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Medicare's Commercial Repayment Center

The purpose of the Medicare Secondary Payer (MSP) program is to ensure that Medicare is aware of situations where it should not be the primary, or first, payer of claims. The Coordination of Benefits and Recovery program (COB&R) serves several purposes, one of which is to identify mistaken payments made my Medicare when anther insurer or entity is the primary payer. The COB&R activities are accomplished through two entities, the Benefits Coordination & Recovery Center ("BCRC") and the Commercial Repayment Center (CRC).

Historically, when Medicare asserted a reimbursement right, it did so through the BCRC. However, as part of the continuing efforts to improve the COB&R program, the Centers for Medicare & Medicaid Services (CMS) transitioned a portion of BCRC workload to the CRC. The BCRC will continue to handle reimbursement requests directed towards Medicare beneficiaries as well as reimbursement requests issued to liability insurers, no-fault insurers or workers' compensation entities before October 5, 2015. The CRC is now responsible for pursuing reimbursement from liability insurers (including self-insured entities), no-fault insurers and workers' compensation entities (all of whom are referred to as "Applicable Plans") where the Applicable Plan is the identified debtor.

Applicable Plans must respond quickly to the CRC. The CRC issues the following types of correspondence.

1. **Conditional Payment Letter ("CPL")**

    - A CPL is issued if a Medicare beneficiary reports a pending case where an Applicable Plan may have primary payment responsibility, before the Applicable Plan submits a Section 111 report. There is no deadline for a response, but the Applicable Plan is encouraged to respond quickly in certain situations.

2. **Conditional Payment Notice ("CPN")**

    - A CPN is issued when the Applicable Plan notifies CMS that it has primary payment responsibility (or submits a Section 111 report) and Medicare has made conditional payments. An Applicable Plan has **30 days** from the date on the CPN to challenge the claims in the CPN. If not disputed within 30 days, a demand letter will be issued requiring payment, and interest will be assessed.

3. **Demand Letter**

    - Demand letters seek payment within 60 days. Applicable Plans have **120 days** from receipt of a demand to file an appeal. Receipt is presumed to be five (5) calendar days from the date of the demand letter absent evidence to the contrary.

Valuable Resources

The CMS web site contains additional information on the CRC and the recovery and appeals process.

- CMS Coordination of Benefits & Recovery Overview
- Insurer NGHP Recovery
- Non-Group Health Plan Recovery
- Non-Group Health Plan Recovery – New Workload to the Commercial Repayment Center
- Frequently Asked Questions about the Commercial Repayment Center Non-Group Health Plan Recovery Workload Transition

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