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Introduction – Medicare Secondary Payer (MSP)

The term *Medicare Secondary Payer* (MSP) refers to situations when the Medicare program is not responsible for paying a claim first. There are several situations which may result in a beneficiary having an insurance which is primary to Medicare. MSP is essentially the Medicare program's coordination of benefits with other insurers including the following:

- Employer Group Health Plans
- Accident/Injury Insurance
- Other Government Sponsored Health Plans

The information in this chapter outlines the specific situations in which these insurers would be primary to Medicare, how Medicare processes MSP claims, and your responsibilities in MSP situations.

Identifying Beneficiary Insurance Coverages

The reporting of MSP has been mandated by the Centers for Medicare & Medicaid Services (CMS). Prior to billing Medicare, you must take an active role in the identification of MSP claims/cases.

Information obtained at the time of contact with the beneficiary is essential in making the Medicare primary or secondary payer determination. After a Medicare beneficiary leaves your office, it is often difficult for pertinent information to be obtained for billing purposes.

A recommended Medicare Secondary Payer Questionnaire to be completed by the beneficiary or registration personnel is available on our website at the link below. When providing services to a Medicare beneficiary, use of this form should facilitate the identification and proper billing of MSP cases. This will help maximize your reimbursement and shorten claim-processing time.

Medicare Secondary Payer Questionnaire

https://www.cgsmedicare.com/jc/forms/pdf/JC_msp_questionnaire.pdf (35K) 

1. Employer Sponsored Group Health Plan Coverage

Working Aged

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §10

Medicare is secondary for beneficiaries 65 years or older who have Employer Group Health Plan (EGHP) coverage through their own current employment or the current employment of a spouse. An EGHP is a health insurance or benefit plan that is offered through an employer of 20 or more employees. The "20 or more employees" threshold is met when an employer has 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. The 20 calendar weeks do not have to be consecutive.

Disability

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §30

Medicare is secondary for beneficiaries under age 65 who are entitled to Medicare on the basis of permanent disability who have health insurance coverage under a Large Group Health Plan (LGHP) either through their own current employment or the current employment of a family member. An LGHP is a health insurance or benefit plan that is offered through an employer who has 100 or more employees or is part of a multi-employer trust or association which has at least one employer of 100 or more employees. The "100 or more employees" threshold is met when an employer has 100 or more full and/or part-time employees on 50 percent or more of its business days during the previous calendar year.

End Stage Renal Disease (ESRD)

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §20

Medicare is secondary for beneficiaries under age 65 who are entitled to Medicare **solely** on the basis of ESRD who have health insurance coverage under an employer sponsored Group Health Plan (GHP) as a result of the current or former employment of the beneficiary or a family member regardless of the size of the employer.

Medicare is the secondary payer to GHPs for individuals eligible for or entitled to Medicare benefits based on ESRD for the following coordination of benefit (COB) periods:

Date of Medicare Eligibility	COB Period
October 1, 1981 - January 31, 1990	12 months
February 1, 1990 - February 29, 1996	18 months
March 1, 1996 - Present	30 months

Dually Entitled Beneficiaries

When an individual is eligible for or entitled to Medicare based on ESRD and also entitled on the basis of age or disability, they are considered dually entitled to Medicare and other provisions apply. Effective August 10, 1993, GHPs are subject to the ESRD COB period for any plan enrollee eligible for or entitled to Medicare based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. However, if Medicare is primary for an individual who is

already entitled on the basis of age or disability when he/she becomes eligible on the basis of ESRD, the ESRD COB period would not apply.

2. Accident/Injury Insurance

Workers' Compensation

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §50

Medicare payment may not be made for covered items or services to the extent that payment has been made or can reasonably be expected to be made under a workers' compensation (WC) law or plan. However, Medicare secondary, primary, or conditional payments may be made in certain situations.

Secondary payment may be made by Medicare if the WC plan does not pay your full charge. However, if you accept or are required under the WC law to accept the WC payment as payment in full, Medicare secondary payment is not allowed. When submitting claims to Medicare for secondary payment, you should attach a copy of the WC explanation of benefits (EOB).

Generally speaking, Medicare primary payment may be made for services not covered under WC, assuming the services are otherwise covered by Medicare. Primary payment may also be made by Medicare for services that are clearly unrelated to the injuries covered under WC.

Conditional Medicare payments may be made when a WC claim is contested. Furthermore, Medicare is authorized to make payment if the WC insurer will not pay or will not pay promptly (120 days). This is allowed in order to avoid imposing a hardship on the Medicare beneficiary, since a long delay may occur between the occurrence of an injury or illness and the final decision regarding the case by the WC agency. Conditional payments issued by Medicare are subject to recovery by Medicare when the WC case is settled.

Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §50(B)

A WCMSA is an allocation of funds from a workers' compensation (WC) settlement, judgment, or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. Where a WC settlement specifies that a portion of the settlement is for a WCMSA, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for, Medicare will pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease.

No-Fault

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §60

Medicare is secondary to both automobile and non-automobile no-fault insurance. No-fault insurance is insurance that pays for medical expenses due to injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage." Services covered under no-fault insurance **must** be billed to the no-fault insurer first. If the charges are not paid in full, a claim may

be submitted to Medicare for possible secondary benefits. Claims for services covered under no-fault insurance should be submitted with an explanation of benefits from the no-fault insurer or evidence that the no-fault insurance benefits have been exhausted.

Under certain circumstances, Medicare may make conditional payments if the no-fault insurance will not pay or will not pay promptly (i.e., 120 days after receipt of the claim). Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under no-fault insurance.

No-Fault Medicare Set-aside Arrangements (NFMSAs)

A NFMSA is an allocation of funds from an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of NFMSA funds.

Liability

CMS Manual System, Pub. 100-05, Medicare Secondary Payer Manual, Chapter 2, §40

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). When you have reason to believe that you provided covered services to a Medicare beneficiary for which payment under liability insurance may be available, you should bill only the liability insurer, unless you have evidence that the liability insurer will not pay within the 120 day promptly period. If you have such evidence, you may bill Medicare for conditional payment, provided you supply documentation to support the fact that payment will not be made promptly. After the 120 day promptly period has ended, you may (but are not required to) bill Medicare for conditional payment if the liability insurance claim is not finally resolved.

If you choose to bill Medicare, you must withdraw claims against the liability insurer or a lien placed on the beneficiary's settlement. If you choose to continue your claim against the liability insurance settlement, you may not also bill Medicare. You may not collect payment from the beneficiary until after the proceeds of liability insurance are available to the beneficiary.

Liability Medicare Set-aside Arrangements (LMSAs)

A LMSA is an allocation of funds from a liability related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA funds.

Ongoing Responsibility for Medicals (ORM)

CMS Manual System, Pub. 100-05, Medicare Secondary Payer Manual, Chapter 5, §20.4

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 workers' compensation law or plan, hereafter referred to as Non-Group Health Plan (NGHP). When "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) assume ongoing responsibility for medicals (ORM) associated to specified medical conditions, Medicare cannot pay. Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the

NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

3. Other Government-Sponsored Health Plans

Black Lung

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 5, §40.1.1.1

Medicare is the secondary payer for beneficiaries entitled to benefits under the Federal Black Lung Program for items and services provided for certain respiratory conditions. Claims with black lung diagnoses should have an EOB or payment determination from the Federal Black Lung Program in order for Medicare to consider payment.

Send claims related to Black Lung Disease to:

Federal Black Lung Program
PO Box 828
Lanham-Seabrook, MD 20703-0828

Phone: 1.800.638.7072

Federal Public Health

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 16, §50

Medicare will not make payment for services authorized and eligible under another federal program, such as Federal Public Health.

Claims for services authorized or guaranteed under other federal programs should be submitted to that program for payment. No claim should be submitted to Medicare until after the authorizing agency has processed the claim.

If a claim is filed to Medicare because of a denial or a balance owed after the other program pays, a copy of the denial notice or explanation of benefits from the other program should be submitted with the Medicare claim.

4. Electronic Billing of MSP Claims

When Medicare is the Secondary Payer Following One Primary Payer

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. You must comply with Section 1.4.1, titled "Coordination of Benefits," found in the 837 version 5010A1 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at <http://www.wpc-edi.com>). You must follow model 1 in section 1.4.1.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. You must use the appropriate loops and segments to identify the other payer paid amount and any associated adjustments amounts on the 837.

Primary Payer Paid Amount:

For line level services, you must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, you must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Adjustments Made by the Primary Payer

Adjustments made by the payer are reported in the CAS on the 835 Electronic Remittance Notice (ERA) or on hardcopy remittance advice. Providers must take the CAS segment adjustments (as found on the 835 ERN) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment. The appropriate Claim Adjustment Reason Code (CARC) should be used to explain the reason for the adjustment. A complete list of these codes can be found at <http://www.wpc-edi.com>.

Obligated to Accept as Payment in Full Amount (OTAF):

If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to Accept as Payment in Full Adjustment (OTAF). Suppliers should no longer identify the OTAF in the CN1 segment of the 837.

5. Medicare Secondary Claim Filing Tips

- A claim should be submitted to the primary insurer first.
- An explanation of benefits (EOB) or payment determination from the primary insurer must accompany each claim submitted to Medicare.
- If Medicare is secondary to a GHP, items 11, 11a, 11b and 11c of the CMS-1500 must be completed.
- If the claim is due to an accident, items 10a, 10b, and 10c should be completed.
- Do not enter the primary insurer's payment amount in item 29 of the CMS-1500. Complete the field only if payment is received from the beneficiary for covered services.
- The claim must be submitted for the total charge, not the difference between your usual charge and the primary insurer's payment (i.e., co-pay). The total charge should not be reduced to reflect the Medicare or primary insurer's allowed amounts.
- Refer to the patient responsibility (PT RESP) field on the Medicare Remittance Advice (RA) to determine how much to bill the beneficiary. The coinsurance (COINS) and deductible (DEDUCT) fields are calculated based on the Medicare primary payment and do not apply to a secondary claim.

6. MSP on Capped Rental Items

Capped rental items, other than power wheelchairs and enteral/parenteral pumps, are rented for a continuous 13 months and then ownership transfers to the beneficiary. When Medicare is the secondary payer, we will make secondary payments for these rental months if all guidelines are met and we could have made a primary payment. A copy of the primary payer's explanation of benefits must be attached to each Medicare claim.

The primary insurance does not have to honor the purchase option if it is not consistent with their policy requirements; however, a claim must be submitted to the primary insurance first.

Medicare as secondary payer cannot pay more than we would have paid as a primary payer. If the primary insurance pays for the lump sum purchase of a capped rental item (except complex rehabilitative power wheelchairs and enteral/parenteral pumps), Medicare cannot make a secondary payment. Medicare would not make a primary payment and therefore could not make a secondary payment for the lump sum purchase of the capped rental item.

Complex rehabilitative power wheelchairs and enteral/parenteral pumps are the only exceptions to capped rental guidelines. Medicare as primary payer could pay for lump sum purchase or rental. When Medicare is the secondary payer, the primary insurance must be filed first and Medicare would process the claim as secondary.

Medicare may not pay secondary benefits when the primary payer pays your charges in full or when you are either obligated to accept, or voluntarily accept, the primary payer's payment as payment in full.

7. MSP Payment Calculation

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 5, §50

Medicare secondary payments are based on the higher allowable charge between the primary insurer and Medicare unless you are obligated to accept the primary insurer's allowable as payment in full. At no time will Medicare pay more secondary benefits than it would have paid as primary payer. All MSP claims are subject to Medicare coverage criteria. The MSP payment calculation applies to both assigned and non-assigned claims.

Secondary payments are calculated as follows:

1. The Medicare primary payment is determined in the usual manner (i.e., as if there were no other coverage).
2. The higher of the Medicare allowable charge or the primary insurer's allowable charge is determined (unless you are obligated to accept the primary insurer's allowable charge)
3. The amount paid by the primary insurer is subtracted from the amount determined in Step 2 above.
4. Medicare pays the lower of Step 1 or 3.

The following are examples of Medicare secondary payment calculations:

Example 1:

Submitted Charge	\$500
Unmet Medicare Deductible	\$0
Medicare Allowable	\$375

Primary Allowable	\$500
Primary Paid	\$400
<ol style="list-style-type: none"> 1. Medicare primary payment is $\\$375 \times 80\% = \\300 2. Primary allowed of \$500 is the higher allowed amount 3. Primary allowed minus primary paid is $\\$500 - \\$400 = \\$100$ 4. The lower of Step 1 or 3 is \$100. (This claim will pay \$100) 	

Example 2:

Submitted Charge	\$300
Unmet Medicare Deductible	\$0
Medicare Allowed	\$250
Primary Allowed	\$200
Primary Paid	\$160
<ol style="list-style-type: none"> 1. Medicare primary payment is $\\$250 \times 80\% = \\200 2. Medicare allowed of \$250 is the higher allowed amount 3. Medicare allowed minus primary paid is $\\$250 - \\$160 = \\$90$ 4. The lower of Step 1 or 3 is \$90. (This claim will pay \$90) 	

MSP and Deductible

Example 1:

Submitted Charge	\$150
Unmet Medicare Deductible (this amount does not reflect current deductible amount)	\$100
Medicare Allowed	\$120
Primary Allowed	\$150

Primary Paid	\$120
<ol style="list-style-type: none"> 1. Medicare primary payment is $\\$120 - \\100 (deductible) $\times 80\% = \\$16$ 2. Primary allowed of $\\$150$ is the higher allowed amount 3. Primary allowed minus primary paid is $\\$150 - \\$120 = \\$30$ 4. The lower of Step 1 or 3 is $\\$16$. (This claim will pay $\\$16$) 	
<p>If the claim is filed assigned, the patient responsibility would be the difference between the Medicare allowed amount and the total amount paid. The patient responsibility is zero and the Medicare deductible is satisfied by this claim.</p>	

Example 2:

Submitted Charge	\$200
Unmet Medicare Deductible	\$0
Medicare Allowed	\$120
Unmet Primary Deductible	\$150
Primary Allowable	\$150
Primary Paid	\$0
<ol style="list-style-type: none"> 1. Medicare primary payment is $\\$120 \times 80\% = \\96 2. Primary allowed of $\\$150$ is the higher allowed amount 3. Primary allowed minus primary paid is $\\$150 - 0 = \\150 4. The lower of Step 1 or 3 is $\\$96$. (This claim will pay $\\$96$) 	
<p>If the claim is filed assigned, the patient responsibility would be the difference between the Medicare allowed amount and the total amount paid. The patient responsibility is $\\$24$ for this claim. The Medicare deductible is satisfied by this claim.</p>	

Obligated to Accept

"Obligated to Accept" is a term used when a supplier has a contractual agreement with the primary insurer to accept the primary insurer's allowed amount as payment in full. When you are obligated to accept, the secondary payment is based solely on the primary insurer's allowed amount.

Example 1:

Submitted Charge	\$300
Unmet Medicare Deductible	0
Medicare Allowed	\$300
Primary Allowed	\$250
Primary Payment	\$200
Supplier is obligated to accept the primary allowed as payment in full.	
<ol style="list-style-type: none"> 1. Medicare primary payment is $\\$300 \times 80\% = \\240 2. Primary allowed of \$250 is the higher allowed amount 3. Primary allowed minus primary paid is $\\$250 - \\$200 = \\$50$ 4. The lower of Step 1 or 3 is \$50. (This claim will pay \$50) 	

8. MSP Overpayment Refunds

It is your responsibility to refund overpayments on MSP claims. To expedite the refund process, please include the following:

1. Explanation of benefits from the third party payer;
2. Type of primary insurance (i.e., EGHP, liability, workers compensation, no fault);
3. Medicare Explanation of Benefits; and
4. Check in the amount of the original Medicare payment.

The claim will then be adjusted according to the MSP guidelines and any additional benefits will be issued at that time.

All refunds should be made payable to CGS and sent to:

CGS
 DME MAC Jurisdiction C
 PO Box 955152
 St. Louis, MO 63195-5152

9. Benefits Coordination & Recovery Center (BCRC)

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 4, §§10.1-2

The Centers for Medicare & Medicaid Services (CMS) has established a centralized Coordination of Benefits (COB) operation by consolidating under a single contractor, the Benefits Coordination & Recovery Center (BCRC), the performance of all activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the BCRC are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The DME MACs are responsible for processing claims submitted for primary or secondary payment.

Supplier Requests and Questions Regarding Claims Payment

DME MACs process claims submitted for primary or secondary payment. Claims processing is not a function of the BCRC. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should be directed to the DME MAC. In addition, you must return inappropriate Medicare payments to the DME MAC which processed the claim. Do not send checks to the BCRC. Questions regarding Medicare claim denials and adjustments should be directed to the DME MAC. If you submit a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the BCRC. This investigation will be performed with the supplier that submitted the claim. MSP investigations are not a function of the DME MAC. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in CMS's Database

The BCRC is the sole authority to ensure the accuracy and integrity of the MSP information contained in CMS's database, known as the Common Working File (CWF). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse, and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the BCRC. The CMS also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage and to report this information when filing claims with the Medicare program.

Contacting the BCRC

BCRC Customer Service Representatives are available to assist you Monday through Friday, from 7:00 am to 7:00 pm Central Time (except holidays), at 1.855.798.2627 or TTY/TDD (for the hearing and speech impaired) at 1.855.797.2627.

Additional information about the BCRC is available on the CMS website at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/index.html>.