



Medicare Secondary Payer



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What's Changed?

- Clarified policy on accepting payment for services if another insurer is primary to Medicare

You'll find substantive content updates in dark red font.

Introduction

The Medicare Secondary Payer (MSP) provisions protect the Medicare Trust Fund from making payments when another entity has the responsibility of paying first. Any entity providing items and services to Medicare patients must determine if Medicare is the primary payer. This booklet gives an overview of the MSP provisions and explains your responsibilities in detail.

MSP

MSP provisions prevent Medicare paying items and services when patients have other primary health insurance coverage. In these cases, the MSP Program contributes:

- **National program savings:** CMS MSP provisions enforcement saved the Medicare Program about \$8.5 billion in FY 2018.
- **Increased provider, physician, and other supplier revenue:** Billing a primary plan before Medicare may offer you better payment rates, and coordinated health coverage may expedite the payment process and reduce administrative costs.
- **Avoiding Medicare recovery efforts:** Filing claims correctly the first time prevents future claim recovery efforts.

To get these benefits, it's important to ask or access accurate, current information about your patient's health insurance coverage. Medicare regulations require providers submitting claims to determine if we are the primary or secondary payer for patient items or services given.

When Medicare Pays First

Primary payers must pay a claim first. Medicare pays first for patients who don't have other primary insurance or coverage. In certain situations, Medicare pays first when the patient has other insurance coverage.

Table 1 lists common situations when a patient has Medicare, other health plan coverage, and which entity pays first (primary payer) and which pays second (secondary payer).

Stay Up to Date

To sign up for automatic updates, enter your email address in the Receive Email Updates box at the bottom of the [Coordination of Benefits & Recovery \(COB&R\) Overview](#) webpage.

Table 1. Common MSP Coverage Situations











Individual	Condition	Pays First	Pays Second
65 or older and covered by a Group Health Plan (GHP*) through current employment or spouse’s current employment	Entitled to Medicare Employer has less than 20 employees	 Medicare	 GHP
65 or older and covered by a GHP through current employment or spouse’s current employment	Entitled to Medicare Employer has 20 or more employees or is part of a multiple or multi-employer group with at least 1 employer employing 20 or more individuals	 GHP	 Medicare
65 or older, has an employer retirement GHP, and isn’t working	Entitled to Medicare	 Medicare	 Retiree Coverage
Under 65, disabled, and covered by a GHP through their current employment or a family member’s current employment	Entitled to Medicare Employer has less than 100 employees	 Medicare	 GHP
Under 65, disabled, and covered by a GHP through their current employment or a family member’s current employment	Entitled to Medicare Employer has 100 or more employees or is part of a multiple or multi-employer group with at least 1 employer employing 100 or more individuals	 GHP	 Medicare

Table 1. Common MSP Coverage Situations (cont.)








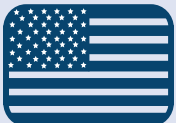


Individual	Condition	Pays First	Pays Second
Coverage under Federal Black Lung Program (FBLP)	Entitled to coverage under the FBLP Medicare covers services or items not related to black lung diagnosis	 FBLP	 Medicare
End-Stage Renal Disease (ESRD) and GHP coverage was primary before individual became eligible and entitled to Medicare based on ESRD diagnosis	Before 30 months of Medicare eligibility or entitlement	 GHP	 Medicare
ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 GHP
ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage before becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement	 COBRA	 Medicare
ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 COBRA
Parts A and B coverage under Medicare Advantage (MA) Plan	Also has a GHP Health Reimbursement Account (HRA)	Contact MA Plan for billing guidance.	None; employer pays individual from HRA for out-of-pocket expenses

Table 1. Common MSP Coverage Situations (cont.)










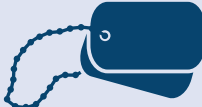





Individual	Condition	Pays First	Pays Second
<p>Workers' Compensation (WC) coverage because of job-related illness or injury</p>	<p>Entitled to Medicare</p>	<p>WC pays health care items or job-related illness or injury services first. See Conditional Payments section.</p>	 <p>Medicare</p>
<p>In an accident or other incident, including automobile accidents, where there's no-fault or liability insurance</p>	<p>Entitled to Medicare</p>	<p>No-fault or liability insurance pays accident- or other incident-related health care services first. See Conditional Payments section.</p> <p>WC, Liability, or no-fault pays first when there's Ongoing Responsibility for Medicals (ORM) reported. Medicare doesn't make a payment.</p>  <p>Accident</p>	 <p>Medicare</p> <p>NOTE: For ORM, Medicare doesn't make a payment until ORM funds exhaust.</p>
<p>In an accident or other incident where there's no-fault or liability insurance involved</p>	<p>Patient has no-fault or liability insurance but refuses to give the information</p>	<p>For Part A claims only, use condition code 08 to prevent the claim from returning to the provider. The Part A claim should reject and assign the patient responsibility.</p>	<p>None</p>

Table 1. Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
65 or older or disabled and covered by Medicare and COBRA	Entitled to Medicare	 Medicare	 COBRA
Dual eligible patient regardless of eligibility reason	Entitled to Medicare and Medicaid	 Medicare	 Medicaid
Covered by Medicare and has a Medigap or Medicare supplement plan	Entitled to Medicare	 Medicare	 Medigap or Medicare Supplemental Plan
Active-duty status military member	Entitled to Medicare and TRICARE	 TRICARE	 Medicare
Inactive status military member treated by civilian providers	Entitled to Medicare and TRICARE	 Medicare	 TRICARE
Inactive status military member treated at a military hospital or by other federal providers	Entitled to Medicare and TRICARE	 TRICARE	 Medicare

* A GHP is any arrangement of, or contribution from, 1 or more employers or employee organizations providing insurance to current or former employees or their families.

MSP Provision Exceptions

There are no exceptions to the MSP provisions. [SSA Section 1862\(b\)\(2\)\(A\)\(i\)](#) and [42 USC 1395\(y\)\(b\)\(2\)\(A\)\(i\)](#) prohibits accepting payment for services from a patient upon admission if another insurer is primary. If you're performing this practice, you must stop immediately.

Participating Medicare providers, physicians, and other suppliers must not accept any copayment, coinsurance, or other payments from the patient when the primary payer is an employer Managed Care Organization (MCO) insurance, or any other type of primary insurance, such as an employer group health plan.

You must follow the MSP rules and bill Medicare as the secondary payer after the primary payer has made payment. We'll inform you on your remittance advice how much you can collect from the patient after we make payment.

NOTE: In situations where you've taken payment from a patient, they have the right to recoup payment and you must reimburse them if necessary.

If Primary Payer Denies Claim

Medicare **may** make payment, assuming the service is Medicare-covered and payable, and the provider files a proper claim, in these situations:

- No-fault or liability insurer doesn't pay during paid promptly period or denies medical bill
- WC program doesn't pay during paid promptly period or denies payment (for example, when WC excludes a medical condition or certain services)
- Patient gets services not directly related to the condition for which they got WC benefits
- Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) or the ORM benefits terminate or exhaust
- GHP denies payment for services because:
 1. Patient exhausted certain plan benefit services
 2. Patient isn't entitled to GHP benefits
 3. Patient needs services the GHP doesn't cover

When submitting an MSP claim, include information identifying why the other payer denied the claim, made an exhausted benefits determination, or another reason that may apply.

Medicare can't make payment if payment was already made or Medicare can reasonably expect another payer. MSP provisions apply even if an entity believes it's the secondary payer to Medicare due to state law or the contents of an insurance policy. [SSA Section 1862\(b\)](#) establishes payment order and takes priority over state laws and private contracts.

Conditional Payments

Often, there's a long delay between an injury and the primary payer decision in a contested compensation case. Medicare **may** make pending case conditional payments to avoid imposing a financial hardship on you and the patient while awaiting a contested case decision.

Medicare can make conditional payments for covered services even if it isn't the primary payer. Medicare may make conditional payments for covered services in liability (including self-insurance), no-fault, and WC situations, **if** these are true:

- Self-insurance, no-fault, or WC holds payment liability and responsibility
- Medicare doesn't expect a prompt payment

Medicare can recover any conditional payments. The Benefits Coordination & Recovery Center (BCRC) recovers conditional payments from the patient or their attorney if the patient gets a settlement, judgment, award, or other payment.

Medicare may pay conditional primary benefits if the provider, physician, supplier, or patient doesn't file a proper claim with the GHP (or Large Group Health Plan [LGHP]) due to the patient's physical or mental incapacity.

If there's a primary GHP and the provider doesn't bill the GHP first, Medicare **will not** pay conditionally on the liability (including self-insurance), no-fault, or WC claim. Providers must bill the GHP before billing Medicare, and the primary payer payment information that appears on all primary payer remittance advices **must appear on all Medicare-submitted claims**. We won't pay conditional primary benefits in other situations where:

- GHP says it's secondary to Medicare
- GHP limits its payment when the patient is entitled to Medicare
- GHP covers the services for younger employees and spouses, but not for employees and spouses 65 and older
- GHP says it's secondary to liability, no-fault, or WC insurance

Additionally, we won't make conditional payments associated with WCMSAs or when ORM exists.

Paid Promptly

For no-fault insurance and WC claims, "paid promptly" means payment within 120 days after the no-fault insurance or WC carrier got the claim for specific items and services. Without contradicting information, you must treat the service date for specific items and services as the claim date when determining the paid promptly period; for inpatient services, you must treat the discharge date as the service date.

For liability insurance (including self-insurance), “paid promptly” means payment within 120 days after 1 of these occur:

- Date someone files a general liability claim with an insurer or someone files a lien against a potential liability settlement
- Date service provided or, in the case of inpatient services, the discharge date

Get more information on conditional payments at:

- [Medicare Secondary Payer Manual, Chapter 1, Section 10.7](#)
- [Medicare Secondary Payer Manual, Chapter 2, Sections 40 and 60](#)
- [Medicare Secondary Payer Manual, Chapter 3, Sections 30 and 40](#)
- [Medicare Secondary Payer Manual, Chapter 5, Section 40](#)
- [Medicare Secondary Payer Manual, Chapter 6, Sections 40.3 and 60](#)

A “Non-Group Health Plan (NGHP)” is liability insurer coverage (including self-insurance), no-fault insurer, and WC carrier. Submit all NGHP claims to the NGHP insurer before submitting to Medicare.

Ongoing Responsibility for Medicals

Medicare can’t make payment when payment “has been made or can reasonably be expected to be made” under liability insurance (including self-insurance), no-fault insurance, or a WC law or plan of the United States, called a primary plan.

When a primary plan reports “Ongoing Responsibility for Medicals (ORM)” to Medicare, it assumes payment responsibility, on an ongoing basis, for certain accident or injury related medical care. We won’t pay for the injury without documentation the ORM terminated or exhausted.



Collecting Patient Health Insurance Information

Coordination of Benefits (COB) allows plans to determine their payment responsibilities. The BCRC collects, manages, and uploads information to the Common Working File (CWF) about patients' other health insurance coverage. **Providers, physicians, and other suppliers must collect accurate MSP patient information to ensure that claims are filed properly.**

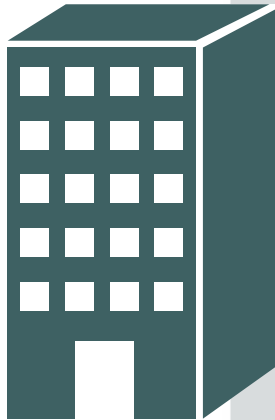
BCRC relies on health insurance maintained by stakeholders, including federal and state programs; plans that offer health insurance, prescription coverage, or both; pharmacy networks; and a variety of assistance programs. Some of the reporting methods Medicare uses to get MSP and COB information include:

- **Voluntary Data Sharing Agreement (VDSA):** The VDSA allows CMS and an employer to electronically exchange GHP eligibility and Medicare information. The VDSA includes Medicare Part D information, allowing VDSA partners to submit primary or secondary records with Part D prescription drug coverage.
- **MSP Mandatory Reporting Process:** GHPs and NGHPs have mandatory MSP reporting requirements insurance arrangements, including liability insurance, self-insurance, no-fault insurance, and WC to report patient MSP information. Find more information on the [Mandatory Insurer Reporting for GHP](#) or [Mandatory Insurer Reporting for NGHP](#) webpages.
- **MSP Claims Investigation:** The BCRC investigates when it learns another insurance plan may have primary responsibility for paying a patient's Medicare claims. The BCRC determines if information is missing from MSP records or MSP cases. Single-source investigations offer a centralized MSP-related inquiries location. Investigations involve collecting other health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or other sources, such as correspondence, accident and injury cases, or phone calls.
- **Electronic Correspondence Referral System (ECRS):** ECRS, a web-based application, allows Medicare contractor representatives and CMS Regional Office MSP staff to electronically send MSP possible lead information or information that questions existing MSP records to the BCRC.

Get more information on the BCRC in [Medicare Secondary Payer Manual, Chapter 4](#).

Provider and Supplier Responsibilities

Part A Institutional Providers (Hospitals)



Use a MSP questionnaire during the admission process. Gather accurate MSP data. Determine if Medicare is the primary payer by asking patients or their representative(s) for MSP information.



Bill primary payer before billing Medicare.



Submit any MSP information on your claim using proper payment information, value codes, condition, and occurrence codes, etc. If submitting an electronic claim, include the necessary MSP claims processing fields, loops, and segments.

Part B Providers (Physicians, Practitioners, and Suppliers)



Gather accurate MSP data. Determine if Medicare is the primary payer by asking patients or their representative(s) for MSP information.



Bill primary payer before billing Medicare.



Submit an Explanation of Benefits (EOB) or remittance advice from the primary payer with all MSP information. If submitting an electronic claim, include the necessary fields, loops, and segments.

Get more Medicare-covered services timely filing requirements information in [Medicare Claims Processing Manual, Chapter 1, Section 70.](#)

Gathering Accurate Data

You must determine if Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter before submitting a Medicare claim. Ask patients about other coverage. Questions you ask help update patient insurance information and verify the patient's CWF record is correct and current.

CMS developed tools, including an MSP model questionnaire, [Admissions Questions to Ask Medicare Beneficiaries](#), to help providers identify the correct primary claims payers for all patient hospital services provided. CMS electronic tools help identify and verify MSP situations. Get more information in [Medicare Secondary Payer Manual, Chapter 3, Section 20](#) or [contact your MAC](#).

Providers must keep completed MSP questionnaire copies and other MSP information for 10 years after the service date. You may keep hard copy files, optical images, microfilms, or microfiches. When storing these files online, keep negative and positive question responses.

BCRC Claims Investigation

If you don't provide us records of other health insurance or coverage that may be primary to Medicare on any claim and there's a sign of possible MSP considerations, the BCRC may request the patient, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire when the:

- MAC gets a claim with EOB or remittance advice from an insurer other than Medicare
- MAC gets electronic claim with other insurance payment information in loops and segments
- Patient self-reports or patient's attorney identifies an MSP situation
- Third-party payer submitted MSP information to MAC or BCRC

Find more information on Secondary Claim Development on the [Reporting Other Health Insurance](#) webpage.

Submit Claims with Other Insurer Information

Medicare may mistakenly pay a claim as primary if it meets all billing requirements, including coverage and medical necessity guidelines. However, if the patient's CWF MSP record shows another insurer should pay primary to Medicare, we deny the claim.

If a MAC doesn't have complete information on the claim about other primary insurance, it is instructed to forward the information to the BCRC. Then the BCRC may send the patient, employer, insurer, or an attorney the SCD Questionnaire for additional information. The BCRC reviews the questionnaire responses and takes action.

Get more information on proper MSP billing in [Medicare Secondary Payer Manual, Chapter 3](#).

File Proper & Timely Claims

File proper and timely claims with the primary payer. Not filing proper and timely claims with the primary payer may result in claim denial. Policies vary depending on the payer; check with the payer to learn its specific policies.

Federal law allows Medicare to recover improper payments. Medicare requires return of any payment made in error as the primary payer. Generally, for MSP GHP situations, Medicare recovers improper payments. We can also fine providers, physicians, and other suppliers for knowingly, willfully, and repeatedly submitting inaccurate health insurance information.

MSP Contact Information

Table 2 offers information about who to contact for specific MSP related questions.

Table 2. Who to Contact With MSP Questions

Contact	Question
<p>BCRC Customer Service Representatives</p> <p>Monday through Friday (except holidays)</p> <p>8 am to 8 pm, ET</p> <p>Toll free lines: 1-855-798-2627</p> <p>Text Telephone (TTY) or Telecommunication Device for the Deaf (TDD) 1-855-797-2627 for the hearing and speech impaired</p>	<ul style="list-style-type: none"> • Medicare development letters and questionnaires • Report a patient’s accident or injury • Report changes to a patient’s employment or health insurance coverage • Report potential MSP situations • Verify Medicare’s primary or secondary status • Contact Medicare’s Commercial Recovery Center (CRC) <p>Find guidance on reporting a patient’s health insurance changes on the Provider Services webpage.</p> <p>Request patient MSP information before billing. To protect patients’ rights and information, the BCRC can’t disclose this information.</p>
<p>MAC</p>	<ul style="list-style-type: none"> • Medicare claim or service denials and adjustments • Billing • Specific claim processing • Returning improper Medicare payments • Voluntary refunds

Find specific BCRC and CRC mailing addresses on the [BCRC contacts](#) webpage.

The CRC is responsible for GHP recoveries and activities related to recovering those improper payments. BCRC is responsible for liability, no-fault, and WC recoveries. The CRC and BCRC manage all Coordination of Benefits & Recovery (COB&R) activities except:

- Medicare Modernization Act of 2003 demonstration recovery demand letters the MSP Recovery Auditors issue
- MSP recovery demand letters MACs issue providers, physicians, and other suppliers

Resources

- [Billing for Services When Medicare is a Secondary Payer](#)
- [CMS MSP Webpage](#)
- [Medicare & Other Health Benefits: Your Guide to Who Pays First](#)
- [Medicare Secondary Payer Manual](#)

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