Medicare's Right to Recovery

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Medicare is a federal health insurance program

- Provides health insurance benefits to people 65 years of age or older, disabled people, and people with end-stage renal disease.
- Administered by the Centers for Medicare and Medicaid Services ("CMS"). Website: https://www.cms.gov/
- Originally enacted in the 1965 Social Security Act, rising Medicare costs eventually led Congress to enact a series of amendments in the 1980s which became known as the Medicare Secondary Payer Act ("MSP").

MSP Act

- Codified as 42 U.S.C. § 1395y, the MSP Act makes Medicare the secondary payer in cases where a primary plan exists.
- The MSP Act defines a "primary plan" as "a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no-fault insurance." 42 U.S.C.A. 1395y.
- If the primary payer has not paid and will not promptly pay, Medicare can conditionally pay the cost of treatment. 42 U.S.C. § 1395y(b)(2)(B).

Conditional Payment Reimbursement

- The MSP Act empowers Medicare to seek reimbursement for any conditional medical payments from the primary payer – or from the recipient of the payment – if it is demonstrated that the primary payer has a responsibility to pay.
- The responsibility of a primary payer may be demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver or release, of payment for items/services included in a claim against the primary plan, or the primary plan's insured; or other means. 42 U.S.C. 1395y(b)(2)(B)(ii).

Medicare can seek satisfaction

for its conditional payment obligation, commonly known as a “Medicare lien”, from a beneficiary, a health care provider or supplier, an attorney, or any party who has received a primary payment. There is no need to give notice to any party as the Medicare’s conditional payment obligation is set by statute and all parties are deemed to have notice of it. 42 C.F.R. Section 411.24.

Recovery Centers

Benefits Coordination and Recovery Center – ("BCRC")

- BCRC is responsible to recover conditional payments made mistakenly in liability, no-fault, and workers' compensations claims (known collectively as Non-Group Health Plans or "NGHP") from beneficiaries.

Commercial Recovery Center – ("CRC")

- If a Group Health Plan ("GHP") has been determined to be the proper primary payer, the CRC will seek recovery from the Employer or GHP.

Section 111 Reporting May Trigger "Rights and Responsibilities" ("RAR") Letter

- Whenever BWC makes a payment to a claimant, it is required as a Responsible Reporting Entity ("RRE") to report that payment to BCRC, under Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 ("MMSEA").
- If BCRC determines Medicare is not the primary insurer, it will send the claimant a Rights and Responsibilities ("RAR") letter.

Rights and Responsibilities Letter ("RAR")

The Rights and Responsibilities letter ("RAR") is sent to educate the average Medicare beneficiary and personal injury attorney. It briefly explains the Medicare lien resolution process (leaving out much of the dispute, appeal, and settlement notice procedures). Additionally, the date at the top of a RAR letter begins a 65-day countdown until your Conditional Payment Letter should arrive. This is 65 days more of an estimate than actual due date.

Conditional Payment Letter ("CPL")

CMS will next send claimant a Conditional Payment Letter ("CPL"). This is NOT a demand for payment and no payment should be sent at this time. But claimant's attorney should immediately prepare to enter negotiations with CMS.

"Consent to Release" ("CTR") &"Proof of Representation" ("POR")

- CMS will not release any information to a claimant's attorney until the beneficiary has filed a Consent to Release ("CTR") form.
- If the claimant's attorney has a CTR on file, BCRC will release a copy of the Conditional Payment Letter ("CPL"), and the eventual Demand Letter, to the beneficiary and copy the attorney. But in order for the attorney to enter negotiations on behalf of the beneficiary, the beneficiary MUST first submit a Proof of Representation ("POR") letter to BCRC. Do not wait to submit these until later, because the process speeds up after the CPL has issued.

Conditional Payment Notification ("CPN")

Once notified of a settlement, judgment, award, or other payment, BCRC will issue a Conditional Payment Notification ("CPN"). A beneficiary has 30 days to respond. If the CTR and POR are on file, the beneficiary's representative can and should now submit proof of charges and services that are not related to the case, attorney fees and other expenses paid by the beneficiary, and documentation of any additional payments pending related to the same incident.

Demand Letter

If BCRC receives no response to the CPN within 30 days, it will issue a Demand Letter without any reduction for fees or costs. BCRC will adjust conditional payment amounts for any costs it agrees are not related to the case. Allow BCRC 45 days to complete its review. Your dispute will be denied if the documentation submitted is not sufficient.

Right to Appeal Demand Letter

- The individual or entity that receives the Demand Letter seeking repayment directly from that individual or entity is able to request an appeal. This means that if the Demand letter is directed to the beneficiary, the beneficiary has the right to appeal. If the demand letter is directed to the liability insurer, no-fault insurer, or Workers' Compensation (WC) entity, that entity has the right to appeal.
- If an individual or entity receives a courtesy copy of a demand letter, that individual or entity does not have the right to appeal.

Personal Identifiable Information ("PII") = Confidential Personal Information ("CPI")

- Personally Identifiable Information ("PII"), is a term CMS uses to refer to information that can be used to distinguish or trace an individual's identity, such as names, claim numbers, addresses, social security numbers, Medicare beneficiary numbers, and so on. CMS imposes restrictions on access to and use of PII and penalties for its misuse.
- It is equivalent to BWC's term, Confidential Personal Information ("CPI"), the access and use of which is also strictly controlled by BWC.

Workers'Compensation Medicare Set-Aside Arrangement ("WCMSA")

When a beneficiary resolves a Workers' Compensation case that may include future medical expenses, BCRC recommends that Medicare's interest be protected by a Medicare Set-Aside Arrangement ("WCMSA"), that allocates a portion of a Workers' Compensation settlement to pay for future medical services related to the Workers' Compensation injury.

Demand Letter followed by accruing interest

For conditional payments made in error, once BCRC issues a Demand Letter, if the debt is not paid by the time specified in that letter, interest will be assessed for each 30-day period the debt remains unresolved.

Intent to Refer Letter ("ITR")

90 days after the Demand Letter has issued, if BCRC has not received full payment or a valid documented defense, it will issue the beneficiary an Intent to Refer ("ITR") letter, warning that the demand will be referred to the Treasury Department for further collection.

Department of Treasury Issues Treasury Notice

If neither full payment nor a valid documented defense is received by BCRC within 60 days of issuing the Intent to Refer Letter, the debt is referred to the Department of Treasury Offset Program for collection and it will issue a Treasury Notice. The law authorizes double damages from any party that is responsible for resolving the matter, but which fails to do so. Once the matter reaches the Treasury Department, it is no longer considered a dispute and there is no opportunity to submit evidence to the contrary.

Medicare Beneficiary Identifier Number ("MBI")

As of January 1, 2020, Center for Medicare/Medicaid Services (CMS) will no longer accept inquiries that do not contain a beneficiary's **Medicare Beneficiary Identifier number (MBI #)**. The MBI # is an (11) eleven characters alpha-numeric identifier that is unique to each beneficiary. It is located on the front of their Medicare Card.

Ohio | Bureau of Workers' Compensation
30 W. Spring St.
Columbus, OH 43215-2256

Governor Mike DeWine
Administrator/CEO Stephanie McCloud
www.ohiobwc.com
1-800-644-6292

MBI [redacted]

February 10, 2022

[redacted]

Dear [redacted]

This letter is in response to your phone call. I have provided a summary of your workers' compensation claim history below. Providing this information to Medicare should resolve the issues with payment for medical services that you are experiencing.

Claim Number(s):	[redacted]
Date of Injury:	[redacted]
Statute of Limitations:	[redacted]
Allowed Condition(s) (ICD-9/ICD-10):	[redacted]
Total Medical Paid:	[redacted]
Date of Last Payment:	[redacted]
Total Indemnity Paid:	[redacted]
Date of Last Payment:	[redacted]

Please note that BWC is an injury-specific insurer and is only permitted to pay for approved medical services and medication for treatment of the allowed condition(s) identified above. For issues related to payment of medical services and medications unrelated to the allowed condition(s) identified above, you will need to contact your primary health insurer.

Sincerely,

Renee Roberson
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Legal Division
(614) 902-4072