4.1.4 Hearing on the Merits of a Case

Because the CMS prices based upon what is claimed, released, or released in effect, the CMS must have documentation as to why disputed cases settle future medical costs for less than the recommended pricing. As a result, when a state WC judge or other binding party approves a WC settlement after a hearing on the merits, Medicare generally will accept the terms of the settlement, unless the settlement does not adequately address Medicare's interests. This shall include all denied liability cases, whether in part or in full. If Medicare's interests were not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the entire dollar amount of the entire WC settlement. Medicare may also assert a recovery claim, if appropriate.

If a court or other adjudicator of the merits (e.g., a state WC board or commission) specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.

4.2 Indications That Medicare's Interests Are Protected

Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare's interests. A WCMSA is not necessary under the following conditions because when they are true, they indicate that Medicare's interests are already protected:

a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement); and

b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment.

These conditions may be demonstrated through one of the following:

- The individual's treating physician documents in medical records that to a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury or illness; or
- The workers' compensation insurer or self-insured employer denied responsibility for benefits under the state workers' compensation law and the insurer or self-insured employer has made no payments for medical treatment or indemnity (except for investigational purposes) prior to settlement, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future or past medical or pharmacy services as a condition of settlement; or
- A Court/Commission/Board of competent jurisdiction has determined, by a ruling on the merits, that the workers' compensation insurer or self-insured employer does not owe any additional medical or indemnity benefits, medical and indemnity benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services; or
- The workers' compensation claim was denied by the insurer/self-insured employer within the state statutory timeframe allowed to pay without prejudice (if allowed in that state) during investigation period, benefits are not actively being paid, and the settlement agreement does not allocate certain amounts for specific future medical services.

In addition, if a settlement leaves WC carriers with responsibility for ongoing medical and prescription coverage once the settlement funds are fully spent, then a WCMSA is not necessary.

Effective July 17, 2025, CMS will no longer accept or review WCMSA proposals with a zero-dollar ($0) allocation. Entities should consider the above parameters in determining whether a zero-dollar WCMSA allocation is appropriate and maintain documentation to support that allocation.

Notes:

- If Medicare made any conditional payments for WC injury-related services furnished prior to settlement, then Medicare will recover those payments. In addition, Medicare will not pay for any WC injury-related services furnished prior to the date of the settlement for which it has not already paid.
- CMS will not issue "verification letters" stating that a WCMSA is not necessary.
- In instances where the above conditions are not met, CMS' voluntary, yet recommended, 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. When CMS reviews and approves a proposed WCMSA amount, CMS stands behind that amount. Without CMS' approval, Medicare may deny related medical claims, or pursue recovery for related medical claims that Medicare paid up to the full amount of the settlement, judgment, award, or other payment.

4.3 The Use of Non-CMS-Approved Products to Address Future Medical Care

A number of industry products exist for the purpose of complying with the Medicare Secondary Payer regulations without participation in the voluntary WCMSA review process set forth in this reference guide. Although not inclusive of all products covered under this section, these products are most commonly termed "evidence-based" or "non-submit."

42 C.F.R. 411.46 specifically allows CMS to deny payment for treatment of work-related conditions if a settlement does not adequately protect the Medicare program's interest. Unless a proposed amount is submitted, reviewed, and approved using the process described in this reference guide prior to settlement, CMS cannot be certain that the Medicare program's interests are adequately protected. As such, CMS treats the use of non-CMS-approved products as a potential attempt to shift financial burden by improperly giving reasonable recognition to both medical expenses and income replacement.

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. This will result in the claimant needing to demonstrate complete exhaustion of the net settlement amount, rather than a CMS-approved WCMSA amount.