**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**Division of Financial Management and Fee for Service Operations, Region VI**

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# Medicare Secondary Payer Procedural Guidance

I have found that a basic understanding of a few topics usually helps reduce the frustration of working through the complex program we call Medicare Secondary Payer. This handout is intended to provide information and tips that will help you with this process. It is not an official statement of policy.

Please read this information carefully because it details information which will serve you well as you work to resolve your client's case. It provides the steps and contact information you will need. Finally, it provides information on the recent transition of Medicare Secondary Payer (MSP) recovery work to the national Medicare Secondary Payer Recovery Contractor (MSPRC).

For those wishing to obtain interim conditional payment amounts and proceed to the final determination of the amount due Medicare relative to a settlement, judgment, award or other payment, the following information should be of great value.

Effective **January 8, 2001**, all notifications of Medicare as a Secondary Payer in liability, no-fault and workers' compensation cases **must be directed to:**

MEDICARE – Coordination of Benefits Contractor
MSP Claims Investigation Project
P.O. Box 33847
Detroit, MI 48232

By telephone, they can be reached at (800) 999-1118. ***This notification should be made at the onset of all cases*.**

All notifications should include:

- the full name, address and date of birth of the Medicare beneficiary
- the Health Insurance Claim Number of the Medicare beneficiary (not always the same as their Social Security Number)
- date of incident/ingestion/exposure
- the full name, address and telephone number of plaintiff's counsel
- the full name, address and telephone number of defendant's counsel
- the full contact information of the workers' compensation board or office
- the full name, address and telephone number of any involved insurance company (provide their representative/agent and claim/policy number(s) if known)
- a detailed listing of the claimed injuries or medical problems **and** the date of incident

- product brand name and manufacturer if it is a product liability case – this information should be given to both the COBC and to the MSPRC

**If the case involves product liability with a global settlement or a multi-jurisdictional, or multi-client global product liability settlement/judgment/award please contact Sally Stalcup at the phone number below before you contact the COBC.**

**My recommendation is that you notify the COB contractor *by telephone*.** If they require clarification, or additional information, they will be able to request it during your call and you will be able to conclude that call knowing that your case file has been established. Please document your records with the date and name of the individual you speak with.

The COB will conduct the initial research and assign jurisdiction for all cases to the MSPRC. Once assigned jurisdiction by the COB, the actual case work will be with the MSPRC.

Effective for cases established on or after October 1, 2009, the "Right to Recovery Letter" issued when a claim for liability insurance (including self-insurance), no-fault insurance, or workers' compensation is reported to CMS' Coordination of Benefits Contractor (COBC) will no longer be issued by the COBC. The letter has been revised, renamed (it is now the "Medicare Secondary Payer Rights and Responsibilities" letter) and will be issued by the MSPRC. Note: If you received a "Right to Recovery Letter" issued by the COBC and dated on or before September 30, 2009, you may follow the instruction in that letter regarding submitting a "Consent to Release" document.

Effective **October 2, 2006**, the Centers for Medicare & Medicaid Services (CMS) transitioned all Medicare Secondary Payer (MSP) recovery workloads to a national Medicare Secondary Payer Recovery Contractor (MSPRC). All attorneys, beneficiaries, and insurance companies now contact the MSPRC to discuss updated conditional payment amounts, provide settlement information and work on any issue to bring their cases to closure. Their contact information is provided below.

After your notification to the COBC, please fax a copy of the completed Proof of Representation or Consent to Release (see www.MSPRC.info) to the MSPRC at (734) 957-0998.

Effective October 1, 2009, the MSPRC will issue information concerning interim conditional payment amounts automatically (that is, without receiving a request for such information) as soon as an interim conditional payment amount is available. For those who had an outstanding request for a conditional payment letter (CPL) for a case established prior to October 1, 2009, the request was processed in the order received. For all new cases, the Medicare beneficiary and any authorized individuals will receive the CPL within 65 days of the issuance of the "Rights and Responsibilities Letter." Please refer to the discussion in the "Rights and Responsibilities Letter" or the "Rights and Responsibilities Brochure" for further information. See www.MSPRC.info

If authorized by a valid Proof of Representation or Consent to Release, the MSPRC will contact counsel for the Medicare beneficiary when the requested information is available. Absent a

valid Proof of Authorization or Consent to Release all requested information will be provided to the Medicare beneficiary.

Upon your receipt of the claim listing from the MSPRC, the attorney and the Medicare beneficiary, or their legal representative, should review that listing to identify any payments which were not related to the incident and/or related to what was claimed and/or released in the settlement, judgment, or award, and notify Medicare of the result of that review. You may fax your response to the MSPRC at (734) 957-0998. Be sure to include the Medicare beneficiary's name, Medicare number and the date of incident. The MSPRC must also be notified immediately upon settlement by provision of specific settlement information such as the total amount of recovery from all sources, the date of all settlements, along with the attorney fees and case expenses. You can find a suggested form for use in providing the MSPRC with this information at www.MSPRC.info. Approximately two weeks after faxing this information to their office, please call the MSPRC at (866) 677-7220 and request a final demand. Within approximately 45 days, the MSPRC will issue a demand for payment which will include payment instructions. Prior to the beneficiary's settlement of the case there is potential debt to the Medicare program but not real debt and a demand cannot be issued and waiver cannot be considered.

All work is addressed on a first-in first-out basis and multiple requests do not expedite a case. However, a phone call to their office a couple of weeks after faxing any documentation to their office may help keep your case on track.

If your client receives assistance from the state (Medicaid), their subrogation department should be contacted to determine their recovery interest.

The national recovery contractor is:

MSPRC Liability
P.O. Box 138832
Oklahoma City, OK 73113
Telephone: 1-866-MSP-RC20 (1-866-677-7220)
Fax (734) 957-0998

Reminder: Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines liability insurance. Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those funds are available to pay for future services related to what was claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered by Medicare.

**Special Alert**

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), adds new mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8) add reporting rules but do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment.

For detailed information about Mandatory Insurer Reporting please visit our website at www.cms.hhs.gov/MandatoryInsRep.

Thank you for your ongoing cooperation. If you have any questions about this information, please feel free to call me at (214) 767-6415.

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