SYNERGY
SETTLEMENT SERVICES

Lien Resolution

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Director Synergy Lien Resolution Services

ALLOWING TRIAL LAWYERS TO FOCUS ON
WHAT THEY DO BEST™

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Medicare Conditional Payments

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Step One - Forms

- Have your client sign two necessary forms to allow access to his/her Medicare information.
  - Form A: Proof of Representation

    https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/ProofofRepresentation.pdf

    Form B: Consent to Release

    http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/ConsenttoRelease.pdf
  - The Proof of Representation allows the attorney to act on behalf of the beneficiary. For example, this allows the attorney to negotiate the lien.
- The Consent to Release allows Medicare to provide information to the attorney. For example, this allows Medicare to send the attorney the payout log.

MODEL LANGUAGE

Medicare Forms

Proof of Representation

PROOF OF REPRESENTATION

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.

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

( ) Individual other than an Attorney: Name: _____

( ) Attorney* Relationship to the Medicare Beneficiary: _____

( ) Guardian* Firm or Company Name: _____

( ) Conservator* Address: _____

( ) Power of Attorney* _____

_____

Telephone: _____

* 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 http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

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

Beneficiary's Health Insurance Claim Number (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 Signature: _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____

Medicare Forms

Consent to Release

MODEL LANGUAGE

CONSENT TO RELEASE

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 _____

(Explain)

Name of entity: _____

Contact for above entity: _____

Address: _____

_____

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 _____

(Provide a specific period of time)

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 http://go.cms.gov/cobro for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): _____

Date of Injury/Illness: _____

Step Two - Notice

- Report your claim to the Benefits Coordination & Recovery Center (BCRC) for Medicare. You can report one of two ways, by telephone 1-855-798-2627 where you can report up to eight claims at a time or by mail to:

MEDICARE-MSP General Correspondence

P.O. Box 138897

Oklahoma City, OK 73113-8897

What to Include in Notice

- Beneficiary Information
  - Beneficiary's Name
  - Medicare HIC Number
  - Beneficiary's Insurer Name & Address
  - Beneficiary's Health Insurance Claim Number
  - Beneficiary's Gender & Date of Birth
  - Beneficiary's Address & Phone Number
- Case Information
  - Date of Injury
  - Description of Alleged Injury or Illness or Harm
  - Type of Claim (Liability Insurance, No-Fault Insurance)
  - Defendant's Name
  - Defendant's Insurer Name & Address
  - Defendant's Claim Number & Policy Number
- Representative Information
  - Representative/Attorney Name
  - Law Firm Name
  - Address & Phone Number

Medicare Secondary Payer Recovery Portal

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Welcome to the MSPRP

The Medicare Secondary Payer Recovery Portal provides a quick and efficient way to request case information and provide information to assist in resolving Medicare's recovery claim. With the use of this portal, you may submit a valid authorization, request an update to the conditional payment amount, submit settlement information and dispute claims.

Getting Started

If you are a Medicare Beneficiary and would like to use the MSPRP to request case information, please login to your MyMedicare account by visiting the MyMedicare.gov website at https://mymedicare.gov/.

For more information, refer to How To Get Started under the How To menu option. To begin the registration process, click the 'New Registration' button.

STEP 1

New Registration

STEP 2

Account Setup

(Account ID and PIN required)

Sign in to your account

User Name:

Forgot ID

Password:

Forgot Password

Login Clear

Step 3-Rights and Responsibilities Letter

- Medicare will respond to notice within 14 days.
- You will need to make sure all the information contained in this letter is correct. If it is not, you will need to fill it out accordingly, and send it back to the address on the letter.
- If you do not receive this letter, then you will need to re-submit your documentation.
- From this point on, you will need to send a Correspondence Cover Sheet with any correspondence to Medicare.
- The Correspondence Cover Sheet can be found here: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/NGHP-Correspondence-Cover-Sheet.pdf

Medicare Forms

BCRC Cover Sheet used to ensure proper routing of correspondence

NGHP Correspondence Cover Sheet

Beneficiary's Name _____

HIC#: _____

Date of Incident: _____

Case ID#:_____*(can be found on Rights and Responsibilities letter)*

This cover sheet is for your use when mailing or faxing in correspondence to the Benefits Coordination & Recovery Center (BCRC). Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the BCRC to facilitate routing. Check all that apply:

- ☐ Check
- ☐ Settlement information
- ☐ Retainer agreement or other authorization documentation
- ☐ Other _____

Note: A Conditional Payment Letter is sent automatically, as soon as the information is available. Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.

In order to accurately associate claims to your case, please include a description of the injury. (i.e.: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

_____

_____

_____

_____

Submit correspondence to the BCRC address listed below:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

NGHP
PO Box 138832
Oklahoma City, OK 73113

Step 4–Conditional Payment Summary

- Sent within 65 days of receiving your Rights and Responsibilities Letter. This letter will list all the claims related to the injuries.
- Conduct an audit of the Conditional Payment Summary
  - Provider Name
  - Diagnosis Codes
  - From-To Dates
  - Total Charges

Step 5 – Dispute

- If unrelated charges are on the Conditional Payment Summary you can request that BCRC remove them.
    - Contact Medicare noting which claims are not related and why.
    - If the injury claimed is complex in nature, provide medical records to support your dispute
    - Do not use a highlighter as Medicare scans their documents in and thus highlighting does not show up.
    - Don't forget to send your Correspondence Cover Sheet

Claims Listing

Print this page

The following are the claims associated to Case ID: **20111 88090 00104**

These claims may also be found on a Payment Summary Form included with the Conditional Payment Letter. This listing may differ from the last issued Payment Summary Form if there has been any recent case activity between the date of the Payment Summary Form and the current date. Examples of recent case activity include claim disputes or requests for updated conditional payment amounts.

If you believe any of the claims listed on this screen are unrelated to the case, you may request the claims be removed by submitting a dispute below.

To select a claim for dispute, click the checkbox to the left of the claim number. When all disputed claims have been marked, click the **Continue** button. The next screen will allow you to verify the claims you have disputed and provide any supporting documentation.

Click **Previous** will return you to the Case Information page, your dispute selections will be lost. Click **Cancel** will return you to the Home Page.

Note: If the checkbox next to the claim number is disabled, the claim may not be disputed.

Claims

Dispute	Claim Control ID (ICN)	Line Number	Total Charges	Reimbursed Amount	Conditional Payment
☐	*******1125502KYA	0	$815,286.37	$168,724.71	$168,724.71
☐	*******83023630	1	$0.00	$0.00	$0.00
☑	*******83023630	2	$25.00	$6.86	$6.86
☑	*******83023630	3	$30.00	$7.22	$7.22
☐	*******83023630	4	$25.00	$6.86	$6.86
☐	*******83023630	5	$25.00	$6.86	$6.86
☐	*******83023640	1	$50.00	$12.18	$12.18
☐	*******83023640	2	$30.00	$6.58	$6.58
☐	*******83023640	3	$30.00	$6.86	$6.86
☐	*******97317560	1	$1,300.00	$162.09	$162.09
☐	*******97317560	2	$900.00	$183.63	$183.63
☐	*******97317560	3	$1,050.00	$215.70	$215.70

Quick Help

Help About This Page

www.synergysettlements.

New Conditional Payment Amount Options

- Will not apply to many cases.
  - $1,000 Threshold (formerly $300)
  - Fixed Percentage Option
  - Pre-Settlement Final Conditional Payment

$1,000.00 Threshold

- $1,000.00 Threshold
  - Not ingestion, exposure or implant
  - Settlement amount is less than $1,000.00
  - No other incident related settlements
  - No Final Demand has been issued
  - Medicare will not seek recovery

Fixed Percentage Option

- Fixed Percentage Option
  - Using Medicare's model language, submit written request to use Fixed Percentage Option
    - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Fixed-Percentage-Election-Model-Language.pdf
    - Request must be sent by mail to the following address:

      Fixed Percentage
      PO Box 138880
      Oklahoma City, OK 73113
  - Medicare's response will be generated within 30 days
  - Right to Appeal and Waiver are LOST
  - Not ingestion, exposure or implant
  - Payment from liability insurance
  - Settlement amount cannot exceed $5,000.00
  - Request made after settlement
  - No other incident related settlements
  - Pay Medicare 25% of gross settlement

Pre-Settlement Final Conditional Payment

- Pre-Settlement Final Conditional Payment
  - Not ingestion, exposure or implant
  - Payment from liability insurance.
  - Settlement amount is less than $25,000.00
  - Date of incident 6 months before request
  - Treatment complete 90 days before request
  - Settlement must occur within 60 days of Medicare Letter.
  - Submit self-calculation along with Medicare model language.
    - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Self-Calculated-Conditional-Payment-Amount-Model-Language.pdf

Pre-Settlement Compromise

Pre-settlement compromise can be requested at any point in the process and may be granted if the beneficiary doesn't have a present or future ability to pay.

Approval is determined on a case by case basis by the assigned Regional Office.

Payment is required within 30 days.

See 42 C.F.R. §411.28;
42 C.F.R. §401.613, §401.615.

Step 6 – Final Demand Letter

- Once you settle your case advise Medicare.
- Download the "Final Settlement Detail Document“
- http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Final_Settlement_Detail.pdf
    - Provide the information on company letterhead
    - Total amount of the settlement
    - Total Amount of Med-Pay or PIP
    - Attorney Fee Amount paid by the beneficiary
    - Additional Procurement Expenses Paid by the Beneficiary
        - Attached itemized list of these expenses
    - Date the Case was Settled

Medicare Forms

Final Settlement Detail Document

Final Settlement Detail Document

Beneficiary Name:
Medicare Number:
Date of Incident:

When a beneficiary receives a settlement, judgment, award, or other payment, Medicare is entitled to recover associated payments made by the Medicare program. If certain conditions are met, Medicare reduces its conditional payment to take into account a proportionate share of the costs incurred in resolving the beneficiary's claim. **See 42 C.F.R. 411.37.** In general, the recovery demand must be against the individual or entity that received payment, the costs must have been incurred because the matter was disputed, and the costs must be paid by the individual or entity against whom/which Medicare seeks recovery. There is no proportionate reduction if payment is not in dispute – for example a payment for no-fault insurance.

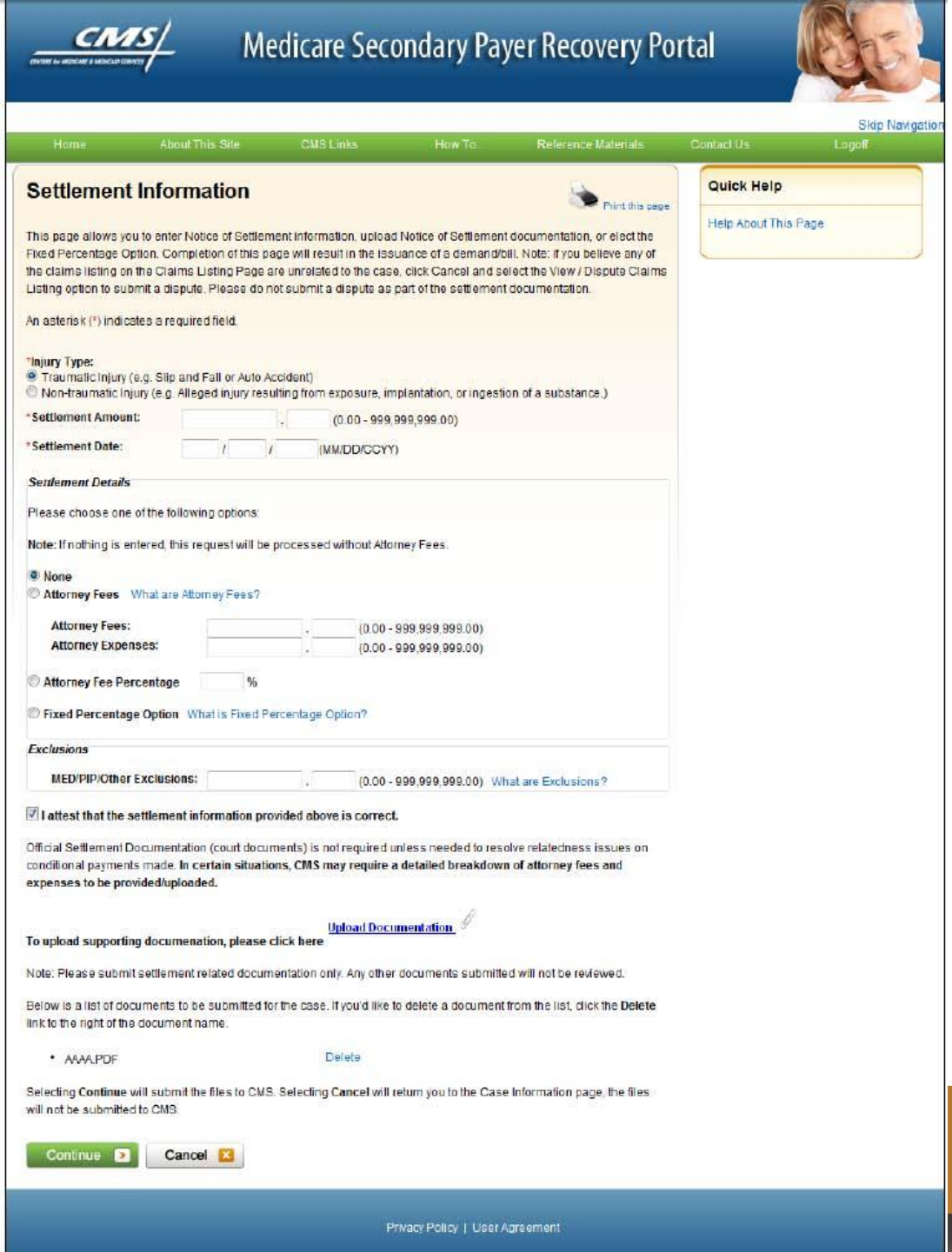
In order for Medicare to properly calculate the net refund it is due, please supply the information outlined below. This information will also be used to update the beneficiary's records to show resolution of this matter. If you have a representative, this information should be submitted by your representative on his/her letterhead.

Total Amount of the Settlement: _____
Total Amount of Med-Pay or PIP: _____
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: ____/____/____

This information should be submitted **along with a copy of this notice** to:

Benefits Coordination & Recovery Center
NGHP
Post Office Box 138832
Oklahoma City, OK 73113

If you have any questions concerning this matter, please call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired) or you may contact us in writing at the address above. If you contact us in writing, please be sure to include the beneficiary's name and his/her Medicare health insurance claim number.



MSPRP Portal

Final Demand Request

Calculations

- C.F.R. 411.37(c)
  - Medicare payments are less than the judgment or settlement.
    - Add (Attorney's Fees) and (Costs) = Total Procurement Costs
    - (Total Procurement Costs) / (Gross Settlement Amount) = Ratio
    - Multiply (Lien Amount) by (Ratio) = Reduction Amount
    - (Lien Amount) - (Reduction Amount) = Medicare Demand Amount
- C.F.R. 411.37(d)
  - Medicare payments are equal to or exceed the judgment or settlement.
    - Add (Attorney's Fees) and (Costs) = Total Procurement Costs
    - (Gross Settlement Amount) - (Total Procurement Costs) = Medicare Demand Amount

Example: Reduction Based on Procurement Costs

Example 1:

Conditional Payment does not exceed settlement under §411.37(c)

$50,000	Gross Settlement
$10,000	Conditional Payment
$16,666.67	Fees
$1,250.00	Costs
$17,916.67	Total Procurement Costs
35.8%	Procurement as a % of Recovery
$3,583.33	Medicare's share of procurement
$6,416.67	Amount due to Medicare
$25,666.66	Net to client

Example: Reduction Based on Procurement Costs

Example 2:

Conditional Payment exceeds settlement under §411.37(d)

$10,000	Gross Settlement
$50,000	Conditional Payment
$3,333.34	Fees
$125.00	Costs
$3,458.34	Total Procurement Costs
N/A	Procurement as a % of Recovery
$3,458.34	Medicare's share of procurement
$6,541.66	Amount due to Medicare
$0	Net to client

Pay or Else!

- You must pay this demand amount within 60 days or the lien will accrue interest.
- Request for Appeal or Waiver does not toll interest.
- Interest is due and payable for each full 30 day period the debt remains unresolved.
- By law all payments are applied to interest first, principal second.
    - 42 C.F.R.411.24(m)
- After receiving payment, Medicare will send a letter stating the lien has been reduced to zero and the case is closed.

Post Final Demand Options

- Appeal
- Financial Hardship Waiver
- Compromise
- “Best Interest of the Program” Waiver

Appeals

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
I. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	At least $130 remains in controversy.
4. Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of the Appeals Council decision or declination of review by DAB	At least $1 ,260 remains in controversy.

Medicare Wavier & Compromise

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Optional Step: Financial Hardship Waiver

- §1870(c) of the Social Security Act;
- Synergy recommends you pay the Final Demand amount and then attempt to obtain a partial or full waiver.
- Waiver of recovery should not be requested until the case is settled and Medicare has issued a demand for repayment letter.
- Requests for waiver must be submitted in writing
- Medicare may grant a full or partial waiver if recovery would negatively affect the beneficiary's standard of living compared to how it was before the accident/injury/illness.
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/SSA-632-Request-for-Waiver.pdf
  - Form is from the Social Security Administration and appears odd but is correct form

Medicare Forms

Waiver Request

Form:
SSA-632-BK

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0037

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

FOR SSA USE ONLY	
ROAR Input	☐ Yes ☐ No
Input Date	
Waiver	☐ Approval ☐ Denial
SSI	☐ Yes ☐ No
AMT OF OP $	
PERIOD (DATES) OF OP	

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

1. A. Name of person on whose record the overpayment occurred: _____

B. Social Security Number □□□–□□–□□□□

C. Name of overpaid person(s) making this request and his/her Social Security Number(s):

_____ □□□–□□–□□□□

_____ □□□–□□–□□□□

_____ □□□–□□–□□□□

_____ □□□–□□–□□□□

2. Check any of the following that apply. (Also, Fill in the dollar amount in B, C, or D.)

A. ☐ The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. ☐ I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have $ _____ withheld each month

C. ☐ I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back $ _____ each month instead of paying all of the money at once.

D. ☐ I am receiving SSI payments. I want to pay back $ _____ each month instead of paying 10% of my total income.

Form **SSA-632-BK** (12-2002) ef (08-2006) Page 1

Post-Settlement Compromise

- The Federal Claims Collection Act (FCCA)
  - Basis for Compromise
    - Inability to Pay
    - Litigative probabilities
    - Cost of collecting the claim
- 31 U.S.C.3711
  - The cost of collection does not justify the enforced collection of the full amount of the claim;
  - There is an inability to pay within a reasonable time on the part of the individual against whom the claim is made; or
  - The chances of successful litigation are questionable, making it advisable to seek a compromise settlement."
  - Medicare Secondary Payer Manual (MSP), Chapter 7 § 50.7.2

Optional Step: "Best Interest of the Program" Waiver

- § 1862(b) of the Social Security Act;
- A separate and distinct evaluation than a request under §1870(c) of the Social Security Act (Financial Hardship Wavier) and a request for a Compromise under the Federal Claims Collection Act (FCCA)
- The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the ***best interests of the program*** established under this title

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