CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB&R
Coordination of Benefits and Recovery

Introduction to Medicare Secondary Payer (MSP) for Beneficiary Representatives

March 27, 2025

Slide 0: Introduction to Medicare Secondary Payer (MSP) for Beneficiary Representatives Webinar

Welcome to the Introduction to Medicare Secondary Payer for beneficiary representatives webinar.

Presentation Overview

- Definition & Background
- MSP & COB
- Recovery Basics
- Recovery Process
- Medicare Secondary Payer Recovery Portal
- Additional Resources
- Questions & Answers

Slide 1: Presentation Overview

The intention of this webinar is to serve as a high-level introduction to Medicare Secondary Payer (MSP) for beneficiaries and their representatives.

During this presentation we will talk about what MSP is including coordination of benefits, MSP types, the basics of the recovery process including the Medicare Secondary Payer Recovery Portal. We will also provide you with additional resources that are available to you to provide more in-depth guidance and then open the call up for questions and answers.

MSP Definitions

MSP provisions can be found within Section 1862(b) of the Social Security Act

MSP:

- The term used when Medicare is not responsible for paying first on a healthcare claim.

Primary Payer:

- The term used to denote paying "first" for a given medical service or item when there are multiple parties that are obligated to make payment for that service or item.

Secondary Payer:

- Denotes paying after the primary payment obligation is satisfied. Medicare is the secondary payer to any entity required (or responsible) to make payment with respect to an item or service under a primary plan services that are also covered by Medicare.

Coordination of Benefits:

- Refers to the process of determining which entity pays primary, secondary, or tertiary on a claim

Slide 2: MSP Definitions

Let's start today by talking about what Medicare Secondary Payer or MSP means and looking at some definitions.

MSP is the term used when Medicare is not responsible for paying first on a healthcare claim.

Primary Payer is the term used to denote paying “first” for a given medical service or item when there are multiple parties who are obligated to make payment for that service or item.

Secondary Payer denotes paying after the primary payment obligation is satisfied. Medicare is the secondary payer to any entity required (or responsible) to make payment with respect to an item or service under a primary plan service that are also covered by Medicare.

Coordination of Benefits refers to the process of determining which entity pays primary, secondary, or tertiary on a claim. We will talk more about coordination of benefits in a moment.

MSP Types

Group Health Plan (GHP)

A type of health insurance coverage provided to a group of people, typically employees of an organization. This coverage is ongoing and covers a large range of benefits, including medical, dental, and vision coverage.

Non-Group Health Plan (NGHP)

For MSP, NGHP collectively refers to the following types of insurance:

- liability insurance (including self-insurance),
- no-fault insurance, and
- workers' compensation

These insurances are triggered by an event such as a car accident or work-related accident or illness and the coverage is limited to treatment related to that accident, injury or illness.

Slide 3: MSP Types

Now that we understand some basic terms, it is also important to know that MSP provisions apply to two broad categories of insurance: Group Health Plan (GHP) and Non-Group Health Plan (NGHP).

GHP is a type of health insurance coverage provided to a group of people, typically employees of an organization. This coverage is ongoing and covers a large range of benefits, including medical, dental, and vision coverage. The term GHP includes self-insured plans, plans of government entities (Federal, State, and local), and employee organization plans such as union plans, employee health and welfare funds, or other employee organization plans.

For MSP, NGHP collectively refers to the following types of insurance:

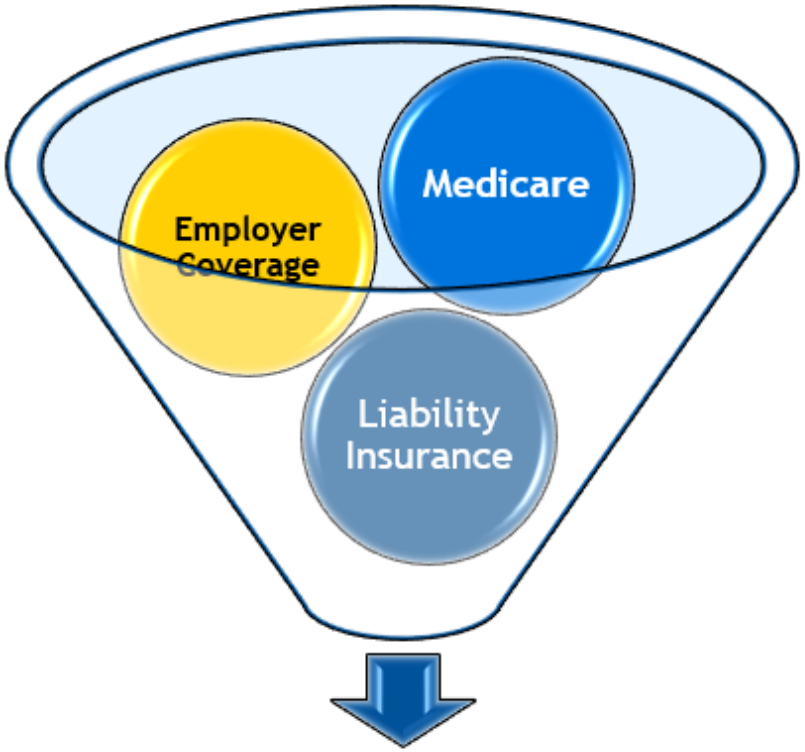
- liability insurance (including self-insurance),
- no-fault insurance, and
- workers' compensation

These insurances are triggered by an event such as a car accident or work-related accident or injury and the coverage is limited to treatment related to those accident or work-related injuries or illness.

For the purposes of this presentation, we will focus on Non-Group Health Plans.

Coordination of Benefits (COB)

- Coordination of Benefits is the collection of data to determine which entity pays primary on a claim and which pays secondary.



Coordination of Benefits

https://www.cms.gov/medicare/coordination-benefits-recovery/overview/coordination-benefits

Slide 4: Coordination of Benefits

As we already mentioned, the decision as to which entity is responsible for paying first on a claim and which entity pays second is known as coordination of benefits (COB).

Coordination of benefits plays an important role in MSP so that Medicare has the information it needs to determine if it should be the secondary payer.

Medicare collects data from multiple sources, through multiple processes for COB purposes. Many entities like Health Plans, Providers and even beneficiaries have a responsibility to help ensure Medicare payments are made in the proper order by being knowledgeable of and participating in the coordination of benefits processes.

More information can be found on the Coordination of Benefits page on CMS.gov.

Medicare's Right to Recovery

- CMS is responsible for protecting the Medicare program's fiscal integrity and ensuring that it pays only for those services that are its responsibility.
- MSP provisions make Medicare a secondary payer to NGHPs, including liability insurers (including self-insured entities), no-fault insurers, and workers' compensation entities.
- CMS has the right to recover any payments made by Medicare that should have been the responsibility of another payer.
- When such payments are identified, Medicare may recover from the insurer, the beneficiary, or any other entity receiving payments from the primary payer.
- **Important Note:** Medicare and MSP is governed by Federal law. Most Non-Group Health Plan policies are governed by State law. If there is a conflict between Federal and State law, Federal law takes precedence. If an insurance policy or plan has a provision that conflicts with Federal law, Federal law must be followed.

Slide 5: Medicare’s Right to Recovery

We have talked about MSP and COB now it is time to talk about the recovery process so let's walk through it step by step.

The first thing to know about recovery is that CMS is responsible for protecting the Medicare program's fiscal integrity and ensuring that it pays only for those services that are its responsibility. MSP provisions make Medicare a secondary payer to NGHPs, which include liability insurers (including self-insured entities), no-fault insurers, and workers' compensation entities. CMS has the right to recover Medicare payments made that should have been the responsibility of another payer.

When such payments are identified, Medicare may recover from the insurer, the beneficiary, or any other entity receiving payments from the primary payer.

For NGHP recovery, the identified debtor is typically a beneficiary who receives a settlement.

Another important thing to remember is that Medicare and MSP are governed by Federal law. While most Non-Group Health Plan policies are governed by State law.

If there is a conflict between Federal and State law, Federal law takes precedence. If an insurance policy or plan has a provision that conflicts with Federal law, Federal law must be followed.

The Medicare Recovery Contractors

Benefits Coordination & Recovery Center (BCRC):

- Recovery where the beneficiary is the identified debtor.
- Main contact for beneficiaries, their attorneys, or other representatives.

Commercial Repayment Center (CRC):

- Recovery where the identified debtor is not a beneficiary and includes all GHP recovery, NF and WC where the identified debtor is the applicable plan (ORM situations)
- Beneficiaries may receive or be copied on letters.

Slide 6: The Medicare Recovery Contractors

Now it's time to learn about the Contractors that Medicare uses in the recovery process.

The Benefits Coordination & Recovery Center (BCRC) is the main contractor that a beneficiary or their representative will interact with, and letters received from the BCRC (which we'll talk about shortly) usually require some response or action by the beneficiary or their representative. The BCRC is also responsible for collecting the information for coordination of benefits and for the recovery of debts where the beneficiary is the identified debtor.

The Commercial Repayment Center (CRC) is generally responsible for recovery where the identified debtor is not a beneficiary, this includes all GHP recovery and Workers' Compensation and No-Fault insurance recovery where the identified debtor is the applicable plan (generally in ORM situations).

Beneficiaries and their representatives will not generally directly interact with the CRC, but it is important to note that a beneficiary may receive or be copied on some CRC letters. These letters are for information purposes only and do not require any action from the beneficiary or their representative.

Since today's webinar is geared towards beneficiaries and their representatives, the rest of the webinar will focus on interactions with the BCRC.

The NGHP Trigger

Slide 7: The NGHP Trigger

NGHP recovery is kicked off by a trigger, that is an accident, injury or illness occurring.

Typically, when a beneficiary is involved in an accident/incident, they will file a claim with the appropriate NGHP insurer (liability, no-fault, or workers' compensation).

It is also 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 what is known as a conditional payment. Medicare's payment to the provider is conditional because it is made on the condition that it will be reimbursed by the Medicare beneficiary, when a settlement occurs. Medicare makes these payments to ensure that a beneficiary will be able to receive the care they need without interruption.

Reporting a Case to the BCRC

Information About…	Type of Information
Beneficiary	• Full name • Medicare Number (“Medicare Beneficiary Identifier,” or MBI) • Gender • 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
Attorney (if applicable)	• Attorney or law firm name • Complete address and phone number

Slide 8: Reporting a Case to the BCRC

Once a beneficiary has a pending liability, no-fault or workers' compensation case it needs to be reported to the BCRC. Let's look at the information that should be provided to the BCRC.

For the beneficiary include full name, Medicare number, gender, date of birth and full address and phone number.

Case information should include the claim type, insurance carrier name and address, description of the alleged injury or illness and the date of the incident.

Lastly if there is an attorney their name along with their address and phone number should be provided.

After the case has been reported, the BCRC will apply the information to the beneficiaries Medicare's record and a case is created.

The Rights and Responsibility (RAR) letter is issued to the beneficiary within 15 days of case creation.

The letter and the enclosed brochure explain what MSP is, the recovery process, the importance of sending authorization information to the BCRC should the beneficiary have an attorney or other representative, and where to go for more information.

A copy of the Rights and Responsibilities Letter can be found in the Download section of the Medicare's Recovery Process page on CMS.gov.

NGHP Recovery Authorization

Medicare and their contractors can't share personally identifiable information (PII) or personal health information (PHI) without the proper authorization.

Two (2) types of authorizations for beneficiary representatives:

- **Consent to Release (CTR):**
  - Allows an authorized party to receive copies of letters but does not allow the entity to make decisions on behalf of the beneficiary.

- **Proof of Representation (POR):**
  - Allows an authorized party to both receive copies of letters and to make decisions for the

Note: Model language for both the CTR and POR on the Medicare's Recovery Process Page on CMS.gov

Slide 9: NGHP Recovery Authorization

As mentioned in the RAR it is important for beneficiaries to understand authorizations.

Medicare and their contractors can't share personally identifiable information (PII) or personal health information (PHI) without proper authorization. If a beneficiary has an attorney or other representative assisting them with their case, they need to submit the proper authorization so that the BCRC can interact with those entities on behalf of the beneficiary.

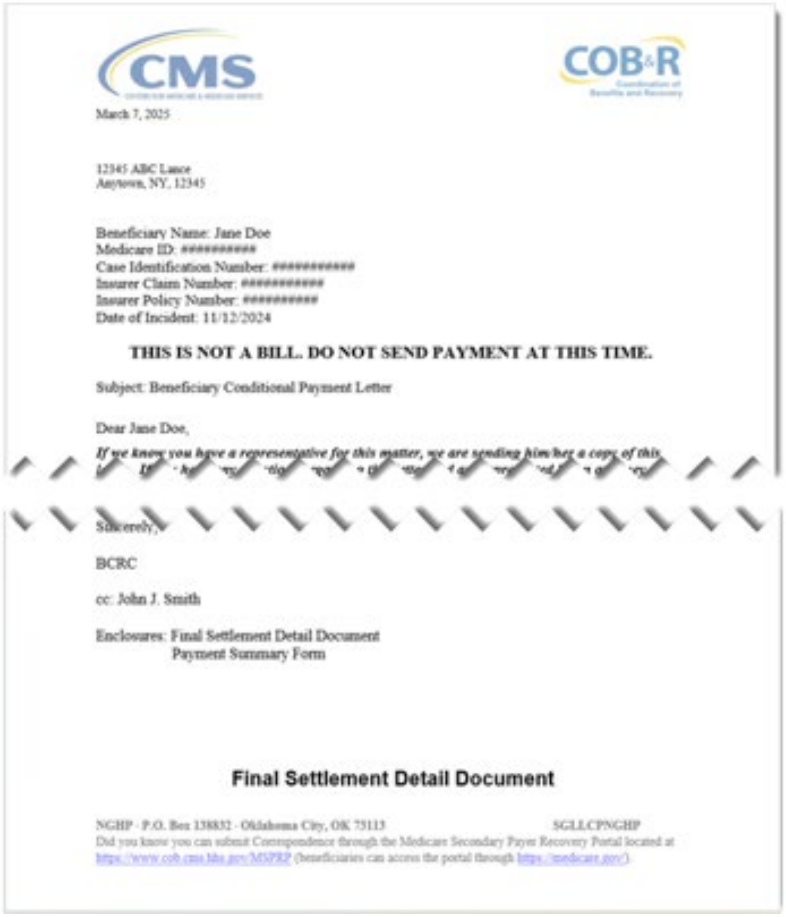
There are two types of authorizations available for beneficiary recovery cases: Consent to Release (CTR) and Proof of Representation (POR).

Consent to Release allows an authorized party to receive copies of letters but does not allow the entity to make decisions on behalf of the beneficiary.

Proof of Representation allows an authorized party to both receive copies of letters and to make decisions (e.g., appeal the debt) for the beneficiary.

Authorization should be submitted as soon as possible. Additional information about the CTR and POR along with model language for both can be found in the Download section of the Medicare's Recovery Process page on CMS.gov.

Conditional Payment Letter (CPL)



CMS

COB&R

March 7, 2025

12345 ABC Lane
Anytown, NY, 12345

Beneficiary Name: Jane Doe
Medicare ID: **********
Case Identification Number: **********
Insurer Claim Number: **********
Insurer Policy Number: **********
Date of Incident: 11/12/2024

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

Subject: Beneficiary Conditional Payment Letter

Dear Jane Doe,

If we know you have a representative for this matter, we are sending him/her a copy of this

Sincerely,

BCRC

cc: John J. Smith

Enclosures: Final Settlement Detail Document
Payment Summary Form

Final Settlement Detail Document

NGHP - P.O. Box 138832 - Oklahoma City, OK 73113 SGLLCPNGHP
Did you know you can submit Correspondence through the Medicare Secondary Payer Recovery Portal located at
https://www.cob.cms.hhs.gov/MSPRP (beneficiaries can access the portal through https://medicare.gov/).

CMS

COB&R

Final Settlement Detail Document

Beneficiary Name: <Insert Name>
Medicare ID: <Insert HICN>
Date of Incident: <Insert DOI>
Case Identification Number: <Insert Case ID>

General Information

If your settlement contains clauses for disability, indemnity, wage loss or any other non-economic reimbursements, please include the settlement release.

Total Amount of the Settlement: _____
Date the Case Was Settled: _____(mm/dd/yyyy)
Insurer Name: _____
Policy Number: _____
Description of Injuries: _____

Type of Settlement:
__No Fault/Med Pay/PIP
__Liability/Bodily Injury/ Under or Uninsured Motorist
__ Workers' Compensation

Attorney Information

Attorney Name: _____
Attorney Fee Amount Paid by the Beneficiary: _____
Additional Procurement Expenses Paid by the Beneficiary: _____
(Please submit an itemized listing of these expenses)
Name of the person who is providing this information: _____
Relationship to the Beneficiary: _____

Submit this information to:
NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for hearing/speech impaired).

NGHP - P.O. Box 138832 - Oklahoma City, OK 73113 SGLLCPNGHP
Did you know you can submit Correspondence through the Medicare Secondary Payer Recovery Portal located at
https://www.cob.cms.hhs.gov/MSPRP (beneficiaries can access the portal through https://medicare.gov/).

Slide 10: Coordination Payment Letter (CPL)

Now that the recovery process has started there several letters that can be sent to the beneficiary and their authorized representatives in the "pre-demand" process. The letters will be clearly marked with CMS logos and will identify which contractor it has come from. They will also tell you who has been copied (if anyone) and if there are enclosures along with the letter. We have included samples of the letters in the next few slides.

As soon as the 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.

The CPL does three things:

1. It notifies the beneficiary of the amount of their potential reimbursement responsibility to Medicare.
2. It allows them to dispute any claims they feel are not related to the case.
3. It provides a Final Settlement Detail document to be filled out and returned once a settlement has been reached.

It is important to know that the CPL is not a bill, it is the BCRC's best estimate of the amount for which Medicare will be seeking reimbursement.

The conditional payment amount is considered an interim amount because Medicare may make additional payments while the case is pending. A beneficiary or their representative can request updated conditional payment letters until a settlement has been reached.

These requests can be made via mail, fax or through the Medicare Secondary Payer Recovery Portal (MSPRP), which we will talk about more later.

Conditional Payment Notice (CPN)

March 7, 2025

1234 ABC Place
Anytown, NY 12345

CONDITIONAL PAYMENT NOTICE
This is NOT A BILL

Current Conditional Payment Amount: $5,102.67
RESPONSE DUE BY: 4/6/2025

Beneficiary Name: Jane Doe
Medicare ID: ##########
Date of Incident: 11/12/2024
Case Identification Number: ##########
Insurer Claim Number: ##########
Insurer Policy Number: ##########

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.
Please be advised the enclosed listing of current conditional payments may not be final.

Subject: Beneficiary Conditional Payment Notification

Dear Jane Doe

If we know you have a representative for this matter, we are sending him/her a copy of this letter. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us

This letter follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments for Medicare Part A and Part B Fee-for-Service claims have been made that we believe are related to your case for the Date of Incident (DOI) listed above.

The Centers for Medicare & Medicaid Services (CMS) has been notified that you have received a settlement, judgment, award, or other payment related to your case for the DOI listed above; therefore, these conditional payments are subject to reimbursement. If you fail to respond to this Conditional Payment Notice, or if after reviewing your response we still determine that Medicare has made conditional payments that must be repaid, you will get a demand letter. The demand letter will explain how Medicare calculated the amount it needs to be repaid. It also explains your appeal and waiver of recovery rights. If you paid attorney fees and costs in order to get your settlement, please send us an itemized list of those fees and costs by April 6, 2025. If we do not get this information by the due date, the demand amount will not be reduced by a share of your fees and costs.

Slide 11: Conditional Payment Notice (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 the beneficiary 30 calendar days to respond with any additional information relevant to the case before a demand (request for repayment) is issued.

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

Dispute Process

If a beneficiary believes that any claims included in the CPL or CPN are not related to the case and should be removed, they can dispute them.

The beneficiary, his or her attorney, or other representative can submit supporting documentation to the BCRC identifying claims that they believe should be removed from Medicare's interim conditional payment amount.

Disputes can be submitted via mail, fax, or on the MSPRP.

The BCRC will adjust the conditional payment amount to account for any claims it agrees are not related to the case.

Please allow 45 calendar days for the BCRC to review the submitted disputes and make a determination.

Slide 12: Dispute Process

After receiving the CPL or a CPN, if a beneficiary believes that any claims included in the CPL or CPN are not related to the case and should be removed, then they must notify the BCRC in writing.

This process can be handled via mail, fax, or internet submission via the MSPRP.

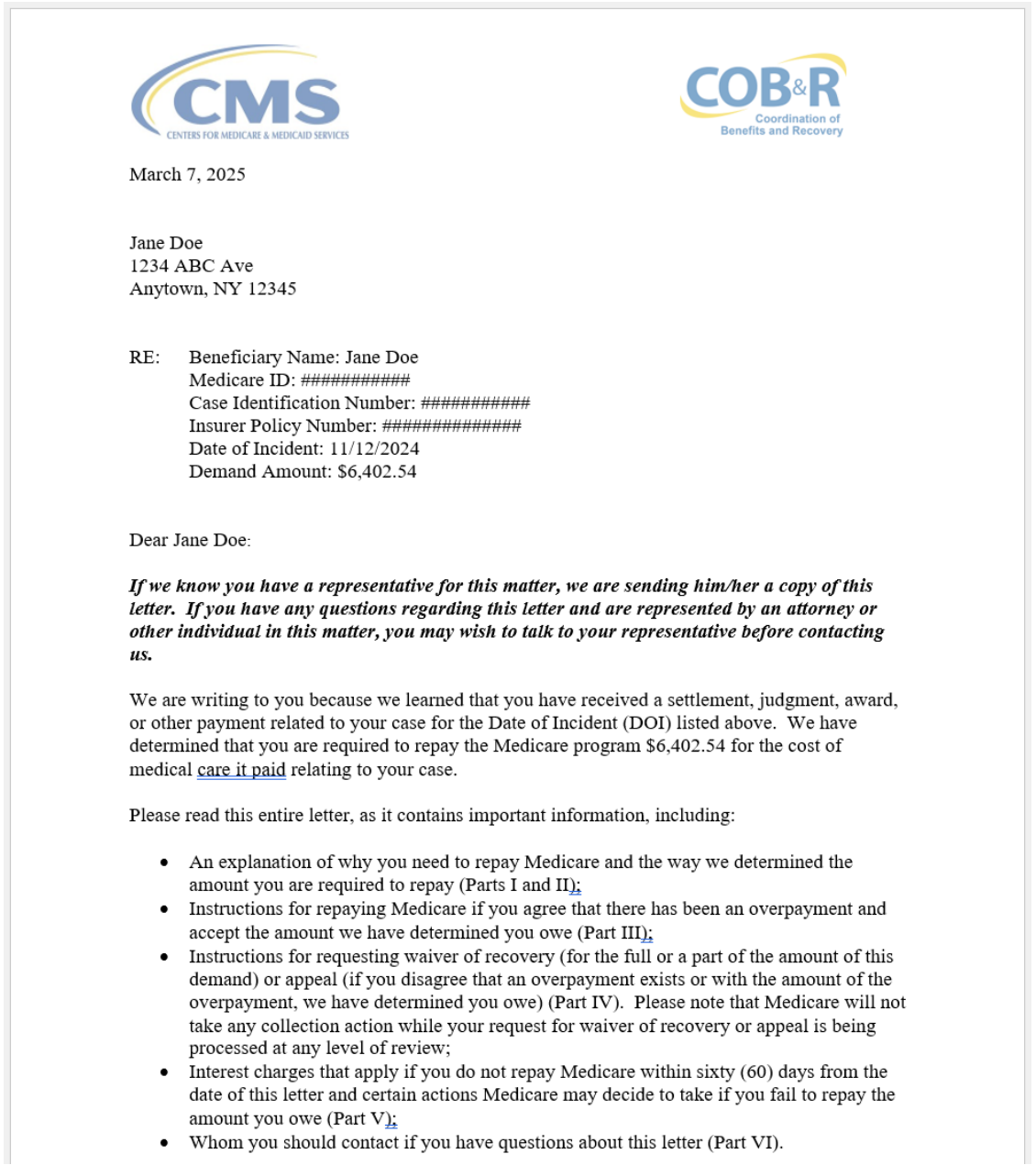
The dispute must clearly identify claims or conditions being disputed, either by circling or marking claims on the Payment Summary Form or by listing them on a separate document. While supporting documentation is not always required, it can be beneficial in supporting a valid dispute.

For example, if claims are being disputed because they occurred after the beneficiary completed treatment for the case-related injury/condition then it would require supporting documentation in the form of a physician's certification showing when case-related treatment was completed.

The BCRC can take up to 45 days to review a dispute. They will then send 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).

Full information about disputes and examples of when supporting documentation is helpful can be found in the NGHP MSP Beneficiary Reference Guide on CMS.gov.

Demand Letter



March 7, 2025

Jane Doe
1234 ABC Ave
Anytown, NY 12345

RE: Beneficiary Name: Jane Doe
Medicare ID: ##########
Case Identification Number: ##########
Insurer Policy Number: ##########
Date of Incident: 11/12/2024
Demand Amount: $6,402.54

Dear Jane Doe:

If we know you have a representative for this matter, we are sending him/her a copy of this letter. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us.

We are writing to you because we learned that you have received a settlement, judgment, award, or other payment related to your case for the Date of Incident (DOI) listed above. We have determined that you are required to repay the Medicare program $6,402.54 for the cost of medical care it paid relating to your case.

Please read this entire letter, as it contains important information, including:

- An explanation of why you need to repay Medicare and the way we determined the amount you are required to repay (Parts I and II);
- Instructions for repaying Medicare if you agree that there has been an overpayment and accept the amount we have determined you owe (Part III);
- Instructions for requesting waiver of recovery (for the full or a part of the amount of this demand) or appeal (if you disagree that an overpayment exists or with the amount of the overpayment, we have determined you owe) (Part IV). Please note that Medicare will not take any collection action while your request for waiver of recovery or appeal is being processed at any level of review;
- Interest charges that apply if you do not repay Medicare within sixty (60) days from the date of this letter and certain actions Medicare may decide to take if you fail to repay the amount you owe (Part V);
- Whom you should contact if you have questions about this letter (Part VI).

Slide 13: Demand Letter

Now let's talk about a Demand and what it means. A demand is Medicare’s request for repayment.

The BCRC will send the demand letter. It states the amount of money owed to Medicare, also referred to as the demand amount.

Like the CPL and CPN, it will include 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 on 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. Which we will talk about more in a moment.

Payment can be made via check (issued from the settlement proceeds) to the BCRC for the amount in the demand letter or payments can be made online using the MSPRP.

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

Appeals Process

1. Redetermination
2. Reconsideration
3. Administrative Law Judge Hearing
4. Medicare Appeals Council Review
5. Judicial Review

Slide 14: Appeals Process

For MSP recovery, only actions that constitute “initial determinations” are subject to appeal. Initial determinations include demand letters and waiver decisions. We will talk more about waivers in a moment.

A beneficiary or his/her representative has the right to 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”. A redetermination can be submitted by mail, fax or via the MSPRP.

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 a redetermination is not favorable, the next steps are, reconsideration, Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, and Judicial review.

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.

For full details on what can be appealed and the details of all the levels of appeal you can refer to the NGHP MSP Beneficiary Reference Guide on CMS.gov.

Not Able to Repay Medicare?

Waiver

A waiver is a request that Medicare waive recovery of the demand amount owed in full or in part. Medicare 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.

Compromise

A compromise is a request that Medicare accept less than the amount you owe Medicare.

- Compromise requests are forwarded from the BCRC for review by Medicare (CMS) directly.
- 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.

Slide 15: Not Able to Repay Medicare

Beneficiaries may also request a waiver or compromise of the debt, in full or in part. But it is important to note that a request for waiver or compromise is not an appeal. If the bene wants to appeal that they owe the debt they need to follow the appeal steps that we discussed previously.

A beneficiary can request that Medicare waives recovery of the demand amount owed in full or in part. Medicare 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.

When a waiver of recovery is requested via mail, fax or the MSPRP, the BCRC will send the SSA-632 "Request for Waiver" form, asking for more specific information about income, assets, expenses, and the reasons why a waiver of recovery should be granted. A link to the SSA-632 form can be found on the Medicare Recovery Process page on CMS.gov.

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 and instructions on appealing the decision.

A compromise is a request that Medicare accept less than the amount you owe Medicare.

The BCRC itself does not have the authority to approve or deny compromise requests; requests are forwarded from the BCRC for review by Medicare (CMS) directly. 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.

For more information on appeals, waivers and compromises you can review the NGHP MSP Beneficiary Reference Guide located in the Download section of the Beneficiary Services page on CMS.gov.

Referral to Treasury

- If MSP debt remains unresolved, the debt must be referred to the Department of the Treasury for collection once it is delinquent for 60 days (or 180 days from the date of demand).
- CMS will issue an "Intent to Refer" (ITR) letter warning of the pending referral no later than 60 days prior to referral.
- Once a debt is referred, the debtor must communicate directly with the Treasury.
- Treasury may use one or more of its programs to collect referred debts including:
  - Treasury Offset Program (TOP)
  - Administrative Wage Garnishment (AWG)
  - Private Collections Agencies (PCAs)
  - Referral to the Department of Justice

Slide 16: Referral to Treasury

Another important thing to remember is that outstanding recovery debts must be referred to the Department of the Treasury.

If a debt remains unresolved, the Debt Collection Improvement Act of 1996 (DCIA) mandates the referral of the debt to the Department of Treasury for collection once it is delinquent for 60 days (or 180 days from the date of demand).

CMS will issue an “Intent to Refer” (ITR) letter warning of the pending referral no later than 60 days prior to referral. Once a debt is referred, the debtor must communicate directly with Treasury.

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 Secondary Recovery Portal (MSPRP)

Slide 17: Medicare Secondary Recovery Portal (MSRP)

Before we start wrapping up, we did want to just give you a bit more information on the MSPRP.

The Medicare Secondary Payer Recovery Portal is a web-based tool designed to assist in the resolution of NGHP recovery cases. The MSPRP gives beneficiaries and their representatives the ability to access and update certain case specific information online including:

1. Submit Proof of Representation and Consent to Release documentation
2. Request conditional payment information
3. Dispute claims included in the conditional payment amount
4. Initiate the demand letter
5. View the status of correspondence that has been sent and received for a case
6. Submit case settlement information
7. Submit waiver, compromise and redetermination requests
8. Self-Report A Case
9. Make an Electronic Payment

Additional Resources

General MSP & COB

- COB&R Overview Section
- Medicare Secondary Payer Page

NGHP Recovery Webpages

- Non-Group Health Plan Recovery Page
- Beneficiary Services Section
- Attorney Services section

NGHP Recovery Downloads

- NGHP MSP Beneficiary Reference Guide
- Beneficiary Recovery Process Flow Chart
- POR vs CTR Presentation

MSPRP

- Medicare Secondary Payer Recovery Portal
- MSPRP Page & Training

Contacts

- BCRC Customer Service 1-855-798-2627
- Contacts Page

Question & Answer Session

Slide 18: Additional Resources

That concludes the presentation portion of the webinar, but we do want to remind you of other resources available to assist you with all your MSP, COB, and recovery questions. And links will be provided when this presentation is posted to CMS.gov.

For more general information on MSP and COB, you can visit the Coordination of Benefits & Recovery Section of CMS.gov and specifically the MSP page.

For NGHP Recovery please visit the NGHP Recovery page on CMS.gov along with the Beneficiary and Attorney Services sections which include information on the full NGHP recovery process including appeals and the waivers and compromises process. They also house some other useful documents like the NGHP MSP Beneficiary Reference Guide, a recovery process flow chart and POR versus CTR presentation.

You can also access the MSPRP training curriculum.

Lastly, BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m. at 1-855-798-2627 or 1-855-797-2627 for the hearing and speech impaired. All the BCRC addresses, and fax numbers are available on the COB&R Contacts page on CMS.gov.

We will now begin the Q&A portion of the call.