Non-Group Health Plan (NGHP) Applicable Plan Appeals

Reference Guide

Version 1.0

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1.0 Introduction

The purpose of the *NGHP Applicable Plan Appeals Reference Guide* is to provide certain Non-Group Health Plans (NGHPs), or applicable plans, and their verified authorized representatives (ARs), with a summary of requirements and guidance when submitting appeals for Medicare Secondary Payer (MSP) recovery claims where Medicare is pursuing recovery against the insurer.

The Centers for Medicare & Medicaid Services (CMS) is responsible for protecting the Medicare program's fiscal integrity and ensuring that it pays only for those services that are its responsibility. MSP provisions make Medicare a secondary payer to certain NGHPs. These applicable plans include liability insurers (including self-insured entities), no-fault insurers, and workers' compensation entities.

MSP situations involving NGHPs are triggered by unexpected incidents such as car accidents or work-related injuries, involve Medicare beneficiaries, and result in medical expenses for which an NGHP, rather than Medicare, has primary responsibility for payment. In these situations, Medicare becomes a secondary payer. In some MSP situations involving NGHPs, Medicare will initially pay for related medical expenses, known as a conditional payment, to ensure the beneficiary has access to needed care. Medicare will later seek to recover those payments.

The following sections describe more about appealing a Medicare demand, how to submit an appeal, an overview of the appeals process, and the types of appeals and general documentation needed to support each type.

2.0 Appealing Medicare's Demand

When an NGHP applicable plan wishes to dispute the amount owed as stated in a demand letter, the identified debtor or their authorized representative generally needs to explain why they believe the amount owed is incorrect and submit supporting evidence for review as part of the administrative appeal process. NGHP applicable plans were granted formal administrative appeal rights beginning with demands issued on April 28, 2015. This is a multi-level process that comports with the regulations starting at 42 C.F.R. § 405.900. A debtor may not proceed to the next level without first exhausting their appeal rights at the preceding level(s).

Debtors should remember that interest on the debt accrues from the date of the demand letter and, if the debt is not resolved within 60 days, is assessed for each 30-day period the debt remains unresolved. If an applicable plan requests an appeal at any level, the debt will not be referred to the Department of Treasury while the appeal is being processed. If the debt is with the Department of Treasury, it will be recalled while the appeal is pending. However, interest will continue to accrue. Applicable plans may choose to pay the demanded amount while still pursuing an appeal to avoid the accrual and assessment of interest. Where an appeal is

successful in full or in part and payment has already been made, a refund will be automatically issued for the appropriate amount.

The following is intended as a broad overview of the administrative appeals process. Identified debtors should always refer to their correspondence for procedural information specific to their case.

1. Initial Determination

   For MSP recovery, only actions that constitute initial determinations are entitled to administrative appeal rights. The demand letter issued on Medicare's behalf by the Commercial Repayment Center (CRC) to an NGHP applicable plan is considered an initial determination (see 42 C.F.R. 405.924).

   If party to the initial determination, the applicable plan may appeal either the amount or the existence of the debt following the process outlined in this guide. Attempts to appeal other issues, including whom CMS identified as the debtor, will be dismissed. Unless good cause for a delay is demonstrated, untimely appeal requests at any level will be dismissed.

2. Redetermination

   The first level of appeal is a redetermination. Redeterminations must be requested by the identified debtor or their authorized representative within 120 calendar days of demand receipt.

   When a redetermination is requested in time and in the proper manner (as described in this document), an independent review is performed at the CRC by different staff who prepared the demand letter. A decision letter is issued by the CRC that explains whether the appeal was granted in full, in part, or denied, as well as how the redetermination decision may be further appealed, including the appropriate address and time frame.

3. Reconsideration

   If the applicable plan disagrees with the redetermination decision, a reconsideration may be requested by the identified debtor or their authorized representative within 180 calendar days of receipt of the redetermination decision.

   Reconsiderations are performed by a CMS Qualified Independent Contractor (QIC). A decision letter is issued by the QIC that explains whether the appeal was granted in full, in part, or denied, as well as how the reconsideration decision may be further appealed, including the appropriate address and time frame.

4. Hearing

   If the applicable plan disagrees with the outcome of the reconsideration, a hearing before an Administrative Law Judge (ALJ) may be requested by the identified debtor or their authorized representative within 60 calendar days of receipt of the reconsideration decision.

   The hearing is performed by a CMS ALJ, but administrative processes related to the ALJ's decision are facilitated by the CMS Administrative QIC (AdQIC). The AdQIC will issue a decision letter that explains whether the appeal was granted in full, in part, or denied, as well as further appeal rights, including instructions for requesting higher level review.

5. Review by the Medicare Appeals Council

   The final level of the administrative appeals process is a review by the Medicare Appeals Council, which is part of the Health and Human Services (HHS) Departmental Appeals Board (DAB). The review must be requested within 60 calendar days of receipt of the ALJ decision. Administrative processes related to the council's decision are facilitated by the CMS AdQIC.

   If an applicable plan disagrees with the decision of the Medicare Appeals Council, the plan may seek remedy through U.S. District Court.

6. Judicial Review

   U.S. District Court judicial review may only be requested after exhaustion of all other levels of appeal. The process for seeking judicial review is governed by the U.S. Federal court system and beyond the scope of this guide.

Note:

As captured in regulation, correspondence is always presumed to be received within five (5) calendar days of the date of the letter, unless demonstrated otherwise. Late appeals at any level may only be accepted if the party shows good cause (e.g., a natural disaster prevented an appeal request from being filed in time).

2.1 How to Submit Redetermination Requests

Redetermination requests may be submitted through the Medicare Secondary Payer Recovery Portal (MSPRP). Please refer to the MSPRP user guide for more information (Section 4.0). Redeterminations may also be submitted on paper by mailing, or faxing, documents to:

Medicare Commercial Repayment Center—NGHP

PO Box 1610

Lathrop, CA 95330

To expedite processing and ensure accurate reviews, redeterminations must include an explanation of the appeal, typically in the form of a cover letter, and supporting documents. Please see Appendix A for samples of cover letters and supporting evidence. The CRC may request additional information to accept a redetermination on a case-by-case basis.

Note:

By law, insurers are required to ensure the information reported to Medicare as mandated by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (commonly referred to as “Section 111 reporting”) is accurate and up to date. Medicare’s CRC proceeds with the recovery process under the expectation the reported records are accurate. For any questions or concerns regarding the reporting process, please contact the Benefits Coordination & Recovery Center’s (BCRC) Customer Service Department at 855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

2.2 Standard Appeals Documentation Requirements

A request for a redetermination must be submitted no later than 120 days from the date of receipt of Medicare’s demand letter, which is assumed to be five days after the demand date unless evidence suggests otherwise. Depending on the nature of the appeal there may be specific information and documentation that must be provided to sustain the appeal request.

Note:

This information must be provided on company letterhead or otherwise indicate its source.

For any level of appeal, a cover letter containing the following information must be submitted by the applicable plan or an authorized representative along with an explanation of why the determination is incorrect.

- Name of the applicable plan and authorized representative of the plan, if applicable
- Name of beneficiary
- Medicare number (Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI))
- Case Number
- Date of Incident (DOI)
- Summary of injuries from the incident and which specific services or items for which an appeal is being requested
- Date(s) of service

Note:

Debtors must clearly identify which claims are being appealed, or if all are under appeal.

2.3 Authorization/Letter of Authority Requirements

If the applicable plan or identified debtor wishes another party to represent them in resolving the demand, an authorization must be submitted with the redetermination request if it has not already been approved by the CRC. This authorization typically takes the form of the Letter of Authority (LOA).

Appeal requests from any entity that is either not the identified debtor (the applicable plan) or their authorized representative will be dismissed. If this occurs, an authorization may be submitted with a request to vacate the dismissal. A request to vacate the dismissal must be resolved within the appeal timeframe, absent good cause to extend this deadline. Submitting authorization is recommended to ensure that proper proof of representation has been submitted when requesting a redetermination. If a representative is late submitting the required authorization, the identified debtor risks having the appeal dismissed because of delays or because it was not submitted on time.

The following CMS.gov website offers model language for authorizations (Section 4.0): https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery. Remember to include a cover letter or other identifying information so your authorization can be linked to the appropriate recovery case.

3.0 NGHP Applicable Plan Appeals

3.1 What Can Be Appealed and Supporting Documentation

Note:

Only the amount or the existence of the debt may be appealed. An appeal on any other basis will be dismissed. Appeals of the amount or the existence of the debt are commonly based upon one or more of the following appeal types:

- Termination of Ongoing Responsibility for Medicals (ORM) Due to Benefits Exhaustion
- Termination of ORM Due to Settlement or Other Claim Resolution
- Termination of ORM Due to Other Policy Terms
- Benefits Denied or Revoked by the Applicable Plan
- Non-Covered Services
- Unrelated Services
- Duplicate Primary Payment

The following sections also discuss the typical supporting documentation required for each appeal type.

3.1.1 Termination of ORM Due to Benefits Exhaustion

This appeal applies if the applicable plan does not have primary payment responsibility for some or all the dates of service included in the demand on the basis that the workers' compensation or no-fault policy limit has been reached and benefits have exhausted as outlined in the policy or plan.

Documentation Needed

A. If the Benefit Exhaust Date has not been updated via Section 111 reporting:

1. Cover letter
2. Payment or billing ledger that demonstrates benefits were appropriately exhausted that accumulates to the reported policy limit.

   Appropriate exhaustion means payment for specific services rendered by physician, facility, or reimbursable to the beneficiary. The documentation must contain the following:

- Date(s) of service
- The total amount of claim(s) billed (billed amount)
- Amount paid to provider
- Provider name
- Name of recipient of processed claim or payment (e.g., if reimbursement was made to the beneficiary for out-of-pocket payment)
- Date payment was processed or issued

B. If the Benefit Exhaust Date has been updated via Section 111 reporting:

1. Cover letter
2. Written confirmation of the benefit exhaust date and that the benefit exhaust date has been reported.

Notes:

Payments to physicians, providers, suppliers, or beneficiaries made after receiving Medicare's demand letter do not excuse the applicable plan in lieu of reimbursing Medicare.

Applicable plans must combine MedPay and Personal Injury Protection (PIP) limits for a given policy, and ORM must be maintained until both the PIP and MedPay benefits are exhausted.

Asserting that policy limits are lower than what is reflected in the records submitted through Section 111 mandatory insurer reporting is not acceptable unless:

(1) Conclusive written documentation the amount reported was incorrect is provided as part of the dispute or appeal, and

(2) The Section 111 reported policy limit has been or will be updated to reflect the correct policy limit. The CRC also requires a declaration page that documents the plan's no-fault policy limits if the policy limit asserted in the appeal differs from the policy limit the insurer reported to CMS via the Section 111 reporting process.

If you have questions specific to reporting, please contact your BCRC EDI Representative for assistance (Section 4.0).

For situations where the applicable plan reimburses a beneficiary or the beneficiary's authorized representative for service(s) where the beneficiary paid out-of-pocket costs, lost wages, transportation, or other payments identified in policy plan provisions, the CRC requires documentation in the form of a payment ledger, with policy documentation that includes provisions identifying beneficiary payments.

3.1.2 Termination of ORM Due to Settlement or Other Claim Resolution

This appeal applies if the applicable plan asserts that it does not have primary payment responsibility for some or all the dates of service included in the demand letter as ORM has terminated due to a settlement, judgment, or award. Generally, Medicare claims with dates of service between the ORM effective and termination dates are the responsibility of the CRC to recover from the applicable plan. The CRC can recover claims up to, but not including, the settlement date, unless the settlement specifically releases the debtor from all primary payer responsibility, or outlines in its documentation other requirements specified by the applicable plan, such as specific coverage information or other responsibilities.

Documentation Needed

1. Cover letter
2. If ORM has terminated due to a settlement, judgement, or award: a copy of the complete settlement documentation along with signatures and effective dates
3. If ORM has terminated due to the policy being terminated or lapsed: supporting documentation that outlines policy effective dates on company letterhead

Note:

Please follow the guidelines in Section 3.1.1 if ORM has terminated due to benefits exhaustion or Section 3.1.3 if ORM has terminated because a policy has terminated due to other policy terms.

3.1.3 Termination of ORM Due to Other Policy Terms

This appeal applies if the applicable plan asserts that the terms of the policy or plan may allow the applicable plan to terminate coverage. A plan may establish assessments, such as a physician’s examination, to determine situations where the applicable plan has no additional payment responsibility.

Note:

This does not negate the applicable plan’s primary payment responsibility should other terms, laws, or regulations require primary payment responsibility to continue (e.g., state law may mandate medical coverage for five years past the date of incident).

Documentation Needed

1. Cover letter

2. Supporting documentation that demonstrates the circumstances that have been met to allow termination of coverage, as well as a copy of any other policy or plan documents that establish the applicable policy terms that permit ending the applicable plan's primary payment responsibility

3. If asserting Medical Maximum Improvement (MMI), the Independent Medical Exam (IME) or MMI report is required.

Notes:

The applicable plan should ensure any information reported through Section 111 reporting is updated as soon as possible if ORM has terminated.

If you have questions specific to reporting, please contact your BCRC EDI Representative for assistance (Section 4.0).

3.1.4 Benefits Denied or Revoked

This appeal applies if the applicable plan asserts that it does not have primary payment responsibility because the workers' compensation or no-fault claim was denied, benefits were revoked, or because an injury that incurred health costs occurred during or after a violation of the policy, or of state or federal law.

Documentation Needed

1. Cover letter

2. Proper documentation must demonstrate that the benefits for the claim were denied or revoked for the DOI in question.

   Include a copy of the decision letter from the applicable plan to the beneficiary, specific to the DOI, indicating the reason the claim was denied or why the benefits were revoked.

Note:

If a workers' compensation or no-fault claim is denied by the applicable plan in its entirety, or benefits were revoked effective upon a specific date, the applicable plan should ensure any information reported through Section 111 is updated or deleted immediately.

3.1.5 Non-Covered Services

This appeal applies if the applicable plan asserts any of the following:

- The beneficiary did not submit the required documentation to the applicable plan needed to process or pay claims for the incident
- Service(s) or service provider was not approved or licensed by the state
- Service(s) required prior authorization
- Service(s) were not covered by the plan

Documentation Needed

1. Cover letter
2. Proper documentation specific to the DOI in question must demonstrate that the services were not covered.

   Include a copy of the plan documents or policy clearly indicating what services are not covered or what policy requirements were not met. To expedite processing of large documents, annotate or highlight the relevant information.
3. A payment or billing ledger showing that the date(s) of service were denied. The payment ledger should contain:
   - Date(s) of service
   - Total amount of claim(s) billed (billed amount)
   - Provider name
   - Date processed or when the payment was denied
   - Denial code or reason stating services were not covered

3.1.6 Unrelated Services

This appeal can be used by the applicable plan when one or more specific claims for service(s) or treatment are for a condition unrelated to the accident, date of loss, or date of incident. When determining relatedness, the CRC must identify services that occur on or around the date of incident and associate claims that appear to be related to the reported diagnosis codes.

Documentation Needed

1. Cover letter

2. Documentation or attestation on the applicable plan's or authorized representative's letterhead identifying the unrelated claims for specific services or diagnosis codes.

3.1.7 Duplicate Primary Payment

This appeal applies when Medicare and an applicable plan both make primary payments for the same date(s) of service listed on a Medicare demand. The applicable plan or authorized representative may provide proof of its primary payment as an appeal.

Documentation Needed:

1. Cover letter

2. Proper documentation, such as a payment ledger form, must clearly outline the information below:

   - Date(s) of service
   - Total amount of claim(s) billed (billed amount)
   - Amount previously paid to provider
   - Date processed or when the payment was made
   - Name of recipient of processed claim or payment

Notes:

The applicable plan or authorized representative may not make primary payment to the provider, supplier, or beneficiary after receiving a Medicare demand letter in lieu of paying the Medicare demand. Appeals that include payments made after the presumed receipt of the demand letter will be denied. If the related coverage records submitted to Medicare were subsequently deleted, a Duplicate Primary Payment defense will be denied.

There must be an active MSP record to process this appeal type. If the MSP record that established the Medicare demand was deleted through the Section 111 reporting process, the MSP record will need to be re-established by the RRE before the CRC can accept a duplicate primary payment appeal.

This appeal does not apply when there are processed claims where the primary payment was applied to a deductible or co-pay or paid to the beneficiary or their representative.

4.0 Additional NGHP Resources

- Insurer NGHP Recovery: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery.
  - Authorization (Model Language): https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Downloads/Recovery-Agent-Authorization-Model-Language%C2%A0.pdf.
  - Letter of Authority (Model Language): https://www.cms.gov/files/document/model-letter-authority-finalpdf.
- NGHP User Guide: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.

MSPRP Application

- MSPRP application: https://www.cob.cms.hhs.gov/MSPRP/
  - MSPRP User Guide: Go to the MSPRP application and select the guide from the *Reference Materials* menu.

MSPRP Information

- https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/MSPRP/Medicare-Secondary-Payer-Recovery-Portal
- For help with MSPRP account setup, login or password issues, or other technical problems, please contact an EDI Representative at the BCRC at: 1-646-458-6740.
- For questions about NGHP ORM cases on the MSPRP, the CRC can be reached at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Appendix A: Appeal Cover Letters

When creating a cover letter for an appeal, at a minimum the following information must be submitted by the applicable plan or authorized representative in addition to any supporting evidence:

- Beneficiary name
- Medicare number (HICN or MBI)
- Case number
- Which specific services or items for which an appeal is being requested and why

Figure A-1: Example Appeal Cover Letter

Recovery Agent, LLC
123 First Street
Citysburg, CA 12345

February 1, 2022

Medicare Commercial Repayment Center - NGHP
PO Box 1610
Lathrop, CA 95330

Re: Appeal for Case Number: 109765421

I'm writing on behalf of my client, Insurance Company, Inc, to appeal the demand received December 15, 2022 (Case number 109765421 related to Jane Brown, MBI 5A55A55AA55). As previously shared, Insurance Company has engaged and authorized Recovery Agent, LLC to act on its behalf in resolving the matter.

Insurance Company has assumed payment responsibility for the treatment of injuries to Ms. Brown's neck and back on July 4, 2021. Please see the enclosed list of claims that we believe are unrelated to the incident on July 4th, as well as information from Ms. Brown's physician documenting the specific nature of the injuries Ms. Brown did sustain.

Please contact me at 555-555-5555 if there are any questions.

Sincerely,

Joan Doe

Joan Doe
Recovery Agent, LLC

Enclosures

Appendix B: Example Payment Ledger

Figure B-1: Example Payment Ledger

Billing Ledger/Payment Log

Date MM/DD/YYYY
Beneficiary Name

Date of Injury MM/DD/YYYY
Injury Type
Policy Limit $10,000.00

Payment Type	Provider Name	Date of Service	Pay To	Total Charged Amount	Total Paid Amount	Paid Date
Medical	Dr. First Name Last Name	MM/DD/YYYY	Physician	$1,550.00	$1,000.00	MM/DD/YYYY
Lost Wages	Patient Name	MM/DD/YYYY	Beneficiary	15,000.00	$2,000.00	MM/DD/YYYY
Medical	Facility Name	MM/DD/YYYY	Facility	$2,905.50	$2,000.00	MM/DD/YYYY
CRC	CRC	MM/DD/YYYY	CRC	$5,000.00	$5,000.00	MM/DD/YYYY
				$24,455.50	**$10,000.00**	

Total Charged Amount **$24,455.50**

Total Paid Amount **$10,000.00**

Appendix C: Model Language for Applicable Plans that Appoint Recovery Agents

General Information

Before CMS can provide information to an applicable plan's recovery agent, there must be confirmation that the recovery agent is authorized to work on behalf of the NGHP applicable plan.

When to Submit an Authorization Such as a Letter of Authority

CMS must have authorization on file for each recovery case. Anytime an applicable plan would like a recovery agent to work on its behalf, CMS must have authorization on file. Please see 42 CFR 405.910 for more information about authorizations.

If an applicable plan designates a recovery agent electronically via Section 111 reporting, further documentation does not need to be submitted unless or until the recovery agent needs to request contractor actions after a demand is issued, such as an appeal.

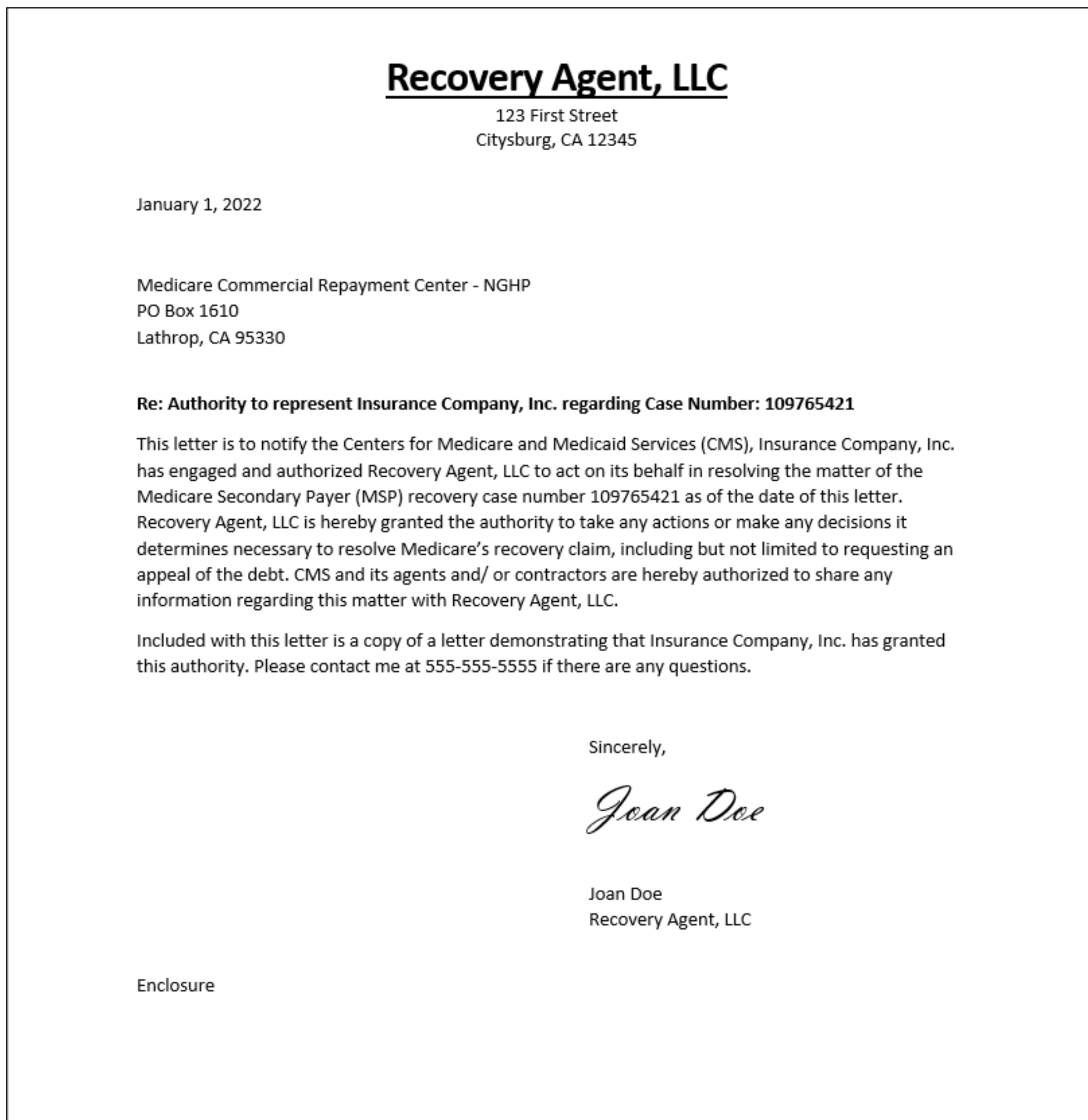
Elements that must be included in Applicable Plan Authorization documentation:

- It must be in writing, signed and dated by both entities.
  - There may be two documents, such as a cover letter and a copy of a contract, as long as there is a clear demonstration of authority or chain of authorization.
- It must state that one entity appoints the other entity to act on its behalf.
- It must include purpose and scope of the authorization.
  - It must describe the reason for the authorization.
- It must include the name, phone number, and address of each entity.
  - These elements are often already part of letterhead.
- It must reference professional status or relationship between the entities.
  - Examples include Attorney/client, Recovery Agent, Third Party Administrator.
- It must reference the recovery case ID, or otherwise provide information that allows CMS' recovery contractor to associate authorization to a particular beneficiary file.
  - Overarching contracts, retainer agreements, and similar documents may be submitted but only partially satisfy the requirements. By regulation, authorizations are only able to be applied on a per individual recovery case basis.

- It must include a timeframe for the recovery agent's authority.
    - "Through the resolution of this matter" and similar language is acceptable.
- It must be submitted to CMS's recovery contractor, the CRC.
    - The CRC automatically includes a copy of the authorization in the case files that are shared with the entities administering higher-level appeals.

Together, the two letters below include all the required elements listed above. Use of the language in the example letters is not required, but any authorization documentation submitted must include each of the elements listed above.

Figure C-1: Example Letter of Authority (Representative)



Recovery Agent, LLC

123 First Street
Citysburg, CA 12345

January 1, 2022

Medicare Commercial Repayment Center - NGHP
PO Box 1610
Lathrop, CA 95330

Re: Authority to represent Insurance Company, Inc. regarding Case Number: 109765421

This letter is to notify the Centers for Medicare and Medicaid Services (CMS), Insurance Company, Inc. has engaged and authorized Recovery Agent, LLC to act on its behalf in resolving the matter of the Medicare Secondary Payer (MSP) recovery case number 109765421 as of the date of this letter. Recovery Agent, LLC is hereby granted the authority to take any actions or make any decisions it determines necessary to resolve Medicare's recovery claim, including but not limited to requesting an appeal of the debt. CMS and its agents and/ or contractors are hereby authorized to share any information regarding this matter with Recovery Agent, LLC.

Included with this letter is a copy of a letter demonstrating that Insurance Company, Inc. has granted this authority. Please contact me at 555-555-5555 if there are any questions.

Sincerely,

Joan Doe

Joan Doe
Recovery Agent, LLC

Enclosure

Figure C-2: Example Letter of Authority (Debtor)

Insurance Company, Inc.

456 Second Street Townsville, ME 54231

December 1, 2020

Re: Authority to represent Insurance Company, Inc. regarding Medicare Secondary Payer (MSP)

This letter is to confirm that Insurance Company, Inc. has engaged and authorized Recovery Agent, LLC to act on its behalf in resolving any and all matters related to Medicare Secondary Payer (MSP) recovery. Recovery Agent, LLC is authorized to take any actions or make any decisions that Insurance Company Inc. would otherwise be entitled to take. Recovery Agent, LLC is authorized to represent Insurance Company, Inc. until either December 13, 2030 or Insurance Company, Inc. revokes this authority in writing.

Sincerely,

John Smith

John Smith
Insurance Company, Inc.

Appendix D: Acronyms

Table D-1: Acronyms

Term	Definition
AdQIC	Administrative Qualified Independent Contractor
ALJ	Administrative Law Judge
AR	Authorized Representative
BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare & Medicaid Services
CRC	Commercial Repayment Center
DAB	Departmental Appeals Board
DOI	Date of Incident
EDI	Electronic Data Interchange
HHS	Health and Human Services
HICN	Health Insurance Claim Number
LOA	Letter of Authority
MBI	Medicare Beneficiary Identifier
MSP	Medicare Secondary Payer
MSPRP	Medicare Secondary Payer Recovery Portal
NGHP	Non-Group Health Plan
ORM	Ongoing Responsibility for Medicals
PIP	Personal Injury Protection
QIC	Qualified Independent Contractor
RRE	Responsible Reporting Entity