Welcome to the Medicare Secondary Payer Recovery Portal (MSPRP) Disputing a Claim course.
As a reminder, you may view the slide number you are on by clicking on the moving cursor. Additionally, you can view the narration by clicking the [CC] button in the lower right-hand corner of the screen.
Disclaimer

While all information in this document is believed to be correct at the time of writing, this Computer Based Training (CBT) is for educational purposes only and does not constitute official Centers for Medicare & Medicaid Services (CMS) instructions. All affected entities are responsible for following the instructions found in the MSPRP User Manual found at the following link: http://www.cob.cms.hhs.gov/MSPRP/.

Slide notes

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Course Overview

- Process for disputing a claim that is not related to the case
- What to expect once a claim has been disputed

Slide notes

This course will explain the process for disputing a claim that is not related to the case and what to expect once a claim has been submitted for dispute.
Under the Medicare Secondary Payer (MSP) laws (42 U.S.C. §1395y(b)), Medicare does not pay for items or services to the extent that payment has been, or may reasonably be expected to be, made through a no-fault or liability insurer or through workers’ compensation.

Medicare may pay for services on behalf of a Medicare beneficiary when there is evidence that the primary plan does not pay promptly.

These payments are referred to as conditional payments because the money must be repaid to Medicare when a settlement, judgment, award, or other payment is secured.

If a claim that is not related to the case has been included in the conditional payment amount, you may select the claim for dispute on the MSPRP.
In order to dispute a claim, go to the Case Information page on the MSPRP for the case. The Current Conditional Payment Amount is shown on the top-half of this page. It includes all medical claims that are related to the case which have been paid by Medicare as of the Conditional Payment Amount Updated on date.

To better communicate the precise status of debts, the Case Information page header and Payment Information tab have been updated. The header has an added case status value of Extended Repayment, as well as new fields when ongoing responsibilities for medicals (ORM) is present and when a case is referred to Treasury. In addition, the Payment Information tab has an updated status note value, rearranged fields, and a new Conditional Payment Letter Amount field.

You can dispute claims when: Case Status is Open, Authorization Type is Proof of Representation, Authorization Status is Verified, and Current Conditional Payment Amount is greater than zero.

For a case that is in the Final Conditional Payment Process, you can dispute claims when the Final Conditional Payment Status is Active. Click the Final Conditional Payment Process tab to view status.
Note: The Case Information page now displays Go Paperless indicators next to the Case ID indicating that the Account associated with the Case has registered for the Go Paperless option. These accounts receive letter notification e-mails instead of mailed letters.
Slide notes

To view and/or dispute the claims included in the Current Conditional Payment Amount, select the View/Dispute Claims Listing action.

Note: If a case has been demanded or has completed or is pending settlement in the Final Conditional Payment process, clicking the View/Dispute Claims Listing action redirects you to the Demand Claims Listing page.

This read-only page displays information regarding the demanded claims for the selected case, such as the Total Charges, Reimbursed Amounts, and Conditional Payments.
Once the View/Dispute Claims Listing action is selected, the MSPRP retrieves all of the claim information that is included in the Current Conditional Payment Amount and displays that information on the Claims Listing page.

Note: The retrieval of this information may be slightly delayed depending on the volume of claims information returned.

The Case ID is displayed at the top of the page. Claim information that is currently associated to the Case ID is displayed under the Claims heading on the bottom half of this page.

To help users select all claims displayed on the Claims Listing page, a Select All/Deselect All hyperlink is now available.

Note: Due to the requirements of the Centers for Medicare & Medicaid Services (CMS) Department of Health & Human Services (DHHS) Privacy Rule, all protected health information (PHI) will not be included on the Claims Listing page.
For each claim included on the Claims Listing Page, the Claim Control ID (ICN), Line Number, Total Charges, Reimbursed Amount and Conditional Payment are displayed.

Also, if applicable, the Dispute Submitted Date and Dispute Decision Date are displayed.

The Claim Number/Internal Control Number assigned to the claim by the Medicare processing contractor is displayed in the Claim Control ID (ICN). The first eight characters will be masked (hidden) from view.

The Line number is a reference to the individual service rendered on the claim. The Total Charges indicate the amount billed by the provider.

The amount Medicare paid the provider is shown in Reimbursed Amount and the amount Medicare is seeking is indicated in the Conditional Payment.

The Dispute Submitted Date is the last date a dispute was submitted on the claim. It is blank if no dispute has been submitted or if a dispute was submitted prior to the implementation of this feature.

If the submitted dispute is denied, the decision date will display in the Dispute Decision Date. However, if a claim dispute is approved, the claim is automatically removed from the Claims Listing page.
In order to assist you in correctly identifying a payment for dispute, it is recommended that you have the Payment Summary Form that is mailed with the Conditional Payment letter.

The Payment Summary Form will have more comprehensive information than what is displayed on the Claims Listing page and will assist you in identifying and matching the claim information for dispute.

The claim information displayed on the Claims Listing page will be listed in the same order as the Payment Summary Form that is mailed with the Conditional Payment letter.

However, the claims displayed on the Claims Listing page may differ from those listed on your Payment Summary Form if there has been any recent case activity between the date of the Payment Summary Form and the current date.

For example, information may have been removed as a result of a dispute or added as a result of a request to update the conditional payment amount.
Payment Summary Form

- Review each claim
  - Dates of Service
  - Rendering physician
  - Diagnosis Code(s)

- Note: Diagnosis codes used by Medicare are known as ICD-9 or ICD-10 CM codes

- For assistance in understanding these codes, go to https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

Slide notes

Review each claim (the dates of service (From and To Dates), the rendering physician (Provider Name) and the Diagnosis Codes) and determine if it is related to the injuries/illness in the lawsuit.

Note: The diagnosis codes used by Medicare are known as ICD-9 or ICD-10-CM codes which mean the International Classification of Diseases 9th or 10th Revision, Clinically Modified.

These codes represent the reason for the office visit or medical test.

Note: An ICD indicator has been added to the system-generated Payment Summary Form with each claim line specifying whether the code is for ICD-9 or ICD-10.

If you need assistance in understanding these codes, go to the following link: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html where CMS publishes updates regarding ICD-9 and ICD-10 diagnosis codes
Slide notes

To dispute the inclusion of a claim(s) that is/are unrelated to your case, click the Dispute checkbox next to the claims(s) in dispute.

Note: If the Dispute checkbox contains a faded checkmark, this indicates the claim has been previously selected for dispute and is currently under review.

When all disputed claims have been selected, click [Continue] to proceed.
The Claims Dispute Verification page displays. This page will allow you to verify the claims you have disputed and to upload documentation that supports the dispute(s).
Slide notes

The Claims Disputed section of this page displays the claims that you selected for dispute for the Case ID.

The Type of Service masked (hidden) Claim Control ID (ICN), Line Number, Total Charges, Reimbursed Amount and Conditional Payment will display for each claim. Verify this list to ensure that it only includes claims you believe are un-related to the case.

To revise the list, click [Previous] to be returned to the Claims Listing page.
Disputing A Claim

Slide 14 - of 27 - Claims Dispute Verification

**Claims Dispute Verification**

Below is a list of claims associated to Case ID: 26111174099030169 you have selected for dispute, please review for accuracy. To revise your selection click the Previous button.

**Developer Note:** Below paragraph text is displayed only when Case is in the Final CP process (i.e., MSPP Final Conditional Payment Status is Active).

This case is a Final Conditional Payment case which means that a claim or line item can only be disputed one time after the Final Conditional Payment process was initiated. However, the identified debtor will maintain his or her appeal rights regarding CMS Medicare Secondary Payer (MSP) recovery determination once CMS issues its final demand.

**Claims Disputed:**

<table>
<thead>
<tr>
<th>Claim Control # (ICN)</th>
<th>Line Number</th>
<th>Total Charges</th>
<th>Reimbursed Amount</th>
<th>Conditional Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>66666666</td>
<td>1</td>
<td>$500.00</td>
<td>$500.00</td>
<td>$500.00</td>
</tr>
<tr>
<td>99999999</td>
<td>2</td>
<td>$200.00</td>
<td>$200.00</td>
<td>$200.00</td>
</tr>
<tr>
<td>00000000</td>
<td>3</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

**Supporting Information & Documentation: What is this?**

You are required to provide a brief description of the injury and explanation for any claims you dispute as unrelated to the case or upload supporting documentation, as applicable. If you have more than one explanation, please provide the date range for each explanation. (Example: Claims with the dates between January 1, 2010 and September 12, 2010 were for back surgery but the case is for a sprained knee.)

Please note: This case is in the Final Conditional Payment process which means that a claim can only be disputed one time. In order to ensure proper review of your disputed claim, it is in your best interest to provide complete and accurate supporting documentation at this time. Once the dispute is submitted, you will not have the option to submit additional documentation until after CMS issues its final demand.

For disputes that require additional information, please upload supporting documentation. (Examples of when supporting documentation should be uploaded include: providing clarification of incident related injuries, proving a pre-existing condition, or establishing medical need or extent of treatment.)

**Slide notes**

After you have verified the claims that were selected for dispute, you must submit documentation (evidence) to support your contention. You can enter up to 500 characters of free-form text to explain the reason for your dispute.

Any text input here will be added to the permanent case file once you select [Continue]. If you click [Previous], the input text will be lost.

If you require additional space to support your dispute, create a .PDF file of your documentation.

Note: If you are providing copies of the corresponding medical records highlight and/or mark the pertinent areas of the records or documents which support your position.
Supporting Documentation Guidelines

<table>
<thead>
<tr>
<th>Reason for Claims Dispute</th>
<th>Supporting Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Health Conditions (e.g., flu, diabetes, etc.)</td>
<td>None</td>
</tr>
<tr>
<td>Dates of service were after the physician completed treatment for the injury</td>
<td>Physician’s certification:</td>
</tr>
<tr>
<td></td>
<td>• Treatment has been completed</td>
</tr>
<tr>
<td>Injuries are not being pursued as part of the case</td>
<td>Medical proof and documentation such as:</td>
</tr>
<tr>
<td></td>
<td>• Court complaint showing condition isn’t being pursued as part of the case</td>
</tr>
</tbody>
</table>

http://go.cms.gov/cobro

Slide notes

Claims that are being disputed for general health conditions (e.g., flu, diabetes, etc.) do not require supporting documentation.

Claims that are being disputed because the dates of service on the claims were after your physician completed treatment for the alleged injury require a physician's certification that treatment has been completed.

Please refer to the “Future Medicals” document found on the Non Group Health Plan Recovery page. The following link may be used to access the section’s main page, http://go.cms.gov/cobro.

Once on the Coordination of Benefits & Recovery Overview page, click the Non Group Health Plan Recovery link on the left side menu and scroll to Downloads area near the bottom of the page.

Claims that are being disputed for injuries that are not being pursued as part of the case (e.g., the case in question is related to the back and some of the claims included in the current conditional payment amount are related to the neck) require medical proof and documentation such as a court complaint that shows this condition isn’t being pursued as part of the case.
Slide notes

To upload supporting documentation, click [Upload Documentation].
Once clicked, the Dispute Claims Documentation Upload page will display.

The MSPRP requires each uploaded file to be: an Adobe Acrobat (.PDF) file less than or equal to 40 MB, and virus free.

The filename must only include the following valid characters: any letter (A-Z or a-z), any number (0-9), and any of the following special characters: hyphen (-), period (.) or underscore (_). The filename cannot include spaces.

Files that do not meet these criteria will be rejected.

Users should not upload documents with formats larger than 8.5 x 11 inches.

Please be aware that if you upload a PDF file that has been annotated (saved with notes using PDF Annotator software), there is no guarantee on how overlapping annotations will be translated in the document when it is sent to the imaging system.

To begin the upload process, enter the file name and path/location in the text box, or click [Browse] to search your computer for the desired file. When you click [Browse], a pop-up box displays.

Locate the file that you want to upload. Once the file is located, click the file name and then click [Open]. When the file has been selected, the file name and location will appear on the Documentation Upload page.
To upload additional files, use the next available text box on the page. Note: You are limited to uploading 5 files at a time.

Once all files have been identified, click [Continue].

If any file is not in .PDF format, exceeds 40 MB, contains a virus, or cannot be located, you will receive an error message.

If you receive an error message, none of the files will be uploaded. You must correct the problem(s) and upload the files again.
Slide notes

If all files are virus free, the Claims Dispute Verification page will display. The name of each uploaded file will display on the bottom of this page.

If you have additional files to upload, select Upload Documentation to repeat the upload process until all of your supporting documentation has been uploaded.
Slide notes

Once all documentation has been uploaded, review the documents that were submitted. If an incorrect file was uploaded, click [Delete] which can be found next to the uploaded item. This will remove the file and it will not be uploaded to the case.

If there is a need to upload a different document, click [Upload Documentation]. You will be returned to the Documentation Upload page.

To complete the submission of the dispute documentation, click [Continue]. The Claims Dispute Confirmation page will display.

Note: If you are submitting documentation via the MSPRP, do not send or fax duplicate copies to Medicare as that will only slow down the review process.
Slide notes

The Claims Dispute Confirmation page confirms that you have successfully submitted claims for dispute.

The masked (hidden) Claim Control ID (ICN), Line Number, Total Charges, Reimbursed Amount and Conditional Payment for each disputed claim will display.

The file names of any documentation submitted to support the contention will also display. Click [Continue] to return to the Case Information page.
Slide notes

Allow 45 days for Medicare to review each disputed claim and make a determination.

Note: Disputes related to Final Conditional Payment (Final CP) are addressed within 11 business days. See Chapter 15 in the MSPRP User Guide for further information.
Next Steps

- CMS will contact you by letter if additional information is required
- Once the review is complete, you will receive a letter explaining CMS’ determination

Slide notes

CMS will contact you by letter if additional information is required to support the removal of the charges before a determination can be made.

You will receive a letter explaining CMS’ determination once the review is complete.

Note: As of July 2018, you will be able to monitor the correspondence that has been sent to you on the Letter Activity tab of the Case Information page.

Note: The Letter Activity tab of the Case Information page, added in July of 2018 to allow users to monitor the correspondence that has been sent, has been updated to allow users to view and print outgoing correspondence on the MSPRP. This page now allows beneficiaries or authorized representatives logged in using MFA to click the Correspondence Type to open a PDF of outgoing correspondence using a new Images for Correspondence Type page.
Next Steps

• If CMS disagrees with your dispute
  ▪ Claims submitted for dispute remain on the Claims Listing page and the Dispute checkbox will be unchecked
  ▪ Dispute Decision Date reflects the date for the dispute decision
  ▪ Case information page not updated

Slide notes

If CMS disagrees with your dispute and determines that all of the claims submitted for dispute are related to the case:

- All claims submitted for dispute will remain on the Claims Listing page;
- The Dispute checkbox will be unchecked;
- The Dispute Decision Date is revised to reflect the date for the dispute decision; and
- The Current Conditional Payment Amount, Conditional Payment Updated On and Conditional Payment Letter Mail Date will not be revised on the Case Information Page.
Next Steps

- **If CMS agrees with your dispute**
  - Conditional Payment Letter sent to all authorized parties
    - Includes the Current Conditional Payment Amount
    - Includes revised Payment Summary Form

**Slide notes**

If CMS agrees (fully or partially) with your dispute and determines that all (or some) of the claims submitted for dispute are not related to the case,

the Conditional Payment Letter will be sent to all parties authorized on the case (i.e., the beneficiary and each individual/entity that has a Verified Proof of Representation, Recovery Agent Authorization, or Consent to Release on file for the case).

This letter will include the Current Conditional Payment Amount and a revised Payment Summary Form.

Note: During this review process, if Medicare identifies additional payments that are related to the case, they will be included in a recalculated Conditional Payment Amount and updated Conditional Payment Letter.

If CMS agrees (fully or partially) with your dispute and determines that all (or some) of the claims submitted for dispute are not related to the case,

the Conditional Payment Letter will be sent to all parties authorized on the case (i.e., the beneficiary and each individual/entity that has a Verified Proof of Representation, Recovery Agent Authorization, or Consent to Release on file for the case).
This letter will include the Current Conditional Payment Amount and a revised Payment Summary Form. 

Note: During this review process, if Medicare identifies additional payments that are related to the case, they will be included in a recalculated Conditional Payment Amount and updated Conditional Payment Letter.
Next Steps

- If CMS agrees with your dispute
  - Claims that CMS has agreed are un-related will automatically be removed from the Claims Listing page
  - Case Information page updated
    - Current Conditional Payment Amount
    - Conditional Payment Updated On
    - Conditional Payment Letter Mail Date

Slide notes

All claims that CMS has agreed are un-related will automatically be removed from the Claims Listing page. All other claims will remain associated to the case.

The Case Information page will be updated with the Current Conditional Payment Amount. The Conditional Payment Updated On will be revised to the date the Current Conditional Payment Amount was updated.

The Conditional Payment Letter Mail Date will be updated to the date the Conditional Payment Letter was sent.
Course Summary

- Process for disputing a claim that is not related to the case
- What to expect once a claim has been disputed

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