MSPRC

Click here to learn what MSPRC does for Medicare

Sign-up for MSPRC E-Newsletter & View Past Newsletters

Quick Links: Skip to main page content

Search Glossary GO

Glossary

All 1 A B C D E F G H I J L M N O P R S T W

1 800 Medicare
: The Centers for Medicare and Medicaid Services (CMS) has established a 24/7 call center for Medicare beneficiaries and their representatives to:
Speak with a customer service representative 24 hours a day, seven days per week to get more help with your Medicare questions

Hear a recording with answers to frequently asked questions

Order Medicare Publications 24 hours a day, 7 days a week (Some are available in large print, Spanish, audio-tape, and Braille.)

Agents
: An entity hired to act on behalf and/or represent an organization or person for a specific matter such as the recovery of a Medicare lien.

Allowed Amount
: The most that the primary insurer is responsible for paying for a specific covered service or supply.

Appeal
: The process of the beneficiary or the beneficiary's representative challenging the final amount owed to Medicare on the recovery of claims, once the recovery demand letter has been issued.

Attorney
: A person licensed to practice law.

Attorney Costs
: The expenses an attorney accrues beyond his/her agreed upon fees.

Attorney Fees
: An amount set forth and agreed upon between the attorney and client who entered into a legal contract for representation of a legal issue.

Award
: An adjustment or agreement by which parties having a dispute reach or ascertain what each owes the other.

Benefits Exhausted
: Benefits Exhausted occurs when the insurer has paid out the maximum amount of benefits under the policy.

Case Id Number
: Identification Number used to identify a case within MSPRC's various systems. This number can be found on correspondence received from the MSPRC.

Center for Medicare & Medicaid Services (CMS)
: The federal agency responsible for administering the Medicare, Medicaid, CHIP (Children's Health Insurance), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs. Additional information regarding CMS and its programs is available at http://www.cms.hhs.gov/.

Conditional Payment
: A Medicare payment conditioned upon possible reimbursement, for medical services if another insurer/entity is responsible for the primary payment.

Conditional Payment Letter (CPL)
Correspondence sent by the MSPRC identifying the conditional payments made by Medicare that are related to an incident.

Consent to Release
Documentation authorizing an individual or entity to receive certain information from the MSPRC for a limited period of time.

Coordination of Benefits Contractor (COBC)
This contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries.

Date of Entitlement
The date a beneficiary became eligible for Medicare.

Date of Incident (DOI)
The date an accident, incident, ingestion, or exposure occurred.

Debtor
An entity responsible for repayment of debt owed to Medicare in the recovery process.

Defense (Valid/Invalid)
Documentation provided to the MSPRC in response to a demand letter denying responsibility of repayment for a specific reason.

Demand
A request for payment identifying the amount owed to Medicare.

Department of Health and Human Services (DHHS)
The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Department of Treasury
A department of the US Government that collects debts owed to the Federal Government.

Disclosure
The act or instance of releasing information.

Duplicate Primary Payment (DPP)
A situation where both Medicare and another insurer make primary payment on the same claim.

End Stage Renal Disease (ESRD)
Permanent kidney failure requiring dialysis or a kidney transplant.

Exhaust Letter
Notice from the no-fault insurer stating that the benefits for that policy have been exhausted.

Explanation of Benefits (EOB)
A summary of benefits from a health insurer giving details as to how and when a claim was processed.

Federal Debt Identification Number
An Identification number used by the Department of Treasury's processing system to assign a specific debt in collections for an employer.

Group Health Plan (GHP)
The term "GHP" means any arrangement of, or contributions by, one or more employers or employee organizations to provide health/medical benefits directly or indirectly to current or former employees, and/or their families.

Health Insurance Portability & Accountability Act
Health Insurance Portability and Accountability Act, enacted in 1996, mandates the use of standards for the electronic exchange of healthcare data.

Hicn/Medicare Number
The health insurance claim number (HICN) refers to the beneficiary's Medicare number.

Incident
The term used to reference any accident, illness, injury or ingestion reported for the purposes of Medicare Secondary Payer Recovery.

Intent to Refer
The MSPRC shall select delinquent debts from their existing debt balances for issuance of the Intent to Refer (ITR) letter to Treasury, when the debt is over 61 days delinquent. The ITR letter will advise the Debtor of CMS' intention to refer the debt to treasury for further collection, if left unresolved.

Internet Only Manuals (IOMs)

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

IRS Data Match

Congress enacted a law (Section 6202 of the Omnibus Budget Reconciliation Act of 1989) to provide the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, with better information about Medicare beneficiaries' Group Health Plan (GHP) coverage.

The law requires the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information that each agency has about whether Medicare beneficiaries or their spouses are working. The process for sharing this information is called the IRS/SSA/CMS Data Match.

The purpose of the Data Match is to identify situations where another payer may be primary to Medicare.

Judgment

An adjustment or agreement by which parties having a dispute reach or ascertain what each owes the other.

Liability

Responsibility or fault for damages arising out of a specified incident.

Liability Insurance

Liability insurance is insurance that protects against claims for negligence, inappropriate action or inaction, which results in personal injury or property damage.

Medicare Beneficiary

An individual eligible for and receiving Medicare benefits.

Medicare Secondary Payer (MSP)

Any situation where another payer or insurer pays your medical bills before Medicare.

Medicare's Right to Recovery (Group Health Plan)

Under the Medicare Secondary Payer provisions of the Social Security Act, employers that sponsor or contribute to the Group Health Plan are entities from which Medicare may recover. (42 U.S.C. 1395y(b))

Medicare's Right to Recovery (Liability, No-fault, and Workers Compensation Cases)

The applicable statute is 42 U.S.C. 1395y (b). See particularly, 42 U.S.C. 1395y (b) (2) (A) & (B). See also 42 CFR Part 411 for the applicable regulations.

Medicare is secondary to all types of Liability Insurance, No-Fault Insurance, or Workers' Compensation. Note: For Liability Insurance, this includes self-insurance which is defined by statute as follows: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."

Medicare may make conditional payments while a NGHP claim is pending but is entitled to repayment. "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."

No-fault Insurance

No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Non-Group Health Plan (NGHP)

Non-Group Health Plan (NGHP) includes Liability, No-Fault, Worker's Compensation, and Malpractice.

Notice of Settlement (NOS)

The Notice of Settlement is a document providing MSPRC notice that the civil dispute resulting from an accident/incident has reached resolution. At a minimum this document contains the following information:

- Amount of Settlement
- Date of Settlement
- Attorney's Fees, if any
- Procurement Costs, if any

Offset

A garnishment made by the Department of Treasury to repay unresolved debts to Medicare.

Overpayment
An Overpayment occurs when repayment for a debt is received that is more than the amount owed to Medicare.

Payment Ledger (Payment Log)
An accounting record of payments made to specific entities including what amounts were paid and the dates they were paid.

Personal Injury Protection (PIP)
Insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It includes "medical payments coverage," "personal injury protection," or "medical expense coverage."

Policy Limit(s)
Maximum benefit of a given insurance policy. Once that policy limit has been reached, the insurance carrier has no further obligation.

Post- Settlement Compromise Request
An amount requested to settle the debt owed to Medicare based on the amount of settlement received.

Power of Attorney
A legal document, giving the beneficiary's representative full legal authority to preside on the beneficiary's behalf.

Pre-Settlement Compromise Request
An amount requested to settle the debt owed to Medicare based on a proposed settlement.

Primary Payer
An insurance policy, plan, or program that pays first on a claim for medical service(s). This could be Medicare or another health insurance.

Privacy Act of 1974
Without the written consent of the individual, the Privacy Act prohibits release of protected information maintained in a system of records unless of 1 of the 12 disclosure provisions apply.

Procurement Costs
Attorney fees and other costs directly related to securing a settlement or judgment that are usually borne by the beneficiary.

Proof of Payment
Documentation furnished to the MSPRC indicating that payment has already been made for a specific date of service. Examples of Proof of payment include: a copy of the original Explanation of Benefits, or the front and back of the canceled check that was used for payment.

Proof of Representation
An authorization document, wherein a beneficiary or other entity responsible for repayment to Medicare (e.g. a worker’s compensation carrier) authorizes an individual or entity (including an attorney) to ACT on their behalf.

Rebuttal
A rebuttal is the MSPRC's response to an invalid defense that has been received detailing the reason it is invalid and what information is still needed.

Secondary Payer
An insurance policy, plan, or program that pays second on a claim for medical service(s). This could be Medicare, Medicaid, or other insurance depending on the situation.

Set-A-Side Account
An Administrative Mechanism used to set-a-side monies for specific purposes (such as Medical expenses) including a self-administered arrangement (state law permitting).

Settlement
An adjustment or agreement by which parties having a dispute reach or ascertain what each owes the other.

Settlement Date
The date that a final settlement amount was agreed upon by all parties associated with a case.

Social Security Administration
The Federal agency that, among other things, determines initial entitlement and eligibility for Medicare benefits.

Special Projects
A Medicare Secondary Payer Recovery Case involving special circumstances outside of the usual Liability, No-fault, or Workers Compensation processes (for example: a class action law suit involving several individuals who suffered injury /damage from the same drug or incident. Illness or injury due to Vioxx, Avandia, and Ephedrine are examples of these types of cases)

Tax payer Identification Number (TIN)

A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS. A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS.

Termination Date

The date that specifies the end of a primary payer's responsibility for claims.

For **Group Health Plan** - the termination date specifies the end of group health plan coverage

For **Liability & Worker's Compensation** cases - the termination date specifies the end of the liable party's responsibility for claims (typically the date of settlement for the liability or worker's compensation case)

For **No-fault** cases - the termination date specifies the end of the liable insurer's responsibility for claims (typically due to benefits being exhausted or the closure of the no-fault case when the beneficiary has completed treatment for their accident related injuries

---

TPA (Third Party Administrator)

An entity hired to act on behalf of and/or represent an organization or person for a specific matter such as the recovery of a Medicare lien. For example, a worker's compensation carrier may hire an "agent" to assist during the Medicare recovery process and provide a proof of representation document allowing that agent to act on their behalf in regards to that specific case.

W-9 Document

A W-9 document certifies an individual's or entity's tax identification number and is used to gather information about that individual or entity.

Waiver

In a Medicare Secondary Payer Recovery situation, a waiver is the forgiveness of the debtor's obligation to satisfy Medicare's demand amount, either in whole or in part, if certain conditions are met.

Workers compensation

The employer's insurance company is required to provide medical care or compensation for an employee who gets sick or injured on the job.

All 1 A B C D E F G H I J L M N O P R S T W