



PROGRAM MATERIALS

Program #36113

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Complying with the Medicare Secondary Payer Program in Your Workers Compensation Case in 2026

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Workers Compensation Medicare Set Aside Rules and Essential Information

Introduction: The following is a brief outline of the topics surrounding Medicare's interests in workers' compensation claims. The outline will highlight new CMS policies regarding obtaining an Amended review from CMS of a previously approved Medicare Set Aside (MSA) allocation, obtaining approval of a zero-dollar MSA, also called a waiver request, and how to correctly notify CMS of a change in MSA vendor.

I. The Basics:

- a. When Do I Need a Medicare Set Aside (MSA)?
 - i. You need a Medicare Set Aside every time you settle the medical portion of a workers' compensation claim or a longshore claim and the injured claimant is anticipated to require future medical care for the work injury.
 - ii. If future medical care is anticipated for the work injury, the MSA should be considered even if the injured claimant is not eligible for Medicare at the time of settlement (see Question 1 of the July 11, 2005 CMS Memorandum.). This is particularly true if the injured claimant is applying for or receiving Social Security Disability benefits.

b. What Types of Medical Care Must be Included in the MSA?

- i. All regular and ongoing medical care to the injured party, including, but not limited to: physician office visits, prescribed medications, diagnostic testing, physical therapy, and durable medical equipment.
- ii. All medical care anticipated to take place in the future and as necessitated by the work injury, including, but not limited to: all recommended surgeries, pain management injections, and the purchase or replacement of durable medical equipment.

c. How is the MSA Funded?

- i. One time lump sum payment.
- ii. Structured annuity approach. CMS requires that structured MSA accounts be initially funded with a seed payment in year one, with the annuity payments beginning one year post-settlement.

d. How is the MSA Account Administered?

- i. Self-administered by the injured person.
- ii. Self-administered by the injured person with the assistance of a competent adult (commonly used in head injury cases or cases with elderly persons suffering from dementia.)
- iii. Professionally administered by a third-party custodial company. (NOTE: All professional administrators charge a fee for their services. CMS requires that these fees must be funded separately from the MSA funds.)
- iv. Note: Medicaid: MSA funds are countable assets for determining Medicaid eligibility. Therefore, Medicaid recipients should utilize a Disability Trust (Special needs) or a Community/pooled trust for MSA funds to ensure on-going eligibility for Medicaid and other needs-based programs.

- v. Note: At death any funds remaining in the MSA account become part of the estate of the injured worker. It is possible for remaining MSA funds to revert back to the workers' compensation carrier, but this must be agreed to at settlement and included in the settlement documents.

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II. When Can I Get CMS Approval of the Proposed MSA Figure and How Long Does it Take?

- a. CMS approval of a proposed MSA figure is always optional for every settlement; no CMS regulation or federal statute requires approval of an MSA.
- b. CMS Workers' Compensation review thresholds: CMS will only review proposed MSA figures for the following situations:
 - i. For Medicare eligible persons: CMS approval can only be obtained if the total settlement value exceeds \$25,000.00.
 - ii. For non-Medicare eligible persons: CMS approval can only be obtained if both of the following criteria are met: 1) there is a reasonable expectation that the injured person will be Medicare eligible within 30 months of the date of settlement, and 2) the total settlement value exceeds \$250,000.00.
- c. CMS approval generally takes 1 to 3 months. NOTE: CMS may send out a "development letter" seeking additional data for the MSA review. Failure to respond timely to such a request will lengthen the review process. Should it take greater than twelve months to respond to a development letter, the entire proposal must be resubmitted and a new CMS Case ID number will be assigned.
- d. An MSA should still be done even if the CMS review thresholds are not met.

- e. Note: As of January 2022 CMS has determined the “evidenced based” MSAs or “non-submit” MSAs may not adequately protect the Medicare program.
- f. How to change MSA vendors/submitter
 - i. The prior vendor must provide a written statement to the WCMSA Review Contractor asking for the CMS MSA review file to be closed and for the vendor to be removed from the file.
 - ii. Once the file is closed, the new vendor may submit a new MSA proposal for review.
 - iii. The claimant must sign a new consent to release form for the new vendor/submitter.
 - iv. Submitter changes will not be accepted after settlement.
 - v. Submitter changes do not constitute a reason for a re-review.
 - vi. CMS will not provide copies of existing documentation to the new submitter. Any such documentation must be obtained from the incumbent submitter.

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III. The Amended Review Process

- a. As of July 31, 2017 parties to settlement can seek re-review of a previously approved workers’ compensation MSA where no settlement occurred, if all of the following criteria are met:
 - i. CMS issued an approval letter at least 12 months prior to the re-review request. **NOTE:** Beginning April 7, 2025, Amended Review requests can be submitted immediately after receiving the CMS determination letter.
 - ii. The case has not yet settled as of the date of the request for re-review
 - iii. Projected care has changed so much that the submitter’s new proposed MSA amount would result in a 10% or \$10,000.00 change (whichever is greater) in CMS’ previously approved amount,
 - iv. Where a re-review request is reviewed and approved by CMS, the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased.
 - v. An Amended Review can only be requested one time.

- a. Items that will change the MSA allocation:
 - i. Changes in medications
 - ii. Surgery recommendations
 - iii. Changes in durable medical equipment needs
 - iv. Changes/recommendations for pain management injections
 - v. Changes/recommendations for implantable devices.
 - vi. Failing to account for change in life expectancy, including expiration of rated ages.

- b. NOTE: Amended Review is a new review process. It is still possible to request a Re-review of the MSA allocation on the basis of: Mathematical error and Missing documentation. If utilizing the "missing documentation" basis for a re-review, the newly provided data must not have been previously considered by CMS and must be dated prior to the submission date of the original proposal.

- c. NOTE: Once settlement of the medical portion of the claim takes place, CMS will not review an MSA proposal. Therefore, if the parties to settlement want to modify, specifically reduce, the MSA funding post-settlement there is no way to obtain CMS approval of this modification. Any such modification should be done cautiously and with significant medical evidence to support the modification. Such medical evidence should be provided by the injured worker's treating physician. If the only evidence to support a post-settlement reduction is an IME or AME report, it is advised not to proceed with the reduction as CMS puts little persuasive weight or value in IME or AME reports.

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IV. Will CMS Approve a \$0.00 MSA Allocation (also called Waiver Requests)?

- a. Beginning July 17, 2025 CMS will **NO LONGER** formally review and approve \$0.00 MSA submissions. The new guidance from CMS indicates that after July 17, 2025, if the parties to a case believe no MSA (or a \$0.00 MSA) is required, the parties must fully document their file regarding all facts that support the

zero-dollar MSA allocation. Section 4.2 of the WCMSA Reference Guide outline the requirements that must be met for a zero-dollar MSA allocation. These same criteria must still be met after July 17, 2025 when formal CMS review of these proposals stops.

- b. CMS will approve a \$0.00 MSA allocation if the injured person has been fully discharged from all treatment for the work injury by the treating physician, and no settlement funds are allocated for future medical needs (see question 20 of the April 22, 2003 CMS Memorandum.)
- c. CMS may approve a \$0.00 MSA allocation in a workers' compensation settlement if the claim has been fully denied or disputed. Obtaining CMS approval in disputed cases is always recommended as CMS may demand an increase to the proposed MSA allocation. NOTE: \$0.00 CMS submissions require a great deal of data and letters. Data will be required from both the injured worker and the workers compensation carrier. CMS changes the requirements for a \$0.00 MSA periodically and, sometimes with very little notice of the change.
- d. CMS will utilize payment of a medical lien holder as proof the parties to the case intend to compensate the worker for medical damages. Should CMS make this determination, the agency will deny the zero-dollar MSA submission and require a fully funded MSA allocation.

V. What May Help to Decrease an MSA?

- a. Rated ages.
- b. Statements from the treating physician that the injured party is no longer a candidate for certain medical procedures, such as surgeries, intrathecal pain pumps, and spinal cord stimulators.
- c. Statements from the injured party that they do not wish to proceed with a recommended surgery or treatment now or in the future. (Note: CMS is not necessarily bound by these statements and may still request an increase to the proposed MSA even if they are obtained.)
- d. A statement from the treating physician that the party can be switched from brand name to generic prescription medications.

- e. NOTE: 42 CFR 411.47 cannot be utilized to reduce future medical funding. CMS specifically stated this in its July 11, 2005 memorandum.

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VI. WCMSA allocations and State Laws

- a. CMS will recognize and honor state-specific statutes addressing the limits of future treatment; including the length or nature of future care.
- b. Submitter must still be able to demonstrate the Medicare’s interests have been fully accounted for and protected.
- c. A copy of the state statute must be provided with the submission.
- d. Submitters requesting alteration of pricing based upon state-legislated time limits must be able to show by finding from a court of competent jurisdiction, or appropriate state entity as assigned by law, that the specific WCMSA proposal does not meet the state’s list of exemptions to the legislative mandate.
- e. For those states where treatment is varied by some type of state-authorized utilization review board, the submitter shall include the alternative treatment plan showing what treatment has replaced the treatment in question from the beneficiary’s treating physician for those items deemed unnecessary by the utilization review board. Failure to include these items initially will result in pricing at the full life expectancy of the beneficiary or the original value of the treatment without regard to the state utilization review board recommendations.
- f. NOTE: Failure to include the required documentation at the time of original submission will not constitute a reason for the request of a re-review.

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VII. Updates and Miscellaneous information

- a. November 8, 2017 MLN Bulletin to medical providers. The goal of the bulletin is to educate all medical providers on the MSP statute. Specifically, providers were informed that Medicare is always the secondary payer to workers compensation, liability, and no fault payments. Further, Medicare should not be billed until settlement proceeds are exhausted. Finally, providers should be paid directly from the patient from a Medicare set aside allocation. Payment from the MSA should take place even if the MSA was not approved by CMS.
- b. CMS has made it clear that Liability and No Fault settlements/payments are primary to Medicare and must comply with the MSP statute. Therefore, if the injured worker has filed a companion Liability claim, keep track of that claim and whether or not settlement includes funding for an MSA.
- c. Commercial Repayment Center: Remember the CRC can audit an open ORM file up to four times per year and issue a Conditional Payment Notice or Letter. The CRC can demand payment of conditional payments prior to settlement. Do not ignore any correspondence received from the CRC.
- d. If no letter has been issued by the CRC demanding payment, but you file a dispute for unrelated charges, it is likely the CRC will process your dispute but also issue a demand for payment. Review all letters received from the CRC very carefully.
- e. The CRC can only see Medicare Part A and Part B payments. If the Injured Workers is participating in a Medicare Part C (Medicare Advantage/HMO) or Medicare Part D (Drug) plan, additional conditional payment searches will be necessary with the Part C or Part D plan administrator.
- f. October 11, 2023 CMS passed the final rule for Section 111 Civil Money Penalties. The rule is effective December 11, 2023. Timely filing requirement beginning October 2024. The penalty will be assessed for untimely filing. The financial penalty will scale up from \$250.00 per day to \$1,000.00 per day. The maximum penalty for any one violation is \$365,000.00 per year. All fines/penalties may be adjusted annually.
- g. Beginning April 2025 all Section 111 reports for workers compensation settlements must include a WCMSA amount.

- h. Beginning February 2026, CMS will report all WCMSA pharmacy data to Part D plans (outpatient prescription drug plans).

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Medicare Advantage Plans

The purpose of this handout is to provide a practical guide to the Medicare lien search process (also known as the Medicare Conditional Payment). It is not intended to provide a historical or theoretical overview of the lien search process, but rather to provide helpful tips and guidance to assist the practitioner in obtaining both the tentative and final Medicare lien amount.

I. Tips for dealing with Medicare Advantage Plans

- a. Statutory authority for both Part C and Part D plans: 43 CFR 422.108 and 42 CFR 423.462
- b. At present the only way to determine if a Medicare beneficiary has participated in a Part C or D plan is to ask the beneficiary. The tools presently available to determine Medicare eligibility can only indicate if the injured person is presently eligible for Medicare but cannot provide any information about the specific Medicare plan or plans they are participating in.
- c. Easiest way to determine if at least one Part C or D plan is involved in your case: If the injured party ever required prescription medications for the injury

in question, ask the injured party for a copy of the card they provide to their pharmacist. Traditional A/B Medicare does not pay for outpatient medications; therefore, the person must provide a different insurance card to their pharmacist.

- d. Beginning December 2021, Responsible Reporting Entities will have access to some Medicare Part C and Part D plan identifying information. (PAID Act data)
- e. Do not forget about Open Enrollment! A person can change their Medicare plan every year. Therefore, it is possible multiple Part C and/or D plans may be involved in the same case. This will require multiple conditional payment searches.
- f. March 2018 United States District Court for Connecticut held that a Part C plan could bring a private cause of action for recovery of unpaid conditional payments but could only bring the recovery action against the Defendant if double damages were sought(the primary plan or payer). The Part C plan could not bring the recovery action against the Medicare beneficiary or the Beneficiary's attorney. Given the holding in this case, Defendants who allow Plaintiffs to do the Part C conditional payment search must obtain copies of all letters and documents from the Part C provider. Further, it is recommended that the Defendant pay the Part C provider directly rather than distributing all settlement funds to plaintiff. See: Aetna Life v Guerrero.

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- g. Each Part C and D plan will handle the lien search process a little differently. Therefore, it is important to ask the plan administrator the best method for requesting lien information. Do not assume all plans have the some processes and procedures.
- h. All plans will allow you to dispute unrelated charges.

- i. All plans will reduce the Part C or D conditional payment amount for procurement costs (attorney's fees and costs) but you will likely have to specifically request this reduction; it may not be given automatically.

- j. August 2022 Eleventh Circuit Court of Appeals held that a four year statute of limitations (28 USC section 1658(a)) will apply when a Medicare Advantage plan brings suit under the Private Cause of Action provision of the MSP. But the SOL begins to run when the action "accrues"; not necessarily when the Plan receives notice of settlement. See MSPA Claims 1 LLC v Tower Hill Prime Insurance 2022 U.S. App. Lexis 22162.

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Medicare Conditional Payment Outline

The purpose of this handout is to provide a practical guide to the Medicare lien search process (also known as the Medicare Conditional Payment). It is not intended to provide a historical or theoretical overview of the lien search process, but rather to provide helpful tips and guidance to assist the practitioner in obtaining both the tentative and final Medicare lien amount.

I. Step by Step Guide to obtaining the Lien amount (Conditional Payment)

- a. As of February 2014 all conditional payment recovery efforts for Medicare Part A and Medicare Part B are handled by the Benefits Coordination & Recovery Center (BCRC). The MSPRC is no longer a relevant contractor and all work previously performed by the MSPRC is now handled by the BCRC.
- b. As of October 5, 2015 the BCRC only handles Medicare Part A/B conditional payment recovery efforts for Liability Cases and cases where CMS is seeking direct recovery of conditional payments from the Medicare beneficiary.

- c. Once initial case data is provided to the BCRC a file will be established in the BCRC system within 5-7 business days
- d. Once the file has been created in the system, draft a letter to the BCRC specifically notifying them of the case and requesting the lien amount
- e. Thirty to forty-five days after you send your letter, you will receive the Tentative Medicare lien notice from the BCRC. NOTE: Do not pay the tentative lien amount.
- f. Review the tentative lien letter; if you believe an error has occurred and the BCRC has included inappropriate payments for reimbursement, you can draft a dispute letter to the BCRC requesting the lien amount be corrected/modified. The dispute process generally takes 1.5-3 months.
- g. If you are satisfied with the tentative lien amount, send a letter to the BCRC with a copy of the fully executed settlement agreement and proof of attorney's fees and costs for the Medicare beneficiary and request the final Medicare lien amount.
- h. Once you receive the final Medicare lien amount you will have 60 days to pay the lien. Failure to pay the lien amount within 60 days will result in the BCRC accruing interest on the lien amount.
- i. In 2009 The Arizona District Court imposed an injunction on CMS from placing conditional payment funds in collections proceedings while an appeal or waiver request was pending. On September 4, 2013 the Ninth Circuit Court of Appeals issued an opinion overturning the 2009 injunction. See Haro v. Sebelius September 4, 2013 included with these materials.
- j. On October 5, 2015 the Commercial Repayment Center (CRC) started lien collection practices for any new case filed after October 5, 2015 where CMS is seeking direct recovery of the debt from the Workers' Compensation carrier or No Fault carrier. The BCRC will continue to handle all debt collection proceedings against the Medicare beneficiary and in Liability cases.

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- k. The CRC will issue a Conditional Payment Notice (not letter; CPN) to the responsible entity when notice is given of an on-going responsibility for medical (ORM) through Section 111 reporting by a responsible reporting entity (RRE). Once the CPN is issued the RRE must respond within 30 days if it wishes to dispute any charges outlined in the Conditional Payment Notice. If no response is made within the 30 day time period the CRC will automatically issue a Final Demand notice which must be paid within the time frame indicated on the final demand notice. The RRE does have formal appeal rights if it wishes to appeal the final demand amount. This process is only for ORM notification. The CRC may issue multiple Conditional Payment Notices on a file until the file is closed and ORM terminated.
- l. The CRC will review the file a minimum of once per year and a maximum of four times per year. During any such review, if conditional payments are identified the RRE will receive a CPN. Therefore, it is possible the CPN and lien recovery process may happen as frequently as four times per year until the case is closed and ORM is terminated. If no conditional payments are identified at the time of a CRC file review, no letter will be generated.
- m. For conditional payment recovery files at the BCRC, the Medicare beneficiary is the primary debtor of record. For conditional payment recovery files at the CRC the Primary Payer or Plan is the primary debtor of record. The primary debtor of record is the entity from which CMS will first seek recovery of the conditional payment amount. The primary debtor of record is the only entity that can dispute or appeal a conditional payment amount. NOTE: CMS can still seek recovery from the Primary Plan or Payer even if they are not the initial primary debtor of record on a file (42 CFR 411.24(i)).
- n. Beginning January 1, 2016 there is the option to begin the process of determining the final Medicare A/B conditional payment amount from the BCRC prior to settlement. The process is called The Final CP Process. To utilize this new process the parties must be within 120 days of settling the claim. A number of other procedures apply to this process, including the requirement that the claim must be settled within three (3) days after the final conditional payment amount is requested. Failure to meet any of the time periods required by the Final CP Process voids the entire process. NOTE: The Final CP process can only be done one time per claim. If you begin the process and it is voided for any reason you cannot re-start the process.

- o. Beginning April 1, 2019 an Electronic Payment option for the Medicare A/B conditional payment amounts is available.
- p. Beginning December 2021, Responsible Reporting Entities will have access to Medicare part C and Part D plan information for Medicare beneficiaries for the three prior years. Data provided only includes Plan identifying information; no actual conditional payment data will be provided via the PAID Act.
- q. Beginning February 2026 CMS will share WCMSA pharmacy data with all Part D plans.

II. Helpful Hints

- a. Provide a detailed description of the body part or illness that is the subject matter of the pending settlement. Also include a list of non-accident related medical conditions and specifically notify the BCRC or CRC that payments for the non-accident related medical conditions should not be included in the lien amount.
- b. Receipt of PIP or MedPay payments directly by the Medicare Beneficiary may nullify or reduce the fee and cost reduction on Medicare A/B conditional payment amounts.
- c. If you believe conditions such as financial hardship may exist that limit the party's ability to fully satisfy the lien amount, include these details in your initial contact letter with the BCRC. Do not wait to plead these factors in an appeal or waiver request.
- d. Waivers of the conditional payment amount can only be requested after the Final Conditional Payment Letter has been issued by the BCRC. Therefore, you must be mindful of interest accruing while your waiver request is pending.
- e. A compromise of the conditional payment amount issued by the BCRC can be proposed at any time; however, these decisions are reviewed directly by the CMS Regional Offices and the decisions cannot be appealed.

- f. The Medicare lien search process can take several months to complete; therefore, it may be prudent to begin the process well before settlement negotiations begin.
- g. If it is necessary for CMS to take legal action to recover the conditional payment amount from the primary payer, CMS may recover twice the amount. (42 CFR 411.24 (c)(2)).
- h. As of January 1, 2024 CMS will not exercise its MSP right of recovery for cases that settle for \$750.00 or less. (Does Not Apply to cases of: Ingestion; exposure; implantable devices)
- i. If your Liability case settles for \$25,000.00 or less you may have the option of self-calculating your final Conditional Payment Amount prior to settlement. However, a number of conditions apply for this option to be valid. See model language from BCRC (formally the MSPRC) included with materials. NOTE: This calculation method is not available for workers compensation or no fault cases.
- j. If your Liability case settles for \$10,000.00 or less you can elect to pay a fixed percentage of the total settlement amount (25%) as the conditional payment amount.
- k. At present there is a split in the circuits regarding whether or not Medicare must apportion its conditional payment amount. See *Bradley v. Sebelius* and *Hadden v. USA* both included with these materials.
- l. CMS can either assert a recovery action against the primary payer (42 USC1395(b)(2)(B)(iii)) or against any entity that received payment from the primary payer or proceeds from a payment made by the primary payer including the attorney representing the Medicare beneficiary (42 CFR 411.24(g)). See: *United States v. Paul J. Harris* included with these materials.
- m. Effective July 10, 2013 a three year statute of limitations will apply to certain MSP recovery actions. The three year statute of limitations will begin to run upon receipt of the Section 111 report (essentially upon receipt of notice of a payment). (See the Smart Act for more information and *MSPA Claims v Kingsway Amigo* February 2020 out of Eleventh Circuit Court of Appeals)
- n. August 2022 Eleventh Circuit Court of Appeals held that a four year statute of limitations (28 USC section 1658(a)) will apply when a Medicare Advantage

plan brings suit under the Private Cause of Action provision of the MSP. But the SOL begins to run with the action "accrues"; not necessarily when the Plan receives notice of settlement. See MSPA Claims 1 LLC v Tower Hill Prime Insurance 2022 U.S. App. Lexis 22162.

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- o. Please be aware that the conditional payment search through the BCRC and CRC is for payments made by Medicare Parts A/B only. If the injured person is participating in a Medicare Part C (HMO/Medicare Advantage plan) or a Medicare Part D (drug) plan additional conditional payment searches will be required with the Part C/D plan administrator(s). Please see In Re Avandia and Humana v. Western Heritage Insurance Company (2016 decision) for a discussion of Part C Plan recovery rights.
- p. Regarding Part C plan recoveries: in March 2018 United States District Court for Connecticut held that a Part C plan could bring a private cause of action for recovery of unpaid conditional payments but could only bring the recovery action against the Defendant (the primary plan or payer) if the Part C plan was seeking double damages. The Part C plan could not bring the recovery action against the Medicare beneficiary or the Beneficiary's attorney. Given the holding in this case, Defendants who allow Plaintiff's to do the Part C conditional payment search must obtain copies of all letters and documents from the Part C provider. Further, it is recommended that the Defendant pay the Part C provider directly rather than distributing all settlement funds to plaintiff. See: Aetna Life v Guerrera.
- q. NOTE: If you have reason to believe Medicare has made payments for the injury in question, but the Medicare A/B lien search (from the BCRC or CRC) comes back showing a zero-dollar conditional payment amount; this is likely a red-flag that the person is participating in a Medicare Part C plan. You must inquire with the Medicare Beneficiary or their attorney and determine if the beneficiary has opted into a Part C plan.
- r. NOTE: If the injured party ever required prescription medications for the injury in question, it is recommended that the attorney ascertain how these

medications were paid. If paid by a Medicare Part C or D plan, an additional Medicare conditional payment search is required.

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- s. California Insurance Guarantee Associates (CIGA) v. Burwell et. al. On January 5, 2017 Judge Wright ruled on a Motion to Dismiss and Motions for Summary Judgment. CIGA argued that CMS had no right to seek recovery for conditional payments with ICD codes unrelated to the compensable workers' compensation injury. The Judge agreed with CIGA and determined that CMS could not seek full recovery for a conditional payment amount simply because the date of service in question include one code related to the compensable work injury. The Judge determined that even the MSP code and internal rules indicated that CMS was to be reimbursed for a "service" or an "item". The Judge did not find CMS' argument persuasive when the government indicated that it was the Agency's practice to "seek full reimbursement for a conditional payment as long as one diagnosis code was related." However, before the practitioner gets too excited regarding the CIGA case, the final determination from the Judge indicates as follows: "The presence of one covered code does not ipso facto make CIGA responsible for reimbursing the full amount of the charge. Instead, CMS must consider whether the charge can reasonably be apportioned between covered and uncovered codes or treatments. Upon such consideration, CMS might still conclude that apportioning the charge is unreasonable. In addition, even if the charge should be apportioned, the Court takes no position on how CMS should do so (e.g., pro-rata by covered codes versus uncovered codes, or some other method)." A copy of the CIGA case is included with these materials.

- t. Future Medical Obligation: 42 CFR 411.39(d) is titled "Obligations with respect to future medical items and services" and states: Final conditional payment amounts obtained via the web portal represent Medicare covered and otherwise reimbursable items and services that are related to the beneficiary's settlement, judgement, award or other payment. This means if the web portal is utilized for the final conditional payment process, Parties to settlement must ensure that they are only paying for transactions with ICD-9 and ICD-10 codes related to your specific injury. If you pay for a code

unrelated to the actual injury, Medicare may refuse to pay for it in the future. It is important to review the codes in both the tentative and final conditional payment letter very carefully prior to issuing any payment. The CFR section is vague and it is unclear if it applies to all requests for the final conditional payment amount through the web portal or only those claims utilizing the Final CP Process which went into effect January 1, 2016.


- u. June 18, 2018: Press Release from the United States Attorney's Office Eastern District of Pennsylvania. Settlement reached with plaintiff's law firm that required the firm to pay a financial settlement to the government, make internal policy and staffing changes, and required the firm to acknowledge a possible False Claims Act violation due to the wrongful retention of government funds.
- v. March 18, 2019: Press Release from the United States Attorney's Office District of Maryland. Settlement reached with plaintiff's law firm that required the firm to pay a financial settlement to the government and make internal policy and staffing changes. However, no requirement to acknowledge a possible False Claims Act violation.
- w. November 4, 2019: Press Release from the United States Attorney's Office District of Maryland. Settlement reached with plaintiff's law firm that required a law firm to reimburse conditional payments even if that law firm was not the primary firm handling the case for the plaintiff.
- x. January 8, 2020: Press Release from the United States Attorney's Office Eastern District of Pennsylvania. Settlement reached with plaintiff's law firm that required the firm to pay a financial settlement to the government, make internal policy and staffing changes, and required the firm to acknowledge a possible False Claims Act violation due to the wrongful retention of government funds. Settlement specifically referenced the prior June 2018 case handled by this same office.

III. Where to find additional information

- a. For additional information regarding the lien search process, including copies of letter templates from the BCRC, go to: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html>

- b. For verification of a person's Social Security or Medicare status, a benefits verification letter can be requested here: <https://www.ssa.gov/myaccount/>

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Complying with Medicare: Everything You Need to Know for Your Workers' Compensation Case

CELESQ

JUNE 23, 2026



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The Basics

- ▶ When do you need a Medicare Set Aside? (MSA)
 - ▶ Medicare status of worker
 - ▶ Social Security Disability status of worker
- ▶ What types of medical care must be included in the MSA?
 - ▶ Routine care
 - ▶ Recommended but not yet occurred

Basics Continued

- ▶ How is the MSA funded?
 - ▶ Lump sum
 - ▶ Annuity
- ▶ How is the MSA account administered?
 - ▶ Self admin
 - ▶ Assistance from a competent adult
 - ▶ Professional company

Basics Continued

- ▶ What happens to the MSA funds at the death of the worker?
- ▶ When can I get CMS approval
 - ▶ Optional
 - ▶ Review thresholds
 - ▶ Timely response to development letter; need to resend proposal if response takes greater than 1 year
- ▶ How do you change an MSA Submitter with CMS?

Newest Information: WCMSA Section 111 Reporting

- ▶ As of April 2025, CMS requires all workers compensation Section 111 reports to include a Medicare set aside allocation amount.
- ▶ The reported MSA amount can be \$0.00
- ▶ The MSA allocation is required for all settlements; even those settlements below \$25,000.00
- ▶ If CMS approval of the WCMSA was obtained, the Section 111 report must include the WCMSA case ID number.
- ▶ The Medicare beneficiary will be notified via mail of the reported WCMSA allocation amount.
- ▶ After the Section 111 report as been processed, a record will be made in the Common Working File. This record will include all reported ICD codes.

Newest Information Zero Dollar MSA Allocations (POST-July 17, 2025)

- ▶ After July 17, 2025 CMS will no longer review/approve any proposal seeking approval of a \$0.00 MSA allocation.
- ▶ The CMS guidelines clearly state that \$0.00 MSA allocation are still acceptable in certain circumstances after July 17th but CMS will not review any such proposal.
- ▶ CMS has instructed the parties to settlement who wish to utilize a \$0.00 MSA after July 17, 2025 to fully document their file that ALL zero-dollar MSA requirements have been met.

Newest Information: Section 111 Reporting Penalty

- ▶ October 11, 2023 CMS Published the final version of the Section 111 Civil Money Penalty Rule
- ▶ Statute of Limitations: 5 years from the date when the noncompliance occurred.
- ▶ Penalty Enforcement date: October 11, 2024. From this date forward RREs will be held accountable for ensuring that all records are reported timely. (First penalties will be issued October 2025)
- ▶ CMS will issue a financial penalty against an RRE if the RRE is found to be noncompliant with the reporting requirements.
- ▶ Noncompliance is defined as any time CMS identifies a new beneficiary record that was not reported to CMS timely.
- ▶ Timeliness is defined as reporting to CMS within 1 year of the date a settlement, judgement, award, or other payment (or the funding of a settlement, judgement, award or other payment if funding was delayed), or the date when an RRE's on-going responsibility for medical payments became effective.

Newest Information continued

For any record selected via the random audit process where the NGHP RRE submitted the information more than 1 year after the date of settlement, judgement, award or other payment (including the effective date of the assumption of ongoing payment responsibility for medical care) the daily penalty will be:

- \$250.00 as adjusted annually for each calendar day of noncompliance where the record was reported 1 year or more, but less than 2 years after the required reporting date;
- \$500.00 as adjusted annually for each calendar day of noncompliance where the record was reported 2 years or more, but less than 3 years after the required reporting date; or
- \$1,000.00, as adjusted annually, for each calendar day of noncompliance where the record was reported 3 years or more after the required reporting date.
- Additionally, the total penalty for any one instance of noncompliance by an NGHP RRE for a given record identified by CMS will be no greater than \$365,000.00 (as adjusted annually)

Newest Information continued

A CMP is not imposed when the NGHP plan fails to report as a result of the plan's inability to obtain an individual's last name, first name, date of birth, gender, MBI, SSN, or the last 5 digits of the SSN and the applicable plan has made a good faith effort to obtain the information by meeting the following:

- Has communicated the need for this information with the individual and their attorney or representative
- Has required the information from the individual or their attorney or representative at least three times
 - Once in writing (including electronic mail)
 - Then at least once more by mail; and
 - At least once more by phone or other means of contact in the absence of a response to the mailings.
- Has not received a response or has received a written response clearly indicating that the individual refuses to provide the needed information. Should the applicable plan receive a written response from the individual or their attorney or representative that clearly and unambiguously declines or refuses to provide any portion of the information specified no additional communications with the individual or their attorney/representative are required.
- Has documented its efforts to obtain the MBI or SSN (or the last 5 digits of the SSN). This documentation, including any written rejection correspondence, must be retained for a minimum of 5 years.

Newest Information continued

- ▶ Case Law: Ruiz v Rhode Island (April 27, 2020):
 - ▶ Liability case
 - ▶ Case settled with no specific requirement in the release agreement that Mr. Ruiz provide the data necessary to verify his Medicare status.
 - ▶ Mr. Ruiz refused to provide his SSN
 - ▶ State did have 4 digits of the SSN and made over 100 queries to try and verify his Medicare status
 - ▶ Court determined State's efforts to verify the Medicare status of Mr. Ruiz was done in good faith and should exempt the state from a CMP.
 - ▶ Important to remember case decided before a final rule issued by CMS.
 - ▶ Case speaks to the importance of ensuring the settlement agreement makes clear that payment of settlement funds is contingent on compliance with the MSP statute and that the Medicare beneficiary will cooperate when necessary to ensure such compliance is obtained.

Newest Information: Evidenced Based MSAs

- ▶ January and March 2022 CMS added Section 4.3 to the WCMSA Reference Guide: The Use of Non-CMS-Approved Products to Address Future Medical Care.
- ▶ CMS specifically stated so-called “evidenced based” or “non-submit” MSAs may not adequately protect Medicare.

Newest Information: Evidenced Based MSAs

- ▶ CMS may treat use of these MSA products as a potential attempt to shift a financial burden to Medicare.
- ▶ If the MSA is deemed a burden shift, CMS will deny payment for medical services related to the WC injury until proof is shown that an amount equal to the total settlement less procurement costs has been spent on medical care related to the WC injury.

The Amended Review Process

- ▶ Available as of July 31, 2017
- ▶ As of April 7, 2025 the one year waiting period has been rescinded.
- ▶ Case has not settled.
- ▶ Must request approval of an MSA that results in a change of 10% or \$10,000.00 (whichever is greater)

The Amended Review Process...

- ▶ Items that may change the MSA
 - ▶ Changes in medications
 - ▶ Surgery recommendations
 - ▶ Changes in DME needs
 - ▶ Changes/recommendation for pain management injections
 - ▶ Changes in life expectancy/rated ages

The Amended Review Process...

- ▶ It is still possible to request a re-review (sometimes called a reconsideration request) of the MSA on the basis of mathematical error or missing documentation.
- ▶ Can only request an Amended review one time.
- ▶ NOTE: Once settlement of the medical portion of the claim takes place, CMS will not review an MSA proposal.

MSAs in Settlements below the Review Thresholds

- ▶ No arbitrary MSAs
- ▶ There is no “safe percentage”
- ▶ Just because this is “how we have always done it”; doesn’t make it right.
- ▶ Regardless of the gross settlement; an MSA must still be supported by the medical evidence.
- ▶ Remember the WCMSA amount will be reported to CMS via Section 111.

What may help decrease the MSA

- ▶ Rated Ages
- ▶ Statement from the treating physician
- ▶ Statement from the injured worker
- ▶ Switch from brand name medications to generic
- ▶ NOTE: 42 CFR 411.47 cannot be utilized to decrease any MSA allocation. See CMS policy memo from July 11, 2005 and section 15.2.1 of the WCMSA reference guide.

WCMSA allocations and State Laws

- ▶ CMS will recognize state specific statutes addressing the limits of future treatment; including the length or nature of future care.
- ▶ Must demonstrate Medicare's interests fully considered.
- ▶ Must include a copy of the statute.
- ▶ Failure to include the documentation is not a basis for re-review.

Commercial Repayment Center

- ▶ October 5, 2015
- ▶ Continuous review of open claims
- ▶ May audit up to four times per year
- ▶ Never ignore any letter from the CRC even if received after the claim has settled.

Commercial Repayment Center

- ▶ Older files may be with the BCRC
- ▶ CRC (and BCRC) can only see Medicare A/B payments. (will discuss Part C and D in a moment)
- ▶ If you fail to include an ORM termination date when you do a Section 111 report of settlement, the CRC may keep their file open.

Commercial Repayment Center

- ▶ CRC will only work with the Workers compensation carrier or their designated MSP recovery agent.
- ▶ CRC will not generally accept requests from the Medicare beneficiary or their attorney.
- ▶ Do not include release language requiring the injured worker to satisfy a CRC conditional payment. This settlement requirement likely cannot be met. You may be setting the settlement up for litigation in court due to impossibility.

Commercial Repayment Center

- ▶ It is possible filing a dispute on a CRC lien will result in the CRC issuing a demand letter. This may happen even if no other letter or notice has been issued by the CRC.
- ▶ Discussion of CIGA case: Co-mingled codes
- ▶ Disputing the conditional payment amount in a fully denied claim
- ▶ Discussion of US Attorney actions against plaintiff's firms and possible False Claims Act Violation.

Medicare Part C and D plans

- ▶ Must do separate conditional payment search for Part C and Part D plans.
- ▶ As of February 2026, CMS will share all WCMSA pharmacy data with Part D plans
- ▶ Case law in favor of Part C and Part D plans.
- ▶ Discussion of March 2018 Aetna case (CT)

Medicare Part C and D plans

P.A.I.D Act

- ▶ The Provide Accurate Information Directly Act became law on December 11, 2020
- ▶ Law requires CMS to provide identifying information for any Part C or Part D Medicare plan an injured person has participated in for the last three year.

P.A.I.D Act

- ▶ Data will be made available to insurance companies via the Section 111 portal
- ▶ Only provides data for the three most recent years
- ▶ Will not provide contact information for the plans
- ▶ Will not provide conditional payment amounts
- ▶ Testing started September 2021
- ▶ Went “live” December 2021

Medicare Part C and D plans

- In 2021 some Medicare advantage plans started including language in their lien letters indicating that the plan would continue payments for the accident-related injuries in the future/post-settlement.
- This language should not be relied upon by the parties to the case as a waiver the MSP Act's requirement that Medicare is secondary to all settlement proceeds post-settlement. A Medicare Advantage plan contractor cannot nullify federal law.
- This language could also be interpreted as coercive or manipulative.
- A future medical allocation should still be carved out of settlement proceeds despite the inclusion of such language in demand letters from Medicare Advantage Plans.

Liability MSA Allocations

- ▶ CMS has made it clear that the MSP statute's requirement to keep Medicare secondary applies to liability and no fault settlements.
- ▶ CMS has not yet published formal review criteria for review of a Liability MSA allocations.
- ▶ CMS policy memo from September 2011 indicates no need for an MSA in a liability case of a Certification of No Treatment statement is provided.

Liability MSA Allocations continued

- ▶ CMS has slowly started increasing the pressure on liability settlements to comply with the statute.
 - ▶ Changes to the common working file
- ▶ Liability lien files with the BCRC; could be duplicate claims.
- ▶ December 2018 CMS issued an alert notifying the stakeholder community of publication of a Notice of Proposed Rulemaking for MSAs by September 2019.
- ▶ This MSA NPRM was formally withdrawn in 2022; but this does not minimize the fact that liability settlements must still comply with federal law.

WCMSA Portal

- ▶ Portal allows you to upload/submit MSA proposals
- ▶ Upload settlement documents
- ▶ Upload annual attestation forms for WCMSA accounts.

Miscellaneous

- ▶ November 8, 2017 MLN Bulletin to medical providers. CMS educational outreach to medical community. Advised medical community Medicare is secondary to settlement proceeds and Medicare should not be billed post-settlement.



Thank you for your time and attention!