DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services



Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff

FACT SHEET http://www.cms.gov/Medicare/Coordination-of-Benefits/MedicareSecondPayerandYou

Maintaining the viability and integrity of the Medicare Trust Fund becomes critical as the Medicare Program matures and the "baby boomer" generation moves toward retirement. Providers, physicians, other suppliers, and individuals involved in the admission and billing procedures can contribute to the appropriate use of Medicare funds by complying with all Medicare requirements, including those applicable to the Medicare Secondary Payer (MSP) provisions. This fact sheet provides a general overview of the MSP provisions and your responsibilities.

What Is Medicare Secondary Payer (MSP)?

The MSP provisions protect the Medicare Trust Fund by ensuring that Medicare does not pay for services and items that certain other health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage. The MSP requirement provides the following benefits for both the Medicare Program and providers, physicians, and other suppliers:

- National program savings Medicare saves more than \$8 billion annually on claims processed by insurances that are primary to Medicare.
- Increased provider, physician, and other supplier revenue Providers, physicians, and other suppliers that bill a primary plan before billing Medicare may get more favorable reimbursement rates. Providers, physicians, and other suppliers can also reduce administrative costs when health insurance or coverage is properly coordinated.
- Avoidance of Medicare recovery efforts Providers, physicians, and other suppliers that file claims correctly the first time may prevent future Medicare recovery efforts on that claim.

To realize these benefits, you must have access to accurate, up-to-date information about all health insurance or coverage that Medicare beneficiaries may have. Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items.

WHEN DOES MEDICARE PAY FIRST?

Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries in the absence of other primary insurance or coverage. Medicare is also the primary payer in certain instances, provided several conditions are met. Table 1 lists some common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer.

TABLE 1. LIST OF COMMON SITUATIONS WHEN MEDICARE MAY PAY FIRST OR SECOND

If the individual	And this condition exists	Then this program pays first	And this program pays second
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment	The employer has less than 20 employees	Medicare	GHP
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals	GHP	Medicare
Has an employer retirement plan and is age 65 or older	The individual is entitled to Medicare	Medicare	Retiree coverage
Is disabled and covered by a GHP through his or her own current employment, or through a family member's current employment	The employer has less than 100 employees	Medicare	GHP
Is disabled and covered by a GHP through his or her own current employment, or through a family member's current employment	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals	GHP	Medicare
Has End-Stage Renal Disease (ESRD) and GHP coverage	Is in the first 30 months of eligibility or entitlement to Medicare	GHP	Medicare
Has ESRD and GHP coverage	After 30 months	Medicare	GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage	Is in the first 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
Has ESRD and COBRA coverage	After 30 months	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) claims	Medicare
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	Medicare
Is age 65 or older OR disabled and covered by Medicare and COBRA	The individual is entitled to Medicare	Medicare	COBRA

ARE THERE ANY EXCEPTIONS TO THE MSP REQUIREMENTS?

Federal law takes precedence over state laws and private contracts. Even if an entity believes that it is the secondary payer to Medicare due to state law or the contents of its insurance policy, the MSP provisions would apply when billing for services.

WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

In the following situations, Medicare **may** make payment, assuming Medicare covers the services and the provider files a proper claim.

- A GHP denies payment for services because the beneficiary is not covered by the GHP;
- A no-fault or liability insurer does not pay or denies the medical bill;
- A WC program denies payment, as in situations where WC is not required to pay for a given medical condition; or
- A WC Medicare Set-aside Arrangement (WCMSA) is exhausted.

In these situations, you should include documentation from the other payer stating the claim was denied and/or benefits were exhausted when submitting the claim to Medicare.

WHEN MAY MEDICARE MAKE A CONDITIONAL PAYMENT?

There is frequently a long delay between an injury and the decision by the primary payer in cases where compensability is contested. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made. A conditional payment is a Medicare payment, conditioned upon reimbursement to Medicare, for services for which another insurer is primary payer. Medicare may make these payments for Medicare-covered services in liability, no-fault, and WC situations where another payer is responsible for payment and the claim is not expected to be paid promptly. Note: If there is a primary GHP, Medicare may not pay conditionally on the liability (including self-insurance), no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed prior to Medicare and the primary payer payment information that appears on all primary payer remittance advices must appear on the claim submitted to Medicare.

"PROMPTLY" DEFINITION

Paid promptly, for no-fault insurance and WC, means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the "promptly" period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the "promptly" period.

Paid promptly, with regard to liability insurance (including self-insurance), means payment within 120 days after the earlier of:

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

NOTE: Medicare has the right to recover any conditional payments.

Medicare will not make conditional payments in association with WCMSAs.

For more information on conditional payments, refer to the following sections of the "Medicare Secondary Payer Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html on the Centers for Medicare & Medicaid Services (CMS) website:

- Chapter 1, Section 10.7;
- Chapter 3, Sections 30.2.1.1, 30.2.2, and 40.3.1;
- Chapter 5, Section 40.6; and
- Chapter 6, Sections 40.3 and 60.

How Is Beneficiary Health Insurance or Coverage Information Collected and Coordinated?

The Coordination of Benefits Contractor (COBC) collects, manages, and maintains information regarding other health insurance or coverage for Medicare beneficiaries. The COBC provides a centralized, one-step customer service approach for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries. **Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the COBC to coordinate the information.**

To support the goals of the MSP provisions, the COBC manages several data gathering programs:

- Initial Enrollment Questionnaire About 3 months before entitlement to
 Medicare, enrolling beneficiaries get a letter explaining enrollment. CMS
 automatically registers new Medicare enrollees to use the MyMedicare.gov website,
 which is Medicare's secure online service. After receiving the letter, the enrolling
 beneficiary can access the website and answer questions on other insurance
 or coverage (including prescription coverage) that may be primary to Medicare.
 Medicare beneficiaries may also complete the questionnaire over the phone by
 calling the COBC.
- Internal Revenue Service/Social Security Administration/CMS (IRS/SSA/CMS) Data Match Project Federal law requires the IRS, SSA, and CMS to share information they have regarding employment of Medicare beneficiaries or their spouses. This information helps identify situations where another payer may be primary to Medicare. Employers are required to complete a Data Match Questionnaire that requests GHP information on identified employees who are either entitled to Medicare or married to a Medicare beneficiary. As an alternative to the Data Match Questionnaire, employers may enter into an Employer Voluntary Data Sharing Agreement (VDSA).
- VDSA The VDSA authorizes CMS and an employer to electronically exchange GHP eligibility and Medicare information. To meet the

mandatory reporting requirements, employers can enter into a VDSA in lieu of completing and submitting the IRS/SSA/CMS Data Match Questionnaire. CMS has expanded the VDSA to include Medicare Part D information, enabling VDSA partners to submit records with prescription drug coverage, be it primary or secondary 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 (Non-Group Health Plans [NGHPs]) to the existing MSP provisions. MMSEA mandated Responsible Reporting Entities to submit GHP and NGHP information to strengthen the MSP coordination of benefits process. Insurers submit enrollment and settlement data electronically to the COBC. For more information and official instructions for Section 111 MSP reporting, visit the Mandatory Insurer Reporting web page at http://www.cms.gov/Medicare/Coordination-of-Benefits/ MandatoryInsRep on the CMS website.
- MSP Claims Investigation The COBC investigates missing information on MSP cases. The single-source investigation offers a centralized approach for MSP-related inquiries. The investigation involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
- Electronic Correspondence Referral System (ECRS) The ECRS is a web-based application that allows contractor MSP representatives and the Regional Office MSP staff to fill out various forms online and electronically transmit them to the COBC.

For more information on the COBC, refer to the "Medicare Secondary Payer Manual," Chapter 4 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ msp105c04.pdf on the CMS website. For more information on updating beneficiary information with the COBC, refer to http://www.cms.gov/Outreach-and-Education/ Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1205.pdf CMS website

How Do I CONTACT THE COBC?

You may contact the COBC at 1-800-999-1118 (TTY/TDD: 1-800-318-8782), Monday -Friday, 8 a.m. to 8 p.m. Eastern Time (excluding holidays). You may contact the COBC to:

- Verify Medicare's primary/secondary status,
- Report changes to a beneficiary's health coverage,
- Report a beneficiary's accident/injury,
- Report potential MSP situations, or
- Ask questions regarding Medicare development letters and questionnaires. 5

For more information about contacting the COBC, visit http://www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/ ContactingtheCOBContractor.html on the CMS website.

NOTE: The COBC will not release insurer information. The provider must request information on payers primary to Medicare from the beneficiary prior to billing. To protect the rights and information of our beneficiaries, the COBC cannot disclose this information.

You should address specific claim-based issues (including claims processing) to your Medicare claims processing contractor.

WHAT ARE MY RESPONSIBILITIES UNDER THE MSP PROVISIONS?

Your responsibilities are listed in Table 2.

TABLE 2. YOUR RESPONSIBILITIES AS A MEDICARE PROVIDER

Type of Medicare Provider	Responsibilities	
Part A Institutional Provider (i.e., Hospitals)	 Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. 	
	 Bill the primary payer before billing Medicare, as required by the Social Security Act. 	
	 Submit any MSP information on your Medicare claim using proper condition and occurrence codes on the claim. 	
Part B Provider (i.e., Physicians and Suppliers)	 Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. 	
	 Bill the primary payer before billing Medicare, as required by the Social Security Act. 	
	 Submit an Explanation of Benefits (EOB) form 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 needed to process an MSP claim. 	

How Do I 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 prior to submitting a bill to Medicare. You can do this by asking Medicare beneficiaries about other coverage. The Common Working File (CWF) also contains MSP information from the COBC. The questions you ask can help you verify that the CWF information is correct and up-to-date. Some questions that you should ask beneficiaries include, but are not limited to:

TIP FOR PROVIDERS

Providers who use CMS Form-1450 should use 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.

 Do you have coverage through a GHP through your current or former employer, or the current or former employer of a spouse or family member? If so, how many employees work for the employer providing coverage?

Copyright © 2011, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of this publication may be copied without the express written consent of the AHA.

- Are you receiving WC benefits?
- Do you have a WCMSA?
- Are you filing a claim with a no-fault insurance or liability insurance?
- Are you being treated for an injury or illness for which another party has been found responsible?

CMS developed an MSP questionnaire for providers to use as a guide to help identify other payers that may be primary to Medicare. This questionnaire is a model of the type of questions you should ask to help identify MSP situations. Refer to the MSP questionnaire in the "Medicare Secondary Payer Manual," Chapter 3, Section 20.2.1 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf on the CMS website.

You should retain a copy of completed MSP questionnaires in your files or online for 10 years. You may keep hard copy files, optical image, microfilm, or microfiche. 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 COBC may request that the beneficiary, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The COBC may send an SCD Questionnaire for the following situations:

- A claim is submitted to Medicare with an EOB attached from an insurer other than Medicare,
- A self-report is made by the beneficiary or the beneficiary's attorney identifying an MSP situation, or
- The third party payer submitted MSP information to a contractor or the COBC.

For more information, see the "Medicare Secondary Claim Development Questionnaire" at http://www.cms.gov/Medicare/Coordination-of-Benefits/InsurerServices/medicaresecclaimdevquest.html on the CMS website.

WHAT HAPPENS IF I SUBMIT A CLAIM TO MEDICARE 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 Medicare record in the CWF indicates that another insurer should have paid primary to Medicare, Medicare will deny the claim, unless it may rightly pay conditionally. If the Medicare Contractor does not have enough information, it may forward the information to the COBC and the COBC may send the beneficiary, employer, insurer, or attorney an SCD Questionnaire to complete for additional information. Medicare will review the information on the questionnaire and determine the proper action to take.

For more information on proper MSP billing, refer to the "Medicare Secondary Payer Manual," Chapter 3 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf on the CMS website.

WHAT HAPPENS IF I FAIL TO FILE CORRECT AND ACCURATE CLAIMS WITH MEDICARE?

Federal law permits Medicare to recover its conditional payments.

Medicare can fine providers, physicians, and other suppliers up to \$2,000 for knowingly, willfully, and repeatedly providing inaccurate information related to the existence of other health insurance or coverage.

RESOURCES

For more information about MSP regulations, visit http://www.cms.gov/Medicare/Coordination-of-Benefits/MedicareSecondPayerandYou on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device.



For more information about Medicare Coordination of Benefits, visit http://www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneral Information on the CMS website.

For more information concerning current MSP billing requirements, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ Downloads/SE1217.pdf on the CMS website.

For more information concerning Medicare conditional payment policy, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ Downloads/MM7355.pdf on the CMS website.

The Medicare Learning Network® (MLN) Educational Web Guides, "MLN Guided Pathways to Medicare Resources," help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about Medicare reimbursement, including MSP provisions, refer to the "Medicare Reimbursement" section in the "MLN Guided Pathways to Medicare Resources — Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions.

Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo on the CMS website.





