Federal Medicare Secondary Payer Rules and California Workers' Compensation Injured Worker Medical Treatments and Settlements

(PART-A INJURED WORKERS ANALYSIS)

March 2, 2026

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FEDERAL MEDICARE SECONDARY PAYER RULES AND CALIFORNIA WORKERS' COMPENSATION: MEDICAL TREATMENT AND SETTLEMENTS

This report explains how federal Medicare law and California workers' compensation rules work together when you are an injured worker who has or will soon have Medicare benefits. It covers how your medical treatment gets approved, what happens when you settle your workers' compensation case, and how to protect your future Medicare coverage.

Part 1: What Is the Medicare Secondary Payer Rule?

Overview of the Law

The Medicare Secondary Payer (MSP) statute is a federal law that says Medicare is not the first one to pay for your medical treatment if another source—like workers' compensation—is responsible. "Secondary payer" means Medicare only pays after workers' compensation has paid or should have paid. This law is found at 42 U.S.C. § 1395y(b) (https://www.law.cornell.edu/uscode/text/42/1395y).

In simple terms: if you were hurt at work and workers' compensation should cover your medical bills, Medicare will not pay those bills first. Workers' compensation must pay first.

Why This Matters to You

If you are a Medicare beneficiary (someone who receives Medicare health insurance) and you have a workers' compensation claim, you must understand this rule. It affects:

- Who pays for your medical treatment right now
- How your workers' compensation settlement is structured
- Whether Medicare will cover your injury-related medical care in the future

> ***Important: If your workers' compensation settlement does not properly protect Medicare's interests, Medicare may refuse to pay for your injury-related medical care in the future. This could leave you paying for treatment out of your own pocket.***

What the Law Requires

The MSP statute at 42 U.S.C. § 1395y(b)(2)(A)(i) (https://www.law.cornell.edu/uscode/text/42/1395y) states that Medicare "may not" pay for any medical item or service when payment "has been made, or can reasonably be expected to be made" under workers' compensation. The Centers for Medicare & Medicaid Services (CMS)—the federal agency that runs Medicare—enforces this rule.

CMS has the legal power to:

- Refuse to pay for medical services that workers' compensation should cover
- Recover money from your settlement if Medicare already paid for work-related treatment
- Pursue recovery from you, your attorney, your employer's insurance company, or anyone who received settlement money

Double Damages Penalty

The law at 42 U.S.C. § 1395y(b)(3)(A) (https://www.law.cornell.edu/uscode/text/42/1395y) allows the federal government to collect double damages (twice the amount owed) against any party that fails to properly reimburse Medicare. This penalty applies to workers' compensation insurance companies, self-insured employers, and third-party administrators.

> ***Critical: The double damages rule is a powerful enforcement tool. It means insurance companies can face liability equal to twice the amount of Medicare payments they failed to reimburse. This is why insurance companies take Medicare compliance seriously during settlement negotiations.***

Mandatory Reporting Requirements

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), workers' compensation insurance companies must report settlement information to CMS. Failure to report carries penalties of up to $1,000 per day per claimant, as described in CMS Mandatory Insurer Reporting guidance (https://www.cms.gov/medicare/coordination-benefits-recovery/mandatory-insurer-reporting).

Part 2: Federal Regulations That Implement the MSP Rule

The Code of Federal Regulations

The detailed rules for implementing the MSP statute appear in 42 C.F.R. Part 411 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411). These regulations explain how CMS processes claims, determines what conditional payments (temporary payments Medicare makes while your workers' compensation case is pending) are owed, and recovers money.

42 C.F.R. § 411.24 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411) gives CMS the right to take action against any party responsible for making payment under a primary plan (your workers' compensation insurance). CMS "may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation."

The Settlement Recognition Rule

An important regulation for settlements is 42 C.F.R. § 411.46 (https://ametros.com/wp-content/uploads/2019/08/42-CFR-411.46.pdf). This rule says:

- When your workers' compensation settlement sets aside money for future medical services, Medicare will not pay for those services until the set-aside money is used up
- If your settlement "appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for treatment of a work-related condition, the settlement will not be recognized"

> ***Note: This means CMS can reject your entire settlement structure if it looks like the parties tried to make Medicare pay for care that workers' compensation should cover.***

Conditional Payments

When workers' compensation does not pay for your medical treatment within 120 days of receiving the claim, Medicare is allowed to make conditional payments under 42 U.S.C. § 1395y(b)(2)(D) (https://www.law.cornell.edu/uscode/text/42/1395y). These are temporary payments that Medicare expects to get back once your workers' compensation case settles. The Benefits Coordination & Recovery Center (BCRC) tracks these payments, as explained in CMS conditional payment guidance (https://www.cms.gov/medicare/coordination-benefits-recovery/attorney-services/conditional-payment-information).

Part 3: California Workers' Compensation Medical Treatment System

Your Right to Medical Treatment

Under California law, your employer must provide you with all medical treatment that is "reasonably necessary to cure or relieve the effects" of your work injury. This right comes from California Labor Code § 4600. The Division of Workers' Compensation (DWC) oversees this process.

California uses a set of medical guidelines called the Medical Treatment Utilization Schedule (MTUS) to determine what treatment is appropriate. These guidelines are based on evidence-based medicine and are published by the DWC Medical Treatment Utilization Schedule (https://www.dir.ca.gov/dwc/mtus/mtus.html).

The Utilization Review (UR) Process

Utilization Review (UR) is the process your employer's insurance company uses to decide whether to approve or deny a doctor's request for your medical treatment. The rules for UR are found in Title 8, Cal. Code Regs. § 9792.9.1 (https://www.dir.ca.gov/t8/979291.html).

Here is how the UR process works:

1. Your doctor submits a treatment request using the DWC Form RFA (Request for Authorization)
2. A qualified medical reviewer employed by the insurance company reviews the request
3. The reviewer decides to approve, modify, or deny the treatment based on MTUS guidelines

The insurance company must respond within these timeframes:

- Standard reviews: 5 to 14 business days
- Expedited reviews (when there is a serious and immediate health threat): 72 hours
- Concurrent reviews (for ongoing treatment): Before stopping current care

The decision must be sent in writing to your doctor, to you, and to your attorney if you have one.

Independent Medical Review (IMR)

If the insurance company denies or changes your doctor's treatment request based on medical necessity (meaning they claim the treatment is not medically needed), you have the right to request an Independent Medical Review (IMR). This process is described at the DWC IMR page (https://www.dir.ca.gov/dwc/imr.htm) and governed by California Labor Code § 4610.

Here is how IMR works:

1. You have 30 days from receiving the UR denial to file an IMR application (DWC Form IMR-1)
2. The Administrative Director decides within 15 days whether your application qualifies
3. If it qualifies, an independent medical reviewer at Maximus Federal Services, Inc. reviews your case
4. For standard cases, the reviewer issues a decision after receiving medical records (typically within 30 days)
5. For emergency cases, the decision must come within 10 days

> ***Important: The IMR decision is binding on all parties. If the reviewer approves your treatment, the insurance company must provide it and pay any outstanding bills within 20 days, as stated in Title 8, Cal. Code Regs. § 9792.10.7 (https://www.dir.ca.gov/t8/9792107.html).***

Part 4: Where California Rules and Medicare Rules Conflict

The Gap Between State and Federal Standards

California's UR and IMR processes decide whether treatment is medically necessary under California state law. Medicare has its own separate rules about what treatments it covers. These two systems do not always agree.

This means: getting your treatment approved under California workers' compensation does not guarantee that Medicare will cover the same treatment in the future.

Examples of Conflicts

The differences become clear in situations like these:

- Compounded medications: A California UR physician may approve compounded pain medications as medically necessary under MTUS guidelines, but Medicare may classify these as non-covered experimental therapies
- Vocational rehabilitation: California IMR may mandate coverage of vocational rehabilitation services, but Medicare explicitly excludes these as non-medical services
- Extended treatment: California may approve a treatment course that goes beyond Medicare's standard utilization limits for a particular diagnosis

Why This Matters for Your Settlement

Neither the UR form nor the IMR process requires anyone to check whether Medicare will cover the approved treatment. The DWC Form RFA (https://www.dir.ca.gov/t8/979291.html) does not include any fields for Medicare coverage analysis. The IMR determination (https://www.dir.ca.gov/dwc/IMR/IMR_FAQs.htm) focuses only on California standards.

> ***Important: If you are a Medicare beneficiary or will become one soon, you or your attorney should independently verify whether Medicare covers your recommended treatments. This is especially important when your treatment involves experimental methods, compounded drugs, high-cost therapies, or courses of care that exceed typical patterns.***

Conditional Payments During the UR/IMR Process

The UR and IMR process can take a long time—sometimes more than 120 days from the initial treatment request to final approval. During this delay, your doctor may bill Medicare for your care. This creates conditional payments that Medicare will want back from your settlement.

A typical timeline looks like this:

1. UR denial issued (Day 14)
2. You file IMR application (Day 44)
3. Administrative Director reviews eligibility (Day 59)
4. Maximus receives records and conducts review (Day 89)
5. Final IMR determination issued (Day 120–130)

Because this process can exceed 120 days, Medicare often makes conditional payments that must be tracked and repaid from your settlement proceeds through the BCRC recovery process (https://www.cms.gov/medicare/coordination-benefits-recovery/beneficiary-services/recovery-process).

Part 5: Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

What Is a WCMSA?

A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a specific amount of money from your settlement that you must set aside in a separate account. This money is used only to pay for future medical expenses related to your work injury that Medicare would otherwise cover. CMS explains WCMSAs in the WCMSA Reference Guide, Version 4.4 (https://www.cms.gov/files/document/wcmsa-reference-guide-version-44.pdf), effective July 2025.

The goal of a WCMSA is to estimate the total cost of all future Medicare-covered medical treatment for your work injury over your remaining lifetime, and to set aside enough money from your settlement to cover that cost.

When You Need CMS Review

CMS has set two review thresholds that determine when you should submit your WCMSA to CMS for approval, as described in CMS WCMSA guidance (https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements):

- Threshold 1: You are already a Medicare beneficiary AND your total settlement exceeds $25,000
- Threshold 2: You have a reasonable expectation of enrolling in Medicare within 30 months AND your anticipated total settlement exceeds $250,000

"Reasonable expectation of Medicare enrollment" means you:

- Are age 62 years and 6 months or older
- Have End-Stage Renal Disease (ESRD)
- Are receiving Social Security Disability Insurance (SSDI)
- Have documented medical conditions likely to cause disability within 30 months

Is Submitting a WCMSA Required?

Submitting a WCMSA to CMS for review is voluntary, not mandatory. However, CMS approval provides important protections, as stated in the WCMSA Reference Guide (https://www.cms.gov/files/document/wcmsa-reference-guide-version-44.pdf):

- If CMS approves your WCMSA amount, Medicare commits to resuming coverage once you properly use up the set-aside funds

- If you do not get CMS approval, Medicare may deny your future injury-related medical claims and demand that you spend the entire net settlement amount on medical care before Medicare will pay anything

> ***Critical: Without CMS approval, you face the risk that Medicare will require you to exhaust your entire settlement (minus attorney fees and conditional payment reimbursement) on medical expenses before it pays for any injury-related care. This could leave you with no settlement money for living expenses.***

Part 6: How WCMSAs Are Calculated and Funded

What Goes Into the Calculation

A WCMSA calculation requires detailed analysis of your medical situation. According to the WCMSA Reference Guide (https://www.cms.gov/files/document/wcmsa-reference-guide-version-44.pdf), the calculation must include:

- How severe and permanent your work injury is
- Your age, health, and life expectancy (how long you are expected to live)
- Your doctor's recommendations for future treatment, including type, frequency, and duration
- Current costs for medications and medical care
- Medicare's fee schedules and coverage rules
- Total projected lifetime costs for your injury-related medical care

Documents You Need

To calculate your WCMSA, you or your representative will need:

- Complete medical records from all treating providers (at least 3–5 years)
- Pharmacy records for at least 6 months showing medications, costs, and refill frequency
- Written statements from your doctor about your future medical needs
- Your current age, health status, and any other medical conditions
- Any independent medical evaluation (IME) reports
- Documentation of the total settlement amount and how it is divided

Lump Sum vs. Structured Settlement Funding

You can fund your WCMSA in two ways, as explained in the WCMSA Reference Guide (https://www.cms.gov/files/document/wcmsa-reference-guide-version-44.pdf) and structured settlement guidance (https://partnerwithsynergy.com/an-examination-of-the-role-of-structured-settlements-in-funding-medicare-set-asides/):

Lump sum funding: You deposit the entire approved WCMSA amount into a separate bank account within 30 days of settlement. The account must be:

- In your name only
- Interest-bearing
- FDIC-insured
- Not mixed with your personal money

Structured settlement funding: An insurance company makes annual payments into your WCMSA account over your lifetime. The first deposit (called a "seed" deposit) covers:

- The first major surgery or procedure for each injured body part
- The first two years of projected annual medical expenses

Structured funding often saves 20–30% compared to lump sum funding because payments are spread over time and annuity payments are tax-free.

Life Expectancy and "Rated Age"

Your life expectancy determines how many years of future medical costs the WCMSA must cover. CMS normally uses standard life expectancy tables from the Centers for Disease Control (CDC).

However, if you have serious medical conditions that may shorten your life, your doctor can provide a medical opinion supporting a "rated age" adjustment. For example, a 55-year-old worker with severe traumatic brain injury might be treated as age 65 for WCMSA purposes, reducing the projected years of future medical costs.

Part 7: Recent CMS Policy Changes (2025)

Zero-Dollar WCMSA Ban

Effective July 17, 2025, CMS stopped accepting WCMSA proposals that allocate zero dollars for future medical expenses. This policy change is described in the WCMSA Reference Guide, Version 4.4 (https://www.cms.gov/files/document/wcmsa-reference-guide-version-44.pdf) and analyzed in industry commentary (https://www.capehart.com/msa-to-submit-or-not-to-submit/).

Previously, parties sometimes settled claims with a "zero-dollar MSA," meaning they allocated no money for future medical care. CMS now considers this an improper attempt to make Medicare pay for care that workers' compensation should cover.

Mandatory Reporting of All WCMSA Amounts

Effective April 4, 2025, all workers' compensation insurance companies must report every WCMSA allocation amount—including zero-dollar amounts—to CMS through Section 111 mandatory reporting. The only exception is for settlements of $750 or less. This requirement is discussed in CLM Magazine reporting analysis (https://www.theclm.org/Magazine/articles/making-sense-of-new-reporting-requirements/2499).

This means CMS now sees every workers' compensation settlement involving a Medicare beneficiary and knows what WCMSA allocation was made.

Elimination of One-Year Waiting Period for Re-Review

Effective April 7, 2025, CMS removed the one-year waiting period for requesting an amended WCMSA review. Previously, if your medical situation changed after CMS approved your WCMSA, you had to wait one year before asking CMS to adjust the amount. Now you can request a re-review sooner if your medical condition has materially changed, as noted in the CMS WCMSA webinar materials (https://www.cms.gov/files/document/june-17-2025-introduction-workers-compensation-medicare-set-aside-arrangements-wcmsa-webinar.pdf).

What These Changes Mean for You

> ***Important: These policy changes significantly increase the risk of settling your case without proper Medicare protections. CMS can now see your settlement details and challenge your WCMSA allocation if it appears too low. If you are a Medicare beneficiary or will become one within 30 months, talk to your attorney about obtaining CMS approval for your WCMSA before finalizing your settlement.***

Part 8: Conditional Payments—Tracking, Disputes, and Repayment

How BCRC Tracks Conditional Payments

The Benefits Coordination & Recovery Center (BCRC) is the part of CMS that tracks payments Medicare makes on your behalf while your workers' compensation case is pending. You should notify BCRC as early as possible—ideally within 30 days of your injury—so they can begin tracking. Contact information and procedures are available at CMS BCRC guidance (https://www.cms.gov/medicare/coordination-benefits-recovery/beneficiary-services/liability-no-fault-workers-compensation-reporting).

After BCRC receives your notice, they will:

1. Send you a "Rights and Responsibilities" (RAR) letter explaining your obligations
2. Within 65 days of the RAR letter, send a Conditional Payment Letter (CPL) listing all Medicare payments related to your work injury and the total amount owed

Disputing Items on the Conditional Payment Letter

You have the right to dispute any items on the CPL that you believe are unrelated to your work injury. To dispute:

- Review each item carefully with your doctor
- Gather medical records showing the service was for a non-work-related condition
- Submit your dispute in writing to BCRC within 30–45 days
- BCRC will review and may issue a modified conditional payment amount

Repayment from Your Settlement

When you settle your workers' compensation case, you must repay Medicare for conditional payments from your settlement proceeds. The CMS recovery process (https://www.cms.gov/medicare/coordination-benefits-recovery/beneficiary-services/recovery-process) works like this:

1. You notify BCRC of your settlement amount and date
2. BCRC issues a final recovery demand letter
3. Your conditional payments may be reduced by a proportionate share of your attorney fees and costs
4. Payment is sent directly to Medicare from settlement proceeds

For example: If conditional payments total $50,000, your total settlement is $150,000, and you paid $30,000 in attorney fees, the fee reduction would be approximately $10,000 (because conditional payments represent about 33% of the settlement, and 33% of $30,000 is roughly $10,000).

Appeal Rights

If you disagree with Medicare's recovery demand, you have the right to appeal through multiple levels as described in the WCMSA Reference Guide (https://www.cms.gov/files/document/wcmsa-reference-guide-version-44.pdf):

1. Redetermination by the BCRC contractor
2. Reconsideration by an independent contractor
3. Hearing before an Administrative Law Judge (ALJ)
4. Review by the Departmental Appeals Board Medicare Appeals Council
5. Judicial review in federal court

> ***Critical: Interest accrues on demand amounts from the date of the demand letter. If you do not respond or pay, Medicare can garnish your wages, make claims against your estate, offset your future Medicare or Social Security benefits, or file a lawsuit in federal court.***

Part 9: The CMS Submission and Approval Process

Step-by-Step WCMSA Submission

If your settlement meets CMS review thresholds, here is the typical process:

1. Prepare the submission package with a qualified MSA vendor or attorney (5–15 business days)
2. Submit electronically through the WCMSA Portal (WCMSAP) at go.cms.gov/wcmsap (https://go.cms.gov/wcmsap), or by mail
3. CMS intake review verifies your submission is complete (within 5 business days)
4. Medical review by the Workers' Compensation Review Contractor (WCRC) (20–45 days)
5. CMS approval letter issued with the final WCMSA amount and funding terms
6. Finalize your settlement incorporating the WCMSA terms
7. Fund the WCMSA account and notify CMS

> ***Note: Current processing times are approximately 30–45 days for standard cases. Complex cases involving multiple body parts or disputed medical needs may take 60–90 days. If CMS needs more information, they will send a development letter, which can add additional weeks.***

After CMS Approval: Account Administration

Once your WCMSA is funded, you must manage the account properly. According to the CMS Self-Administration Toolkit (https://www.cms.gov/files/document/self-administration-and-you-beneficiary-toolkit-workers-compensation-medicare-set-aside-arrangements.pdf) and CMS self-administration guidance (https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements/self-administration):

You can administer the account yourself (self-administration) or hire a professional administrator. CMS "highly recommends" professional administration for accounts over $25,000.

As account administrator, you must:

- Keep detailed records of every deposit and withdrawal
- Save all receipts and explanation of benefits documents
- Only use the money for Medicare-covered, work-injury-related medical expenses and prescriptions
- Keep all bank statements
- Submit an annual attestation letter to CMS within 30 days of each settlement anniversary

Annual Attestation Requirements

Your annual attestation letter must include:

- Total medical expenses paid from the account during the year
- Total prescription drug expenses paid during the year
- Interest income earned by the account
- Remaining account balance
- Your signed certification that funds were used only for approved purposes

The attestation must be witnessed by a second person who is not the account administrator. Submit it to the BCRC (typically at P.O. Box 138832, Oklahoma City, OK 73113, or through Medicare.gov (https://www.medicare.gov)).

> ***Important: Keep all records for at least 7 years. CMS can audit your WCMSA account at any time.***

When Your WCMSA Runs Out

When your WCMSA account is fully used up, you must submit a final attestation letter to CMS showing the account is depleted. Once CMS confirms proper exhaustion, Medicare resumes paying for your injury-related medical care as the primary payer. Without proper exhaustion documentation, Medicare may continue denying your claims indefinitely.

Part 10: Settlement Strategies and Risk Assessment

Submit vs. Non-Submit: Comparing Your Options

This table compares the risks of submitting your WCMSA to CMS versus not submitting:

Factor	Submitting to CMS	Not Submitting to CMS
Timeline	30–60 day delay for CMS review	No CMS delay
Finality	CMS approval guarantees Medicare will resume coverage	Risk that Medicare denies coverage or demands full settlement repayment
Your financial risk	Moderate—CMS sets the amount	High—Medicare may require you to spend your entire settlement on medical care first
Insurance company risk	Low to moderate	High—CMS may demand repayment of the net settlement amount
Medicare coverage guarantee	High—Medicare commits to resume coverage	Low to moderate—Medicare keeps discretion to deny
Cost	MSA vendor fees ($3,000–$8,000 typical)	Minimal upfront cost but potentially large future costs

Alternative: Keeping Medical Benefits Open

Instead of closing future medical benefits and creating a WCMSA, you can structure your settlement to keep Ongoing Responsibility for Medicals (ORM). This means:

- Workers' compensation continues to pay for your injury-related medical care after settlement
- Medicare remains the secondary payer
- No WCMSA is needed

This approach works well when:

- Future medical needs are genuinely uncertain
- You are young and medical projections are unreliable
- You have not yet reached Medicare-eligible age

The tradeoff: you get certainty about medical coverage, but you do not get full finality on your case, as described in CMS ORM guidance (https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-non-group-health-plans/nghp-training-material/downloads/ongoing-responsibility-for-medicals-orm.pdf).

Recommended Settlement Language

Your settlement agreement should clearly state:

- Whether you are or will become eligible for Medicare
- The specific dollar amount allocated for conditional payment reimbursement to BCRC
- The specific dollar amount allocated for the WCMSA
- The remaining amount allocated for wage loss, disability, and other non-medical damages
- Whether the WCMSA was CMS-approved or independently calculated

Your settlement should not include language that:

- Claims to waive Medicare's right to recover payments
- Tries to protect the insurance company from Medicare recovery claims
- Makes you solely responsible for Medicare reimbursement
- Characterizes the settlement as waiving future medical benefits without WCMSA funding

California WCAB Perspective

The California Workers' Compensation Appeals Board (WCAB) has shown skepticism toward settlement language that attempts to limit Medicare's federal rights. In Irma Dufelmeier v. Kaiser Foundation Hospitals, the Workers' Compensation Judge stated that the WCAB does not have "jurisdiction or obligation to provide a blanket approval and ratification to contracts between parties extraneous to the actual jurisdiction of the WCAB, especially to jurisdiction enjoyed by the Federal Government over Medicare," as discussed in California Lawyers Association analysis (https://calawyers.org/workers-compensation/the-wcb-and-msa-approvals/).

> ***Note: California state settlement law cannot override federal Medicare rights. Your settlement must comply with both state and federal requirements.***

Part 11: Pre-Settlement Checklist

Steps to Complete Before Finalizing Your Settlement

Use this checklist if you are a Medicare beneficiary or expect to become one within 30 months:

- ☐ Verify your Medicare eligibility status through the Social Security Administration or your Medicare card
- ☐ Obtain written statements from your treating doctor about your future medical needs
- ☐ Contact the BCRC to track any conditional payments Medicare has made
- ☐ Calculate your total settlement and allocate it among medical damages, wage loss, and other categories
- ☐ Determine whether your case meets CMS review thresholds ($25,000 for current beneficiaries or $250,000 for near-beneficiaries)

- ☐ Decide whether to submit your WCMSA to CMS for approval
- ☐ Select a qualified MSA vendor with experience in WCMSA calculations
- ☐ Compile all medical records and pharmacy records for the MSA vendor
- ☐ Review the completed WCMSA calculation
- ☐ Draft settlement language that clearly allocates funds for conditional payment reimbursement, WCMSA, and non-medical damages
- ☐ If submitting to CMS, allow 30–60 days for approval before scheduling final settlement
- ☐ Set up your WCMSA bank account
- ☐ Decide whether to self-administer or hire a professional administrator
- ☐ Review the final settlement agreement for Medicare compliance

Timing Your WCMSA Calculation

> ***Critical: Start your WCMSA calculation before settlement negotiations begin—not after you agree on a dollar amount. If you wait until after the settlement amount is agreed upon, you may discover that there is not enough money to properly fund the WCMSA after paying attorney fees and reimbursing conditional payments.***

Part 12: Key Definitions

Here are the important terms used in this report:

- Medicare Secondary Payer (MSP): The federal rule that Medicare does not pay first when another source like workers' compensation is responsible
- Workers' Compensation Medicare Set-Aside Arrangement (WCMSA): Money from your settlement kept in a separate account to pay for future injury-related medical care that Medicare would cover
- Conditional Payment: A temporary payment Medicare makes for your work-related medical care while your workers' compensation case is pending
- Benefits Coordination & Recovery Center (BCRC): The CMS office that tracks and recovers conditional payments
- Utilization Review (UR): The process California insurance companies use to approve or deny medical treatment requests
- Independent Medical Review (IMR): The appeal process when your treatment is denied based on medical necessity
- Medical Treatment Utilization Schedule (MTUS): California's official medical treatment guidelines for workers' compensation
- Compromise and Release (C&R): A type of settlement that closes some or all of your workers' compensation benefits
- Ongoing Responsibility for Medicals (ORM): When workers' compensation continues to pay for your medical care after settlement
- Rated Age: An adjusted age used in life expectancy calculations when medical conditions may shorten your lifespan

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Federal Medicare Secondary Payer Rules and California Workers' Compensation Injured Worker Medical Treatments and Settlements

(PART-A INJURED WORKERS ANALYSIS)

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March 2, 2026

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Federal Medicare Secondary Payer Rules and California Workers' Compensation Injured Worker Medical Treatments and Settlements

The intersection of federal Medicare Secondary Payer (MSP) law and California workers' compensation regulations creates a complex framework governing both the authorization of medical treatment for injured workers and the structuring of settlements for beneficiaries who are or will become eligible for Medicare benefits. The Centers for Medicare & Medicaid Services (CMS) operates under statutory authority to enforce secondary payer status, meaning that Medicare cannot pay for medical expenses that workers' compensation should cover, and when Medicare makes payments for work-related injuries despite this prohibition, it possesses broad powers to recover those amounts from settlements. Simultaneously, California maintains its own medical treatment authorization system through Utilization Review and Independent Medical Review procedures, governed by the Medical Treatment Utilization Schedule and state Labor Code provisions. This report examines the controlling legal frameworks, recent developments in CMS enforcement practices, practical implementation requirements for injured workers and their representatives, and the strategic considerations that arise when settling claims involving individuals who are Medicare beneficiaries or approaching Medicare eligibility. The analysis addresses procedural compliance requirements, risk assessment frameworks, and the mechanics of establishing compliant Workers' Compensation Medicare Set-Aside Arrangements to ensure that settlements adequately protect both the injured worker's interests and Medicare's statutory entitlements.

Executive Summary

Federal Medicare law designates Medicare as a secondary payer to workers' compensation for work-related medical treatment and related expenses, creating binding obligations on all parties to California workers' compensation claims involving current or prospective Medicare beneficiaries.[1][29] The Centers for Medicare & Medicaid Services operates the Benefits Coordination & Recovery Center (BCRC) to track conditional payments Medicare makes on behalf of injured workers whose workers' compensation claims remain pending or disputed, and CMS possesses statutory authority to pursue recovery of these payments from workers' compensation insurers, beneficiaries, or their representatives upon settlement.[1][8][8] California's Division of Workers' Compensation operates a parallel medical treatment authorization system through Utilization Review for disputed treatment requests and Independent Medical Review for treatment denials based on lack of medical necessity, but this state regulatory framework operates independently from Medicare's coverage determination process, creating potential points of conflict when state-approved treatment may not qualify as a covered service under Medicare.[3][6][9]

When a workers' compensation case involves a Medicare beneficiary or an individual with reasonable expectation of Medicare enrollment within thirty months, CMS mandates establishment of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) that allocates a specific portion of the settlement to pay for future work-injury-related medical expenses otherwise covered by Medicare.[5][5][16][16] The CMS review thresholds require WCMSA submission when a current Medicare beneficiary's total settlement exceeds twenty-five thousand dollars or a non-beneficiary has reasonable Medicare enrollment expectation and anticipated total settlement exceeds two hundred fifty thousand dollars.[5][16][16] Submission of a WCMSA to CMS for review is voluntary, but failure to obtain CMS approval creates substantial risk that Medicare will deny future injury-related medical claims and demand repayment equal to the entire unapproved settlement amount rather than the specific set-aside allocation.[5][5][5][5]

The risk assessment for claims involving Medicare beneficiaries or near-elderly injured workers must account for three distinct but related financial obligations: reimbursement of any conditional payments Medicare has already made (tracked by the BCRC and recovered from settlement proceeds separate from the WCMSA), adequate WCMSA funding for projected lifetime medical expenses related to the work injury, and compliance with annual attestation and accounting requirements to demonstrate proper fund utilization.[1][8][8][31][48] Failure to properly address Medicare's secondary payer interests can result in Medicare denying future medical coverage for the work-related condition indefinitely, exposing the injured worker to catastrophic out-of-pocket medical costs and potentially giving rise to double-damages liability against the workers' compensation insurer and settling parties for attempting to shift costs improperly to Medicare.[1][8][28][47]

Legal Framework

Statutory Authority: Federal Medicare Secondary Payer Act

The Medicare Secondary Payer statute, codified at [42 U.S.C. Section 1395y(b)][29], establishes the fundamental principle that Medicare does not pay for any items or services to the extent that payment has been made or can reasonably be expected to be made under workers' compensation laws or plans of the United States or any state.[26][29] Section 1395y(b)(2)(A)(i) specifically provides that "payment under this title may not be made...with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under" applicable workers' compensation laws.[29] This statutory framework grants CMS direct authority to decline payment for services covered by workers' compensation and to recover from any entity that has received payment from a workers' compensation settlement, including the Medicare beneficiary, medical providers, attorneys, and the workers' compensation insurer itself.[1][28][29]

The statute further establishes a private right of action under [42 U.S.C. Section 1395y(b)(3)(A)][29], permitting the United States to recover double damages from any entity that fails to promptly reimburse Medicare for conditional payments made on behalf of a Medicare beneficiary.[1][28] This enforcement mechanism applies to workers' compensation insurers and carriers, self-insured employers, third-party administrators, and any entity receiving payment from the settlement proceeds.[1][28] Additionally, [42 U.S.C. Section 1395y(b)(8)][29] establishes mandatory reporting requirements for responsible reporting entities (workers' compensation insurers and carriers) to report settlement information to CMS through Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) mechanisms, with substantial penalties for non-compliance reaching one thousand dollars per day per claimant for failure to report.[55]

The statutory framework requires that workers' compensation be recognized as the primary payer, but [42 U.S.C. Section 1395y(b)(2)(D)][29] expressly permits Medicare to make conditional payments when workers' compensation does not pay promptly-defined as failure to pay within one hundred twenty days of claim receipt. These conditional payments are made with the expectation of reimbursement once the workers' compensation claim is settled, and Medicare possesses statutory authority to pursue recovery through demand letters to identified debtors (the beneficiary, insurer, or other responsible entity) with rights of appeal and judicial review.[1][8][8][8]

Regulatory Framework: Code of Federal Regulations

The regulatory implementation of Medicare secondary payer rules appears primarily in [42 C.F.R. Part 411][14], which establishes the procedures for MSP claims processing, conditional payment determination, and recovery mechanisms. [42 C.F.R. Section 411.24][28] grants CMS and its recovery contractors direct right of action against any entity responsible for making payment under a primary plan, including the authority to recover from any entity that has received payment from a primary plan or from proceeds of a primary plan's payment.[28] Critically, [42 C.F.R. Section 411.24(b)][28] provides that "CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan."[28]

The regulatory framework addressing Medicare Set-Aside Arrangements appears in [42 C.F.R. Section 411.46][51], which establishes that when a workers' compensation settlement allocates funds for specific future medical services, Medicare will not pay for those services until medical expenses related to the injury equal the amount allocated to future medical expenses in the settlement.[51] This regulatory provision specifically permits settlement agreements to allocate portions for future medical care, but requires that such allocation be treated as primary payment responsibility that must be exhausted before Medicare obligation arises.[51] The regulation further states that "if a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for treatment of a work-related condition, the settlement will not be recognized."[51]

WCMSA Reference Guide and CMS Policy Guidance

The Centers for Medicare & Medicaid Services has established comprehensive guidance for WCMSA establishment, calculation, submission, and administration in the WCMSA Reference Guide, Version 4.4, effective July 2025.[5][5][5][5][5][5] This guidance document, while technically not binding regulatory authority, represents CMS policy and practice regarding acceptable WCMSA methodologies and submission standards. The Reference Guide establishes that the goal of a WCMSA is "to estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for

work-injury-related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost."[5][5][5][5][5][5]

Critically, effective July 17, 2025, CMS updated its WCMSA policy to no longer accept or review WCMSA proposals containing zero-dollar allocations.[2][22][23] This policy change reflects CMS's determination that zero-dollar MSAs represent an impermissible attempt to shift financial burden to Medicare by failing to allocate adequate funds for future medical care while maximizing disability and wage-loss portions of the settlement.[22][53] CMS guidance explicitly states that WCMSAs are never mandatory to submit for CMS review, but submission is strongly recommended because "the WCMSA amount review process is the only process that offers both Medicare beneficiaries and Workers' Compensation entities finality, with respect to obligations for medical care required after a settlement, judgment, award, or other payment occurs."[5][5][5][5][5][5]

The Reference Guide establishes that when CMS reviews and approves a proposed WCMSA amount, CMS is bound by that approval and will resume primary payment once the approved set-aside amount is appropriately exhausted and accurately accounted for to CMS.[5][5][5][5][5][5] Conversely, when no CMS approval is obtained, "CMS may at its sole discretion deny payment for medical services related to the WC injuries or illness, requiring attestation of appropriate exhaustion equal to the total settlement as defined in Section 10.5.3 of this reference guide, less procurement costs and paid conditional payments, before CMS will resume primary payment obligation for settled injuries or illnesses."[5][5][5][5][5][5] This language, with the permissive "may" rather than mandatory "shall," reflects CMS discretion but creates substantial uncertainty and risk for claimants and their representatives who fail to obtain CMS approval.

California Workers' Compensation Medical Treatment Authorization Framework

California Labor Code Section 5307.1 requires the Administrative Director of the Division of Workers' Compensation to establish and adopt medical fee schedules and medical treatment guidelines consistent with evidence-based medicine principles.[12][46] The Medical Treatment Utilization Schedule (MTUS), codified in Title 8, California Code of Regulations Section 9792.20 through 9792.27.23, contains medical treatment guidelines adopted from the American College of Occupational and Environmental Medicine (ACOEM) and establishes the framework for determining what constitutes "reasonable and necessary" medical treatment to cure or relieve effects of a work-related injury.[12][12]

California Labor Code Section 4600 establishes the fundamental obligation that employers must provide injured workers with all medical treatment that is "reasonably necessary to cure or relieve the effects of the injury."[6][9] This state law definition of compensable medical treatment operates independently from Medicare's coverage determination rules, creating potential conflicts when state law recognizes treatment as reasonable and necessary but Medicare's coverage policies would exclude it as non-covered or investigational.[3][6][7][9]

The California Utilization Review process, governed by Title 8, California Code of Regulations Section 9792.9 and Section 9792.9.1, requires that all requests for authorization of medical treatment be submitted on the DWC Form RFA and reviewed by a qualified medical reviewer within defined timeframes: prospective reviews within five to fourteen business days, expedited reviews within seventy-two hours in cases of imminent and serious health threats, and concurrent reviews before discontinuation of ongoing care.[3][6] The UR decision must be issued in writing to the requesting physician, injured worker, and the injured worker's attorney (if represented), and must specify the medical information reviewed, grounds for approval or denial, and the injured worker's right to pursue Independent Medical Review if the decision denies or modifies treatment based on medical necessity grounds.[3][6]

Independent Medical Review (IMR) Process

California Labor Code Section 4610 and Title 8, California Code of Regulations Section 9792.10 establish the Independent Medical Review process as the mechanism for resolving disputes when a claims administrator denies or modifies a physician's request for medical treatment on medical necessity grounds.[7][9][27] The IMR process, administered by the Division of Workers' Compensation through contracted independent medical review organizations (currently Maximus Federal Services, Inc.), provides a non-judicial procedure for injured workers to challenge UR denials.[7][9]

An injured worker has thirty days from receipt of a UR determination denying or modifying treatment to file an IMR application (DWC Form IMR-1), which must include a complete copy of the UR determination and be signed by the injured worker or designated representative.[7][9] Upon receipt of a timely and complete IMR application, the Administrative Director determines eligibility within fifteen days, considering whether the application is timely, complete, and whether a prior IMR request involved the same disputed treatment.[7][9] If eligible, the Administrative Director refers the dispute to Maximus for medical review by a qualified independent medical reviewer.[7][9]

For standard IMR cases, medical records must be provided by the claims administrator within fifteen calendar days (or twelve calendar days if electronically submitted), and Maximus conducts a thorough medical review comparing the UR denial rationale against current medical evidence and MTUS guidelines.[7][9] For expedited IMR cases (involving imminent and serious health threats), records must be provided within twenty-four hours and Maximus must issue a determination within ten days.[7][9] The IMR final determination is deemed the determination of the Administrative Director and is binding on all parties.[7][9]

Critically for purposes of this report, the IMR determination binds the claims administrator to implement approved treatment, and if treatment has already been provided, the claims administrator must reimburse the medical provider within twenty days of the final IMR determination.[9][27] However, the IMR determination operates within California's regulatory framework and does not directly address Medicare coverage or secondary payer obligations-creating a procedural gap where state-approved medical treatment may not qualify for Medicare payment.

Current Legal Landscape

Recent CMS Developments: Zero-Dollar WCMSA Prohibition

Effective July 17, 2025, the Centers for Medicare & Medicaid Services implemented a policy prohibiting acceptance or review of Workers' Compensation Medicare Set-Aside Arrangement proposals containing zero-dollar allocations for future medical expenses.[2][22][23][5] This policy change represents a significant enforcement escalation, as zero-dollar MSAs had previously been used by settling parties to finalize claims quickly without detailed future medical expense calculations, typically accompanied by language purporting to indemnify the insurer and beneficiary against future Medicare recovery.[22][53]

CMS's stated rationale for eliminating zero-dollar MSA submissions is that such arrangements represent an impermissible attempt to shift financial burden to Medicare by failing to allocate funds for projected future medical care while maximizing disability and wage-loss portions of the settlement. The CMS Reference Guide explicitly notes that "as of July 17, 2025, CMS will no longer accept submissions for zero-dollar MSAs," and further clarifies that "the need to submit an MSA to CMS for approval remains optional" for non-threshold cases, but parties cannot simply allocate zero dollars and avoid CMS review.[22][5][5]

This policy change has substantial practical implications for California workers' compensation settlements. Claims that previously settled with non-submit zero-dollar MSA allocations now face regulatory barriers. Effective April 4, 2025, all Responsible Reporting Entities (workers' compensation insurers) have been required to report any WCMSA amount, including zero-dollar allocations, to CMS through Section 111 mandatory reporting mechanisms, with very limited exceptions (settlements of seven hundred fifty dollars or less).[22][38] This mandatory reporting requirement gives CMS visibility into every workers' compensation claim involving a Medicare beneficiary and creates enforcement opportunities if the parties have failed to adequately consider Medicare's interests.

Recent CMS Enforcement Actions Against Insurers

CMS has increasingly pursued aggressive recovery actions against workers' compensation insurers and carriers for alleged failure to protect Medicare's interests in settlement structures. Notable case examples, while not published as precedential decisions, demonstrate CMS's willingness to demand repayment of entire settlement net amounts (less procurement costs) rather than the specific CMS-approved WCMSA allocation when the insurer failed to submit the WCMSA for CMS review prior to settlement.[5][5][5][5]

The CMS enforcement position is articulated in the Reference Guide language stating: "As a matter of policy and practice, CMS may at its sole discretion deny payment for medical services related to the WC injuries or illness, requiring attestation of appropriate exhaustion equal to the total settlement as defined in Section 10.5.3

of this reference guide, less procurement costs and paid conditional payments, before CMS will resume primary payment obligation for settled injuries or illnesses, unless it is shown, at the time of exhaustion of the MSA funds, that both the initial funding of the MSA was sufficient, and utilization of MSA funds was appropriate."[5][5][5][5][5][5] This language has created uncertainty among practitioners regarding the consequences of non-submission of proposed WCMSAs meeting CMS review thresholds.

California State Court Decisions on Medicare Set-Aside Issues

The California Workers' Compensation Appeals Board has issued decisions addressing the intersection of state settlement law and Medicare interests. In Irma Dufelmeier v. Kaiser Foundation Hospitals, the WCAB declined to approve a settlement that included a non-submit Medicare addendum purporting to allocate WCMSA funds while indemnifying the parties against Medicare recovery claims. The Workers' Compensation Judge stated: "I do not believe I have either jurisdiction or obligation to provide a blanket approval and ratification to contracts between parties extraneous to the actual jurisdiction of the WCAB, especially to jurisdiction enjoyed by the Federal Government over Medicare."[40] The panel affirmed the WCJ's decision, suggesting that at least some California judges question whether they possess authority to validate settlement language attempting to waive or limit Medicare's federal rights.

This California judicial skepticism regarding Medicare addendum language creates practical settlement complications. While California law permits compromise and release settlements that close future medical benefits, the federal Medicare Secondary Payer statute cannot be contracted away by state parties. The WCAB's hesitation to rubber-stamp Medicare addendum language reflects awareness that Medicare's recovery rights exist independent of state settlement law. However, other California judges have proven willing to approve settlement language containing WCMSA allocations with findings that the settlement "adequately considers Medicare's interests," suggesting variation in judicial approach across different workers' compensation judges in the state.

CMS Processing Timelines and Approval Rates

Current CMS WCMSA review processing timelines have stabilized at approximately thirty to forty-five days for standard cases with complete submissions and no development requests, though complex cases with multiple body parts, high-cost future medical needs, or disputes about projected future utilization can extend to sixty to ninety days.[33][34][44][23] The Workers' Compensation Review Contractor (WCRC), which performs the medical review analysis on behalf of CMS, maintains standard processing capacity but occasionally issues development letters requesting additional information, clarification of medical records, or supplemental pharmacy data, which extends timelines substantially.

CMS approval rates for submitted WCMSAs are very high when calculations are reasonable and include adequate supporting documentation. Denials or requests for amendment typically arise when: (1) the proposed WCMSA amount appears substantially below what treating physicians' records support as necessary future care, (2) life expectancy calculations are questioned, (3) medication projections appear underestimated for chronic conditions requiring lifetime management, or (4) the submit cover letter contains internal inconsistencies regarding settlement components or funding mechanisms.

Medical Treatment Authorization and Medicare Secondary Payer Interface

Integration and Conflict Between California UR/IMR and Medicare Coverage Standards

A critical but often overlooked issue arises from the procedural and substantive differences between California's Utilization Review process for determining medical necessity and Medicare's separate coverage determination process. California UR decisions focus exclusively on whether requested treatment is "medically necessary to cure or relieve the effects of the work-related injury" under the MTUS guidelines and evidence-based medicine principles.[3][6][9] Medicare coverage determinations, by contrast, apply Medicare's statutory coverage criteria, Local Coverage Determinations (LCDs), and National Coverage Determinations (NCDs) to assess whether a service is covered and paid under the Medicare program-a determination that operates independently from whether the service is clinically appropriate or necessary.[5][5]

The divergence becomes stark in clinical scenarios where: (1) a California workers' compensation UR physician approves pain management with compounded medications or experimental modalities as medically

necessary under MTUS guidelines, but Medicare's coverage policy treats such medications as non-covered experimental therapies; (2) an IMR determination mandates coverage of ongoing vocational rehabilitation or case management services as medically necessary under California law, but Medicare explicitly excludes such services as non-medical rehabilitation services; or (3) a California-approved treatment course extends beyond Medicare's documented utilization norms for a particular diagnosis code, creating a pattern of care that Medicare might recognize as beyond "reasonable and necessary" levels.[3][7][9]

Neither the California UR process nor the IMR determination requires the claims administrator or reviewing physician to evaluate Medicare coverage or secondary payer implications. The UR form (DWC Form RFA) does not include fields for Medicare coverage analysis, and the IMR determination focuses on medical necessity under California standards without expressly addressing Medicare's separate coverage criteria.[3][7][9] This creates a procedural vacuum where an injury can be fully approved for treatment under California law, creating medical expenses that Medicare will ultimately refuse to cover once the UR/IMR process concludes and the beneficiary attempts to bill Medicare secondarily.

The strategic implication for injured workers and their representatives is that obtaining California UR approval or an IMR determination mandating treatment does not guarantee Medicare will ultimately cover that treatment as secondary payer. A prudent injured worker or attorney should simultaneously verify Medicare coverage eligibility for recommended treatments, particularly when: (1) the injured worker is already Medicare-eligible, (2) the treatment exceeds typical MTUS utilization patterns, (3) the treatment involves experimental, compounded, or high-cost modalities, or (4) the projected future medical expenses approach or exceed proposed WCMSA thresholds.

Conditional Payment Triggers and UR/IMR Procedural Timing

Medicare may make conditional payments for medical services related to a pending or disputed workers' compensation claim when workers' compensation delays payment beyond one hundred twenty days of claim receipt.[1][8][8][8] The UR process, including any subsequent IMR dispute, can extend timelines substantially. A typical scenario involves: (1) UR denial occurring within two weeks of treatment request (day 14), (2) injured worker filing IMR application within thirty days (day 44), (3) Administrative Director eligibility determination within fifteen days (day 59), (4) Maximus receiving medical records and conducting review within fifteen to thirty days (day 89), and (5) final IMR determination and claims administrator authorization occurring by day 120-130.

During this entire UR/IMR process, the medical provider may submit bills to Medicare, potentially triggering conditional payment if workers' compensation has not paid or continues to dispute medical necessity. Medicare's conditional payment creates a recovery obligation tied to the eventual workers' compensation settlement. Because UR/IMR timelines can extend beyond one hundred twenty days, and because UR denials may impede payment even when IMR ultimately mandates coverage, conditional payments frequently arise in cases involving complex medical necessity disputes or delayed IMR processing.

The strategic implication is that parties contemplating WCMSA calculations must account for potential conditional payments already made by Medicare during the UR/IMR process. The BCRC tracks such conditional payments and issues a Conditional Payment Letter (CPL) within sixty-five days of notifying the beneficiary of MSP obligations.[8][8][8] A complete WCMSA submission must include identification and accounting of any conditional payments, with settlement proceeds allocated to reimburse Medicare for these past payments prior to exhaustion of WCMSA funds for future medical care.

Workers' Compensation Medicare Set-Aside Arrangements: Thresholds, Calculation, and Approval

CMS Review Thresholds and Mandatory Reporting Requirements

The Centers for Medicare & Medicaid Services applies two separate workload review thresholds determining whether a proposed WCMSA must be submitted for CMS review:[5][5][16][16][16]

Threshold One: The claimant is a current Medicare beneficiary (eligible for Medicare Parts A, B, C, and/or D) and the total workers' compensation settlement amount exceeds twenty-five thousand dollars.[5][5][16][16][16]

Threshold Two: The claimant has a reasonable expectation of Medicare enrollment within thirty months of the settlement date, and the anticipated total settlement amount for future medical expenses and disability or lost

wages over the life or duration of the settlement agreement exceeds two hundred fifty thousand dollars.[5][5][16][16][16]

Determining "reasonable expectation of Medicare enrollment" requires examining whether the injured worker: (1) is sixty-two years and six months or older (eligibility age for Medicare at sixty-five requires approximately thirty-month lookback); (2) has End-Stage Renal Disease (ESRD) diagnosis; (3) is receiving Social Security Disability Insurance (SSDI) with less than thirty months until age sixty-five; or (4) has documented medical evidence of conditions projected to render the worker disabled within thirty months (though this assessment involves substantial subjectivity).[33][38][44]

Critically, settlement amounts triggering the higher two-hundred-fifty-thousand-dollar threshold for non-Medicare beneficiaries include only the anticipated total settlement amount for future medical expenses and disability or lost wages-not pain and suffering, structured settlement present values, or other non-medical damages.[38][44] This creates opportunities for strategic calculation but also requires documentation supporting the projection of future medical and disability costs. If parties underestimate or artificially reduce the projected future damages component to fall below the threshold, CMS may challenge the characterization and demand that the true total settlement amount be used for threshold calculation.

Importantly, CMS will not issue "verification letters" or confirmation that review thresholds have not been met.[5][38][5] If a settlement falls below the threshold, settling parties must independently determine this and have no CMS confirmation of the determination. This creates practical risk that settlement structures falling below the threshold may still trigger CMS enforcement action if the agency later determines the threshold calculation was improper.

Additionally, effective April 4, 2025, all Responsible Reporting Entities must report any WCMSA allocation amount (or zero-dollar allocation) to CMS through Section 111 mandatory reporting, except for settlements of seven hundred fifty dollars or less.[22][38] This mandatory reporting requirement applies regardless of whether the settlement meets CMS review thresholds. The consequence is that CMS receives notice of every workers' compensation claim involving a Medicare beneficiary and has visibility into the WCMSA allocation parties have adopted. This visibility creates enforcement opportunities if the allocated amount appears inadequate to cover projected future medical expenses.

Calculation Methodology and Medical Necessity Documentation Requirements

WCMSA calculations must include detailed analysis of: (1) the severity and permanence of the work-related injury or illness, (2) the injured worker's age, health status, and life expectancy, (3) treating physicians' documented recommendations for future medical treatment, including type, frequency, and duration, (4) current medical and prescription drug costs for comparable treatment, (5) application of Medicare fee schedules and coverage rules to determine what services would qualify for Medicare payment, and (6) projection of total lifetime costs for work-injury-related medical care.[5][5][5][5][5][5]

CMS requires that WCMSA calculations be supported by: (1) complete medical records documenting the work-related injury, treatment to date, and prognosis, (2) treating physician statements specifically addressing future medical needs and anticipated treatment timeline, (3) most recent pharmacy records (minimum six months) showing current medication regimens and costs, (4) documentation of the injured worker's age, health status, and any comorbidities affecting life expectancy, (5) explanation of the life expectancy calculation used (either using standard age or rated age adjusted for medical conditions), and (6) detailed breakdown of projected future costs segregated by body part, treatment type (medical visits, procedures, medications), and annual cost estimates.[5][5][5][5][5][5]

Professional WCMSA vendors typically require twenty to thirty complete medical records files, two to six years of pharmacy records, treating physician detailed projections, and current income/disability documentation to conduct comprehensive calculations. Standard WCMSA vendor preparation timelines are five to ten business days for straightforward cases involving single body parts and stable chronic conditions, but complex cases involving multiple body parts, contested diagnoses, or uncertain future treatment needs may require thirty to sixty days.

Lump Sum versus Structured Settlement WCMSA Funding

WCMSAs can be funded through two mechanisms: lump-sum payment (where the entire approved WCMSA amount is deposited into a separate interest-bearing account at settlement) or structured settlement annuity funding (where an initial "seed" deposit covers first-year and near-term treatment costs, with annual subsequent deposits made based on projected utilization).[5][5][22][23][44][61][23]

For lump-sum WCMSAs, the entire approved CMS amount must be deposited into a separate interest-bearing Federal Deposit Insurance Corporation (FDIC)-insured account within thirty days of settlement, and Medicare prohibits any withdrawals for purposes other than paying for Medicare-covered work-injury-related medical expenses and prescription drugs.[32][48][32][32] The claimant (or a professional administrator) is responsible for paying medical providers and pharmacies directly from the WCMSA account for injury-related medical expenses, maintaining detailed documentation of all transactions, and submitting annual attestations to CMS demonstrating appropriate fund utilization within thirty days of each anniversary date of the settlement.[32][48][32][32]

For structured settlement WCMSA funding, CMS requires an initial seed deposit calculated to cover: (1) the first major surgery or procedure for each body part identified in the medical analysis, and (2) the first two years of projected annual medical expenses (medications, routine office visits, diagnostic testing, and therapy).[5][22][44][61][23] Subsequent annual deposits, calculated as structured settlement payments annuitized over the claimant's life expectancy, are made each year on the settlement anniversary. If deposits in a given year are not fully exhausted through payment of medical expenses, the remaining balance carries forward and accumulates with the next year's deposit.[5][22][44][61][23]

Structured WCMSA funding frequently produces twenty to thirty percent cost savings compared to lump-sum funding because (1) annuity payments are tax-free (whereas lump-sum interest income is taxable to the beneficiary), (2) funds are deployed only as needed rather than held in accounts subject to minimal interest earnings, and (3) the present value of future annuity payments is lower than the lump-sum equivalent due to time-value-of-money calculations.[44][61]

Parties must carefully align the settlement offer structure with the WCMSA funding mechanism. If defense proposes a settlement figure representing a lump sum intended to cover all damages including future medicals, but the WCMSA funding mechanism specified in CMS approval contemplates structured settlement annuity, a mismatch arises regarding what funds are available for wage-loss, pain-and-suffering, and other non-medical damages.[44][61] CMS determinations that recommend structured settlement funding will specify both the initial seed deposit amount and the annual payment amounts, with the total combined annuity payments representing the full WCMSA commitment.[5][22][44][61][23]

CMS Approval and Implementation Timeline

Once parties decide to submit a WCMSA to CMS for review, the process typically unfolds as follows: (1) preparation of WCMSA submission package by MSA vendor or claimant's representative, typically requiring five to fifteen business days; (2) electronic submission through the WCMSA Portal (WCMSAP) or paper/CD submission by mail; (3) WCRC initial intake review within five business days to verify completeness; (4) medical review by WCRC physician within twenty to forty-five days; (5) CMS approval letter issued with final WCMSA amount and funding terms; (6) finalization of settlement agreement incorporating WCMSA terms; and (7) funding of WCMSA account and filing with CMS Regional Office.[5][5][5][22][33][34][5][5][44][5]

The critical procedural point is that settlement does not necessarily close when the parties execute a Compromise and Release. If a WCMSA submission is pending CMS review, many practitioners recommend that the settlement agreement remain conditional on CMS approval of the proposed WCMSA amount. If CMS issues a counter-proposal requiring higher WCMSA allocation than parties projected, the settlement may require renegotiation if insufficient funds remain after payment of the higher WCMSA. Conversely, if CMS approves an WCMSA amount lower than parties proposed, this creates additional settlement flexibility.

Effective April 7, 2025, CMS eliminated the one-year waiting period for requesting amended WCMSA review (re-review).[22] Previously, parties seeking to revise an approved WCMSA amount due to changed medical circumstances had to wait one year from the initial approval. This change facilitates modifications when medical status improves unexpectedly (reducing future care projections) or deteriorates (increasing projected needs), though amended reviews require documentation of material changes in medical status since the original submission.

Conditional Payment Mechanics and Recovery Processes

Benefits Coordination & Recovery Center (BCRC) Notification and Tracking

The Benefits Coordination & Recovery Center operates within CMS to track and manage Medicare's secondary payer obligations and recovery of conditional payments in workers' compensation, liability, and no-fault insurance cases.[1][8][10][8][8][36] Upon learning of a pending workers' compensation claim involving a Medicare beneficiary, the BCRC must be notified so that CMS can track medical claims Medicare pays on the beneficiary's behalf pending workers' compensation resolution.[1][8][8][36][54]

Notification to BCRC should occur as early as possible in the claims process-ideally within thirty days of the work-related injury or illness. Contact with BCRC requires: (1) claimant's full name, Medicare number, date of birth, and contact information; (2) type of claim (workers' compensation), insurer or carrier name and contact information; (3) description of the alleged work-related injury or illness; (4) date of injury; (5) attorney or representative name and contact information (if applicable); and (6) any other contact names and numbers for the parties.[54]

After BCRC receives notice, the agency sends a "Rights and Responsibilities" (RAR) letter explaining Medicare's obligations and the beneficiary's obligations regarding reporting medical expenses, changes in coverage status, and settlement information.[8][8][36] Within sixty-five days of the RAR letter, BCRC issues a Conditional Payment Letter (CPL) listing all items and services Medicare has paid conditionally and identified as related to the pending workers' compensation claim, along with current conditional payment total.[8][8][8][36]

If the claimant delays notifying BCRC until after settlement has already occurred, BCRC issues a Conditional Payment Notification (CPN) in lieu of the standard CPL.[8][8][8][36][52] A CPN provides notice of conditional payments and requires the beneficiary to respond within thirty days with documentation regarding: (1) any items listed on the CPN that are unrelated to the workers' compensation injury, (2) settlement documentation establishing what portion of settlement was allocated to medical expenses, (3) documentation of any procurement costs or attorney fees paid by the beneficiary, and (4) proof of payment of Medicare's conditional payments from settlement proceeds.[8][8][8][36][52]

Calculation of Conditional Payment Amounts and Settlement Coordination

Medicare's conditional payment amount represents the sum of all medical services and supplies that: (1) Medicare paid (whether through Parts A, B, C, or D); (2) relate to the workers' compensation injury or illness; and (3) would ordinarily be covered by Medicare. The conditional payment amount does not include services that Medicare's coverage rules exclude (such as purely cosmetic procedures unrelated to functional restoration) or services that, upon review, are determined to be unrelated to the work-related injury or illness.[8][8][8][36]

When calculating settlement obligations regarding conditional payments, parties must account for: (1) any conditional payments already made and tracked by BCRC, (2) potential for additional conditional payments through the settlement date (if claims continue to be billed to Medicare), (3) a proportionate reduction for attorney fees and procurement costs (CMS permits reduction of conditional payments by beneficiary-borne attorney fees and costs, but the reduction formula is complex and frequently subject to dispute).[8][8][36]

The proportionate reduction calculation typically applies the ratio of conditional payment amounts to total settlement amount, then multiplies beneficiary-borne attorney fees and costs by this ratio. For example, if conditional payments total fifty thousand dollars and total settlement is one hundred fifty thousand dollars (representing a ratio of 33%), and the claimant paid thirty thousand dollars in attorney fees and costs from the settlement, the permitted reduction would be approximately ten thousand dollars (thirty thousand multiplied by 33%).[8][8][28][36]

Critically, insurance carriers and employers do not receive a proportionate fee reduction if they are the identified debtors to Medicare. Only beneficiary-borne fees and costs qualify for reduction. This creates a practical effect that when the insurance carrier settles with the claimant for a gross amount, then the claimant's attorney takes a contingency fee from the settlement proceeds (typically 25-33%), the remaining net settlement may be insufficient to cover both the claimant's required Medicare reimbursement and the WCMSA, leaving the injured worker with inadequate net recovery.

Recovery Demand Process and Appeal Rights

When Medicare learns of a workers' compensation settlement through the BCRC process or through Section 111 mandatory reporting from the insurance carrier, BCRC issues a recovery demand letter specifying: (1) beneficiary's name and Medicare number, (2) date of accident/injury, (3) summary of conditional payments made by Medicare, (4) the total demand amount (conditional payments with interest accrued from the demand letter date), and (5) information regarding waiver and administrative appeal rights.[36][54]

Beneficiaries and their representatives have administrative appeal rights through multiple levels: (1) redetermination by the BCRC contractor, (2) reconsideration by a qualified independent contractor, (3) hearing before an administrative law judge (ALJ), (4) review by the Departmental Appeals Board Medicare Appeals Council, and (5) judicial review in federal court.[8][36][49]

Workers' compensation insurers and carriers also possess appeal rights when CMS pursues recovery directly from the responsible plan (as opposed to pursuing recovery from the beneficiary). These appeal rights parallel beneficiary appeal processes but apply when the insurer is identified as the responsible debtor. Insurers may appeal both the amount of the debt and the existence of the debt.[8][36][49]

Interest accrues on demand amounts from the date of the demand letter at applicable federal interest rates if the debt is not repaid or otherwise resolved within specified timeframes. If a beneficiary or responsible entity does not respond to a demand letter within specified periods, Medicare will pursue collection, potentially including: wage garnishment (against beneficiaries), claims against the beneficiary's estate, offset against future Medicare payments or Social Security benefits, and litigation in federal court seeking double damages against workers' compensation insurers for alleged intentional failure to protect Medicare's interests.[1][8][28][36][49]

Medicare's Double Damages Authority Against Workers' Compensation Insurers

[42 U.S.C. Section 1395y(b)(3)(A)][29] grants the United States authority to "collect double damages against any such entity" that fails to promptly reimburse Medicare for conditional payments made on behalf of a Medicare beneficiary or fails to protect Medicare's interests in workers' compensation settlements.[29] This double-damages authority applies to workers' compensation insurers, carriers, self-insured employers, third-party administrators, and any entity that received payment from the workers' compensation settlement proceeds.[1][28][29]

The double-damages provision operates as a strong enforcement tool-potentially exposing insurers to liability equal to twice the amount of conditional payments not properly reimbursed. This authority explains why prudent insurers verify Medicare status before settlement, obtain CMS WCMSA approval when thresholds are met, and ensure that settlements unambiguously allocate adequate funds to reimburse any conditional payments prior to WCMSA fund allocation.

However, federal courts have imposed limitations on double-damages recovery. A Medicare beneficiary lacks standing to pursue double-damages claims against an insurer unless the beneficiary can demonstrate actual injury-specifically, that the beneficiary risks denial of future medical care or that Medicare has pursued recovery directly against the beneficiary.[50] This limiting principle means that beneficiaries cannot simply invoke the statutory double-damages language without demonstrating concrete harm. Additionally, some courts have held that contested workers' compensation claims (where the insurer disputes coverage or liability) do not trigger MSP obligations until final resolution, potentially limiting when the insurer must establish WCMSA arrangements for disputed claims.[50]

California Workers' Compensation-Specific Implementation

California Division of Workers' Compensation Response to Medicare Secondary Payer Requirements

The California Division of Workers' Compensation acknowledges federal Medicare secondary payer requirements but provides limited specific guidance on the interaction between state UR/IMR procedures and federal MSP law. The DWC website, administrative regulations, and official medical fee schedule guidance do not contain detailed provisions addressing Medicare MSP coordination, WCMSA requirements, or how to resolve conflicts between state-approved medical treatment and Medicare's secondary payer status.[12][30][12][46]

This regulatory gap creates practical implementation challenges for California claims administrators and injured workers' representatives. When a workers' compensation UR decision approves expensive treatment under California MTUS guidelines, neither the state UR regulations nor the approved treatment authorization obligates the claims administrator to verify whether Medicare will cover that treatment as secondary payer. The IMR process, similarly, focuses exclusively on medical necessity under California standards without requiring Medicare coverage analysis.[3][7][9]

Consequently, California's regulatory framework places responsibility on parties to independently address federal MSP compliance. Professional practice standards increasingly require that California workers' compensation claims administrators, particularly those handling settlements with Medicare beneficiaries, engage MSA vendors to calculate WCMSA amounts and verify Medicare coverage implications of approved treatments. Some larger insurers maintain internal expertise or contracts with MSA vendors specifically to address Medicare secondary payer integration.

California Workers' Compensation Appeals Board Settlement and Medicare Considerations

The California WCAB has not issued comprehensive published guidance on WCMSA requirements or Medicare secondary payer compliance, but the Board's decisions reflect growing awareness that federal Medicare interests exist independent of state settlement law. In addition to the Dufelmeier decision discussed above, the Board has acknowledged that state compromise and release settlements cannot waive or negate federal Medicare statutory rights.[19][40]

The WCAB's approach suggests that while California law permits parties to settle claims with closed future medical benefits, any settlement language purporting to indemnify parties against Medicare recovery, shift Medicare's costs to the claimant, or waive Medicare's rights is likely to receive skeptical judicial review. Some workers' compensation judges have expressed willingness to add findings in settlement orders that the settlement "adequately considers Medicare's interests" when coupled with documented WCMSA calculations, while other judges remain reluctant to address Medicare issues, viewing them as outside the WCAB's jurisdiction.[40]

For practitioners, this suggests a dual strategy: (1) ensure that settlement documentation clearly allocates funds to address Medicare obligations (both past conditional payment reimbursement and future WCMSA funding), and (2) avoid settlement language that purports to waive federal rights or indemnify against Medicare recovery. Language stating that the settlement "was negotiated in full awareness of Medicare's secondary payer status and was structured to comply with applicable federal law" may be more favorably received than language purporting to eliminate Medicare's interest in the claim.

CMS-Insurer Communication and Section 111 Reporting Integration

Effective April 4, 2025, responsible reporting entities (workers' compensation insurers and carriers) became obligated to report all WCMSA allocations (including zero-dollar amounts, except for settlements under seven hundred fifty dollars) to CMS through Section 111 mandatory reporting to the Benefits Coordination & Recovery Center.[22][38][55] This mandatory reporting requirement applies regardless of whether the settlement meets CMS's voluntary submission thresholds for WCMSA review.[22][38][55]

The Section 111 reporting requirement operates on two tracks: (1) reporting of a settlement, judgment, award, or other payment (TPOC-Total Payment Obligation), and (2) reporting of the Ongoing Responsibility for Medicals (ORM) if workers' compensation maintains responsibility for future medical expenses after settlement.[55][62] For lump-sum compromise and release settlements that close future medical benefits, the TPOC reporting includes the settlement amount and corresponding WCMSA allocation. The ORM indicator would be "N" (no ongoing responsibility) since future medicals are closed.[55][62]

Non-compliance with Section 111 reporting obligations carries penalties of up to one thousand dollars per day per claimant for each day of failure to report, capped at three hundred sixty-five thousand dollars per individual per year.[22][38][55] This substantial penalty exposure has motivated insurers to implement new systems and procedures ensuring timely and accurate Section 111 submissions.

The practical effect of mandatory WCMSA reporting is that CMS receives data on every workers' compensation settlement involving a Medicare beneficiary. If an insurer reports a settlement with an WCMSA allocation that appears inadequate based on CMS's analysis of available medical records, CMS may initiate

direct contact with the beneficiary, issue supplemental conditional payment notifications, or initiate enforcement proceedings alleging that the settlement failed to adequately protect Medicare's interests.

Northern California Implementation Considerations

Northern California claims administration practices vary substantially depending on insurer size, geographic location, and handling of workers' compensation medical benefits. Large national carriers typically maintain regional WCMSA compliance coordinators or contracts with dedicated MSA vendors to ensure proper WCMSA calculation and CMS submission procedures. Mid-sized regional carriers and self-insured employers may rely on third-party administrators (TPAs) who, in turn, contract with MSA vendors for complex settlements involving Medicare beneficiaries.

The San Francisco, Oakland, and surrounding Northern California regions contain substantial concentrations of injured workers who are Medicare-eligible or approaching Medicare eligibility, particularly in industries with aging workforces such as longshoremen, public sector employees, and construction workers. These regions have correspondingly developed expertise among MSA vendors, workers' compensation attorneys, and claims administration professionals regarding Medicare MSP issues.

Additionally, California's SB 54 (California Values Act) limits immigration enforcement cooperation but does not restrict workers' compensation claim administration. However, the statute's principles regarding state protection of personal information may limit some federal-state cooperation regarding Section 111 reporting. Clarification of how California's constitutional privacy protections interact with mandatory Section 111 reporting is potentially emerging as a jurisdiction-specific issue, though no recent California appellate decisions have specifically addressed this intersection.

Strategic Analysis Framework: Arguments and Risk Assessment

Arguments Favoring Claimant Position: Medicare Coverage Protections

The injured worker's strongest arguments rest on federal statutory authority establishing Medicare as secondary payer to workers' compensation and the corresponding obligation on all settling parties to protect Medicare's interests as a predicate to finality of settlement. Federal law unambiguously requires that workers' compensation pay for work-related medical treatment before Medicare obligation arises, and any settlement that fails to allocate adequate funds for identified future medical needs creates substantial risk that Medicare will deny coverage and pursue recovery, effectively shifting medical costs to the injured worker.[1][5][5][29][5][5]

A claimant's argument should emphasize that: (1) the injured worker has the strongest incentive to ensure Medicare continues coverage for ongoing injury-related treatment throughout the worker's lifetime, as Medicare denial would require the claimant to pay out-of-pocket or receive no treatment; (2) federal law protects the injured worker by requiring that WCMSA funds be exhausted before Medicare obligation arises, ensuring that settlement proceeds are dedicated to work-injury-related care rather than diverted to insurer cost savings; and (3) professional WCMSA calculation and CMS review provides the only mechanism to guarantee finality and prevent future Medicare denial of coverage for injury-related medical expenses.[5][5][5][5][5][5]

Claimants should resist settlement structures that minimize WCMSA allocations by inflating wage-loss or permanent disability components while understating medical cost projections. If future medical needs are genuinely uncertain or contested, the injured worker's position should be that WCMSA amounts be calculated conservatively to cover reasonably projected care rather than minimum theoretical requirements. This approach provides buffer against premature WCMSA exhaustion and unnecessary recourse to Medicare or the claimant's personal resources for injury-related care.

Arguments Opposing Claimant Position: Insurer Cost Management and Discretion

Insurance carriers defending settlement positions emphasize that: (1) MSP law does not mandate establishment or CMS review of WCMSA arrangements-submission to CMS is voluntary-and parties retain discretion to settle with non-submit WCMSA allocations at their chosen amounts; (2) determinations of whether WCMSA review thresholds are met involve substantial discretion (particularly regarding whether a claimant has "reasonable expectation of Medicare enrollment"), and insurers legitimately question whether certain claimants will become Medicare-eligible; and (3) requiring CMS pre-approval before settlement

creates unacceptable delays and procedural burdens, particularly when medical status improvements or other changed circumstances affect future care projections.[5][5][5][5]

Insurers also argue that injured workers have incentive to maximize WCMSA allocations beyond reasonable amounts to inflate settlement proceeds, with excess amounts remaining in WCMSA accounts after injury-related care needs conclude. Insurers therefore argue for conservative, evidenced-based WCMSA calculations tied to documented treating physician statements rather than "worst-case scenario" projections of possible future medical needs.[5][5][5][5][5][5]

The insurer's strongest argument is currently that CMS has not yet pursued widespread aggressive enforcement against carriers for non-submit WCMSA settlements, suggesting that the regulatory risk may be lower than the procedural costs of obtaining CMS pre-approval. However, this argument has weakened substantially following CMS's July 2025 prohibition on zero-dollar MSAs and April 2025 mandatory Section 111 reporting requirements, which have increased CMS visibility into and enforcement focus on WCMSA adequacy.[2][22][23]

Risk Assessment Matrix: WCMSA Submission vs. Non-Submission Strategy

Factor	Submitting WCMSA to CMS	Non-Submitting WCMSA
Timeline Impact	30-60 days CMS review delay	Eliminates CMS approval delay
Settlement Finality	CMS approval guarantees finality re: approved WCMSA amount	Risk Medicare will deny coverage or demand repayment of full settlement amount
Claimant Financial Risk	Moderate: if CMS approves lower than proposed, funds available for other damages	High: if Medicare later disputes adequacy, claimant faces denied medical coverage or repayment demands
Insurer Financial Risk	Low-moderate: CMS approval limits recovery exposure	High: CMS may demand repayment equal to net settlement less procurement costs if inadequacy challenged
Medicare Coverage Guarantee	High: Medicare commits to resume coverage upon WCMSA exhaustion	Low-moderate: Medicare retains discretion to deny coverage based on settlement structure inadequacy
Regulatory Compliance	Aligns with CMS guidance; reduces enforcement risk	Complies with MSP law (no legal requirement to submit) but creates potential enforcement target
Cost	MSA vendor fees ($3,000-$8,000 typical) + delayed settlement	Minimal; faster settlement realization

Qualitative Likelihood Assessment: Success Factors for WCMSA Adequacy

The qualitative likelihood of WCMSA adequacy surviving potential future Medicare challenge depends on multiple factors. Cases presenting low risk of Medicare denial typically involve: (1) documented treating physician statements specifically recommending future treatment with projected frequency and duration, (2) WCMSA calculations that conservative relative to documented care recommendations (e.g., including contingency amounts for unforeseen complications), (3) CMS pre-approval of the proposed WCMSA amount, (4) claimant age and health status supporting reasonable life expectancy projections, and (5) settlement documentation clearly allocating separate funds for conditional payment reimbursement and WCMSA.

Cases presenting medium risk typically involve: (1) treating physician prognoses indicating possible but uncertain future treatment needs, (2) WCMSA calculations based on historical utilization patterns that may not accurately project future costs due to medical advances, technological changes, or medication availability changes, (3) WCMSA amounts proposed but not submitted to CMS for review, (4) settlement language that is ambiguous regarding which settlement proceeds are designated for WCMSA vs. other damages, and (5) documented treating physician statements suggesting higher future care needs than the allocated WCMSA amount would support.

Cases presenting high risk of Medicare enforcement challenge typically involve: (1) no documented treating physician statements regarding future care; (2) WCMSA allocations substantially below amounts

recommended by independent medical evaluators or vocational rehabilitation specialists; (3) settlement documentation containing language appearing to waive Medicare rights or indemnify against Medicare recovery; (4) evidence suggesting parties inflated wage-loss or disability components while minimizing medical cost allocations; (5) claimant age and health status highly suggestive of Medicare enrollment (age 63+, ESRD, SSDI recipient) but parties allocated minimal WCMSA; or (6) documented conditional payments from Medicare that are not accounted for in settlement allocation.

Practical Implementation Roadmap

Medical Treatment Authorization: Procedural Integration with Medicare Secondary Payer Status

When a medical treatment authorization request proceeds through California's UR process, the claims administrator should simultaneously: (1) verify the claimant's current Medicare status or reasonable likelihood of Medicare enrollment within thirty months, (2) research Medicare coverage determination for the requested treatment using Medicare's official coverage documentation (NCDs, LCDs, and coverage with evidence development policies), (3) determine whether Medicare's coverage standards diverge from California's MTUS standards for the requested treatment, and (4) if divergence exists, alert the UR physician to Medicare coverage limitations so the UR decision can explicitly account for secondary payer implications.

Procedurally, this integration typically occurs at the initial UR phase rather than waiting for IMR determination. UR physicians reviewing treatment requests can annotate their medical necessity determination to note Medicare coverage status, such as: "Requested treatment is medically necessary under California MTUS guidelines for the documented work-related condition. Note: Medicare coverage for this treatment should be independently verified before claimant bills Medicare secondarily, as Medicare coverage policies may diverge from state medical necessity standards."

For injured workers and their representatives, the implication is that obtaining UR approval or IMR determination for treatment does not guarantee that Medicare will ultimately cover that treatment as secondary payer. Counsel should independently verify Medicare coverage by reviewing Medicare's official coverage documentation or requesting informal coverage determinations from appropriate Medicare contractors before proceeding with expensive or high-utilization treatment plans.

WCMSA Calculation Process: Timeline, Documentation, and Vendor Selection

The WCMSA calculation timeline should be initiated at or before settlement negotiations commence-not after parties have agreed on settlement amounts. Initiating early calculation allows counsel to understand how much settlement proceeds must be allocated to address Medicare obligations, and therefore what funds remain available for wage-loss, pain-and-suffering, and other non-medical damages. Delaying WCMSA calculation until after settlement terms are agreed creates risk that insufficient proceeds remain to adequately fund the WCMSA, forcing renegotiation or leaving the claimant with inadequate funding for future medical care.

Selecting a qualified MSA vendor is critical. Vendors should: (1) maintain professional certifications or extensive experience with WCMSA calculations (at minimum 50+ prior submissions); (2) employ medical consultants familiar with current Medicare coverage policies and medical fee schedules; (3) maintain current knowledge of CMS Reference Guide provisions and recent policy changes; (4) provide clear documentation of calculation assumptions, life expectancy methodology, and future cost projections; and (5) offer clear pricing with no hidden costs for CMS submission or amendment requests.

Required documentation for WCMSA calculation includes: (1) comprehensive medical records from all treating providers for the work-related injury (minimum 3-5 years if available), (2) complete pharmacy records for minimum six months and preferably two years showing current medications, costs, and refill frequency, (3) written treating physician statements specifically addressing: (a) permanence of injury/illness, (b) anticipated future medical needs and treatment timeline, (c) estimated frequency and duration of treatment, (d) anticipated future surgeries or major procedures, and (e) prognosis for functional recovery and ongoing disability, (4) injured worker's current age, health status, and any comorbidities affecting life expectancy, (5) documentation of workers' compensation classification code for the injury type, (6) any prior workers' compensation IME reports or vocational rehabilitation evaluations addressing future medical needs, and (7) settlement documentation outlining total settlement amount, allocation to medical damages, and settlement timeline.

Settlement Documentation: WCMSA Allocation and Medicare Compliance Language

Settlement agreements involving Medicare beneficiaries or beneficiaries approaching Medicare eligibility should include specific allocation language addressing Medicare secondary payer obligations. Recommended settlement language includes:

> The parties acknowledge that the injured worker [is/will be within thirty months] eligible for Medicare benefits and that workers' compensation is the primary payer for work-related medical expenses. The parties have established that [Medicare has/has not] made conditional payments related to this claim. The settlement allocation is as follows: > > (1) Conditional Payment Reimbursement: Settlement proceeds in the amount of $[X] are designated for reimbursement of any conditional payments Medicare has made or will make through settlement date, to be paid directly to the Benefits Coordination & Recovery Center (BCRC). > > (2) Workers' Compensation Medicare Set-Aside Arrangement: Settlement proceeds in the amount of $[Y] are designated to be deposited in a separate interest-bearing account (WCMSA) dedicated exclusively to payment of future medical expenses related to the work-related injury that are otherwise covered by Medicare. > > (3) Non-Medical Settlement Components: Remaining settlement proceeds of $[Z] are designated for wage-loss, disability, pain-and-suffering, and other non-medical damages. > > The parties have negotiated this allocation based on [CMS-approved/independently calculated] projection of future medical needs. The injured worker [has selected self-administration/will engage professional administrator] for WCMSA account management.

Settlement language should explicitly avoid provisions purporting to: (1) waive Medicare's rights to recover conditional payments, (2) indemnify the insurer against Medicare recovery claims, (3) impose on the claimant responsibility for Medicare reimbursement of conditional payments, or (4) characterize the settlement as a waiver of future medical benefits under workers' compensation (as opposed to a closure of those benefits with WCMSA funding provided).

CMS WCMSA Submission Process and Portal Requirements

If settlement meets CMS review thresholds and parties decide to pursue CMS WCMSA approval, the submission should be prepared by a qualified MSA vendor or counsel familiar with WCMSA submission requirements. Submission occurs through the WCMSA Portal (WCMSAP), accessible at go.cms.gov/wcmsap, or alternatively by paper/CD submission by mail to CMS.

The WCMSA submission package must include: (1) completed WCMSA cover letter with sections for claimant information, injury information, rated age (if applicable), life expectancy, total settlement amount breakdown, settlement funding mechanism (lump sum vs. structured), WCMSA funding amount and proposed funding structure, treating physician future care recommendations, and consent to release authorization; (2) complete medical records from all treating providers related to the work injury (formatted chronologically), (3) most recent six months of pharmacy records (or full pharmacy history if available), (4) treating physician statement(s) addressing future medical needs, (5) independent medical evaluation reports if available, (6) vocational rehabilitation assessment if available, (7) proof of Medicare eligibility (Medicare card copy or Social Security Administration verification), and (8) signed consent to release form authorizing CMS to review the submission.

Upon electronic submission through WCMSAP, CMS issues an acknowledgment receipt with a case control number. The submitting party can track status through the Portal. If CMS requires additional information, a development letter specifying requested documents is issued, and the claimant/representative typically has 15-30 days to respond. Once WCRC completes medical review, CMS issues an approval letter specifying the approved WCMSA amount, funding mechanism, and any conditions for account setup and administration.

WCMSA Account Setup and Ongoing Administration Responsibilities

Upon settlement and receipt of CMS approval (if applicable), the WCMSA funds must be deposited into an account meeting specific CMS requirements: (1) separate account in the injured worker's name, not co-mingled with personal funds or other accounts, (2) interest-bearing account (required to generate interest income, with interest treated as account earnings and not requiring separate claimant income reporting), (3) FDIC-insured account with low or no monthly maintenance fees, (4) account permitting direct payment to medical providers and pharmacies or convenient check-writing capability, and (5) account established within thirty days of settlement.

The WCMSA account administrator (either the claimant self-administering or a professional administrator engaged by the claimant) is responsible for: (1) maintaining itemized records of every deposit (initial WCMSA funding and any subsequent structured settlement annual deposits), (2) maintaining itemized receipts or explanation of benefits documents for every withdrawal, (3) maintaining bank statements showing account activity, (4) confirming that every withdrawal represents payment for Medicare-covered medical services or prescription drugs directly related to the work-injury, (5) retaining all records for CMS audit or beneficiary review, and (6) submitting annual attestation letters to CMS within thirty days of each settlement anniversary.

Annual attestation letters must be signed by the account administrator, witnessed by a second party, and submitted to the BCRC at the address specified in CMS approval documentation (typically P.O. Box 138832, Oklahoma City, OK 73113, or electronically through Medicare.gov portal). The attestation must specify: (1) total medical expenses paid from the WCMSA account during the annual period, (2) total prescription drug expenses paid from the WCMSA account during the annual period, (3) total expenditures (sum of medical and prescription drug expenses), (4) any interest income earned by the account, (5) account balance remaining after withdrawals, and (6) administrator's certification that funds were used exclusively for Medicare-covered, work-injury-related medical and prescription drug expenses.

CMS has stated that professional administration is "highly recommended," and the majority of substantial WCMSA accounts use professional administrators rather than claimant self-administration.[32][32][60][32] Professional administrators maintain compliance expertise, handle submission of attestation documents, coordinate with medical providers and pharmacies to ensure proper billing against WCMSA accounts, and provide a buffer reducing direct administration burden on the injured worker.

Conditional Payment Management and BCRC Coordination

When a claim involves potential conditional Medicare payments, the claims administrator should notify the BCRC at or before settlement, providing case information (claimant name, Medicare number, date of injury, insurer information) and requesting issuance of a Conditional Payment Letter specifying conditional payment amounts and related diagnosis codes.[1][8][8][8][36]

The CPL typically arrives within 60-90 days and specifies all items and services Medicare paid conditionally and identified as related to the workers' compensation claim. The beneficiary and representative have the right to dispute any items listed on the CPL as unrelated to the compensable work injury, submitting documentation establishing that the service relates to a separate, non-work-related condition. BCRC typically allows 30-45 days to submit disputes, after which the conditional payment amount is finalized.

Upon settlement, the beneficiary must promptly notify BCRC of the settlement amount, settlement date, and allocation of proceeds to Medicare reimbursement. This notification triggers BCRC's final recovery demand letter specifying the amount due to Medicare from settlement proceeds. In most settlements, the claims administrator remits payment directly to Medicare (or to the BCRC recovery contractor) from settlement proceeds, with the beneficiary receiving only the portion remaining after Medicare reimbursement and WCMSA funding.

Disputes regarding conditional payment amounts should be raised early in the settlement process. If the beneficiary believes certain claimed services are unrelated to the work injury, comprehensive medical records, treating provider statements, and diagnosis documentation establishing the non-related nature of services should be submitted to BCRC in writing with evidence. BCRC reviews disputes and may issue modified conditional payment amounts, though the review process can extend 30-45 days and may delay settlement finalization.

Northern California Implementation Details and Practice Considerations

San Francisco and Bay Area Insurance Carriers' Medicare MSP Compliance Practices

Insurance carriers operating in the San Francisco and Northern California regions display varying levels of Medicare secondary payer compliance sophistication. Large national carriers (State Fund, Liberty Mutual, Zenith, Zurich, Hartford) maintain dedicated Medicare MSP compliance coordinators or contracts with external MSA vendors and typically ensure routine WCMSA review for settlements exceeding twenty-five thousand dollars involving Medicare-eligible claimants.[5][5][16][16] These carriers have implemented

Section 111 mandatory reporting procedures and, as of April 2025, report WCMSA allocations for all qualifying settlements.[22][38]

Mid-sized regional carriers and self-insured employers vary more substantially. Some proactively engage MSA vendors for settlement WCMSA evaluation, while others apply a more minimal approach, calculating WCMSA only when claimants or representatives raise the issue. Third-party administrators serving Northern California employers have increasingly implemented systems to flag Medicare-eligible beneficiaries and trigger MSA vendor engagement, though consistency remains variable.

The Bay Area's concentration of technology sector employers and employees has created a unique demographic where injured workers may have high wage-loss settlement components (due to above-average earnings) alongside substantial future medical needs. In such cases, settlement allocations become particularly important-inadvertently under-allocating to WCMSA while over-allocating to wage-loss can result in inadequate Medicare set-aside funding despite substantial total settlement amounts.

San Francisco Asylum Office Location and Local Rules

This reference to "San Francisco Asylum Office" appears to be extraneous to the workers' compensation and Medicare law topic, as asylum law falls outside workers' compensation scope. The research focused appropriately on workers' compensation medical treatment and settlement law, not immigration/asylum law. Reference to asylum offices should be disregarded for this report.

Northern California State Court Workers' Compensation Issues: Civil Procedure Intersections

While workers' compensation is exclusively governed by the state Labor Code and Workers' Compensation Appeals Board (not civil courts except for limited appellate review), Northern California civil courts occasionally address Medicare secondary payer issues indirectly through collateral litigation. For example, when an injured worker's attorney settles a personal injury or third-party liability claim (separate from the workers' compensation claim), federal court judges in Northern California (NDCal, CDCal) have addressed Medicare MSP implications and WCMSA requirements in the context of liability settlements.[28][36]

Principles from liability case settlements apply equally to workers' compensation settlements: Medicare's secondary payer status cannot be contracted away, federal courts enforce Medicare's recovery rights regardless of state settlement law provisions, and attempts to shift Medicare's costs to injured workers through settlement language will not be recognized as valid federal court interpretation of MSP law.[1][28][29][36]

This collateral application means that Northern California practitioners experienced in personal injury or products liability litigation are frequently better positioned than workers' compensation-only practitioners to understand Medicare secondary payer issues, simply due to exposure to federal court Medicare precedent and DOJ enforcement positions.

California State Law Protections: PC Section 1473.7 and Workers' Compensation Intersections

While primarily addressing criminal procedure, California Penal Code Section 1473.7 permits modification or vacatur of criminal convictions when the defendant demonstrates that the conviction may have had immigration consequences. When a workers' compensation claimant has a criminal history potentially affecting workers' compensation or disability benefits eligibility, counsel should evaluate whether prior convictions can be vacated or modified, which might affect future benefit eligibility or settlement structuring.

This intersection is particularly relevant when settlement structures address future disability benefits or when claimant's age and criminal history might delay Medicare eligibility. While not directly addressing Medicare, correction of past criminal convictions that affected benefit eligibility can indirectly affect projected future income, life expectancy, or benefit interdependencies relevant to WCMSA calculations.

Northern California Medical Providers and Fee Schedule Alignment with Medicare

California's Official Medical Fee Schedule (OMFS) for physicians and non-physician practitioners includes a Medicare multiplier mechanism, typically ranging from 100-120% of Medicare rates depending on service type and date of service.[12][30][12][35][45][46] Effective March 1, 2026, California DWC issued updated OMFS reflecting Medicare fee schedule changes, updated relative value units, and inflation factor adjustments.[46]

For WCMSA calculation purposes, the alignment between California workers' compensation fee schedules and Medicare rates is relevant-because WCMSA funding projections must account for the actual costs claimants will face when presenting bills to the WCMSA account. If California's fee schedule significantly exceeds Medicare rates, WCMSA calculations that rely on California rates would project higher costs than Medicare would actually reimburse. Conversely, if Medicare rates exceed California rates (in limited service categories), WCMSA adequacy might be understated.

Northern California MSA vendors have become increasingly sophisticated in recognizing this fee schedule alignment issue and adjusting projected future medical costs to reflect realistic Medicare fee schedules rather than inflated California workers' compensation rates when calculating what the WCMSA account will actually need to cover.

Medicare MSP Enforcement Authority and Current CMS Positions

CMS Authority to Deny Payment and Demand Reimbursement

Federal law grants CMS extraordinarily broad authority to deny Medicare payment for medical services related to workers' compensation claims and to demand repayment when settlement structures appear to inadequately protect Medicare's interests. [42 C.F.R. Section 411.46(b)][51] specifically states: "If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for treatment of a work-related condition, the settlement will not be recognized."[51] This language gives CMS substantial discretion to reject settlement structures on policy grounds, not merely technical WCMSA calculation grounds.

The reference guide language emphasizing CMS's discretion to deny payment-using "may" rather than mandatory "shall"-reflects CMS policy that the agency can exercise enforcement discretion based on case-specific circumstances. CMS has indicated it will more aggressively exercise this discretion against non-submit WCMSA settlements following the July 2025 prohibition on zero-dollar MSAs, viewing such structures as indicative of inadequate Medicare interest protection.[2][22][5][5]

However, CMS has not yet published detailed standards for what constitutes an "attempt to shift" responsibility to Medicare, leaving substantial uncertainty regarding enforcement thresholds. Case-by-case analysis of CMS enforcement decisions (accessed through Freedom of Information Act requests and published administrative decisions) shows that CMS tends to focus on: (1) whether medical records supported treating physician recommendations for future care that significantly exceed the allocated WCMSA, (2) whether settlement language appears designed to waive Medicare rights, and (3) whether the claimant's age and health status indicated high probability of Medicare enrollment with minimal projected future medical costs allocated.

Recent Federal Court Litigation on MSP Enforcement

While published federal court decisions directly addressing workers' compensation WCMSA adequacy disputes are limited, decisions addressing liability and no-fault insurance WCMSA disputes (where parallel MSP law applies) provide interpretive guidance. Courts have generally upheld CMS's authority to pursue recovery and deny payment when settlements fail to adequately allocate funds for future medical care.[1][28][36] However, courts have also imposed meaningful limitations-notably, requiring that parties prove actual injury (risk of payment denial or direct recovery against the beneficiary) to pursue double-damages claims, rather than permitting abstract enforcement of MSP interests.[50]

Additionally, some federal courts have held that the MSP statute's limitations period for CMS recovery claims-three years from the date the item or service was furnished-operates as a statute of limitations on CMS's ability to challenge settlement structures or pursue recovery.[29][36][49] This three-year period may extend to three years from final settlement in workers' compensation contexts, creating potential uncertainty about when CMS enforcement windows close.

CMS Regional Office Implementation Variations

CMS operates through ten regional offices implementing national policy with some local variation. The CMS Region IX office, covering California, typically implements national WCMSA policy consistently but may exercise discretion in enforcement priorities. Practitioners working with California settlements should be aware that CMS Region IX staff are available for informal pre-settlement consultation on WCMSA adequacy

questions (available through CMS.gov regional office contact numbers), and seeking informal guidance can sometimes clarify whether proposed settlement structures are likely to survive CMS scrutiny before final settlement.

MSA Calculation Methodologies and Medical Expense Projection

Life Expectancy Calculations and Rated Age Determinations

A critical component of WCMSA calculation is determining the appropriate life expectancy for projecting future medical expenses. CMS Reference Guide Section 15 establishes criteria for life expectancy calculation: (1) using standard actuarial life expectancy tables (Centers for Disease Control CDC or other accepted actuarial sources) based on the injured worker's current age, or (2) using "rated age"-an adjusted age accounting for medical conditions and impairments that may affect longevity-when documented medical evidence supports such adjustment.[5][5][5][5][5][5]

For injured workers with severe injuries or significant medical conditions affecting life expectancy (severe traumatic brain injury, ESRD, advanced cancer, severe cardiopulmonary disease), treating physicians may provide medical opinions regarding prognosis and projected lifespan. When such medical evidence is available and documented, CMS permits adjustment of actuarial life expectancy through "rated age" methodology. For example, an injured worker aged 55 with documented severe traumatic brain injury and multiple comorbidities might receive a rated age adjustment resulting in treatment as age 65 for life expectancy purposes-reflecting the reality that medical conditions may reduce longevity compared to population averages.

Conversely, when medical records do not support specific life expectancy reduction, CMS typically requires use of standard actuarial tables without adjustment. CMS WCMSA determinations typically reference CDC life expectancy tables (CDC Wonder database) as the source for standard life expectancy calculations.

For WCMSA calculation purposes, conservative life expectancy assumptions are generally preferred. Underestimating life expectancy risks inadequate WCMSA funding for medical expenses extending beyond the projected lifespan. CMS permits amendment of WCMSA determinations if life expectancy assumptions change based on new medical evidence (previously unavailable rated age documentation, for example), but such amendments require re-review requests and may extend the total WCMSA process timeline.

Medical Cost Projection Methodologies: Utilization-Based vs. Future-Prediction Models

WCMSA calculations employ two general methodologies for projecting future medical costs: (1) utilization-based models that examine historical medical cost patterns for the specific injured worker and project those patterns into the future with inflation adjustment, and (2) evidence-based prediction models that rely on clinical literature, treating physician recommendations, and standardized cost data for comparable medical conditions to project likely future costs.

Utilization-based models examine the injured worker's actual medical spending history (typically 2-5 years of treatment records and costs) and identify patterns regarding treatment frequency, type, and annual expense. For example, if an injured worker's past medical records show annual costs of five thousand dollars for medications, four office visits annually at the treating physician's office, and approximately one imaging study per year, the utilization model projects similar patterns continuing, adjusted for inflation. This model is most appropriate for stable chronic conditions where historical patterns reliably predict future utilization.

Evidence-based prediction models rely on clinical guidelines, peer-reviewed literature, and national cost databases to project what future medical care should look like for the documented injury/condition, regardless of whether the individual worker's historical pattern matches the projection. This model is more appropriate for conditions where: (1) the injured worker's treatment history is limited or incomplete, (2) significant medical events (surgeries, disease progression) are projected but have not yet occurred, or (3) the treating physician specifically recommends future treatment protocols that differ from the worker's historical pattern.

Most sophisticated WCMSA calculations employ hybrid approaches, using actual historical utilization patterns as baseline but adjusting for documented treating physician statements regarding anticipated future treatment changes. For example, if an injured worker has received ten years of conservative treatment but the most recent treating physician note states "recommend shoulder replacement within next two years due to

progressive degenerative changes," the calculation would incorporate historical baseline costs plus the one-time major surgical expense and post-operative recovery costs documented in the physician statement.

Medication Cost Projections and Pharmacy Benefit Integration

Prescription drug expenses frequently represent substantial WCMSA components, particularly for injured workers with chronic pain conditions managed with opioids or other controlled substances, individuals with comorbidities requiring multiple medications, or workers with post-surgical pain management needs. WCMSA calculations must examine: (1) current medications and refill frequencies, (2) documented indication for each medication and prognosis regarding how long treatment will continue, (3) current medication costs (using Medicare prescription drug fee schedules or actual pharmacy billing data), and (4) anticipated medication changes based on treating physician statements.

Medicare prescription drug coverage for injury-related medications falls under Medicare Part D (prescription drug plans) or Part B (when covered items administered in clinical settings, such as intravenous infusions). The WCMSA calculation must account for what portion of prescription drug expenses will be covered by Medicare Part D plans (which frequently apply beneficiary cost-sharing through deductibles, copayments, and coverage gaps) versus what portion falls within the beneficiary's responsibility.

CMS guidance requires that WCMSA funding account for the full cost of medications to be paid from WCMSA account (not reduced by Medicare Part D copayment amounts), because the WCMSA account is primary and pays medication costs before Medicare Part D obligation arises. This means WCMSA calculations project and fund the entire medication cost, even though Medicare Part D beneficiaries typically pay only copayments from personal funds.

Recent WCMSA calculations have increasingly incorporated specialty pharmacy costs for injectable biologics, monoclonal antibodies, and other high-cost therapies used in chronic condition management. For injured workers with complex orthopedic injuries requiring advanced pain management or immunosuppressive therapies, specialty pharmaceutical costs can exceed five hundred thousand dollars over a projected lifespan, requiring substantial WCMSA allocations.

Account Administration, Compliance, and Annual Attestation Requirements

Self-Administration vs. Professional Administration: Practical Considerations

Injured workers have the statutory right to self-administer WCMSA accounts, maintaining the account themselves and submitting annual attestation documentation directly to CMS. Self-administration provides maximum flexibility and control over WCMSA funds, allowing the claimant to direct exactly how funds are deployed for medical treatment.[32][48][32][32]

However, CMS "highly recommends" professional administration, and the vast majority of substantial WCMSAs (exceeding twenty-five thousand dollars) are professionally administered. Professional administrators: (1) maintain compliance expertise regarding CMS documentation requirements, (2) coordinate with medical providers and pharmacies to ensure proper billing and account payment, (3) maintain detailed accounting records and transaction documentation, (4) prepare and submit annual attestation letters on time, and (5) provide beneficiary support and education regarding appropriate WCMSA fund usage.[32][48][32][60][32]

For injured workers with complex medical conditions, multiple treating providers, or limited financial management experience, professional administration substantially reduces the risk of improper fund usage (which could result in Medicare denial of future coverage or demand for repayment) and ensures compliance with annual reporting requirements.

Annual Attestation Letter Requirements and Deadlines

Every year beginning no later than thirty days after the settlement anniversary date, the WCMSA account administrator must submit an attestation letter to CMS specifying: (1) total medical expenses paid from the account, (2) total prescription drug expenses paid from the account, (3) total combined expenditures, (4) interest income earned by the account, (5) remaining account balance, and (6) administrator's certification that funds were used exclusively for Medicare-covered, work-injury-related medical and prescription drug expenses.[32][48][32][32][23]

The attestation must be signed by the account administrator and witnessed by a second party (not the claimant or administrator). Failure to submit timely annual attestations creates regulatory risk-CMS may interpret non-submission as evidence of improper fund usage, and Medicare may suspend coverage for injury-related medical services, demand repayment, or pursue other enforcement actions.

Attestations should be submitted to the BCRC at the address specified in CMS approval documentation or electronically through Medicare.gov portal. Copies of attestations and supporting transaction documentation should be retained by the account administrator for minimum seven years (consistent with Medicare documentation retention requirements) in case CMS conducts future audits of WCMSA account administration.[32][48][32][32][23]

Exhaustion Letters and CMS Notification Upon Account Depletion

When WCMSA account funds are completely exhausted (all funds deployed to pay for Medicare-covered, work-injury-related medical and prescription drug expenses), the account administrator must submit a final attestation letter specifying that the account is now permanently depleted. Once CMS confirms permanent exhaustion and receives final reconciliation documentation, Medicare will resume primary payment for future injury-related medical expenses (no longer requiring WCMSA account depletion before Medicare obligation arises).[5][5][5][5][5][5][48][32][32][23]

For lump-sum WCMSA accounts, exhaustion occurs when account balance reaches zero. For structured settlement WCMSA accounts, exhaustion occurs when the beneficiary has received and appropriately deployed all planned annual payments and achieves zero balance. CMS permits beneficiaries to request expedited exhaustion letter procedures if medical status changes unexpectedly (e.g., serious illness, unexpected recovery reducing future care needs) and remaining WCMSA funds are no longer medically necessary.

The significance of exhaustion documentation is that it creates definitive date from which Medicare resumes primary payment obligation. Without proper exhaustion documentation, Medicare may continue requiring WCMSA account depletion indefinitely, even after all funds are actually depleted, creating coverage gaps.

Settlement Considerations and Risk Mitigation Strategies

Pre-Settlement WCMSA Evaluation Checklist

Before finalizing any workers' compensation settlement involving a Medicare beneficiary or beneficiary approaching Medicare eligibility, counsel should complete the following WCMSA evaluation checklist:

| Item | Status | Notes |

|---|---|---|

| Claimant age and Medicare eligibility status verified | ☐ | Document through SSA letterhead verification or Medicare card |

| Treating physician statements addressing future medical needs obtained | ☐ | Specify projected treatment type, frequency, and duration |

| Conditional Medicare payments tracked through BCRC | ☐ | Request CPL if not already received |

| Settlement amount calculated and allocated among damages categories | ☐ | Separate medical damages from wage-loss, pain-and-suffering |

| CMS review threshold analysis completed | ☐ | Determine if Medicare beneficiary + $25K OR non-beneficiary + $250K settlement |

| Decision made: submit WCMSA to CMS or use non-submit structure | ☐ | Document rationale for decision |

| MSA vendor selected and engagement letter executed | ☐ | Confirm vendor expertise and fee structure |

| Medical records compiled for MSA vendor | ☐ | Include complete treatment history, recent pharmacy data |

| WCMSA calculation completed and reviewed | ☐ | Verify calculation assumptions and projected expenses |

| Settlement allocation language drafted | ☐ | Specify conditional payment reimbursement, WCMSA, and non-medical components |

| Approval documents (if CMS submission planned) received | ☐ | Account for CMS approval timeline in settlement scheduling |

| WCMSA account setup procedures explained to beneficiary | ☐ | Confirm beneficiary understands compliance requirements |

| Professional administrator engaged (if planned) | ☐ | Provide documentation and consent forms |

| Final settlement agreement reviewed for Medicare compliance | ☐ | Ensure allocation language is clear and compliant |

Alternative Settlement Structures: Keeping Medical Benefits Open vs. Lump-Sum Closure

An alternative to establishing a WCMSA upon settlement is to structure the settlement as a "compromise and release" that closes indemnity (disability) benefits while maintaining ongoing responsibility for medicals (ORM). When workers' compensation maintains ongoing responsibility for future medical expenses related to the work injury, a WCMSA is not necessary-because workers' compensation remains obligated to pay for injury-related medical care as it arises, and Medicare's secondary payer status continues to apply during the entire post-settlement period.[5][5][5][5][5][5]

The ORM structure provides an alternative to WCMSA calculation and funding, allowing parties to finalize indemnity settlement (frequently the more disputed component) while deferring medical benefit resolution. From a beneficiary perspective, maintaining ORM means workers' compensation continues to authorize and pay for injury-related medical treatment throughout the beneficiary's lifetime, with Medicare remaining secondary. From an insurer perspective, maintaining ORM means ongoing future obligation to pay for medical expenses, potentially extending decades into the future.

ORM structures are often employed when: (1) future medical needs are genuinely uncertain and parties prefer to avoid large WCMSA funding commitments, (2) the injured worker is young and medical projections are unreliable, (3) parties expect significant medical cost inflation over the beneficiary's lifetime and prefer to preserve workers' compensation's flexibility to adjust benefits, or (4) the claimant has not yet reached Medicare-eligible age and parties prefer not to contemplate Medicare secondary payer issues.

The strategic tradeoff is clear: ORM structures provide flexibility but defer finality. For injured workers, maintaining ORM provides ongoing workers' compensation medical coverage certainty but leaves open the possibility that future workers' compensation disputes could arise regarding whether specific treatments are work-related or compensable. For insurers, ORM structures defer cost certainty but preserve ongoing medical benefit obligations.

Non-Submit WCMSA vs. CMS-Submitted WCMSA: Updated Risk Assessment Post-July 2025

Prior to July 2025, parties settling workers' compensation claims frequently employed "non-submit" WCMSA structures-calculating a reasonable WCMSA amount, allocating settlement proceeds accordingly, but deliberately choosing not to submit the allocation to CMS for approval. The rationale was that non-submission avoided CMS review delays while still demonstrating effort to protect Medicare's interests through documented allocation calculations.

However, CMS's July 2025 policy prohibition on zero-dollar MSAs and April 2025 mandatory Section 111 reporting requirements have substantially increased the risk profile of non-submit WCMSAs. CMS now receives mandatory notice of every workers' compensation settlement involving a Medicare beneficiary and sees what WCMSA allocation was made, creating visibility that previously did not exist.

Under current conditions (as of March 2026), non-submit WCMSA strategy carries medium-to-high risk of future CMS enforcement. If CMS reviews the Section 111 report and determines that the allocated WCMSA amount appears inadequate based on available medical records or other evidence, CMS may: (1) contact the beneficiary directly to inquire about the allocation, (2) issue supplemental conditional payment notifications,

(3) deny coverage for injury-related medical expenses once the allocated amount is exhausted, or (4) pursue double-damages recovery against the insurer alleging improper settlement structure.

CMS-submitted WCMSA strategy, by contrast, eliminates most enforcement risk once approval is received. CMS approval letter commits the agency to resume primary payment once the approved amount is exhausted, providing finality and certainty. The cost of CMS approval is primarily timeline delay (30-60 days additional time) and the MSA vendor fees (typically $3,000-$8,000).

For risk-averse parties (injured workers, their representatives, and careful insurers), CMS submission is increasingly viewed as the only prudent approach when settlement meets review thresholds, given the post-2025 enforcement environment.

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Conclusion

The intersection of federal Medicare Secondary Payer law and California workers' compensation regulations creates a complex but increasingly important compliance framework affecting medical treatment authorization and settlement structuring for injured workers who are Medicare beneficiaries or approaching Medicare eligibility. The federal statutory mandate that workers' compensation pay for work-related medical treatment before Medicare obligation arises operates independently from California's state regulatory framework, creating potential conflicts when state-approved medical treatment does not align with Medicare's coverage policies or when settlement structures inadequately allocate funds for future medical expenses otherwise covered by Medicare.

Recent CMS enforcement escalation-particularly the July 2025 prohibition on zero-dollar Medicare Set-Aside Arrangement submissions and April 2025 mandatory Section 111 reporting requirements-has substantially increased regulatory visibility into workers' compensation settlement structures and corresponding enforcement risk for inadequate WCMSA allocations. Responsible parties can no longer assume that non-submit WCMSA arrangements insulate them from Medicare enforcement