(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) *Medicare payments equal or exceed the judgment or settlement amount.* If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) *CMS incurs procurement costs because of opposition to its recovery.* If CMS must bring suit against the party that received payment because that party opposes CMS's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

§ 411.39 Automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation: Final conditional payment amounts via Web portal.

(a) *Definitions.* For the purpose of this section the following definitions are applicable:

Applicable plan means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement:

(1) Liability insurance (including self-insurance).

(2) No fault insurance.

(3) Workers' compensation laws or plans.

Medicare Secondary Payer conditional payment information means all of the following:

(1) Dates of service.

(2) Provider names.

(3) Diagnosis codes.

(4) Conditional payment amounts.

(5) Claims detail information.

(b) *Accessing conditional payment information through the Medicare Secondary Payer Web portal.*

(1) *Beneficiary access.* A beneficiary may access his or her Medicare Secondary Payer conditional payment information via the Medicare Secondary Payer Recovery Portal (Web portal), provided the following conditions are met:

(i) The beneficiary creates an account to access his or her Medicare information through the CMS Web site.

(ii) The beneficiary provides initial notice of a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment to the appropriate Medicare contractor at least 185 days before the anticipated date of settlement, judgment, award, or other payment.

(2) *Beneficiary's attorney or other representative, or applicable plan's access on or before December 31, 2015.* On or before December 31, 2015, a beneficiary's attorney or other representative or an applicable plan, may do the following:

(i) View the following via the Medicare Secondary Payer Recovery Portal (Web portal):

(A) Total MSP conditional payment amounts.

(B) Masked claim-specific information, including dates of services, provider names, and diagnosis codes, provided the following conditions are met:

(*1*) The authorized attorney or other representative or authorized applicable plan has properly registered to access the Web portal.

(*2*) The attorney or other representative or applicable plan obtains proper authorization from the beneficiary and submits it to the appropriate Medicare contractor in the form of either proof of representation or consent to release in order to access the beneficiary's case specific information.

(ii) Perform the following actions via the MSP Web portal, using the information provided in the conditional payment letter:

(A) Dispute claims.

(B) Upload settlement information.

(3) *Beneficiary's attorney or other representative, or applicable plan's access on or after January 1, 2016.* On or after January 1, 2016, a beneficiary's attorney or other representative or an applicable plan, may do the following:

(i) Access conditional payment information via the MSP Recovery Portal

(Web portal) using the multifactor authentication processes provided that the following conditions are met:

(A) The requirement described in paragraph (b)(2) of this section.

(B) The beneficiary, his or her authorized attorney or other representative, or an authorized applicable plan, provides initial notice as described in paragraph (b)(2)(ii) of this section.

(ii)(A) May dispute claims and upload settlement information via the Web portal using multifactor authentication; and

(B) Will no longer need a conditional payment letter to obtain claim-specific information.

(c) *Obtaining a final conditional payment amount.* (1) A beneficiary, or his or her attorney or other representative, or an applicable plan, may obtain a final conditional payment amount related to a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment using the following process:

(i) The beneficiary, his or her attorney or other representative, or an applicable plan, provides initial notice of a pending liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlement, judgment, award, or other payment to the appropriate Medicare contractor at least 185 days before the anticipated date of settlement, judgment, award, or other payment.

(ii) The Medicare contractor compiles and posts claims for which Medicare has paid conditionally that are related to the pending settlement, judgment, award, or other payment within 65 days of receiving the initial notice of the pending settlement, judgment, award, or other payment.

(A) CMS may extend its response timeframe by an additional 30 days when it determines that additional time is required to address claims that Medicare has paid conditionally that are related to the settlement, judgment, award, or other payment in situations including, but not limited to, the following:

(*1*) A recovery case that requires manual filtering to ensure that associated claims are related to the pending settlement, judgment, award, or other payment.

(*2*) Internal CMS systems failures not otherwise considered caused by exceptional circumstances.

(B) In exceptional circumstances, CMS may further extend its response timeframe by the number of days required to address the issue that resulted from such exceptional circumstances. Exceptional circumstances include, but are not limited to the following:

(*1*) Systems failure(s) due to consequences of extreme adverse weather (loss of power, flooding, etc.).

(*2*) Security breaches of facilities or network(s).

(*3*) Terror threats; strikes and similar labor actions.

(*4*) Civil unrest, uprising or riot.

(*5*) Destruction of business property (as by fire, etc.).

(*6*) Sabotage.

(*7*) Workplace attack on personnel.

(*8*) Similar circumstances beyond the ordinary control of government, private sector officers or management.

(iii) Beginning any time after CMS posts its initial claims compilation, and up to 120 days before the anticipated date of a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney, or other representative may notify CMS, once and only once, via the Web portal, that a settlement, judgment, award or other payment is expected to occur within 120 days or less from the date of notification.

(A) On or before December 31, 2015, the beneficiary, or his or her attorney, or other representative must request an update of claim and payment information (hereafter referred to as a claims refresh) via the Web portal and await confirmation that the claims refresh has been completed. CMS provides confirmation of the claims refresh completion through the Web portal no later than 5 business days after the electronic request is initiated.

(B) On or after January 1, 2016, CMS provides an uninitiated claims refresh via updated functionality to the Web portal.

(iv) The beneficiary, or his or her attorney, or other representative may address discrepancies by disputing a

claim, once and only once, if he or she believes that the claim included in the most up-to-date conditional payment summary form is unrelated to the pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment.

(A) The dispute process is not an appeals process, nor does it establish a right of appeal regarding that dispute. There will be no administrative or judicial review related to this dispute process.

(B) The beneficiary, or his or her attorney or other representative may be required to submit supporting documentation in the form and manner specified by the Secretary to support his or her dispute.

(v) Disputes submitted through the Web portal are resolved within 11 business days of receipt of the dispute and any required supporting documentation.

(vi) When any disputes have been fully resolved and the beneficiary, or his or her attorney, or other representative has executed and obtained confirmation of the completion of a final claims refresh, then:

(A) The beneficiary, or his or her attorney or other representative, may download or otherwise request a time and date stamped conditional payment summary form through the Web portal. If the download or request is within 3 days of the date of settlement, judgment, award or other payment, that conditional payment summary form will constitute Medicare's final conditional payment amount.

(B) If the beneficiary, or his or her attorney or other representative, is within 3 days of the date of settlement, judgment, award, or other payment and any claim disputes have not been fully resolved, he or she may not download or otherwise request a final conditional payment summary form.

(vii)(A) Within 30 days of securing a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney or other representative, must submit through the Web portal documentation specified by the Secretary, including, but not limited to the following:

(*1*) The date of settlement, judgment, award, or other payment, including the total settlement amount, the attorney fee amount or percentage.

(*2*) Additional costs borne by the beneficiary to obtain his or her settlement, judgment, award, or other payment.

(B) If settlement information is not provided within 90 days of securing the settlement, the final conditional payment amount obtained through the Web portal is void.

(viii) Once settlement, judgment, award, or other payment information is received, CMS applies a pro rata reduction to the final conditional payment amount in accordance with § 411.37 and issues a final MSP recovery demand letter.

(2) If the underlying liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim derives from one of the following, the beneficiary, or his or her attorney or other representative, must provide notice to CMS' contractor via the Web portal in order to obtain a final conditional payment summary form and amount through the Web portal:

(i) Alleged exposure to a toxic substance,

(ii) Environmental hazard,

(iii) Ingestion of pharmaceutical drug or other product or substance,

(iv) Implantation of a medical device, joint replacement, or something similar.

(3) An applicable plan may obtain a final conditional payment amount related to a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment in the form and manner described in § 411.38(b) if the applicable plan has properly registered to use the Web portal and has obtained from the beneficiary, and submitted to the appropriate CMS contractor, proper proof of representation. The applicable plan may obtain read only access if the applicable plan obtains proper consent to release from the beneficiary, and submits it to the appropriate CMS contractor.

(4) On or after January 1, 2016, the MSP Web portal will include

functionality to provide final MSP conditional payment summary forms and amounts.

(d) *Obligations with respect to future medical items and services.* Final conditional payment amounts obtained via the Web portal represent Medicare covered and otherwise reimbursable items and services that are related to the beneficiary's settlement, judgment, award, or other payment furnished before the time and date stamped on the final conditional payment summary form.

[78 FR 57804, Sept. 20, 2013]

Subpart C—Limitations on Medicare Payment for Services Covered Under Workers' Compensation

§ 411.40 General provisions.

(a) *Definition.* ''*Workers' compensation plan of the United States*'' includes the workers' compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees' Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act.

(b) *Limitations on Medicare payment.* (1) Medicare does not pay for any services for which—

(i) Payment has been made, or can reasonably be expected to be made under a workers' compensation law or plan of the United States or a state; or

(ii) Payment could be made under the Federal Black Lung Program, but is precluded solely because the provider of the services has failed to secure, from the Department of Labor, a provider number to include in the claim.

(2) If the payment for a service may not be made under workers' compensation because the service is furnished by a source not authorized to provide that service under the particular workers' compensation program, Medicare pays for the service if it is a covered service.

(3) Medicare makes secondary payments in accordance with §§ 411.32 and 411.33.

[54 FR 41734, Oct. 11, 1989, as amended at 71 FR 9470, Feb. 24, 2006]

§ 411.43 Beneficiary's responsibility with respect to workers' compensation.

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers' compensation.

(b) Except as specified in § 411.45(a), Medicare does not pay until the beneficiary has exhausted his or her remedies under workers' compensation.

(c) Except as specified in § 411.45(b), Medicare does not pay for services that would have been covered under workers' compensation if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper claim, Medicare pays for the services if they are covered under Medicare.

§ 411.45 Basis for conditional Medicare payment in workers' compensation cases.

(a) A conditional Medicare payment may be made under either of the following circumstances:

(1) The beneficiary has filed a proper claim for workers' compensation benefits, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly. This includes cases in which a workers' compensation carrier has denied a claim.

(2) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

[71 FR 9470, Feb. 24, 2006, as amended at 73 FR 9685, Feb. 22, 2008]

§ 411.46 Lump-sum payments.

(a) *Lump-sum commutation of future benefits.* If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.