**MEDICARE SECONDARY PAYER (MSP)**

This section covers policy and claims filing information when Medicare is the secondary payer. It is not true that as long as a patient has Medicare, Medicare is to be billed first. The guidelines in this section will help you determine whether or not Medicare is secondary. If Medicare is secondary, Medicare Services coordinates payment of benefits. This practice is called "Coordination of Benefits."

**REIMBURSEMENT FOR MEDICARE SECONDARY PAYMENT**

The formula for calculating Medicare secondary payment is:

**Note:** The formula must be done on each line of the claim.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description of Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Subtract the primary insurance company's payment from the provider's actual submitted charge.</td>
</tr>
</tbody>
</table>
| 2    | Determine what Medicare's payment would be if it were the primary insurer.  
(Medicare Fee Schedule – deductible) x .80 = payment  
**Note:** Payment for some areas (e.g., outpatient psychiatry) may be less than 80% of fee schedule amount. |
| 3    | Determine which is higher, the primary insurer's allowable charge or Medicare's. Then subtract the primary payment amount from the higher allowable charge. |
| 4    | The lowest of Step 1, Step 2, or Step 3 is what Medicare pays as secondary. |

**Example:** An individual received treatment from a physician and the physician charged $200. The individual still had $25 of the Medicare deductible to meet. The primary insurance approved $190 and paid $152 (80%). The Medicare allowed amount for this treatment is $100. The Medicare secondary payment is calculated as follows:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description of Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The primary insurance payment is $152, which is subtracted from the actual charge of $200 to get $48.</td>
</tr>
</tbody>
</table>
| 2    | (Medicare Fee Schedule – deductible) x .80 = payment  
($100 – $25) x .80 = $60. |
| 3    | The primary insurance allowable is $190, which is higher than Medicare's allowable of $100. The primary payment amount of $152 is subtracted from $190, which = $38. |
| 4    | Medicare will pay $38 (the lowest of Step 1, Step 2, and Step 3). (The employer plan's payment will credit the individual's Medicare deductible, in this case a $25 credit.) |

**Note:** Any portion of the Medicare approved charges paid by a primary plan for outpatient services furnished by an independently practicing physical or occupational therapist and credited to the beneficiary's annual deductible is also charged against the annual limit on Medicare payment for that type of service.
If the total amount paid by the primary payer and Medicare equals or exceeds Medicare's Fee Schedule, the provider cannot collect any balance from the patient on assigned claims.

In addition, physicians cannot collect any balance from the patient on nonassigned claims if the total amount paid by the primary payer and Medicare equals or exceeds the limiting charge.

**Remember:** When filing claims to Medicare for secondary payment, please include the other insurer’s entire Explanation of Benefits (EOB) form and the definitions of the action (e.g., reason for denial taken on the claim). Many EOBS include an explanation of the denial code on the back or on the second page of the EOB form. Medicare needs this information to process the claim correctly.

For example, if the primary carrier denied the claim as “need additional information to finalize,” or “duplicate claim,” then Medicare, as the secondary carrier, needs to know that information. We cannot process secondary payment until the primary carrier determines a firm denial or payment. When we receive all necessary information concerning the claim (description of the other carrier’s denial code), we are able to process the claim in a timely manner.

**SECONDARY CLAIM REQUIREMENTS**

When Medicare is the secondary insurer, specific information is required that enables the contractor to coordinate benefits. Unless all required information is included with the secondary claim, Medicare cannot determine the appropriate payment and correctly process the claim.

Medicare Services often receives “secondary” claims that include an explanation of benefits (EOB) but there is either no explanation of the remark codes used by the primary insurer or an explanation of one or more remark codes is missing. When this occurs, it limits the information available to Medicare to determine secondary benefits making it necessary to deny the claim or return the unprocessed claim to the submitter.

When submitting claims for consideration on a secondary basis, it is necessary to include the following information with the claim:

- An explanation of benefits from the primary insurer,
- The primary insurers name and address must appear on the EOB, and
- An explanation of all remark codes used by the primary insurer.

In addition, the “total charge” billed to Medicare must be the same as the amount initially billed to the primary insurer. If these amounts do not match, Medicare Services is unable to correctly coordinate benefits.

In accordance with Medicare requirements, Medicare Services will deny secondary claims that do not include ALL information necessary to coordinate benefits. Therefore, it is imperative that all members of your staff are aware of these requirements and includes all the necessary information with EACH claim submitted for coordination of benefits.

**MSP FREQUENTLY ASKED QUESTIONS**

The following information includes the most frequently asked questions received by MSP specialists at Medicare Services:

**Q.1:** I’ve received a denial indicating my patient has insurance primary to Medicare. What is the most efficient way to obtain secondary payment?

**A.1:** **Upon receiving the denial, obtain the primary insurer information from your patient if it is unknown. Submit a new claim to the primary insurer. Once you receive the Explanation**
of Benefits (EOB) from the primary insurer, submit a new claim to Medicare Services. It is important to remember the HIPAA requires new claims to be submitted electronically beginning October 16, 2003, with few exceptions.

Q.2: When I resubmit the new claim including the primary insurer’s EOB, do I need to write or stamp anything on the hard copy claim?

A.2: Your claim will be handled more efficiently if the following terms are omitted from the claim: “corrected claim”, “resubmittal”, “please reprocess”, “second request”, “please review”, “appeal”. Special handling is required when these phrases are indicated on the claim.

Q.3: I submitted a hard copy claim and a copy of the primary insurer’s EOB and received a CO-16 remittance message indicating my claim lacks information needed for adjudication. The MA04 message tells me that ‘Secondary payment cannot be considered without the identity of or payment information from the primary payer.’ How can I assure my claim will be processed correctly?

A.3: We have learned that some insurers print company identification information only on the Page 1 of their Explanation of Benefits. If your patient’s information is not on page 1, the insurer information is not identified. It is helpful if you include this page of the EOB along with the page containing your patient’s services. Other situations that may generate this message include the fact that the patient’s information is not found at all on the EOB or the service dates do not match the services billed on the CMS-1500 form.

Q.4: Do I need to send a copy of the primary insurer’s description of codes along with the claim and EOB?

A.4: The remark codes are a requirement for a claim determination to be made. Unfortunately, we will have to deny all claims that this information is not received with. When codes are not easily identifiable, the claim requires special handling and could cause delays.

Q.5: In what situations should I contact the Coordination of Benefits contractor (COBC)?

A.5: The patient should contact the COBC when you receive primary payments from Medicare and from another insurer following notification from our office that the COBC records do not indicate the existence of another payer. The COBC responds efficiently to beneficiary requests. When the COBC updates the patient’s records, we can properly pay primary benefits or coordinate benefits, whichever applies. The phone number to the COBC is (800) 999-1118.

In addition, if you receive multiple denials from Medicare indicating a primary payer exists and you are aware that your patient is not currently employed and covered under a group health plan (GHP), verify with the patient whether their spouse is employed and has coverage under a group health plan. Verify with your patient whether they have become eligible for Medicare secondary benefits due to a disability. Has the patient fallen at a business, been involved in an automobile accident, or become injured at work? All of these situations create the need for Medicare to coordinate benefits with other insurers.

Q.6: What is the correct mailing address for sending refunds to Medicare Services?

A.6: All refunds (whether it’s requested by Medicare or voluntary) should be sent to: Medicare Services, PO Box 8075, Little Rock, AR 72203.
Q.7: I need to notify Medicare that two insurers have paid primary benefits. Medicare should be secondary. Do you prefer that I send a refund for the entire primary payment and then file a new claim with the insurer’s EOB?

A.7: When two insurers have paid primary benefits and Medicare should be the secondary payer, the most simple way to resolve this is to send a refund to Medicare for the difference between what the primary payer paid and what Medicare will pay as secondary insurer. It will be necessary for you to send a copy of the primary insurer’s EOB in order for proper claim adjustments to be made. Filing a new secondary claim before the refund check is posted in our internal system will cause your new claim to deny for duplication.

EMPLOYER GROUP HEALTH PLAN (EGHP) COVERAGE

Working Aged

An EGHP is one that is contributed to by an employer of 20 or more employees. Patients aged 65 and older who have EGHP coverage through their own or their spouse’s employment are considered "working aged."

Claims Filing Requirement for Working Aged

1. Claims should be sent to the EGHP and then to Medicare.
2. The name and address of the EGHP and group number should be stated in item 11 of the CMS-1500 claim form.
   Note: Blocks 4, 6, 7, 11b (when applicable), and 11c must also be completed when a policy number is given in block 11.
3. Attach the EGHP’s payment or denial notice (Explanation of Benefits, EOB) to the CMS-1500 claim form. Medicare will not consider payment without a copy of the EGHP’s Explanation of Benefits.

End Stage Renal Disease (ESRD)

EGHP Criteria

Medical group coverage through current or previous employment of the patient, the patient’s spouse or parent, without regard to the number of employees or whether the employer contributed to the EGHP.

Medicare benefits are secondary to benefits payable under an EGHP for individuals who are entitled to Medicare benefits solely on the basis of ESRD. Secondary benefits are payable for a period of up to 30 months which is known as the "Coordination Period." For individuals who started a course of maintenance dialysis or who received a kidney transplant before Dec. 1, 1989, the coordination period begins the earlier of:

1. The first month of dialysis;
2. In the case of an individual who received a kidney transplant, the first month in which the individual became entitled to Medicare, or, if earlier, the first month for which the individual would have been entitled to Medicare benefits if he or she had filed an application for such benefits; or
3. For individuals other than those specified above, the coordination period begins with the earlier of the first month of entitlement to, or eligibility for, Medicare Part A based solely on ESRD.
REQUIREMENTS FOR MEDICARE TO BE SECONDARY

1. The patient must be younger than age 65 and Medicare eligible solely as a result of ESRD.
2. The patient must have EGHP coverage, including employee pay-all plans, through either the patient’s own employment or as a spouse or dependent child.
3. The patient must be within his/her coordination period.

Currently, an ESRD patient’s employer insurance pays primary for the first 30 months of eligibility and Medicare pays secondary. After the 30 months are over, Medicare is primary. On or after August 31, 1997, all ESRD patients that would have reached the 30-month mark, will now have to wait until 30 months has elapsed for Medicare primary coverage.

This important change will affect how you bill Medicare Part B. Submit your patient’s ESRD claims to his or her primary insurer during this 30-month period. After the 30 months has expired, submit his or her ESRD claims to Medicare Part B as primary. This change is effective for any ESRD patient who has reached the 18-month mark on or after August 31, 1997.

DUAL ENTITLEMENT AND ESRD

Under prior law, Medicare became the primary payer at the point of dual Medicare entitlement (or eligibility). That is, if a beneficiary with ESRD became entitled to Medicare on the basis of age or disability, Medicare became the primary payer. However, effective August 10, 1993, Medicare remains the secondary payer throughout the entire 30-month coordination period, even if the beneficiary becomes entitled to Medicare based on disability or age before the coordination period ends. Additionally, a coordination period will start for aged or disabled beneficiaries if the ESRD provision begins to apply.

Upon completion of the 30-month coordination period, Medicare will revert to primary status. Medicare will remain primary as long as Medicare dual entitlement exists. For dual Medicare entitlement/eligibility situations that occurred before August 10, 1993, the only situations that will be affected are those whose 30-month ESRD-based eligibility or entitlement period has not passed as of August 1, 1993. Below you will find some clarifications of various possible situations:

- If a patient is entitled to Medicare as their primary insurance for age or disability and the patient develops ESRD, Medicare will remain the primary payer. The other insurance does not have to revert to primary for this reason.
- If a patient has group health plan coverage that pays primary to Medicare and the patient develops ESRD and becomes eligible for ESRD benefits, the group health plan will remain primary throughout the 30-month coordination period.
- If a patient’s Medicare entitlement is based solely on ESRD, and he or she subsequently also becomes entitled because he or she turns 65 or goes on disability, the employer group health plan will remain primary for the patient throughout the 30-month coordination period. After the 30-month coordination period is complete, Medicare becomes primary.

CLAIM FILING REQUIREMENT FOR ESRD

1. Claims should be sent first to the EGHP and then to Medicare.
2. The name and address of the EGHP and group number should be stated in item 11 on the CMS-1500 claim form.
Note: Blocks 4, 6, 7, 11b (when applicable), and 11c must also be completed when a policy number is given in block 11.

3. Attach the other plan's EOB to the CMS-1500. Medicare will not consider payment without a copy of the EGHP's EOB.

AUTOMOBILE MEDICAL, NO-FAULT OR LIABILITY INSURANCE

Note: All Inquiries regarding above should be referred to the MSPRC 1-866-677-7220

Medicare is secondary to all automobile medical, no-fault or liability insurance.

Definitions

Automobile: Any self-propelled land vehicle of a type that must be registered and licensed in the state in which it is owned.

No-Fault Insurance: 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. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include automobile no-fault insurance, often referred to as personal injury protection (PIP), and homeowners and commercial medical payments insurance, commonly referred to as Medpay coverage.

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

Prompt or Promptly: When used in connection with payment by a liability insurer, “prompt or promptly” means payment within 120 days after the earlier of the following:

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

Proper Claim: Means a claim that is filed timely and meets all other claim filing requirements specified by any primary insurer.

Self-Insured Plan: A plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the federal government to pay for liability claims under the Federal Tort Claims Act.

Underinsured Motorist Insurance: Means insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.
**Uninsured Motorist Insurance:** Liability insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance, carries less than the amount of insurance required by law, or is underinsured.

**Services Reimbursable under Automobile, Medical No-Fault Insurance**

Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, for the items or services under no-fault insurance (including a self-insured plan). Medicare is secondary to no-fault insurance even if state law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. If Medicare payments have been made, but should not have been, or if the payments were made on a conditional basis, they are subject to recovery.

If services are covered under no-fault insurance, the no-fault insurer must be billed first. If the insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted to supplement the amount paid by the insurer. Medicare can pay for services related to an accident if benefits are not currently available under the individual's no-fault insurance coverage.

The question in each case involving accident-related medical expenses is whether no-fault benefits can be paid for those particular services. If so, the no-fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save his/her insurance benefits to pay for future services or for non-covered medical services or non-medical services. Since no-fault insurance benefits would be currently available in that situation, they must be used before Medicare can be billed.

**Liability Insurance**

Liability insurance differs from the other insurance policies or plans that are primary to Medicare. In the case of other types of insurance that are primary to Medicare (i.e., automobile medical and no-fault insurance, employer group health plans, and workers compensation) there is a contractual relationship between the injured party and the third party payer, and a physician or supplier has the right to bill the third party payer.

In the case of liability insurance, unlike the other policies or plans, there is no direct or indirect contractual or quasi-contractual relationship between a physician or supplier and the liability insurer of the person who is allegedly at fault. A party alleging injury has a relationship to the liability insurer only through the accused and must try to prove negligence by the accused. Physicians and suppliers, in contrast, have no standing to sue the accused; their relationship is solely to the injured party to whom they have furnished Medicare covered services.

If the situation occurs in which the patient either has or intends to file a liability case, the provider must still file a claim with Medicare for a conditional payment. If the claim is filed on an assigned basis, the provider can only balance bill the patient for co-insurance, any amounts applied to the patient’s annual deductible or non-covered services.

If a settlement is reached the provider may not return the conditional payment made by Medicare to our office and bill the patient for their submitted charge. **This means the assignment agreement cannot be rescinded.** In most cases, Medicare is notified directly by the liability insurer. The assignment of benefits remains binding. In addition, in rare cases, the patient may contact our office stating they have received their settlement and ask how much they must refund. In this situation, the patient will be referred to the new Medicare Secondary Payer Recovery Contractor (MSPRC) for the amount of Medicare’s payment.
If, after a settlement is reached, the amount does not cover all medical expenses incurred, Medicare may consider partial payment responsibility. A coordination of benefits between what the liability insurance settlement covered and Medicare’s covered services would be performed. If secondary payment is due from Medicare, this could reduce the amount owed to Medicare by the liability insurer or the patient. However, the original assignment agreement entered into by the provider’s office remains in effect.

If a check is received from a provider attempting to refund the payment issued by Medicare because the liability settlement was reached, Medicare Services will return that check to the provider. This is because the assignment agreement cannot be rescinded. If the refund by the provider is based on payment by an insurance defined as MSP insurance, this refund can be accepted.

**Payable Services**

Services payable by liability insurance are considered covered. The rights and responsibilities of physicians and suppliers regarding services for which liability insurance payments have been made, or can reasonably be expected, are governed by the provisions of section 1862(b) (the Medicare secondary provision) and section 1842(b)(3)(B)(ii) (the assignment agreement) of the Act. Section 1862(b) is a limitation of payment provision rather than a non-coverage provision. Therefore, when Medicare is secondary under this provision, the services do not lose their identity as Medicare covered services. If the services were not covered, Medicare could not pay secondary benefits for them. In the case of liability insurance, primary Medicare benefits are paid conditionally and then recovered. Payment could not be made for services (even on a conditional basis) if they were not considered covered services.

It is important to remember that you have 120 days to collect from a liability insurer as defined under the definition of prompt or promptly. If you choose not to bill or file a lien against the liability insurer, then you must bill Medicare. You cannot choose to bill the beneficiary pending a liability settlement. If you choose to bill or file a lien with the liability insurer, then you must wait until your 120 days have passed or you have dropped the lien to bill Medicare. You cannot bill both Medicare and the liability insurer at the same time.

**Trauma/Injury Diagnosis**

Centers for Medicare & Medicaid Services (CMS), effective October 1, 2000, Medicare will begin sending letters to patients requesting clarification if claims include a trauma or injury diagnosis regardless of the amount billed. Prior to October 1, 2000, the claim amount had to exceed five hundred dollars before Medicare issued a letter to the patient. However, after this date, a claim for any dollar amount (with a trauma or injury diagnosis) must be questioned. This change will greatly affect Medicare patients. Therefore, we are requesting your support in encouraging your patients to respond to the letters they receive from Medicare in a timely manner.

**Veteran’s Administration**

Veterans who are also entitled to Medicare may choose either Medicare or Veterans Administration (VA) for payment for services covered by both programs. Claims cannot, however, be submitted to both programs for the same dates and types of treatments.

**Submitting Claims**

*Submit claims to the VA in the following situations:*
1. When hospital care was authorized by the VA in advance, or within 72 hours of admission.
2. When outpatient medical services were authorized by the VA in advance.
   Note: A VA fee-basis ID card is not considered by Medicare to be an authorization, and the veteran retains his or her right to elect VA or Medicare coverage.
3. When the VA has not authorized care in advance, the veteran is eligible for payment for care as an unauthorized service, and the veteran chooses to submit a claim to the VA for unauthorized services rather than using Medicare benefits.

Submit claims to Medicare in the following situations:
1. When the veteran is eligible for Medicare benefits and hospital care was not authorized by the VA in advance or within 72 hours of admission.
2. When the veteran is eligible for Medicare benefits, has a VA fee-basis ID card and elects Medicare coverage rather than VA.
3. When the veteran is eligible for Medicare benefits and has no prior authorization from the VA for care -- unless the veteran is eligible for payment for care as an unauthorized service, and the veteran chooses to submit a claim to the VA for unauthorized services rather than using Medicare benefits.
4. When the veteran is eligible for Medicare benefits and the VA has authorized care for only a part of the hospital treatment period.

Medicare and the VA will be performing computer data matches to identify duplicate payments. When necessary, Medicare will pursue recovery of payment.

FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM

Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse’s current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

Under the Spouse Equity Act, the individual is no longer on the former spouse’s policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.
**WORKERS' COMPENSATION**

The Workers' Compensation carrier should be billed first for work-related illnesses or injuries. If the claim is contested, the Worker's Compensation Board will notify you. Pending the board's decision, you may bill Medicare. Include with your bill a copy of the notice from the Workers' Compensation Board.

**INDIAN HEALTH SERVICES (IHS)**

In the case of contract health services to Indians and their dependents covered under the IHS program (www.ihs.gov) and Medicare, Medicare is the primary payer and the IHS the secondary payer.

If the patient is strictly eligible, claims should be sent to and processed by the IHS carrier for the region. Send claims to:

Blue Cross & Blue Shield of New Mexico  
IHS Contract Health Services  
P.O. Box 13509  
Albuquerque, NM 13509-3509

**BLACK LUNG**

If the Medicare beneficiary is entitled to Black Lung medical benefits, bill the U.S. Dept. of Labor at:

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

If all services were not covered, you may then bill Medicare for those services with the denial notice from the Department of Labor. If Medicare denies a claim for black lung or black lung related services, providers should submit the claim to the address above.

**DISABILITY**

Medicare coverage for those individuals who are disabled and have health insurance coverage under a large group health plan (LGHP) by reasons of their employment or the employment of a family member, will continue to be secondary. **For those disabled individuals who do not have LGHP as a result of their own or a family member's current employment status, Medicare is the primary payer.**

A "large group health plan" means any health plan of, or contributed to, by an employer or by an employee organization (including a self-insured plan) that provides health care directly or through other methods such as insurance or reimbursement, to:

- employees or former employees,
- the employer,
- others associated or formerly associated with the employer in a business relationship, or
- their families.
These groups of people are covered if they are employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year.

Claims Filing Requirements

1. Send claims first to the LGHP and then to Medicare.
2. State the name and address of the LGHP and group number in item 11 of the CMS-1500 claim form.
   **Note:** Blocks 4, 6, 7, 11b (when applicable), and 11c must also be completed when a policy number is given in block 11.
3. Attach the other plan's EOB to the CMS-1500. Remember, Medicare will not consider payment without a copy of the LGHP's EOB.

**SUMMARY OF INFORMATION REQUIRED ON MSP CLAIMS**

1. Beneficiary’s name, address and Health Insurance Number.
2. Other insurance information in item 11 of the CMS-1500 claim form.
   **Note:** Blocks 4, 6, 7, 11b (when applicable), and 11c must also be completed when a policy number is given in block 11.
3. Patient's relationship to the insured.
4. Private insurance number and group number.
5. In item 10 of the CMS-1500, check the appropriate box if the condition is work or auto accident related. Check "other liability" only if you have information that the payment liability lies with another insurer.
6. A copy of the primary insurance EOB.

**REDUCING ADJUSTMENTS FOR MSP CLAIMS**

Medicare Services has seen an increase in the number of adjustments for claims when Medicare is the secondary payer. You can help us reduce MSP adjustments and claim re-submissions by implementing these suggestions:

- If you know Medicare is secondary to another insurer, please file with the other insurer first, then wait until you receive an Explanation of Benefits (EOB) from the primary insurer before submitting a claim to Medicare. Always submit a copy of the primary insurer’s EOB with the claim. However, do file a claim with Medicare within the timely filing period even if you have not received a notice from the other insurer.
- If you have received payment from Medicare then find out Medicare is secondary, submit the claim to the primary insurance before refunding Medicare. Be sure to send a copy of the other insurance’s EOB along with the refund.
- Our office often receives both a telephone call and a written request to correct the same claim. Please submit a single request for adjustment, either by telephone or in writing, but not both.
- If Medicare denies a claim indicating that Medicare is secondary, automatically re-submitting the claim will result in duplicate claim denials. Please submit a request for payment along with a copy of the denial or Explanation of Benefits from the primary insurer.

Instances When Medicare Would Be Primary
1. A Medicare patient fell in their home or on their own property (this should be noted on the claim or in the documentation submitted with the claim).

2. A nursing home resident, who has Medicare, fell at the nursing home, unless they have filed a liability claim against the nursing home (this should be noted on the claim or in the documentation attached to the claim).

3. A Medicare patient fell at a business, church or someone else’s resident but are not blaming them and do not plan to file a liability claim for medical coverage (a signed note/letter from the patient should be submitted with the claim).

4. A Medicare patient who is in an automobile, four wheeler, ATV, bicycle or moped accident but was found at fault (a signed note/letter from the patient or their auto insurance should be submitted with the claim). The type of accident should be noted on the claim or in the documentation submitted with the claim.

5. A Medicare patient receives medical services for a diagnosis that is not related to the automobile accident, liability accident or workers’ compensation case (this should be noted on the claim or in the documentation attached to the claim).

6. A working aged or disability Medicare patient who is offered group health plan coverage because of their current employment or a family member’s current employment but chose to reject coverage (a signed note/letter from the patient should be attached to the claim).

TEMPORARY LEAVE OF ABSENCE

MSP rules state that if an employee retains their employment status, Medicare remains the secondary payer. Examples of retained employment rights can include: company-approved temporary leave of absence for any reason, furlough, temporary layoff, sick leave, short-term or long-term disability, leave for teachers and seasonal workers who normally do not work year round, and for employees who have health coverage that extends beyond or between active employment periods. The employees in the latter category are sometimes referred to as having an “hours bank” arrangement.

CLAIMS FILING REQUIREMENTS FOR EDI SECONDARY PAYER CLAIMS

1. All providers must indicate if Medicare is the primary or secondary insurer for a beneficiary. If Medicare is primary, then enter "N" in the SM-PRIM-INS (DA0.04) field. If you indicate “Y” in the SM-PRIM-INS field, which means Medicare is secondary, then you must complete the following required fields for accurate claim processing when another insurance company is primary to Medicare:
   a) Indicate the total amount the primary insurance paid in the PRIM-TOTAL-PAID (DA1.14) field.
   b) Indicate the amount of the deductible applied to this claim from primary insurance in the PRIM-DEDUCT (DA1.12) field.
   c) Indicate the amount the primary insurance allowed and paid on each procedure in the DET-PRIM-ALLOW (DA1.11) and DET-PRIM-PAID fields.

   Note: For the CMS-1500 paper claim forms, you should not use the “paid amount” field to reflect the payments that have been issued by the primary insurer.

2. If Medicare is the primary insurance, do not complete the SM-DET-PRIM-ALLOW field.

3. Do not submit secondary claims to Medicare until you receive the explanation of benefits (EOB) from the primary insurance company.
4. Do not send a paper copy of the primary insurance explanation of benefits (EOB) to Medicare. Keep the copy of the EOB in the patient's file as your documentation.

5. Indicate why Medicare is secondary payer in the INS-TYPE (DA0.06) field by using the appropriate code.

**MEDICARE SECONDARY PAYER (MSP) POLICY FOR HOSPITAL AND INDEPENDENT REFERENCE LAB SERVICES**

Hospitals are no longer required to collect Medicare Secondary Payer (MSP) information where there is no face-to-face encounter with a beneficiary because independent reference laboratories no longer need the information to bill Medicare for reference laboratory services.

Affected providers should ensure that their billing staff enter “None” in block 11 of the CMS-1500 when filing claims to Medicare for reference laboratory services when there is not a face-to-face encounter with the Medicare beneficiary.

Section 943 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that:

“(T)he Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.”

Prior to the enactment of MMA, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services.

**MSP OVERPAYMENT REFUNDS**

**Duplicate or Mistaken Payments**

If you receive a duplicate MSP payment or overpayment, you have 60 days to refund Medicare from the day you received the duplicate payment or overpayment. However, once you receive a “demand” letter from Medicare Services, you will have 30 days to refund the duplicate payment. When returning an MSP overpayment, remember to include a copy of the primary insurer’s EOB.

Any time providers are aware of an overpayment by Medicare, they must refund the overpaid amount to Medicare within sixty (60) days of receipt of the overpayment.

Refund only the overpaid amount rather than the full Medicare primary payment.

**Determining MSP Refund**

Calculate the overpaid amount on assigned claims as follows:

1. Determine the amount allowed by Medicare from the remittance advice.
2. Compare the amount allowed by the primary insurer with the amount allowed by Medicare. Use the higher of the two allowed amounts in the Medicare Secondary Payer calculation.
3. Subtract the amount paid by the primary insurer from the allowed amount determined in Step 2.
4. Compare the amount determined in Step 3 with the amount already paid by Medicare. If the amount determined in Step 3 is lower than the Medicare payment already received, subtract the amount determined in Step 3 from the amount paid by Medicare. Refund the difference to Medicare.

Send MSP refunds to the address found on the “demand” letter or contact your state’s Customer Service department for the address.

If the amount determined in Step 3 is higher than the Medicare payment already received, no refund is necessary. However, you must submit the Medicare remittance notice with the explanation of benefits from the primary insurer to Medicare so the savings to the program be reported monthly.

**EFFECT OF FAILURE TO FILE PROPER CLAIM**

The term “proper claim” means one that is filed on time and meets all other filing requirements of the third party (e.g., mandatory second opinion, prior notification before seeking treatment).

When you or a beneficiary who is not physically or mentally incapacitated receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment is the amount Medicare would have paid if the third party had paid on the basis of a proper claim.

You, or the beneficiary, must inform Medicare that a reduced payment was made and the amount the third party would have paid if a proper claim had been filed.

However, when a claim was improperly filed due to the beneficiary's physical or mental incapacity, we consider the primary claim to have been properly filed. In this instance, Medicare will pay secondary benefits without regard to any third party benefit reduction due to failure to file a proper claim.

**Note:** Time limits for filing Medicare claims must be followed, even in cases involving a second insurer. These time limits will not be waived when a provider fails to file the claim because he/she is waiting for the other insurance company to pay.

**EFFECT OF PRIMARY PAYMENTS ON DEDUCTIBLES AND COINSURANCE**

Expenses that would be credited to a beneficiary's cash or blood deductibles if Medicare were primary are credited to the deductibles if a third party reimburses the expenses. This is true even if the third party paid the entire bill and no Medicare benefits were payable. If a third party paid Medicare-covered expenses in whole or in part, the Part B deductible is credited based on the Medicare fee schedule amount, not the third party's payment.

After deductibles are credited, a third party's payments are used to satisfy a beneficiary's obligation to pay a Part B coinsurance amount. The Part B deductible for non-inpatient psychiatric services is credited based on 62.5% of the Medicare fee schedule amount because expenses incurred for these services are limited at that rate.

**RIGHT OF PHYSICIAN OR SUPPLIER TO CHARGE BENEFICIARY**

When a beneficiary has been paid by a third party, the amount you collect for Medicare covered services from the beneficiary is limited to the following:

- The amount paid or payable by the third party to the beneficiary. If this amount exceeds the amount that would be payable by Medicare as primary (without regard
to deductible or coinsurance), you may retain the third party payment in full without violating the assignment conditions.

- If the third party payment is less than the applicable Medicare deductible and coinsurance amounts, then you are limited to the difference between the Medicare fee schedule amount (or the amount you are obligated to, if less) and the sum of the third party primary payment and the Medicare secondary payment.

In the case of non-inpatient psychiatric services, the amount the beneficiary can be charged is the difference between the Medicare fee schedule amount and a lesser third party payment amount. (The 50 + % cost sharing rule applies. The beneficiary is responsible for that portion of the fee schedule amount not paid by Medicare, i.e., no less than 50%)

If you receive from a payer that is primary to Medicare a payment that is reduced because you failed to file a proper claim, you may charge the beneficiary an amount equal to any third party payment reduced due to improperly filing a claim. However, you may charge the beneficiary this amount only if you can show that you or the beneficiary filed the claim improperly for a reason other than the mental or physical incapacity of the beneficiary.

CHARGING INTEREST

CMS policy states that Medicare Services should begin charging interest based on the date we send the demand letter. Once the 30 day grace period stated on the demand letter lapses, Medicare Part B assesses interest back to the date of the demand letter.

MSPs AND MCOs COORDINATE

Most Managed Care Organizations (MCOs), such as Health Maintenance Organizations (HMOs), Competitive Medical Plans (CMPs), and Health Care Prepayment Plans (HCPPs), charge co-payment amounts that Medicare Part B may consider for secondary payment once the individual has met the Part B deductible.

The Medicare Part B deductible can be met by covered services obtained either outside the MCO or through the MCO. The amounts credited to the deductible for MCO services are the Medicare allowed amounts that would have been allowed for the services if they had been furnished on a fee-for-service basis (traditional Medicare) plus any co-payments charged for the services.

Once the deductible is met, the Medicare secondary payment is the amount Medicare would pay if the services were not covered by a third party payer, the MCO or the co-payment amount, whichever is lower. The MCO must file a claim showing all the usual claims information, except the amount of the charges and the amount paid, since payment is made on a capitation basis.

If the MCO does not submit the claims, we suggest that you ask the patient to submit the co-payment receipts together with a signed statement to the MCO. This statement should explain that he or she is a member of an employer-sponsored MCO that is primary to Medicare and that he or she requests that Medicare pay secondary benefits for the MCOs co-payment charges. This explanation will serve as a substitute for the third party payer's explanation of benefits notice.
Billing Examples

Example 1
Mr. Green is enrolled in a non-Medicare HMO that is his primary payer. His Part B deductible has not been met. He required the services of a specialist and the HMO referred him to Dr. Drang, who does not accept assignment. The doctor charged him a copayment of $25 for each visit. After eight visits, Mr. Green contacted the carrier and requested secondary benefits.

Mr. Green must submit his copayment receipts with a signed and dated statement that he is requesting secondary benefits from Medicare for the copayments he paid to the physician. This statement will then serve as Mr. Green’s claim. You will then need to request the HMO to submit Form CMS-1500 showing the usual claims information, except for the charges and the amount paid.

The Medicare allowable amount for the non-participating physician was $55. The Medicare secondary payment is calculated as follows:

1. Determine the Medicare payment in the usual manner:
   \[ 0.8 \times \$440 (\$55 \text{ per visit } \times 8 \text{ visits}) = \$352. \]
2. The copayments for the 8 visits (\$25 \times 8) total $200.
3. Pay $200, the total copayment, since that amount is lower than the amount Medicare would pay as primary payer.

Example 2
Mr. Blue belongs to an employer-sponsored HMO that is primary to Medicare. He had two visits with a doctor for which he paid a $10 copayment per visit. He has not met his Medicare deductible. He wishes Medicare to make secondary payment to reimburse him for these copayments.

The Medicare allowable amount for each of Mr. Blue’s visits was $32, giving a total of $64 for the two visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

1. Determine the Medicare payment in the usual manner:
   \[ 0.8 \times \$64 (\$32 \text{ per visit } \times 2 \text{ visits}) = \$51.20 \]
2. The copayments for the 2 visits total $20.
3. If the deductible had been met, the lowest of Steps 1 or 2 would be payable. Since it was not met, the amount credited toward the deductible is:
   a) The Medicare allowable amount for the covered services if they had been furnished on a fee-for-service basis ($32 \times 2 = \$64$).
   b) To this amount, add the total copayments for those covered services:
      \[ \$64 + (\$10 \times 2) = \$84. \]

Mr. Blue is credited with $84 toward his deductible. Since Mr. Blue has not met the Medicare deductible, no MSP amount is payable.

MSP HINTS

Here are a few hints to help when billing for Medicare as Secondary Payor:

(a) If the provider discovers that Medicare paid primary and should have paid secondary, the provider should send a check for the entire refund, copy of the remittance notice and
claim, explanation of benefits (EOB) from primary insurance company and a brief explanation about the refund. Then, when Medicare corrects the claim for secondary payment, the monies can be calculated correctly with a corrected Medicare Summary Notice (MSN) and remittance notice. Many times, Medicare receives an incorrect partial refund, which causes additional work for our office and yours. It also often results in an overpayment letter to your office.

(b) When you send a voluntary refund because of liability claims, be sure to include the full name and address of the liability insurance company, their claim number and the date of loss for the Medicare patient.

(c) If you are submitting an Explanation of Benefits (EOB) from an insurance company and the service(s) is denied, please include the reason the service is denied. Often Medicare doesn’t know the other insurance company’s reason for denial, which delays claim payment to your office or the Medicare patient.

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>Condition</th>
<th>Who Pays First?</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Plan (GHP) and Medicare Based on Age</td>
<td>Beneficiary or spouse is employed, and Employer has fewer than 20 employees.</td>
<td>Medicare</td>
<td>Medicare beneficiary May Jones is 72 years old and works full time. Her employer has 75 employees. She has group health coverage through her employer. Therefore, her group health plan will be the primary payer, which makes Medicare the secondary payer.</td>
</tr>
<tr>
<td>(65 or over)</td>
<td>Beneficiary or spouse is working but is not covered by a GHP based on current employment status.</td>
<td>Medicare</td>
<td></td>
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<tr>
<td></td>
<td>Beneficiary and spouse are retired.</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beneficiary or spouse is employed, and Employer has 20 or more employees or is in a multi-employer plan in which at least one employer has 20 employees.</td>
<td>GHP</td>
<td></td>
</tr>
<tr>
<td>Large Group Health Plan (LGHP) and Medicare Based on</td>
<td>Beneficiary or family member is employed, and, Employer has 100 or more employees or is in a multi-employer plan with 100 or more employees (this is called a Large Group Health Plan, or LGHP).</td>
<td>LGHP</td>
<td>Jon Kessler works for a company that has 120 employees. He has large group health coverage for him and his wife. His wife has Medicare because of a disability. Therefore, Jon’s LGHP coverage pays first for his wife, and Medicare pays second.</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
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<tr>
<td>Type of Insurance</td>
<td>Condition</td>
<td>Who Pays First?</td>
<td>Example</td>
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</tr>
<tr>
<td>Large Group Health Plan (LGHP) and Medicare Based on Disability (continued)</td>
<td>Beneficiary or family member is employed, and Employer has fewer than 100 employees.</td>
<td>Medicare</td>
<td>Refer this issue to your supervisor.</td>
</tr>
<tr>
<td>GHP and Medicare Based on End-Stage Renal Disease (ESRD)</td>
<td>Beneficiary or family member has group coverage (which does not have to be based on current employment). It is during the first 30 months of eligibility or entitlement to Medicare, whichever is earlier.</td>
<td>GHP</td>
<td>40 year-old Juan Bonito just became entitled to Medicare based on ESRD and is covered through his family member’s GHP. Therefore, the GHP pays first for the 30 months after eligibility for Medicare and Medicare pays second. After this time, Medicare will pay first if the individual has enrolled in Medicare.</td>
</tr>
<tr>
<td></td>
<td>Beneficiary or family member has group coverage (which does not have to be based on current employment). It is after the first 30 months of eligibility or entitlement to Medicare, whichever is earlier.</td>
<td>Medicare</td>
<td>Refer this issue to your supervisor.</td>
</tr>
<tr>
<td></td>
<td>Beneficiary is dually entitled to Medicare based on ESRD and age or ESRD and disability.</td>
<td>Medicare</td>
<td>Refer this issue to your supervisor.</td>
</tr>
<tr>
<td></td>
<td>Beneficiary has no GHP coverage.</td>
<td>Medicare (only payer)</td>
<td>Refer this issue to your supervisor.</td>
</tr>
<tr>
<td>Type of Insurance</td>
<td>Condition</td>
<td>Who Pays First?</td>
<td>Example</td>
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</tr>
<tr>
<td>Employer Retiree Plan</td>
<td>Beneficiary is entitled to Medicare based on age or disability.</td>
<td>Medicare</td>
<td>Medicare beneficiary Theodore Lacroix is 66 years old and has coverage through an Employer Retiree Plan. Mr. Lacroix gets pneumonia. His claim will be submitted to Medicare because Medicare usually pays before Employer Retiree Plans.</td>
</tr>
<tr>
<td></td>
<td>Beneficiary is not entitled to Medicare.</td>
<td>Employer Retiree Plan (only payer)</td>
<td></td>
</tr>
<tr>
<td>Workers' Compensation</td>
<td>Claim is related to services covered by Workers' Compensation.</td>
<td>Workers’ Compensation</td>
<td>Ted Walund was injured at work. He went to the hospital and was treated for these injuries. He filed a claim for Workers’ Compensation insurance, and his doctor billed the state Workers’ Compensation.</td>
</tr>
<tr>
<td></td>
<td>Claim is not related to services covered by Workers’ Compensation.</td>
<td>Medicare</td>
<td></td>
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<tr>
<td></td>
<td>Claim is submitted to Workers’ Compensation but is not paid within 120 days.</td>
<td>Route call to post-pay MSP specialist</td>
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</tr>
<tr>
<td></td>
<td>The beneficiary has not received a settlement from Workers’ Compensation, and Workers’ Compensation denies the claim.</td>
<td>Medicare will pay for Medicare-covered services.</td>
<td></td>
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<tr>
<td></td>
<td>Workers’ Compensation claim is denied in court.</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Federal Black Lung Program</td>
<td>Claim is related to black lung disease.</td>
<td>Federal Black Lung Program</td>
<td>Medicare beneficiary John MacNichol is a 69-year-old retired coal miner. He has black lung disease and has recently received medical services related to treatment of this condition. Claims related to the treatment of this condition should be sent to the Federal Black Lung Program. Medicare will not pay for doctor or hospital services that are covered under the Federal Black Lung Program.</td>
</tr>
<tr>
<td></td>
<td>Claim is not related to black lung disease.</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Type of Insurance</td>
<td>Condition</td>
<td>Who Pays First?</td>
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</tbody>
</table>
| Liability Insurance  
(Includes all types of liability insurance: automobile, malpractice, product liability, etc.) | Claim is for an accident or injury.  
Liability insurance does not pay the claim within 120 days.  
Liability denies the claim. | Liability insurance  
If a product liability question is involved (defective products, etc.), refer the question to an MSP specialist.  
Route call to post-pay MSP specialist.  
Medicare will pay for Medicare-covered services. | Medicare beneficiary John Smith is in an automobile accident in a liability auto insurance state. The other driver's liability insurance, Greenway, acknowledges that the person insured under Greenway caused the accident. The hospital should bill Greenway insurance for any services John receives for his injuries at the hospital emergency room. |
| No-Fault Insurance  
(Includes automobile no-fault, homeowners, personal injury protection, automobile medical payments, etc.) | Claim is for an accident or injury.  
No-fault insurance does not pay the claim within 120 days.  
No-fault denies the claim. | No-Fault insurance  
Route call to post-pay MSP specialist.  
Medicare will pay for Medicare-covered services. | At a sporting event, Medicare beneficiary Nancy Roberts falls and breaks her leg. Nancy is treated for her broken leg at the hospital emergency room. The sports complex's insurance states that medical expenses associated with injuries sustained on the premises should be paid for without regard to the circumstances giving rise to the injury. Therefore, the hospital should bill the sports complex's no-fault insurance instead of Medicare for any services Nancy receives for her broken leg at the hospital emergency room. |
| Veterans Affairs (VA) | Beneficiary chooses to use Medicare benefits for the doctor visit or health care services provided by a non-VA hospital or doctor. | Medicare  
Medicare beneficiary Roy Letterman is a veteran and goes to a non-VA hospital for a service that is authorized by the VA. While at the non-VA hospital, Mr. Letterman gets other non-VA-authorized services for which the VA refuses to pay. Some of these services are Medicare-covered services. Medicare may pay for some |
<table>
<thead>
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<tbody>
<tr>
<td><strong>TRICARE</strong></td>
<td>Beneficiary chooses to use VA benefits for the doctor visit or health care service.</td>
<td>VA Note: Medicare may be able to pay the VA coinsurance for VA-authorized care by a non-VA doctor or hospital.</td>
<td>Medicare beneficiary Steven Mellon is a retiree of the uniformed services. Mr. Mellon receives medical services that are covered by both TRICARE and Medicare. For services covered by both TRICARE and Medicare, Medicare will pay first and the remaining out-of-pocket expenses will be paid by TRICARE. Note: Retirees of the uniformed services must be enrolled in Part B to keep TRICARE if they also have Medicare.</td>
</tr>
<tr>
<td>TRICARE</td>
<td>Beneficiary receives services in a VA facility.</td>
<td>VA</td>
<td></td>
</tr>
<tr>
<td>TRICARE</td>
<td>For services covered by TRICARE and Medicare.</td>
<td>Medicare, then TRICARE</td>
<td></td>
</tr>
<tr>
<td>TRICARE</td>
<td>For services covered by TRICARE but not Medicare.</td>
<td>TRICARE only</td>
<td></td>
</tr>
<tr>
<td>TRICARE</td>
<td>For services covered by Medicare but not TRICARE.</td>
<td>Medicare only</td>
<td></td>
</tr>
<tr>
<td>TRICARE</td>
<td>For services received in a military hospital.</td>
<td>TRICARE only</td>
<td></td>
</tr>
<tr>
<td><strong>COBRA</strong></td>
<td>Beneficiary loses his or her job and elects COBRA continuation coverage for himself or herself and his or her spouse.</td>
<td>Medicare</td>
<td>Medicare beneficiary Mary Troy reduced her hours of work. She elected COBRA continuation coverage for herself and her husband Bill, also a Medicare beneficiary. When Mary or Bill receives medical services that are covered by Medicare, Medicare is the primary payer.</td>
</tr>
<tr>
<td>Type of Insurance</td>
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</tr>
<tr>
<td>COBRA Continuation of Coverage and Medicare Based on Disability</td>
<td>Beneficiary’s spouse loses his job and elects COBRA coverage for himself and his family member.</td>
<td>Medicare</td>
<td>Medicare beneficiary Erin Klein is 50 years old and has COBRA continuation coverage from her spouse’s previous employment. Ms. Klein has Medicare based on a disability. When Ms. Klein receives medical services that are covered by Medicare, Medicare is the primary payer.</td>
</tr>
<tr>
<td>COBRA Continuation of Coverage and Medicare Based on ESRD</td>
<td>During the first 30 months of eligibility or entitlement to Medicare, whichever is earlier.</td>
<td>COBRA</td>
<td>Thomas Little has Medicare based on ESRD and COBRA continuation coverage. The COBRA continuation coverage will be the primary payer and Medicare is the secondary during the first 30 months of eligibility. After the first 30 months of Medicare eligibility, Medicare will pay primary if the individual has enrolled in Medicare.</td>
</tr>
</tbody>
</table>
## Frequently Appearing ANSI Reason Codes

<table>
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<tr>
<th>MSP Issue</th>
<th>Reason Code</th>
<th>Definition of Reason Code</th>
<th>Action by Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Aged</td>
<td>22 or 23</td>
<td>A claim must be sent to the patient's group health plan first. After the claim has been processed by the plan, resubmit the claim with the notice that the other insurance company sent if the bill has not been paid in full.</td>
<td>If the patient or spouse has retired, advise the patient to contact his or her state's Customer Service or MSP Customer Service department. Change your records to show that the patient has retired. If the employment status for either the patient or spouse has not changed and the denial code is correct, bill the patient's group health plan first.</td>
</tr>
<tr>
<td>Disability</td>
<td>22 or 23</td>
<td>A claim must be sent to the patient's group health plan first. After the claim has been processed by the plan, resubmit this claim with the notice that the other insurance company sent if the bill has not been paid in full.</td>
<td>If the disability status has changed for the patient or spouse, advise the patient to contact his or her state's Customer Service or MSP Customer Service department to have his or her Medicare secondary-payer records changed.</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)</td>
<td>22 or 23</td>
<td>Medicare pays secondary for ESRD patients for the first 30 months of Medicare entitlement. A claim must be sent to the group health plan first.</td>
<td>Remember that Medicare is secondary for the first 30 months. If services were rendered after the 30-month period, bill the patient's group health plan first. If services were rendered after the 30-month period and rejection from Medicare is received, advise the patient to contact his or her state's Customer Service department or MSP Customer Service department to have his or her Medicare secondary-payer records changed.</td>
</tr>
<tr>
<td>MSP Issue</td>
<td>Reason Code</td>
<td>Definition of Reason Code</td>
<td>Action by Provider</td>
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</tr>
</tbody>
</table>
| Auto Accident/No-Fault Liability | 21 or 23    | Items and services which can be paid for under an automobile medical insurance plan, or under No-Fault, are not covered.                                                                                                     | Verify the type of injury that the patient sustained:  
  - If the injury was caused by an auto accident, bill the patient’s auto insurance first or the primary Medical Payments or PIP coverage that belongs to the party they were riding with.  
  - If the injury was caused due to a slip/fall, bill the primary No-Fault coverage.  
  - If the diagnosis is not related to the auto accident or slip/fall, resubmit the claim(s) to Medicare with documentation showing that the diagnosis is not related to the auto accident or slip/fall.  
  If you receive a denial from the primary insurance indicating that the primary coverage has been exhausted, resubmit the claim(s) to Medicare with a copy of the denial from the primary insurer. |
| Workers’ Compensation     | 23          | Workers’ compensation services are not covered by Medicare.                                                                                                                                                               | Verify the injury was work-related. If so, bill the worker’s compensation plan where the patient has filed a claim. If the diagnosis was not work-related, resubmit the claim(s) to Medicare with documentation showing that the diagnosis is not related to the work-related injury. |
| Black Lung                | 22 or 23    | Services for black lung benefits are not covered by Medicare.                                                                                                                                                           | Submit claims to this address:  
  Federal Black Lung Program  
P.O. Box 828  
Lanham-Seabrook, MD 20703-0828                                                                                                                                           |
COORDINATION OF BENEFITS FOR PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. CMS awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB Contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations will be initiated from, and researched at the COB Contractor. This will no longer be a function of your local Medicare fiscal intermediary (FI) or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor will provide customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers and suppliers.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of insurance that is primary to Medicare. In such situations, the other health plan has the legal methods and programs to identify situations in which Medicare beneficiaries have other health obligation to meet the beneficiary’s health care expenses first before Medicare. The table below describes a few of these methods and programs.

<table>
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<tr>
<th>Method/Program</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Initial Enrollment Questionnaire (IEQ)</td>
<td>Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.</td>
</tr>
<tr>
<td>IRS/SSA/CMS Data Match</td>
<td>Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.</td>
</tr>
<tr>
<td>MSP Claims Investigation</td>
<td>This activity 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.</td>
</tr>
<tr>
<td>Voluntary MSP Data Match Agreements</td>
<td>Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between CMS and employers or various insurers.</td>
</tr>
</tbody>
</table>
Provider Requests for Claims Payment

FIs and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB Contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local FI or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor. Questions regarding Medicare claim or service denials and adjustments should continue to be directed to your local FI or carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local FI or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in CMS’s Database

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

Contacting the COB Contractor

Effective January 1, 2001, please refer all MSP inquiries; including, the reporting of potential MSP situations, changes in a beneficiary’s insurance coverage, changes in employment, and general MSP questions/concerns to the COB contractor. Continue to call your local FI and/or carrier regarding claims-related questions. The COB Contractor’s Customer Call Center toll free number is 1-800-999-1118 or TDD/TTY 1-800-318-8782. Customer Service Representatives are available to assist you from 8 AM to 8 PM, Monday through Friday, Eastern Standard Time, except holidays. To view the COB website, log on to website is www.cms.hhs.gov/medicare/cob