Reducing WCMSAs:

Practical Strategies to Lower Allocations and Settle Claims

July 28, 2026

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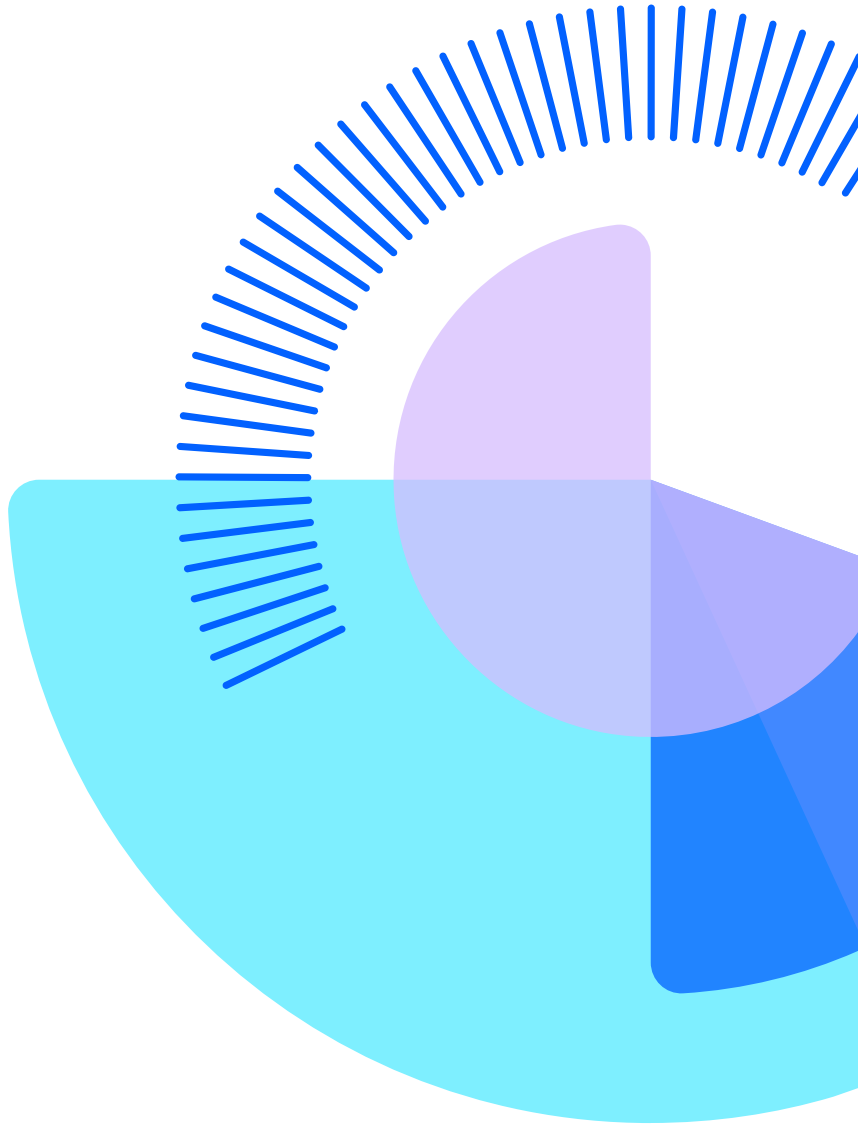

Today's Presenters

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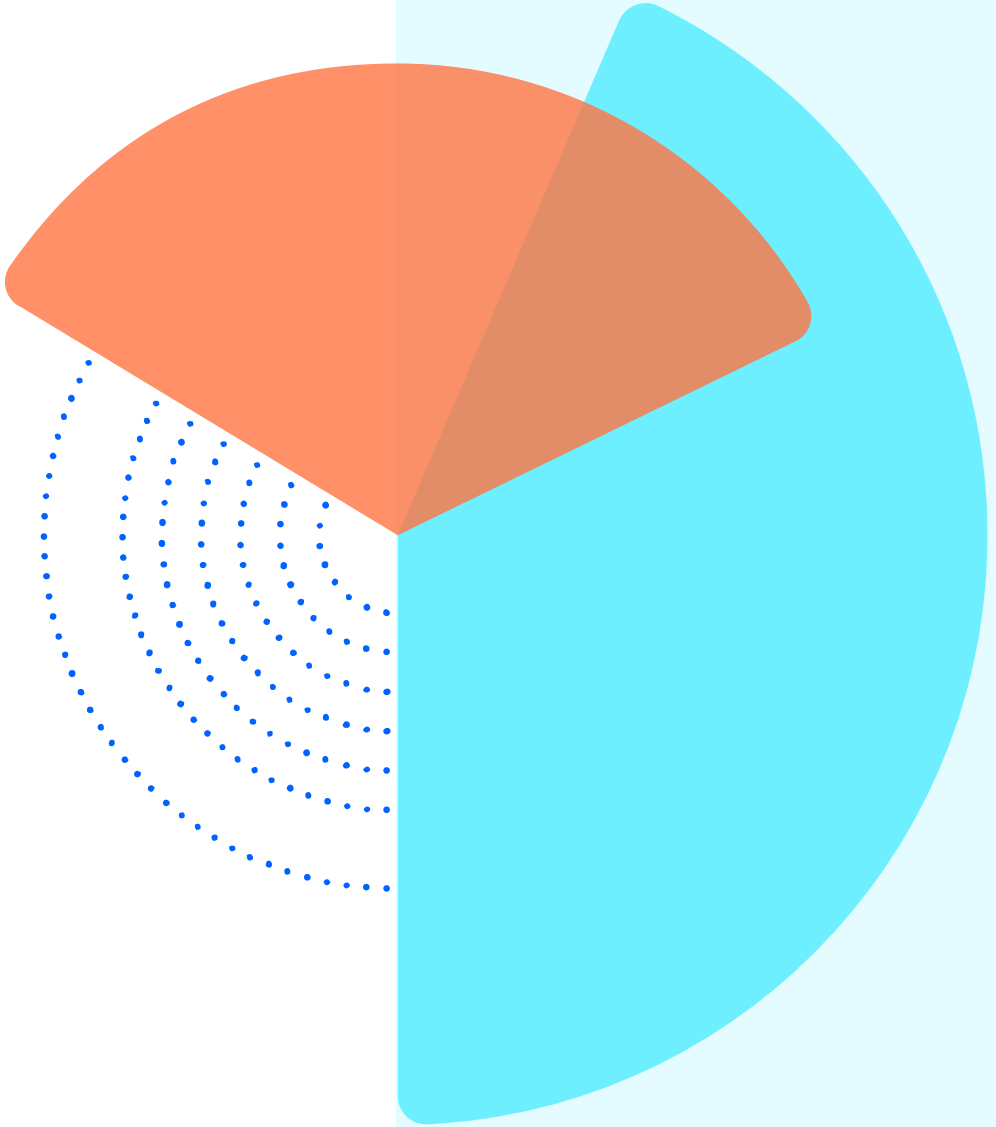
Today's agenda

1. Understanding CMS' WCMSA allocation approaches
2. WCMSA cost mitigation – Key consideration points
3. Reducing MSAs – Savings examples!
4. Making it work better – Building cost mitigation strategies
5. Poll Questions
6. Q/A



Understanding CMS – Methodology and approaches

CMS's WCMSA Pricing Policies

1.

CMS tends to be formulaic with their approach to allocating for treatment.

2.

CMS will allocate for certain treatment in all MSAs regardless of whether it is recommended. (Physician visits, diagnostics).

3.

Certain treatment will lead to revisions depending on the claimant's life expectancy and regardless of whether it is recommended. (Joint replacements, spinal cord simulators).

4.

Not equipped to handle nuances in state law.

5.

CMS does not want to pay for treatment as a Secondary Payer. The "see it price it" rule.

Understanding how CMS allocates treatment in an WCMSA

Common Examples:

Services

1. Physician visits are allocated at current frequency
2. 12-24 PT per body part & surgery
3. X-ray/MRIs are almost always included
4. CMS will try to include treatment if it is mentioned
5. DME priced using fee schedule versus actual pricing (custom items)

Medications

1. Allocated at the current frequency and dosage for life expectancy.
2. Pricing – Redbook AWP
3. Brand vs. generic
4. Generally calculated within the past 6 months
5. Rx pay history vs. Medical records.

CMS Trends and Updates

TENS Units	Previously excluded as non-covered for lumbar – now covered/included.
SCS Replacements	CMS assumes placement on year one if not placed yet; uses actual placement year to reduce years to next placement.
Acupuncture	For lumbar spine, is covered by Medicare.
Non-specific Surgery Discussion	CMS may default to the higher cost surgery; e.g. lumbar fusion rather than lower cost decompression only if specific surgery not listed.
Historical Medications	Where Rx lists are often repeated in more current visits, CMS at times price them even if not clearly currently prescribed.

WCMSA Cost Mitigation

Reducing WCMSA Amounts – Three Main Steps

1.
Get RX drug costs under control

Considerations:
- Brand vs. Generic
- Weaning/Tapering
- Patent expiration
- Off label use
- Dosage/Formulation

2.
Clean-up the Medical Records

Problems:
- Dangling treatment recommendations
- Historical medication lists

The Solution:
- Obtain written clarification from PTP

3.
Fight back against CMS on Submit MSAs

Options:
- Re-review
- Amended Review

Reducing Rx Allocation Amounts: Key Strategies (Examples)

Brand to Generic

How it impacts MSAs:

If the physician is willing to prescribe the generic, CMS will allocate it. Generics are considered "equivalent""

- Brand Celebrex 200mg ($19.70 each) versus generic celecoxib ($2.09 each)
- Brand Ambien 10mg ($28.33 each) versus generic zolpidem 10mg ($1.27 each)

Weaning/tapering

How it impacts MSAs:

CMS will not factor a physician's tapering schedule but will take a snapshot of the current reduced medication use.

- OxyContin reduced from 80mg to 40mg with plan to reduce to 20mg next visit, CMS likely to price 40mg

Dosage/Formulation changes

How it impacts MSAs:

If a medication has several dosage variations, it may be more cost effective in a MSA for a physician to prescribe the lower cost version

- naproxen 550mg is $3.56 per pill, while the 500mg is only $1.05 per pill

Monitoring pricing changes

How it impacts MSAs:

AWP pricing may change overtime and monitoring pricing changes monthly may present opportunities to reduce prior MSA if the claim did not settle. Recent price decreases:

- Generic celecoxib 200mg dropped from $2.67 to $1.41 per pill
- Generic Sumatriptan dropped from $25.13 to $1.47 per pill

Rx Mitigation: A Closer Look at Strategies

Lower Cost Alternatives

Category of Medication

- tizanidine 4mg ($1.46 each) versus cyclobenzaprine ($.02 each)

Generic instead of a Brand

- Cymbalta 60mg ($4.79 each) versus generic duloxetine 6mg ($1.16 each)

Dosage & frequency combinations

- tramadol 50mg ($.14 each) versus tramadol 100mg ($1.92 each versus tramadol 100mg TER ($3.62 each)

As Needed Use

- Medication is appropriate for as-needed use
- Medication is filled intermittently
- Medical records indicate "PRN" or "as needed use" permissible
- Examples of Rx that can be "as needed use"

Cost Mitigation Techniques in Action

Naproxen Formulation Changed

Savings:

Over $561,000

- Records and pharmacy history note Naproxen-Esomeprazole being actively prescribed
- Adjuster gets written confirmation that Naproxen-Esomeprazole has been changed to Naproxen
- WCMSA updated accordingly ….
  SAVINGS = Over $561K!

Spinal Cord Stimulator (SCS) Removed

Savings:

$412,000

- Original MSA was for $459,000.
- Primary cost driver was the recommended SCS
- Adjuster contact primary treating physician (PTP) wo agreed that the SCS was no longer recommended
- Updated MSA amount of $47,000.
  SAVINGS = $412K!

Brand Name OxyContin Changed to Generic oxycodone

Savings:

Over $341,000

- MSA included brand name OxyContin 80MG, accounting for over $627,000 of the MSA cost.
- PTP agreed to change OxyContin to the generic form, oxycodone.
- WCMSA updated to reflect the change, resulting in a SAVINGS = Over $341K!

Fighting Back!
Options to Challenge CMS!

Challenging CMS WCMSA Approvals – Two Possible Options

Re-Review
a/k/a
"rebuttal"

Mathematical Error

New information that pre-dates original submission

Submission Error

Amended Review
Verisk's
"Second Look"
service
can help

Parties can submit
new medical documentation
to CMS to adjust a prior WCMSA
approval in certain cases!

MSA Second Look (Amended Review)

Amended Review – Criteria

1. Allowed one time;
2. CMS has issued a WCMSA approval
3. Settlement has not occurred (case is still open); and
4. Projected care has changed at least 10% or $10,000 (whichever is greater from the initially approved amount)

Second Look Features

- Analysis of whether claim will qualify for "Amended Review"
- Identification of cost mitigation options and strategies
- File consultation with our med/legal team

Second Look – Benefits

- Helps optimize CMS's Amended Review Process
- Opportunity to reduce prior CMS WCMSA approvals for qualifying cases – "second bite at the apple!"
- Case by case – or as part of a Second Look settlement project!

Verisk's Second Look Client savings: 2025 = $5.1M! Nearly $60M over life of program!

Verisk's Second Look Examples – Amended Review savings!

Case #1

Second Look Savings = $965,550

- Original CMS approved WCMSA = $1,042,675.
- Primary cost drivers = high-cost brand name medications
- New medical records showed:
  - Overall reduction in Rx
  - Provider documented discontinuation of one of the prescribed medications, along with a change to the generic form of another medication.

Amended Review WCMSA approved for

$77,125.00

(Savings: $965,550)

Case #2

Second Look Savings = $641,105

- Original CMS approved WCMSA = $679,957.
- Primary cost driver = SCS replacements, intrathecal pain pump and costly long-acting opioid.
- Updated records showed:
  - SCS was no longer of benefit and was due to be removed
  - Intrathecal pain pump no longer recommended
  - Opioid was discontinued

Amended Review WCMSA approved for

$38,851.00

(Savings: $641,105)

CMS's New $0 WCMSA Policy

$0 WCMSA Requests

New Change Effective 7/17/2025

Effective 7/17/2025, CMS will no longer accept or review $0 WCMSA requests – but states that parties

Insurers must maintain documentation to support that allocation.

(WCMSA Reference Guide, Section 4.2)

*CMS reserves the right to audit $0 WCMSAs as part of their new TPOC/WCMSA reporting requirements

Under Section 4.2, CMS notes the following bases for a $0 WCMSA. You can still have $0 WCMSAs after 7/17/25, but, per CMS, you must maintain documentation in support of your $0 WCMSA.

1. Medical Basis

- Treating Physician Note
- Physician indicates: To a reasonable degree of medical certainty the individual will no longer require any treatments or medications related to the settling WC injury.

2. Denied Claim and No Payments

- Denied claim under law
- No payments medical or indemnity, unless investigating
- Medical and indemnity not actively paid

3. Court Determination

- Ruling on the merits that no benefits are owed
- Medical and indemnity not actively paid

4. Denied claim and payments made without prejudice period

- Denied claim under law
- Payments made without prejudice within rules of WC law
- Medical and indemnity not actively paid

Building WCMSA cost reduction strategies (and how Verisk can help!)

Building WCMSA Cost Mitigation Strategies

Identify Cost Drivers

What is driving up the cost of the MSA?

- Medications
- Implanted devices – SCS/Morphine pumps
- Surgeries – spinal fusions, major joint replacement surgeries
- High frequency visits such as psychotherapy (based on current frequency in records)

Identify Ambiguity

The number one reason for unexpected results.

What is ambiguous?

- Services or medications that are mentioned but not recommended
- Medications the carrier no longer pays for but there is no physician note indicating it was discontinued
- When non-industrial medication could be interpreted as prescribed to treat the industrial injury

Apply Cost Mitigation Strategy

What is the focus area(s)?

- Medications?
- Services?
- Ambiguity?

Determine course of action.

Verisk's Provider Outreach

Key Features

- **Record Acquisition** active engagement with providers to obtain missing records
- **Nurses & Attorneys Identify** cost drivers and cost mitigation opportunities in each file
- **Mitigation Recommendations** are provided for cost savings
- **Develop** outreach strategy for mitigation or clarification
- **Cost Mitigation Outreach** direct to provider for clarifications and recommendations Provider Outreach Cost Mitigation Program:

Total Client Savings: $24M

Success Rate: 89%

Benefits

- Expertise in Medicare & CMS review practices to identify the documentation needed for CMS approval
- Obtain missing medical & Rx records, clarify last treatment date & surgery recommendation
- Saves time in the process and conserves claims handler resources
- Achieve maximum savings on file, with minimal investment

Shifting gears...
WCMSA non-submission

Challenging CMS WCMSA Approvals – Two Possible Options

Settlement Meets CMS's "review thresholds" – parties include MSA, but do NOT submit the MSA to CMS

CMS submission is voluntary

Typical approach here is to use an "Evidenced-Based MSA (EBMSA)" or similar allocation

Settlement DOES NOT meet CMS's "review thresholds," but parties still include an MSA

- TPOC/WCMSA reporting has refocused attention to including allocations in these situations
- Allocation approaches differ (under-threshold MSA)

Evidenced-Based MSA (EBMSA) allocation points

Key allocation approaches:

- EBMSA product is not submitted to CMS for review/approval.
- EBMSA does not utilize CMS' formulaic calculation methods when pricing treatment, and instead, focuses on reasonable treatment through evidence-based medicine guidelines.
- Considers the patient's condition, treatment status, treatment trajectory, and compares these factors to the anticipated treatment outcome for a similar injury. Consequently, the prices and frequency of treatment can be lower in an EBMSA.
- Factors in IMEs, state treatment guidelines, URs.

Non-Threshold MSAs – Allocation Points

Settlement DOES NOT meet CMS's "review thresholds" –but parties still include an allocation

Key allocation approaches:

	DDMSA	Under Threshold MSA
About it	Automated solution built using Verisk's team of experts. Provides a fast, cost-effective MSA for under threshold claims. Used for claims under $25k.	A cost-effective alternative to a traditional MSA for those clients who want a nurse involved in determining the MSA amount.
Automated Allocation	Yes	No
Allocated by	Data model	Nurse
Medical records reviewed	No	Yes – 6 months
Rx pay histories reviewed	No	Yes
Attorney review	No but is QA'd by member of DDMSA team	Yes
Itemization of Services Provided	No	Yes
Turnaround Time	2 days	Standard client 8-10

5 Steps to Reduce WCMSAs

5 Steps to Reduce WCMSAs

1. Identify Cost Drivers
2. Consider Cost Mitigation Options
3. Implement Strategies to Impact the MSA
4. Assert Arguments to Support Position
5. Utilize Re-review Options

Services/Resources Spotlight

How Verisk can Help! – MSA and Allocation Services

Proactive and customizable services to help you reduce costs and settle claims…

- MSA link
- Medicare Set Aside
- Data-Driven MSA
- Under-Threshold MSA
- Pre-MSA
- $0 WCMSAs (Legal or Medical)
- MSA Second Look/ CMS Amended Review
- Medical Cost Projections
- Submissions & Re-Reviews
- Provider Outreach
- Medicare/SSD status check

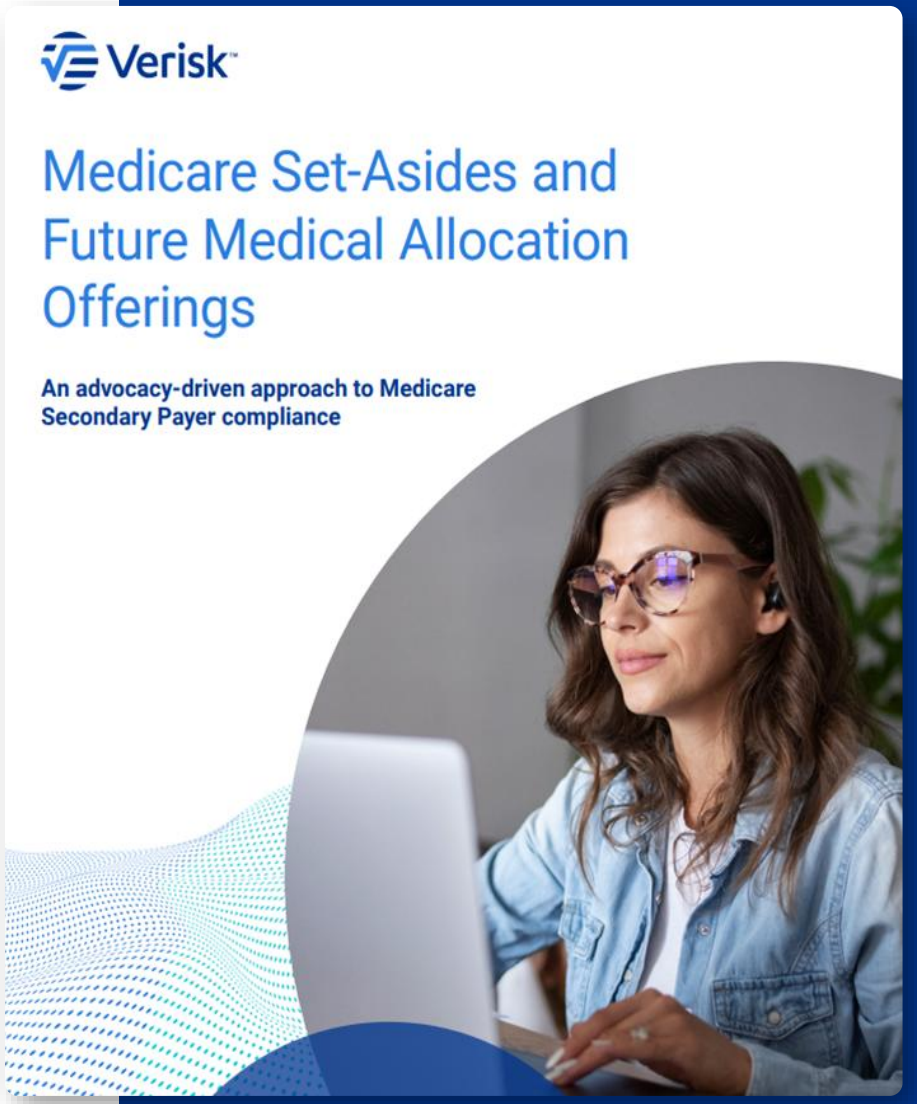
Benefits of our Approach:

- Medical/ Legal Dedicated Team
- Proactive Cost Mitigation
  - Saved clients over $58M in 2025
  - MSA Second Look Savings – $5M (2025)
- Robust QA & SME support
- Highest volume CMS submitter in industry allows for better accuracy

Medicare Set-Asides and Future Medical Allocation Offerings

Learn More about our Allocation Services

- MSA
- Pre-MSA
- Evidence-Based MSA (EBMSA)
- Indemnified EBMSA (iEBMSA)
- Strategic MSA
- MSA Link
- Data-Driven MSA
- Legal/Medical $0 WCMSAs
- Medical Cost Projections
- CMS Submission
- Provider Outreach/Cost Mitigation
- Second Look
- Click here to learn more!



Medicare 2026 Watch List Report

Download the report!

[Medicare 2026 Watch List Report: Connecting the Data Dots to Meet New Compliance Challenges]

Questions?

How to Make a Referral

On-line
https://cpreferrals.verisk.com

Phone:
(866) 630-2772 (ext.1)

Email:
referrals@verisk.com

Fax:
(978) 825-8121

File records and other related documents can be sent to us via email, document upload, or through the mail to 25 Main Street Unit 2, Box #413, North Reading, MA 01864. We also offer complimentary copy/pick up service.

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