National Alliance of Medicare Set-Aside Professionals

Volume 1, Issue 2 June 2009

President's Letter to NAMSAP

To all NAMSAP members,

New CMS guidance on drug pricing is the latest issue to face members. Your Board of Directors is reacting and contacting CMS on your behalf. Often, those of us in the trenches of the MSA world feel that no one is listening to our concerns. Your BOD works tirelessly to share the views of the membership with CMS.

Our unique listserv program allows us to share with each other our thoughts and issues. The BOD always monitors concerns expressed in the listserv. The BOD uses your input in formulating our responses and policies. You see these reflected in the "members only" section of the website and the newsletter which is the official voice of NAMSAP. Listserv is our public forum for sharing ideas, questions, knowledge and even opinions of individual members, but is not the official voice or policy statement of the organization.

As we move forward, be assured that NAMSAP continues to be that quiet voice of reason with CMS. There are many groups, representing a variety of interests and agendas, pounding on CMS's door. We believe that as an organization we can have more effective dialogue, by being a quiet voice that works with CMS to improve the system. Nothing in federal government works quickly or exactly as every stakeholder desires. We continue to move the glacier of a federal program in the direction that serves all stakeholders.

Planning is on for our annual meeting, we look forward to a great program, currently being fine tuned by Leslie Schumacher and the Education Committee. The Education Committee welcomes your suggestions and offers of participation. Look to the website to find out how to become more involved.

As you will notice this newsletter will address the pressing issues of the day, as NAMSAP continues to educate and share information with our members. We welcome your contributions, on listserv, the newsletter and at the annual meeting.

Michael E. Westcott
President, NAMSAP

Michael E. Westcott
President, NAMSAP

Special Points of Interest:

- 2009 Meeting: September 30th through October 1st, Las Vegas.
- MARC Coalition is holding a legislative summit on June 3, 2009, and June 4, 2009.
- Upcoming NAMSAP Webinar on June 25, 2009: "Shall I put Medicare's Name on the Settlement Check?": An Update on Legal Issues Affecting Injury Claims when Medicare may be Involved.

Inside this issue:

NAMSAP 5th Annual Meeting and Educational Conference

Wednesday, September 30, 2009, through Thursday, October 1, 2009

The National Alliance of Medicare Set-Aside Professionals (NAMSAP) 2009 Annual Meeting and Educational Conference is scheduled for September 30, 2009, through October 1, 2009, at the Rio Hotel in Las Vegas, Nevada.

If you wish to make a presentation proposal, please submit your proposal at www.namsap.org/speaker_request_form.html. Please complete the form in its entirety, as only completed forms will be considered. NAMSAP requires speakers to provide information in an educational, non-commercial and non-self-promotional manner.

The Education Committee is interested in programs that provide professional development opportunities for those working with the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. We hope you will take advantage of this opportunity to share your knowledge with our meeting attendees. The deadline for submissions is July 1, 2009.

If you have any questions, please contact Leslie Schumacher, Education Committee Chairperson, at lschumac@comcast.net. Thank you for your interest in presenting a program at the 2009 NAMSAP Annual Meeting and Educational Conference.

Exhibitor and Sponsorship Opportunities:

Sponsors and exhibitors have an exclusive opportunity to showcase their products and services to the members of this unique organization. Sponsorships will be accepted on a first-come, first-serve basis. Sponsorship recognition will include a listing in the program, signage at the conference and acknowledgement at the podium.

Sponsorship opportunities form: click here

General Meeting Information:

Time:

September 30th, 1:00pm to 6:00pm
October 1st, 8:00am to 11:00am

Registration Rate:

$200 for members
$325 for non-members

Room Rate:

$99.00 (mention NAMSAP during registration)

This rate will be honored by the hotel through the weekend.

Online Registration Information: click here

CEU credits are available.

About NAMSAP:

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. Its members are comprised of attorneys, nurses, settlement planners, claims professionals and others professionals who tackle the issues of Medicare compliance in an informed and professional manner.

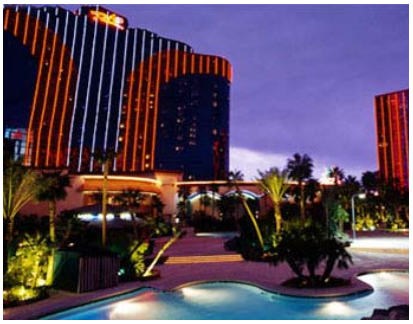
NAMSAP was formed to help individuals and organizations address claims impacted by the Medicare Secondary Payer Statute (MSP). The MSP is federal legislation designed to prevent the shifting of responsibility from a primary payer to the federal government in liability and workers' compensation claims.

NAMSAP Mission Statement:

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

Purposes of NAMSAP:

- Develop standards and define best practices for the industry;
- Promote a multidisciplinary approach to the Medicare Set-Aside practice;
- Provide a forum for learning and shared knowledge between all associated disciplines;
- Provide a unified voice to affect change and improve the Medicare Set-Aside process; and
- Protect the interests of all partied in settlements involving Medicare Set-Aside related issues.



Book your reservations now at the Rio Las Vegas for the 5th Annual NAMSAP Meeting and Educational Conference.

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

MMSEA: Section 111, Mandatory Insurer Reporting (MIR)

By: J. Williams, Gould and Lamb

Medicare Overview:

Medicare was established by Congress in 1965 to pay medical expenses for persons aged 65 or disabled. Initially, Medicare paid virtually all expenses for eligible participants. However, in 1980, in an effort to curb inappropriate Medicare spending, Congress passed the Medicare Secondary Payer Statue (MSP). The MSP was de-signed to prevent cost shifting to Medicare from other parties who might be responsible for, or have caused, the beneficiary's injury or illness. Under the MSP, responsible parties are called "primary payers" – the idea being that they should pay before Medicare – and include providers of liability insurance, self-insurance, no–fault insurance and workers' compensation (WC has been primary since the original 1965 Medicare Act. Liability, self-insurance and no-fault were added in the 1980 MSP statute).

In July of 2001, the Centers for Medicare & Medicaid Services (CMS) introduced the Workers' Compensation Medicare Set-Aside (WCMSA) program, which recommended the review and approval of certain types of settlements by CMS. While this program has been successful for CMS over the last 8 years, it has only scratched the surface of Medicare's recovery potential under the MSP. In search of additional revenue to fund the rapidly depleting Medicare Trust Fund, Congress created Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA or SCHIP). Medicare's recovery rights under the MSP remain unchanged, but they now have the means to enforce them in all instances under this new law.

With passage of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 Congress updated the rules. Now, after revising the start date, beginning in April 2010, CMS will require primary payers to provide data that will allow Medicare to recover payments that should have been paid by primary payers (commonly referred to as conditional payments or Medicare liens) and ensure that any additional future medical costs are covered by primary payers or the claimant's settlement proceeds, not Medicare. The regulations require primary payers to submit quarterly reports to CMS with detailed information about any claim involving a Medicare beneficiary.

Section 111 of the MMSEA will have serious implications, including:

- Civil penalties of $1000 per day/claim for failure to comply with reporting requirements;
- Requirements to discover/resolve conditional payments as part of any settlement agreement; and
- Increased usage of allocations to protect against future risks for the claimant and insurer.

Accordingly, companies that provide any form of liability insurance, no–fault auto insurance, and/or workers' compensation insurance to individuals who are Medicare beneficiaries must be in full compliance with Section 111 by July 1, 2010 to prevent incurring liability pursuant to the MMSEA. MSP compliance has been required since December 5, 1980.

Responsible Reporting Entities:

Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities (RREs). RREs must register with CMS via the Coordination of Benefits Secure Website (COBSW) between May 1, 2009 and September 30, 2009. Registration after September 30, 2009 is possible, but any exposure an RRE may have had prior to registration will not be mitigated. RREs must report quarterly, in a single electronic file, to CMS all claims involving Medicare beneficiaries where they have "Ongoing Responsibility for Medicals" (ORM) or cases resolved through a single payment settlement, judgment, or award as the "Total Payment Obligation to the Claimant" (TPOC). There are specific dates and thresholds around what types of claims need to be reported and RREs should review the CMS website to understand all of the guidelines and rules related to reporting exceptions on cases with ORM and TPOC. The site is http://www.cms.hhs.gov/MandatoryInsRep.com. Each RRE will receive a reporting period that is seven days in length. There are 12 cycles per quarter and 1 of 12 cycles will be assigned by CMS for each RRE ID. The reporting must be completed within the seven -day period assigned by CMS after the completion of the registration process. The

Medicare was established by Congress in 1965 to pay for persons aged 65 or disabled.

" The MSP was designed to prevent cost shifting to Medicare from other parties who might be responsible for, or have caused the beneficiary's injury or illness."

The Medicare Secondary Payer Statute has required that the obligations of a primary payer not be shifted to Medicare in any liability or no-fault insurance situation since 1980.

Continuation: MMSEA: Section 111, Mandatory Insurer Reporting (MIR)

By: J. Williams, Gould and Lamb

reporting timeframes are not uniform and a company with multiple-RRE IDs may have different reporting periods for various lines of business.

Insurance carriers are responsible for compliance with Section 111 for companies covered by an insurance policy with first dollar coverage (no deductible). However, companies with a deductible policy who pay their own claims are considered self-insured pursuant to Section 111. Such self-insured companies must register and report claims that are within the deductible retention. Companies who are truly self-insured and hold a self-insured retention (SIR) also must register and report claims that are within the SIR. If the claim exceeds the self paid deductible or SIR and moves into the insurer's layer, the insurer will become the RRE if they are funding the claim and the previous RRE will need to complete a final report indicating no further ORM. There is a great deal of conflicting information in the marketplace on this topic and CMS is expected to provide further guidance at some point.

Section 111 permits RREs to designate a third party to report claims and these entities are referred to as Reporting Agents. Third party administrators (TPAs) that manage claims and separate companies independent of the TPA can be appointed by the RRE as their Reporting Agent. Before designating a Reporting Agent, each RRE must register with CMS. The authorized representative for the RRE must have authority to enter into the CMS agreements on behalf of the RRE. An RRE has two options for SCHIP reporting:

- They can choose to be a direct reporting entity to CMS.
- They can choose to utilize a Reporting Agent to submit to CMS.

This can become a complex matter when an RRE's claims are managed by multiple administrators. CMS will only allow one input file per quarter per RRE ID. If you have multiple administrators, you must determine how those administrators will be reporting and decide if you wish to register multiple times and establish a separate RRE ID for each administrator or utilize a 3rd party data consolidator to roll-up all administrators data into a single report to CMS. There are substantial advantages to a single registration in these scenarios.

Reportable Events:

Section 111 mandates the reporting of claims involving Medicare beneficiaries if there is Ongoing Responsibility for Medical (ORM), if there is a change from the initial report in key data elements, and when the case is resolved through settlement, judgment, or award (S/J/A). There are special exclusions for cases with ORM and thresholds for cases closed through S/J/A. To simplify matters, here are some general guidelines to note when discussing reportable events and the exclusions. One should review CMS guidance on this topic closely.

Reportable Events:

- Cases with ORM as of July, 1, 2009.
- Cases with TPOC closed through settlement, judgment, or award (S/J/A) on or after January 1, 2010.
- Cases closed due to inactivity after January 1, 2010, but continue to have ORM as of July 1, 2009.
- Cases closed due to inactivity prior to January 1, 2010, but are reopened after January 1, 2010, and have ORM as of July 1, 2009.

Excluded Events and Thresholds:

- Contested Cases Exclusion:
  - No ORM and no payments have been made to or for the benefit of the claimant (only excluded until S/J/A occurs).
- TPOC Threshold Exclusions:
  - TPOC amounts below $5000 are not reportable between 01/01/10 and 12/31/10.
  - TPOC amounts below $2000 are not reportable between 01/01/10 and 12/31/11.
  - TPOC amounts below $600 are not reportable between 01/01/10 and 12/31/12.
  - All TPOC amounts are reportable after 01/01/13.
- WC Claims with ORM Exclusion:
  - For workers' compensation claims where all of the following are true; "medical only" lost time of no more than seven (7) calendar days, total payment does not exceed $600, and all payments have been made directly to the medical provider, RREs are excluded

Insurance carriers are responsible for compliance with Section 111 for companies covered by an insurance policy with first dollar coverage (no deductible).

"The authorized representative for the RRE must have authority to enter into the CMS agreements on behalf of the RRE."

Section 111 permits RREs to designate a third party to report claims and these entities are referred to as Reporting Agents.

Continuation: MMSEA: Section 111, Mandatory Insurer Reporting (MIR)

By: J. Williams, Gould and Lamb

from reporting until 01/01/11. Note: If ORM still exists as of 01/01/11, these case will be reportable in the next query cycle.

CMS requires submission of over 125 data elements for each claim that meets the reporting criteria. Section 111 reporting requirements were originally scheduled to go into effect July 1, 2009. The period between January 1, 2010 and March 31, 2010 will now be a test phase for the transmission of data from RREs to CMS. RREs must begin submitting actual data in the second quarter of 2010. Failure to comply with the reporting requirements of Section 111 could result in civil money penalties of $1,000 per day per claim for non-compliance. It is wise to start this process sooner than later as registration, data testing, live return response, claims data back-fill, and MIR data testing are all steps that need to be complete prior to MIR live data feeds.

Impact on Settlements:

Implementation of the new rules is expected to complicate the settlement of all claims. Although SCHIP merely establishes claim reporting requirements, the MSP is also at work here and happens to be administered by CMS – the same entity responsible for enforcing Section 111 Reporting. CMS has the ability to enforce their Secondary Payer rights on every claim now that they have knowledge of them. The industry should expect:

- Numerous conditional payment recovery letters from CMS on old claims.
- CMS stopping payments for medical benefits tied to injury related diagnoses.
- Post-settlement, CMS is exercising its authority to collect the entire settlement amount.

There is an absolute need to develop claims handling practices now to mitigate the exposure from these rights of recovery. It is imperative that claims handlers be knowledgeable about what to do when a conditional payment recovery letter arrives from CMS. Legal counsel must be prepared to address conditional payments and consideration of Medicare's future interests in settlements. Proper disclosure needs to be made with regard to Medicare's rights of recovery when a settlement is consummated.

Contrary to urban legend, there is no requirement to seek CMS review and approval of a liability settlement. While CMS will review and approve certain types of workers' compensation settlements, the burden is on the liability insurer to demonstrate that it adequately protected Medicare's interests in each settlement. Insurers should measure their tolerance for risk carefully.

Stay Alert:

CMS continues to publish news, alerts, and memoranda to conduct telephonic "Town Hall" meetings, and to update its User Manuals. There is a very high probability that something has changed from the time this article was written to the moment you are reading it. Stay alert and pay attention to the changes. NAMSAP will continue to monitor this matter and provide updates as necessary.

CMS requires submission of over 125 data elements for each claim that meets the reporting criteria.

"There is an absolute need to develop claims handling practices now to mitigate the exposure from these rights of recovery."

CMS continues to publish news, alerts, and memoranda to conduct telephonic "Town Hall" meetings, and to update its User Manuals.

"It's Crazy, But It's True": Medicare Issues in Liability Cases

By: Jacqueline G. Griffin & Vanessa De Rosa, Attorneys at Law, Eraclides, Johns, Hall, Gelman, Johannessen, and Goodman, LLP

Recently, there has been much buzz in the liability arena about the upcoming "$1,000.00 a day penalty" and MSAs. However, the reality is, these are two distinct topics, although there is an intersection of Medicare and liability cases.

In December 2007, Congress passed the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (the Act). "Section 111" of the Act is what the entire buzz is about. This law, specifically Section 111(a)(8), requires liability insurers (including self-insurers), no fault insurers, and workers' compensation insurers to determine a claimant's Medicare benefits status and report the status to Medicare when the claimant is a Medicare recipient.

It's crazy, but it's true that Medicare is requiring insurers to check the Medicare benefits status with Medicare, then report this status back to Medicare. The cause for alarm, however, is the provision of a $1,000.00 a day penalty, per claim, when this obligation is not met. Pursuant to the Statute, the start date for this responsibility is July 1, 2009; however, the Office of Financial Management/Financial Services Group has now published a "Revised Implementation Timeline," wherein the actual reporting deadline appears to have been extended to July 1, 2010.

Unfortunately, the Act is incomplete about how exactly an insurer (or self-insured) should go about fulfilling its responsibilities, and thus avoiding the $1,000.00 a day penalty. Recently, the Centers for Medicare and Medicaid Services (CMS) have been holding public "town hall forums," or conference calls, with the CMS representatives, to provide guidance. These forums began on October 1, 2008, and since then, there have been several others. Details about the forums can be found here. The transcripts from the past conference calls can be found at that link, as well. The forums are continuing, and several are scheduled through at least December 15, 2009. CMS representatives attempt to answer the questions of hundreds of callers each time, but unfortunately, many questions still remain about how exactly this determination and reporting is to occur.

With a relatively short time to go until the threatened penalty is to be implemented, insurers and self-insured hopefully have already started putting into place protocols to determine which claimants are Medicare-entitled, and developing with their IT departments ways that this information will be compiled and transmitted to CMS. For determining who is Medicare-entitled, CMS is developing a query function, which will be available only to entities who have registered to receive this information. CMS has published a "User Guide," dated March 16, 2009, which details the required format for transmitting this documentation to Medicare by the "Responsible Reporting Entity" (RRE), which is the insurer (or self-insured), or their appointed representatives. The User Guide can be viewed at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf.

Understandably, the Act has triggered an upheaval among risk managers. Interestingly, however, the rumor is that Medicare Set-Asides are now required in liability cases by the Act. This, in fact, is not the case. A careful reading of the new Section 111 itself shows that there are no references to Medicare Set-Asides, or even explicitly, a directive to protect Medicare's future interest in liability cases.

This is not to say, however, that liability carriers do not have a responsibility to protect Medicare's interest in liability cases. They do, but they had this responsibility long before the Medicare, Medicaid and SCHIP Act of 2007.

The Medicare Secondary Payer Statute has required that the obligations of a primary payer not be shifted to Medicare in any liability or no-fault insurance situation since 1980. For workers' compensation cases, this has been true since the Social Security Act of 1965. In fact, it appears that 42 CFR 411.46 gave rise to a series of memoranda, first published by CMS in 2001, which introduced the concept of a "Medicare Set-Aside" in workers' compensation cases. A Medicare Set-Aside (MSA), put simply, is just a vehicle for doing that which was always required by the Medicare Secondary Payer Statute. It is,

In December 2007, Congress passed the "Medicare, Medicaid, and SCHIP Extension Act of 2007"

" Understandably, the Act has triggered an upheaval among risk managers."

The Medicare Secondary Payer Statute has required that the obligations of a primary payer not be shifted to Medicare in any liability or no-fault insurance situation since 1980.

Continuation: "It's Crazy, But It's True": Medicare Issues in Liability Cases

By: Jacqueline G. Griffin & Vanessa De Rosa, Attorneys at Law, Eraclides, Johns, Hall, Gelman, Johannessen, and Goodman, LLP

essentially, carving out a specific portion of a settlement, and earmarking it specifically for future medical treatment of the type normally covered by Medicare, so that no prohibited "burden shifting" occurs. In workers' compensation cases, it has been used as a way of identifying that Medicare shall not pay for a work-related condition, until that portion of the settlement has been correctly exhausted.

Some may say, "It's crazy," but it's true, there is nothing in the Medicare Secondary Payer Statute which requires that future medical expenses formally be addressed in liability settlements. In other words, there is no liability equivalent to 42 CFR 411.46, which does address future medical responsibility in workers' compensation cases.

Presently, there is no statute, case law, or even CMS memorandum, which specifically directs that a Medicare Set-Aside be used in the liability arena. It does make sense, however, that the same vehicle, an MSA, could be used in liability settlements to show that the parties are not trying to shift the burden from the primary payer to Medicare.

Part of the confusion, however, has probably been spurned by CMS representatives, participating in panel discussions at various workers' compensation seminars. There, they have informally stated that while CMS has no requirements for MSAs, nor any formal review process for MSAs in liability cases, CMS has been reviewing such, when voluntary submitted in very large liability settlements.

It is clear that the intention of the passage of the Act is to further expand Medicare's ability to identify instances where Medicare is making payments for financial obligations, which should be the responsibility of some other payer. This information will allow Medicare to better identify primary payers, and most importantly, seek reimbursement for conditional payments made by Medicare, a statutory right long-provided by 42 USC 1395y. Because of Medicare's intention to further attempts at preserving its financial integrity, it is, therefore, reasonable to anticipate that over time, additional statutory changes may be made. These are likely to extend primary payers' obligations, in not just the workers' compensation arena, but also in the liability arena.

It is now necessary for risk managers to develop a program to address the fast approaching obligations under the new Medicare, Medicaid, and SCHIP Extension Act of 2007. Congruent with the "old" law, the Medicare Secondary Payer Statute, it is still necessary to ensure "burden shifting" to Medicare does not occur in liability cases, and now with the new Act, Medicare has made it clear that it will begin to crack down and seek reimbursement, otherwise. As such, competent, experienced legal counsel is recommended to ensure that maximum protection is afforded under the law.

Disclaimer: The purpose of this article is informational and is not for the purpose of providing legal advice. No attorney-client relationship is created with any reader.

Presently, there is no statute, case law, or even CMS memorandum, which specifically directs that a Medicare Set-Aside be used in the liability arena.

"Some may say, "It's crazy," but it's true, there is nothing in the Medicare Secondary Payer Statute which requires that future medical expenses formally be addressed in liability settlements."

It is now necessary for risk managers to develop a program to address the fast approaching obligations under the new Medicare, Medicaid, and SCHIP Extension Act of 2007.

MARC Coalition Update

By: Bill Van Wambeke, Board of Directors

NAMSAP holds a spot on the Steering Committee of MARC, the Medicare Advocacy Recovery Coalition, which is dedicated to education and reform regarding Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

On February 5, MARC was successful in having CMS officials Sherri McQueen, Barbara Wright, William Decker and John Albert present at its board meeting in Washington, DC for a question and answer session. During and after that meeting MARC was allowed considerable input into the implementation of Section 111, including the Medicare status query, the definition of Responsible Reporting Entity (RRE), a possible reporting threshold and other issues. The lines of communication having been opened. MARC promptly followed up with a letter formally requesting a reporting threshold and a delay in the implementation of the mandatory reporting.

NAMSAP holds a spot on the Steering Committee of MARC, the Medicare Advocacy Recovery Coalition.

In March of this year, CMS published the important User Guide to Section 111 and, within days, issued an ALERT that was significant for MARC in two ways. First, it delayed implementation of the MSP reporting process by 3 months, until January 1, 2010. Second, it imposed an interim reporting threshold for liability claims of $5,000, which is reduced down to $600 over time, and an interim exclusion from reporting for workers compensation cases that meet all of these criteria:

a. "Medical Only"
b. "Lost Time" of no more than Seven (7) Calendar Days
c. All Payments are made to the Medical Provider
d. Total Payment does not Exceed $600.00

This represented a major achievement for MARC and was followed last month by an extension of the original May 1, 2009, to June 30, 2009, RRE registration period to allow RRE's to register up to September 30, 2009, and a further delay in the reporting implementation until April 1, 2010, thereby again extending the testing period.

Although many implementation issues remain and MARC will continue on that front, on June 3 and 4, 2009, MARC will shift its focus to legislative reform as it holds its first legislative summit in Washington, DC. The legislative agenda will seek to accomplish the following:

- Ask CMS to provide a conditional payment demand before settlement, not after;
- Provide safe harbor alternatives that the parties to a settlement can take advantage of to satisfy conditional payments; should CMS not be able to provide its demand;
- Mandate reporting thresholds;
- Provide safe harbor for good faith efforts to obtain the SSN;
- Process to allow private parties to allocate settlement proceeds, short of proceeding to trial;
- Elimination of Agent liability to CMS, but preserve private principal - Agent claims for E&O;
- Establish a clear limitations period;
- Soften penalties to be more in line with the settlement amount; and
- Provide for an appeal process, if the need arises, to challenge CMS decisions.

"The lines of communication have been opened. MARC promptly followed up with a letter formally requesting a reporting threshold and delay in the implementation of mandatory reporting."

MARC has invited all sides to this summit including plaintiff and defense bars, the insurance industry, the TPA industry, self-insureds, professional societies, business groups, and Medicare advocacy groups. The meetings will be held at the offices of MARC's law firm, Patton Boggs -- widely regarded as one of the leading legislative action firms in Washington.

On behalf of NAMSAP, I will participate in this summit and in MARC's continuing efforts surrounding Section 111 implementation and reform. If you have any questions, I can be reached at wvanwambeke@mhayes.com or (410) 628-4050 extension 1132. More information about MARC can be found at www.marccoalition.com.

NAMSAP Committee Meeting Updates

Ethics and Standards Committee:
The Ethics/Standards Committee has been inactive after completing their tasks, including development of the ethics and standards and presenting them to the Board of Directors.

Membership Committee:
The Membership Committee grew in 2009 with the addition of four (4) new members to the Committee itself. Our first activity was to contact all 2008 NAMSAP members who had not yet renewed for 2009. The results of this effort yielded a reduction of non-renewed members from 138 to 67. The majority of the 67 non-renewed members sited change in professionalism as rationale for non-renewal.

The focus of the 2009 Membership Committee is two-fold: Retention and Recruitment. The Committee has several innovative ideas in front of the NAMSAP Board for consideration. In addition, the Committee is currently cross-referencing the NAMSAP membership with the IHCC listing of certified MSCC's. Any certified MSCC who is not yet a NAMSAP member will be forwarded an invitation to join NAMSAP this fall.

Education Committee:
The Education Committee has announced that the Annual Conference will be held in Las Vegas, Nevada, on September 30, 2009, and October 1, 2009. Details have been released via the listserv and will be posted at www.namsap.org.

The Education Committee would also like to announce an upcoming webinar.

Webinar Name: "Shall I put Medicare's Name on the Settlement Check?":
An Update on Legal Issues Affecting Injury Claims when Medicare may be Involved.
Date: June 25, 2009, 1:00pm Eastern
Presenters: Jill G. Schroeder, Baylor Evnen, and Benjamin Basista, Burns, White and Hickton, LLC
Member Cost: $60.00

NAMSAP is proud to announce an educational webinar to address the questions that arise every day as to how coordination of benefits with Medicare is best accomplished. Can I settle a claim before the conditional payment amount is known? Is approval of a Medicare Set Aside allocation required before State court approval of a settlement? Shall I put Medicare's name on the settlement check? What happens if I fail to adequately protect Medicare's interest in a settlement? Federal and State courts have answered many of these questions, and those decisions may provide guidance to practitioners as to best practices for handling claims involving Medicare beneficiaries.

With the advent of Mandatory Insurer Reporting, now, more than ever, injured individuals, insurers, employers, attorneys, and allocators need to keep informed about legal developments that have arisen under the Medicare Secondary Payer Act. This webinar will focus upon recent court decisions involving claims under the Medicare Secondary Payer Act, issues being debated as to the way current laws and regulations are applied, and proposed legislative changes to the Medicare Secondary Payer Act. So, how long does Medicare have to assert a right of recovery?

NAMSAP will be hosting a Webinar on June 25, 2009: "Shall I put Medicare's Name on the Settlement Check?": An Update on Legal Issues Affecting Injury Claims when Medicare may be Involved.

Legislative Committee:
The legislative committee reconvened in late May after a one month hiatus from formal meetings. During the month off, the sub-committees continued their efforts to track legislation, MSP case law and changes in the MSA process. Specifically, the legislative tracking committee reported the introduction of HR 2641 (The Tanner Bill). The details of the Bill are outlined below. MSP cases have also continued to emerge and a summary of recent case law is also provided below. On the MSA end of things the most notable update is the implementation of Medicare's April 3, 2009 prescription drug memorandum. Finally, discussions within the group have begun on a retooled "Go to Washington" event. Details about the event will be published in future newsletters.

Tanner WC MSA Reform (HR 2641)
On May 21, 2009, Representative John Tanner from Tennessee reintroduced the Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009. The bill has been introduced twice in the past, with the most recent time being HR 2549 in the 110th Congress. In addition to other things the Tanner Bill proposes guidelines for changes to the MSA process, MSA administration and outlines a formal MSA appeals process. The committee will provide further comment on the progress of the Tanner Bill and its potential impact on the NAMSAP membership in future newsletters. The Bill can be found at: http://www.govtrack.us/congress/bill.xpd?bill=h111-2641.

MSA case law update:
Elena A. Lidrbauch dedicated her time to providing a summary of eight (8) of the most recent cases that deal with MSA and MSP issues.

Prescription Memorandum:
On April 3, 2009 CMS released a memo outlining their intention to independently review and price prescription medications in MSA proposals as of June 1, 2009. The memo was then followed by a guidance memo that was released on June 2, 2009. In the coming months the legislative committee will be seeking comments from the membership on the impact that the change in prescription drug review and pricing is having on the MSA industry, the industry's clients and the settlement of claims. After gathering research collaboration will take place between the legislative committee, the Board and the membership regarding the efforts that NAMSAP will take in reaching out to CMS on this specific issue.

With a month taken to regroup and reform, the Legislative Committee has reorganized and is looking forward to working at providing the NAMSAP membership with efforts in each of the areas outlined above.

Sponsorship and Partner Information

Platinum Sponsors

Crowe Paradis Services Corporation (CPSC) - 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.

Gould & Lamb - At Gould & Lamb, our MSA team has extensive experience in legal, medical or workers' compensation disciplines. This experience allows us to consistently deliver the lowest defensible allocation that CMS will accept.

Medivest - 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

PMSI - PMSI MSA services blend knowledge from in-house clinical, pharmacy and regulatory experts to deliver the lowest defendable MSA allocations. PMSI is an industry pioneer in best practices and new requirements impacting MSAs.

Protocols - Protocols 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.

Gold Sponsors:
Experea Healthcare
MedAllocators, Inc.

Silver Sponsors:
The Center for Lien Resolution
The Center for Medicare Set-Aside Administration
The Center for Special Needs Trust
CompEx
MEDVAL, LLC
NuQuest/Bridge Pointe
Procura Management Inc.
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 second quarter 2009 newsletter to be published in June. 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.

Educational Opportunities:
The Law Offices of John C. Campbell, P.C., and Medicare Allocations, Inc., will be hosting "The Complete MSA Training Course" on October 22, 2009, and October 23, 2009, in New Orleans, Louisiana. Hotel arrangements are being finalized for this course now. Information regarding the training course, faculty and course curriculum are available at www.msatrainingcourse.com. This website will be updated as new information is finalized. The full course includes a take-home practicum and is accredited by the ICHCC for 30 CEUs toward the MSCC certification. The classroom portion of the course alone (without the take-home practicum) provides 15 CEUs for those individuals seeking recertification. For additional information, please visit www.msatrainingcourse.com.

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.

National Alliance of Medicare Set-Aside Professionals

341 N. Maitland Avenue
Suite 130
Maitland, FL 32751

Phone: (407) 647-8839
Fax: (407) 629-2502
E-mail: info@namsap.org

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!