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

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Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff

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GROUP HEALTH INSURANCE

MEDICARE

WORKERS' COMPENSATION

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The Medicare Secondary Payer (MSP) provisions support the viability and integrity of the Medicare Trust Fund. Compliance with the MSP provisions contributes to the appropriate use of Medicare funds. This fact sheet provides a general overview of the MSP provisions and outlines your responsibilities. When "you" is used in this publication, we are referring to providers, physicians, other suppliers, and billing staff, unless stated otherwise.

Please note:

The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

What Is Medicare Secondary Payer (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 primarily responsible for paying. The MSP provisions apply to situations where 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:

- **National program savings** – The Centers for Medicare & Medicaid Services (CMS) enforcement of the MSP provisions save the Medicare Program billions annually on claims paid by other insurers that are primary to Medicare.
- **Increased provider, physician, and other supplier revenue –** If you bill a primary plan before billing Medicare, you may get more favorable reimbursement rates. Also, health coverage properly coordinated may reduce your administrative costs.
- **Avoidance of Medicare recovery efforts –** If you file claims correctly the first time, you prevent future Medicare MSP recovery efforts on that claim.

Coordination of Benefits & Recovery (COB&R) Overview

The Centers for Medicare & Medicaid Services (CMS) is restructuring its Coordination of Benefits and Medicare Secondary Payer Recovery activities. To sign up for automatic notification of updates, select the "Subscription Sign-up for COB&R Overview Web Page Update Notification" link in the "Related Links" section at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html on the CMS website.

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

When Does Medicare Pay First?

Primary payers are those with first responsibility for paying a claim. Medicare pays first for beneficiaries in the absence of other primary insurance or coverage. Medicare may also pay first where the beneficiary has other insurance coverage, but a special condition also exists. Table 1 lists some common situations where a beneficiary has both Medicare and other health insurance coverage and analyzes which entity is the primary payer.

Table 1. Analysis of Common MSP Coverage Situations

Individual	Condition	Pays First	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 the employer is part of a multi-employer group employing 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 under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The employer has less than 100 employees	 Medicare	 GHP
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The employer has 100 or more employees, or the employer is part of a multi-employer group employing 100 or more individuals	 GHP	 Medicare

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

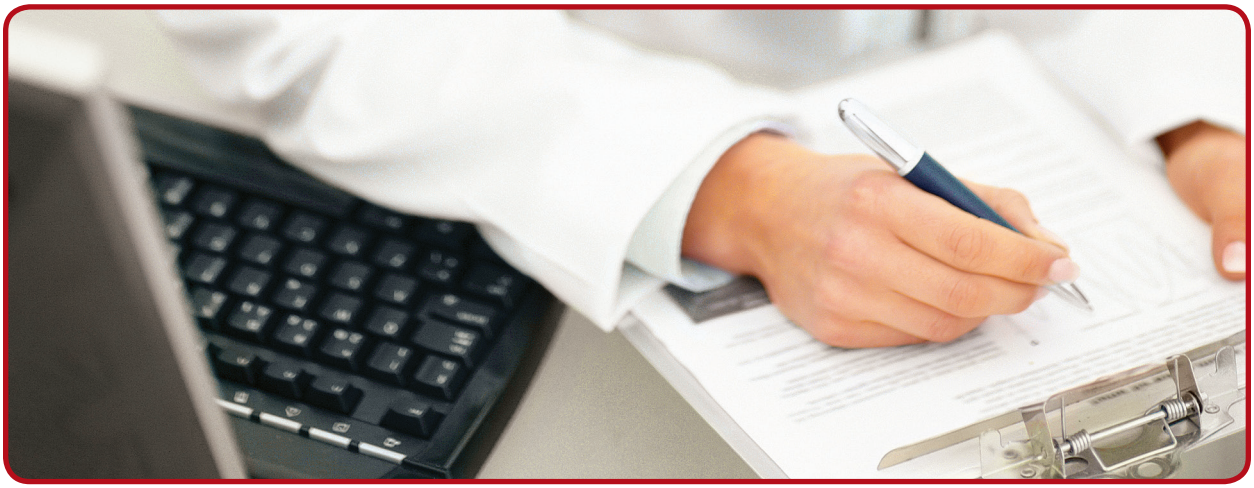
Individual	Condition	Pays First	Pays Second
Has End-Stage Renal Disease (ESRD) and GHP coverage	Is in the first 30 months of Medicare eligibility or entitlement	 GHP	 Medicare
Has ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage	Is in the 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) claims  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) Accident	Medicare
Is age 65 or older **or** is disabled and covered by Medicare and COBRA	The individual is entitled to Medicare	Medicare	COBRA

Are There Any Exceptions to the MSP Requirements?

There are no exceptions to the MSP requirements. Federal law takes precedence over State laws and private contracts. 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 denies payment (for example, where WC excludes a particular medical condition);
- The beneficiary has exhausted a WC Medicare Set-Aside Arrangement (WCMSA); or
- A GHP denies payment for services because:
  - The beneficiary has exhausted plan benefit services;
  - The beneficiary has no coverage under the GHP; or
  - 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 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 to avoid imposing a financial hardship on you and the beneficiary awaiting a decision in a contested case.

A conditional payment occurs where Medicare is not the primary payer, and yet it makes a reimbursable payment on behalf of its beneficiaries for Medicare-covered services until the compensation case is resolved. Medicare may make conditional payments for covered services in liability (including self-insurance), no-fault, and WC situations under the following circumstances:

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

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

If there is a primary GHP and the provider omits billing 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 make conditional payments in association with WCMSAs.

"Paid 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 services must be treated as the claim date when determining the "paid 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 "paid 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.

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 CMS website:

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

For instructions on submitting a claim for conditional payment, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf on the CMS website.

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

Coordination of Benefits (COB) allows plans that provide coverage for a person with Medicare to determine their respective payment responsibilities. The Benefits Coordination & Recovery Center (BCRC) performs activities related to collecting, managing, and reporting other insurance coverage for Medicare beneficiaries. **Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the BCRC to coordinate the information**.

COB 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. Below you will find some of the methods used to obtain COB information:

- **Initial Enrollment Questionnaire (IEQ)** – About 3 months before entitlement to Medicare, enrolling beneficiaries get a letter explaining Medicare enrollment. Medicare advises new beneficiaries to use the MyMedicare.gov website. This secure online service gives beneficiaries, or their designee, access to their personal Medicare information, such as health care claims, preventive services, Medicare Summary Notices (MSNs), and more. When first-time beneficiaries log in to their MyMedicare.gov account, they receive a request to complete the IEQ. This questionnaire asks about any other health care coverage that may be primary to Medicare, including the person's own health insurance and coverage under a family member's insurance. The IEQ responses are processed, and a record is established indicating if there is other insurance primary to Medicare or if there is no other insurance. The information is entered in the Common Working File (CWF) MSP Auxiliary Record. The CWF is a database that maintains a record of beneficiary data. It is important to have MSP information in place to ensure proper payment of claims.

- **Internal Revenue Service/Social Security Administration/CMS (IRS/SSA/CMS) Data Match Project** – Federal law requires the IRS, SSA, and CMS to share their information about Medicare beneficiaries and their spouses. Employers complete an online Data Match Questionnaire that requests GHP information on identified employees entitled to Medicare or married to a Medicare beneficiary where the GHP may be primary to Medicare. As an alternative to the Data Match Questionnaire, employers may enter into an employer Voluntary Data Sharing Agreement (VDSA).
- **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 (Non-Group Health Plans [NGHPs]) to report beneficiary MSP information. For more information, visit the Mandatory Insurer Reporting web page at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html on the CMS website.
- **MSP Claims Investigation** – The BCRC investigates missing information on 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.
- **Electronic Correspondence Referral System (ECRS)** – The 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.

COB Agreement (COBA) Program

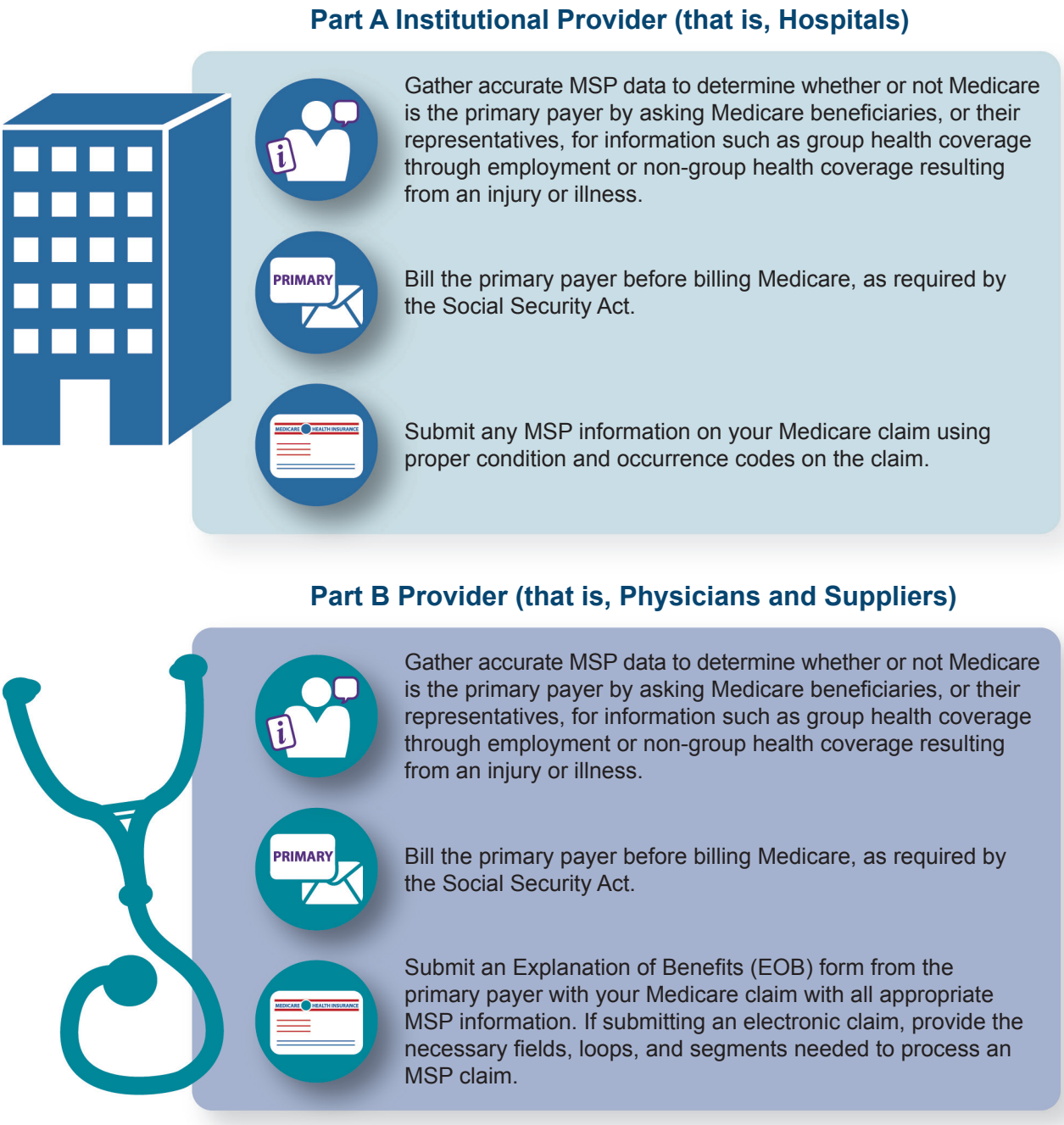
The COBA program establishes a national standard contract between the BCRC and other health insurance organizations for transmitting enrollee eligibility data and Medicare-paid claims data. This means Medigap plans, Part D plans, employer supplemental plans, and others rely on a national repository of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

For more information on the BCRC, 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.

What Are Your Responsibilities Under the MSP Provisions?

Figure 1 shows your responsibilities.

Figure 1. Your Responsibilities as a Medicare Provider



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 prior to submitting a claim to Medicare. You can do this by asking Medicare beneficiaries about other coverage. The CWF also contains MSP information. The questions you ask can help you verify the CWF information is correct and up to date. Some questions providers should ask beneficiaries include, but are not limited to:

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.

Provider MSP Questions for Beneficiaries

- Do you have GHP coverage through your current or former employer or through a family member's coverage? If so, how many employees work for the employer providing coverage?
- 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. Your Medicare Administrative Contractor (MAC) may also offer questionnaire tools for you to use.

You should retain a copy of completed MSP questionnaires in your files or online for 10 years. 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 the beneficiary, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire for the following situations:

- The MAC receives a claim with an EOB attached from an insurer other than Medicare;
- The beneficiary self-reports or beneficiary's attorney identifies an MSP situation; or
- The third-party payer submitted MSP information to a MAC or the BCRC.

For more information on "Secondary Claim Development," visit http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Reporting-Other-GHP-Insurance/Reporting-Other-Health-Insurance.html on the CMS website.

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 unless it may rightly pay conditionally. If the MAC does not have enough information, it may forward the information to the BCRC, and the BCRC 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 You Fail to File Correct and Accurate Medicare Claims?

Federal law permits Medicare to recover its erroneous 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.

Who Do You Contact With MSP Questions?

Table 2 provides additional information about who to contact for specific MSP-related questions or situations. For more information, visit http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html on the CMS website.

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., Eastern Standard Time (EST) 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 health coverage; • Report potential MSP situations; • Verify Medicare's primary/secondary status; or • Contact Medicare's Commercial Recovery Center (CRC). For guidance on reporting changes to a beneficiary's health coverage, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf on the CMS website. **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 http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.	• Questions about Medicare claim or service denials and adjustments; • Questions concerning how to bill; • Questions about the processing of a specific claim; or • Return inappropriate Medicare payments.

GHP recoveries are the responsibility of Medicare's CRC, and liability, no-fault, and WC recoveries are the responsibility of the BCRC. Two exceptions to this rule are:

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

Resources

Table 3 provides resources about MSP provisions.

Table 3. Resources

Resource	Location
CMS MSP website	For more information about MSP regulations, visit http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device.
CMS COB&R website	http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html
"Medicare and Other Health Benefits: Your Guide to Who Pays First"	http://medicare.gov/pubs/pdf/02179.pdf
Medicare Learning Network® (MLN) Matters® Article "Guidance for Correct Claims Submission When Secondary Payers Are Involved"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1217.pdf
MLN Guided Pathways (GPs)	The MLN GPs help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about MSP, refer to the Medicare Payment section in the "MLN Guided Pathways: Basic Medicare Resources for Health Care Professionals, Suppliers, and Providers" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other GP resources, visit 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.

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