

no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) *Medicare payments are less than the judgment or settlement amount.* If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(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.

(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 appropriate Medicare contractor has received initial notice of a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment and has posted the recovery case on the Web portal.

(2) *Beneficiary's attorney or other representative or applicable plan's access using the multifactor authentication process.* 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).

(ii) Dispute claims.

(iii) Upload settlement information via the Web portal using multifactor authentication.

(c) *Obtaining a final conditional payment amount.* (1) A beneficiary, or his or her attorney or other representative, or an authorized 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 before accessing information via the Web portal.

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

(iii) 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 statement and amount through the Web portal:

(A) Alleged exposure to a toxic substance.

(B) Environmental hazard.

(C) Ingestion of pharmaceutical drug or other product or substance.

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

(iv) Up to 120 days before the anticipated date of a settlement, judgment, award, or other payment, the beneficiary, or his or her attorney, other representative, or authorized applicable plan 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) 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.

(v) The beneficiary, or his or her attorney, or other representative may then address discrepancies by disputing individual conditional payments, once and only once, if he or she believes that the conditional payment included in the most up-to-date conditional payment summary statement 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.

(vi) Disputes submitted through the Web portal and after the beneficiary, or his or her attorney, other representative, or authorized applicable plan has notified CMS that he or she is 120 days or less from the anticipated date of a settlement, judgment, award, or other payment, are resolved within 11 business days of receipt of the dispute and any required supporting documentation.

(vii) When any disputes have been fully resolved, the beneficiary, or his or her attorney or other representative, may download or otherwise request a time and date stamped conditional payment summary statement through the Web portal.

(A) If the download or request is within 3 days of the date of settlement, judgment, award, or other payment, that conditional payment summary statement will constitute Medicare's final conditional payment amount.

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(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 statement.

(viii) Within 30 days or less 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:

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

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

(I) If settlement information is not provided within 30 days or less of securing the settlement, the final conditional payment amount obtained through the Web portal is void.

(2) [Reserved]

(ix) 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) An applicable plan may only 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 from the beneficiary, and submits to the appropriate CMS contractor, proper consent to release.

(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, as amended at 81 FR 30492, May 17, 2016]

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