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Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP)

Beneficiary Reference Guide

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

DISCLAIMER:

This guide is intended to provide Medicare beneficiaries with a reference manual to help them navigate the Medicare conditional payment recovery process. It is in no way intended as an exhaustive, step-by-step guide, nor is it intended to replace, supersede, or otherwise contradict any existing policy or procedural guidance. If anything in this manual appears to create ambiguity or to alter an existing process or obligation in any way, we recommend that the reader seek further guidance.

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1.0 Introduction

If you have Medicare, you have health insurance that pays many of your medical bills. By law, Medicare may not pay first, or "primary," when another insurer should be responsible for those bills. This is to ensure Medicare's financial well-being, so that Medicare is a good steward of taxpayer money—your money! In this situation, Medicare is known as the "secondary payer." This secondary payer situation may occur when a Medicare beneficiary has insurance through an employer's group health insurance plan (GHP), or through non-group health insurance plan (NGHP) coverage such as liability, no-fault, or workers' compensation that results from an accident, incident, injury, or illness.

Common triggers for NGHP coverage:

- Auto accidents
- Exposure to a dangerous substance
- Implantation of a faulty medical device
- Slip and fall accidents
- Ingestion/injection of a dangerous substance
- Medical malpractice

If you were involved in or experienced an injury from something like the examples mentioned above, you probably have some negotiations going on with another party who might be responsible for your medical bills resulting from that injury. An auto insurer might be evaluating damage to the car or injuries to you before payment, or a workers' compensation insurer might be in negotiations with your legal representative for coverage of your ongoing medical care, or perhaps there's a legal settlement in a pending court case that will reimburse you for suffering and pay your medical costs—as soon as it's finalized. In the meantime, Medicare may have paid for medical bills, or "claims," when another party like those just mentioned is actually responsible for paying your bills. Medicare does this to make sure you have timely access to medical care, instead of having you wait for treatment until the settlement is finalized. In these cases, Medicare has made a "conditional payment." In other words, Medicare has paid your medical provider(s) on the *condition* that Medicare will be reimbursed once the settlement funds are available. Congress passed a law so that the Medicare Secondary Payer (MSP) program reviews claims, determines who should have paid, and notifies the other parties of its findings, along with a demand for repayment. This is known as "pursuing recovery"—the process of recovering funds that Medicare "paid primary" (or first), but Medicare should have actually been the secondary payer (or paid *after* the NGHP insurance coverage).

IF WE SAY: … WE MEAN:

Your representative: Your attorney, family member, or other individual or company you appoint who is your authorized representative. Authorizations are discussed in Section 2.5.

This *NGHP MSP Beneficiary Reference Guide* describes how Medicare recovers primary payments from beneficiaries who have or will have NGHP settlements, when NGHP coverage should have paid first. If you are a beneficiary who has NGHP coverage, this document will guide you through the MSP recovery process.

IF WE SAY: … WE MEAN:

Settlement: Settlement, judgment, award, or other payment

Incident: Accident, incident, exposure, ingestion, illness…

There are many kinds of incidents that can result in secondary payer situations, and many ways to resolve the many types of claims.

2.0 The Recovery Process

This chapter takes you through the details of the recovery process, what information you must provide to Medicare, what information you will receive, and timelines for responses. The next chapter, Section 3.0, covers appeals and other ways of disagreeing with Medicare about what you owe. For a flowchart showing the process, see Appendix A.

At a high level, the recovery process looks like this for you:

You have an accident/incident or illness that requires medical care and that should be covered by a payer other than Medicare (for instance, under liability, no-fault, or worker's compensation insurance). You go to the hospital and receive treatment from a doctor. The hospital submits a claim (bill) for payment. Medicare makes a "conditional payment" for that treatment. In other words, Medicare has paid that bill on the condition that the primary payer will pay Medicare back when the case is settled.

Someone—you, your representative, or the insurer who should have paid primary—notifies the Benefits Coordination & Recovery Center (BCRC), a Medicare contractor, of the accident/incident or illness. The BCRC begins gathering information about your medical incident and insurance coverage. The BCRC then creates a case that includes all the medical bills related to this incident and sends you a letter outlining your rights and responsibilities in the matter, known as the Rights and Responsibilities letter.

If you have an attorney or other representative such as a family member assisting you, by law they must submit appropriate authorization to Medicare, to prove they have permission to make decisions on your behalf or even to talk about your medical and financial situation.

The BCRC then identifies medical claims that Medicare paid and that are related to your case and issues the Conditional Payment Letter (CPL). You or your representative may challenge claims that are not related to the case but that were included in the CPL.

Eventually, your claim is resolved: you will reach a settlement with the responsible insurer and any other parties to the case, or a judge will issue an order, or an insurer will agree on an amount at arbitration, or somehow, you get clarity on who owes you payment for the amount of your medical bills. You or your representative must submit this settlement information to the BCRC, including the amount, date, and attorney's fees and costs. A portion of those fees and costs may be deducted from the amount you owe—this is called a "pro rata" reduction.

The BCRC identifies the total conditional payment amount, calculates the final amount owed to Medicare, and issues what is known as the demand letter—a request for repayment. From here, there are three ways for your case to proceed:

1. **Payment**: Out of your settlement proceeds, you or your representative issues a check to the BCRC for the amount in the demand letter (known as the demand amount or simply the demand). This completes the recovery activity.
2. **Case correspondence**: You may have questions about your case, want to appeal the debt, want to request a waiver or compromise, or otherwise want to talk to the BCRC about your situation. In this case, you send your correspondence to the BCRC as soon as possible for review. Ideally, you will come to some agreement with the BCRC and Medicare and successfully resolve the case by either paying what you owe, or by Medicare agreeing you do not owe the full amount. If a resolution cannot be reached and you have a balance, the third outcome applies.
3. **No payment and referral to Treasury**: You do not pay the amount owed to Medicare on time. In this case, interest accrues from the date of the demand letter and is assessed if the debt is not resolved 60 days after the demand letter date. The Intent to Refer Letter is sent 90 days after the demand letter to notify you that you have just 60 more days to pay the debt or otherwise resolve the matter before Medicare refers the debt, with interest, to the Department of Treasury for collection.

2.1 Types of NGHP Coverage

No-Fault and Liability Insurance

No-fault insurance is insurance that pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who is at fault for causing the accident. No-fault insurance may be found as part of:

- Automobile insurance policies
- Homeowners' insurance policies
- Commercial insurance plans
- Medical Payments Coverage/Personal Injury Protection/Medical Expense Coverage

Liability insurance (including self-insurance) is coverage that protects the policyholder or self-insured entity against claims based on negligence, inappropriate action, or inaction that results in bodily injury or damage to property. Liability insurance includes, but is not limited to, the following:

- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Workers' Compensation

Workers' compensation is a law or plan that compensates employees who get sick or injured on the job. Most employees are covered under workers' compensation plans.

As part of a workers' compensation settlement, funds may be set aside to pay for future medical and prescription drug expenses related to the injury, illness, or disease that would normally be covered by Medicare. These funds are deposited into an interest-bearing account and are used to pay for medical and prescription drug expenses related to the workers' compensation injury or illness. This process is known as a Workers' Compensation Medicare Set-Aside Agreement (WCMSA). See Section 6.0 for a link to more information on WCMSAs.

2.2 Accident/Illness/Injury Occurs

Typically, when you are involved in an accident/incident, you will file a claim with the appropriate NGHP insurer. It is common for beneficiaries to hire a legal representative to help with the claim.

If you receive medical treatment, the medical provider may ask a series of questions to determine the appropriate primary payer. As required by law, medical providers must bill the appropriate primary payer before they can submit a bill to Medicare for payment.

When the primary payer is unknown or does not pay the provider promptly (within 120 days), then the provider may bill Medicare for a conditional payment. Medicare's payment to the provider is conditional because it is made on the condition that it will be reimbursed by you, the Medicare beneficiary, when a settlement occurs.

2.3 Reporting Your Case to Medicare

Always contact the Benefits Coordination & Recovery Center (BCRC) whenever you have a pending liability, no-fault, or workers' compensation claim. See Section 5.0 for BCRC contact information.

Information you need on hand when contacting the BCRC:

Information about…	Type of Information
Beneficiary (you)	• Full name • Medicare Number (the "Medicare Beneficiary Identifier," or MBI), which can be found on your red, white, and blue Medicare card • Gender and date of birth • Complete address and phone number
Case	• Type of claim (liability, no-fault, workers' compensation) • Insurer or workers' compensation carrier name and address • Description of alleged injury, illness, or harm • Date of incident* *Note: The date of incident is not always obvious, especially for situations involving multiple exposures or visits. When you report a potential liability settlement, the BCRC customer service representative will walk you through reporting the correct date, but guidelines are listed in the Resources chapter, Section 6.0.
Attorney (if applicable)	• Attorney or law firm name • Complete address and phone number

After the case has been reported, the BCRC will apply the information to Medicare's record, and determine which recovery contractor is responsible for potential recovery efforts.

- The BCRC is responsible for recovery directly from you, the beneficiary. A case will be established to initiate the recovery process and determine if any repayment is due to Medicare. This guide assumes that your case is a BCRC case.
- The CRC is responsible for recovery directly from the insurer. You will receive copies of Medicare's correspondence sent to the no-fault insurer or workers' compensation carrier, as a courtesy and for your awareness. You are not required to respond to those letters, though you may want to share them with your attorney or other representative.

2.4 The Rights and Responsibilities Letter

After you report your case, the BCRC will send you the Rights and Responsibilities (RAR) letter. The RAR letter explains what information you must send the BCRC and what information the BCRC will send you. See Appendix C for a copy of the Rights and Responsibilities Letter.

2.5 Authorizations

By law, Medicare cannot release information from your records without an appropriate authorization on file. In order to communicate with the BCRC about your case, any person or entity (other than you) must be properly authorized by means of either a Proof of Representation (POR) or a Consent to Release (CTR) document. There is a difference between these types of authorizations.

- Proof of representation (POR) authorizes another individual or entity to receive certain information from the BCRC and to act on your behalf. A POR is most appropriate for your representative to assist with the incident.
- Consent to Release (CTR) authorizes another individual or entity to receive certain information from the BCRC for a limited time. They may not take any actions regarding your recovery case; they may only receive information that is also available to you. A CTR is most appropriate for a third-party insurer/agency.

Please see Appendix C for a sample of both POR and CTR. Please note that for either document, you must sign the authorization.

Even with an authorization in place, all letters will continue to be addressed to you, with a copy sent to anyone else authorized with a POR or CTR. Always check the "CC" field at the end of the letters to ensure that all appropriate parties (and only the appropriate parties) are receiving copies of these letters.

2.6 Conditional Payment Letter (CPL)

As soon as the Rights and Responsibilities (RAR) letter is sent, the BCRC begins identifying conditional payments that Medicare has made that are related to the case, based on details provided when the incident was reported. Medicare's recovery of conditional payments starts at the date of incident and ends at the date of settlement.

Within 65 days of the date of the RAR letter, the BCRC sends the Conditional Payment Letter (CPL) to all authorized parties. The CPL provides a Payment Summary Form (PSF) that lists all conditional payments related to the case. A blank Final Settlement Detail document is also attached; see Appendix C in this guide for a sample.

The CPL does three things:

1. It notifies you of the amount of your potential reimbursement responsibility to Medicare.
2. It allows you to dispute any claims you feel are not related to the case (see Section 2.8).
3. It provides a Final Settlement Detail document to be filled out and returned once a settlement has been reached (see Appendix C for a sample. See Section 2.10 for more information regarding settlements).

The CPL is not a bill, and no payment should be made at this point. The CPL is the BCRC's best estimate of the amount Medicare will be seeking for reimbursement (that is, the "interim total conditional payment amount"). The conditional payment amount is considered an interim amount because Medicare may make additional payments while the case is pending. This can depend on the amount of medical treatment you receive and on when bills are submitted to Medicare for payment.

You or your representative can request updated conditional payment letters until a settlement has been reached. These requests can be made through the BCRC or through the Medicare Secondary Payer Recovery Portal (MSPRP), which you can access through Medicare.gov. See Sections 5.0 and 6.0 for information on contacting the BCRC and accessing the MSPRP.

2.7 Conditional Payment Notification (CPN)

If the BCRC is made aware of a settlement that occurred before or at the time of recovery case creation, a Conditional Payment Notification (CPN) will be sent instead of the CPL. Like the CPL, the CPN provides a Payment Summary Form (PSF) that lists all conditional payments related to the case, but the CPN gives you **30 calendar days** to respond with any additional information relevant to the case before a demand for repayment is issued. You must send the following items to the BCRC if you have not already done so:

- POR/CTR documentation, if applicable (see Section 2.4),
- Proof of any items and services that are not related to the case, if applicable (see Section 2.8),
- Procurement costs (attorney fees and other expenses) you paid, to be deducted on a pro-rata basis from the final amount of the debt* and
- Documentation for any additional or pending settlements related to the same incident.

If your response is received within 30 calendar days, the BCRC will review it before issuing a demand (request for repayment). Otherwise, a demand letter will automatically be issued using the information on file.

* Pro-rata reduction for fees and costs: If your settlement amount is $100,000, and Medicare's conditional payment was $40,000, that is the base amount Medicare looks to recover. That amount is adjusted by a proportional reduction for fees and costs. If fees and costs add up to $34,000, they are 34% of the total settlement amount of $100,000. Medicare will reduce the amount it seeks to recover by 34%, thus: $40,000 * .34 = $13,600, so Medicare will seek to recover $40,000 - $13,600 = a total of $26,400.

2.8 Dispute Process

If you believe that any claims included in the CPL or CPN are not related to the case and should be removed, then you must notify the BCRC in writing. This process can be handled via mail, fax, or internet submission via the MSPRP. See Sections 5.0 and 6.0 for contact information and MSPRP access instructions.

You must clearly identify claims or conditions being disputed, either by circling or marking claims on the Payment Summary Form or by listing them on a separate document. While supporting documentation is not always required, it can be beneficial in supporting a valid dispute.

- Claims you dispute for general health conditions (e.g., flu, diabetes, etc.) do not require supporting documentation.
- Claims you dispute because they occurred after you completed treatment for the case-related injury/condition require a physician's certification showing when case-related treatment was completed.
- Claims you dispute for injuries/conditions that are not being pursued as part of the case (for example, claims were for pre-existing conditions, not accepted as part of the suit, or related to a

different incident) may require supporting documentation such as medical records, a court complaint, or settlement release that shows this condition isn't being pursued as part of the case.

It can take up to 45 calendar days for the BCRC to review the disputes and make a decision. They will send you a dispute response letter saying if the BCRC agreed, partially agreed, or disagreed with the dispute and will provide an updated Payment Summary Form (PSF). During its review process, the BCRC may identify additional claims that are related to the case—these will also be listed on the PSF.

2.9 Pre-Demand Calculation Options

Once you have received a CPL or CPN, there are several options to obtain or calculate the final amount owed to Medicare without waiting for the BCRC's processes. Specific criteria must be met for these options to be used.

1. Fixed Percentage Option (Section 2.9.1)
2. Final Conditional Payment (Section 2.9.2)
3. Self-Calculated Conditional Payment Amount (Section 2.9.3)

2.9.1 Fixed Percentage Option

The Fixed Percentage Option (FPO) offers a simple, straightforward process to obtain the amount due to Medicare by allowing you to pay 25% of the total settlement as full and final resolution. It saves time and resources since you will not have to wait for Medicare to calculate the conditional payment amount before settlement.

Important things to note:

- This is a flat-rate reimbursement option.
- A pro-rata reduction (proportional reduction; see note at end of section 2.7) for attorney fees and costs, if applicable, will not be granted.
- If you choose the Fixed Percentage Option and the BCRC approves it, you may not seek an appeal or waiver of recovery.

Eligibility criteria:

- Your case must pertain to a liability incident.
  - No-fault and workers' compensation incidents are ineligible.
- Your case must be for a physical-trauma-based injury.
  - Injuries caused by exposure, ingestion, or medical implant are ineligible.
- Your case must be settled, and the total settlement must be $10,000 or less.
- You must choose this option within the required timeframe (within the 30-day response timeframe specified in the CPN and/or before a demand letter or other request for reimbursement has been sent).

- You have not received and do not expect to receive any other settlements, judgments, awards, or other payments related to the incident.

Actions that must be taken:

Step	Actions	Notes
1	Verify you meet the eligibility criteria.	See list above.
2	Fill out the Fixed Percentage Option documentation	See Appendix C for sample documentation.
3	Send the written request to the BCRC	The request must be submitted: • Prior to, or with, your notice of settlement documentation (See Section 2.10), or • Within the 30-day response timeframe specified in the CPN, if applicable Send the complete request to the following address: Fixed Percentage Option P. O. Box 138880 Oklahoma City, OK 73113
4	BCRC will review the request and make a determination (decision) within 30 days.	• If your request is approved, the response letter will provide additional instructions for making your payment. If your request is rejected, the response letter will explain why.

2.9.2 Final Conditional Payment Process

The Final Conditional Payment process lets you receive time- and date-stamped final conditional payment summary documents before reaching settlement, so you know what Medicare expects to be repaid before a demand is issued. This process, and all actions related to it, can only be requested on the MSPRP. See Section 6.0 for information on accessing the MSPRP.

Important things to note:

- This option is only available on cases that have not yet settled (see Section 2.8).
- All Final Conditional Payment actions must be completed on the MSPRP.
- The process can only be started by you or your representative.
- The process can only be started ONCE per case.

Eligibility criteria:

- Your case must pertain to liability or workers' compensation incidents.
- Your case must be within 120 days of settlement.

Actions that must be taken:

Step	Action	Notes
1	Verify you meet the eligibility criteria.	See list above.
2	Use the MSPRP to notify the BCRC that you are within 120 days of settlement.	• Select the Portal option "Begin Final Conditional Payment process and provide 120 days' Notice of Anticipated Settlement." • The BCRC will issue a "Notice of Anticipated Settlement Letter" that advises you of the current conditional payment amount and next steps.
3	Use the MSPRP to submit any claim disputes, if applicable, during the 120-day timeframe.	• Select the Portal option "View/Dispute Claims Listing." • The BCRC will respond to your dispute within 11 days. • You may only submit **one** dispute.
4	Use the MSPRP to request the Final Conditional Payment Amount.	• Select the Portal option "Calculate Final Conditional Payment Amount." • You **must** request the Final Conditional Payment Amount no more than 120 days after initiating the process (Step 2), or you will no longer be eligible for this option.
5	Settle your case.	Your settlement date must be within three business days of requesting the Final Conditional Payment amount (as shown on your settlement documentation), or you will no longer be eligible for this option.
6	Use the MSPRP to submit your settlement information within 30 calendar days of requesting the Final Conditional Payment amount.	• Select the Portal option "View/Provide Notice of Settlement Information." • Your settlement information **must** be submitted within 30 calendar days, or you will no longer be eligible for this option.

2.9.3 Self-Calculated Conditional Payment Amount

The self-calculated conditional payment amount enables you to self-calculate the demand amount before settlement in certain situations. You will be asked to give up the right to appeal the amount or existence of the debt. However, you will keep the right to pursue a waiver of recovery.

Eligibility criteria:

- This option is only available on cases that have not yet settled (see Section 2.10).
- Your case must pertain to a liability incident.
  - No-fault and workers' compensation are ineligible.
- Your case must be for a physical-trauma-based injury.

  - Injuries caused by exposure, ingestion, or medical implant are ineligible.
- Your case must be for a date of incident that occurred at least six months ago.
- Your total settlement must be $25,000 or less.
- Your medical treatment for the injury must have been completed for at least 90 days prior to selecting this option and no further treatment is expected.
  - These requirements are met when you provide either a physician's written confirmation OR your certification that you have not had care related to the case within the last 90 days and you expect no further related care.

For a sample document, please see Appendix C.

Actions that must be taken:

Step	Action	Notes
1	Verify you meet the eligibility criteria.	See list above.
2	Using the Payment Summary Form attached to the Conditional Payment Letter, mark each claim that is related to your case with a "Y" (yes, it is related) or an "N" (no, it is not related).	On the Self-Calculated Conditional Payment Amount sample document, you will be asked to provide an explanation for why you believe the claims you marked with "N's" are unrelated to your case.
3	Add additional claims for related care you received after the BCRC issued your Conditional Payment Letter.	Include as much detail as possible, such as: • The dates you received the care and the provider's name, • The Medicare Approved Amount or Allowed Amount, if available. (You can access this information using the "Blue Button" at MyMedicare.gov.)
4	Fill in the information required in the Self-Calculated Conditional Payment Amount sample document.	For a sample, please see Appendix C.
5	Send your Self-Calculated Conditional Payment Amount sample document, your Payment Summary Form with your marks and TOTAL on it, and your physician attestation (if applicable).	Send to the following address: Self-Calculated Conditional Payment PO Box 138880 Oklahoma City, OK 73113

Step	Action	Notes
6	Within 60 days, the BCRC will notify you of a decision. • BCRC Agreement—If they agree with your Self-Calculated Conditional Payment Amount, we will send a letter telling you that the amount is considered final. • BCRC Disagreement—If they disagree with your Self-Calculated Conditional Payment Amount, but you are otherwise eligible for the process, the BCRC will send you a Medicare Amended Final Conditional Payment Amount.	You **must** settle your case within 60 days of the date of our letter and the total value of your settlement must be $25,000 or less.
7	Send your settlement information to the BCRC.	Include the following: • The settlement agreement, showing the total settlement amount and date the agreement was signed • Attorney fees and procurement costs • The BCRC's letter accepting your Self-Calculated Conditional Payment Amount or the letter offering you Medicare's Amended Conditional Payment Amount.
8	The BCRC will calculate the demand amount and issue a request for payment or formal demand within 20 days.	A pro-rata reduction for attorney fees and costs may be applied, as appropriate

2.10 Settlement

Eventually, you will reach a settlement or other payment decision with any other parties to the case. The term "settled" is defined as the date a settlement, or payment obligation, is created. This is the date the settlement release is signed, if there is a written agreement, or the date of court approval. If there is no written agreement, it is the date the payment (or first payment if there will be multiple payments) is issued.

The BCRC will not accept proposed or tentative settlement notifications. Once the case is settled, according to the definition above, you or your representative must provide specific settlement details to the BCRC:

Information	How it is used
Settlement amount	Medicare will not seek recovery of conditional payments that are more than this amount
Settlement date	Medicare will not seek recovery on claims with dates of service after this date

Information	How it is used
Attorney fees and procurement costs, if applicable	Medicare will grant a pro-rata reduction of the conditional payment owed

These settlement details can be provided using the Final Settlement Detail Document attached to the CPL, or on attorney or insurer letterhead. This process can be handled via mail, fax, or internet via the MSPRP. See Sections 5.0 and 6.0 for contact information and MSPRP access instructions.

Once they receive settlement details, the BCRC will identify the total conditional payment amount, including any newly identified accident-related claims, calculate the final amount owed to Medicare, and issue a formal request for repayment known as the demand letter.

Sometimes the BCRC receives a "notice of settlement" before settlement has actually happened, because beneficiaries understandably want finality regarding how much they may owe Medicare. Please be aware that this can have serious, negative consequences for beneficiaries, including referral to the Department of Treasury before the settlement has even occurred. By law, Medicare needs the finalized settlement information to help ensure that the demand is not only accurate, but also issued only after the settlement proceeds have been disbursed.

2.11 The Demand

The BCRC will send the demand letter to you and your representative. It states the amount of money you owe to Medicare, also referred to as the demand amount. It includes a Payment Summary Form (PSF) that lists all conditional payments related to the case, starting from the date of incident, and ending with settlement. The demand letter requests full payment of the demand amount within 60 days. It also provides instruction for how to pay Medicare, details about interest rates and accrual, and information on applicable waiver and appeal rights—that is, how to challenge what Medicare says you owe.

From here, there are three ways for your case to proceed:

1. **Payment**: You or your representative issue a check (from your settlement proceeds) to the BCRC for the amount in the demand letter or pay online using the MSPRP. This completes the recovery activity.
2. **Case correspondence**: You have questions or wish to challenge the debt in some way. Post-demand challenges and outcomes are discussed in detail in Section 3.0 of this guide.
3. **No payment/refer to Treasury**: When payment is not received within the 60-day timeframe given in the demand, the debt will accrue interest and Medicare will use other methods for debt collection.

2.12 Repaying Medicare

You, your representative, or the responsible insurer can repay Medicare by mailing a check to the BCRC or via electronic ACH payment through the MSPRP. See Sections 5.0 and 6.0 for contact information

and MSPRP access instructions. Payment will be applied first to any accrued interest and second to the principal balance.

If you pay the debt in full, then the BCRC will send a letter acknowledging full payment. If you pay part of the debt, the BCRC will send an acknowledgment of partial payment letter that will also state the remaining balance owed.

In some cases, the BCRC may be able to offer an extended repayment plan that will allow you to satisfy the debt via scheduled payments to the BCRC. This request must be submitted to the BCRC in writing. Note that the debt will continue to accumulate interest until it is fully paid.

2.13 Assessment of Interest and Failure to Respond

Interest accrues from the date of the demand letter and, if the debt is not repaid or otherwise resolved within the 60-day period specified in the demand letter, is assessed for each 30-day period the debt remains unresolved. Payment is applied to interest first and principal second. Interest continues to accrue on the outstanding principal portion of the debt. If you request an appeal or a waiver, interest will continue to accrue. You may choose to pay the demand amount to avoid the accrual and assessment of interest. If the waiver/appeal is granted, you will receive a refund.

Failure to respond within the specified time frame may result in the initiation of additional recovery procedures, including the referral of the debt to the Department of the Treasury for further collection actions and/or the Department of Justice for legal action.

2.14 Referral of Debt to the Department of Treasury

By law, Medicare must send all debts that are not paid in full or otherwise promptly resolved to the Department of Treasury (“Treasury”) for further collection activities. To help you avoid this situation, the BCRC issues a notice before referral happens. If you do not resolve the debt within 90 days of the demand, the BCRC will send you an “Intent to Refer” letter. This your formal notice that the debt may soon be referred to Treasury. Please note that this letter is sent automatically, even if you may have a payment or appeal request pending.

If the debt is not resolved (either paid or otherwise resolved) within 60 days of the Intent to Refer letter (that is, 150 days from the demand letter), the debt is then referred to Treasury. The BCRC may not communicate with you anymore once the debt is referred, and the Treasury will be your primary point of contact after it receives the debt.

Treasury may use one or more of its programs to collect referred debts. These include the Treasury Offset Program (TOP), where the amount of the debt is “offset” or withheld from payments such as Social Security benefits or tax refunds. Debts may also be collected through Administrative Wage Garnishment (AWG), Private Collection Agencies (PCAs) hired by Treasury, and even referral to the Department of Justice for collection litigation.

Medicare may also refer uncollected debts to the Department of Justice on its own for legal action, at its discretion. The law permits the Federal government to collect double damages in these situations—twice the actual demand amount.

3.0 Appealing the Debt

You have the right to appeal the existence of the debt (for example, whether the MSP rules apply to the situation) or the amount owed (for example, whether a doctor visit was related to your injury and should not be included in your demand). You also have a right to appeal a waiver decision that is less than fully favorable.

There are multiple levels of appeal available if you disagree with the amount you owe Medicare as identified in the demand letter. It is important to start at the first level of appeal because each level:

- builds on the level before;
- has its own strict time limits; and
- is processed by different contractors or parties on behalf of the Medicare program.

If you miss a deadline without good cause (such as serious illness or natural disaster), or you attempt to "skip ahead" in the process, your appeal request will be dismissed.

3.1 What Can Be Appealed

The following are situations that may call for an appeal of Medicare's decisions or determination of your debt. The first are a set of appeal types:

- Claims not related to the accident, injury, or medical malpractice
  - If the non-related service is for a body part or region injured in the accident, supporting documentation such as doctor's notes or proof of pre-existing condition may be needed.
  - For details on appealing for this reason, see Section 3.2.3.2.
- Benefits exhausted by payment to medical providers
  - If a party to the settlement paid you the amount intended to cover your medical expenses, Medicare will attempt to recover those funds. But if you paid all of those funds to your medical providers, and can prove that to the BCRC's satisfaction, they will accept that as an appeal of the existence of the debt. You will need medical billing and payment records showing what you paid your providers, and settlement documents showing what you were paid and for what purpose.

3.2 The Appeals Process

You, or your representative, may appeal the existence of the debt, the amount of the debt, and a waiver decision that is less than fully favorable. This appeal is called a "redetermination" (first-level appeal).

The BCRC reviews submitted appeals, as they have responsibility for the recovery of conditional payments where a beneficiary is the identified debtor.

3.2.1 Levels of Appeal

The following steps describe the full process of appeal.

1. **Initial Determination**

   For MSP recovery, only actions that constitute "initial determinations" are subject to appeal. Initial determinations include demand letters and waiver decisions.

2. **Redetermination (first-level appeal)**

   The first level of appeal is called a "redetermination." A request for a redetermination must be submitted to the BCRC no later than 120 calendar days from the day you receive Medicare's initial determination. You should include all documentation that supports your argument against the previous decision.

   Appeal requests at the first level may be mailed or submitted through the MSPRP, which you can access through your Medicare.gov login. See Section 8.0 for the address to submit by mail and Section 9.0 for information on accessing the MSPRP.

   When a redetermination is requested promptly and in the proper manner, an independent review is performed at the BCRC by different staff from those who prepared the demand letter. The BCRC issues a decision letter that explains whether the appeal was granted in full, in part, or denied, as well as how you can further appeal the redetermination decision (including the appropriate address and time frame).

3. **Reconsideration (second-level appeal)**

   If you disagree with the results of the first-level appeal ("redetermination"), then you or your representative may request a second-level appeal (called a "reconsideration") within 180 calendar days of when you received the redetermination decision.

   Reconsiderations are performed by a Centers for Medicare & Medicaid Services (CMS) Qualified Independent Contractor (QIC). This party is entirely unrelated to the BCRC, and you will send the request and supporting information to the QIC directly. The QIC will evaluate your request and request your case file from the BCRC. The QIC then issues a decision letter that explains whether the appeal was granted in full, in part, or denied. If you disagree with the outcome of the reconsideration, the letter will also explain how you may appeal the decision (including the appropriate addresses and time frames) at the next level.

4. **Hearing before an Administrative Law Judge**

   If you disagree with the results of the second level appeal (reconsideration), then you or your representative may request a hearing before an Administrative Law Judge (ALJ) within 60 calendar days of when you received the reconsideration decision.

   The hearing is performed by a Centers for Medicare & Medicaid Services (CMS) ALJ, and all administrative processes related to the hearing are facilitated by CMS contactors called Administrative QICs (AdQICs). The ALJ and AdQICs are entirely unrelated to the BCRC, and you will send the hearing request and supporting information to the AdQIC as directed in the reconsideration decision letter.

   Hearings may be conducted live or by reviewing the case documentation. On behalf of the ALJ, the AdQIC will issue a decision letter that explains whether the appeal was granted in full, in

part, or denied. If you disagree with the outcome of the hearing, the letter will also explain how you may appeal the decision (including the appropriate addresses and time frames) at the next level.

5. **Review by the Medicare Appeals Council**

   The final level of the administrative appeals process is a review by the Medicare Appeals Council (MAC, not to be confused with the Medicare Administrative Contractors). The MAC is part of the Health and Human Services (HHS) Departmental Appeals Board (DAB). The review must be requested within 60 calendar days of when you received the ALJ decision letter. Administrative processes related to the council's decision are facilitated by the CMS AdQIC. You will send the review request and supporting information to the AdQIC as directed in the hearing decision letter.

   If you disagree with the decision of the Medicare Appeals Council, you may seek remedy through the U.S. District Court.

6. **Judicial Review**

   You may only request U.S. District Court judicial review after you have been through all other levels of appeal. The process for seeking judicial review is governed by the U.S. Federal court system and beyond the scope of this guide.

Note: As captured in regulation, correspondence is always presumed to be received within five (5) calendar days of the date of the letter, unless demonstrated otherwise. Late appeals at any level may only be accepted if the party shows good cause (for example, a natural disaster prevented an appeal request from being filed in time).

3.2.2 Dismissal of an Appeal Request

If you or your representative requests to withdraw the appeal, the appeal will be considered "dismissed." The BCRC (or other parties, depending on the level of the appeal) may also dismiss an appeal request for various reasons where consideration of the appeal request is not appropriate. These situations may include:

- A demand letter has not yet been issued.
- You fail to file the request within the appropriate timeframe and do not show an appropriate reason (such as serious illness or natural disaster) for late filing.
- The party requesting the appeal is not properly authorized by the debtor named in the demand letter (see Section 2.4).
- The requestor is not a "proper party." This means that an appeal is requested by any party other than the debtor named on the demand letter or their authorized representative. For example, an appeal from your insurance company when the demand letter is addressed to you will be dismissed unless you provide written authorization for your insurance company to represent you.
- The appeal has not been filed to the proper level. For example, you request a third-level appeal (hearing by an ALJ) without an appeal decision at the first and second levels of appeals.

You may appeal the dismissal and, in some cases, resolve the issue that caused the dismissal and still submit the appeal as long as there is time remaining to submit the appeal request. Because of the time limitations, it is critical that you and your representative(s) review all timeframes and appeal requirements and be sure to submit appeals as soon as possible.

3.2.3 Appeal Examples and Supporting Documentation

Any written beneficiary communication that indicates disagreement with the initial determination will be treated as a request for redetermination. Although this section is specific to appeal requests, the BCRC, at its discretion, may process the appeal request as a "reopening," which is separate from the appeals process. At a high level, a reopening is a remedial action taken to correct errors in the calculation of a debt; see Section 4.0.

The appeals outlined below must be submitted in writing to the BCRC. These can be handled via mail, fax, or internet via the MSPRP. See Sections 5.0 and 6.0 for contact information and MSPRP access instructions.

3.2.3.1 Appealing your Ability to Pay the Demand

A demand was issued but certain situations may make it difficult to pay the demand.

Scenario	Examples of Supporting Documentation
Delayed disbursement of settlement funds	• Court document or letter from the responsible insurer stating that funds have not been disbursed • A copy of the settlement check showing the date that the settlement check was issued
Settlement funds are not sufficient to cover all accident-related expenses	This cannot be appealed, but a waiver or compromise request may be more appropriate
Settlement funds have already been spent on something other than case-related medical costs	Medicare has priority right of recovery and this type of appeal will be denied

3.2.3.2 Appealing the Demand Amount

Demand calculation discrepancies and claim-relatedness appeals are the most common types of appeals. Claims or conditions being appealed must be clearly identified, by either circling or clearly marking claims on the Payment Summary Form or by listing the claims/conditions on a separate document. Depending on the reason for your claims appeal, specific supporting documentation may be required.

Scenario	Examples of Supporting Documentation
Demand calculation error • No pro-rata reduction was granted for attorney fees and costs • Settlement amount/date is inaccurate	• Written notice showing fees and procurement costs • Signed settlement agreement
Unrelated claims • Pre-existing conditions • A different incident/injury • A general health condition • Anything otherwise unrelated to the settlement	• Written explanation detailing why the claims are not related • Physician's statement showing last date of treatment, or professional medical opinion • Independent Medical Evaluation (IME) • Medical records • The complaint • Settlement release showing what was claimed and released
Duplicate Primary Payment A provider received primary payment from both Medicare and another entity	• Proof the provider was paid for claims that are on the BCRC demand • Insurer explanation of benefits showing submitted and paid amounts for claims that match to the BCRC's demand • A copy of the beneficiary's payment to the provider for services that match to claims on the BCRC's demand

3.2.3.3 Appealing the Existence of Medicare's Demand

If you believe Medicare has issued a demand to you prematurely or in error, then you must notify the BCRC in writing.

Scenario	Examples of Supporting Documentation
Case not settled	• Proof that the settlement notification to the BCRC did not meet the BCRC definition of settlement (see Section 2.10). • Letter from the entity who reported the settlement confirming it was reported in error.
Settlement is not recoverable	• Official settlement documentation showing the settlement does not offer compensation for medical care or otherwise release the other party from responsibility for medical costs, thus Medicare might not have a claim to settlement funds. This must be documented by a copy of the settlement agreement, court document, or similar documentation.
No-fault benefits paid to the beneficiary are exhausted	• When no-fault benefits were paid directly to you, you must provide proof that those benefits were paid directly to providers.

Special note: Regulations do **not** allow you to appeal a debt on the basis that Medicare should recover from a different party. However, in the event the settlement documentation states another party such as the insurer is responsible for medical expenses or for repaying Medicare's conditional payments, you may send that documentation to the BCRC for the BCRC to review under a different process. Asking Medicare to cease recovery from a liability settlement because no-fault benefits are still available is not a valid request and will be denied.

3.2.3.4 Appealing a Waiver Decision

You, or your representative, may appeal a waiver decision that is less than fully favorable.

Scenario	Examples of Supporting Documentation
Waiver decision partially favorable or unfavorable	• Any additional documentation that would support why a full waiver should be granted that was not provided in the original request.

4.0 What If You Can't Repay Medicare?

4.1 Waiver of Recovery

You have the right to request that the Medicare program waive recovery of the demand amount owed in full or in part, even though you agree that you owe Medicare the identified amount. The Medicare program may waive recovery of the amount owed if the following conditions are met:

- The beneficiary is not at fault (due to fraudulent activity) for Medicare making conditional payments, and
- Paying back the money would cause financial hardship or would be unfair for some other reason.

If you believe that both conditions apply, you can send a letter to the BCRC that explains the reasons. If an attorney or other representative requests a waiver on your behalf, Medicare needs to have proper authorization (POR; see Section 2.5) to review the request. When you request a waiver of recovery, the BCRC will send the form SSA-632 "Request for Waiver," asking for more specific information about your income, assets, expenses, and the reasons why a waiver of recovery should be granted. You may also find a copy of this form on the CMS.gov website.

If the BCRC is unable to grant the request for a waiver of recovery, the BCRC will send a letter that explains the reason(s) for the decision. Waiver decisions may be appealed, and the steps to be followed to appeal that decision are included in the decision letter.

In any case: if you have a situation not covered by this guide, or you have questions about the process or your case, please call the BCRC, and their customer service representatives will walk you through. See Section 5.2 for contact information.

4.2 Compromise

A compromise is a request that Medicare accept less than the amount you owe Medicare, even though you agree that you owe Medicare the identified amount. Compromise requests can be sent pre-demand and post-demand. Please note that if you disagree with the precise amount owed, you should use the appeal process. The right to request a compromise of recovery is separate from the right to appeal the debt, and both a compromise and an appeal and/or waiver may be requested at the same time. The BCRC itself does not have the authority to approve or deny compromise requests; requests are forwarded from the BCRC for review by Centers for Medicare & Medicaid Services (CMS) staff. CMS staff will decide whether to compromise a debt, though consultation with CMS counsel and the Department of Justice may be necessary for higher-value debts.

- Pre-demand compromise: In extremely rare and exceptional circumstances, a compromise request may be considered before a demand letter is issued. You will need to justify why the compromise request needs to be considered before settlement occurs; wanting to know the "final" amount owed to Medicare is not sufficient. You also need to have a reasonably accurate estimate of the final settlement amount and any attorney fees. However, in the vast majority of circumstances, compromise requests received before a demand letter is issued will be denied.
- Post-demand compromise: In the vast majority of situations, compromise requests should be requested after settlement has happened and the demand letter has been received, to allow the beneficiary and CMS the opportunity to make the best determination for the situation.

CMS is limited by law on what basis a compromise may be granted. When you submit a compromise request, you must state the reason why you believe CMS should compromise the debt and you must include supporting information or documentation. For example, if you believe that you are unable to pay the full amount identified in the demand letter even with the available settlement proceeds, you need to explain why, and supply as much supporting detail as possible.

CMS's decisions regarding compromises are final and may not be disputed or appealed. If a compromise is offered, it must be accepted in writing and the amount paid in full within 60 days, or the offer will be rescinded.

You can submit compromise requests by fax, mail, or via the MSPRP; see Section 6.0 for MSPRP access information. If an attorney or other representative requests a compromise on your behalf, Medicare needs to have proper authorization (POR; see Section 2.4) to review the request.

5.0 Contacting the BCRC

5.1 When to Contact the BCRC

The beneficiary or beneficiary's attorney or other representative may contact the BCRC for any of the following:

- Questions about Medicare's recovery rights or the reimbursement process
- To obtain conditional payment amounts

- To obtain Medicare's final recovery claim amount
- Questions regarding MSP recovery demand letters
- Questions with respect to a "Notice of Intent to Refer Debt to the Department of Treasury" letter
- Questions regarding repaying Medicare
- To request a waiver of recovery with respect to a beneficiary MSP debt. (**Note:** A waiver of recovery request cannot be accepted or processed until a recovery demand letter is issued.)
- To request a first-level appeal with respect to the determination contained in a beneficiary MSP recovery demand letter or a determination made on a waiver of recovery request from a beneficiary.

5.2 Contacts

BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

For Non-Group Health Insurance Plan (NGHP) Recovery initiated by the BCRC:

The following addresses and fax are for information related to NGHP Recoveries (e.g., all NGHP checks and inquiries including liability, no-fault, workers' compensation, Congressional, Freedom of Information Act (FOIA), Bankruptcy, Liquidation Notices and Qualified Independent Contractor (QIC)/ Administrative Law Judge (ALJ)):

Non-Group Health Insurance Plan (NGHP) Inquiries and Checks (including POR and CTR):

NGHP
P.O. Box 138832
Oklahoma City, OK 73113

Product Liability Case Inquiries

Special Projects
P.O. Box 138868
Oklahoma City, OK 73113

Self-Calculated Conditional Payment Amount Option and Fixed Percentage Option:

Self-Calculated Conditional Payment Amount/Fixed Percentage Option
P.O. Box 138880
Oklahoma City, OK 73113

Fax: 1-405-869-3309

Workers' Compensation Set-Aside Arrangement (WCMSA) Proposal/Final Settlement:

WCMSA Proposal/Final Settlement
P.O. Box 138899
Oklahoma City, OK. 73113-8899

Fax: 1-405-869-3306

For electronic submission of documents, please use the WCMSA Portal through your Medicare.gov login.

Contact 1-800-MEDICARE (1-800-633-4227) to:

- Obtain general Medicare information.
- Obtain information about Medicare Health Plan choices.
- Order Medicare publications.
- Get assistance with Medicare.gov.
- Get assistance with billing, payment of claims, or claim denials.

Contact the Social Security Administration (1-800-772-1213) to:

- Enroll in the Medicare program.
- Replace your Medicare card.
- Change your address.
- Verify Medicare coverage.

6.0 Additional Resources

Helpful Links

- Proof of Representation (POR) and Consent to Release (CTR) (see Appendix C for model language): https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Proof-of-Representation-and-Consent-to-Release/Proof-of-Representation-and-Consent-to-Release
- Conditional Payment Notice: https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/beneficiary-services/medicares-recovery-process/medicares-recovery-process-items/conditional-payment-letters-and-notices-beneficiary
- Redetermination (First-Level Appeal): https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor
- Self-Calculated Conditional Payment Amount (see Appendix C for model language): https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/beneficiary-services/downloads/selfcalculatedfinalcp.pdf
- NGHP User Guide: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide
- WCMSAs: https://www.cms.gov/medicare/coordination-benefits-recovery/workers-comp-set-aside-arrangements

How to Access the Medicare Secondary Payer Recovery Portal (MSPRP) Application

Beneficiaries: After logging in to Medicare.gov, click "Check My Claims" under "What do you want to do?" On the *My claims* page, scroll down to the *Medicare Secondary Payer (MSP) Claims* box and click "See MSP Case Info"; accept the disclaimer; on the *Medicare Secondary Payer (MSP) Cases*" page, either click the **Go to MSP** button near the top of the page, or click **Open Case Details** by the case you want to review.

- For login, setup, or technical issues with your Medicare.gov account, contact Medicare at 1-800-MEDICARE (1-800-633-4227).

Representatives: The MSPRP application is located at https://www.cob.cms.hhs.gov/MSPRP/.

- For help with MSPRP account setup, login or password issues, or other technical problems, please contact the BCRC at: 1-646-458-6740.

Once you are logged in to the MSPRP application, you can find the MSPRP User Guide linked from the *Reference Materials* menu.

Date of Incident Guidelines

For this type of case…	…the Date of Incident (DOI) is:
Automobile wreck or other accident	The date of the accident
Claims involving exposure (such as occupational disease or other cumulative injury)	The date of first exposure
Claims involving ingestion	The date of first ingestion
Claims involving implants	The date of the implant, or of the first implant if there are multiple implants
Claims involving cumulative injury or failure to diagnose/treat	The earlier of: • The date that treatment for any manifestation of the injury began, when that treatment came before formal diagnosis, or • The first date that formal diagnosis was made by any medical practitioner (that is: the DOI is the date you began treatment for any symptom of the injury, even if the doctor had not diagnosed the true issue yet.)
Neglect-type injuries	The date of first symptoms

Appendix A: NGHP Recovery Process Flowchart

Figure 1: Flowchart, page 1

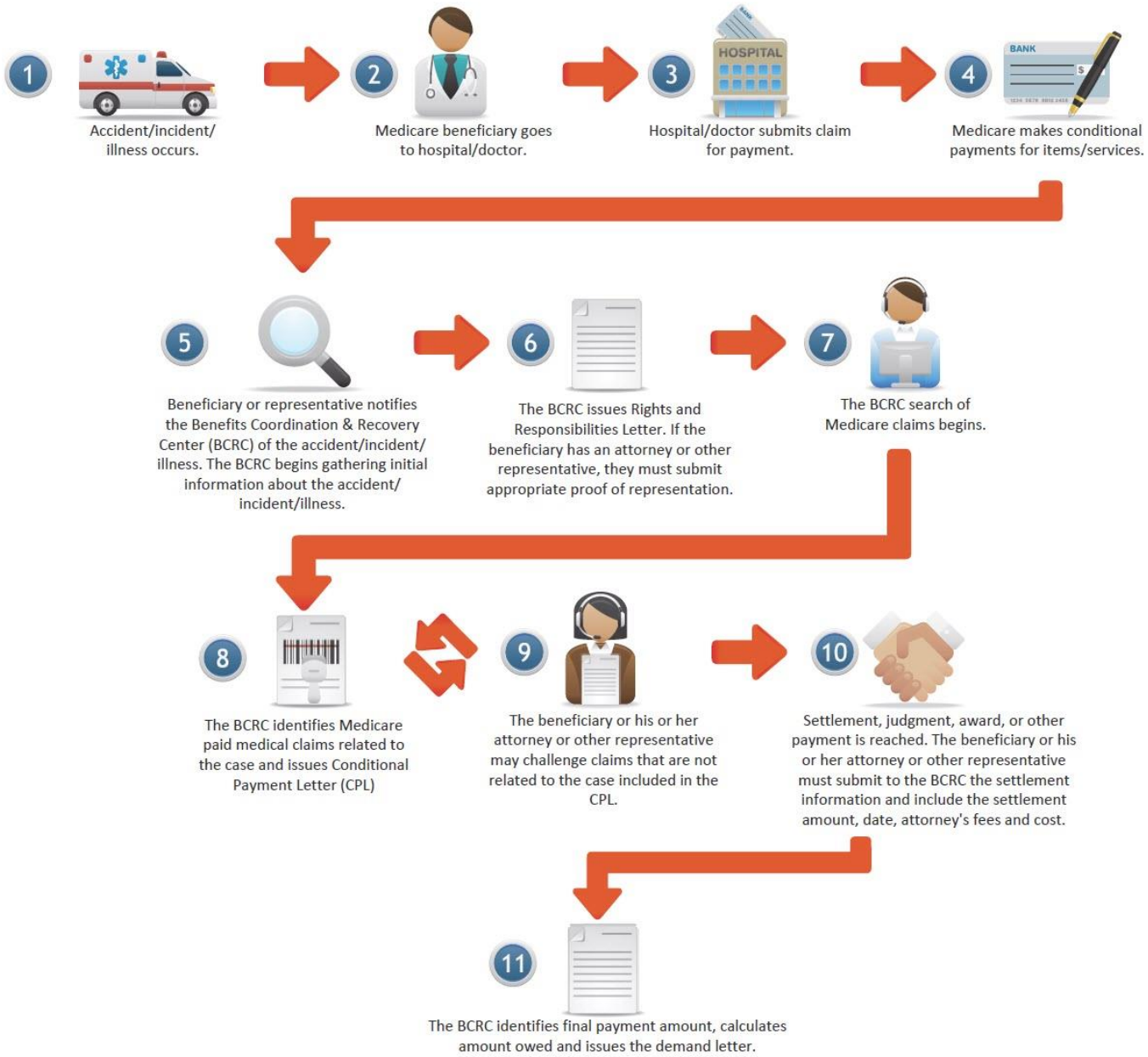
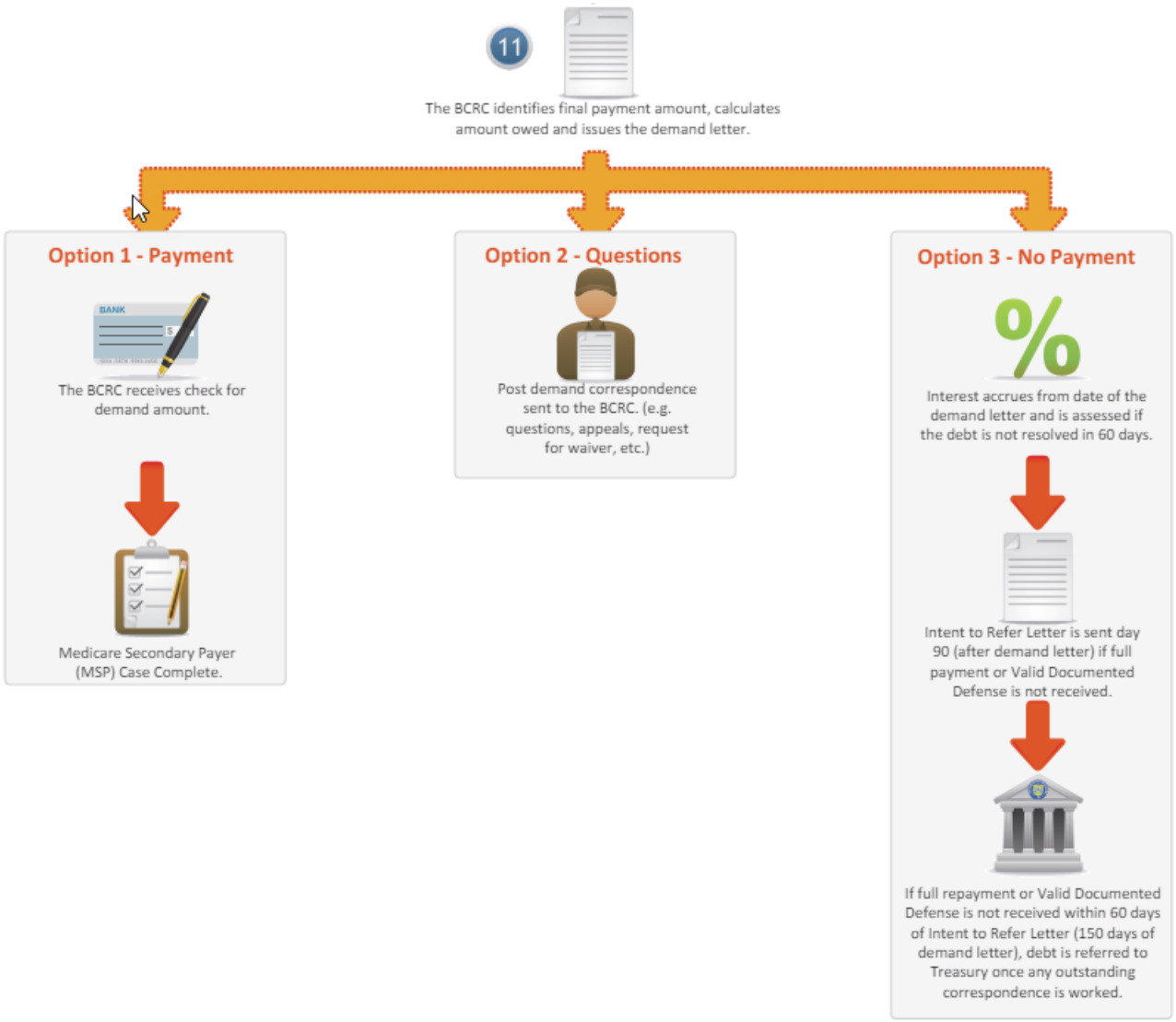


Figure 2: Flowchart, page 2



Appendix B: Sample Appeal Submission

Cover Letter (Sample)

[Written on law firm letterhead of the identified debtor]

[Date]

To: Medicare Benefits Coordination and Recovery Center
NGHP
PO Box 138832
Oklahoma City, OK 73113

Re: Our Client: Susan Smith
Case ID: 12345 12345 12345
Medicare ID: A12345678910
Date of Loss: January 01, 2024

Dear Third-Party Claims:

Please be advised that we are disputing two claims included in your {Month Day, Year} demand. These claims are related to a prior {claim}. Please see the attached payment summary form showing the disputed claims.

1. ICN 123456789, Line #, Provider {Fist Last Name}, Conditional Payment $12.34
2. ICN 987654321, Line #, Provider {First Last Name}, Conditional Payment $123.45

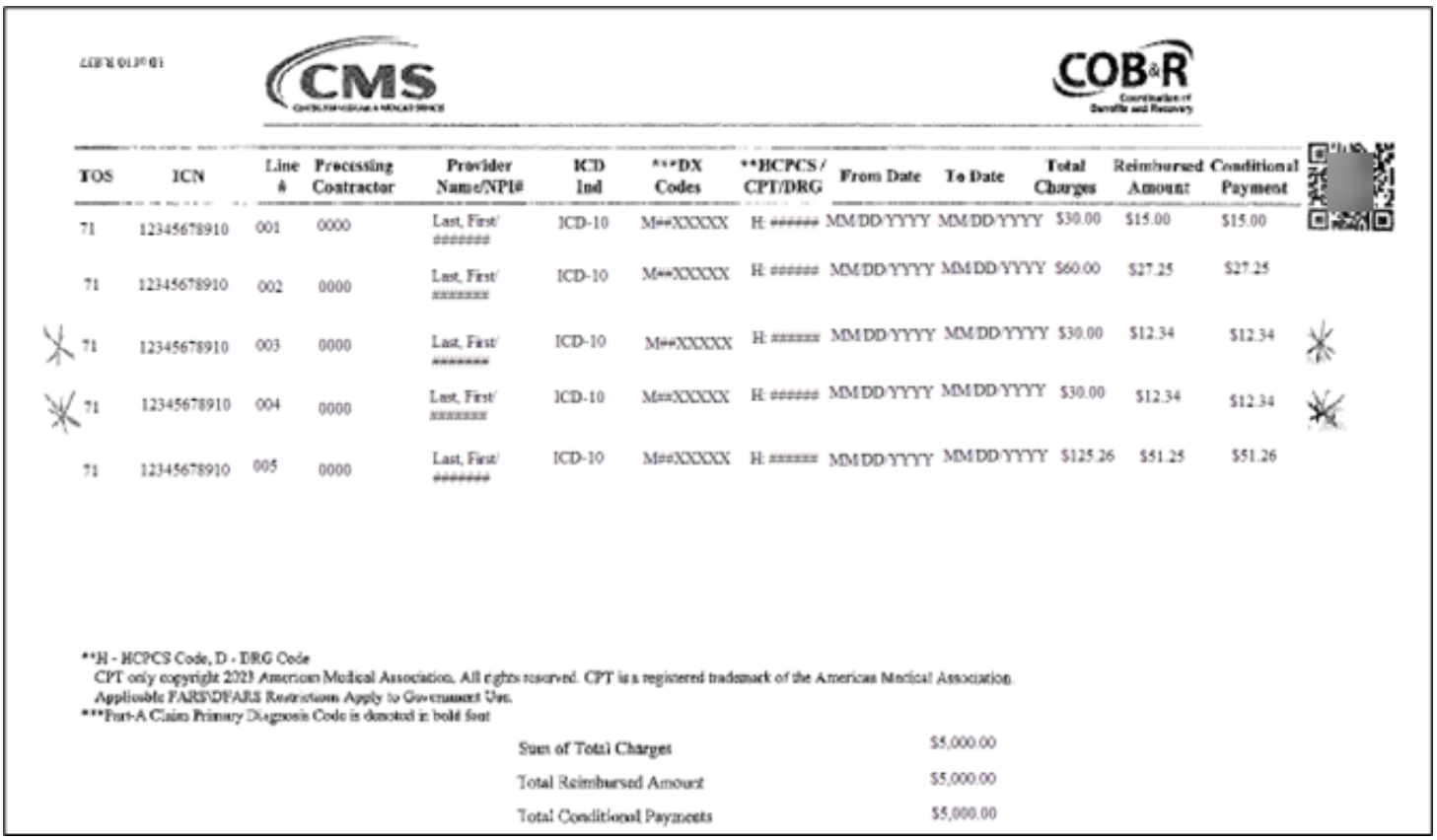
In support of the dispute, attached are the medical records for the disputed claims, as well as a copy of our demand letter showing the treatment was not included.

As we have already reimbursed Medicare for these claims, please provide a refund to our office payable to "Susan Smith."

If you have any questions or need additional information, please let me know.

Sincerely,

[Partner Name]
[Title]
[Contact information of the person issuing the correspondence]



CMS

COB&R

TOS	ICN	Line #	Processing Contractor	Provider Name/NPI#	ICD Ind	***DX Codes	**HCPCS / CPT/DRG	From Date	To Date	Total Charges	Reimbursed Amount	Conditional Payment
71	12345678910	001	0000	Last, First/ #######	ICD-10	M**XXXXX	H: ######	MM/DD/YYYY	MM/DD/YYYY	$30.00	$15.00	$15.00
71	12345678910	002	0000	Last, First/ #######	ICD-10	M**XXXXX	H: ######	MM/DD/YYYY	MM/DD/YYYY	$60.00	$27.25	$27.25
71	12345678910	003	0000	Last, First/ #######	ICD-10	M**XXXXX	H: ######	MM/DD/YYYY	MM/DD/YYYY	$30.00	$12.34	$12.34
71	12345678910	004	0000	Last, First/ #######	ICD-10	M**XXXXX	H: ######	MM/DD/YYYY	MM/DD/YYYY	$30.00	$12.34	$12.34
71	12345678910	005	0000	Last, First/ #######	ICD-10	M**XXXXX	H: ######	MM/DD/YYYY	MM/DD/YYYY	$125.26	$51.25	$51.26

**H - HCPCS Code, D - DRG Code

***Part-A Claim Primary Diagnosis Code is denoted in bold font

Sum of Total Charges	$5,000.00
Total Reimbursed Amount	$5,000.00
Total Conditional Payments	$5,000.00

Settlement Offer Letter (Sample)

[Written on law firm letterhead of the beneficiary's legal representative]

[Date]

[Insurer Name]
[Insurer Address 1]
[Insurer Address 2]
[City], [State] [Zip]

Re: Our Client: Susan Smith
Date of Loss: January 01, 2024
Claim No.: 123456789

Dear [Insurer Name]:

This office represents Susan Smith for injuries sustained on January 01, 2024. All communication regarding this claim should be directed through this office. This letter and its contents are being submitted to you for settlement purposes and is not admissible should this matter proceed to litigation.

GENERAL CLIENT INFORMATION

Date of Birth:	MM/DD/YYYY
Sex:	Female
Current Medical Specials:	$20,000.25
Date of First Treatment:	MM/DD/YYYY

ENCLOSURES

Exhibit 1: Police Report

Exhibit 2: Medical Billing Summary

Exhibit 3: Pictures of Property Damage

Exhibit 4: The Clinic Bills

Exhibit 5: The Clinic Records

FACTS OF COLLISION AND LIABILITY

On January 01, 2024, Ms. Smith was driving approximately ##mph on {Street Name} in {City, State}. As she was slowing down for traffic, she was rear-ended by a Ford F-150 truck. Mr. John Doe was driving the truck when he attempted to stop and avoid the collision. The truck's brakes locked up and he was unable to avoid striking Ms. Smith's vehicle.

PROPERTY DAMAGE

Ms. Smith's 2008 Ford Fiesta was totaled because of the collision.

MEDICAL TREATMENT

ICD-10	**Summary of Injuries**
M##XX	Long Description
R###XX	Long Description
S##XXX	Long Description
V##XXXX	Long Description
Z##XXX	Long Description

Treatment

Primary Care Appointments

Physiatry Appointments

Neurosurgery Appointments

Imaging/Testing

X-Rays Joints (MM/DD/YYYY)

X-Rays Thoracic Spine (MM/DD/YYYY)

MRI Thoracic Spine (MM/DD/YYYY)

MRI Cervical Spine (MM/DD/YYYY)

CT Head (MM/DD/YYYY)

Procedures

Left C7 Injection (MM/DD/YYYY)

Left SI Joint Injection (MM/DD/YYYY)

Left SI Joint Injection (MM/DD/YYYY)

Clinic Name

Dates of Treatment: MM/DD/YYYY to MM/DD/YYYY

On January 02, 2024, the day following the collision, Ms. Smith presented to her primary care physician {Physician First Last Name, MD} at {Clinic Name}. She reported {detail symptoms} immediately after the collision. At the time of her appointment, she reported {detail symptoms}.

{Dr. Last Name} diagnosed Ms. Smith with neck, back, and hip strain, and recommended {detail recommendations}. They prescribed {medication name and dosage} as needed for muscle spasms and recommended {medication name} for pain relief.

Ms. Smith returned to see {Dr. Last Name} on {Month Day, Year}. She reported worsening symptoms since her last visit with pain in her back and left SI joint, as well as new headaches, nausea, and memory issues. X-rays of the thoracic spine and joints were performed, and no fractures or abnormalities were found. {Dr. Last Name} ordered a CT of the head for possible concussion and referred Ms. Smith to physiatry. The CT was performed on {Month Day, Year} and was normal.

Ms. Smith saw {First Last Name, MD} at {Clinic Name} on {Month Day, Year}. She reported {detail symptoms}. She also reported concussion symptoms, including chills, nausea, and difficulty finding words, as well as soreness in her left hip. Exams found Ms. Smith had {detail findings}. {Dr. Last Name} ordered thoracic and cervical spine MRIs.

The thoracic spine MRI was performed on {Month Day, Year} and demonstrated: 1) Worsening of now moderate to severe decreased disc height. 2) Small posterior disc protrusions at {anatomical location}. 3) No significant change in moderate to severe left foraminal narrowing with contact of the nerve root.

The cervical spine MRI was performed on {Month Day, Year} and demonstrated: 1) Mild central canal narrowing. 2) Severe left and moderate narrowing.

SPECIAL DAMAGES

Current Medical Expenses

Ms. Smith has incurred medical expenses for treatment of the injuries sustained in this collision. The total incurred medical expenses in the amount of $20,000.25 are as follows:

Date	Provider	Amount
MM/DD/YYYY to MM/DD/YYYY	Clinic Name	$5,000.10
MM/DD/YYYY to MM/DD/YYYY	Medical Center	$15,000.15

GENERAL DAMAGES

Ms. Smith experienced a tremendous amount of pain and dysfunction because of the collision. The pain caused her discomfort with almost all activities of daily living, such as standing, bending over, lifting, and lying down. Despite over a year of treatment, including numerous injections, Ms. Smith continues to suffer from pain. The joint injections have not offered any permanent relief.

The factors considered for general damages are the points mentioned throughout this letter as well as the factors noted in the {State Instructions}.

SETTLEMENT PROPOSAL

For the above reasons, Ms. Smith requests that you evaluate her claim. We will be calling soon to confirm that you have received this demand package and to discuss whether this matter can be resolved without the need for litigation.

Please contact me should you wish to discuss the matter further.

Sincerely,

[Partner Name]

[Title]

[Partner contact information]

Physician Progress Note (Sample)

[Written on physician letterhead]

Patient Name:	Susan Smith
Date of Birth:	MM/DD/YYYY
Medical Record Number:	12345678910
Date of Service:	MM/DD/YYYY

CHIEF COMPLAINT

Provide patient's complaint.

HISTORY OF PRESENT ILLNESS

Provide patient's history of present illness.

PAST MEDICAL HISTORY, FAMILY HISTORY, WORK HISTORY, ALLERGIES, SOCIAL HISTORY, and REVIEW OF SYSTEMS

Reviewed with patient and documented on intake form.

CURRENT MEDICATIONS

Medication prescribed by other providers was reviewed and is documented.

RECORD REVIEW

Patient's referring doctors' notes, past visits, previous physical therapy, and past interventions are reviewed and documented.

IMAGING REVIEW

X-ray dated MM/DD/YYYY

SOCIAL HISTORY

Provide patient's history.

REVIEW OF SYSTEMS

Provide review.

PHYSICAL EXAMINATION

Provide details of patient's physical exam.

IMPRESSIONS

Provide details of impressions.

PLAN

Provide detailed plan for patient's treatment.

DISCUSSION

Explained diagnosis and treatment plan with patient.

PROCEDURES

Provide details pertaining to procedures completed.

ADDITIONAL DOCUMENTATION

Provide additional documentation. Possible examples include:

- Orders placed
- Medication changes
- Medications administered
- Visit diagnoses
- Referrals

[Physician Name, MD]

Appendix C: Sample Documents

Proof of Representation Sample Language

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Note: If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit https://go.cms.gov/cobro for further instructions.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

Individual other than an Attorney:

_____

( ) Attorney

( ) Guardian

( ) Conservator

( ) Power of Attorney

Name: _____

Relationship to the Beneficiary: _____

Firm or Company Name: _____

Address: _____

Address Line 2: _____

City/State/ZIP: _____

Telephone: _____

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name: _____
(please print exactly as shown on your Medicare card)

Beneficiary's Medicare ID (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a
liability insurance, no-fault insurance, or Workers' Compensation claim: _____

Beneficiary's Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____

Consent to Release Sample Language

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier ( ) Other _____

Name of entity: _____

Contact for above entity: _____

Address: _____

Address Line 2: _____

City/State/ZIP: _____

Telephone: _____

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION

(The period you check will run from when you sign and date below.):

( ) One Year ( ) Two Years ( ) Other _____

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit https://go.cms.gov/cobro for further instructions.

Medicare ID (The number on your Medicare card.): _____

Date of Injury/Illness: _____

Rights and Responsibilities Letter

Date

Insert name
Insert address 1
Insert address 2
Insert city, state, ZIP code

SUBJECT: Medicare Secondary Payer Rights and Responsibilities
Beneficiary Name:
Medicare ID:
Case Identification Number:
Insurer Claim Number:
Insurer Policy Number:
Date of Incident:

Dear [Addressee Name]

You are receiving this letter because we were notified that you filed a liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. This is confirmation that a Medicare Secondary Payer (MSP) recovery case has been established in our system. The enclosed brochure will provide information pertinent to the Medicare recovery process. Please retain this brochure for your future reference.

You can also keep track of your Recovery case by visiting the Medicare Secondary Payer Recovery Portal (MSPRP). To access your Recovery case, please log into your account on http://www.Medicare.gov or visit http://go.cms.gov/msprp to learn more about the MSPRP.

If we know that you have a lawyer or other person representing you, we have sent him or her a courtesy copy of this letter and you will see him or her listed as a "cc" at the end of this letter.

What Happens When You Have Medicare and You File a Liability Insurance (including Self- Insurance), No-Fault Insurance, or Workers' Compensation Claim

Applicable Medicare law says that liability insurance (including self-insurance), no-fault insurance, and workers' compensation must pay for medical items and services before Medicare pays. This law can be found at 42 U.S.C. Section 1395y(b)(2)(A) and (B). However, Medicare makes "conditional payments" (payments made to make sure you get the medical services you need while your insurance or workers' compensation claim is being processed).

Later, if you get a(n) insurance or workers' compensation settlement, judgment, award, or other payment, Medicare is entitled to be repaid for the items and services for whit it made these conditional payments. If Medicare determines it must be reimbursed for conditional payment, you will get a demand letter. The demand letter explains how Medicare calculated the amount it needs to be repaid and it also explains your appeal and waiver rights. If you decide to appeal or request a waiver of recovery. Medicare will not take any collection action while your appeal or waiver of recovery request is being processed at any level of review. Please note, however, that interest will continue to accrue on any unpaid balance.

The enclosed brochure explains Medicare's recovery process in more detail and what information we need to work with your attorney or other representative, if you have one. There are also two special streamlined recovery processes outlined below.

1. **Fixed Percentage Option for Repayment:** If you experienced a physical trauma-based injury and you get a liability insurance settlement, judgement, award, or other payment of $10,000 or less, Medicare offers the option to pay 25.000% of your gross settlement, judgement, award, or other payment, instead of the amount that Medicare would otherwise calculate.

   If you wish to choose this option, you must formally elect it, at the same time that you send us information on your settlement, judgement, award, or other payment. Please visit the Beneficiary (http://go.cms.gov/beneficary) or Attorney (http://go.cms.gov/attorney) sections of the BCRC website for all of the additional details. You will find model language that can be used to elect this option, as well as a special mailing address to ensure efficient processing.

2. **Self-Calculation Option for Medicare's Final Conditional Payment Amount:** if you experienced a physical trauma-based injury, can demonstrate that treatment has been completed, and you expect to get a settlement of $25,000 or less, you may calculate Medicare's Conditional Payment Amount to help us expedite resolution of your case. Please visit the Beneficiary (http://go.cms.gov/beneficary) or Attorney (http://go.cms.gov/attorney) sections of the BCRC website for all of the additional details.

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired), in writing at the address below, or by fax to 405-869-3309.

Sincerely,

BCRC

Enclosure: Correspondence Cover Sheet
Benefits Coordination & Recovery Center Brochure

CC:

Final Settlement Detail Document

Beneficiary Name:
Medicare Number:
Date of Incident:
Case Identification Number:

Please supply the information outlined below to help Medicare to properly calculate the amount it is due. This information will also be used to update your records.

Total Amount of the Settlement: _____

Total Amount of Med-Pay or PIP: _____

***only if paid directly to the beneficiary or the beneficiary's representative*

Attorney Fee Amount Paid by the Beneficiary: _____

Additional Procurement Expenses Paid by the Beneficiary: _____

(Please submit an itemized listing of these expenses)

Date the Case Was Settled: _____/_____/_____

Description of Injuries: _____

Name of person who is providing this information: _____

Relationship with the Beneficiary: _____

This information should be submitted to:

NGHP
PO Box 138832
Oklahoma City, OK 73113

If you have any questions concerning this matter, please contact the Benefit Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired), in writing at the address above, or by fax to 405-869-3309. When sending correspondence, please include the Beneficiary Name along with the Medicare and Case Identification Numbers (shown above)

Self-Calculated Conditional Payment Amount Model Language

All Information Is Required Unless Inapplicable

Self-Calculated Conditional Payment
PO Box 138880
Oklahoma City, OK 73113

Dear Benefits Coordination & Recovery Center (BCRC):

I expect to receive a physical trauma-based liability insurance settlement for approximately $_____ and I would like to calculate my Final Conditional Payment Amount (CPA). I have calculated my Final CPA to be $_____, which is supported by the documentation I am enclosing with this letter.

Beneficiary Name: _____ Date of Incident: _____/_____/_____

Medicare Number: _____

I certify that the following statements are true:

- I expect to receive a liability insurance settlement for $25,000.00 or less for a physical trauma-based injury. (The injury did not relate to ingestion, exposure, or a medical implant.)
- My incident/injury occurred at least six (6) months ago.
- My medical treatment related to my case is finished and I am able to demonstrate this in one of
- two ways: (Please check one.)

  ☐ I have included a physician attestation; OR

  ☐ I certify that I have not had care related to my case within the last 90 days and expect no further care.

- I have included all Medicare covered and reimbursable items and/or services related to my case (what was claimed or released). I have not knowingly disregarded related items or services that have been or will be provided through the date of settlement.
- I understand that if my self-calculated amount is accepted, I will be required to give up my right to appeal the amount or existence of the debt.

  I have not received and do not expect to receive any other liability insurance settlements, judgments, awards, or other payments related to the incident referenced above. If I receive any, I will notify Medicare because Medicare may have an additional recovery claim.

Sincerely,

Beneficiary Signature _____Date: _____

Attorney or Representative Printed Name: _____

* Attorney or Representative Signature: _____ Date: _____

* If the attorney or representative signs and the beneficiary does not sign, a proper authorization must be on file or included with the Self Calculation documents in order for the Self-Calculated Amount to be reviewed.

☐ Check here if you do not have an attorney or other representative.

Self-Calculated Conditional Payment Amount Proposal Cover Sheet

All Information Is Required Unless Inapplicable

Please place a Y (yes, related to the case) or N (no, not related to the case) next to each claim on Medicare's Payment Summary Form. Add any additional claims not already included on the sheet. Include a TOTAL labeled Self-Calculated Conditional Payment Amount. Provide a brief description of the injury and an explanation for any claims you labeled with a "N" as not being related to the case.

Brief Description of Injury:

_____

_____

_____

Explanation for Disputed Claims: *(If you have more than one explanation, please provide the date range for each explanation.)*

Example: Claims with dates between January 1, 2010, and September 13, 2010, were for back surgery but my case is for a sprained knee.

_____

_____

_____

_____

_____

_____

Fixed Percentage Option Model Language

ALL INFORMATION IS REQUIRED

Fixed Percentage Option
P.O. Box 138880
Oklahoma City, OK 73113

Dear Benefits Coordination & Recovery Center (BCRC):

I received a *liability insurance* settlement for $ _____ and I choose the fixed payment option to repay Medicare. My payment will be $ _____, which is 25% of my **total** settlement amount. (Note: Do not reduce the total settlement amount for attorney fees and costs.)

Beneficiary Name: _____ Date of Incident: _____

Medicare Number: _____ Date of Settlement: _____

Brief Description of Injury:

_____

_____

I certify that the following statements are true:

- I have received a liability insurance settlement for $10,000 or less.
- I have not received any other bill or request for payment from Medicare related to this liability insurance settlement.
- I agree to pay $ _____, which is 25% of my total settlement.
- I understand that, as part of choosing the option, I have given up my right to appeal the fixed payment amount or request a waiver of recovery.
- The injury that I alleged was a physical trauma-based injury. (This means that it did not relate to ingestion, exposure, or a medical implant.)
- I have not gotten and do not expect to get any other settlements, judgments, awards, or other payments related to the incident referenced above. (However, if I receive any, I will notify Medicare because Medicare may have an additional recovery claim.)

Check One:

☐ I have included a check or money order for $ _____ made out to Medicare. This amount is 25% of my total settlement. I have included my name and Medicare number on the check or money order.

☐ I have NOT included payment and will pay once I receive the bill.

Sincerely,

Name: _____ Date: _____

☐ Please check if you are an attorney or representative signing for a beneficiary. In order to sign for the beneficiary, you MUST submit with this form (or have previously submitted) a valid proof of representation (model language is available on the CMS.gov website at Medicare's Recovery Process).

Appendix D: Glossary

Beneficiary—Here, someone who benefits from Medicare.

Claim—A medical bill.

Compromise—A request for Medicare to reduce the amount owed.

Conditional payment—A payment Medicare made on condition that it is repaid by the responsible party—the true primary payer, in this case your settlement; in the case of a group health insurance plan, the insurer.

Demand—A request for repayment.

Initial determination—First decisions; in the MSP context, this means demand letters and waiver determinations.

Offset—The debt amount taken out of or "offset from" some other amount, such as a Social Security payment or tax refund.

Payer—A person or entity responsible for medical bill payment; in MSP, we usually mean insurers or insurance carriers, but in NGHP MSP, we mean your settlement.

Primary payer—The insurer, or in this case, settlement, that pays a medical bill first.

Recovery—The process by which Medicare seeks to be repaid for a conditional payment.

Redetermination—A decision reconsidered; in this case, the first level of appeal.

Secondary payer—The insurer, or in this case, settlement, that pays after the primary payer, usually for things like coinsurance or copayments.

Waiver—A request for Medicare to waive recovery of (that is, not take back) all or part of the demand amount.

Appendix E: Acronyms

Table E-1: Acronyms

Term	Definition	First Discussed
AdQIC	Administrative Qualified Independent Contractor	3.2.1
ALJ	Administrative Law Judge	3.2.1
BCRC	Benefits Coordination & Recovery Center	2.0
CMS	Centers for Medicare & Medicaid Services	3.2.1
CPL	Conditional Payment Letter	2.6
CPN	Conditional Payment Notice	2.7
CRC	Commercial Repayment Center	2.0
CTR	Consent to Release	2.5
DAB	Departmental Appeals Board	3.2.1
HHS	Health and Human Services	3.2.1
MBI	Medicare Beneficiary Identifier	2.3
MSP	Medicare Secondary Payer	1.0
MSPRP	Medicare Secondary Payer Recovery Portal	2.6
NGHP	Non-Group Health (insurance) Plan	1.0
POR	Proof of Representation	2.5
PSF	Payment Summary Form	2.6
QIC	Qualified Independent Contractor	3.2.1
RAR	Rights and Responsibilities	2.0
WCMSA	Workers' Compensation Medicare Set-Aside Agreement	2.1