



Frequently Asked Questions about the Commercial Repayment Center Non-Group Health Plan Recovery Workload Transition

As part of the continuing efforts to improve the Coordination of Benefits & Recovery (COB&R) program the Centers for Medicare & Medicaid Services (CMS) has transitioned a portion of the Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) recovery workload from the Benefits Coordination & Recovery Center (BCRC) to its Commercial Repayment Center (CRC). The CRC has assumed responsibility for the recovery of conditional payments where CMS is pursuing recovery directly from a liability insurer (including a self-insured entity), no-fault insurer or workers' compensation (WC) entity (referred to as "applicable plans") as the identified debtor. The following Frequently Asked Questions (FAQ) are intended to provide additional information about this transition.

Q1. When should I talk to the Benefits Coordination and Recovery Center?

A1. Please contact the Benefits Coordination and Recovery Center (BCRC) for all of the following:

- When you are reporting or updating an MSP occurrence.
- When Medicare is pursuing recovery from the beneficiary as the identified debtor. Medicare beneficiaries and their representatives should **always** contact the BCRC.
- When you are an applicable plan that is already working with the BCRC on a recovery case, you should continue to do so until the case is resolved.

Q2. When should I talk to the Commercial Repayment Center?

A2. Please contact the Commercial Repayment Center (CRC) if you are an applicable plan or recovery agent for an applicable plan and you have questions about recovery cases initiated by the CRC (that is, you have received correspondence from the CRC).

Q3. When is CMS pursuing recovery from a beneficiary versus recovery from the applicable plan?

A3. The CMS may recover from the primary payer, the beneficiary, or any other entity receiving payments from the primary payer when there is a settlement, judgment, award, or other payment.

- In general, CMS pursues recovery directly from an applicable plan as the identified debtor when an applicable plan reports that it has ongoing responsibility for medicals (ORM) or otherwise notifies CMS of its primary payment responsibility, as the assumption is that the applicable plan's responsibility is not in dispute. This situation most frequently occurs in no-fault insurance and workers' compensation.



- In general, CMS pursues recovery from the beneficiary when the applicable plan has not reported ORM and has not otherwise notified CMS of primary payment responsibility. Typically this is when the beneficiary obtains a lump sum settlement, judgment, award, or other payment. This situation most frequently occurs with liability insurance, including self-insurance.

Q4: What prompts the CRC to issue a Conditional Payment Notice versus a Conditional Payment Letter to the applicable plan?

A4: The Conditional Payment Notice (CPN) and Conditional Payment Letter (CPL) provide the same information regarding conditional payments and allow recipients an opportunity to dispute conditional payments before the demand is issued. The CRC will issue the CPN and CPL in slightly different circumstances than when the BCRC issues CPNs and CPLs.

A CPN will be issued by the CRC when the applicable plan has notified CMS that it has primary payment responsibility for certain care and Medicare has made conditional payments.

- CMS may be notified through MMSEA Section 111 Reporting or other notification made to the BCRC (i.e., telephone call or written correspondence).
- In the absence of a dispute received by the CPN response due date, the CRC will issue a demand letter automatically. The demand will include conditional payments included in the CPN as well as any additional conditional payments identified after the CPN was issued.

A CPL will be issued by the CRC when a beneficiary (or their representative) reports a pending case where an applicable plan may have primary payment responsibility for certain care injury **and** the MSP occurrence was not otherwise reported by the applicable plan itself (through MMSEA Section 111 reporting or by other means).

- The applicable plan may dispute conditional payments, although there is no specific response due date.
- The CPL is not automatically followed by the demand letter. The CPL is intended to provide information about conditional payments and allow the applicable plan an opportunity to ensure CMS' records are correct.

Q5. How may an applicable plan appoint a recovery agent to work with the CRC and BCRC to resolve a case?

A5. An authorization is required any time that an applicable plan is represented by an agent that will work with CMS' contractors to resolve Medicare Secondary Payer recovery cases on behalf of that applicable plan. Please review the "Recovery Agent Authorization Model Language" download available on the [Insurer NGHP Recovery](#) page for the specific information required for an authorization.

Q6. Can an applicable plan appeal a CRC demand letter?



A6. Applicable plans have formal administrative appeal rights if the demand letter was issued after April 28, 2015.

Please review the presentation from the May 5, 2015 “Applicable Plan” Appeals webinar download available on the [Insurer NGHP Recovery](#) page for more detailed information regarding appeal requirements, limitations, and the different levels of appeal. All appeal requests must be sent to the contractor that issued the demand letter (e.g., an appeal on a CRC demand letter should be sent to the CRC).

Q7. Will an applicable plan receive multiple demand letters from the CRC related to the same date of incident?

A7. The applicable plan may receive multiple CPNs and demands from the CRC associated with the same Medicare beneficiary’s date of incident when additional conditional payments are identified.

Q8. Will the CRC issue “zero” CPNs or CPLs?

A8. In general, the CRC will not issue correspondence when CMS has not made conditional payments. In limited situations, such as when a beneficiary (or their representative) reports a pending case, a letter indicating that no conditional payments were identified will be issued to alert the applicable plan and the beneficiary that CMS was notified of and has reviewed the pending case.

Q9: How does Medicare identify conditional payments that are related to the insurance or workers' compensation claim?

A9: CMS’ contractors rely upon the diagnosis code information reported to the BCRC through MMSEA Section 111 Reporting, beneficiary self-reporting, and other means, to identify conditional payments associated with the MSP occurrence. When more specific and complete information is provided, the BCRC and CRC can identify conditional payments with greater accuracy.