Settling a workers comp case rarely feels simple. When future medical care is involved, you have to reconcile a human story of injury, pain, and recovery with a federal system built to prevent cost shifting onto Medicare. That is where a Medicare Set-Aside, or MSA, comes in, and why the right workers compensation lawyer becomes more than just an advocate. They become a project manager, translator, and guardrail.

I have walked clients through everything from a straightforward shoulder repair to complex spinal cord injuries with lifetime attendant care. The technical pieces matter, but the heart of this work is practical: making sure an injured worker can get treatment tomorrow without sabotaging Medicare eligibility next year. Below is how a seasoned approach brings order to a process that can otherwise stall a settlement or leave a client exposed.

What a Medicare Set-Aside Is Trying to Solve

Medicare is a secondary payer for work-related injuries. If a settlement includes money for future medical treatment that Medicare would otherwise cover, the parties must protect Medicare's interests. An MSA does this by carving out a portion of the settlement as a dedicated fund for future injury-related care that Medicare would normally pay. The injured worker uses that fund first, then Medicare steps back in.

Two questions drive the work:

- How much money belongs in that bucket to reasonably cover future injury-related, Medicare-covered care and prescriptions?
- How will the worker use and document those funds so Medicare recognizes the process and continues to provide benefits when the MSA is properly spent?

Those answers are both technical and personal. They depend on the medical record, the treating doctors' plans, medication regimens, likelihood of surgery, and the state's workers comp fee schedule. They also depend on the person's age, comorbidities, and life goals after the case closes.

When CMS Review Applies, and Why It Matters

The Centers for Medicare and Medicaid Services, better known as CMS, offers a voluntary review process for WCMSAs. Not every case needs CMS review, but there are widely followed thresholds that CMS uses to accept a submission:

- The claimant is a Medicare beneficiary and the total settlement is over 25,000 dollars, or
- The claimant has a reasonable expectation of becoming a Medicare beneficiary within 30 months and the settlement is over 250,000 dollars.

These numbers can evolve, and lawyers check the most current guidance before advising a client. Even when a case does not meet those thresholds, many carriers and self-insured employers still prefer a CMS-reviewed MSA to reduce future disputes. If CMS approves the allocation and the injured worker administers it correctly, Medicare should not refuse to pay once the funds are properly exhausted. That is real peace of mind.

I have seen adjusters insist on CMS review even on borderline files, especially if the future medical picture is murky or pharmacy costs are high. On the other hand, I have negotiated payers away from unnecessary submissions when surgery had already occurred and the long-term plan was well-documented with low variance.

The Core Workflow a Lawyer Uses to Build a Defensible MSA

If you could stand behind my desk during a typical MSA case, the work would look like a structured checklist with a lot of judgement calls in between. Here is the spine of that process.

- Triage the case for MSA need: confirm Medicare status and settlement posture, and decide whether to seek CMS review.
- Gather and clean the record: obtain two to three years of medical records and pharmacy history, address duplicate entries and contradictory notes, and chase missing operative reports and DME invoices.
- Nail down the treatment plan: get a clear statement from treating physicians on anticipated care, frequency, and likely surgeries, with CPT and HCPCS codes where possible.
- Build and test the allocation: project future Medicare-covered care and Part D drugs using appropriate fee schedules and realistic frequencies, then run sensitivity checks based on age, comorbidities, and adherence.
- Align the settlement and administration: choose lump sum or structured funding, decide on self vs professional administration, and educate the client on reporting, interest, and exhaustion rules.

Each step involves stakeholders who speak slightly different dialects. Doctors focus on clinical possibilities, adjusters on cost containment, and clients on what their life will be like after the check clears. The lawyer's job is to get them on the same page long enough to make smart decisions and document them.

Records and Reality: Why the File You Have Often Beats the File You Want

The most common source of inflated MSAs is a chart that suggests far more care than a patient will ever receive. Old orders linger. A doctor mentions a procedure to keep options open, then never schedules it. A pharmacy list shows meds a patient stopped taking a year ago.

I once handled a lower back case where the file included a "consider fusion" note from an early consult. The treating surgeon had since pivoted to conservative care, and the patient was doing well on a home exercise plan and a low-dose anti-inflammatory. If we had taken that early note at face value, the MSA would have ballooned by six figures. It took two phone calls and a short letter from the surgeon to clarify that surgery was no longer indicated. That letter saved the client from an overfunded, locked-up chunk of their settlement.

On the flip side, I never paper over likely care just to force a number down. CMS will flag wishful thinking, and the person living with the injury deserves an allocation that will actually carry them through. If nerve conduction studies are pending after persistent radicular pain, I would rather pause, get the data, and build an allocation on the right foundation.

Fee Schedules, U&C Rates, and Why Pricing Is Not One Size Fits All

Pricing is where many non-specialists get tripped up. Workers comp uses state fee schedules or negotiated rates, and these can be significantly lower than retail or usual and customary charges. CMS expects the MSA to price services and prescriptions consistent with what would be paid post-settlement. If the worker will leave the workers comp network, you may need to price at Medicare rates or local U&C, depending on the state and the anticipated point of service.

Pharmacy is its own minefield. A brand-name drug at 800 dollars per month looks devastating in a 20-year projection. Yet in practice, a generic might be available at 30 dollars, or the patient could taper off within a year under a weaning plan documented by the prescriber. I do not assume those changes. I secure a clear medication plan from the doctor, then price to that plan using realistic sources, including Part D pricing references. For opioids

and adjuvant pain meds, a taper letter changes the whole curve, and CMS gives weight to a specific schedule backed by clinical history.

Rated Ages and Life Expectancy: The Quiet Lever

Life expectancy affects the allocation because the projection multiplies annual costs by anticipated years of life. Rated ages, which reflect impairment-based actuarial adjustments, can modestly shorten the expectancy compared to a standard table. I think of rated ages as a reality check. They require clinical support and must come from credible underwriters. I never shop for the lowest possible number. If three independent ratings converge in a tight range, that range is defensible. If one outlier drops several years with thin rationale, I do not use it. A balanced rated age can reduce funding without gaming the system, especially for older workers with cardiac or pulmonary comorbidities.

Submitting to CMS: Timing, Packaging, and Patience

Once the allocation is built, someone has to shepherd it through CMS if review is appropriate. Submission packages work best when they read like a single story. That means aligned records, clear physician statements, pharmacy plans, and credible pricing. Disorganized or contradictory materials invite development requests, which delay settlement.

Typical CMS response times run about six to twelve weeks, sometimes faster, sometimes slower depending on volume and complexity. If CMS counters with a different number, you can ask for a re-review under limited conditions, such as a mathematical error or new material evidence that pre-dates submission. I advise clients to expect some back and forth. A two month pause is worth it if the final letter will preserve Medicare access years down the road.

I have had success clarifying misunderstood items, like a post-settlement carrier discount mistakenly applied during pricing, or a discontinued medication that the pharmacy list kept dragging forward. A concise addendum can sometimes move the needle.

Funding Mechanics: Lump Sum, Structured, or a Hybrid

Once you have an approved or agreed MSA amount, you decide how to fund it. The two core models create real trade-offs.

- Lump sum funding, where the entire MSA is paid into the account at settlement, gives maximum flexibility and immediate access. The downside is opportunity cost if the amount is large, since those dollars are locked for medical use only.
- Structured funding, where an annuity pays an initial seed deposit then annual replenishments, can reduce the settlement’s cash demand and smooth out spending. It can also lower the present cost to the payer. The limits are practical: the injured worker has to navigate annual funding cycles, and if high-cost treatment is front-loaded, the seed must be sized to carry that risk.

I like to run at least two scenarios with the client: a pure lump sum and a structured plan that includes a healthy seed and several years of top-heavy payments if a surgery is likely within five years. People often assume structure means less control. In practice, a well-designed structure can match real usage and leave more general settlement funds accessible for life needs like housing changes.

Who Should Administer the MSA: Self or Professional

Administration is the day-in, day-out reality after the last settlement paper is signed. CMS allows self-administration if the injured worker is comfortable with recordkeeping, bill review, and annual reporting. Professional administration is available for a fee and often includes a discount network that helps dollars go further. The best choice depends on the worker's capacity, the complexity of care, and the availability of a reliable caregiver.

I have seen disciplined clients manage a modest MSA with a simple spreadsheet and a dedicated bank account, tracking receipts, interest, and attestations. I have also seen a well-meaning spouse get overwhelmed by a spinal cord injury case with layered DME, recurring catheter supplies, and rotating home health aides. For high-needs or pharmacy-heavy allocations, professional administration usually pays for itself through negotiated rates and error reduction. Lawyers should not oversell self-administration to save fees if it risks noncompliance that could jeopardize Medicare coverage.

What an MSA Account Must Do, Year After Year

MSA funds must sit in an interest-bearing account, separate from personal funds. Interest stays inside the MSA and must be used for injury-related care or administration costs. The worker pays only for Medicare-covered, injury-related services out of the MSA. Non-covered items, like certain over-the-counter supplies or experimental treatments, should not be charged to the MSA unless CMS guidance specifically allows it.

Every year, the administrator submits an attestation to CMS showing beginning balance, deposits, interest earned, qualified expenses, and ending balance. If the account temporarily exhausts in a given year, Medicare can pay for covered, injury-related services until the next annual deposit lands, in structured cases. With lump sums, once the total MSA exhausts properly, Medicare steps in going forward for covered services related to the injury.

A key counseling point: keep every receipt, EOB, and bill. Sloppy documentation is the fastest route to headaches later. I give clients a simple packet with examples, a one-page cheat sheet on covered versus non-covered items, and contact information for help when a provider submits the wrong code.

Common Pitfalls, and How a Careful Lawyer Avoids Them

Three mistakes show up again and again in disputed or delayed MSAs.

First, pricing off irrelevant rates. Using retail drug prices when Part D would apply, or using a workers comp fee schedule in a state where post-settlement care will follow Medicare rates, can swing the number tens of thousands of dollars. The fix is to anchor pricing to the most likely post-settlement payer and site of service, and to explain that logic in the submission.

Second, leaving in therapies and meds that are unlikely to continue. A ten-year projection that assumes weekly PT forever is unrealistic unless a unique clinical justification exists. The lawyer's job is not to slash care, but to secure accurate physician statements with duration and frequency. Most doctors, when asked directly, will convert a vague "continue PRN" into a practical plan, like six visits after exacerbations, then home program.

Third, ignoring Part D nuances. CMS expects Part D pricing and recognizes generic substitution and step therapy when supported by the prescriber. A strong letter that documents a taper or a switch to a safer alternative can change an allocation meaningfully. Without it, CMS may default to the highest, longest-term cost.

Settlements That Involve Future Surgery

Surgery drives anxiety because it is expensive and uncertain. A lumbar fusion can swing between twenty thousand and over a hundred thousand dollars depending on approach, levels, geography, and complications. You never have perfect foresight, but you can reduce guesswork.

I ask the surgeon to work injury claim attorney specify whether surgery is indicated, probable, possible, or not indicated. If probable, nail down levels, approach, and CPT codes. If possible but not indicated now, explain the clinical triggers that would justify it. I then design funding so the MSA carries enough for surgery within the near term, especially if structured. A higher seed, or a supplemental annuity payment in year one or two, puts the worker in a position to act if symptoms worsen.

On one neck case, the surgeon gave a 30 percent chance of a two-level ACDF within five years. We priced the procedure realistically using local data, then added a buffer for imaging and post-op therapy. The MSA structure front-loaded the first three years with larger payments, then tapered. The client never needed the surgery, and the funds comfortably covered ongoing conservative care. If they had, the dollars were ready.

Conditional Payments and Section 111: Cleaning the Slate

Medicare may have paid for injury-related care before settlement, creating conditional payments that must be reimbursed. I never finalize an MSA without checking the Medicare portal for conditional payments and resolving disputes. Ignoring them risks offsets or demands later. Section 111 reporting also matters, since it alerts Medicare to the settlement and injury codes. Consistency between the settlement release, ICD codes, and the MSA narrative keeps the file clean.

Compromise and Release vs Stipulated Awards

Not every settlement closes future medicals. Some states allow a compromise and release that ends all benefits, others limit what can be settled. An MSA generally applies when future medical is being settled or commuted. If future medical stays open and the carrier remains responsible, an MSA may be unnecessary. But watch for practical shifts. If the worker will move out of state or change providers post-settlement, the payment routes and rates can change, making an MSA more relevant even when the statute feels protective.

A thoughtful workers compensation lawyer maps these state-specific boundaries early, so the parties do not design an MSA around a settlement structure that the judge will not approve.

Educating the Client, Because Compliance Is Lived, Not Theorized

Clients do not need to become experts in federal reimbursement, but they do need five or six points crystal clear:

- Keep MSA funds separate, track every transaction, and save receipts.
- Use the MSA only for injury-related, Medicare-covered expenses and related admin costs.
- Submit annual attestations on time, and ask for help if something is confusing.
- If the account runs out properly, Medicare steps in for covered, injury-related services.
- Call before making big purchases like power wheelchairs or home modifications, because coverage rules vary.

I meet clients where they are. Some want a binder and a spreadsheet, others want a professional administrator. The right answer is the one they can follow on a tough day when the pain spikes and a pharmacy cashier is asking for a card they have never used before.

What Negotiation Looks Like When Dollars Get Tight

There are cases where the MSA number strains the settlement. A 52-year-old with CRPS and multiple meds can outpace the indemnity value quickly. In those moments, I look for levers rooted in real medicine and accurate pricing, not wishful cuts. Can we document a functional restoration program that reduces long-term opioid use? Is a nerve ablation appropriate and cost-effective compared to indefinite escalation of medication? Would a compounding cream be non-covered and thus better funded from general settlement proceeds, saving the MSA for covered items?

Sometimes the answer is structural. A structured MSA lowers the up-front cash demand and preserves settlement room for other needs. Sometimes it is administrative, where professional management reduces pharmacy spend enough to bridge a gap. I am candid with clients: there is no magic trick. There is careful building, clear documentation, and respectful, data-driven dialogue with the payer.

After Settlement: The First Year Matters Most

The first twelve months set the tone. If a worker learns to submit bills correctly, capture interest, and keep clean files, everything gets easier. I schedule a 60-day and a six-month check-in whenever possible. That is when small issues surface, like a provider coding a visit as non-injury-related or a pharmacy toggling to a non-generic without prior notice. A short letter or a corrected claim fixes most of these. Without attention, they pile up and sour the experience.

I keep one sticky note story on my wall. A warehouse worker with a complicated knee settled with a structured MSA. At month four, his physical therapist started billing the wrong diagnosis code after a software update. Medicare denied, then the MSA administrator flagged the problem. One email with the correct ICD-10 codes and a rebill solved it. He told me later that getting help fast made him feel like the system had not forgotten him after the settlement. That is the job.

What Good Looks Like

If you are a claimant, a defense adjuster, or a family member trying to support someone through settlement, success looks like this:

- The allocation matches reality. It funds what the medical record and treating doctors say will happen, at prices that mirror where care will be provided.
- The structure fits the life. Lump sum or structured, the money shows up when it is needed, not when an annuity calendar says so.
- The paperwork stands on its own. If CMS reviews it, they can see the logic and the documentation without guessing. If they do not, the file still tells a clear story.
- The person understands the rules in plain language, and has a phone number to call when they get stuck.

That is what a meticulous workers compensation lawyer brings to an MSA. Not just compliance with an acronym, but a plan a real person can live with.

Final Thoughts from the Trenches

MSAs inspire strong opinions. Some see them as bureaucratic drag. I see them as a promise. You are trading the scaffolding of an open claim for the freedom of a settled life, and the MSA is the bridge that makes sure your medical needs still have a safe lane. Built well, it protects Medicare, avoids overfunding, and grounds the future in what your doctors actually expect to do.

The details will always matter. New CMS memos will tweak submission rules, fee schedules will shift, and drug prices will keep us all on our toes. But the fundamentals stay steady. Tell the truth of the medical history, price it fairly, choose funding and administration that fit the person, and keep the records clean. Do that, and an MSA becomes not a hurdle, but a tool.