DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 411

[CMS–6054–IFC]

RIN 0938–AR90

Medicare Program; Obtaining Final Medicare Secondary Payer Conditional Payment Amounts via Web Portal

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period specifies the process and timeline for expanding CMS' existing Medicare Secondary Payer (MSP) Web portal to conform to section 201 of the Medicare IVIG and Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act). The interim final rule specifies a timeline for developing a multifactor authentication solution to securely permit authorized users other than the beneficiary to access CMS' MSP conditional payment amounts and claims detail information via the MSP Web portal. It also requires that we add functionality to the existing MSP Web portal that permits users to: notify us that the specified case is approaching settlement; obtain time and date stamped final conditional payment summary forms and amounts before reaching settlement; and ensure that relatedness disputes and any other discrepancies are addressed within 11 business days of receipt of dispute documentation.

DATES: *Effective date:* These regulations are effective on November 19, 2013.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 19, 2013.

ADDRESSES: In commenting, please refer to file code CMS–6054–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed).

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.regulations.gov.* Follow the instructions for "Comment or Submission" and enter the filecode to find the document accepting comments.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6054–IFC, P.O. Box 8013 Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–6054–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201;

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Suzanne Mattes, (410) 786–2536.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

The Medicare IVIG and Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act) was enacted on January 10, 2013. Section 201 of the SMART Act amends section 1862(b)(2)(B) of the Social Security Act (the "Act") and requires the establishment of an internet Web site (hereinafter referred to as the "Web portal") through which beneficiaries, their attorneys or other representatives, and authorized applicable plans (as defined in section 1862 (b)(8)(F) of the Act (42 U.S.C. 1395y(b)(8)(F))) who have pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlements, judgments, awards, or other payments may access related CMS' MSP conditional payment amounts and claims detail information. We are issuing this interim final rule to implement our timeframe for the expansion of the existing MSP Web portal in order to comply with the SMART Act.

The existing MSP Web portal currently permits authorized users (including beneficiaries, attorneys, or other representatives) and applicable plans to register through the Web portal in order to access MSP conditional payment amounts electronically and update certain case-specific information online.

Beneficiaries are able to log into the existing Web portal by logging into their MyMedicare.gov accounts. The Web portal provides detailed data on claims that Medicare paid conditionally that are related to the beneficiary's liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment (hereinafter, for ease of reference, referred to as "settlement(s)"). This detailed claims data for each claim includes dates of service, provider information, total charges, conditional payment amounts, and diagnosis codes.

A beneficiary's attorney or other representative may also register through the Web portal to access conditional payment information. However, in

accordance with federal privacy and security requirements, including the Federal Information Security Management Act (FISMA), we do not permit attorneys and other representatives to view certain aspects of the beneficiary's claims data via the internet. This means that an attorney or other representative currently must pre-register to use the Web portal and must submit proper proof of representation before he or she is able to access a beneficiary's case, but the Web portal limits what the attorney or other representative is able to view.

Once the attorney or other representative is designated as an authorized user, he or she may log into the Web portal to view the conditional payment amount and perform certain actions, which include addressing discrepancies by disputing claims and uploading settlement information. However, in order to dispute claims, the attorney or other representative must have a conditional payment letter (CPL) in hand. A CPL contains data points like diagnosis codes, provider names, and dates of service. The Web portal restricts or ''masks'' certain information— including diagnosis codes, provider names, and dates of service—for individuals other than the beneficiary. Using the CPL, the attorney or other representative can decipher the masked claim-specific information, identify the claim lines that the attorney or representative believe are unrelated to the settlement, and issue the dispute to Medicare's contractor through the Web portal. The masked information will not be displayed through the Web portal to a beneficiary's attorney or other representative until we implement a multifactor authentication solution.

These same security limitations mean that the applicable plan must also pre-register and must submit proper consent to release in order to access a beneficiary's case through the Web portal. The applicable plan is unable to take action on a beneficiary's case unless it has obtained proof of representation that authorizes it to act on behalf of the beneficiary.

As described later in this interim final rule with comment period, we intend to implement a security feature known as multifactor authentication to the Web portal. Multifactor authentication uses a combination of two or more different methods to authenticate a user identity. More information regarding multifactor authentication may be found in the CMS Enterprise Information Security Group Risk Management Handbook, Volume III, Standard 3.1, CMS Authentication Standards, Version 1.2 (Document Number: CMS–CISO–2012–vIII–STD3.1)

This version of CMS' Risk Management Handbook can be found at *http:// www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/ Downloads/RMH_VIII_3-1_ Authentication.pdf.* When we implement multifactor authentication, an authorized attorney or other representative, or an authorized applicable plan, will be able to view claim-specific data—including diagnosis codes, provider names, and dates of service—via the Web portal. Until then, an authorized attorney or other representative and an authorized applicable plan may only view the total conditional payment amount associated with a beneficiary's case.

In keeping with the requirements of the SMART Act, this interim final rule with comment period begins the process of developing a solution that will securely permit authorized users other than the beneficiary to access the beneficiary's personal health information via the internet. We are adding functionality to the existing Web portal that permits users to notify us when the specified case is approaching settlement, download or otherwise obtain time and date stamped final conditional payment summary forms and amounts before reaching settlement, and ensure that relatedness disputes and any other discrepancies are addressed within 11 business days of receipt of dispute documentation.

II. Provisions of the Interim Final Regulations

A. Accessing Conditional Payment Information Through the Medicare Secondary Payer Web Portal

We will continue to provide beneficiaries with access to details on claims related to their pending settlements through the Web portal. This will include dates of service, provider names, diagnosis codes, and conditional payment amounts. Beneficiaries and their attorneys or other representatives will continue to be able to dispute the relatedness of claims and submit a notice of settlement and other types of documentation through the Web portal. We will add functionality that will permit beneficiaries to download or otherwise electronically obtain time and date stamped payment summary forms, and exchange other information securely with Medicare's contractor via the Web portal.

A beneficiary's attorney or other representative and the applicable plan will continue to be able to register through the Web portal and access

conditional payment information related to a beneficiary's pending settlement. However, their access will remain limited until we develop and implement a multifactor authentication process, as defined in and required by the most recent version of the CMS Enterprise Information Security Group Risk Management Handbook, Volume III, Standard 3.1, CMS Authentication Standards, developed in accordance with FISMA and regulations promulgated by the National Institute of Standards and Technology (NIST). The most recent version of CMS' Risk Management Handbook can be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/ Downloads/RMH_VIII_3-1_ Authentication.pdf.*

We will develop a multifactor authentication solution for use in the Web portal within 90 days of the effective date of this interim final rule with comment period. We expect to implement the solution no later than January 1, 2016. Once this solution has been implemented, a beneficiary's authorized attorney or other representatives or an authorized applicable plan that has appropriately registered to access the Web portal will have access to the beneficiary's MSP conditional payment information for a specified MSP recovery case. This information will include dates of services, provider names, diagnosis codes, and conditional payment amounts.

B. Obtaining a Final Conditional Payment Amount

The beneficiary, his or her attorney or other representative, or an applicable plan is required to provide initial notice of pending liability insurance (including self-insurance), no-fault insurance, and workers' compensation settlements, judgments, awards, or other payment to the appropriate Medicare contractor at least 185 days before the anticipated date of settlement. This 185-day timeframe encompasses the 120-day ''protected'' period in section 1862(b)(2)(B)(vii)(I) of the Act and the 65-day Secretarial response period in section 1862(b)(2)(B)(vii)(V) of the Act. The Medicare contractor will compile and post claims that are related to the pending settlement for which Medicare has paid conditionally. This information will be posted to the Web portal within 65 days of receipt of the initial notice of the pending settlement.

Section 1862(b)(2)(B)(vii)(V) of the Act permits us to extend our response timeframe by an additional 30 days if we determine that additional time is

required to address related claims that Medicare has paid conditionally. We anticipate that such situations would include, but are not limited to, the following:

• A recovery case that requires CMS' contractor to review the systematic filtering of associated claims for a case and subsequently adjust those filters manually to ensure that claims are related to the pending settlement, and

• CMS systems failures that do not otherwise fall within the definition of exceptional circumstances.

Section 1862(b)(2)(B)(vii)(V) of the Act also permits us to further extend our claims compilation response timeframe by the number of days required to address the issue(s) that resulted from "exceptional circumstances" pertaining to a failure in the claims and payment posting system. Per the statute, such situations must be defined in regulations in a manner such that "not more than 1 percent of the repayment obligations . . . would qualify as exceptional circumstances." Therefore, we are adding new regulations at 42 CFR 411.39 that define "exceptional circumstances" to include, but not be limited to: System failure(s) due to consequences of extreme adverse weather (loss of power, flooding, etc.); security breaches of facilities or network(s); terror threats; strikes and similar labor actions; civil unrest, uprising or riot; destruction of business property (as by fire, etc.); sabotage; workplace attack on personnel; and similar circumstances beyond the ordinary control of government or private sector officers or management.

The beneficiary, or his or her attorney or other representative, may notify CMS, once and only once, via the Web portal, of an impending settlement, any time after Medicare's contractor has posted its initial claims compilation (65 days after initial notice to Medicare) and up to 120 days before the anticipated date of settlement.

It is important to note that the beneficiary, or his or her attorney or other representative, may request a claims refresh via the Web portal any time after Medicare posts its initial claims compilation. However, the beneficiary, or his or her attorney or other representative, *must* request and receive confirmation of a claims refresh via the Web portal before he or she will be able to obtain a final conditional payment amount. We will provide confirmation of the completion of a claims refresh through the Web portal no later than 5 business days after the electronic request is initiated.

If the beneficiary, or his or her authorized attorney or other

representative, believes that claims included in the most up-to-date conditional payment summary form are unrelated to the pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation "settlement," he or she may address discrepancies through a dispute process available through the Web portal. The beneficiary, or his or her authorized attorney or other representative, may dispute a claim once and only once. The beneficiary or his or her authorized attorney or other representative may be required to submit additional supporting documentation in a form and manner specified by the Secretary to support the assertion that the disputed claim is unrelated to the settlement.

Disputes submitted through the Web portal will be resolved within 11 business days of receipt of the dispute and any required supporting documentation as per 1862(b)(2)(B)(vii)(IV) of the Act.

After disputes have been fully resolved, and the beneficiary, or his or her attorney or other representative, has executed a final claims refresh and obtained confirmation that the refresh has been performed, he or she may download or otherwise request a time and date stamped final conditional payment summary form through the Web portal. This form will constitute the final conditional payment amount if settlement is reached within 3 days of the date on the conditional payment summary form. If the beneficiary or his or her attorney is approaching settlement and any disputes have not been fully resolved, he or she may not download or otherwise request a final conditional payment summary form until the dispute has been resolved.

It is important to note that, as per section 1862(b)(2)(B)(vii)(IV) of the Act, this 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. However, the beneficiary will maintain his or her appeal rights regarding CMS' MSP recovery determination, once CMS issues its final demand. Those appeal rights are explained in the final demand letter issued by CMS and more information may be found in 42 CFR part 405, subpart I.

Within 30 days of securing the settlement, the beneficiary or his or her attorney or other representative must submit through the Web portal "settlement" information specified by the Secretary. We expect that the amount and type of "settlement" information required will be the same

information that CMS typically collects to calculate its final demand amount. This information will include, but is not limited to: The date of "settlement", the total "settlement" amount, the attorney fee amount or percentage, and additional costs borne by the beneficiary to obtain his or her "settlement". We will require that this information is provided within 30 days of the date of settlement. Otherwise, the final conditional payment amount obtained through the Web portal will expire. Once settlement information is received, we will apply a pro rata reduction to the final conditional payment amount in accordance with 42 CFR 411.37 and issue a final MSP recovery demand letter. We understand that providing settlement information within 30 days of the date of settlement may be challenging at times, but we would like to encourage beneficiaries and their attorneys or other representatives to assist us in providing swift resolutions to these matters and promotE timely recoveries for Medicare. We expect to incorporate a method into the Web portal that will allow settlement information to be entered directly through the Web portal and/or uploaded directly through the Web portal.

If the underlying liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim derives from alleged exposure to a toxic substance or environmental hazard, ingestion of pharmaceutical drug or other product or substance, or implantation of a medical device, joint replacement or something similar, the beneficiary or his or her attorney or other representative must provide notice to the CMS contractor via the Web portal before beginning the process to obtain a final conditional payment summary form and amount through the Web portal. Many of these types of recovery cases require additional manual filtering and review to ensure that the claims included in the payment summary form are related to the pending settlement.

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", in the form and manner described in 42 CFR 411.39(c), if the applicable plan has properly registered to use the Web portal and has obtained from the beneficiary and submitted to the appropriate Medicare contractor proper proof of representation. The applicable plan may obtain read only access if the applicable plan obtains from the beneficiary proper consent to release

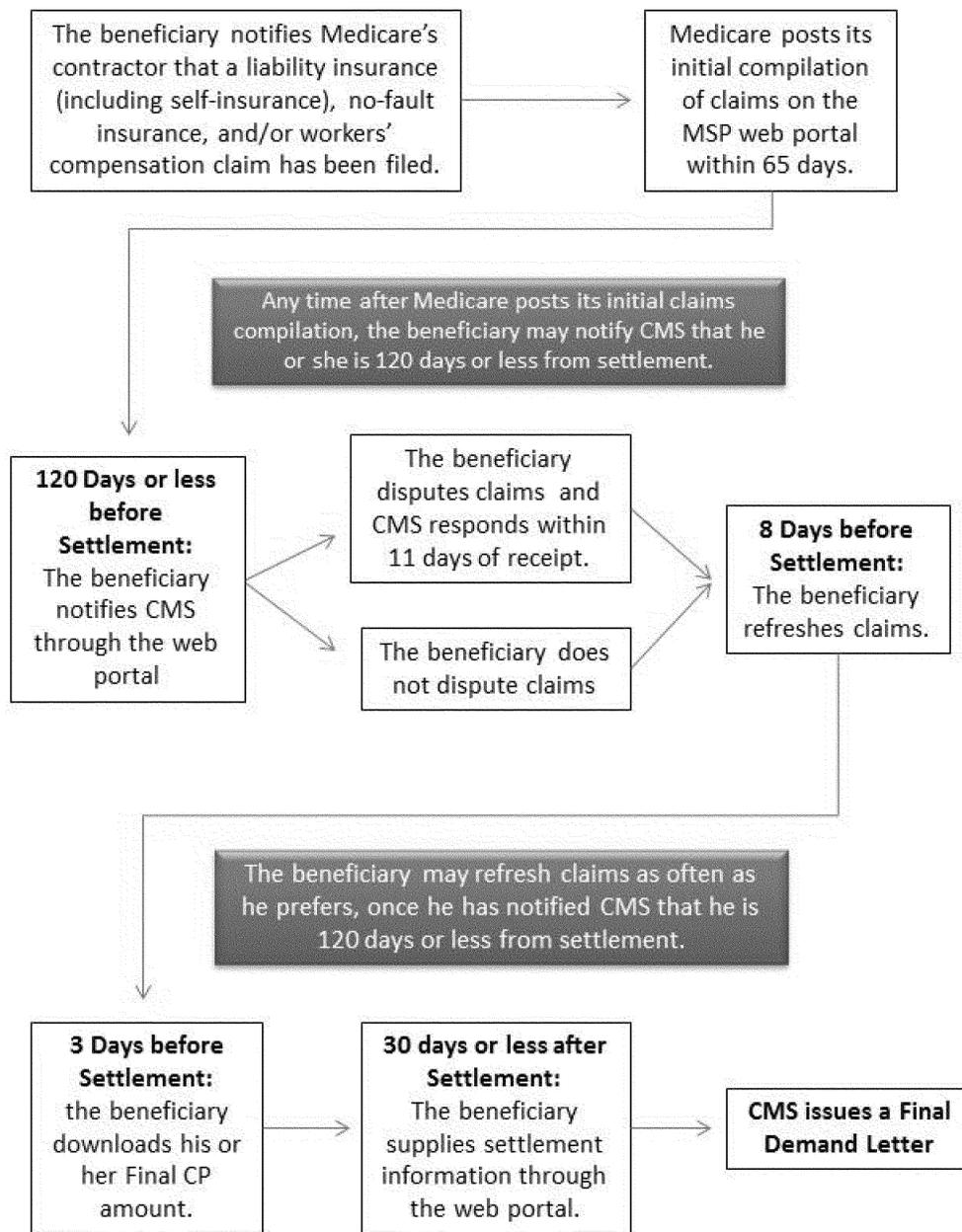and submits it to the appropriate Medicare contractor.

The 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 and that are furnished prior to the time and date stamped on the final conditional payment summary form. Systems and process changes to provide final conditional payment summary forms and amounts via the Web portal will be implemented no later than January 1, 2016.

BILLING CODE 4120–01–P

DIAGRAM 1

The beneficiary notifies Medicare's contractor that a liability insurance (including self-insurance), no-fault insurance, and/or workers' compensation claim has been filed.

Medicare posts its initial compilation of claims on the MSP web portal within 65 days.

Any time after Medicare posts its initial claims compilation, the beneficiary may notify CMS that he or she is 120 days or less from settlement.

120 Days or less before Settlement: The beneficiary notifies CMS through the web portal

The beneficiary disputes claims and CMS responds within 11 days of receipt.

The beneficiary does not dispute claims

8 Days before Settlement: The beneficiary refreshes claims.

The beneficiary may refresh claims as often as he prefers, once he has notified CMS that he is 120 days or less from settlement.

3 Days before Settlement: the beneficiary downloads his or her Final CP amount.

30 days or less after Settlement: The beneficiary supplies settlement information through the web portal.

CMS issues a Final Demand Letter

BILLING CODE 4120–01–C

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. Under Section 553(b) of the Administrative Procedure Act, this procedure can be waived for good cause, if an agency finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. We find that notice-and-comment rulemaking is unnecessary for this rule and that waiving it is in the public interest.

The SMART Act amended the MSP provisions of the Act to establish a new clause in section 1862(b)(2)(B)(vii) of

the Act. This amendment requires us to develop a Web portal through which beneficiaries, their attorneys or other representatives, and authorized applicable plans can obtain Medicare's final conditional payment information before the date of settlement, judgment, award, or other payment.

These new MSP provisions of the Act focus on actions that must be taken by the Secretary to provide the specified Web portal service to the public. This regulation simply provides timeframes that the Secretary must comply with in order to ensure the required enhancements to the already existing MSP Web portal are completed, and that the functionality of the Web portal provides the information required by the Act. Accordingly, we find that notice-and-comment rulemaking is unnecessary because this regulation provides an additional procedural option for stakeholders, but does not change any substantive provision of the MSP program or otherwise impact our administration of the MSP program. In addition, we find that waiving notice-and-comment rulemaking would be in the public interest because requiring a notice of proposed rulemaking and public comment thereon would delay public access to this Web portal. We note that the SMART Act requires that we promulgate regulations to carry out the development and implementation of this Web portal not more than 9 months after enactment of this new legislation (which occurred January 10, 2013). For all of these reasons, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 60-day public comment period.

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

V. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism

(August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that the effect of this proposed rule on the economy and the Medicare program is not economically significant, since it imposes certain requirements on the Agency to merely improve its current mechanism for providing conditional payment information to beneficiaries, their attorneys or other representatives, and authorized applicable plans.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $7.0 million to less than $35.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We have determined that this proposed rule would not have a significant economic impact on a substantial number of small entities because there is and will be no change in the administration of the MSP provisions. Therefore, we are not preparing an analysis for the RFA.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 for proposed rules of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We have determined that this interim final rule with comment period would not have a significant effect on the operations of a substantial number of small rural hospitals because there is and would be no change in the administration of the MSP provisions. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also

requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately $141 million. This proposed rule has no consequential effect on state, local, or tribal governments or on the private sector because there is and will be no change in the administration of the MSP provisions.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

■ 2. Subpart B is amended by adding § 411.39 to read as follows:

§ 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.

Dated: July 18, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 11, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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