



Billing in Medicare Secondary Payer (MSP) Liability Insurance Situations

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This MLN Matters® Article is intended for all providers, physicians, and other suppliers who bill in a situation where liability insurance (including self-insurance) is a consideration. The article is of particular importance for those who elect not to file the claim with Medicare, and instead seek payment for their services from a Medicare beneficiary's liability insurance (including self-insurance) claim.

PROVIDER ACTION NEEDED

This article is based on information received from Medicare beneficiaries, their legal counsel and other entities that assist these individuals, indicating that providers, physicians, and other suppliers that elect to seek payment from the beneficiary's liability insurance claim instead of submitting the claim for items or services to Medicare have not generally billed in accordance with the instructions provided or referenced in this article. The FAQs in this article are intended to remind providers, physicians, and other suppliers of the fundamental guidance governing billing where liability insurance (including self-insurance) is involved. Please review your billing practices to be sure they are in line with the information below.

BACKGROUND

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits are primary payers to Medicare. However, CMS' regulations and policy for liability insurance billing are distinct from those for no-fault insurance and workers' compensation benefits. Because the liability insurance billing rules are different and place distinct obligations on providers, physicians, and other suppliers (including termination of liens tied to the expiration of Medicare's timely filing requirements), it is important that these rules be reviewed in detail.

The options when seeking payment from the liability insurance, and the obligations and restrictions that accompany them, are discussed with more specificity in the “Internet Only Medicare Secondary Payer Manual” (Pub 100-05), Chapter 2, Section 40.2 found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf>. See also, MLN Matters Article MM7355 “Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers’ Compensation (WC) Medicare Secondary Payer (MSP) Claims”. This article is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf>. (Although not the subject of this article, the instructions for situations involving no-fault insurance or workers’ compensation benefits can be found in Chapter 3 of the MSP Manual.)

FAQs for Liability Insurance (Including Self-Insurance) Billing

Q1. What are the “promptly period” rules and do they apply when billing in situations involving liability insurance (including self-insurance)?

A1. The “promptly period” is 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge. The “promptly period” does apply even when a provider, physician, or other supplier is aware that liability insurance may end up indirectly funding the defendant’s settlement. However, following expiration of the 120 days or during that time if it is demonstrated (for example, a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, the provider, physician, or other supplier has an option (with certain limitations) to bill Medicare or maintain a claim/lien against the liability insurance/beneficiary’s liability insurance settlement.

Q2. Who do I bill...Medicare or the liability insurance/beneficiary’s liability insurance settlement? (I hear so many different things. My patient was in an accident and I need to know whether to bill Medicare or the patient. My other patient is suing some manufacturer, what do I do about my bill for services to this patient?)

A2. Once the “promptly period” has expired, with the exception of the special rule for Oregon (see below), the provider, physician, or other supplier may bill *either* Medicare or the liability insurer/beneficiary’s liability insurance settlement *as long as the Medicare timely filing period has not expired*. Billing both Medicare and maintaining a claim against the liability insurance/beneficiary’s liability insurance settlement is not permitted. Once Medicare has been billed, the provider, physician, or other supplier is limited to Medicare’s approved amount or the limiting charge if the claim is non-assigned, even if they subsequently return any payment made by Medicare. Claims/liens against the liability insurance/beneficiary’s liability settlement must be dropped once Medicare’s timely filing period has expired. See also the Q’s/A’s below for more detail.

Q3. What is the Oregon rule?

A3. By court order, there are very specific alternative billing rules for Oregon. Generally speaking, the provider, physician, or other supplier may bill either Medicare or the liability insurance if the liability insurer pays within 120 days. See the MSP Manual (CMS Pub. 100-05), Chapter 2, Section 40.2 for specifics on the Oregon rule.

Q4. Do Medicare's timely filing rules still apply if the timely filing period expires while the provider, physician, or other supplier is waiting for the liability insurance payment/beneficiary's liability insurance settlement? (It's been 3 years and the patient's case still hasn't settled. Can I bill Medicare now?)

A4. The existence of a liability insurance or potential liability insurance situation does not change or extend Medicare's timely filing requirements. If Medicare is not billed within the applicable timely filing period, the claim will be denied. Additionally, see the information below regarding the requirement that claims/liens against the liability insurance/beneficiary's liability insurance settlement (with certain exceptions) be withdrawn once the timely filing period has expired.

Q5. How long can a claim/lien be maintained against the liability insurer/the beneficiary's liability insurance settlement? (Can I direct bill/maintain my lien once Medicare's timely filing period has expired?)

A5. CMS' liability insurance billing policy is that providers are required to drop their claims/liens and terminate all billing efforts to collect from a liability insurer or a beneficiary once the Medicare timely filing period expires, unless the liability insurance claim was paid or settled prior to the expiration of the Medicare timely filing period.

- All such claims/liens must be withdrawn (except for claims related to items or services not covered by Medicare and for Medicare deductibles and co-insurance) when the provider, physician, or other supplier bills Medicare or when Medicare's timely filing period has expired – whichever occurs first.
- If there is a settlement, judgment, award, or other payment before the timely filing period expires, the provider, physician, or supplier may maintain its claim/lien despite the expiration of the timely filing period.
- All such claims/liens are limited by state lien laws/requirements. The MSP provisions do not create lien rights when those rights do not exist under state law.
- Under the Oregon rule all such claims/liens must be withdrawn following the expiration of the applicable 120 day period.

Q6. How much can the provider, physician or other supplier bill the liability insurance/beneficiary's liability insurance settlement? (What if the beneficiary's case settled, but the amount was not large enough to pay everyone? What if Medicare and the attorney were paid, but because very little remained the attorney asked all the doctors and other providers to take reduced amounts; do we have to?; what about our bill?)

A6. Where Medicare has a recovery claim, Medicare's claim has the priority right of recovery. In general, the provider, physician, or other supplier:

- Is limited to the Medicare approved amount (limiting charge when non-assigned) once they have billed Medicare, even if they return any payment received from Medicare.
- May charge actual charges but is limited to the amount available from the settlement less applicable procurement costs (for example, attorney fees, other litigation costs).
- May only bill for non-covered services, or co-insurance and deductibles, if Medicare timely filing has expired before payment or settlement. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)
- May not collect from the beneficiary until the proceeds are available to the beneficiary.

Q7. What about physician and other suppliers who do not participate in Medicare and do not submit an assigned claim (and would not be required to submit an assigned claim if they submitted a claim to Medicare) – what can they pursue?

A7. Such physicians and other suppliers can pursue liability insurance, but the amount may not exceed the limiting charge.

Q8. Are there risks involved in deciding whether to pursue the liability insurance vs. billing Medicare once the promptly period has expired?

A8. Providers, physicians, and other suppliers who do not file a Medicare claim once the “promptly period” has expired (and before timely filing has expired) run the risk that insurance proceeds will not be available or may be less than Medicare’s payment would have been if Medicare had been billed. They also run the risk that they will be limited to billing for co-insurance and deductibles if there is no payment or settlement before Medicare’s timely filing expires.

Q9. Are there additional rules if a patient receives both Medicare and Medicaid or other benefits?

A9. If the individual receives assistance from the state, additional regulations govern provider billing. If a Medicare beneficiary received Medicaid benefits at the time the services were rendered, providers should contact their state Medicaid office to obtain the state’s policy on provider billing.

Q10. What if the items or services in question are not covered by Medicare?

A10. If the items or services rendered are services that are not covered by the Medicare program, providers, physicians, and other suppliers may charge and collect actual charges without regard to whether the proceeds of the liability insurance are available to the beneficiary. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)

ADDITIONAL INFORMATION

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

DOCUMENT HISTORY

| Date of Change | Description |
|--------------------|---------------------------|
| September 19, 2017 | Initial article released. |

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