff to advise as to any Medicare Advantage enrollment and provide a MA lien verification. The MA plan may very likely have sent collection information to the beneficiary, thus communication with the beneficiary is key.

Please contact our office should you have any questions regarding the Medicare lien process, Medicare Advantage recovery, the Medicare Advantage lien process, or any updates regarding specific jurisdictions. Atlas Settlement Group and our Medicare partners can assist in traditional Medicare verification, MA plan verification, and negotiation.

Workers' Compensation MSA Threshold Review

Medicare has provided thresholds for the review of workers' compensation MSAs. 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 2.5, Section 8.1*

Liability MSA Update - CMS Announces Consideration of Expansion of Review

On June 8, 2016, the Centers for Medicare and Medicaid Services (CMS) issued an announcement indicating that they are considering expanding the Medicare Set-Aside (MSA) voluntary review process to include the review of proposed liability insurance (including self-insurance) and no-fault insurance plans. CMS noted that the agency plans to work with the community to identify how to best implement the potential expansion. CMS provided no further details, but noted that future announcements of the proposal and town hall meetings are anticipated later in the year and parties may continue to monitor the CMS website for further updates. https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Whats-New/Whats-New.html

If the reader will recall, this is not the first time that CMS has contemplated a more "formalized" process of liability review. Back in June 2012 CMS published an Advanced Notice of Public Rulemaking (ANPRM) in the Federal Register. The ANPRM sought public comment regarding a series of proposed options for formal liability MSA review. The MSA industry reacted strongly offering a good number of comments, proposals, and some objection. For quite some time the process seemed to hit a standstill. Then the process formally stalled in October 2014. CMS rather quietly submitted and then withdrew a guarded proposal entitled "Medicare Secondary Payer and Future Medicals" after it failed to gain approval from the Office of Management and Budget (OMB). It will be interesting to learn what CMS proposes this time around.

Current Status Of Liability Review:

At present there are no specific thresholds for the voluntary review of liability MSAs. While CMS may again begin the process of considering whether they want to establish a more formal system of voluntary liability and no-fault liability review, at present there is no real review system. CMS will "allow" each of the 10 Regional Offices to undertake review should they opt to do so, but there is limited actual review at this stage. The offices do not have the resources devoted to the process and typically note that "resource constraints" limit their review.

Despite the lack of a formal review process, informally Medicare has stated that a MSA should be considered in any substantial liability settlement and that Medicare should be notified of any and all settlements involving a Medicare beneficiary. As such, if you have a liability case involving a Medicare beneficiary or a party "reasonably expected" to become a beneficiary, the parties should consider whether Medicare's interests should be contemplated in the matter, whether or not submission and approval is sought.

We suggest reviewing liability matters on a case by case basis and will be happy to discuss a file with you to determine if a liability MSA is suggested. Specifically, if the Plaintiff is a **current Medicare beneficiary** and the 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 *potential* submission to the appropriate Regional Office of CMS. Most offices offer very limited review at present. Regardless of submission, make sure to include the value of the MSA in the settlement documents with all appropriate indemnity language.

If Plaintiff is not yet a Medicare beneficiary, but has a **"reasonable expectation" of Medicare eligibility within 30 months of settlement**, we suggest a consideration of a set-aside, factoring in settlement value, future medical needs, etc. A MSA may potentially be warranted in more substantial claims.

Finally, where there is a **liability claim with an underlying workers' compensation claim**, CMS has issued some guidance (**4/21/03 Memo Q19**). "*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.

****These sample scenarios cover many, but not all settlement situations and are not formal legal guidelines. Please address with your counsel the legal and business ramifications concerning Medicare issues in your individual claims.**.**

Atlas Settlement Group, Inc.

Who's in Your Corner?

Workers' Compensation MSA Reference Guide Version 2.5 Published

In April 2016 CMS published Version 2.5, an update of the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide.

- 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 through an outline of the WCMSA process, including submission, with sample.
- Provides an overview of administration options, necessary record keeping post approval, and issues that may arise following settlement. (Useful for liability as well.)
- Confirms CMS' policy regarding drug weaning and tapering. CMS remains hesitant to allow any weaning or tapering in plans, with the exception of evidence of actual *current* activity - latest weaned dosage and current actual tapering. CMS looks toward what is proven in the records, not what parties/provider indicate *might* occur.

Drug Weaning/Tapering

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. 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 2.5, p. 27

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SECTION 111 MMSEA USER GUIDE

For the most comprehensive Section 111 reporting information please see the most recent **Section 111 User Guide**, **Version 4.9**, published December, 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

Materials current through May 15, 2015. Please contact Atlas Settlement Group for updates.

Atlas Settlement Group, Inc., offers a full range of Medicare services focused on ensuring compliance with the MSP. On a national scale Atlas Settlement Group and our partners 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 regarding the Medicare Secondary Payer 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.