mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

MEDICARE SECONDARY PAYER

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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The Medicare Secondary Payer (MSP) provisions protect the Medicare Trust Fund. Compliance with the MSP provisions contributes to the appropriate use of Medicare funds. This booklet provides a general overview of the MSP provisions and outlines your responsibilities.

When "you" is used in this booklet, we are referring to providers, physicians, other suppliers, and billing staff, unless stated otherwise.

WHAT IS MSP?

The MSP provisions protect the Medicare Trust Fund by ensuring Medicare does not pay for items and services when other health insurance coverage is primary to Medicare. The MSP provisions apply when Medicare is not the primary or first payer of claims. In these cases, the MSP requirements provide the following benefits for you and the Medicare Program:

STAY UP TO DATE

To sign up for automatic updates, select the "Subscription Sign-up for COB&R Overview Web Page Update Notification" link on the Coordination of Benefits & Recovery Overview webpage.

- **National program savings** – The Centers for Medicare & Medicaid Services (CMS) enforcement of the MSP provisions saved the Medicare Program roughly $8.5 billion in Fiscal Year (FY) 2015.
- **Increased provider, physician, and other supplier revenue** – If you bill a primary plan before billing Medicare, you may get more favorable reimbursement rates. Also, properly coordinated health coverage may expedite the payment process and reduce your administrative costs.
- **Avoidance of Medicare recovery efforts** – If you file claims correctly the first time, you prevent future Medicare recovery efforts on claims.

To get these benefits, you must access accurate, up-to-date information about your Medicare beneficiary's health insurance coverage. Medicare regulations require anyone submitting Medicare claims to determine whether Medicare is the primary payer for items or services provided to the beneficiary.

WHEN DOES MEDICARE PAY FIRST?

Primary payers have the responsibility to pay a claim first. Medicare pays first for beneficiaries in the absence of other primary insurance or coverage. Medicare may also pay first when the beneficiary has other insurance coverage but a special condition exists.

Table 1 lists some common situations where a beneficiary has both Medicare and other health plan coverage and lists which entity pays first (primary payer) and pays second (secondary payer).

DEFINITION OF "SPOUSE"

"Spouse," under the MSP Working Aged provisions, includes both same-sex and opposite-sex marriages.

Table 1. Analysis of Common MSP Coverage Situations

Individual	Condition	Pays First	Pays Second
Is 65 or older, and covered by a Group Health Plan (GHP*) through current employment or spouse's current employment	The individual is entitled to Medicare The employer has less than 20 employees	 Medicare	 GHP
Is 65 or older, and covered by a GHP through current employment or spouse's current employment	The individual is entitled to Medicare The employer has 20 or more employees, or the employer is part of a multi-employer group with at least one employer employing 20 or more individuals	 GHP	 Medicare
Is 65 or older, has an employer retirement GHP, and is not working	The individual is entitled to Medicare	 Medicare	 Retiree Coverage
Is under 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has less than 100 employees	 Medicare	 GHP
Is under 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has 100 or more employees, or the employer is part of a multi-employer group with at least one employer employing 100 or more individuals	 GHP	 Medicare

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Has End-Stage Renal Disease (ESRD) and GHP coverage was the primary plan prior to the individual becoming eligible and entitled to Medicare based on ESRD	First 30 months of Medicare eligibility or entitlement	 GHP	 Medicare
Has ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage prior to becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement	 COBRA	 Medicare
Has ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury	The individual is entitled to Medicare	WC for health care items or services related to job-related illness or injury. See section titled, "When May Medicare Make a Conditional Payment?"  Workers' Compensation	 Medicare

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Was in an accident or other situation where no-fault or liability insurance is involved	The individual is entitled to Medicare	No-fault or liability insurance for accident- or other situation-related health care services claimed or released. See section titled, "When May Medicare Make a Conditional Payment?" WC, Liability, or No-Fault where ongoing responsibility for medicals (ORM) is reported. Medicare does not make a payment. **Accident**	**Medicare** **NOTE: For ORM, Medicare does not make a payment until ORM funds are exhausted.**
Is 65 or older, **or** is disabled and covered by Medicare and COBRA	The individual is entitled to Medicare	**Medicare**	**COBRA**
Dual eligible beneficiary regardless of reason for eligibility	The individual is entitled to both Medicare and Medicaid	**Medicare**	**Medicaid**

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Covered by Medicare **and** carries a Medigap or supplemental plan	The individual is entitled to Medicare	Medicare	Medigap/ Supplemental Plan
Active duty status military member	The individual is entitled to Medicare and TRICARE	TRICARE	Medicare
Inactive status military member treated by civilian providers	The individual is entitled to Medicare and TRICARE	Medicare	TRICARE
Inactive status military member treated at a military hospital or by other Federal providers	The individual is entitled to Medicare and TRICARE	TRICARE	Medicare

*** A GHP is any arrangement of, or contribution from, one or more employers or employee organizations to provide insurance to current or former employees or their families.**

NOTE: For more instances of how Medicare works with other government payers, take the Medicare Learning Network® (MLN) Web-Based Training course "Medicare Secondary Payer Provisions."

ARE THERE EXCEPTIONS TO THE MSP PROVISIONS?

There are no exceptions to the MSP provisions. Federal law (Social Security Act, Section 1862(b)) takes precedence over State laws and private contracts and establishes the payment order. This law prohibits Medicare from making payment if payment has been made, or can reasonably be expected to be made, by certain primary payers under certain conditions. Even if an entity believes it is the secondary payer to Medicare due to State law or the contents of its insurance policy, the MSP provisions apply when billing for services.

WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

In the following situations, Medicare **may** make payment, assuming the service is a Medicare-covered and payable service and the provider files a proper claim:

- A no-fault or liability insurer does not pay during the "paid promptly" period or denies the medical bill
- A WC program does not pay during the "paid promptly" period or denies payment (for example, where WC excludes a particular medical condition or certain services)
- The beneficiary received services not directly related to the condition for which they are receiving WC
- Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) or the ORM benefits terminate or exhaust
- A GHP denies payment for services because:
  - The beneficiary exhausted plan benefits for particular services
  - The beneficiary is not entitled to benefits under the GHP
  - The beneficiary needs services not covered by the GHP

When submitting a claim to Medicare in these situations, you should include information showing why the other payer denied the claim, made an exhausted benefits determination, or did both.

WHEN MAY MEDICARE MAKE A CONDITIONAL PAYMENT?

Frequently, there is a long delay between an injury and the decision by the primary payer in a contested compensation case. Medicare may make conditional payments on a pending case to avoid imposing a financial hardship on you and the beneficiary while awaiting a decision in a contested case.

Medicare can make conditional payments on behalf of beneficiaries for Medicare-covered services even if it is not the primary payer. Medicare may make conditional payments for covered services in liability (including self-insurance), no-fault, and WC situations if both the following are true:

- Liability (including self-insurance), no-fault, or WC insurer is responsible for payment
- The claim is not expected to be **paid promptly**

NOTE: Medicare has the right to recover any conditional payments. The Benefits Coordination & Recovery Center (BCRC) recovers conditional payments when the Medicare beneficiary receives a settlement, judgment, award, or other payment.

Medicare may pay conditional primary benefits if the provider, the physician or other supplier, or the beneficiary failed to file a proper claim with the GHP (or Large Group Health Plan [LGHP]) due to physical or mental incapacity of the beneficiary.

Otherwise, if there is a primary GHP and the provider does not bill the GHP first, Medicare may not pay conditionally on the liability (including self-insurance), no-fault, or WC claim. Providers must bill the GHP before billing Medicare, and the primary payer payment information that appears on all primary payer remittance advices **must appear on the claim submitted to Medicare**. Medicare will not pay conditional primary benefits in other situations where:

- The GHP alleges it is secondary to Medicare
- The GHP limits its payment when the individual is entitled to Medicare
- The GHP covers the services for younger employees and spouses, but not for employees and spouses age 65 and older
- The GHP alleges it is secondary to liability, no-fault, or WC insurance

Medicare will not make conditional payments associated with WCMSAs or where there is ORM.

“Paid Promptly” Definition

For no-fault insurance and WC claims, “paid promptly” means payment within 120 days after the no-fault insurance or WC carrier received the claim for specific items and services. Without contradicting information, the date of service for specific items and services must be treated as the claim date when determining the “paid promptly” period.

Furthermore, regarding inpatient services, without contradicting information, the date of discharge must be treated as the date of service when determining the “paid promptly” period.

For liability insurance (including self-insurance), "paid promptly" means payment within 120 days after whichever of the following occurs first:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement
- The date the service was furnished or, in the case of inpatient services, the date of discharge

For more information on conditional payments, refer to the following sections of the Medicare Secondary Payer Manual:

- Chapter 1, Section 10.7
- Chapter 3, Sections 30 and 40
- Chapter 5, Section 40
- Chapter 6, Sections 40.3 and 60

A Non-Group Health Plan (NGHP) is coverage provided by a liability insurer (including self-insurance), no-fault insurer, and WC carrier. All NGHP claims must first be sent to the appropriate NGHP insurer before being sent to Medicare. Refer to the Clarification of Medicare Conditional Payment Policy article for instructions on submitting a claim for conditional payment.

Ongoing Responsibility for Medicals (ORM)

Pursuant to Social Security Act, Section 1862(b) (42 U.S.C. 1395y(b)(2)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made" under liability insurance (including self-insurance), no-fault insurance, or a WC law or plan, hereafter, referred to as a primary plan, such as a GHP, LGHP, or NGHP.

Where a primary plan has reported ORM, it has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

HOW IS BENEFICIARY HEALTH INSURANCE OR COVERAGE INFORMATION COLLECTED AND COORDINATED?

Coordination of Benefits (COB) allows plans that provide coverage for people with Medicare to determine their respective payment responsibilities. The Benefits Coordination and Recovery Center (BCRC) collects, manages, and uploads information to the Common Working File (CWF) about other health insurance coverage for Medicare beneficiaries. **Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the BCRC to coordinate the information.**

BCRC relies on many databases maintained by stakeholders, including Federal and State programs; plans that offer health insurance, prescription coverage, or both; pharmacy networks; and a variety of assistance programs. Some of the methods to obtain COB information are:

COBA PROGRAM

The COB Agreement (COBA) program establishes a national standard contract between the BCRC and other health insurance organizations for transmitting enrollee eligibility data and Medicare-paid claims data. This means Medigap plans, prescription drug plans, employer supplemental plans, and others rely on a national repository of information with unique identifiers to receive Medicare-paid claims data for the purpose of calculating their secondary payment.

- **IRS/SSA/CMS Data Match Project** – Federal law requires the Internal Revenue Service (IRS), Social Security Administration (SSA), and CMS to share information about Medicare beneficiaries and their spouses.

  The Data Match Project's purpose is to identify situations where an employer insurance plan may pay primary to Medicare due to a beneficiary or family member's current employment status.

  Employers complete an online Data Match Questionnaire that requests GHP information on identified employees entitled to Medicare or married to a Medicare beneficiary. The BCRC reviews and analyzes the data from employers concerning possible periods of insurance coverage primary to Medicare. As an alternative to the Data Match Questionnaire, employers may enter into an employer Voluntary Data Sharing Agreement (VDSA).

IEQ UPDATE

In the past, the Initial Enrollment Questionnaire (IEQ) gathered COB information from beneficiaries enrolling in Medicare. The law enforcing the IEQ was repealed, and the IEQ is no longer included in Medicare's initial enrollment package.

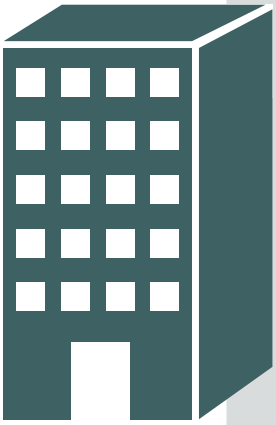
- **VDSA** – The VDSA allows CMS and an employer to electronically exchange GHP eligibility and Medicare information. The VDSA includes Medicare Part D information, enabling VDSA partners to submit primary or secondary records with prescription drug coverage to Part D.

- **MSP Mandatory Reporting Process** – Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) adds mandatory MSP reporting requirements for GHP insurance arrangements, liability insurance (including self-insurance), no-fault insurance, and WC to report beneficiary MSP information. For more information, visit Mandatory Insurer Reporting for GHPs or Mandatory Insurer Reporting for NGHPs.
- **MSP Claims Investigation** – The BCRC initiates an investigation when it learns another insurance plan may have primary responsibility for paying the beneficiary's Medicare claims. The BCRC determines if information is missing from MSP records or MSP cases. Single-source investigations offer a centralized location for MSP-related inquiries. Investigations involve collecting data on other health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources, such as correspondence, accident and injury cases, or phone calls.
- **ECRS** – The Electronic Correspondence Referral System (ECRS) is a web-based application that allows Medicare contractor representatives and the CMS Regional Office MSP staff to electronically transmit MSP information to the BCRC.

For more information on the BCRC, refer to the Medicare Secondary Payer Manual, Chapter 4.

WHAT ARE YOUR RESPONSIBILITIES UNDER THE MSP PROVISIONS?

Part A Institutional Providers (for example, Hospitals)



Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information such as group health coverage through employment or non-group health coverage resulting from an injury or illness.

Bill the primary payer before billing Medicare, as required by the Social Security Act.

Submit any MSP information on your Medicare claim using proper payment information, value codes, condition and occurrence codes, etc. (If submitting an electronic claim, provide the necessary fields, loops, and segments for Medicare to process an MSP claim.)

Part B Providers (for example, Physicians and Suppliers)

Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information, such as group health coverage through employment or non-group health coverage resulting from an injury or illness.

Bill the primary payer before billing Medicare, as required by the Social Security Act.

Submit an Explanation of Benefits (EOB), or remittance advice, from the primary payer with your Medicare claim, with all appropriate MSP information. (If submitting an electronic claim, provide the necessary fields, loops, and segments for Medicare to process an MSP claim.)

NOTE: Normal timely filing requirements apply for Medicare-covered services. For more information, refer to the Medicare Claims Processing Manual, Chapter 1, Section 70.

HOW DO YOU GATHER ACCURATE MSP DATA FROM THE BENEFICIARY?

As a Medicare provider, you must determine whether Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter before submitting a claim to Medicare. You can do this by asking Medicare beneficiaries about other coverage. The questions you ask help update the beneficiary insurance information and verify that the beneficiary record, found in Medicare's CWF is correct and up to date.

TIP FOR PROVIDERS

Providers who use CMS Form-1450, or its electronic equivalent, should report condition code 08 ("beneficiary would not furnish information concerning other insurance coverage") when a beneficiary refuses to answer or provide you with other payer information.

CMS developed tools, including an MSP Questionnaire to help providers identify other payers that may be primary to Medicare. The questionnaire asks questions that help identify MSP situations. Refer to the MSP Questionnaire in the Medicare Secondary Payer Manual, Chapter 3, Section 20.2.1. Your Medicare Administrative Contractor (MAC) may also offer questionnaire tools. For contact information for your MAC, visit the Review Contractor Directory – Interactive Map.

You should retain a copy of completed MSP Questionnaires and other MSP information for 10 years after the date of service. You may keep hard copy files, optical images, microfilms, or microfiches. If you store these files online, you must keep both negative and positive responses to questions.

If you do not furnish Medicare with a record of other health insurance or coverage that may be primary to Medicare on any claim and there is an indication of possible MSP considerations, the BCRC may request that the beneficiary, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire when:

- The MAC receives a claim with an EOB, or remittance advice, attached from an insurer other than Medicare
- The MAC receives an electronic claim that contains other insurance payment information in the appropriate loops and segments
- The beneficiary self-reports or beneficiary's attorney identifies an MSP situation
- The third-party payer submitted MSP information to a MAC or the BCRC

For more information on Secondary Claim Development, visit CMS' Reporting Other Health Insurance webpage.

WHAT HAPPENS IF YOU SUBMIT A CLAIM TO YOUR MAC WITHOUT PROVIDING THE OTHER INSURER'S INFORMATION?

Medicare may erroneously pay the claim as primary if it meets all Medicare requirements, including coverage and medical necessity guidelines. However, if the beneficiary's MSP record in the CWF indicates another insurer should have paid primary to Medicare, Medicare will deny the claim.

If the MAC does not have enough information on the claim or correspondence, it may forward the information to the BCRC, and the BCRC may send the beneficiary, employer, insurer, or an attorney the SCD Questionnaire for additional information. The BCRC will review the response information on the questionnaire and take the proper action.

For more information on proper MSP billing, refer to the Medicare Secondary Payer Manual, Chapter 3.

WHAT HAPPENS IF YOU FAIL TO FILE CORRECT AND ACCURATE CLAIMS?

You must file a proper and timely claim with the appropriate primary payer. Not filing a proper and timely claim with the appropriate primary payer may result in a claim denial by that payer. Policies vary depending on the payer; please check with the payer to learn about its specific policies.

Federal law permits Medicare to recover its erroneous payments. Medicare will require the return of any payment it erroneously paid as the primary payer. Medicare can also fine providers, physicians, and other suppliers for knowingly, willfully, and repeatedly providing inaccurate information related to the existence of other health insurance or coverage.

WHO DO YOU CONTACT WITH MSP QUESTIONS?

Table 2 provides information about who to contact for specific MSP-related questions or situations.

Table 2. Who to Contact for MSP Questions

Contact	Question
BCRC Customer Service Representatives Monday through Friday (except holidays) 8 a.m. to 8 p.m., ET Toll free lines: 1-855-798-2627 Text Telephone (TTY) or Telecommunication Device for the Deaf (TDD) 1-855-797-2627 for the hearing and speech impaired	• Questions about Medicare development letters and questionnaires • Report a beneficiary's accident/injury • Report changes to a beneficiary's employment or health insurance coverage • Report potential MSP situations • Verify Medicare's primary/secondary status • Contact Medicare's Commercial Recovery Center (CRC) For guidance on reporting changes to a beneficiary's health coverage, refer to the MLN Matters® article on Updating Beneficiary Information. **NOTE:** The BCRC will not release insurer information. The provider must request MSP information from the beneficiary prior to billing. To protect the rights and information of our beneficiaries, the BCRC cannot disclose this information.
MAC For contact information for your MAC, visit the Review Contractor Directory – Interactive Map.	• Questions about Medicare claim or service denials and adjustments • Questions concerning how to bill • Questions about the processing of a specific claim • Returning inappropriate Medicare payments • Voluntary refunds

See the BCRC contacts webpage for specific mailing addresses within the BCRC and CRC.

Activities related to the recovery of erroneous payments are handled by the CRC, which is responsible for GHP recoveries, and the BCRC, which is responsible for liability, no-fault, and WC recoveries. The BCRC and CRC comprise all Coordination of Benefits & Recovery (COB&R) activities with two exceptions:

- Recovery demand letters issued by the MSP Recovery Auditors under the demonstration authorized by the Medicare Modernization Act of 2003
- MSP recovery demand letters issued by MACs to providers, physicians, and other suppliers

RESOURCES

Table 3. Resources

Resource	Location
CMS MSP Website	CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html
Medicare & Other Health Benefits: Your Guide to Who Pays First	Medicare.gov/pubs/pdf/02179.pdf
MLN Matters Article SE1217 "Guidance for Correct Claims Submission When Secondary Payers Are Involved"	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1217.pdf

Table 4. Hyperlink Table

Embedded Hyperlink	Complete URL
BCRC Contacts	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html
Clarification of Medicare Conditional Payment Policy	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf
Coordination of Benefits & Recovery Overview	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html
Includes Both Same-Sex and Opposite-Sex Marriages	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8875.pdf
Mandatory Insurer Reporting for GHPs	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html
Mandatory Insurer Reporting for NGHPs	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html
Medicare Claims Processing Manual, Chapter 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

Table 4. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Medicare Learning Network® (MLN) Web-Based Training	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
Medicare Secondary Payer Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html
Medicare Secondary Payer Manual, Chapter 3	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf
Medicare Secondary Payer Manual, Chapter 4	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c04.pdf
Reporting Other Health Insurance	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Reporting-Other-GHP-Insurance/Reporting-Other-Health-Insurance.html
Review Contractor Directory – Interactive Map	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Social Security Act, Section 1862(b)	https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
Updating Beneficiary Information	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf