

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 411

[CMS-6054-F]

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: Final rule.

SUMMARY: This final rule 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 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 statements 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: These regulations are effective June 16, 2016.

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

SUPPLEMENTARY INFORMATION:

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 (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.

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.

Beneficiaries' attorneys or other representatives, as well as applicable plans, may register through the Web portal to access conditional payment information. In order to comply with federal privacy and security requirements, including the Federal Information Security Management Act (FISMA), we have implemented a multifactor authentication tool that will permit authorized individuals, other than the beneficiary, to securely access detailed conditional payment information through the Web portal.

Once the beneficiary's 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. It is important to note that, in situations where there is a pending insurance or workers' compensation settlement, the beneficiary is designated as the "identified debtor". This means that only the beneficiary and his or her attorney or other representative have the authority to take action on the beneficiary's MSP recovery case. This includes disputing claims and requesting a final conditional payment amount through the Web portal. An applicable plan is only able to take these actions if it submits proper proof of representation. The applicable plan cannot take action on a beneficiary's case unless it has obtained proof of

representation that authorizes it to act on behalf of the beneficiary.

In keeping with the requirements of the SMART Act, we have added 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 statements 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 Rule With Comment and Analysis of and Response to Public Comments

A. Introduction

In the September 20, 2013 **Federal Register** (78 FR 57800), we published an interim final rule with comment period (IFC) that specified 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 required 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 statements 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. We received 21 timely public comments. In this final rule, we provide a general overview of the public comments received by subject area, with a focus on the most common issues and suggestions raised.

B. Definitions

In the September 2013 IFC (78 FR 57804), we defined "Applicable plan" as the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan or arrangement:

- Liability insurance (including self-insurance).
- No fault insurance.
- Workers' compensation laws or plans.

We also defined "Medicare Secondary Payer conditional payment information" as a term that means all of the following:

- Dates of service.
- Provider names.
- Diagnosis codes.
- Conditional payment amounts.
- Claims detail information.

Comment: Many commenters requested that we define certain terms in the regulation.

Response: We note we have defined “applicable plan” in § 411.39(a) of the regulation text.

We note that we are removing the definition of “Medicare Secondary Payer conditional payment information” to avoid redundancy and confusion. The language of the rule, itself, specifies which pieces of conditional payment information will be available via Web portal, based upon the level of authorization the user has when he or she accesses the Web portal.

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

In the September 2013 IFC (78 FR 57801), we noted that 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 have added functionality that will permit beneficiaries to download or otherwise electronically obtain time and date stamped payment summary statements, 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 to use the Web portal and access conditional payment amounts. To access more detailed information related to a beneficiary’s pending settlement, users will register to use 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.

With this tool, a beneficiary’s authorized attorney or other representatives or an authorized

applicable plan that has appropriately registered to access the Web portal, and has registered to use the multifactor authentication tool, has access to more detailed MSP conditional payment information for a specified MSP recovery case. This additional information includes dates of services, provider names, diagnosis codes, as well as the conditional payment amounts already available through the Web portal. If an authorized user does not register to use the multifactor authentication tool, he or she will continue to have access to the conditional payment amounts and he or she will continue to be able to perform certain functions, but details, including dates of service, provider names, diagnosis codes, will not be visible to that user.

Comment: Many commenters stated that beneficiaries should not be required to set up separate accounts to access the Web portal because they can already access the information on the Web portal through their *MyMedicare.gov* accounts.

Response: The provisions of the September 2013 IFC do not require that beneficiaries set up separate accounts. Beneficiaries who access the existing Web portal are instructed to login to their *MyMedicare.gov* accounts. Beneficiaries will continue to access information on the Web portal through their *MyMedicare.gov* accounts.

Comment: Many commenters stated that “pre-registration” to use the Web portal negates its utility and pre-registration should not be required.

Response: To clarify, registration is already required when accessing the existing Web portal for the first time. Once an authorized user has access to the portal, the user may, at any time, elect to register to use the multifactor authentication tool to access more detailed information. We note that authorized users will be able to view information on the Web portal, regardless of whether the beneficiary has accessed the portal or logged in through *MyMedicare.gov*.

Comment: Many commenters stated that multifactor authentication is not needed because CMS already provides this information by mail and it will delay development of the Web portal solution.

Response: We require written proof of representation or consent to release (depending on the nature of the relationship between the beneficiary and the individual or entity requesting the beneficiary’s information) before we provide privacy protected information, by mail or by phone, to authorized representatives or other authorized

individuals or entities. To provide information that is categorized as personally identifiable information via the internet, all government agencies, including CMS, are bound by statutory requirements imposed by the Federal Information Security Management Act (FISMA), as well as security regulations promulgated by the National Institute of Standards and Technology. For more information on security requirements, see section II.D. of this final rule.

D. Obtaining a Final Conditional Payment Amount

In the September 2013 IFC (78 FR 57801), we noted that once the beneficiary, his or her attorney or other representative, or an applicable plan provides notice of pending liability insurance (including self-insurance), no-fault insurance, and workers’ compensation settlements, judgments, awards, or other payments to the appropriate Medicare contractor, the Medicare contractor will compile and post claims that are related to the pending settlement for which Medicare has paid conditionally. Once a recovery case is established and posted on the Web portal, the beneficiary, or his or her attorney, other representative, or authorized applicable plan may access the recovery case through the Web portal, and notify CMS once—and only once—that a settlement is expected to occur in 120 days or less. Conditional payment information will be posted to the Web portal within 65 days or less of receipt of the 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.
- 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 result 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.

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 statement are unrelated to the pending liability insurance (including self-insurance), no-fault insurance, or workers’ compensation settlement, he or she may address discrepancies through the dispute process available through the Web portal. The beneficiary, or his or her authorized attorney or other representative, may dispute the relatedness of an individual conditional payment 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 conditional payment is unrelated to the settlement. If the Medicare contractor does not accept a dispute for a particular conditional payment, that conditional payment will remain part of the total conditional payment amount and may not be disputed through this process again.

Once CMS has been notified that a pending settlement is 120 days or less from settlement, disputes submitted through the Web portal will be resolved within 11 business days of receipt of the dispute, including any required supporting documentation, as per section 1862(b)(2)(B)(vii)(IV) of the Act.

After 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 final conditional payment summary statement through the Web portal. This statement will constitute the final conditional payment amount if settlement is reached within 3 days of the date on the conditional payment summary statement. 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 statement until the dispute has been resolved.

It is important to note that, 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 405, subpart I.

The beneficiary or his or her attorney or other representative may obtain the recovery demand letter by submitting settlement information specified by the Secretary through the Web portal in 30 days or less from date of settlement. The amount and type of settlement information required will be the same information that CMS typically collects to calculate its recovery 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. This information must be provided within 30 days or less of the date of settlement. Otherwise, the final conditional payment amount obtained through the Web portal will expire and any additional conditional payments with dates of service through and including the date of settlement will be included in the recovery demand letter. 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 MSP recovery demand letter. 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.

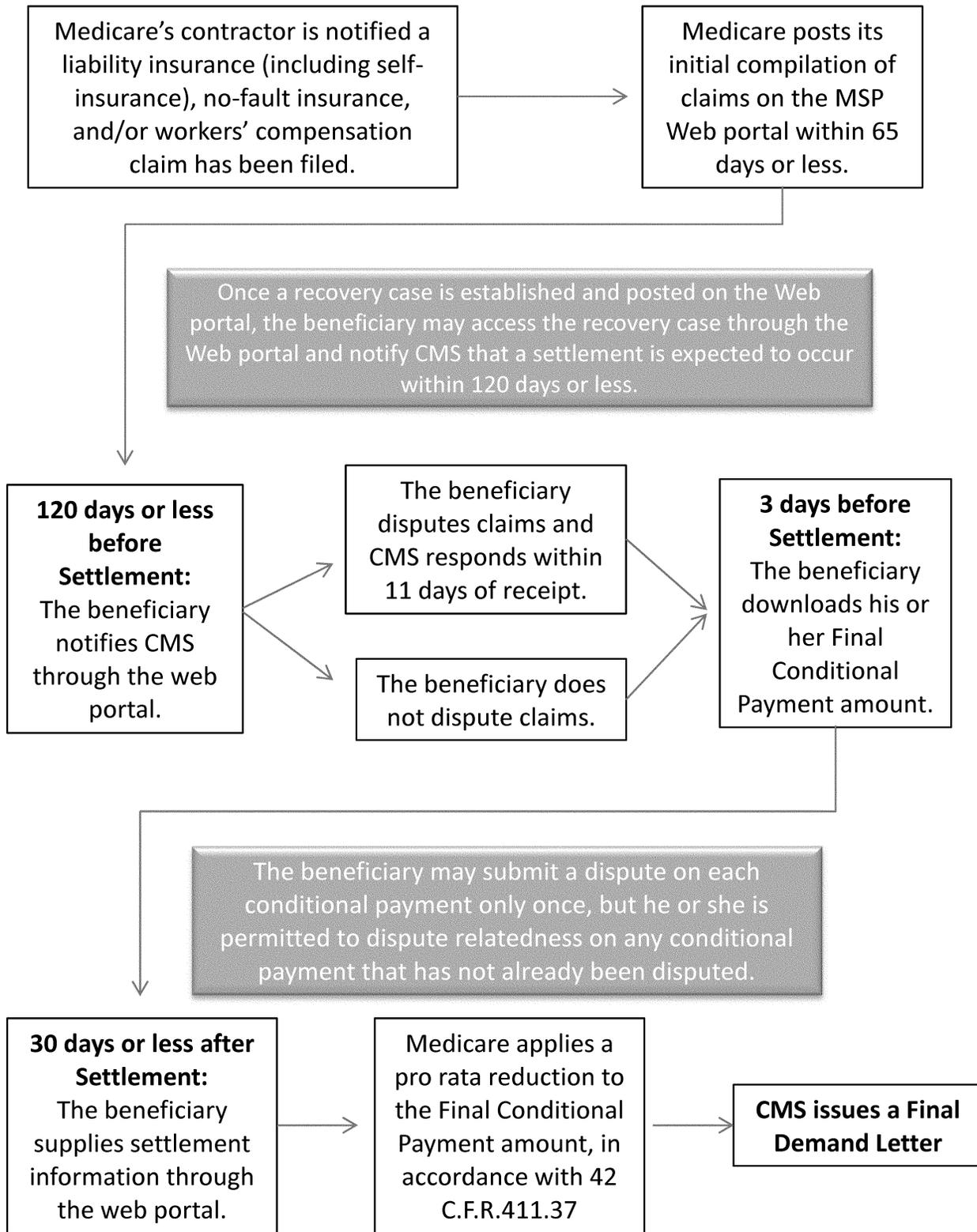
If the underlying liability insurance (including self-insurance), no-fault insurance, or workers’ compensation claim derives from alleged exposure to a toxic substance or environmental hazard, ingestion of pharmaceutical drug or other product or substance, or implantation of a medical device, joint replacement 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 statement 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 statement are related to the pending settlement.

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, 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 amount obtained via the Web portal represents 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 statement. Systems and process changes to provide final conditional payment summary statements and amounts via the Web portal were implemented on January 1, 2016.

BILLING CODE 4120-01-P

DIAGRAM 1



Comment: Many commenters requested clarity on what it means to dispute a claim “once and only once.”

Response: We have clarified the language in the final rule to reflect that a claim, meaning an individual conditional payment amount, or line item, on a payment summary statement, may be disputed once and only once. An individual or entity may submit disputes more than once, but never for the same conditional payment or line item.

Comment: Many commenters requested clarity on what it means to provide initial notice and why notice about the impending settlement must be supplied separately.

Response: In order for us to establish an MSP recovery case and initiate claims compilation in our system, we must know that there is a pending insurance or workers’ compensation claim. This means that a beneficiary, his or her attorney or other representative, or the insurer or workers’ compensation entity must call or write to us. This type of notice does not necessarily mean that the reported insurance or workers’ compensation claim is 120 days (or less) from settlement. If the insurance or workers’ compensation claim is, in fact, 120 days or less from settlement, that notice may be provided through the Web portal, once a recovery case has been posted on the Web portal.

Comment: Many commenters requested clarification regarding whether Medicare continues to make conditional payments after the initial claims compilation is complete, how the claims refresh interacts with the dispute process, and whether the concept of the claims refresh is consistent with what the SMART Act requires.

Response: Medicare pays conditionally up through and including the date of settlement. In this final rule, we have removed the claims refresh requirement.

Comment: Many commenters requested that we remove the limitation that an anticipated settlement may be reported to CMS once and only once, via the Web portal, after we have completed the initial claims compilation.

Response: We recognize that it can often be difficult to project exactly when a settlement will occur. However, the SMART Act imposed workload timeframes on CMS related to the processing of cases that expect to settle within 120 days. Where we fail to comply with such timeframes, the SMART Act requires us to relinquish certain rights related to recovery. As a result, we have developed the “once and only once” requirement to

encourage conscious decision-making by identified debtors and to promote our ability to provide timely and responsive service.

Comment: Many commenters requested clarification regarding the timeframe in which settlement information must be provided and specifically requested that CMS utilize a 90-day timeframe, rather than a 30-day timeframe. A few commenters requested that the 30-day timeframe remain optional because this timeframe is not in the SMART Act. They further asserted that there is no need for such a timeframe because many beneficiaries do not have attorneys, thereby negating the need to apply a pro rata reduction.

Response: In this final rule, we clarify that settlement information must be submitted within no more than 30 days of reaching settlement in order for CMS to remain bound by any final conditional payment amount it provided through the Web portal.

We recognize that the intent of the final conditional payment process is to expedite Medicare reimbursement and promote timely settlement. However, we are required to apply a pro rata reduction, in accordance with 42 CFR 411.37, to account for attorney fees and costs borne by the beneficiary to obtain his or her settlement. In order to comply with this regulatory requirement and comport with the aforementioned intent of the final conditional payment process, we have imposed a requirement that settlement information must be submitted within no more than 30 days of reaching settlement.

Comment: Many commenters expressed concern that being required to reach a settlement within 3 days of obtaining a final conditional payment amount is not a reasonable timeframe.

Response: The SMART Act specifically established this 3-day timeframe. As a result, we maintain this requirement in this final rule. If settlement is not reached within 3 days of obtaining the final conditional payment amount, we are not bound by the final conditional payment amount. This means that, once settlement information is submitted, we will review any conditional payments it made for dates of service up through and including the date of settlement and issue our demand letter.

Comment: Many commenters raised concerns regarding the IFC’s reference to future medical obligations.

Response: We recognize that the SMART Act did not specifically reference future medical care, but medical care related to the insurance or workers’ compensation claim may continue to be provided after the date of

settlement. As a result, we have retained the language referencing future medical items and services.

E. Discussion of Additional Comments by Public Comment Topic

1. Publication of an IFC Versus a Proposed Rule

Comment: Many commenters requested that CMS retract the IFC and issue a proposed rule before finalizing a rule related to the MSP Web portal.

Response: Section 201 of the SMART Act imposed an obligation on the Secretary to promulgate final regulations not later than 9 months after the date of the enactment of this clause. In order to promulgate a final rule in such a short timeframe, we were required to forego the more traditional rulemaking process, which would have resulted in significant delay, and publish an IFC that simply reflected the addition of key process components that the SMART Act requires CMS to include in existing recovery program.

2. Timeframes of the IFC

Comment: Many commenters questioned whether certain timeframes stipulated in the IFC comported with the requirements in the SMART Act.

Response: We recognize that there is some confusion regarding the 65-day Secretarial response timeframe and 120-day protected period. We have clarified the language in this final rule to establish that a final conditional payment amount may be requested at any time after a recovery case has been posted on the Web portal. Additionally, there is no requirement that 120 days must elapse before a final conditional payment amount may be requested.

Comment: Many commenters raised concerns that beneficiaries will be unable to meet timeframes specified in the IFC because they do not have or use computers or because they do not access the Internet.

Response: We understand these concerns, but pursuing a final conditional payment amount before settlement is not required. Information will be available on the Web portal, regardless of whether the Final conditional Payment process is used. Further, the existing process that CMS’ contractor uses to provide conditional payment information and demand letters via mail will continue to be available.

III. Provisions of the Final Regulations

After consideration of all of the comments received, we are finalizing the provisions included in the September 2013 IFC (78 FR 57800) with the following modifications to § 411.39:

• Paragraph (a), we are removing the definition of “Medicare Secondary Payer conditional payment information” to avoid redundancy and confusion.

• Paragraph (b), we removed language related to Web portal functionality before January 1, 2016.

• Paragraph (c)(1)(iii), we removed the claims refresh requirement.

• Paragraphs (c)(1)(iv) and (v), we revised the language to clarify that a claim, meaning an individual conditional payment amount, or line item, on a payment summary statement, may be disputed once and only once. An individual or entity may submit disputes more than once, but never for the same conditional payment or line item.

• Paragraph (c)(1)(viii), we revised the language to clarify that settlement information must be submitted within no more than 30 days of reaching settlement in order for CMS to remain bound by any final conditional payment amount it provided through the Web portal.

• Paragraph (c)(2), we revised the language to clarify that a final conditional payment amount may be requested at any time after a recovery case has been posted on the Web portal.

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 final 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 \$7.5 million to less than \$38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We have determined that this final rule will 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 final rule will 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 2015, that threshold is approximately \$146 million. This final 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 final rule 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 final rule 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 adopts as final, the interim rule amending 42 CFR part 411 which was published on September 20, 2013 (78 FR 57800) with the following changes:

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. Amend § 411.39 by:

■ A. In paragraph (a) removing the definition of “Medicare Secondary Payer conditional payment information”.

■ B. Revising paragraph (b)(1)(ii).

■ C. Removing paragraph (b)(2).

■ D. Redesignating paragraph (b)(3) as (b)(2).

■ E. Revising newly redesignated paragraph (b)(2).

■ F. Revising paragraph (c).

The revisions 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.

* * * * *

(b) * * *

(1) * * *

(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.

(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.

(1) 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.

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Dated: April 25, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 29, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2016-11270 Filed 5-13-16; 11:15 am]

BILLING CODE 4120-01-P