

OPTION TO
SELF-CALCULATE
YOUR FINAL
CONDITIONAL
PAYMENT AMOUNT
PRIOR TO
SETTLEMENT

Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments Only.

Eligibility Criteria

- The liability insurance (including self-insurance) settlement, judgment, award, or other payment must be for a **physical trauma based injury**.
 - The settlement does not relate to ingestion, exposure, or medical implant.
- The total liability settlement, judgment, award, or other payment is expected to be and ultimately is \$25,000 or less.
- The Date of Incident occurred at least **six months ago**.
 - It must be six months from the date of incident to the date the beneficiary or his/her representative submits the self-calculated final conditional payment amount to Medicare for review.
- The beneficiary demonstrates that treatment has been completed and no further treatment is expected.
 - **This must be demonstrated through either:**
 - A written physician attestation, **OR**
 - A written certification provided by the beneficiary that:
 - No medical treatment related to his/her case has occurred for at least **90 days** prior to submitting the self-calculated final conditional payment amount to Medicare, **AND**
 - He/she expects no further care related to his/her case.
- The beneficiary will be asked to give up the right to appeal the amount or existence of this debt. However, he/she will keep the right to pursue waiver of recovery.

How to self-calculate your final conditional payment amount

Make sure you have already reported your liability insurance (including self insurance) situation to our Coordination of Benefits Contractor (COBC). If you have not reported your case, [click here](http://www.cms.gov/COBGeneralInformation/) for reporting instructions (http://www.cms.gov/COBGeneralInformation/).

1. **Verify** that you meet the eligibility criteria.
2. Go through your Payment Summary Form that came with your Conditional Payment Letter . **Mark each claim** that is related to your case with a "Y" (yes, it is related) or a "N" (no, it is not related).
 - ▣ On the Self-Calculated Conditional Payment Amount Model Language document, you will be asked to provide an explanation for why you believe the claims you marked with "N's" are unrelated to your case.
3. **Add additional claims** for related care you received after we issued your Conditional Payment Letter. Include as much detail as possible, such as:
 - ▣ The dates you received the care and the provider's name,
 - ▣ The Medicare Approved Amount or Allowed Amount, if available. (You can access this information using the "Blue Button" at MyMedicare.gov.)
4. **Fill in the information required** in the Self-Calculated Conditional Payment Amount model language document found [here](#). Be sure to fill it out completely.
5. **Send us** your Self-Calculated Conditional Payment Amount model language document, your Payment Summary Form with your marks and TOTAL on it, and your physician attestation (if applicable).

Please send these items to us at the following address:

MSPRC Self-Calculated Conditional Payment
PO Box 138880
Oklahoma City, OK 73113

Medicare's Review

Within 60 days, the MSPRC will:

- Let you know whether we agree or disagree with your self-calculated amount.
 - If we agree with your Self-Calculated Conditional Payment Amount, we will send you a letter telling you that the amount is considered final, as long as you settle within 60 days of the date of our letter and your settlement is \$25,000 or less.
 - If we disagree with your Self-Calculated Conditional Payment Amount, but you are otherwise eligible for the process, we will send you a Medicare Amended Final Conditional Payment Amount. This letter will tell you that the amount we calculated will be considered final, as long as you settle within 60 days and your settlement is \$25,000 or less.

Once you settle, please send us:

- The first and last page of the settlement agreement showing the total amount of the settlement, and the date it was signed, AND
- The actual amount of the attorney's fees and other costs you had to pay to obtain your settlement, AND
- The MSPRC's letter accepting your Self-Calculated Conditional Payment Amount or the letter offering you Medicare's Amended Conditional Payment Amount.

This information should be sent to the following address:

MSPRC Self-Calculated Conditional Payment
PO Box 138880
Oklahoma City, OK 73113

When we receive your settlement information, we will calculate the amount of Medicare's demand, reducing the self-calculated or Medicare Amended Conditional Payment Amount for attorney fees and costs, as appropriate. We will then issue a request for payment or formal demand within 20 days.

Tips

□ **Reporting Your Case**

- If you plan to self-calculate your conditional payment amount, you may choose to wait until you are closer to settlement, approximately 5 months, to report your liability insurance case to our Coordination of Benefits Contractor (COBC).
 - You will have a better idea of what your expected settlement will be.
 - The Payment Summary Form you receive will contain more up-to-date information.
 - It will be easier for you to demonstrate that you have completed care and do not expect to require more care.
 - [Click here](http://www.cms.gov/COBGeneralInformation/) for reporting instructions.
(<http://www.cms.gov/COBGeneralInformation/>)

□ **Check out www.Medicare.gov.**

- Even if you do not participate in this process, MyMedicare.gov provides a lot of information that you may find valuable.

Example Submission Package

Self-Calculated Conditional Payment Amount Model Language
All Information Is Required Unless Inapplicable

[MSPRC Address]
[MSPRC Address]
[Address]
[Address]

[Fax Number]

Dear MSPRC:

I expect to receive a physical trauma-based **liability insurance** settlement for approximately \$ 7,500 and I would like to calculate my Final Conditional Payment Amount (CPA). I have calculated my Final CPA to be \$ 93.52, which is supported by the documentation I am enclosing with this letter.

Beneficiary Name: John Doe Date of Incident: 2/22/2010
Medicare Number: 123-45-6789A

I certify that the following statements are true:

- I expect to receive a **liability insurance** settlement for \$25,000.00 or less for a physical trauma based injury. (The injury did not relate to ingestion, exposure, or a medical implant.)
- My incident/injury occurred at least six (6) months ago.
- My medical treatment related to my case is finished and I am able to demonstrate this in one of two ways: (Please check one.)
 - I have included a physician attestation; OR
 - I certify that I have not had care related to my case within the last 90 days and expect no further care.
- I have included all Medicare covered and reimbursable items and/or services related to my case (what was claimed or released). I have not knowingly disregarded related items or services that have been or will be provided through the date of settlement.
- I understand that if my self-calculated amount is accepted, I will be required to give up my right to appeal the amount or existence of the debt.
- I have not received and do not expect to receive any other **liability insurance** settlements, judgments, awards, or other payments related to the incident referenced above. If I receive any, I will notify Medicare because Medicare may have an additional recovery claim.

Sincerely,

John Doe
Beneficiary Signature

Date: 12/29/2011

Bob Attorney
Attorney or Representative Printed Name

Bob Attorney
* Attorney or Representative Signature

Date: 12/30/2011

* If attorney or representative signs and the beneficiary does not sign, a proper authorization must be on file or included with the Self-Calculation documents in order for the Self-Calculated Amount to be reviewed.

Check here if you do not have an attorney or other representative.

Self-Calculated Conditional Payment Amount Proposal Cover-Sheet
All Information Is Required Unless Inapplicable

Please place a Y (yes, related to the case) or N (no, not related to the case) next to each claim on Medicare's Payment Summary Form. Add any additional claims not already included on the sheet. Include a TOTAL labeled Self-Calculated Conditional Payment Amount. Provide a brief description of the injury and an explanation for any claims you labeled with a "N" as not being related to the case.

Brief Description of Injury:

Bus accident. Some bruising from seatbelt. Pain in
Abdomen.

Explanation for Disputed Claims: (If you have more than one explanation, please provide the date range for each explanation.)

Example: Claims with dates between January 1, 2010 and September 13, 2010 were for back surgery but my case is for a sprained knee.

Most of the claims listed are unrelated. I was in
the bus accident on 12/22/2010. In the beginning
of March, I dislocated my shoulder and cut my
hand while cutting up a fallen tree in my back
yard.

I did not need to go to the doctor for any injury from
the bus accident besides the two things I circled.
I am in physical therapy for ~~the~~ dislocating my
shoulder from cutting up the tree.

Payment Summary Form

Contractor:
Beneficiary Name: JOHN DOE
Beneficiary HICN: 123-45-6789A

Case ID:
Case Type: Liability
Date of Incident: 2/22/2010

TOS	ICN	Processing Contractor	Provider Name	Diagnosis Codes	From Date	To Date	Total Charges	Reimbursed Amount	Conditional Payment
71	661110000000	630	JONES, AMELIA	8820	3/15/2010	3/15/2010	\$48.00	\$24.90	\$24.90
71	661110000000	630	MENDELSON, JOHN	7231, 7194	4/16/2010	4/16/2010	\$60.00	\$29.29	\$29.29
71	661110000000	9102	GREEN, ADAM S	78900, 95912	2/22/2010	2/22/2010	\$216.00	\$48.87	\$48.87
71	591010000000	9102	GREEN, ADAM S	78900, 95919	2/22/2010	2/22/2010	\$219.00	\$44.65	\$44.65
71	661110000000	630	MENDELSON, JOHN	71941, 7231	3/8/2010	3/8/2010	\$130.00	\$73.68	\$73.68
71	661110000000	630	MENDELSON, JOHN	71941, 7231	3/8/2010	3/8/2010	\$78.00	\$26.66	\$26.66
71	661110000000	630	MENDELSON, JOHN	71941, 7231	3/8/2010	3/8/2010	\$70.00	\$21.28	\$21.28
71	661110000000	630	BAILEY, CHARLES M	7394, 7246, 7291, 7392	6/16/2010	6/16/2010	\$45.00	\$27.18	\$27.18
71	661110000000	630	JONES, AMELIA	8820	3/8/2010	3/8/2010	\$90.00	\$44.27	\$44.27
40	211060000000	130	GREENCASTLE PHYSICAL THERAPY SPORTS MEDICINE	7242, 71941	12/16/2010	12/16/2010	\$71.00	\$53.65	\$53.65
40	211060000000	130	GREENCASTLE PHYSICAL THERAPY SPORTS MEDICINE	71941, 7231	3/26/2010	3/26/2010	\$99.00	\$73.37	\$73.37

Sum of Total Charges:

~~\$1,126.00~~

Total Conditional Payment:

~~\$467.80~~

Total = \$ 93.52

Open hand wound

hand

Abdomen Pain

frank injury

Shoulder & Neck

Back

open hand wound

Neck & Back

N

Y

N