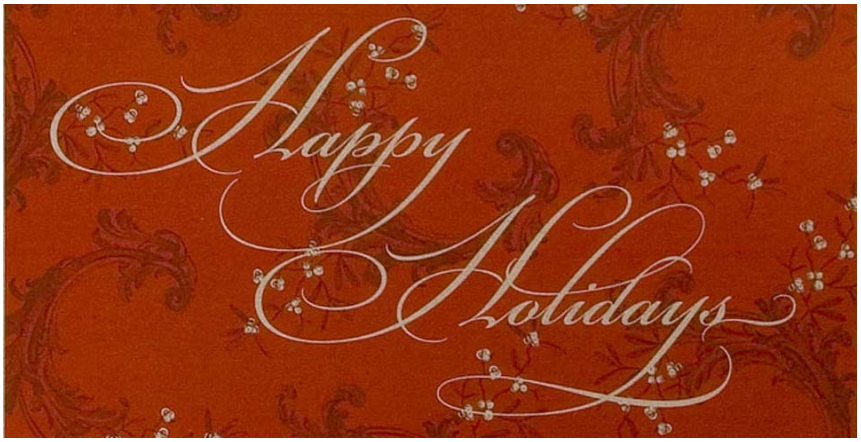
NAMSAP

National Alliance of Medicare Set-Aside Professionals

Quarterly Newsletter December 2009



Special Points of Interest:

- 2009 NAMSAP Survey Summary Results are posted on page two.

Inside this issue:

President's Letter to NAMSAP

To all NAMSAP members,

Michael E. Westcott
President, NAMSAP

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President, NAMSAP

NAMSAP Survey Summary 2009

The NAMSAP Membership Committee recommended that a membership survey be conducted in an effort to develop strategies to attain the 2009 committee goals which are to retain members and increase recruitment opportunities. The committee compiled a summary of the findings to identify areas where this professional organization may more effectively meet the expectation of its members. The survey was also a tool to assist the Membership Committee in establishing its goals for 2010.

NAMSAP SURVEY SUMMARY 2009

1. Why are you a member of NAMSAP?
   - To keep up to date on the industry news and the legislative changes
   - Networking, relationship-building and educational opportunities
   - Access to the Listserv
2. What would you like to see NAMSAP do that the organization is not currently doing?
   - Quarterly conference call to discuss concerns: a "dial in" where we could then pose questions and receive feedback; quarterly meetings in cities with the largest NAMSAP membership
   - Education Seminars/Lunch Seminars
   - More current CMS information: Promptly post the updates from CMS onto the NAMSAP website when there are new memorandum, regulations, policies and procedures, and legislation updates
   - Listserv to be organized with a topical index
   - NAMSAP to be more visible to the State Bar Associations
   - Develop a NAMSAP Code of Ethics in an effort to prevent unauthorized practice of law
   - More information from the plaintiff attorney perspective
   - NAMSAP to consider broadening the information available related to MMSEA Section 111 Reporting/MSP Compliance versus just the WCMSA
   - NAMSAP access to guidelines for durable medical equipment, such as pain pumps, stimulators, and prosthetics that states the U&C pricing and frequency of replacement
   - Access to educational material for the claimant on the WCMSA and material for the insurance industry
3. What specific education topics would you suggest NAMSAP that NAMSAP offer in an effort to keep membership interest?
   - Updates on the MARC Coalition
   - WCMSA submission process
   - Pharmacy updates related to: the MSA, new medications, newly released generics, etc.
   - Liability Medicare Set-Asides and how to educate the client
   - Structured Settlement Process
   - Legal issues with MSA settlements
   - Treatment guidelines and ODG
   - CMS MSA guidelines/updates
   - Medicare Part D guidelines and cost containment strategies
   - Step-by-Step process to settle a workers' compensation claim that requires a WCMSA
4. Would you be in favor of having members post CMS approved MSAs to a Members Only area of the NAMSAP website with all of the protected health information redacted?
   - 72% of NAMSAP members are in favor of the posting. The main concern of those who were not in favor was the "stealing" of intellectual capital
5. Would you be in favor of a member forum/bulletin board on the NAMSAP website where members can post questions or concerns, or is the Listserv sufficient?
   - 45% of NAMSAP members were in favor of a member forum. There was mention of a Facebook type forum.
   - 55% of NAMSAP members opined that the Listserv was adequate, but there was mention of the need for access to all answers and the need to create efficiencies within the Listserv
6. What is an idea you have to boost NAMSAP membership?
   - Creation of a more stringent certification process
   - Advertisement of the organization in insurance publications, legal journals, and educational entities who teach the MSA allocation process and offer MSCC certification preparation
   - Incentive of reduced membership fee for referring a new member
   - Attendance of NAMSAP representatives at the Bar Association annual meetings and various Industry conferences in various states
   - Increase the educational and training opportunities
   - Creation of separate tracks for different professionals, i.e., legal structures, medical, MSA administration (at least on the website and Listserv)
   - Access to more MSA resources, fee schedules, drug pricing information, etc.
7. Which trade publication do you regularly read and/or subscribe?
   - Law Journals
   - Nursing and Case Management Journals
   - AASCIN
   - Risk and Insurance
   - Business Insurance Risk Manager
   - Coding Edge
   - WC Central
   - AALNC
   - Daily Business Review
8. Do you feel that there are sufficient opportunities to become involved in NAMSAP?
   - The majority did not respond in the affirmative
9. If NAMSAP could change its name, which would you prefer?
   - The majority of the respondents noted "no change"
   - Tied for second choice was:
     - NAMSAC (National Association of Medicare Set-Aside Consultants)
     - NAMSAA (National Association of Medicare Set-Aside Allocators)
   - The third response was:
     - NAMSAE (National Association of Medicare Set-Aside Experts)

"The mission of NAMSAP is to foster the highest standards of integrity and competence among Medicare Set-Aside Professionals and those they serve."

Reporting on the 5th Annual NAMSAP Conference

By: Adeyemi Coker, President, Alpha-MSA, Inc.

On Wednesday, September 30, 2009, MSA Practitioners, medical and legal entities, and members of NAMSAP convened for the fifth Annual meeting at the RIO All-Suites Casino Resort in Las Vegas, Nevada. The two-day conference started with elections of officers, and opening remarks from the association's current president, Michael E. Westcott.

The first day's agenda was quite informative, but no one captivated the audience better than our guest speaker, Thomas Bosserman, Health Insurance Specialist from the Centers for Medicare and Medicaid Services' (CMS) San Francisco Regional Office. Mr. Bosserman was quite candid in his message to the group, prefacing his speech with a disclosure statement. He proceeded to read off the exact verbiage relating to the need for MSA proposals for liability cases. He reiterated that Section 111 was strictly a reporting instrument for CMS, and that MSA proposals are not required for "liability claims". Notwithstanding, some of CMS' Regional Offices seem to be accepting them, but that was not the normal practice of the agency. Unfortunately, this did not assuage the concerns of most attendees; the myriad interpretations of Section 111 elicited debates, questions, and more concerns. Nonetheless, Mr. Bosserman reiterated the verbiage, and offered to forward electronic copies to anyone who needed it. The CMS accepted statement is as follows: "The Centers for Medicare & Medicaid Services (CMS) has no current plans for a formal process for reviewing and approving Liability Medicare Set-Aside Arrangements. However, even though no formal process exists, there is an obligation to inform CMS when future medicals were a consideration in reaching the Liability settlement, judgement, or award, as well as any instances where a Liability settlement, judgement, or award specifically provides for medicals in general or future medicals." Absent the discourse on Section 111, Mr. Bosserman did not offer any urgent or pressing news or updates from the CMS.

After a short break, the agenda resumed with Stephen Franckhauser, Esq. who shared a very informative presentation on "Building Your Own Small Business". The crux of his message advised new start ups to conduct exhaustive research to find the most up-to-date information that would prevent any problems with their businesses.

Vice-President, Fran Provenzano coordinated review and assessment of a Medicare Set-aside case. The group deliberations were quite informative. The exercise revealed the innumerable interpretations in reviewing medical reports while preparing MSA proposals, proof that the practice in our industry is not static.

Matt Larkin provided an educational review of the current updates in the pharmacy world, and how it impacts our business. In his presentation, he explained the ongoing challenges with pricing prescription medications (i.e. calculation of medication prices at the percentiles). More questions ensued from his discussion and he generously availed himself for further discussions.

Wrapping up day one, we were treated to a buffet style dinner at the Voodoo Lounge, a rooftop restaurant/bar with a panoramic view of the city. It was a feast that would satisfy the most fastidious appetite. As many of our colleagues did not make the meeting, it would be unfair to reproduce the menu in this report. As an indication of our collective delight of the evening's rich culinary experience, I offer my congratulations to the planning committee and to the chef at the Voodoo Lounge for those delectable delicacies.

The conference continued through Thursday, October 1, 2009. Just when we thought dinner was the apex of our culinary experience, continental breakfast was redefined. Yet again, the spirit of fairness forbids me from sharing the menu, but my humble congratulations to the planning committee and the catering staff at the RIO All-suites Casino for their proper representation of the continents should suggest that, breakfast was indeed redefined. With coffee and tea cups in hand, we reconvened the agenda, and attended to the reason for the meeting.

The MMSEA panel discussions focused on Section 111. The discussions picked up from Mr. Bosserman's presentation from the previous day. In summary, the interpretations on the right course of action (as it relates to preparation and submission of MSA proposals for liability cases) remain nebulous.

Roy Franco, founder of the Medicare Action Recovery Coalition (MARC) continues an aggressive campaign to inform the community about the objective and benefits of this coalition. He announced his partnership with NAMSAP, expressing that it is an added step towards making in-roads towards a common goal.

And yes time, being a scarce and elusive commodity, was once again inadequate to continue the networking and deliberations. However, the meeting was informative enough to elicit ongoing debate about our evolving industry. At the closing of this year's meeting, the president and chair, Mr. Westcott, announced the date and place of the next annual meeting. Perhaps, by strategic planning or mere fortuity, we will be in Washington D.C. just in time for mid-term elections.

"The first day's agenda was quite informative, but no one captivated the audience better than our guest speaker, Thomas Bosserman."

NAMSAP's 5th Annual Meeting was held September 30, 2009, through October 1, 2009, at the Rio All-Suites Hotel and Casino in Las Vegas, Nevada.

Unlocking Medicare Conditional Payment Information

By: Angelo Paul Servarino, Esq.

Q1. What is the Medicare Secondary Payer Act?

A1. The Medicare Secondary Payer Act (MSP) gives rise to Medicare Conditional Payments. The MSP is found at Section 1862(b) of the Social Security Act 42 USC 1395y(b)(2). Applicable regulations are found at 42 CFR Part 411 (1990). The MSP provides that Medicare may not make payment for medical services or prescription drug therapy charges where a payment has been made or can reasonably be expected to be made under a workers' compensation law or plan of the United States or a State, or under a liability, no-fault or group health policy. Under this authority, Medicare has a priority right of recovery from the primary payer, as well as, from parties in receipt of third party payments such as a beneficiary provider, supplier, physician, attorney, state agency, or private insurer pursuant to 42 CFR 411.25(g).

Q2. How does the practitioner investigate whether there are Medicare conditional payments?

A2. Contacting the Coordination of Benefits Contractor (COBC) is always the first step in the process. For the initial Medicare conditional medical payment inquiry, the practioner should first call CMS/COBC at (800) 999-1118, send a fax to (646) 488-6762, or go to www.cms.hhs.gov/cobgeneralinformation, and request that CMS initiate a "lien search". The practitioner may also initiate the process by letter with proper Proof of Representation and Consent to Release forms included. These documents are required whether the injury is by telephone or in writing. The COBC mailing address is: CMS, Coordination of Benefits Contractor, PO Box 33847, Detroit, MI 48232-5847.

Note: MSPRC will provide conditional payment information to a workers' compensation entity/carrier or no-fault insurer without a Consent to Release document. However, MSPRC will not provide conditional payment information to a liability insurer, including a self-insurance entity, without a proper Consent to Release document.

Any inquiry to the COBC requires the following information be provided:

- Claimant's name and address;
- Claimant's SSN or HICN;
- Claimant's attorney's name, address and telephone number;
- Employer's name and address;
- Insurer's name and address;
- Insurer's claim number;
- Insurer's attorney's name, address and telephone number
- Claimant's Medicare entitlement date;
- Date of Injury or onset of illness;
- Claimant's date of birth;
- Body part(s)/system(s) involved;
- ICD9 codes, if available;
- Total settlement amount, if known;
- Description of how the injury occurred or illness contracted; and
- Proof of Representation with Consent to Release authorizations.

Upon receipt of this information, the COBC will apply it to the Claimant's Medicare record and assign the case to a Medicare contractor (MSPRC) and release the Rights and Responsibilities Letter.

Q3. What is the Medicare Secondary Payer Rights and Responsibilities Letter?

A3. Effective for cases established on or after October 1, 2009, the "Right to Recovery Letter" issued when a claim for liability insurance (including self-insurance), no-fault insurance, or workers' compensation is reported to the COBC will no longer be issued by the COBC. The letter has been revised, renamed (it is now the "Medicare Secondary Payer Rights and Responsibilities Letter"), and will be issued by the MSPRC. Note: If you received a "Right to Recovery Letter" issued by the COBC and dated on or before September 30, 2009, you may follow the instruction in that letter regarding submitting a "Consent to Release" document.

Q4. What is the Conditional Payment Letter?

A4. Effective October 1, 2009, the MSPRC will issue information concerning interim conditional payment amounts automatically (that is, without receiving a request for such information) as soon as an interim conditional payment amount is available. This is by way of the Conditional Payment Letter (CPL). If you have an outstanding request for a CPL for a case established prior to October 1, 2009, the request will be processed in the order received. For all new cases, the Medicare beneficiary and any authorized individuals will receive the CPL within 65 days of the

The Medicare Secondary Payer Act gives rise to Conditional Payments..

" The MSP provides that Medicare may not make payment for medical services or prescription drug therapy charges where payment has been made or can reasonably be expected to be made under a workers' compensation law or plan of the United States or a State, or under a liability, no-fault or Group Health Policy."

Medicare has a priority right of recovery from the primary payer, as well as, from parties in receipt of third party payments.

Continuation: Unlocking Medicare Conditional Payment Information

By: Angelo Paul Servarino, Esq.

issuance of the "Right and Responsibilities Letter".

Once all claims have been retrieved from Medicare systems and determined to be related to the reported claim, the MSPRC will issue a CPL to all authorized parties on record. The practitioner must understand that a careful review of this letter is required as not all items listed in the CPL properly belong to the claim and must be challenged. The most effective way to do this is by way of a review of the listed ICD9 codes as reported by Medicare to ensure that all claims are related to the work or accident related injury or illness.

Q5. How is conditional payment information updated?

A5. Once MSPRC has issued its original conditional payment information, updated information may be viewed on the MyMSP tab at www.mymedicare.gov.

Q6. What is "Proof of Representation"?

A6. This is the form wherein the claimant has authorized the individual or entity (including an attorney) to act on the claimant's behalf. The representation has no independent standing, but may receive or submit information/requests on behalf of the claimant, including responding to requests from the MSPRC, receiving a copy of the recovery demand letter if Medicare has a recovery claim, and filing an appeal (if appropriate) when that claimant is involved in a liability, workers' compensation, or auto/no-fault situation. Under these circumstances, the exchange of information is a two way street. The representative may provide necessary information to or interact with the MSPRC, on behalf of the claimant, in order to resolve Medicare's recovery claim.

If the party requesting MSPRC information is not the attorney of record on the underlying claim, the following information is required to be included in the Proof of Representation form:

- The claimant's name as shown on his/her Medicare card;
- The claimant's Medicare Health Insurance Claim Number (HICN);
- Representative name, address and telephone number;
- Type of representative;
- Firm company name; and
- Signature with date of appointment.

The representative must sign and date the document to show that he/she has agreed to represent the beneficiary.

Q7. What is the "Consent to Release Form"?

A7. This is the form wherein a claimant has authorized an individual or entity to receive certain information from the MSPRC for a limited period of time. The release does not give the entity the authority to act on behalf of the beneficiary. Under these circumstances, the exchange of information is a one-way street. The claimant has authorized the MSPRC to provide privacy protected data to the specified individual or entity, BUT this foes not authorize the individual or entity requesting information to act on behalf of or make decisions on behalf of the claimant.

Q8. What is the "Final Settlement Detail Statement" and "Final Demand Letter"?

A8. Once a settlement is reached, the Final Settlement Detail Statement must be sent to the MSPRC. This document includes the total settlement amount, itemization of procurement costs including attorney fees and costs, and date of settlement. Upon receipt, the MSPRC will send the practitioner a Final Demand Letter indicating the amount of recoupment MSPRC is seeking from settlement. Interest begins to accrue on this amount 60 days after issuance of the Final Demand Letter regardless of whether the practitioner is disputing or appealing the amount claimed. The MSPRC may be contacted by telephone at (866) 677-7220, or by fax at (734) 957-0998. Settlement information can be sent to the following MSPRC addresses:

Workers' Compensation Settlements:
MSPRC
PO Box 33831
Detroit, MI 48232-5831

Liability Settlements:
MSPRC
PO Box 33828
Detroit, MI 48232-5828

Group Health Plan Reconciliations:
MSPRC
PO Box 33829
Detroit, MI 48232-5829

The MSPRC will be issuing Conditional Payment Information as of October 1, 2009.

"The practitioner must understand that a careful review of this letter is required as not all items listed in the CPL properly belong to the claim and must be challenged."

Once a settlement is reached, the Final Settlement Detail Statement must be sent to the MSPRC.

WCMSA War Stories: New CMS Review Strategies Creating a Large Burden for Settlements

Many NAMSAP members have faced an increasingly difficult time in creating Medicare Set-Asides that protect the interests of the claimant, carrier or employer, and CMS. The shift in review strategies by CMS has become a burden to the industry, causing many settlements to collapse after CMS review is returned. The following stories have been submitted anonymously, in the hopes that they will help other vendors submitting WCMSAs.

MSA Case A:

Claimant: John Doe, 16.2 Year Life Expectancy
Surgeries: Repair of Torn Meniscus, TKR
CMS Recommendation:

The MSA included the following statement: "In January 2009, Dr. X advised that any current treatment including medications is not related to Mr. Doe's total knee placement and no further surgery is anticipated." A copy of that documentation was included. The claimant had no work related medications filled after September 18, 2007.

We received a second request for drug information. We again sent a pharmacy listing which showed that no medications were filled after September 18, 2007. Again, we sent documentation form the treating physician which said that no medications were related to the workers' compensation injury.

CMS added Lyrica for the life expectancy of this claimant. We appealed and were told that it would not be changed, and got exactly the same approval letter back. This raised a $500 MSA to $50,000.

MSA Case B:

Claimant: James Smith, Knee Injury
Surgery: Bilateral Knee Replacements
CMS Recommendation:

The MSA, which included bilateral total knee replacements, was approved as submitted. However, CMS added knee injections and multiple MRI's. We could be missing something, but we are not sure what value knee injection and MRI's have after a total knee replacement.

MSA Case C:

An anonymous law firm has had two instances in the last eight weeks where proposed set-asides were rejected and the CMS replay required that the MSA's be increased two to three fold. One was a significant MSA, over $100,000, and CMS required the MSA to increase to over $300,000. The primary culprit for each increase appears to be prescription drug expenses.

MSA Case D:

Claimant: Jane Doe, Right Knee Injury
CMS Recommendation:

The claimant injured her right knee and it was determined that she needed a right total hip replacement for avascular necrosis. This is not related to the workers' compensation injury. This has been documented by the treating physicians, and was even acknowledged by the claimant and her attorney. CMS refused to acknowledge the treating physician's written statement, and the statement of the claimant and her attorney. The included a total hip replacement and revisions. The total hip replacement had already been completed at the time of submittal. We provided documentation proving this and again stressed and appeal/request for reconsideration that it was unrelated per her treating physicians, noted clearly in the medical records. CMS has persisted that they will include it in the MSA without an order from the Judge that the hip replacement is unrelated.

MSA Case E:

An anonymous vendor recently submitted a MSA that included the AWP NDC codes with the medications. The CMS response raised the MSA by $36,000 using higher NDC codes. We are currently working with the Regional Office to see "what happened".

MSA Case F:

An anonymous settlement broker recently issued the following complaint. Some MSA allocators are continuing to submit MSA's with drug utilization, donut hole calculations, and use of generics. CMS then counters higher because they are adding the drugs and costs back in to the MSA. It makes it difficult to quote an annuity based on the original MSA. When CMS counters higher, the cost of the annuity goes up, and the client gets upset.

MSA Case G:

A vendor had a recent counter from CMS where they came back double on the pharmacy. CMS also ignored the rated age, even though the correct language was included, along with all copies of the rated ages. The claimant was taking minimal medications, but CMS added in medications that the person had not taken for many years. We contacted the treating physician, obtained a document from them indicating that the patient had not been prescribed this medication, and resubmitted with numerous phone calls. After about three months, we prevailed and CMS reconsidered the counter.

MSA Case H:

A vendor received a counter from CMS in the month of December. CMS priced Zanaflex, 60 pills per fill, at the cost of $20,000. The claimant only filled this prescription for two months, and has not been prescribed this drug for over six months. We are working on a reconsideration at this time, since this is completely unreasonable.

MSA Case I:

A vendor has a recent MSA where CMS actually countered lower on medications. However, their review was done incorrectly. The claimant required brand name medications, and this was well documented in the medical reports. We included a letter from the physician indicating that the claimant had to fill brand name medications. We have resubmitted with another letter from the physician, pharmacist, and numerous medical records.

MSA Case J:

An MSA was submitted for a right knee injury. The claimant went on to require a right hip replacement. The claimant had a non-work related left total knee replacement and left total hip replacement. The left side was denied as work related, and the department of labor approved this. A copy of the denial and the Department's approval letter were included in the submission. CMS included revisions of both the left and the right hips and knees. It is in the process of reconsideration with the Regional Office. The MSPRC would not respond when we contacted them for review.

The shift in review strategies by CMS has become a burden to the industry, causing many settlements to collapse after CMS review is returned.

" It makes it difficult to quote an annuity based on the original MSA. When CMS counters higher, the cost of the annuity goes up, and the client gets upset."

Prescription drug changes are raising WCMSA claims dramatically.

NAMSAP Committee Meeting Updates

Ethics and Standards Committee:
The Ethics/Standards Committee is currently inactive, having accomplished their task of establishing a document on Ethics which was accepted by the Board of Directors. They have also completed a proposed document on Standards which has been submitted to the current Board for review.

Membership Committee:

The NAMSAP Membership Committee has posted the 2009 Survey Results. Please see Page Two of the newsletter.

Education Committee:

The Education Committee is currently planning the 2010 Annual Meeting which will be held in Washington D.C. Details will be released soon.

In addition, a new subcommittee is planning webinars for the upcoming year. Their first meeting was at the end of November, and their goal is to offer six to eight quality webinars next year that will provide NAMSAP members and supporters with cutting edge information on the ever-evolving area of MSP and MMSEA compliance. Other goals include a better resource for education on Medicare related topics and continuing to promote NAMSAP as a leader in the area of Medicare Secondary Payer Issues.

MSA Case Law Update

The recent case law of Gory vs. US Food Service, State of California Appeals Board, has come to the attention of the NAMSAP Board and Communications Committee. The issue at hand is whether a state, in this case California, can invalidate a Federal lien, in this case, one arising out of Medicare conditional payments. This case also highlights the fact that a Medicare Set-Aside agreement cannot be used to repay Medicare conditional payments, since the MSA is calculated for future medical bills and prescription drug therapy charges, while the lien is asserted against claims that have been paid before the date of settlement. It is clear that the state cannot trump the federal regulations in this regard, yet there is some indication in the order that a waiver of that claim was made by Medicare because it filed the MSPRC notice. NAMSAP is urging attorneys familiar with California state law to respond to the court order sent via the listserv. As responses are returned, we will update NAMSAP members on this case law.

TIPS

1. **Medicare Parts A & B do not cover**:
    - Acupuncture
    - Attendant/Custodial Care
    - Dental Services
    - Diabetic Syringes/Insulin
    - Eye Exams/Glasses (exception made for frames and lenses after cataract surgery)
    - Nursing Home Care
    - Transportation
    - Routine Care (meaning that there is no underlying disease or symptom for which service was provided)
    - Routine Yearly Physical Exams (exception made for coverage starting after 01/01/05. A one time physical examination within the first six (6) months will be provided if the person has Part B)

2. **Disability** is determined according to the criteria in 1382c(a)(3) of the Social Security Act. To be considered "disabled", an individual must have a diagnosed medical condition (including mental illness) that is expected to last at least 12 months or to result in death. Further, the individual must be unable to engage in substantially gainful activity due to his or her medical condition.

Sponsorship and Partner Information

Platinum Sponsors

Crowe Paradis Services Corporation (CPSC) is a national Medicare compliance company founded by a group of entrepreneurial attorneys with extensive experience in the group disability, liability, workers' compensation and health insurance markets. By combining a best practices legal and medical approach to the Medicare Secondary Payer compliance challenge, CPSC has become a trusted consultant and provider to many of the leading insurance carriers, TPA's, self-insured's and attorneys nationwide.

Medivest professionally administers medical custodial accounts, provides premier MSA Allocations and other innovative solutions to preserve, protect and stretch settlement dollars in workers' compensation and liability disputes. www.medivest.com

Protocols, LLC is a multidisciplinary consulting firm that specializes in medical settlement planning for all parties involved in workers' compensation and personal injury liability cases -- from the simple to the complex. The Protocols team of experts - medical, benefits and legal - works together with clients to create a comprehensive plan for the projected medical care of an injured person. We also advise on the best and most cost-effective way to finance this care. Among Protocols specialty services are medical cost projections, life care planning and Medicare set-aside analysis, allocation and administration.

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PMSI/MSA
Procura Management Inc. (A Healthcare Solutions Company)
Rising Medical Solutions

Announcements

Call for Articles:
The Communications Committee would like to extend an offering to all interested authors. We are currently receiving articles for the first quarter 2010 newsletter to be published in March. We currently have three categories for articles: Legal, Legislative, and Medical. If you are interested in contributing to one of these categories, or have an idea for a new category, please contact April Pettengill, Chairperson for the Communications Committee. You can contact April by email at april@alpmedicalconsultants.com, or call her at (802) 849-2956.

"Letters to the Editor":
In addition to contributing authors, every interested member is invited to send their "Letters to the Editor", or provide comments on articles that are published in the newsletter.

CMS Updates:
One of the primary goals of the Communications Committee is to provide updates on each CMS regional office. If you have an experience with a particular regional office of CMS, please submit those to April so we can share those with other members of NAMSAP.

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The mission of NAMSAP is to foster the highest standards of integrity and competence among Medicare Set-Aside Professionals and those they serve.

NAMSAP is the only non-profit association exclusively addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. Through the voluntary efforts of our members, NAMSAP is a forum for the exchange of ideas and is a leading resource for information and news in this constantly evolving area of practice. The collective knowledge of our members and NAMSAP's resources will provide you with the ingredients essential to your success!