NAMSAP

National Alliance of Medicare Set-Aside Professionals

Quarterly Newsletter September 2009

Special Points of Interest:

- 2009 Meeting: September 30th through October 1st, Las Vegas.

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President's Letter to NAMSAP

To all NAMSAP members,

We are swiftly approaching our annual meeting, and we look forward to a great program. The Education Committee has planned a wonderful meeting, and they welcome your suggestions and offers of participation. The website offers various ways that each member can become involved, and your participation is much appreciated.

This year, the annual meeting will be held at the Rio All Suites Resort in Las Vegas, Nevada, on September 30th and October 1st. Registration is still available so please visit the website if you would like to join us.

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 the listserv, the newsletter and at the annual meeting.

Michael E. Westcott
President, NAMSAP

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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.

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, 12:00pm to 6:00pm
October 1st, 8:00am to 12:00pm

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 October 4, 2009.

Online Registration Information: click here

CEU credits are available.

Tentative Agenda

Wednesday, September 30, 2009:

1:00pm	Opening Remarks
1:30pm	Keynote Speaker - Thomas Bosserman, CMS
2:30pm	Break with Exhibitors
2:45pm	"Building Your Own Small Business"
3:30pm	Break with Exhibitors
3:45pm	"Medicare Set-Aside Case Study"
5:00pm	"Pharmacy Trends"
6:00pm	Food and Cocktails with Exhibitors

Thursday, October 1, 2009:

8:00am	Breakfast with Exhibitors
8:30am	"Section 111 Panel Discussion"
10:15am	Break with Exhibitors
10:30am	"Medicare Action Recovery Coalition"
11:15am	"Industry Updates and Trends"
12:00pm	Conclusion

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.

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 parties 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."

Lump Sum vs. Annuity When Funding a Medicare Set-Aside

By: David J. Korch, JD, AIC, SCLA, Vice President and National Director of Workers' Compensation, EPS Settlements Group

The main goal of every settlement is to achieve the best claim outcome for the injured worker and the insurer or self-insured. When Medicare put out its first memo regarding Medicare set aside accounts, the insurance industry thought this would escalate the cost of settlements. The early vendors were putting together allocations that included an inflation factor then applied a discount rate to reduce the figure to present value (PCV). Later, CMS addressed the inflation factor issue in the October 15, 2004 memo, indicating that the allocations do not need an inflation factor; however they cannot be reduced to PCV. The inability to reduce the set aside to PCV increased the cost of settlements, however, the memo further went on to spell out that funding the settlement via a structured settlement was allowable, creating an opportunity for the insurer to see cost savings.

Structured settlements date back to the mid-1970's when they were first introduced by Kenneth Wells. Mr. Wells' concept was to fund the future needs of catastrophically injured people via periodic payments to insure that an injured individual could not outlive their benefits. This concept was further validated by the IRS via several rulings including the structured settlement act and section 130 of the IRS Code, which made these periodic payments tax free.

Medicare recognizes this as a viable method of funding MSA Accounts and gives specific instructions for calculating a MSA using a structured settlement annuity. They further advise that Medicare will become the primary payer of medical expenses once documentation is provided showing funds were spent appropriately, and continue to pay medical expenses until the next annual payment is made from the structured settlement.

This was a win-win for the insurance industry and injured workers. Since this would allow the carrier to spread out the Medicare funds over the injured worker's lifetime and allow this to be funded via an annuity purchased from a life insurance company. By illustrating this cost savings to the carrier, it increased the possibility for the settlement of workers compensation claims allowing injured workers to see finality to their claim, allowing them to move on with their life outside of the confines of the workers compensation venue.

As anyone can realize, spreading lifetime funds over an individual's life expectancy can result in a lower cost of settling the claim. Numerous individuals have conducted studies concerning the cost differential between the life time lump sum and the cost of funding the MSA via periodic payments. When looking at the different studies they all reach the same conclusion, an average savings of 46%. This percentage is even higher with males after CMS began using non-gender- specific life expectancies.

Since the common goal of the Medicare set aside industry and the structured settlement consultants' is to achieve the best claim outcome on these cases which result in a significant savings for the industry, why would we as Medicare set aside professionals not submit the Medicare set aside to Medicare reflecting a structured settlement in lieu of a lump sum? By submitting as a lump sum, with no consideration of a structured settlement, the cost of settlement increases by 46% or greater.

The submission as a structured settlement does not forgo the possibility of settling the case as a lump sum, but it does allow the option to settle either as a lump sum or structured settlement. Why not give our clients the option of saving 46% or more in their settlements.

A set aside submitted as a structured settlement is reviewed with the same medical standards as a lump sum. When the review center completes their review, they add one further step, calculating the initial seed and

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Continuation: Lump Sum vs. Annuity When Funding a Medicare Set-Aside

By: David J. Korch, JD, AIC, SCLA, Vice President and National Director of Workers' Compensation, EPS Settlements Group

annual payments over the life expectancy. The approval letter received from CMS states both the lump sum amount and the periodic payment amounts. From this, the settlement can proceed either as a lump sum or annuity.

Over the past several months our settlement consultants at EPS Settlements Group have seen several approval letters returned as a lump sum only. When we have inquired, we learned that the case was submitted as a lump sum with no mention of a structured settlement. In most instances, the case had already been negotiated as a structured settlement and, in a few instances, no settlement had yet been negotiated. In all these cases, the results were added costs to the carrier (our mutual client). These costs included the cost difference between the lump sum and annuity and further delay in obtaining the Workers' Compensation court's approval while supplemental letters are submitted to CMS to change the settlement from a lump sum to annuity.

The largest, most troubling cost increase was in resolving the problem with the injured worker and, in most instances, their legal representative. The attorney is willing to discuss the funding via the annuity but insists that the difference between the lump sum amount and the cost of the structured settlement funding be given to his client.

In the cases I have reviewed, the difference was $35,000 and in one instance on a catastrophic case, over $200,000. Although a majority of cases are less than the amounts above, we only have to assimilate these figures over the number of submissions and see that this is not a trivial matter.

In a study released by CMS in October, 2008, they indicated that over a three year period they approved lifetime amounts totaling $1,530,538,733 or approximately $510,179,544 per review year. If all had been funded via periodic payment, the resulting savings to the industry would be $234,682,590 per year. They also stated that they reviewed 10,154 cases a year. If we use the cases I mentioned earlier averaging $35,000 difference, the cost increase to the carrier, if only submitted as a lump sum, would be $355,390,000.

Something else to consider is the cost to have allocations completed in relationship to the cost of funding. Based on 10,154 reviews by CMS (See above) and an average cost of $2,800 per file, the cost for allocations nationally is about $28.5 million. If we show savings to the industry of between $234.6 million and $355.4 million, the cost to have the allocation completed is less than 10% of the savings.

This will also go a long way to resolve some issues between the MSA industry and the structured settlement industry. The allocation industry has been obtaining rated ages to calculate the life time figure, but few of these cases were ever structured. By presenting more cases as structures, the life companies, who bear the cost to underwrite the mortality calculation but provide these ages to the industry (free of charge) will see more MSA cases being funded via annuities making the process of providing this service worth their efforts. (As most of you realize, several life companies will not provide rated ages on workers' compensation cases since the volume of reviews were only being used to calculate a lump sum MSA.)

If our goal as an organization, is to provide the most cost effective and defendable allocation for our clients as well as superior service, why aren't we submitting these cases as structured settlements?

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MSA's From a Claimant's Attorney's Perspective

By: Paul M. Doolittle, Esq., Jacksonville, Florida

As a taxpayer, I am grateful that MSA's are forcing Claimants to "park" money to pay for their future medical expenses. It is clearly wrong for Claimants to receive settlement monies, which include future medical benefits, yet use that money for other purposes while billing Medicare for their work related medical expenses. Prior to the advent of MSA's, Employer/Carriers would say, in effect, "Your client is on Medicare, so why doesn't he settle and use Medicare to pay for his future medical expenses?" My retort was always "Why should taxpayers in Alaska pay for medical treatment that is the responsibility of the Florida Employer/Carrier?"

Today, I have different beefs. With respect to the Employer/Carrier- chosen vendors, in my opinion many of them are disingenuous and less than honest. With respect to Claimant's attorneys, as I know from my mediation practice, many of them: 1) have not reviewed and/or seen the proposed MSA until just before or during the mediation conference; 2) have failed to determine whether conditional payments have been made; and 3) don't have a clue about "gap" coverage and, therefore, not only leave money on the table, but potentially commit malpractice. Allow me to elaborate.

Upon receipt of a proposed MSA, which I obtain weeks prior to a mediation conference, I review it with a fine tooth comb, picking it apart. For example, a proposed MSA noted the rated age to be 55 years and the life expectancy to be 25 years, however, using the National Vital Statistics Report, the life expectancy was 26.6 years. Whether that number was rounded up or down to a whole number, the life expectancy would not be 25 years. In another, it was noted that no further surgical intervention or other treatment was required, however, the recommendation was made by a physician of a specialty other than that required for such treatment. Therefore, we had the treating surgeon resolve that issue prior to submission of the MSA, so as to ensure that appropriate provisions were made for future treatment. In yet another case, a vendor noted the cost of a spinal cord stimulator to be $5,163.00, while CMS stated the cost was $8,321.00. Moreover, the vendor did not include funding for reprogramming or replacement, which CMS noted to be needed every seven years for chronic pain patients. The Claimant's attorney must ensure that the vendor accurately portrays the Claimant's medical needs, such as the appropriate number of monthly or yearly visits to physicians, psychiatrists, psychologists, x-rays, MRI's, laboratory tests, TENS units, supplies, etc. In almost all cases, I take relevant portions of the MSA, supply it to the treating physician(s), and obtain opinions as to whether the proposed MSA accurately reflects the Claimant's future medical needs. I don't understand how, when the Claimant has been seeing his psychologist monthly for years, that the proposed MSA magically determines that the Claimant only needs to see the psychologist three times a year. Where did the vendor come up with that conclusion?

In claims with high dollar prescription expenses, some vendors are using "clinical justification" to claim over-utilization in order to reduce the current regime or a "pharmacy drug review" in an attempt to help reduce a Carrier's exposure for future prescription medications. I have seen an MSA wherein the vendor indicates the Claimant could be weaned from narcotic medication, which the Claimant had taken for years, and substitute it with heat therapy, the use of a TENS unit, a home exercise program and time! Claimant's attorneys should be hiring an outside vendor to review the Employer/Carrier vendor's MSA in order to determine its accuracy.

Claimant's attorneys are clearly doing their client a disservice by not reviewing the proposed MSA from a vendor chosen by the Employer/Carrier prior to discussing settlement. Likewise, failure to determine whether conditional payments have been made, well in advance of settlement negotiations, is irresponsible. However, the most egregious error I see in my mediation practice is the failure of the Claimant's attorney to protect his client in the event that a projected future prescription cost will fall within the "gap" period.

In 2009, the deductible for Medicare Part D, prescription coverage, is $295.00. Thereafter, the Claimant pays co-insurance of 25% until the initial coverage limit of $2,700.00 is met. At that point, the Claimant has fallen into the "doughnut hole" or the "gap". The Claimant must pay his entire prescription costs until he has spent $4,350.00 that year (including the $295.00 deductible, the 25% co-pay, plus $3,453.75); after that, he must pay an approximate co-payment of $6.00 per prescription. As such, the Claimant will be expected to pay, out of his pocket, in excess of $4,350.00 per year in the event he has significant prescription costs, i.e. those that plow through the "gap". The last thing I would want, as a Claimant attorney, is for my client to come back to me a year after the settlement to ask why he is paying money out of his own pocket for prescription medication that, prior to the settlement, was being paid for entirely by the Employer/Carrier.

In addition, several medications are not covered under Part D, including medication for weight dysfunction, erectile dysfunction, barbiturates-used primarily for daytime sedation and the treatment of seizure disorders, benzodiazepines-used to induce sleep or relieve anxiety, and treat muscle spasms (including Xanax, Valium, Klonopin, Ativan, Restoril, and Ambien), and may include other medications that are medically necessary and causally related to the work accident. How many times have injured workers required medication for weight dysfunction, erectile dysfunction, or sleep aids? Again, the Claimant's attorney must ensure that all

All members of the settling parties should review MSA proposals carefully before settlement.

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Continuation: MSA's From a Claimant's Attorney's Perspective

By: Paul M. Doolittle, Esq., Jacksonville, Florida

medical treatment/care be included in the settlement, either through the MSA or in a separate "bucket" for non-Medicare covered treatment.

If the Employer/Carrier wishes to proceed with the settlement prior to CMS approval of the proposed MSA, ensure that the Employer/Carrier will fund any difference required by CMS. Never agree to hold an Employer/Carrier harmless from or indemnify them for anything related to the MSA, conditional payments, etc. I typically insist that the following language be included in the settlement documents:

- The Carrier further agrees to indemnify the Employee and his/her attorney for any claim or potential claim of Medicare for payment of any lien or right of recovery, arising out of benefits paid to or on behalf of the Employee for any care or treatment provided as a result of the Employee's work related conditions.

All stakeholders have a duty to ensure that Medicare's interests are taken into account. I discuss the MSA with my client in detail so that he understands that not all medical treatment and prescription medications will be paid from the MSA. I confirm my client's obligations with respect to the MSA in writing. Vendors, lawyers, and Carriers have a duty to provide all relevant records to CMS. If an attorney, whether claimant or defense, has knowledge that his client is not abiding by the requirements of the MSA or not taking Medicare's interests into consideration, he should contact his Bar Association to determine his obligations. By making settlements contingent upon CMS approval, they are not binding, which may pose additional ethical considerations. What happens if the client dies while waiting for CMS approval and his family then complains when the settlement is not effectuated?

Of course, MSA's only cover treatment/medication if it's provided by Medicare. The Claimant's attorney must, when settling, obtain additional funds for non-Medicare related medical expenses which are also the responsibility of the Employer/Carrier. For example, in one case, my client utilized ice packs, Tylenol, and memory aides (watch with alarm, pill reminder and planner, etc). These items cost $97.00 per year. With a 15 year life expectancy, this amounted to $1,455.00, which must be added to the settlement amount. In another case, the client needed a lift chair, a wheelchair, a ramp, and a lift on the back of his truck. Understandably, since these items were not covered by Medicare, they were not included in the MSA. However, the Claimant's attorney needs to ensure that when settling, funds are provided for these medically necessary and causally related devices.

In a situation where a proposed surgery is included in the MSA, the Claimant attorney should ensure that one year's deductible for Medicare Part A is also included. For 2009, the deductible is $1,068.00. The last thing you need is for the Claimant to submit to surgery, use his MSA funds to pay for the surgery, and yet possibly be exposed to the Medicare Part A deductible for his hospital stay. As you know, Medicare B does not cover all services, including, but not limited to, chiropractic services (except manipulation), custodial care (except in a skilled nursing facility), dental care, eye exams, routine foot care, hearing aides, hearing tests, certain laboratory tests, and mileage. Many work-related injuries require dental care, eye exams, foot care, hearing aides, and so forth. Every work-related claim includes mileage (currently at $0.55 per mile for privately-owned vehicles). Moreover, many claims have an attendant care component.

The Claimant's attorney also has a duty to discuss funding for the MSA with his client. The Carrier will most likely wish to fund the MSA with an annuity, as it is less expensive for the Carrier, which results in additional monies to be paid directly to the Claimant. Moreover, an annuity helps prevent the Claimant from spending the MSA funds on something other than medical care. The Claimant's attorney should discuss with his client the difference between guaranteed and non-guaranteed annuities. An annuity that is not guaranteed will cost less to purchase and may pay the Claimant more in periodic payments. However, should the Claimant pass away, the Claimant's estate or beneficiary receives nothing. One should also explore the option of an annuity that is guaranteed for a certain, specific, period of time. When an annuity is being discussed, the Claimant's attorney should always obtain advice from his own structured settlement vendor. More often than not, the Claimant's vendor is able to obtain more favorable terms. It also provides an additional layer of liability coverage for that rare event when things go wrong. Remember that interest earned from the MSA monies must stay in the account, even though the Claimant must pay taxes on that money.

For years, I have inserted language into settlements that allot various sums to future compensation benefits, past medical benefits (if any), future non-Medicare medical expenses, future Medicare medical expenses (which should be separated into two entries if the Claimant is to receive initial MSA seed monies and an amount to be used to purchase an annuity), vocational rehabilitation expenses (if any), and attorney's fees/costs. The indemnity and medical funds are broken down over the Claimant's life expectancy, which helps protect the Claimant's disability benefits.

Finally, Claimant's attorneys (and all stakeholders) need to know that the United States has a long arm that will reach out and "touch" them in the event they do not protect Medicare's interest: see United States of America v. Harris, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. Mar. 26, 2009). In Harris, the Plaintiff attorney failed to protect Medicare's interest, and was personally sued by the United States. Govern yourself accordingly.

Medicare Part B does not cover all services, so it is important to know coverage entering the settlement.

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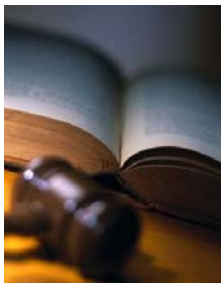

In United States of America vs. Harris, the Plaintiff attorney failed to protect Medicare's interest, and was personally sued by the United States.

The final installment of the MARC Coalition's three part series regarding MSP and MMSEA will provide a comprehensive educational overview of all facets of the Medicare Secondary Payer Statute and the negative impact its regulations have on the regulated community. The discussion will be highlighted by detailed information on the existing MSP and MMSEA laws, contingent liabilities, and resolutions for broader MSP reform through legislative action.

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

The final webcast of the installment titled "Claims involving a Medicare Beneficiary: What is the Law and How do we Follow or Change it?", will take place on Thursday, September 17, 2009, from 2:00pm to 3:30pm EST. The discussion will include:

- Existing Medicare laws, regulations and rules and contingent liabilities (Medicare beneficiary privacy and associated penalties with non-compliance);
- The most recent efforts to reform the MSP and about legislative resolutions;
- Whether potential exists to change the MSP through litigation; and
- Resources for the MSP-regulated community.

Speakers include R. Matthew Cairns of Gallagher, Callahan and Gartrell, from Concord, New Hampshire, Roy A. Franco, Risk Management Strategies Director for Safeway Inc. in Pleasanton, California, and Jeffrey J. Signor of Goldberg Segalla in Buffalo, New York. The Webcast Program Chair will be Susan Murdock of the Medicare Advocacy Recovery Coalition.

Registration is $150.00 for MARC members and $180.00 for non-members. Discounts are provided for multiple attendees. To register online, please go to http://dri.org/open/Webcasts.aspx.

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.

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 begun the process of working on the Committee's 2009 goal of Retention and Recruitment. A short survey will be coming soon to the NAMSAP members. This survey is the Membership Committee's effort to discover what elements of the organization entice you to remain, and what we can do to improve our membership census. The findings will be shared with the organization and utilized to retain and recruit members.

NAMSAP's current member census is 489. We have acquired 148 new members. There are 349 professional members, 14 associate members, 18 partner members, and 108 partner representatives. The Membership Committee is confident that the census will continue to increase throughout the year.

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.

General Meeting Information:

September 30th, 12:00pm to 6:00pm

October 1st, 8:00am to 12:00pm

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 October 4, 2009.

Online Registration Information: click here

CEU credits are available.

MSA Case Law Update

Ferreira vs. Home Depot and Sedgwick CMS - 06/09/09

Claimant Mary Ferreira entered into a settlement agreement that included funds for her to establish a Medicare Set-Aside account. The contract stated that Ferreira, not the employer or carrier, be responsible for administering the account. The agreement also provided that the employer/carrier would deposit seed money in the amount of $10,851.08 and $33,694.64 for the purchase of an annuity that would yield $2,154.18 per year, and that amount was final, not subject to change or approval by CMS. The parties also agreed that if CMS demanded a larger amount, Ferreira would be responsible.

Ten months after the settlement was approved, the employer/carrier filed a motion seeking to compel Ferreira to return an "overpayment" of the MSA seed money. The employer/carrier had received correspondence from CMS that the gross amount of the MSA was accurate, but the sums projected for annual deposits were deficient. The employer/carrier had not yet purchased an annuity to fund the deposits. They demanded that Ferreira pay the additional amount so they could buy an annuity that met CMS's requirements.

The judge of compensation claims granted the employer/carrier's motion, reasoning the Ferreira had agreed to fund or pay the difference should CMS deem that more money was necessary for future medical expenses. Ferreira appealed.

Analysis: In its majority opinion, the first DCA said that the judge of compensation claims had misinterpreted the settlement contract. Noting in the agreement required Ferreira to pay anything more than the sums that were promised to purchase the annuity to fund the future deposits into the MSA.

By not purchasing the annuity as promised, the employer/carrier created a predicament whereby the JCC was forced to rectify the potentially conflicting provisions which, on one hand, provided the annuity amounts were fixed, not subject to change, and not dependant of CMS approval, and on the other hand, made the claimant responsible for any deficiencies later identified by CMS, the opinion said.

Disposition: Reversed and Remanded

To read the opinion, visit www.workcompcentral.com/pdf/2009/misc/ferreira060909.pdf.

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.

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

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
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 fourth quarter 2009 newsletter to be published in December. 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.

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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!