



Medicare Secondary Payer (MSP)

Revised January 2007



Part B
TX, MD, DC/DE, VA & Indian Health
A CMS Contracted Intermediary and Carrier

★★ IMPORTANT ★★

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MEDICARE SECONDARY PAYER (MSP)

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PATIENT REGISTRATION/SCREENING

During patient registration, it is important for front office staff to identify whether a beneficiary's expenses should be covered by other insurance before, or in addition to Medicare. This information helps the office determine who to bill and how to file claims with Medicare.

This is not an easy task. There are many insurance benefits a patient could have, and many combinations of insurance coverage to consider before determining who pays and when. Depending on the type of additional insurance coverage a patient has (if any), Medicare may be the primary payer for a patient's claims or be considered the secondary payer.

There are several tasks the front office personnel or person who receives initial patient information performs that are vital to the efficiency and financial welfare of the health care organization to which they belong.

The office staff should:

- Copy the Medicare card and/or other insurance cards.
- Obtain essential patient information through use of completed medical information/history and insurance forms.
- Determine Medicare eligibility.
- Obtain appropriate information to allow the claim to be submitted to the appropriate insurance payer.

Copying the Medicare Card

Verification is important since the information from the Medicare card should be obtained during the patient's initial visit. Medicare also recommends that office personnel periodically verify a beneficiary's insurance information to determine if any changes have occurred.

Pay close attention to:

- Exact patient name.
- Claim number.
- Type of insurance coverage.
- Effective date of coverage.

Claim rejections or denials could occur if complete information is not obtained and supplied on the Medicare claim form submitted.

MEDICARE  HEALTH INSURANCE	
Social Security Act	
Name of Beneficiary AnnaBell D Goodworth	
Medicare Claim Number 123-45-6789-B	Sex FEMALE
Is Entitled To HOSPITAL INSURANCE (PART A) MEDICAL INSURANCE (PART B)	Effective Date 7/1/2004 7/1/2004
Sign Here	<i>AnnaBell D Goodworth</i>

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Obtaining Essential Patient Information

Office staff should obtain additional patient information when registering patients. Usually this is accomplished by the patient completing a medical information/history and insurance information form.

Pay close attention to:

- Obtaining the patient's full name directly from the card.
- Patient address and phone number.
- Obtaining the name and identification number of other insurance (Medicare or other type of insurance plan involved).
- Date of birth.
- Patient's signature.
- Item 12 of the CMS-1500 claim form must be signed if the patient authorizes the release of medical information to Medicare and payment of Medicare benefits to the provider.
- Item 13 of the CMS-1500 claim form must be signed by the patient if there is a Medigap insurance plan and the patient authorizes payment of benefits to the provider.

The accuracy and verification of the Medicare card information is extremely important because this information will be used on many claim forms and medical documentation materials throughout the patient's history with the provider's office.

Mistakes in patient information can carry over to Medicare claims causing claim rejects, delays and even denials. These mistakes cause more work and can be quite costly for an office.



Many offices also collect information such as: health status and previous condition/injury information, spouse and/or emergency contact information, and information about the events surrounding the accident or condition. The provider should also have the patient's signature or the patient's authorized representative on file to authorize the release of any medical or other information necessary to process claims submitted to Medicare.

Reminder: Item 12 authorizes medical information to be released and Item 13 authorizes the claim to be forwarded to a Medigap insurance plan.

MEDICARE SECONDARY PAYER (MSP)

Verification of correct patient information can also help providers from potential Medicare fraud in cases where individuals are attempting to falsely represent themselves as Medicare beneficiaries. Providers should always ask their patients if they have changed their address or legal name since they last visited their office. Many offices now ask for a valid photo ID when registering a new or established patient or in cases where the identity of a current patient is in question.

Determine Medicare Eligibility

Determine and identify all of the medical insurance benefits that each patient has. Patients can be covered by a wide range of insurance plans, including Medicare.

Remember: Obtaining complete and accurate information from the patient is essential to ensuring the accuracy of the Medicare claim information and patient identity information on medical documents and records.

Reminder: The Interactive Voice Recognition (IVR) will allow providers to verify the patient’s Medicare eligibility.

Providers may call:

- Texas and IHS.....(877) 392-9865**
- District of Columbia/Delaware(877) 391-2610**
- Maryland(866) 539-5591**
- Virginia(866) 502-9049**

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Skilled Nursing Facility Consolidated Billing (SNF CB)

Some services for patients residing in a Skilled Nursing Facility (SNF) are affected by Consolidated Billing (CB) guidelines. Services that are included in the CB requirements should not be billed to Medicare Part B. Some services could be denied if the patient is in a covered or non-covered Part A stay. Offices need to obtain information regarding where the patient resides. If the patient is a resident of an SNF, some services may not be paid separately. Prior to the provider rendering services to Medicare patients, he should determine if the patient is enrolled in an SNF. Providers may do this by including an inquiry in their screening process (i.e., Are you a resident of a nursing home?).

It is important to screen your patient for this type of information.

A complete list of the services affected by SNF CB can be found on the Centers for Medicare & Medicaid Services (CMS) Web site at:

www.cms.hhs.gov/SNFConsolidatedBilling/

Background and additional regulations can be found at:

www.trailblazerhealth.com

Sample agreements and communication tools for use by SNFs and their suppliers and practitioners can be located at:

www.cms.hhs.gov/SNFPPS/08_bestpractices.asp

The samples are to provide guidance to enter into arrangements regarding services that fall under the Consolidated Billing guidelines. The use of the sample documents is not required. Providers, suppliers and practitioners may chose to modify any of these documents to reflect more closely and accurately the realities of the parties' relationship. These documents only provide sample language, and CMS does not prescribe or endorse the use of any particular format or language.

Reminders for Patient Screening

- The name used on all documents should match the Medicare card exactly.
- The Medicare number used should match the Medicare card exactly.
- Patient eligibility can be obtained from the Medicare card.
- Periodically verify the patient's insurance information to determine if any changes have occurred. If changes have occurred, the patient's records should be updated accordingly.

MEDICARE SECONDARY PAYER (MSP)

OVERVIEW

Providers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Social Security Act requires all entities seeking payment for any item or service furnished to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim relating to the availability of other health insurance. Any provider that bills Medicare for services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services. Asking Medicare beneficiaries or their representative's questions concerning the beneficiary's Medicare Secondary Payer (MSP) status may accomplish this determination.

To conform to the law and regulations, the provider must verify MSP information prior to submitting a bill to Medicare. Verifying MSP information means confirming that the information furnished about the presence of another payer that may be primary to Medicare is correct, clear and complete, and that no changes have occurred.

INTRODUCTION

"Medicare Secondary Payer" is the term used by Medicare when it is not responsible for paying a claim first. When Medicare began on July 1, 1966, it was the primary payer for all beneficiaries, except for those who received benefits from the Federal Black Lung Program or Workers' Compensation and those who received all covered health care services through the Veterans Health Administration programs. Beginning in 1980, changes to Medicare laws increased the number of coverage and benefit programs that are primary to Medicare. These changes help to preserve the Medicare Trust Fund and limit the beneficiary's out-of-pocket costs. However, these changes also made the billing process more complex, especially when trying to determine if Medicare is the first or second payer.

In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional *primary plans*. The purpose was to shift costs from the Medicare program to private sources of payment.

These provisions prohibit Medicare from making payment if payment has been made or can reasonably be expected to be made by the following primary plans when certain conditions are satisfied: *group health plans, workers' compensation plans, liability insurance or no-fault insurance*. If payment has not been made or cannot be expected to be made promptly *by a workers' compensation plan, liability insurance or no-fault insurance*, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment. When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second.

MEDICARE SECONDARY PAYER (MSP)

The role of Medicare as the secondary payer is similar to the coordination of benefits clause in private health insurance policies. By federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans. Medicare should be viewed as the secondary payer when a beneficiary can reasonably be expected to receive medical benefits through one or more of the following means:

- An Employer Group Health Plan (EGHP) for working age beneficiaries.
- A Large Group Health Plan (LGHP) for disabled beneficiaries.
- Beneficiaries eligible for End Stage Renal Disease (ESRD).
- Auto/medical/no-fault/liability insurance.
- Veterans Affairs (VA).
- A Workers' Compensation (WC) plan.
- The Federal Black Lung Program.

Any conditional primary payment(s) made by Medicare for services related to an injury is subject to recovery. A conditional payment is a payment made by Medicare, for Medicare-covered services where another payer is responsible for payment and the claim is not expected to be paid promptly (i.e., within 120 days from receipt of the claim). Medicare makes conditional payments to prevent the beneficiary from using his or her own money to pay the claim. However, Medicare has the right to recover any payments. This includes payments that should have been paid under:

- Workers' Compensation.
- Liability.
- Automobile, medical or no-fault insurance.

Federal law permits Medicare to recover its conditional payments. Providers can be fined up to \$2,000 for knowingly, willfully and repeatedly providing inaccurate information relating to the existence of other benefit plans.

Under law, the Centers for Medicare & Medicaid Services (CMS), the Internal Revenue Service (IRS) and the Social Security Administration (SSA) share information about whether Medicare beneficiaries or their spouses are working and whether they have employment-related health insurance.

In most cases, federal law takes precedence over state laws and private contracts. Even if a state law or insurance policy states they are a secondary payer to Medicare, the MSP regulations should be followed when billing for services.

MEDICARE SECONDARY PAYER (MSP)

HOW WE GET THIS INFORMATION

One way of obtaining the beneficiary's employment information at the time of eligibility is a questionnaire letter that is sent to the beneficiary. This letter asks questions related to employment and other situations. When the beneficiary receives the questionnaire letter, he must answer the questions and return the letter back to the carrier. Once this letter is received, a file is maintained and kept on file designating what insurance should pay first.

This questionnaire letter is sent from the **Coordination of Benefits Contractor (COBC)**, a contracted carrier in New York, to the beneficiary. If the beneficiary does not respond to the first letter that is sent, a second letter is mailed. At this time, if there is no response, a third letter is sent; this letter will be sent to the physician's/provider's office.

It is very important to screen Medicare beneficiaries to obtain the correct and most current insurance information. Providers should maintain this information in the patient's file so that if they receive a questionnaire letter for one of their patients, they will be able to complete this form and return it to the contractor. Due to the Privacy Act, the type of information needed to complete this letter would not be available from the Medicare carrier. Providers should screen their patients up front, so the claims can be filed to the correct insurance company.

Medicare also obtains information on beneficiary and employment insurance plans through Data Match. This is a process of sharing information between agencies (i.e., IRS, SSA or CMS) to find cases where Employer Group Health Plans (EGHPs) should pay first on Medicare claims. The COBC contacts the employer to confirm EGHP coverage. When this information is obtained, it is recorded and kept on file.

All of the beneficiary employment information is then held within the COBC and shared among all the agencies that are affiliated with the beneficiary's health care.

Providers can:

- Verify Medicare's primary/secondary status.
 - Note:** Insurer information will not be released. The provider must request information on payer's primary to Medicare from the beneficiary prior to billing. The patient's privacy rights will be protected, so this information cannot be disclosed.
- Report changes to a beneficiary's health coverage.
- Report a beneficiary's accident/injury.

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The COBC will be unable to help the provider with:

- Information on how to bill for payment. Providers should contact the Medicare contractor for this information.
- Inquiries related to specific claims or recoveries.
- Beneficiary entitlement data. Regulations do not allow the COBC to provide entitlement data to the providers.
- Insurer information. The COBC is permitted to indicate whether Medicare is primary or secondary but they cannot provide the name of the other insurer.

MEDICARE COORDINATION OF BENEFITS CONTRACTOR (COBC)

The purpose of the COBC program is to identify health benefits available to Medicare beneficiaries and to coordinate the payment process to prevent or minimize overpayments of Medicare benefits. Information on eligibility and benefits entitlement is obtained from the COBC central file and is used to facilitate accurate payment. All MSP claim investigations will be initiated and researched by the COBC contractor, not by the local Medicare intermediary or carrier. The COBC contractor will provide customer service to all callers from any source, including but not limited to beneficiaries, attorneys or other beneficiary representatives, employers, insurers, providers and suppliers. All MSP inquiries, including the reporting of potential MSP situations, changes in a beneficiary's insurance coverage, changes in employment and general MSP questions or concerns, should be directed to the COBC.

MEDICARE SECONDARY PAYER (MSP)

COBC CONTACT INFORMATION

Toll Free **(800) 999-1118**

TDD/TYY **(800) 318-8782** (for the hearing- and speech-impaired)

Mail questionnaires and correspondence to:

Medicare – COBC

Data Match Project

P.O. Box 125

New York, NY 10274-0125

Medicare – COBC

MSP Claims Investigation Project

P.O. Box 5041

New York, NY 10274-5041

Medicare – COBC

Voluntary Agreement Project

P.O. Box 660

New York, NY 10274-0660

Medicare – COBC

Initial Enrollment Questionnaire Project

P.O. Box 17521

Baltimore, MD 21203-7521

When contacting the COBC please provide the following:

- Medicare provider number.
- Client's/patient's full name.
- Date of birth.
- Gender.
- Client's/patient's Medicare or Social Security number.

The following would be additional information helpful to the COBC in reporting an accident/injury:

- Date of incident.
- Date of illness.
- Name and address of the other insurance.
- Name of injured.
- Policy/claim number.

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CATEGORIES***Working Aged***

Medicare pays secondary for Part A and Part B benefits for an individual who:

- Is age 65 or older.
- Is working for or whose spouse is working for an employer who has 20 or more employees, or at least one employer is a multi-employer group, which employs 20 or more individuals.
- Is entitled to Part A (hospital insurance) on the basis of the individual's own Social Security or railroad retirement earnings record, or federal quarters of coverage, or the earnings record or the federal quarters of coverage of another person.
- Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

Reminders:

- Where a Group Health Plan (GHP) is primary payer but does not pay in full for the services, secondary Medicare benefits may be paid to supplement the amount it paid for the Medicare-covered service. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if Medicare covers the services. Primary Medicare benefits may not be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries.
- A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. Medicare contractors must evaluate claims under existing guidelines derived from the law and regulations to ensure services are covered by the program regardless of any employer plan involvement.
- If the beneficiary elects not to be covered by the EGHP, that employer may not provide the beneficiary with a supplemental plan.
- The GHP cannot discriminate against employees aged 65 or older or their spouses, regardless of whether they have Medicare. The benefits offered to these individuals under the plan cannot differ in any way from the benefits offered to individuals who do not have Medicare.
- Employees or spouses can reject coverage under the group health plan and choose Medicare as their primary payer. If they reject coverage under the group health plan, the plan may not offer them or subsidize a plan intended only to supplement Medicare's benefits. Additionally, the employer may not purchase or subsidize an individual's supplement policy for the employee or family member.

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The Medicare secondary payer provision for working aged does not apply to:

- Individuals enrolled in Part B only.
- Individuals enrolled in Part A on the basis of a monthly premium.
- Anyone who is under age 65. (Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65).
- Individuals covered by a health plan other than a group health plan as defined above (e.g., one that is purchased by an individual privately, and not as a member of a group and for which payment is not made through an employer).
- Employees of employers of fewer than 20 employees who are covered by a single employer plan.
- Members of multi-employer plans, which have been approved by CMS for the “multi-employer exemption,” who the plan identified as employees of employers with fewer than 20 employees.
- Retired beneficiaries who are covered by group health plans as a result of past employment and who have group health plan coverage as a result of their own or a spouse’s current employment status.
- Individuals enrolled in single employer group health plans of employers with fewer than 20 employees.
- Members of multi-employer plans who the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.
- Domestic partners who are given “spousal” coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus, for this purpose a domestic partner cannot be recognized as a spouse.
- Former spouses who have Federal Employees Health Benefit coverage under the Spouse Equity Act.
- Temporary Leave of Absence.

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MSP rules state that if an employee retains their employment status, Medicare remains secondary. Examples of retained employment rights include:

- Company-approved temporary leave of absence for any reason.
- Furlough.
- Temporary layoff.
- Sick leave.
- Short-term or long-term disability.
- Leave for teachers.
- Seasonal workers who normally work year-round.
- Employees with health coverage that extends beyond or between active employment periods.

GROUP HEALTH PLANS FOR DISABLED BENEFICIARIES

Medicare is secondary for beneficiaries who are under age 65 and entitled to Medicare due to a disability other than ESRD. The following are the criteria for this situation:

- The beneficiary has coverage under a Large Group Health Plan (LGHP) with 100 or more employees.
- The beneficiary is entitled to Medicare based solely on a disability (other than ESRD).
- The beneficiary is actively employed or covered as a dependent of an actively employed person covered under an LGHP with 100 or more employees.

Medicare is not secondary payer under the MSP for the disabled provision for individuals:

- Who work for employers of fewer than 100 employees unless the group health plan is a multiple employer plan in which at least one employer of 100 or more employees participates.
- Covered by a large group health plan as a result of past employment (e.g., as a retired former employee or as the spouse of a retired former employee) and whose coverage is not also based on current employment status of their own or a family member's current employment status.
- Covered by a health plan other than a large group health plan (e.g., one that is purchased by the individual privately and not through an employer).
- Who have federal employee health benefit coverage under the Spouse Equity Act.

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COVERAGE DUE TO ESRD

The ESRD criteria applies to individuals, including dependent children, who are entitled to Medicare on the basis of ESRD and who are covered under an EGHP, regardless of work status or the size of the plan. This provision applies regardless of the number of employees employed by the employer and regardless of whether the individual or other family member has current employment status. Once the Medicare beneficiary has received his or her entitlement based on the condition of ESRD, a coordination period begins. The length of the coordination period is 30 months, during which Medicare is the secondary payer. Medicare will remain the secondary payer throughout the entire coordination period, even if the beneficiary becomes entitled to Medicare based on disability or age before the coordination period ends.

The criteria are:

- If an EGHP is offered through an employer because of his employment or employment of spouse or other family member's active employment, Medicare is secondary to an EGHP for individuals who have Medicare benefits based on ESRD. The beneficiary can be any age.
- The period in which Medicare is secondary is called the coordination period. Secondary benefits are payable for a period up to 30 months.

Note: Section 4631(b) of the Balanced Budget Act (BBA) of 1997 permanently extended the coordination period to 30 months for any individual who had not completed an 18-month coordination period by July 31, 1997. If the termination date is August 1, 1997, or later, the coordination period would be extended (an additional 12 months) to 30 months. Prior to August 1, 1997, the coordination period was 18 months.

Medicare is the secondary payer to group health plans for items and services furnished during a period of up to 30 consecutive months, which begins with the earlier of:

- The month in which a regular course of renal dialysis is initiated.
- If the patient undergoes a course of self-dialysis training the first day of the month in which the training occurred.
- If an individual received a kidney transplant, the first month in which the individual became entitled.

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DETERMINATION FOR SUBSEQUENT PERIODS OF ESRD ELIGIBILITY

If an individual has more than one period of eligibility or entitlement based solely on ESRD, a coordination period is determined for each period of eligibility. If Medicare entitlement is not correctly terminated three years after a successful transplant, it is still considered a new period of eligibility and consequently a new coordination period begins.

WORKING AGE, DISABILITY AND ESRD EMPLOYER HEALTH MAINTENANCE ORGANIZATIONS (HMOS)***HMO Secondary (Employer Group HMO)***

Medicare is only secondary to an HMO acting as an EGHP:

- Medicare Part B secondary payment may be made for part or all of the copayments.
- The capitation payments made by the HMO discharges the beneficiary's liability to pay for covered services except for the copayment.
- The copayment receipts together with a signed statement from the beneficiary explaining the situation will serve in lieu of the primary benefit notice.

Services by Outside Sources Not Covered

Where Medicare is secondary payer for a person enrolled in an employer sponsored managed care health plan (Health Maintenance Organization (HMO)/Competitive Medicare Plan (CMP)), Medicare does not pay for services obtained from a source outside the employer-sponsored managed care plan if:

- The same type of services could have been obtained as covered through, or paid for by, the managed care employer health plan, or
- Particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded under these circumstances even if the individual receives services outside of the managed care health plan's service area, e.g., while the individual is away from home.

During patient screening, **before** the patient is seen, providers are to ask beneficiaries that are enrolled in a group health plan, whether the plan is a managed care health plan. If the patient is enrolled in such a plan, Medicare will not pay for the service(s) provided.

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The patient would be responsible for the denied services as “payment will not be made for non-plan services that could have been obtained from or through the prepaid health plan.”

HMO Supplemental

Medicare would be the primary payer to a supplemental HMO plan. The beneficiary would have coverage through a specific insurance company that would pay **after** Medicare. This coverage could result from purchasing coverage from an outside insurance company or from a previous employer. This coverage would normally be through a network of providers – doctors, hospitals and other health care professionals within a specific geographic area.

Note: For coverage or guideline restrictions established for the supplemental HMO plan, the beneficiary would need to contact that particular insurance company.

LIABILITY***General Effect of Liability Insurance on Medicare Payments***

Under Section 1862(b)(2) of the Social Security Act, Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan. Under certain circumstances, Medicare may make conditional payments if the liability insurance will not pay or will not pay promptly. 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 a liability insurance policy or plan (including self-insured plan). Medicare’s right to recover its benefits from liability insurers and from those who have been paid by liability insurers takes precedence over the claims of any other party.

Definitions

Accident - An unintended occurrence outside the normal course of events that causes illness, injury, or damage to a person or property.

Conditional Payment - A Medicare payment, *conditioned upon reimbursement to Medicare*, for services for which another insurer is primary payer.

Employee - An individual who is working for an employer or an individual who, although not actually working for an employer, is receiving from an employer payments that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code (IRC).

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Family Member - Family member means a person enrolled in a GHP based on another person's enrollment. Family members may include, *but are not limited to*, a spouse (including a divorced or common law spouse); a natural adopted, or foster child; a stepchild; a parent; or a sibling.

Liability Insurance - Insurance (including a self-insured plan) that provides payment based on alleged legal liability for injuries, illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages.

Med-Pay - A payment made by an insurer intended specifically to pay for medical expenses without regard to the fault of any party to the accident. Med-Pay is a form of no-fault insurance.

No-Fault Insurance - Insurance that pays for medical expenses for injuries sustained or 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. This insurance includes but is not limited to automobile, homeowners' and commercial plans. It *includes* "medical payments coverage," "personal injury protection" or "medical expense coverage." Examples of no-fault insurance include homeowners' and commercial medical payments insurance, commonly referred to as Med-pay coverage.

Prompt or Promptly - With regard to liability insurance means payment within 120 days after the earlier of the following:

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

With regard to no-fault and WC insurance, prompt or promptly means payment within 120 days after receipt of the claim.

Proper Claim - A claim that is filed timely and meets all other claims filing requirements specified by the plan, program, or insurer (e.g., mandatory second opinion, prior notification before seeking treatment).

Subrogation - Subrogation means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary.

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Under-Insured Motorist Insurance - Insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the party's policy or plan.

Uninsured Motorist Insurance - Insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or carries less than the amount of insurance required by law.

Self-Insured Plan - A plan under which an individual or other entity is authorized by state law to carry its own risk instead of taking out insurance with a carrier. "Authorized by state law" means not prohibited by state law. The plan established for the federal government under the Federal Tort Claims Act is also a self-insured plan.

Medicare does not pay as the primary insurer for medical services covered by no-fault policies. Therefore, all no-fault claims should be filed to the no-fault insurance company first.

Medicare pays as the primary insurer if the entire primary insurer allowance on the automobile insurance claim is applied to the deductible, regardless of the deductible amount.

Note: If services are payable under a plan indicated below, that insurance plan should be billed until all benefits are exhausted:

- Automobile.
- Medical.
- Liability.
- No-fault.
- Personal Injury Protection (PIP).
- Third-party Liability.

Difference Between Liability Insurance and Other Primary Plans

Liability insurance differs from the other insurance policies or plans that, under Section 1862(b) of the Social Security Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., no-fault insurance, group health plans and Workers' Compensation, the insurance has a contractual obligation to pay for medical services provided to the covered/injured person. Liability insurance, however, has a contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party.

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Automobile, Medical, No-Fault, Personal Injury Protection and Third Party Liability

Section 953 of the Omnibus Budget Reconciliation Act of 1980, amended by the Deficit Reduction Act of 1994, precludes Medicare payment for items or services to the extent that payment has been made or can reasonably be expected to be made under automobile, medical, Personal Injury Protection (PIP), no-fault or any liability insurance plan or policy including self-insurance plans. Services that should be billed to these insurance plans are as follows:

- Services payable under one of the above plans. That plan should be billed until all benefits are exhausted.
- Any payments made by Medicare for services payable under one of these policies constitute overpayments and are subject to recovery.
- Liability insurance plan is an exception to the above rule. The physician/supplier has the option to bill Medicare for conditional primary payment.

Note: If services are payable under any of the plans listed below, that plan should be billed until all benefits are exhausted:

- Automobile.
- Medical.
- Liability.
- No-fault.
- PIP.
- Third-party Liability.

A trauma development letter may be sent by the COBC when information regarding an accident, illness or injury is received and/or a diagnosis appears on a claim that indicates an accident, illness or injury has occurred. This incident may be related to workers' compensation, an automobile accident or another liability situation. The trauma development letter may be sent to the beneficiary, the provider, the attorney or the insurer to collect information regarding the existence of other insurance that may be primary to Medicare. If an MSP liability situation is identified after Medicare pays the claim, Medicare has the right to recover any conditional payments made on behalf of the beneficiary.

No-Fault Insurance

Medicare is secondary to any no-fault insurance, including all forms of automobile no-fault insurance, automobile medical payments, and non-automobile no-fault insurance. No-fault insurance is a form of insurance that pays for medical expenses for 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. MedPay is a form of no-fault insurance even when included in automobile insurance of any type. Payment may not be made under Medicare for otherwise

MEDICARE SECONDARY PAYER (MSP)

covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under no-fault insurance. A conditional Medicare payment may be made if the no-fault insurance has not paid and cannot reasonably be expected to make payment promptly.

Liability Insurance

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). Liability insurance means insurance (including a self-insurance plan) that provides payment based on the policyholder's alleged legal liability for injury or illness or damage to property. It includes, but is not limited to homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It includes payments under state "wrongful death" statutes that provide payment for medical damages. An entity that engages in a business, trade, or profession is considered to be self-insured for liability purposes to the extent that it has not purchased liability insurance.

Conditional Primary Medicare Benefits

The Medicare statute stipulates that Medicare may not make payment if Workers' Compensation (WC), no-fault, or liability insurance is the proper primary payer. The statute further authorizes Medicare to make a conditional payment if the WC, no-fault, or liability insurance will not pay or will not pay promptly. Such payments are conditioned upon reimbursement to the trust fund if it is demonstrated that the WC, no-fault, or liability insurance has or had the responsibility to make primary payment. Such responsibility may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured, or by other means.

Note: If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a Group Health Plan (GHP), the provider, physician or other supplier bills the liability insurer or no-fault insurer and/or GHP as appropriate before requesting conditional Medicare payments. Medicare does not make conditional primary payment when there is GHP coverage that is a primary payer to Medicare.

MEDICARE SECONDARY PAYER (MSP)

BILLING LIABILITY INSURANCE***Billing Options and Requirements – Alternative Billing***

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) Promptly means payment within 120 days after the earlier of:

- The date the claim is filed with an insurer or a lien is filed against a potential liability settlement.
- Or,
- The date the service was furnished or, in the case of inpatient hospital services, (the date of discharge) rather than bill Medicare. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, a provider, physician or other supplier **may either**:
 - Bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance).
 - Or,
 - Maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.

Charges to Patients**Physician and Other Supplier Charges to Patients for Services *Covered* by Medicare**

The following applies to physicians and other suppliers **who participate** in Medicare:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.
- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

MEDICARE SECONDARY PAYER (MSP)

The following applies to physicians and other suppliers **who do not participate** in Medicare and who submit or would be required to submit an assigned claim:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.
- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

Physicians and other suppliers **who do not participate** in Medicare and who submit a non-assigned claim may charge beneficiaries no more than the limiting charge and may collect without regard to whether the liability insurance is available to the beneficiary.

Physicians and other suppliers who do not participate in Medicare, do not submit a non-assigned claim, and are not required to submit an assigned claim if they submitted a claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services **Not Covered** by Medicare

- For services for which there is no Medicare coverage available regardless of who furnishes them, providers, physicians, and other suppliers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.
- For services of foreign hospitals that have no election to bill Medicare, providers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.
- For services of foreign physicians and other suppliers, the physician or other supplier may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

MEDICARE SECONDARY PAYER (MSP)

Provider, Physician or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary's Liability Insurance Settlement

As cited above, providers, physicians, and other suppliers must withdraw all claims/liens against liability insurance/beneficiary's liability insurance settlement (except for claims related to services not covered by Medicare and for Medicare deductibles and coinsurance) when they bill Medicare. If Medicare is advised of a situation where the provider, physician or other supplier billed Medicare but did not withdraw the claim/lien, Medicare will:

- Advise the provider, physician or other supplier and beneficiary that the act of billing Medicare limits the payment that the provider, physician or other supplier may receive for the services billed to the Medicare approved amount. This applies even if Medicare did not pay the claim or the provider, physician or other supplier refunded the Medicare payment to Medicare.
- If the provider, physician or other supplier collected on a claim/lien after billing Medicare, Medicare will advise the provider, physician or other supplier and beneficiary that:
 - The provider, physician or other supplier must refund the Medicare payment in instances where the amount collected on the claim/lien is for the full charges of the claim/lien and the Medicare payment is greater than or equal to the full charges of the claim/lien and greater than or equal to the amount collected on the claim/lien (see example one below for an illustration of this policy).
 - Or,
 - The provider, physician or other supplier must refund the lesser of the amount collected on the claim/lien or the Medicare payment in instances where the amount collected on the claim/lien is less than the full charges of the claim/lien due to policy limits.
 - And,
 - The provider, physician or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment if the provider, physician or other supplier received payment for services not covered by Medicare and for Medicare deductibles and coinsurance.
 - Or,
 - The provider, physician or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment less any amounts due from the beneficiary for services not covered by Medicare and for Medicare deductibles and coinsurance.

MEDICARE SECONDARY PAYER (MSP)

Charging the Beneficiary

A physician or supplier who has received assigned benefits may not return the Medicare payment to the carrier and bill full charges to a beneficiary who has received a liability award or settlement. Nor may a physician or supplier who has accepted assignment but not yet received the Medicare payment decline on similar grounds to accept Medicare payment and bill the patient full charges. Under the terms of the assignment, the physician or supplier may bill only for the applicable deductible and coinsurance amounts. The beneficiary's receipt of a liability award or settlement does not permit rescission of the assignment agreement.

The following are special circumstances:

- When a no-fault plan denies some or all of a claim on the basis of benefit exhaustion or specific no-fault policy coverage exclusion applicable to all policyholders, Medicare may pay for the services, subject to meeting normal Medicare guidelines. A copy of the denied Explanation of Benefits from the no-fault plan must accompany the claim to Medicare.
- Primary Medicare benefits may not be paid merely because the beneficiary wants to save his automobile insurance for future benefits.

A physician or supplier who accepts assignment may not file a lien against a beneficiary's liability insurance proceeds. To do so would be a violation of the assignment agreement.

Important Contacts for MSP Recovery Contractor

The Centers for Medicare & Medicaid Services (CMS) awarded the national MSP Recovery Contract (MSPRC) to Chickasaw Nation Industries, Inc. – Administration Services, LLC (CNI). This contract was implemented on October 2, 2006.

MEDICARE SECONDARY PAYER (MSP)

TELEPHONE INQUIRIES

The Medicare Secondary Payer Recovery Contractor's (MSPRC) trained staff can help you with MSP post-payment recovery inquiries. The Customer Service Representatives are available Monday through Friday, 8 a.m. to 8 p.m., Eastern Time, except holidays, at toll-free lines:

- **(866) MSPRC-20**
Or,
- **(866) 677-7220**
Or,
- **(866) 677-7294** (for the hearing and speech impaired)

WRITTEN INQUIRIES

Address all liability insurance or no-fault insurance MSP recovery inquiries to the address below. (Liability insurance includes self-insurance and all types of liability insurance, including but not limited to: automobile liability insurance, uninsured motorists' insurance, underinsured motorists' insurance, homeowners' liability insurance malpractice insurance, product liability insurance and general casualty insurance. No-fault insurance includes but is not limited to automobile, homeowners' and commercial plans. Sometimes no-fault insurance is called medical payments coverage or personal injury protection.)

**MSPRC Auto/Liability
P.O. Box 33828
Detroit, MI 48232-3828**

Address Group Health Plan insurance MSP recovery inquiries to:

**MSPRC GHP
P.O. Box 33829
Detroit, MI 48232-3829**

Address Workers' Compensation MSP recovery inquiries to:

**MSPRC WC
P.O. Box 33831
Detroit, MI 48232-3831**

Additional information regarding the MSP Recovery Contractor can be found on the TrailBlazer Web site at the following link: www.trailblazerhealth.com/msp/index.asp?

MEDICARE SECONDARY PAYER (MSP)

BLACK LUNG DISEASE

The Department of Labor's Black Lung Program provides for the treatment of Black Lung Disease (Coal Miner's disease). The Black Lung Program also provides coverage for other pulmonary/respiratory illnesses associated with the effects of coal mining. Medicare is the primary payer for services rendered for conditions **other** than Black Lung to beneficiaries that are eligible for both Medicare and the Black Lung Program. The following is additional information concerning Black Lung benefits:

- Beneficiary carries a card identifying himself as a recipient of this program and to certain survivors of a miner.
- Benefits are more prevalent in northern states.
- Specific diagnoses may indicate Black Lung disease.

When services or items are provided to a beneficiary covered under the Federal Black Lung Program, claims should be sent to the Department of Labor if the diagnosis, procedure or service is directly related to Black Lung. Services not directly related to the patient's Black Lung condition should be submitted to the "traditional" Medicare carrier.

Services provided that fall under the jurisdiction of the Black Lung Program should be filed to the following address:

**Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook, MD 20703-0828**

Individuals with questions about the Federal Black Lung Program may call (800) 638-7072.

UNITED MINE WORKERS OF AMERICA (UMWA)

United Mine Workers of America is a multi-employer insurance plan that "funds" health and pension benefits to retired coal miners and their eligible dependents. All claims for Medicare Part B services provided to Medicare eligible beneficiaries must be submitted to the "funds" for payment. Services will automatically deny (regardless of diagnosis) when billed to Medicare for beneficiaries entitled to UMWA insurance.

Individuals with questions about the United Mine Workers Association may call (800) 291-1425.

MEDICARE SECONDARY PAYER (MSP)

VETERAN BENEFITS

Veterans who are also entitled to Medicare may choose which program will be responsible for payment for services that are covered by both programs. However, claims for the same date and service may not be submitted to both programs. Claims for services for which the veteran elects Medicare coverage should be submitted to Medicare in the usual manner. A denial from Veterans' Affairs (VA) is not needed prior to submitting a claim to Medicare.

Medicare as Primary

Medicare will be primary to VA in the following situations:

- The VA denies the services and the services are covered under Medicare.
- Correspondence received indicates "No VA Coverage."

Medicare as Secondary

The following are most often seen when processing Medicare secondary claims:

- If the VA is unable to provide treatment for the services at one of its own facilities or by one of its own physicians, it may refer the beneficiary to an outside facility or physician.
- Preauthorization is obtained from VA to use an outside facility.
- The beneficiary has been issued a "fee basis" card. (The card is an agreement by the VA to pay up to a specified dollar amount for treatment of a specific disability or for any condition specified on the face of the "fee basis" card.)

Note: The beneficiary can choose to go to a VA facility and use VA benefits or to see the physician of his choice and use Medicare benefits. Beneficiaries do not have to use the VA benefits just because they are entitled.

Providers with questions concerning VA benefits may call (800) 827-1000.

MEDICARE SECONDARY PAYER (MSP)

WORKERS' COMPENSATION (WC)

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can be expected to be made for such items or services under Workers' Compensation law or plan of the United States or any state. If it is determined that Medicare has paid for items or services that can or could have been paid, the Medicare payment constitutes an overpayment.

All WC Acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some states there are limits to the amount of medical and hospital care provided.

Federal law precludes payment for services payable under a WC policy. If services are work-related, the WC policy should be billed until all benefits are exhausted. Medicare remains primary payer for services not related to WC. When filing claims where workers' compensation may be involved:

- Medicare may make payments for Medicare-covered services if not payable under the WC policy.
- Services, payable under a WC policy, which have been paid by Medicare constitute overpayments and are subject to recovery.
- A beneficiary's statement that an injury or illness is not work-related may be accepted in absence of reasonable doubt. Where WC does not pay for all services furnished to a beneficiary, Medicare benefits may be paid for those services not covered under WC.

What Happens if the Primary Payer Denies a Claim?

In some situations Medicare may make payment assuming the services are covered and a proper claim has been filed.

- The group health plan denies payment for services because the beneficiary is not covered by the health plan.
- The no-fault or liability insurer does not pay or denies the medical bill.
- The WC program denies payment, as in situations where WC is not required to pay for a given medical condition.
- The Federal Black Lung Program will not pay the bill.

In these situations, providers should include documentation from the primary payer stating the claim has been denied and/or benefits have been exhausted when submitting the claim to Medicare.

MEDICARE SECONDARY PAYER (MSP)

Medicare Advantage Plans, aka Health Maintenance Organizations (HMOs), aka Medicare+Choice***Introduction***

The Medicare Modernization Act (MMA) expanded the existing options available to Medicare beneficiaries to enroll in private health plans. Approximately 4.8 million beneficiaries are enrolled in Medicare+Choice plans. The Medicare+Choice plans, which include both coordinated care plans and private fee-for-service plans, generally provide more benefits at a lower cost to beneficiaries.

CMS has done everything possible to make sure the final rule will ensure that the Medicare+Choice plans that participate in Medicare will closely resemble Preferred Provider Organization (PPO) products already available in the non-Medicare market. CMS intends to ensure that Medicare beneficiaries are offered a robust number of choices from which they can receive their Medicare and prescription drug benefits.

The MMA allows for three categories of local Medicare+Choice plans:

Coordinated Care Plans: These include Health Maintenance Organizations (HMOs), with and without Point-of-Service (POS) options, and Preferred Provider Organization (PPO) plans. About 4,755,000 Medicare beneficiaries are enrolled in these coordinated care plans.

Private Fee-for-Service Plans: This plan option is offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the private Fee-for-Service organization to arrange for health care coverage for Medicare beneficiaries who have enrolled in the Private Fee-for-Service plan. About 58,000 Medicare beneficiaries are enrolled in private Fee-for-Service plans.

Medical Savings Account (MSA) Plans: Under this option, the beneficiary chooses a qualifying Medicare MSA high-deductible insurance plan. Medicare then pays the premium for the MSA plan and generally makes a deposit into the Medicare MSA that is established for the beneficiary. The beneficiary uses the money in the Medicare MSA to pay for services provided before the deductible is met, and for other health care services not covered under the MSA plan. Any remaining funds are allowed to accrue from year-to-year. The MSA option is similar to the health savings accounts (HSAs) the MMA made available for the non-Medicare population. These products are designed to allow participants to play a greater role in their health care purchasing decisions. As more beneficiaries enter Medicare with HSAs, this option will allow them to continue to support their account.

Note: Currently there are no MSA plans contracting with Medicare.

MEDICARE SECONDARY PAYER (MSP)

Medicare+Choice

- Local and regional plans must provide all Medicare-covered benefits.
- The plans generally provide Medicare benefits at a much lower cost to Medicare beneficiaries and they also provide non-Medicare benefits that enhance and improve upon the Medicare package.
- Examples of improved benefits:
 - Preventive care.
 - Disease management for chronic illnesses.
 - Dental and vision care.
 - Other services not previously listed.

Most Medicare+Choice plans require enrollees to use network providers for care to be covered by the plan (except in emergencies).

Medicare+Choice Plan Listing

There are many Medicare+Choice plans that have entered into a contract to participate with the Medicare program. There may be other plans seeking approval from CMS. Remember: Always obtain complete information from the beneficiary. Providers should contact the Medicare+Choice plan directly for any additional information.

For a current up-to-date list of Medicare+Choice Plans, access CMS' Web site at:
www.cms.hhs.gov/MedicareAdvtgSpecRateStats/01_Overview.asp#TopOfPage

MEDICARE SECONDARY PAYER (MSP)

HOW TO SUBMIT A CLAIM FOR MEDICARE SECONDARY BENEFITS***Insurance Screening for Claim Submission***

All providers and practitioners should screen their Medicare patients to obtain correct health insurance information before submitting a primary claim to Medicare. Listed below are some questions that a provider may ask his patient during the confidential screening that will help the provider recognize circumstances where Medicare may be the secondary payer.

- Are you currently employed?
- Is your spouse or other family member currently employed?
- If so, how many employees work for the employer providing coverage?
- Are you or your spouse covered under an employer or union health plan that should be primary over Medicare? If your spouse is covered, are you also covered under his plan?
- Did you sustain an injury/illness while at work?
- Are your injuries related to an accident? (i.e., is the patient being treated for an injury or illness for which another party could be held liable?)

By using the above questions to initially screen Medicare patients, providers will help reduce costs to the Medicare program as well as administrative costs to their practice. When Medicare is found to be secondary and a provider is submitting a new claim, the provider must submit the primary insurer's EOB or complete necessary date fields for electronically submitted claims.

When Medicare is determined to be the secondary payer, providers should always submit the claim to the primary payer first. When submitting the CMS-1500 claim form or EMC claim, providers should be sure to complete all primary insurance information, including WC carriers and automobile/no-fault and liability insurance. The accident and employment information will help Medicare identify the insurance information provided.

Claim Submission

Section 3 of the Administrative Simplification Act, Pub. Law 107-105 (ASCA), and regulation 42 CFR 424.32 require that all initial claims for reimbursement under Medicare (except small providers) be submitted electronically effective October 16, 2003, with limited exceptions.

Based on this law, Medicare will not cover claims submitted on paper that do not meet the limited exception criteria. If it is established that a provider has improperly submitted paper claims, he or she will be notified that Medicare will deny any paper claims after a certain date. These instructions will only apply to providers who do not meet the exceptions.

MEDICARE SECONDARY PAYER (MSP)

In every situation where Medicare is secondary payer, always submit a claim to the primary payer first. Upon receipt of the primary payer's determination, complete either the CMS-1500 claim form or submit the claim electronically to be considered by Medicare.

Note: Do not enter the amount paid by the primary plan in Item 29 on the CMS-1500 claim form or the electronic equivalent. This field is for any amount the patient pays for covered Medicare services and should not be used for primary insurance payments. Providers may use this field to indicate any copayment amount collected from the patient, coinsurance amounts or unmet deductible.

To ensure correct reimbursement when Medicare is secondary payer to another insurance company, use the following instructions:

- Screen Medicare beneficiaries for secondary coverage.
- Send claims to the primary insurance and then to Medicare.
- If filing a Medicare secondary claim on a CMS-1500 claim form, list all services on the detail lines. Include a copy of the primary insurance company's EOB.
- If filing electronically, do not include a copy of the primary insurance company's EOB. The claim does require the submission of five additional data elements:
 - Primary payer insurance type code.
 - Amount paid by primary payer.
 - Amount allowed by primary payer.
 - OTAF amount (if applicable).
 - Date the primary payer paid.

Mandatory Claim Submission

Section 1848(g)(4) of the Social Security Act instructs all participating and non-participating physicians and suppliers to submit Medicare Part B claims for covered services provided to Medicare patients. This also applies to patients who have Medicare as their secondary payer. The submission of MSP claims can fall under an exemption to this mandatory submission requirement. If a physician or provider does not possess the information essential for filing an MSP claim, the requirement is waived. If the physician or provider receives the information (primary insurer's remittance advice) necessary to file a Medicare secondary claim, the claims filing requirement is not waived and a claim must be filed with Medicare. The physician or provider must file a Medicare secondary claim if he/she receives the primary remittance advice directly from the patient as well.

MEDICARE SECONDARY PAYER (MSP)

Time Limits for Filing Claims

Under Medicare law, the carrier accepts claims for dates of service in the current year, the previous year and the last three months of the year prior.

Example:

- Current year.
- Previous year.
- Or,
- October, November and December of the year prior to that.

Note: Medicare assigned claims must be filed within one year from the service date or payment will be reduced by 10 percent.

Participation Agreements for Physicians/Suppliers

When Medicare is the secondary payer on assigned claims, all provisions of accepting assignment still apply.

If the primary payer's payment exceeds the Medicare allowable, the physician/supplier may accept the amount without being in violation of the agreement.

Limiting Charge When Medicare is Secondary Payer

The statute prohibits non-participating physicians and non-participating providers who do not accept assignment from billing or collecting amounts above the applicable limiting charge, regardless of whether Medicare is primary or secondary. The limiting charge applies to services when they are submitted as non-assigned and is 115 percent of the allowable charge, including those services reported with a 22 modifier.

The non-participating physician or non-participating provider, who does not accept assignment, cannot collect from the patient more than their limiting charge amount.

MEDICARE SECONDARY PAYER (MSP)

CMS-1500 Claim Form Instructions

Items 4, 6 and 7 must be completed if the patient has insurance primary to Medicare, either through the patient or spouse's employment or any other source. List the name of the insured here.

- Item 4** If the patient has insurance primary to Medicare, either through the patient or spouse's employment or any other source, *list the name of the insured* here. When the insured and the patient are the same, enter the word "SAME." If Medicare is primary, leave blank.
- Item 6** Check the appropriate box for *patient's relationship to insured* when Item 4 is completed.
- Item 7** Enter the insured's *address and telephone number*. When the address is the same as the patient's, enter the word "SAME." Complete this item only when Items 4 and 11 are completed.
- Item 10** Check yes or no in Item 10a-c to indicate whether employment, auto liability, or accident applies to one or more of the services described in Item 24 (procedures). Enter the state postal code (e.g. Texas =TX) if auto accident is marked "Yes." In addition, if "Yes" is checked in any of these fields, you are indicating that there may be another insurance primary to Medicare. Continue to Item 11 to identify primary insurance information.
- Item 11** Item 11 must be completed. This is a REQUIRED field. By completing this item, the physician or provider acknowledges having made a good-faith effort to determine whether Medicare is the primary or secondary payer. If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11a-11c. If there is no insurance primary to Medicare, enter the word "NONE" and proceed to Item 12. If there has been a change in the insured's insurance status, e.g., retired, enter the word "NONE" and proceed to Item 11b.

Enter the appropriate information in Item 11c if insurance primary to Medicare is indicated in Item 11.

- Item 11a** Enter the insured's eight-digit birth date (MM/DD/CCYY) and sex if different from Item 3.
- Item 11b** Enter the employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter the six-digit or eight-digit retirement date (MM/DD/CCYY) preceded by the word "RETIRED."

MEDICARE SECONDARY PAYER (MSP)

- Item 11c** Enter the nine-digit PAYER ID identification number of the primary insurance plan or program. If no PAYER ID number exists, enter the complete primary payer's program name or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in Item 11.
- Item 11d** Leave blank. Not required by Medicare.
- Item 29** Enter only the amount collected from the patient for the primary insurance copayment.

Note: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's EOB notice must be forwarded along with the claim form.

Electronic Claim Submission

Submitting an MSP claim electronically does not require the submission of the primary payer's EOB, but does require the submission of five additional data elements:

- Primary insurer type code.
- Amount paid by primary payer.
- Amount allowed by primary payer.
- OTAF amount (if applicable).
- Date the primary payer paid.

Per the Administrative Simplification Compliance Act (ASCA) of 2001, Medicare Secondary Payer (MSP) is not an exempt claim type and must be submitted electronically by covered entities. An MSP claim with more than one primary payer (Medicare tertiary) is an exemption to electronic billing.

MEDICARE PART B

MEDICARE SECONDARY PAYER (MSP)

Following is required information for submitting claims when Medicare is the secondary payer. The primary payer's Explanation of Benefits (EOB) is not required when submitting MSP claims electronically:

Claim/Header Level Requirements for v4010A1	Loop	Segment	Comments
Claim total submitted charge	2300	CLM02	Must be equal to the sum of the line items.
Claim primary payer paid amount	2320	AMT02 AMT01=D	Must be equal to the sum of the line items.
Claim primary payer allowed amount	2320	AMT02 AMT01=B6	Must be equal to the sum of the line items.
CAS Segment Code	2320	CAS Segment Code	This field is only required if the primary allowed and primary paid amounts both equal zero and the provider chooses to indicate the non-payment reason by CAS code.
Comment field		NTE02	Enter narrative indicating why primary insurance allowed and paid zero. (i.e., out of network provider, deductible, etc.)
Claim adjudication date (Primary payer paid date)	2330	DTP01=573	Required. Date the primary payer paid.
Claim OTAF amount	2320	CN102 CN101=09	Must be equal to the sum of the detail lines. The claim level CN1 should be used only when the service line CN1 is not available (optional).
Medicare Secondary Payer Type Code	2000B	SBR05	Select type code value based on type of primary insurance plan.

MEDICARE PART B**MEDICARE SECONDARY PAYER (MSP)**

Line/Detail Level Requirements	Loop	Segment	Comments
Line submitted charge	2400	SV102	Only one per line item, 25 max per claim.
Line primary payer paid amount	2430	SVD02	Service line paid amount.
Line primary payer allowed amount	2400	AMT02 AMT01=AAE	If there is no value in the allowed amount field, use the value in the approved amount field.
CAS Segment code	2430	CAS Segment Code	This field is only required if the primary allowed and primary paid amounts both equal zero and the provider chooses to indicate the non-payment reason by CAS code.
Line adjudication date (Primary payer paid date)	2430	DTP01=573	Required. Date the primary payer paid.
Line OTAF amount	2400	CN102 CN101=09	Optional.
Medicare Secondary Payer Type Code	2000B	SBR05	Select type code value based on type of primary insurance plan.

MEDICARE SECONDARY PAYER (MSP)

Primary Insurance Type Code: Code identifying the type of insurance policy within a specific insurance program. Required when the destination payer is Medicare and Medicare is not the primary payer. Insurance type code should be submitted in the 2000B SBR05 loop/segment.

- 12Working Age
- 13End Stage Renal Disease (ESRD)
- 14Auto/Med/No-fault Liability
- 15Workers' Compensation
- 41Federal Black Lung
- 42Veterans Affairs (VA)
- 43Disability
- 47Other Liability

Primary Insurance Amount Paid: For line-level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

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

Enter the total amount paid by the primary payer on the claim. If no payment was made, "zero" this field.

Note: Subtract the copayment amount from the primary allowance and enter this amount in this field. This will allow Medicare to pay on the copayment amount.

Primary Insurance Allowed Amount: For line-level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment, with AAE as the qualifier in the 2400 AMT01 segment of the 837.

For claim-level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, loop ID 2320 AMT02 AMT01=B6. Enter the total amount allowed for services on the claim by the primary payer. If no amount was allowed, "zero" this field.

Note: If the primary allowed amount is not indicated on the primary EOB, enter the Medicare-approved amount for the claim in the Secondary Allowed (SA) amount field. Calculate the Secondary Paid (SP) amount by subtracting the copayment amount from the Medicare approved amount. This will allow Medicare to pay the copayment amount as the secondary payer.

MEDICARE SECONDARY PAYER (MSP)

If the primary insurance allowed amount and the primary insurance paid amounts are both 0.00, providers **must** take an additional step to file this type of claim. Medicare requires the providers to indicate the reason for no allowed amount as well as non-payment of the primary insurance. You may do this in one of three ways:

- Comment field. Indicate in the comment field the reason for non-payment. NTE02 Segment (i.e., patient saw doctor outside of network provider listing, pre-existing condition, deductible, benefits exhausted).
- Fax/Mail Documentation. Providers can submit additional claim information by completing the fax cover sheet and mailing or faxing additional information to Medicare. You can find complete fax/mail instructions at the following Web site link: www.trailblazerhealth.com/partb/tx/edi.asp. In the comment field (NTE02 Segment) indicate primary explanation of benefits was fax/mailed and the date.
- CAS Segment codes. Claim status codes communicate information about the status of a claim. (i.e. paid, denied, rejected, non-covered) The CAS codes would inform Medicare of the claim processing decision of the primary insurance company in place of submitting the primary insurance remittance notice. These codes are in a downloadable file on the following Web site links:
 - www.wpc-edi.com
 - www.wpc-edi.com/codes/claimadjustment

Providers need to review the claim adjustment reason codes and the remittance advice remark codes and indicate the appropriate code to indicate the reason for the primary insurance allowed amount and paid amounts were zero.

The CAS code(s) should be indicated in the following electronic fields:

- Claim level: Loop 2320 CAS segment
- Line level: Loop 2430 CAS segment

Obligated to Accept as Payment in Full (OTAF): The OTAF amount is a third-party payment (which is less than a physician's or supplier's charge) that a physician or supplier is either obligated to accept or voluntarily accepts as full satisfaction of the patient's payment obligation.

For line-level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero.

For claim-level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero.

MEDICARE SECONDARY PAYER (MSP)

The above electronic billing instructions for coding MSP are based on the ANSI X12N 4010 837 billing requirements. Physicians and suppliers must comply with Section 1.4.2, titled “Coordination of Benefits,” found in the 837 version 4010 *Professional Implementation Guide (IG)* regarding the submission of Medicare beneficiary MSP claims. (The IG can be found at hipaa.wpc-edi.com/HIPAA_40.asp.)

Providers must follow Model 1 in Section 1.4.2 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Providers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount and the OTAF amount on the 837.

Date the Primary Payer Paid

For line-level services, physicians and suppliers must indicate the primary payer paid date for that service line in loop ID 2430 loop with DTP01 segment and a 573 qualifier.

For claim-level information, the physicians and suppliers must indicate the other payer paid date for the claim in loop ID 2330 loop with DTP01 segment and a 573 qualifier.

HMO Secondary Claims Submission

Electronic: Medicare will pay secondary to the HMO’s copayment amount. Submitting an electronic claim for HMO insurance does not require the submission of the primary payer’s Explanation of Benefits (EOB), but does require the submission of five additional data elements as stated above. Providers will also need to indicate the copayment collected from the patient in the patient paid field.

Patient Paid

Enter any amount collected from the patient for primary insurance copayment in this field:

- Loop 2300 Segment AMT02 (F5)

When Medicare is the Secondary Payer Following Two Primary Insurance Payers

Submission of Hardcopy MSP Claims with Multiple Primary Payers: There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on the CMS-1500 claim form. Physicians and suppliers must attach the other payer’s EOB, or remittance advice, to the claim when sending it to Medicare for processing.

MEDICARE SECONDARY PAYER (MSP)

Reporting the OTAF on the X12N 837 (Version 4010)

Change Request No. 2007/Program Memorandum No. B-02-025: The OTAF amount is a third-party payment (which is less than a physician's or supplier's charge) that a physician or supplier is either obligated to accept, or voluntarily accepts, as full satisfaction of the patient's payment obligation. Reporting of the OTAF on the ANSI X12N 837 Version 4010 is being published as adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for Medicare Secondary Payer (MSP) claims.

Effective October 6, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (Version 4010), unless physicians and suppliers request a one-year extension to comply with HIPAA Version 4010 under the provisions of the Administrative Simplification Compliance Act.

Currently, there are fields to identify the other payer's allowed and paid amount on the 837. The OTAF amount is a payment (which is less than charges) that providers are obligated to accept or have agreed to accept as payment in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim.

The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

OTAF at header: 2320 Loop CN102, CN 101=09 must be equal to sum of detail lines.

The claim level CN1 should be used only when the service line is not available.

The line OTAF should be sent in the 2400 loop, CN102, CN101=09.

When migrating to the X12N 4010 837, providers must use the line-level contract information (CN1) segment to report OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102. If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 *Professional Implementation Guide* allows for claim-level OTAF reporting using the CN1 segment as described above, as well as line-level reporting using the line-level CH1 segment. Furnish line-level primary payer data, including the OTAF amount, when available.

Providers should ensure their software vendor is making the appropriate changes necessary for submitting the MSP OTAF amounts for the X12N 837 (Version 4010). For questions regarding the EDI format, please contact the EDI Technology Support Center at (866) 749-4302.

MEDICARE SECONDARY PAYER (MSP)

Secondary Payment Calculation

To assist providers in the Secondary Payment calculations, a feature has been added to the Medicare Secondary Payer section of the TrailBlazer Web site. This tool is for providers needing assistance with calculating Medicare Secondary Payer (MSP) payment amounts.

The estimation tool can be accessed on the TrailBlazer Web site at:

www.trailblazerhealth.com/tools/MSP.asp

MSP/OTAF OVERPAYMENT CALCULATOR FORM INSTRUCTIONS

[MSP Manual Calculator](#)

When the Medicare payment is questioned the MSP/OTAF calculation form should be used to determine the correct Medicare payment. Only one detail should be calculated at a time.

The Obligated to Accept as Payment in Full (OTAF) amount is a third party payment (which is less than a physician's or supplier's charge) that a physician or supplier is either obligated to accept, or voluntarily accepts, in full satisfaction of the patient's payment obligation. On most claims, the **OTAF** amount is greater than the amount the primary payer actually paid on the claim.

FIELD DESCRIPTION

- A - The total amount charged for the service.
- B - The Medicare allowed amount for the service.
- C - The primary insurance allowed amount for the service.
- D - The primary insurance OTAF amount for the service (if applicable).
- E - The primary insurance paid amount for the service.

EXAMPLE DETAIL LINE USING OTAF

\$40.00 charge.
 Medicare allows \$32.00, paid \$25.60
 Primary insurance allowed \$35.00, paid \$20.00 and has an OTAF amount of \$35.00

The charges should be entered into the appropriate sections of the form.

A. Total Charge For Procedure	0.00
B. Medicare Allowed Amount	0.00
C. Non-Contracted Insurance Amount	0.00
D. Contracted Insurance Allowed Amount (OTAF)	0.00
E. Primary Insurance Paid Amount	0.00

The Medicare calculation-using block "B" should be completed.

B. Medicare Allowed Amount	0.00
Medicare Deductible	0.00
Sub Total	
Paid by Medicare at 80%	0.00

In the above example the primary insurance is "Obligated To Accept Assignment in Full" therefore you would skip 4.

The lower section of the form will determine the correct Medicare payment. The totals from the above sections will be used to complete this section.

If 'D' Applies (OTAF) Then:

Note: This feature should only be used as an estimation.

MEDICARE PART B

MEDICARE SECONDARY PAYER (MSP)

Medicare Secondary Payer (MSP) Quick Reference Billing Guide

MSP Situation	Refer to Working Age, Disability or ESRD	Bill Other Insurance as Primary	Bill Medicare as Primary	Bill Medicare as Secondary
Person with disability is under 65 years of age and ...				
The beneficiary is not covered under a Large Group Health Plan (LGHP) and does not have a spouse.			X	
The beneficiary is covered under an LGHP from a past or present employer. The employer has fewer than 100 employees; the beneficiary has no spouse.			X	
The beneficiary is covered under an LGHP from a past employer. The employer has more than 100 employees; the beneficiary has no spouse.			X	
The beneficiary is covered under an LGHP from a present employer. The employer has more than 100 employees; the beneficiary has no spouse.		X		X
The beneficiary is not covered under any LGHP from a past or present employer, but the beneficiary has a spouse or family member who is employed and has the beneficiary covered under his LGHP. The spouse's or family member's employer has fewer than 100 employees.			X	

MEDICARE PART B

MEDICARE SECONDARY PAYER (MSP)

MSP Situation	Refer to Working Age, Disability or ESRD	Bill Other Insurance as Primary	Bill Medicare as Primary	Bill Medicare as Secondary
The beneficiary is not covered under LGHP from a past or present employer, but the beneficiary has a spouse or family member who is currently employed and has the beneficiary covered under his LGHP. The spouse's or family member's employer has more than 100 employees.		X		X
The disabled child is covered under a parent's contract; the employer has fewer than 100 employees.			X	
The disabled child is covered under a parent's contract; the employer has more than 100 employees.		X		X
End Stage Renal Disease (ESRD)				
The beneficiary has coverage under a current or former employer and is entitled to Medicare solely on the basis of ESRD.		X Up to the 30- month coordination period		X
The beneficiary does not have any employer group health coverage through self or family member.			X	

MEDICARE PART B

MEDICARE SECONDARY PAYER (MSP)

MSP Situation	Refer to Working Age, Disability or ESRD	Bill Other Insurance as Primary	Bill Medicare as Primary	Bill Medicare as Secondary
<i>Working-aged beneficiary is 65 years of age or older and ...</i>				
The beneficiary is not employed and does not have a spouse.			X	
The beneficiary is still employed and covered under an Employer Group Health Plan (EGHP); the employer has fewer than 20 employees.			X	
The beneficiary is still employed and covered under an EGHP; the employer has more than 20 employees.		X		X
The beneficiary is not employed, but has a spouse or family member who is still employed and has the beneficiary covered under his EGHP; the spouse's employer has fewer than 20 employees.			X	
The beneficiary is not employed, but has a spouse or family member who is still employed and has the beneficiary covered under his EGHP; the spouse's employer has more than 20 employees.		X		X

MEDICARE PART B

MEDICARE SECONDARY PAYER (MSP)

Medicare does not usually pay for services related to the following because the diagnosis indicates that other insurers may provide coverage: Auto Accidents, Black Lung, Third-Party Liability or Workers' Compensation.	Bill Other insurance	Bill Medicare	Bill Medicare as Secondary	Medicare May Make a Conditional Payment
The beneficiary is involved in an auto accident or workers' compensation accident. The provider is billing a claim with a diagnosis that is related to the injury.	X		X	
The beneficiary is involved in an auto accident or workers' compensation accident. The provider is billing a claim with a diagnosis that is not related to the injury.		X		
The beneficiary is involved in a third-party accident. The provider is billing a claim with a diagnosis that is related to the injury. **	X			X
The beneficiary is involved in a third-party accident. The provider is billing a claim with a diagnosis that is not related to the injury.		X		
The beneficiary is receiving Black Lung benefits. The provider is billing a claim with a diagnosis that is payable under Black Lung.	X			
The beneficiary is receiving Black Lung benefits. The provider is billing a claim with a diagnosis that is not payable under Black Lung.		X		

**If the provider chooses to bill the third-party insurer or file a lien against the potential settlement, he cannot also bill Medicare at the same time. If he cannot collect from the third-party insurance promptly, as defined, he can bill Medicare for a conditional payment.

Note: Some beneficiaries may choose to be covered by Medicare or Veterans Affairs insurance. Both cannot cover them. For this reason, if a beneficiary is covered under VA insurance, Medicare cannot be billed even as a secondary payer, except for the copayment amount.

MEDICARE SECONDARY PAYER (MSP)

REVISION HISTORY

Section	Revision
MSP Recovery Contractor	Per CR 5105 dated 07/03/06, CMS announced the contractor that will handle all MSP recovery efforts. The mailing address and phone numbers were updated due to this announcement.
Medicare Advantage Plans	CMS renamed Medicare Advantage Plans to Medicare+Choice Plans.
Veterans Administration	Veterans Administration updated to Veterans Affairs.
CMS-1500 Form Instructions	Item 10 was added to the MSP claim filing instructions as a result of the new CMS-1500 claim form.
MSP Calculation Sheet	The MSP calculation sheet located on the TrailBlazer Web site has now been updated. This section reflects the new tool to assist with calculating MSP payment amounts.