Workers' Comp

Settling Future Medical? Don’t Let Medicare Turn It Into a Reopen

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2 MIN READ

You are trying to close a file. Then Medicare shows up late and turns a clean settlement into a messy one. That is the kind of surprise that lands back on your desk when you least need it.

Federal rules make it clear that future medical costs should not be shifted from the primary payer to Medicare when the injured employee will need future treatment after settlement. If Medicare’s interests are not protected, legal action can follow against the injured employee, attorney, carrier, or employer.

If you are settling future medical and Medicare risk is in play, a **Medicare Set-Aside** (MSA) keeps the deal clean and reduces late surprises.

When an MSA should be on your radar

Ask these two questions:

- *Are the future medicals being settled?*
- *Is the claimant a Medicare beneficiary now, or expected to become one within 30 months?*

Common trigger signals include:

- Claimant self-reports Medicare beneficiary status
- Claimant is age 62.5 or older and will become a Medicare beneficiary within 30 months due to age
- Claimant has received Social Security Disability benefits over two years
- Section 111 reporting identifies Medicare beneficiary
- Correspondence from Medicare

You will also hear thresholds referenced for Medicare review:

- Medicare beneficiary and total settlement over $25,000
- Reasonable expectation of Medicare within 30 months and total settlement over $250,000

Important: Medicare’s interests must still be protected even if the settlement does not hit the workload threshold.

What it is, and what it is not

An MSA allocates and projects future treatment, but it only includes medical services and medications that would be covered by Medicare. That is the sharp line between an MSA and a broader medical cost projection.

What to gather so this does not stall your file

Send these items up front to avoid rework:

- First Notice of Loss, if available
- Two years of active treatment records
- Claim payment printout for medical payments
- Detailed pharmacy history
- Denial letters issued to the claimant

Your power move: get the "why" behind the number

A number alone does not help you manage risk. You need to know what is driving the allocation.

The **Cost Driver Letter** identifies the components driving the overall allocation, highlights risk factors found in the medical records, and recommends actions and services that could reduce exposure.

When you need cost-saving leverage

If treatment plans or pharmacy regimens are inflating exposure, these add-on services can help change the direction:

- Peer-to-peer discussion with the treating physician to review prior, current, and future treatment and discuss complex issues and medications
- Nurse task assignment to clarify prescriptions and future treatment
- Drug utilization review by a clinical pharmacist to identify interactions, contraindications, and dosing recommendations

If future medical is part of the settlement, do not wait for late surprises. Start with the records checklist and request a Cost Driver Letter so you can act on the real drivers before you negotiate.

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