

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



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

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

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

WHAT IS MEDICARE SECONDARY PAYER (MSP)?

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

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

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

WHEN DOES MEDICARE PAY FIRST?

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

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

If the individual...	And this condition exists...	Then this program pays first...	And this program pays second...
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment...	The employer has less than 20 employees...	Medicare	GHP
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment...	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals...	GHP	Medicare
Has an employer retirement plan and is age 65 or older...	The individual is entitled to Medicare...	Medicare	Retiree coverage
Is disabled and covered by a GHP through his or her own current employment, or through a family member's current employment...	The employer has less than 100 employees...	Medicare	GHP
Is disabled and covered by a GHP through his or her own current employment, or through a family member's current employment...	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	GHP	Medicare
Has End-Stage Renal Disease (ESRD) and GHP coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	GHP	Medicare
Has ESRD and GHP coverage...	After 30 months...	Medicare	GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	Medicare
Has ESRD and COBRA coverage...	After 30 months...	Medicare	COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury...	The individual is entitled to Medicare...	WC (for health care items or services related to job-related illness or injury) claims	Medicare
Was in an accident or other situation where no-fault or liability insurance is involved...	The individual is entitled to Medicare...	No-fault or liability insurance for accident or other situation related health care services claimed or released	Medicare
Is age 65 or older OR disabled and covered by Medicare and COBRA...	The individual is entitled to Medicare...	Medicare	COBRA

ARE THERE ANY EXCEPTIONS TO THE MSP REQUIREMENTS?

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

WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

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

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

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

WHEN MAY MEDICARE MAKE A CONDITIONAL PAYMENT?

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

“PROMPTLY” DEFINITION

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

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

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

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

Medicare will not make conditional payments in association with WCMsAs.

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

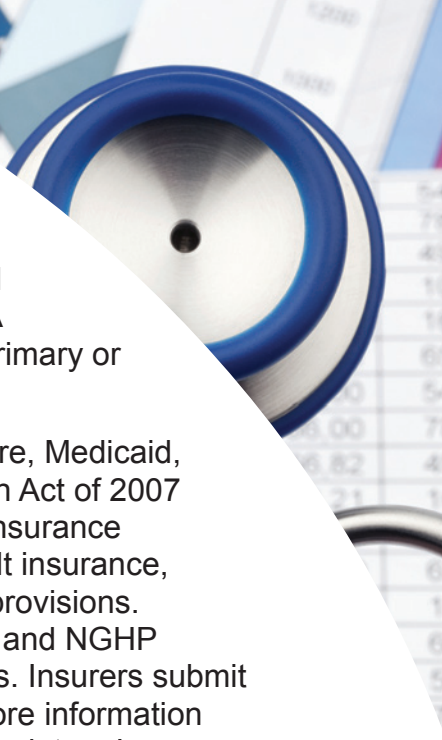
- Chapter 1, Section 10.7;
- Chapter 3, Sections 30.2.1.1, 30.2.2, and 40.3.1;
- Chapter 5, Section 40.6; and
- Chapter 6, Sections 40.3 and 60.

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

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

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

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



mandatory reporting requirements, employers can enter into a VDSA in lieu of completing and submitting the IRS/SSA/CMS Data Match Questionnaire. CMS has expanded the VDSA to include Medicare Part D information, enabling VDSA partners to submit records with prescription drug coverage, be it primary or secondary to Part D.

- **MSP Mandatory Reporting Process** – Section 111 of the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) adds mandatory MSP reporting requirements for GHP insurance arrangements, liability insurance (including self-insurance), no-fault insurance, and WC (Non-Group Health Plans [NGHPs]) to the existing MSP provisions. MMSEA mandated Responsible Reporting Entities to submit GHP and NGHP information to strengthen the MSP coordination of benefits process. Insurers submit enrollment and settlement data electronically to the COBC. For more information and official instructions for Section 111 MSP reporting, visit the Mandatory Insurer Reporting web page at <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep> on the CMS website.
- **MSP Claims Investigation** – The COBC investigates missing information on MSP cases. The single-source investigation offers a centralized approach for MSP-related inquiries. The investigation involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
- **Electronic Correspondence Referral System (ECRS)** – The ECRS is a web-based application that allows contractor MSP representatives and the Regional Office MSP staff to fill out various forms online and electronically transmit them to the COBC.

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

How Do I CONTACT THE COBC?

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

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

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

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

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

WHAT ARE MY RESPONSIBILITIES UNDER THE MSP PROVISIONS?

Your responsibilities are listed in Table 2.

TABLE 2. YOUR RESPONSIBILITIES AS A MEDICARE PROVIDER

Type of Medicare Provider	Responsibilities
Part A Institutional Provider (i.e., Hospitals)	<ul style="list-style-type: none"> • Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. • Bill the primary payer before billing Medicare, as required by the Social Security Act. • Submit any MSP information on your Medicare claim using proper condition and occurrence codes on the claim.
Part B Provider (i.e., Physicians and Suppliers)	<ul style="list-style-type: none"> • Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. • Bill the primary payer before billing Medicare, as required by the Social Security Act. • Submit an Explanation of Benefits (EOB) form from the primary payer with your Medicare claim with all appropriate MSP information. If submitting an electronic claim, provide the necessary fields, loops, and segments needed to process an MSP claim.

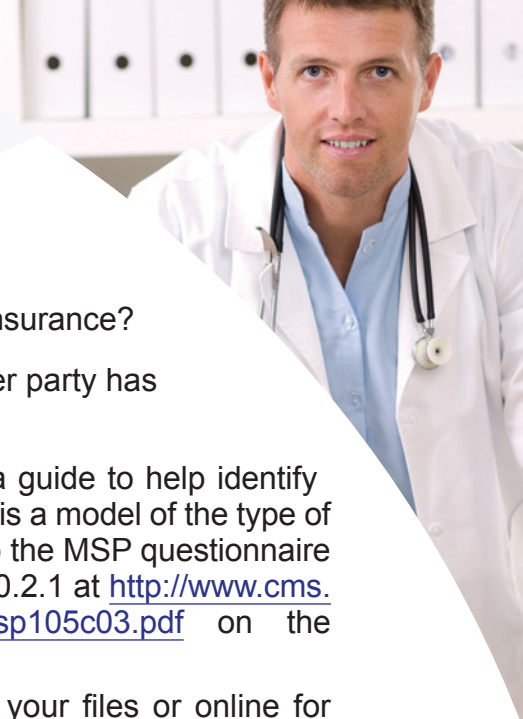
HOW DO I GATHER ACCURATE MSP DATA FROM THE BENEFICIARY?

As a Medicare provider, you must determine whether Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter prior to submitting a bill to Medicare. You can do this by asking Medicare beneficiaries about other coverage. The Common Working File (CWF) also contains MSP information from the COBC. The questions you ask can help you verify that the CWF information is correct and up-to-date. Some questions that you should ask beneficiaries include, but are not limited to:

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

TIP FOR PROVIDERS

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

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

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

You should retain a copy of completed MSP questionnaires in your files or online for 10 years. You may keep hard copy files, optical image, microfilm, or microfiche. If you store these files online you must keep both negative and positive responses to questions.

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

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

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

WHAT HAPPENS IF I SUBMIT A CLAIM TO MEDICARE WITHOUT PROVIDING THE OTHER INSURER’S INFORMATION?

Medicare may erroneously pay the claim as primary if it meets all Medicare requirements, including coverage and medical necessity guidelines. However, if the beneficiary’s Medicare record in the CWF indicates that another insurer should have paid primary to Medicare, Medicare will deny the claim, unless it may rightly pay conditionally. If the Medicare Contractor does not have enough information, it may forward the information to the COBC and the COBC may send the beneficiary, employer, insurer, or attorney an SCD Questionnaire to complete for additional information. Medicare will review the information on the questionnaire and determine the proper action to take.

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

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

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

RESOURCES

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



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

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

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

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

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