

Medicare Secondary Payer (MSP)

Published March 2012



IMPORTANT



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Provider Outreach and Education

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

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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HOW WE OBTAIN THIS INFORMATION

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

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

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

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

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

Providers can:

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

The COBC will be **unable** to help the provider with:

- Information on how to bill for payment. Providers should contact the Medicare contractor for this information.

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- Inquiries related to specific claims or recoveries.
- Beneficiary entitlement data. Regulations do not allow the COBC to provide entitlement data to the providers.
- Insurer information. The COBC is permitted to indicate whether Medicare is primary or secondary but it cannot provide the name of the other insurer.

COBC

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

COBC Contact Information

Toll Free: (800) 999-1118

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

Address general written inquiries to:

Medicare – Coordination of Benefits

P.O. Box 33847

Detroit, MI 48232

Mail questionnaires and correspondence to:

Medicare – COBC

Data Match Project

P.O. Box 33848

Detroit, MI 48232

Medicare – COBC

MSP Claims Investigation Project

P.O. Box 33847

Detroit, MI 48232

Medicare – COBC

Voluntary Agreement Project

P.O. Box 660

New York, NY 10274-0660

Medicare – COBC

Initial Enrollment Questionnaire Project

P.O. Box 17521

Baltimore, MD 21203-7521

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When contacting the COBC, please provide the following:

- Medicare provider number.
- *Beneficiary's last name and first initial.*
- Date of birth.
- Medicare number.
- Gender.

The COBC requires all of the above information to assist the caller. If the information cannot be provided, the COBC will ask the caller to submit the request in writing for further research.

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

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

Effective April 1, 2011, CMS implemented a process where private insurers (both group health plans and non-group health plans) will submit coverage information to the COBC when they also provide coverage to a Medicare patient. The COBC currently receives data files from approximately 1,500 group health plans! This new process will allow CMS to accurately determine who (a private insurance plan or Medicare) has primary, secondary or claims coverage responsibility.

Occasionally, the information submitted to the COBC is conflicting and can be attributed to the number of sources contributing to the insurance information on record.

CMS has developed a "Reporting Hierarchy" process to help reduce such conflicts in the future. Complete guidelines can be found in MLN Matters® Number SE1205:

<http://www.cms.gov/MLNMattersArticles/Downloads/SE1205.pdf>

The following steps are now in place at the COBC to help providers update MSP records:

Provider attempting update with the beneficiary in the office:

- *The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call.*

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- *For any subsequent calls made to update the record after April 4 2011, no update will be made on the call, but two options are available:*
 - *Proof of information can be faxed or mailed on the insurer's or employer's company letterhead and the update will be made in 10–15 business days.*
- Or,**
- *Contact the insurer or employer organization that last updated the record.*

Provider attempting update when the beneficiary is not in the office:

No update will be made from a telephone call. The provider has three options to have the record updated:

- *Have the beneficiary contact the COBC.*
 - *Contact the beneficiary's insurer to resolve the issue.*
- Or,**
- *Fax or mail proof of information on the insurer's or employer's company letterhead and the update will be made in 10–15 business days.*

Provider with new information:

The COBC will take new information for a beneficiary, but if the new information requires changes to an existing record, two options are available:

- *The beneficiary will need to call to close out the record.*
- Or,*
- *Fax or mail proof of information on the insurer's or employer's company letterhead and the update will be made in 10–15 business days.*

Provider update for deceased beneficiary:

*A **single** update can be made by **one** provider for a deceased beneficiary once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.*

Additional information about the COBC's new processes can be found in MLN Matters® Number SE1205 on the CMS Web site at:

<http://www.cms.gov/MLNMattersArticles/downloads/SE1205.pdf>

For more information, visit the COBC Web site at:

http://www.cms.gov/COBGeneralInformation/01_Overview.asp

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MSP Reopening for Claims Paid as Secondary

Note: *The information and example below is not a “change” in Medicare claims processing or policy, but in the event this scenario happens in your office, you will have the needed information.*

Example:

If Medicare processes and pays as secondary on a claim (i.e., the claim paid secondary based on the Common Working File (CWF) records at the time the claim processed along with the receipt of the primary insurer's remittance notice) and later a party discovers Medicare was primary for that claim's date of service (i.e., other payer paid primary in error and now wants to correct their claim), Medicare will only reopen a claim within one year of the claims' process date unless good cause exists.

Important Note: *CMS provides Medicare with specific guidelines on the definition of “good cause” in respect to these situations:*

In general, Medicare does not consider a situation where: (a) Medicare processed a claim in accordance with the information on the claim form and consistent with the information in the Medicare's systems of records; and (b) a third-party mistakenly paid primary when it alleges that Medicare should have been primary to constitute “good cause” to reopen.

Note: *Third-party payer error in making a primary payment determination does not constitute good cause for the purposes of reopening an initial determination or redetermination when Medicare processed the claim in accordance with the information in its system of records or on the claim form. Contractors may only reopen for third-party payer error under the “within one year for any reason” standard. This is true for both contractor-initiated reopenings as well as reopenings requested by a party. All providers and suppliers have a legal obligation to determine the correct primary payer when billing Medicare. Failure to do so, regardless of third-party payer error, does not constitute “good cause” that will permit reopening beyond one year. Information regarding such error does not constitute “new and material evidence.”*

This reference can be found in the Internet-Only Manual (IOM), Pub. 100-04, Chapter 34 on the CMS Web site at:

<https://www.cms.gov/manuals/downloads/clm104c34.pdf>

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MEDICARE SECONDARY PAYER PROVISIONS

Working Aged

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

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

Reminders:

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

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The MSP provision for working aged does not apply to:

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

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

- Company-approved temporary leave of absence for any reason.
- Furlough.
- Temporary layoff.
- Sick leave.
- Short-term or long-term disability.
- Leave for teachers.
- Seasonal workers who normally work year-round.

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- Employees with health coverage that extends beyond or between active employment periods.

Reminders:

- If the employer offers health care coverage to spouses, the same coverage must be offered regardless of age. This equal-benefit rule applies to coverage offered to full-time and part-time employees or retirees.
- Medicare beneficiaries are free to reject employer plan coverage, in which case, they retain Medicare as their primary coverage. When Medicare is the primary payer, employers cannot offer such employees or their spouses a supplemental plan for services covered by Medicare.

GHPs for Disabled Beneficiaries

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

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

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

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

Reminders:

- If the employer offers health care coverage to spouses, the same coverage must be offered regardless of age. This equal-benefit rule applies to coverage offered to full-time and part-time employees or retirees.

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- Medicare beneficiaries are free to reject employer plan coverage, in which case, they retain Medicare as their primary coverage. When Medicare is the primary payer, employers cannot offer such employees or their spouses a supplemental plan for services covered by Medicare.

Coverage Due to ESRD

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

The criteria are:

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

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

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

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

Determination for Subsequent Periods of ESRD Eligibility

If an individual has more than one period of eligibility or entitlement based solely on ESRD, a coordination period is determined for each period of eligibility. If Medicare

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entitlement is not correctly terminated three years after a successful transplant, it is still considered a new period of eligibility and, consequently, a new coordination period begins.

Employer Health Maintenance Organizations (HMOs) – Working Aged, Disability and ESRD

Health Maintenance Organization (HMO) Plan (Employer Group HMO)

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

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

Services by Outside Sources Not Covered by HMO Plan

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

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

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

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

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

HMO Supplemental

Medicare would be the primary payer to a supplemental HMO plan. The beneficiary would have coverage through a specific insurance company that would pay **after** Medicare. This coverage could result from purchasing coverage from an outside

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insurance company or from a previous employer. This coverage would normally be through a network of providers – doctors, hospitals and other health care professionals within a specific geographic area.

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

Liability

General Effect of Liability Insurance on Medicare Payments

Under Section 1862(b)(2) of the Social Security Act, Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan.

Liability insurance is coverage that protects against claims based on negligence, inappropriate action, or inaction that results in bodily injury or damage to property. Liability insurance includes but is not limited to:

- Homeowners' liability insurance.
- Automobile liability insurance.
- Product liability insurance.
- Malpractice liability insurance.
- Uninsured motorist liability insurance.
- Underinsured motorist liability insurance.

Under certain circumstances, Medicare may make conditional payments if the liability insurance will not pay or will not pay promptly. Conditional payments are conditioned upon reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including self-insured plan). Medicare's right to recover its benefits from liability insurers and from those who have been paid by liability insurers takes precedence over the claims of any other party.

Definitions

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

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

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

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

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

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

No-Fault Insurance – Insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners' and commercial plans. It includes "medical payments coverage," "personal injury protection" or "medical expense coverage." Examples of no-fault insurance include homeowners' and commercial medical payments insurance, commonly referred to as Med-Pay coverage.

Prompt or Promptly – With regard to liability insurance, means payment within 120 days after the earliest of the following:

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

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

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

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

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

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

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

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

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

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

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

Difference Between Liability Insurance and Other Primary Plans

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

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

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

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

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

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

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

No-Fault Insurance

Medicare is secondary to any no-fault insurance, including all forms of automobile no-fault insurance, automobile medical payments, and non-automobile no-fault insurance. No-fault insurance is a form of insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident. Med-Pay is a form of no-fault insurance even when included in automobile insurance of any type. Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can be

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

Liability Insurance

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

Conditional Primary Medicare Benefits

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

If it is determined that the no-fault liability or liability insurer will not pay "promptly," providers may submit claims to Medicare for a conditional payment. When proceeds from the no-fault or liability settlement become available, Medicare has priority right of recovery. Medicare will collect the money it used for the conditional payment from the settlement before other providers and suppliers may collect from the settlement.

After the provider has waited the 120-day period, the provider may choose to bill Medicare conditionally. In a liability insurance situation, if the provider chooses to bill Medicare, he must withdraw claims against the liability insurer and any liens placed on the beneficiary's settlement. If the provider chooses to continue the claim(s) against the liability insurance settlement, a claim may not be billed to Medicare.

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

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Billing Liability Insurance

Billing Options and Requirements – Alternative Billing

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

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

Charges to Patients

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

The following applies to providers **who participate** in Medicare:

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

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

Physicians and other suppliers, who do not participate in Medicare, do not submit a non-assigned claim and are not required to submit an assigned claim if they submit a

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claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services Not Covered by Medicare

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

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

Permissible Liens

The MSP provisions do not create lien rights when those rights do not exist under state law. Where permitted by state law, a provider, physician or other supplier may file a lien for full charges against a beneficiary's liability settlement. (A lien against a beneficiary will be considered a lien against a liability settlement if there is a binding agreement that the lien will only be enforced if there is a settlement and will be withdrawn otherwise.)

- The provider, physician or other supplier may enforce a permissible lien up to the lesser of the amount of the settlement and charges for the services incorporated in the lien. The provider, physician or other supplier may not charge interest, lien filing and administrative fees to the beneficiary or against the lien.

Charging the Beneficiary

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

The following are special circumstances:

- When a no-fault plan denies some or all of a claim on the basis of benefit exhaustion or specific no-fault policy coverage exclusion applicable to all

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policyholders, Medicare may pay for the services, subject to meeting normal Medicare guidelines. A copy of the denied Explanation of Benefits (EOB) from the no-fault plan must accompany the claim to Medicare.

- Primary Medicare benefits may not be paid merely because the beneficiary wants to save his automobile insurance for future benefits.

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

Note: Submission of a liability-related claim to Medicare falls under the same timely filing claim submission requirements (current year, previous year and the last three months of the year prior to that).

Important Contacts for MSP Recovery Contractor

CMS awarded the national Medicare Secondary Payer Recovery Contract (MSPRC) to Chickasaw Nation Industries, Inc. – CNI Administration Services, LLC. This contract was implemented October 2, 2006. *At this time, CMS has contracted with Group Health Incorporated to perform MSP recovery activities while a full and open competition for this work is being conducted. The current phone numbers and mailing addresses for these activities remain unchanged.*

Telephone Inquiries

The MSPRC's trained staff can help with MSP postpayment recovery inquiries. The Customer Service representatives are available Monday through Friday, 8 a.m. to 8 p.m. ET, except holidays, at toll-free lines:

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

Please have the patient's Medicare number when calling the MSPRC phone lines.

Written Inquiries

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

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GHP Inquiries and Checks

(All GHP inquiries and checks including congressional, Freedom of Information Act (FOIA), bankruptcy and Qualified Independent Contractor (QIC)/Administrative Law Judge (ALJ))

Address GHP insurance MSP recovery inquiries to:

**MSPRC – GHP
P.O. Box 138856
Oklahoma City, OK 73113**

Non-GHP Inquiries and Checks

(All non-GHP inquiries and checks including liability, no-fault, workers' compensation, FOIA, bankruptcy, liquidation notices and QIC/ALJ)

Address non-GHP insurance MSP recovery inquiries to:

**MSPRC – NGHP
P.O. Box 138832
Oklahoma City, OK 73113**

Special Projects

(All product liability case inquiries and special projects checks)

Address special projects insurance MSP recovery inquiries to:

**MSPRC – Special Projects
P.O. Box 138868
Oklahoma City, OK 73113**

Fax MSPRC correspondence to:

**MSPRC Fax Correspondence
(405) 869-3309**

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Reminders:

- Always provide the identity of the correspondence as GHP or NGHP on the fax cover sheet.
- The patient's Medicare number, date of incident and case ID number are required on all written/fax correspondence.

Black Lung Disease

The Department of Labor's Black Lung Program provides for the treatment of black lung disease (coal miner's disease). The Black Lung Program also provides coverage for other pulmonary/respiratory illnesses associated with the effects of coal mining. The Federal Black Lung program is a workers compensation program for individuals with a condition attributable to lung diseases and conditions caused by coal mining. Medicare is the primary payer for services rendered for conditions **other** than black lung to beneficiaries that are eligible for both Medicare and the Black Lung Program. *This program provides two types of medical services related to black lung disease:*

- *Diagnostic testing for all miner claimants to determine the presence or absence of black lung disease and the degree of associated disability.*
 - *Coverage includes chest X-ray, pulmonary function study, arterial blood gas study and physical examination.*
- *For miners entitled to monthly benefits, medical coverage for treatment of black lung disease and disability.*
 - *Coverage includes costs for prescription drugs, office visits and hospitalizations. Also includes, with specific approval, items under durable medical equipment, such as hospital beds, home oxygen and nebulizers; outpatient pulmonary rehabilitation therapy and home nursing visits.*

The following is additional information concerning black lung benefits:

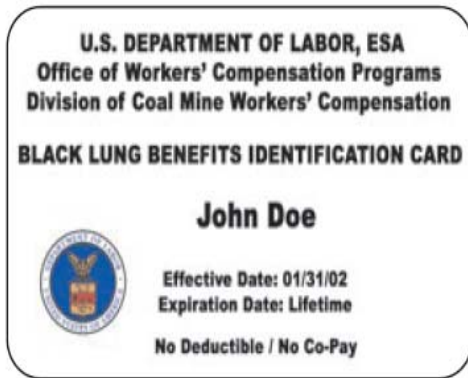
- The eligible beneficiary will carry a card identifying himself as a recipient of the program.
- Benefits are more prevalent in northern states.
- Specific diagnoses may indicate black lung disease.

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

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Sample of Black Lung Benefits Identification Card



1. This card is the property of the U.S. Government and its counterfeiting, alteration or misuse is a violation of Section 499, Title 18, U.S. Code.
2. Carry this card with you at all times and show it to your doctor, clinic or hospital when you are in need of medical services for your lung condition.
3. The U.S. Department of Labor will pay for medical treatment that is authorized under the Black Lung Act. Call 1-800-638-7072 for specific details.
4. All bills should be submitted to the DOL Black Lung Program, P.O. Box 8302, London, KY 40742-8302.
5. If found, drop in mailbox. Postmaster, postage guaranteed. Return to: DOL Black Lung Program, P.O. Box 8302, London KY 40742-8302.
6. When using the DOL OWCP bill payment website (<http://owcp.dol.acs-inc.com/>) to request an authorization for medical services or to verify eligibility, your doctor must use the following Card ID Number: 1234567830. Claimants can also use this Card ID Number to access the DOL OWCP bill payment website.

MISUSE OF CARD IS PUNISHABLE BY LAW

The U.S. Department of Labor black lung benefits identification card is white with a Department of Labor logo, and is imprinted with the patient's name, an effective date and possibly an expiration date. (**Note:** Previously, the ID cards were red and white and are now obsolete.)

Providers not already participating in the federal Black Lung Program can apply at any time.

For questions about enrollment or billing:
(800) 638-7072
Monday – Friday, 8 a.m. – 8 p.m. ET

Providers may also apply as a Black Lung Program provider online at:

<http://owcp.dol.acs-inc.com/portal/providerEnrollment.do>

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

**Federal Black Lung Program
P.O. Box 8302
London, KY 40742-8302**

Patients with questions about the Federal Black Lung Program, medical bills, reimbursement forms for treatment, prescriptions, travel or a replacement black lung benefits identification card should call (800) 638-7072 (Monday – Friday, 8 a.m. – 8 p.m. ET). Providers can obtain more information related to federal black lung benefits at:

<http://www.dol.gov/compliance/topics/benefits-comp-blacklung.htm>

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United Mine Workers of America (UMWA)

United Mine Workers of America (UMWA) is a multi-employer insurance plan that funds health and pension benefits to retired coal miners and their eligible dependents.

UMWA benefits should not be confused with the Federal Black Lung program. (Black Lung is a workers compensation program for individuals with a condition attributable to lung diseases and conditions caused by coal mining.) Some UMWA Funds' ("the Funds") beneficiaries have medical coverage under the Black Lung program. These beneficiaries' claims may be paid by the Funds, Department of Labor (DOL) or Responsible Mine Operator (RMO), depending upon the service and DOL beneficiary assignment.

If a beneficiary is Medicare-eligible, he must elect to take the Medicare Part B entitlement (medical insurance) and pay the monthly premiums to keep the Funds' health services card. The Funds will not provide health benefits for otherwise eligible beneficiaries who are not enrolled in Medicare. Through a contractual arrangement with the Centers for Medicare & Medicaid Services, the Funds is the primary payer for Medicare Part B services if there is no other insurance that may be primary. The Funds also pays for some of the expenses Medicare does not pay. For example, the Funds pays Medicare copayments, coinsurance and deductibles for the beneficiary.

All claims for Medicare Part B services provided to Medicare eligible beneficiaries must be submitted to the "funds" for payment. Services will automatically deny (regardless of diagnosis) when billed to Medicare for beneficiaries entitled to UMWA insurance.

Providers may submit medical claims to the Funds on paper or electronically.

Paper medical claims can be mailed to:

Claims Submissions
UMWA Health and Retirement Funds
P.O. Box 99002
Lubbock, TX 79490-9002

For information and assistance on how to file electronic medical claims, contact CareVu at (877) 737-0510.

Providers needing assistance with claims may contact UMWA Provider Customer Service at (888) 865-5290.

Additional UMWA information can be found on its Web site at:

<http://www.umwafunds.org/HealthBenefits/Assistance and Contact Providers.htm>

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Veterans' Benefits

Veterans who are also entitled to Medicare may choose which program will be responsible for payment for services that are covered by both programs. However, claims for the same date and service **may not** be submitted to both programs.

When services are authorized by Veterans Affairs (VA), the authorization binds the VA to pay in full for the items and services provided. No payment is made by Medicare for such authorized service, so therefore no claim should be filed if the service was preauthorized/authorized for payment by the VA.

Note: Medicare can reimburse veterans for (or credit toward Medicare deductible or coinsurance amounts) VA copayment amounts charged for VA authorized services furnished by non-VA sources. Medicare does not pay for any item or service rendered by a non-federal provider pursuant to an authorization issued by a federal agency, under the terms of which the federal government agrees to pay for the services.

Medicare may pay for (covered) services for which the VA does not make any payment. For example, if a veteran is authorized "fee basis" care at VA expense for a service-connected back injury and receives treatment for a different condition for which the VA does not pay, Medicare can pay for the (covered) services that are not reimbursable by the VA.

When the physician does not accept the fee basis card (i.e., bills the veteran directly), the veteran may file a claim with the VA. The VA may either reimburse the beneficiary for out-of-pocket costs or pay the physician based on a claim filed by the beneficiary. If the VA payment to the beneficiary or physician based on a claim filed by the beneficiary is less than the Medicare fee schedule or allowable amount for the services, Medicare can pay secondary benefits to supplement the VA payment, provided the beneficiary submits a copy of the VA's explanation of benefits, which accompanies the VA payment.

If a physician accepts the fee basis card and bills the VA, the VA payment is considered payment in full. If the VA bills the beneficiary a copayment amount for authorized physician/supplier services that are covered by Medicare in the absence of the VA authorization, the contractor pays a secondary benefit to the beneficiary consisting of the lower of the VA copayment amount or the amount Medicare would pay in the absence of VA coverage.

Generally, it is advantageous for Medicare beneficiaries who are veterans to have items and services paid by the VA where possible, since in most cases the VA has no deductible or coinsurance requirements. Claims for services for which the veteran elects Medicare coverage should be submitted to Medicare in the usual manner. A denial from the VA is not needed prior to submitting a claim to Medicare.

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VA 'Fee Basis Card'

The fee basis card is a method used by the VA to authorize a physician service to be paid or considered by the VA. This card is issued to certain veterans with a service-connected disability, as well as certain other veterans who require medical services for an extended period when VA and other federal health care facilities are not capable of furnishing economical care, or, because of geographical inaccessibility, are not capable of furnishing the care or services required. The card constitutes an agreement by the VA to pay up to a specified monthly dollar amount for treatment of specific disabilities or for any condition specified on the face of the card. The veteran is not restricted in choice of physician nor does the physician selected by the veteran have to inform the VA in advance that he will be treating the veteran. (The physicians are not participating physicians in the VA program nor does the VA have an express "assignment" procedure.)

When the charges for the services exceed the specified monthly amount routinely allowed by the VA, the VA may allow an additional amount if the physician justifies the need for the additional cost.

VA Medicare Billing Guidelines

During patient screening, if a VA patient is identified, the billing provider should take an additional step in Medicare claim submission. Veterans who are also entitled to Medicare may choose which program will be responsible for payment for services covered by both programs. Before filing a claim, the provider should identify if those services have been preauthorized or will be paid by the VA.

- If the VA is to be responsible for the procedure/service, **no** claim should be filed to the Medicare program for consideration.
- If the VA **is not** responsible for the procedure/service and no claim will be filed to the VA, the claim should be submitted to Medicare for consideration. The claim must also be submitted indicating that the VA did not authorize the service.

Note: If the claim is for multiple services, the provider must identify for each service billed if the VA has not been and will not be authorized and filed with the VA.

Claim Submission Requirements

Paper claim submitters:

- Include an attachment to the CMS-1500 claim form indicating for each service billed:
 - VA did not authorize.

Reminder: If the claim is for multiple services, identify for each service whether the VA has not authorized and will not be filed or a claim has been authorized and will be filed.

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Electronic claim submitters:

- For each service billed:
 - Loop 2300 or 2400 Segment:
 - NTE01= Add.
 - NTE02=: VA did not authorize.

If this additional step is not taken, providers will receive an Automated Development System (ADS) letter for each claim that is submitted when a patient is entitled to veterans' benefits and Medicare. The ADS letter will indicate: **OUR RECORDS SHOW THIS BENEFICIARY IS COVERED BY THE VETERANS ADMINISTRATION (VA). WE NEED TO KNOW IF THE VA AUTHORIZED THIS SERVICE FOR PAYMENT.**

Providers will have to respond to each ADS letter and return to Medicare to allow the claim to continue processing. Providing the information up front will prevent the ADS development process, mailing of the additional information back to Medicare and possible claim processing delays or even denials for the information not being received timely or not received by Medicare.

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

Workers' Compensation

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

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

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

- Medicare may make payments for Medicare-covered services if not payable under the Workers' Compensation policy (e.g., services of a physician not authorized to furnish medical care under workers' compensation).
- Services payable under a Workers' Compensation policy that have been paid by Medicare constitute overpayments and are subject to recovery.
- A beneficiary's statement that an injury or illness is not work-related may be accepted in absence of reasonable doubt. When Workers' Compensation does

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not pay for all services furnished to a beneficiary, Medicare benefits may be paid for those services not covered under workers' compensation.

- If workers' compensation pays a physician in full or pays a lesser amount based on its reasonable charge/fee schedule, which must be accepted as payment in full, Medicare secondary benefits may not be paid to supplement the amount paid by workers' compensation. The physician cannot charge the patient or any other party for the services. Workers' compensation medical benefits constitute a service benefit; the payment constitutes full discharge of the patient's liability for the services.

In an effort to prevent Medicare from making a conditional payment for future medical expenses that should be covered by workers' compensation, CMS has established a tracking process to notify Medicare contractors to discontinue conditional payments for diagnosis codes related to workers' compensation liability claims.

Some workers' compensation benefits result in a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA). This is an allocation of funds from a workers' compensation-related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare.

The creation of this new process will permit Medicare to generate an automatic claim denial for those patients with a set-aside arrangement. The patient would receive a message on the Medicare Summary Notice stating, "Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for future medical expenses and prescription drug treatment related to your injury(ies)." The provider denial message will have a related message indicating WCMSA should be responsible for the denied service.

Medicare can make payments under the set-aside provision once the set-aside amount is exhausted and accurately accounted for. Claims should be submitted reflecting the workers' compensation reason for non-payment for Medicare to consider payment.

Reference: Change Request (CR) 5371/MLN Matters[®] MM5371.

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WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

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

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

In these situations, providers should include documentation from the primary payer indicating the claim has been denied and/or benefits have been exhausted when submitting the claim to Medicare. Providers submitting claims on the CMS-1500 claim form should include necessary documentation from the primary payer indicating the reason for non-payment. Providers submitting electronic claims should indicate the reason for non-payment/non-coverage in the Claim Adjustment Segment (CAS).

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MEDICARE ADVANTAGE PLANS, ALSO KNOWN AS MEDICARE PART C, HMOs OR MEDICARE+CHOICE

Introduction

The Medicare Modernization Act (MMA) expanded the existing options available to Medicare beneficiaries to enroll in private health plans. Nearly 45 million people are covered by the Medicare program. Nearly 11 million beneficiaries are enrolled in Medicare Advantage plans. The Medicare Advantage plans, which include both coordinated care plans and private fee-for-service plans, generally provide more benefits at a lower cost to beneficiaries.

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

Medicare Advantage (MA) plans are health plan options that are approved by Medicare and run by private companies. They are part of the Medicare program and are sometimes called “Part C.” MA plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays a set amount of money to these private health plans for their members’ health care. **People must have both Medicare Part A and Part B to join an MA plan.**

MA plans provide Medicare covered benefits to members through the plan and may offer extra benefits that Medicare doesn’t cover, such as vision or dental services. Members may have to pay an additional monthly premium for the extra benefits. The plan may have special rules that its members need to follow. Plan members generally receive their Medicare-covered health care through that plan. Some plans also include Medicare prescription drug coverage. Benefits may be different from those in “traditional” Medicare and since each plan can vary, it is very important that people review the plan materials for details about copayment and coverage information.

Persons can join an MA plan when they first become eligible for Medicare (i.e., during their Initial Coverage Election Period, which begins three months immediately before the individual’s first entitlement to **both** Medicare Part A and Part B, the Medicare fall open enrollment period (also known as the “Annual Election Period”), the Medicare Advantage Open Enrollment Period, or in certain special situations that provide a Special Enrollment Period).

Generally, enrollment in a plan is for a year. People can only join one plan at a time.

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A person can make changes:

- During the Medicare fall open enrollment period, also referred to as the “Annual Election Period” (AEP).
- During the Medicare Advantage Open Enrollment Period (OEP).
- Under special circumstances:
 - If a person moves out of the service area or moves and new MA or Part D options are now available to them.
 - If a person qualifies for extra help to pay for Medicare prescription drug coverage.
 - If the plan decides to leave the Medicare program or reduce its service area at the end of the year, there are special rules that allow for enrollment in a different MA plan or original Medicare and a Medigap policy.

Medicare Fall Open Enrollment Period – This occurs every year November 15–December 31. Persons can make changes in their plan enrollment, including choosing which MA plan or Medicare Prescription Drug Plan they want to join for the upcoming year. They can also choose to return to original Medicare. Their new plan will start the following January 1.

Starting October 1 every year, MA plans could send information or make calls to persons with Medicare about the Medicare prescription drug coverage they are offering for the following year.

Organizations may conduct outbound telemarketing activities for health-related products to the extent permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. As long as they follow the processes outlined in Section 12 (page 142) of the Medicare Marketing Guidelines, all prescription drug plans approved by Medicare may use the Medicare Rx seal in their materials. The marketing guidelines can be found at:

http://www.cms.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp

Beneficiaries should call 1-800-MEDICARE if they are not sure if a plan is approved by Medicare.

MA plans must:

- Use marketing materials that have been submitted to CMS and reviewed according to the marketing guidelines and other applicable guidance.
- Comply with the “Do not call registry.”
- Provide beneficiaries with information in a professional manner.
- Use a state-licensed, certified or registered individual to perform marketing if the state has such a marketing requirement.

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MA plans may **not**:

- Solicit Medicare beneficiaries door-to-door prior to receiving an invitation.
- Send unsolicited e-mail to a beneficiary.
- Enroll people by phone, unless the person calls them.
- Offer beneficiaries cash payment as an inducement to enroll.
- Misrepresent or use high-pressure sales tactics to enroll a beneficiary.

The MMA allows for five categories of local Medicare Advantage plans:

- **HMO Plans** – Managed care plans that cover all Part A and B services and may provide extra services. Beneficiaries generally only go to doctors, specialists or hospitals that are part of the plan’s network, except in an emergency. *This type is generally the most restrictive (controls utilization by requiring referrals or restricting patients to a designated network of providers).*
- **Preferred Provider Organizations (PPOs)** – *Managed care that has a network of providers contracted to accept the plan’s reimbursement and coverage. Typically the patient has covered benefits whether provided by a network or outside of the network.*
- **Local Medicare PPO Plans** – Similar to an HMO plan but members can see any doctor or provider that accepts Medicare and do not need a referral to see a specialist. If the beneficiary goes to a provider who is not part of the plan’s network, it will generally cost more out-of-pocket. A Medicare Regional Preferred Provider Organization (RPPO) is structured like a local PPO and has a contracted network but serves an entire region or regions.
- **Regional PPOs (RPPOs)** – *These were introduced in an effort to expand the access of Medicare managed care to Medicare beneficiaries, including those in rural areas. This type plan can only be offered in a region established by CMS. A map of these regions can be found on the CMS Web site at: <http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/MAPDRegions.pdf>.*
- **Medicare Special Needs Plans (SNPs)** – Beneficiary membership is limited to certain groups of people, such as those in some institutions (like a nursing home) eligible for both Medicare and Medicaid, or with certain chronic or disabling conditions. *This plan provides eligibility for those entitled to medical assistance under a state plan and other high-risk groups of individuals with one or more severe or disabling chronic conditions specified by CMS. There are three SNP categories for the targeted population:*
 - *Chronic Conditions SNPs (C-SNPs) – Designed for beneficiaries with severe or disabling chronic conditions who would benefit from enrollment in a coordinated care plan.*
 - *Dual-eligible SNPs (D-SNPs) – Designed for beneficiaries entitled to medical assistance under both Medicare and a state’s Medicaid program (Title XIX of the Social Security Act).*

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- *Institutionalized SNPs (I-SNPs) – Serve beneficiaries who reside or are expected to reside for 90 days or longer in a long-term care facility. Beneficiaries living in the community but requiring a level of care equivalent to that of those individuals in long-term care facilities are also eligible to enroll in an I-SNP. (Note: An institutionalized individual is one who is residing or expected to reside for 90 days or longer in a Skilled Nursing Facility (SNF), Nursing Facility (NF), SNF/NF, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or inpatient psychiatric facility.*

There are two additional types of MA plans available:

- **Private Fee-for-Service (FFS) Plans** – Beneficiaries can go to any provider that accepts the plan's terms and conditions of payment and payment amounts, and may receive extra benefits. The private company decides how much it will pay and how much members will pay for services.
- **Medical Savings Account (MSA) Plans** – *This type of plan combines a high deductible and a medical savings account.* These plans typically have two parts. Under Part 1 of the MSA option, the beneficiary chooses a qualifying Medicare MSA high-deductible insurance plan. This health plan will not begin to pay covered costs until the person has met the annual deductible, which varies by plan. Part 2 is the MSA into which Medicare deposits premium money that the person with Medicare may use to pay health care costs. *An MSA is a trust or custodial account that is established in conjunction with an MA plan. An MSA trustee may be a bank, an insurance company or any other entity that is approved by the Internal Revenue Service to be a trustee or custodian of an Individual Retirement Account (IRA) and that meets CMS requirements.* The beneficiary uses the money in the Medicare MSA to pay for services provided before the *high* deductible is met and for other health care services not covered under the MSA plan.

Medicare Advantage Plans

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

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

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Medicare Advantage Plan Listing

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

Providers can verify Medicare eligibility for patients who have enrolled in an MA plan by calling the Interactive Voice Response (IVR) system. Notification that the patient has joined a plan, the effective dates and the identification number of that specific plan will be released.

CMS also has a plan directory that provides further information regarding an MA plan. The plan directory, listing all of the MA plans and identification numbers and addresses, can be found *on the TrailBlazer How Do I ... Web page.*

- *Access the How Do I ... Web page and click the Medicare Advantage Plan Codes link under “How Do I Find ...” at <http://www.trailblazerhealth.com/CustomService/HowDol.aspx>.*
- *This will open the File Download window. Select **Open**.*
- *Several file choices will be listed; select the file that best fits your search needs. Typically, there will be an Excel database along with PDF files to choose from. Medicare Advantage files are alphabetical listings of the current plans by name as well as by plan identification number and address information. These choices will allow a search for the information needed in a manner that is easiest for the provider.*

It is important to remember that:

- People who join a Medicare Advantage plan are still in the Medicare program.
- People who join a Medicare Advantage plan still have Medicare rights and protections.
- The MA plan will issue a member ID card that should be used in place of the “traditional” Medicare red, white and blue card.
- Through the plan, people who join a Medicare Advantage plan still receive all their regular Medicare-covered services that are offered under Part A and Part B.
- People who join a Medicare Advantage plan may receive additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing or dental care and/or health and wellness programs. Extent or duration of coverage may vary.
- *People who are members of a Medicare Advantage plan can switch back to “traditional” Medicare between January 1 – February 14. To disenroll from the plan, they must contact the MA plan directly or call 1-800-MEDICARE.*

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HOW TO SUBMIT A CLAIM FOR MEDICARE SECONDARY BENEFITS

Insurance Screening for Claim Submission

All providers and practitioners should screen their Medicare patients to obtain correct health insurance information before submitting a primary claim to Medicare. Patient screening is a vital step that is critical to every type of practice. Front office staff plays a key role in the success of claims being filed correctly and timely, just based on a few minutes spent up-front with the patient or the patient's responsible party.

Listed below are some questions that a provider may ask his patient during the confidential screening that will help the provider recognize circumstances where Medicare may be the secondary payer.

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

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

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

The *Patient Registration and Screening Guide*, located on the TrailBlazer Web site, offers tips/suggestions to enhance or implement patient screening within the office:

<http://www.trailblazerhealth.com/Publications/TrainingManual/PatientRegistrationScreening.pdf>

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Mandatory Claim Submission

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

Time Limits for Filing Claims

The Patient Protection and Affordable Care Act (PPACA) will change the claim filing time limit to one year after the date of service.

- Dates of service on or after January 1, 2010:
 - Must be filed within one calendar year after the date of service.

Participation Agreements for Physicians/Suppliers

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

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

Limiting Charge When Medicare Is Secondary Payer

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

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

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Primary Payer Billing Conflicts With Medicare Billing Requirements

Effective for services furnished on or after January 1, 2010, Medicare will no longer accept consultation codes. Special billing guidelines for MSP claims may apply.

Consultation Codes (CPT ranges 99241–99245 and 99251–99255)

If the primary payer for the services will accept the consultation codes, providers may bill in one of two ways:

Option 1: Bill the primary payer an Evaluation and Management (E/M) code that is appropriate for the service, then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for claim determination.

Option 2: Bill the E/M consultation code to the primary payer for a claim determination, then report the same billed amount and select a “covered” E/M code that is appropriate or representative of the consultation service and submit the secondary claim to Medicare for consideration. The claim will need to include the required MSP payment information, the primary allowed amount, the primary paid amount, etc. Providers may want to indicate in the patient’s medical records the change of procedure codes due to primary insurance billing guidelines versus Medicare claim submission guidelines.

Additional information can be found in MLN Matters® article MM6740:

<http://www.cms.gov/MLNMattersArticles/downloads/MM6740.pdf>.

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CMS-1500 Claim Form Instructions

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

Item 4 If the patient has insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word "Same." If Medicare is primary, leave blank.

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe John or SAME

Item 6 Check the appropriate box for patient's relationship to insured when Item 4 is completed.

6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>

Item 7 Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word "Same." Complete this item only when Items 4 and 11 are completed.

7. INSURED'S ADDRESS (No., Street)

Enter the street address on the first line, the city and state on the second line, and the ZIP code on the third line.

Note: *Enter the street address on the first line, the city and state on the second line and the ZIP code on the third line.*

Item 10a-c Check "Yes" or "No" to indicate whether employment, auto liability or accident applies to one or more of the services described in Item 24 (procedures). Enter the state postal code (e.g., Texas = TX) if auto accident is marked "Yes." In addition, a "Yes" checked in any of these fields indicates there may be another insurance primary to Medicare. Continue to Item 11 to identify primary insurance information.

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. AUTO ACCIDENT? PLACE (State)	
<input type="checkbox"/> YES	<input type="checkbox"/> NO _____
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

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Item 11 Item 11 must be completed. This is a **required** field. By completing this item, the physician or provider acknowledges having made a good-faith effort to determine whether Medicare is the primary or secondary payer. If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11a–11c. If there is no insurance primary to Medicare, enter the word "None". If there has been a change in the insured's insurance status, e.g., retired, enter the word "None" and proceed to Item 11b.

11. INSURED'S POLICY GROUP OR FECA NUMBER

Item 11a Enter the insured's eight-digit birth date (MM/DD/CCYY) and sex if different from Item 3.

a. INSURED'S DATE OF BIRTH	SEX
MM DD YY	M <input checked="" type="checkbox"/> F <input type="checkbox"/>
## ## ####	

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

b. EMPLOYER'S NAME OR SCHOOL NAME
ABC Factory

Item 11c Enter the nine-digit Payer ID identification number of the primary insurance plan or program. If no Payer ID number exists, enter the complete primary payer's program name or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in Item 11.

c. INSURANCE PLAN NAME OR PROGRAM NAME
#####

Item 11d Leave blank. Not required by Medicare.

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Item 29 Enter only the total amount the patient paid on the Medicare covered services.

Reminder: Providers should never enter the amount the primary insurance paid in Item 29 or the electronic equivalent.

29. AMOUNT PAID
\$ _____

Note: Do not enter the amount paid by the primary plan in Item 29 of the CMS-1500 claim form or the electronic equivalent. This field is for any amount the patient pays for covered Medicare services and should not be used for primary insurance payments.

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

Reminder: If there is insurance primary to Medicare (Medicare is secondary), enter the insured's policy or group number and proceed to Items 11a–11c. Items 4, 6 and 7 must also be completed. If there is no primary insurance to Medicare, enter the word "NONE" and proceed to Item 12. Claims with missing/incomplete/invalid information in this section will result in claim rejections and/or denials. Complete claim submission requirements can be found in the *CMS-1500 Claim Form and Unprocessable/Rejected Claims* manual on the TrailBlazer Web site at:

<http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf>

Electronic Claim Submission

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

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

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

Reminder: If a provider does not meet the limited exception criteria, claims will deny if they are submitted on the CMS-1500 claim form. The complete exception list can be

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found in the CMS Internet-Only Manual (IOM) Pub. 100-04, Chapter 24, Section 90.2, at:

<http://www.cms.gov/manuals/downloads/clm104c24.pdf>

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

- Screen Medicare beneficiaries for secondary coverage.
- Send claims to the primary insurance and then to Medicare.
- *Complete all the requirements for MSP claim submission and submit a copy of the primary insurance remittance notice along with the CMS-1500 claim form.*
- When filing electronically, a copy of the primary insurance company's *remittance notice is not* required. The electronic claim will require the submission of additional data elements.

Electronic Claim Submission Data Elements

Submitting an MSP claim electronically requires the submission of the following data elements:

- Insured's name.
- Patient's relationship to insured.
- Insured's address and telephone number.
- "Yes" or "No" response to whether service is related to employment, auto liability or accident. If yes, enter the state where auto accident occurred (if applicable).
- Subscriber's payer identification (group plan or plan name).
- Primary insurer type code.
- Amount paid by primary payer.
- *Primary insurance paid date.*
- OTAF amount.
- CAS codes.

Per the ASCA of 2001, MSP is not an exempt claim type and must be submitted electronically by covered entities. An MSP claim with more than one primary payer (Medicare tertiary) is an exemption to electronic billing *and a claim can be filed on the CMS-1500 claim form along with both insurance companies' remittance notice.*

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It is very important for the information submitted on the claim to match what the Common Working File (CWF) reflects. Medicare verifies each claim to CWF to verify the patient's name, Medicare number, eligibility, MSP benefits and other key patient eligibility items. Patient screening is more important now than ever in submitting claims correctly to Medicare. Instances where the provider does not submit accurate and/or consistent primary insurance information can lead to rejection of the claim.

Following is required information for submitting claims when Medicare is the secondary payer using the electronic 5010 format. This information would be entered in addition to the routine information that is populated for an electronic claim. The information listed crosswalks the CMS-1500 claim form to the electronic claim submission requirements. The primary payer's EOB is not required when submitting MSP claims electronically:

Note: The blue within the crosswalk indicates changes due to the transition to 5010 electronic billing.

The complete "Part B Crosswalk to the CMS-1500 Claim Form," for those providers that file electronically, can be found on the TrailBlazer Web site at:

<http://www.trailblazerhealth.com/Publications/Job Aid/Crosswalkto1500ClaimForm.pdf>

Examples from the Crosswalk:

Item #	Claim Description	Loop	Segment	Electronic Instructions	Status	Example	Requirements
4+	Insured's Name	2330A	NM103	Last Name	C	Doe	If the patient has insurance primary to Medicare, enter the insured's last name, first name and middle initial.
			NM104	First Name		John	
			NM105	Middle Name		X	
6+	Patient's Relationship to Insured	2000B	SBR02	Self Relationship	C	18	Must = Self (18) or Spouse (01) for Medicare
		2320	SBR02				
7+	Insured's Address	2330A	N301	Address Line 1	C	Address	Enter the insured's address and telephone number.
			N302	Address Line 2		Address	
			N401	City Name		City	
			N402	State Code		TX	
			N403	Zip Code		#####	
10 a-c	Is Patient's Condition related to Employment? Auto Accident? Other Accident?	2300	DTP01	Date of Accident		439	Required if date of accident is used.
			CLM11-1	Employment/Auto/Other Accident		AA	Auto accident
			CLM11-2			EM	Employment
			CLM11-4	Place (State)		OA	Other Accident
						TX	State

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11	Insured's Policy or Group Number/Information Medicare Secondary Payer (MSP) Information ONLY	2320	SBR01	Payer Responsibility	P	P	P = Primary, S = Secondary T = Tertiary
			SBR03	Insured's Group or Policy Number		###	Policy or Group number
		2330A	NM108	Identification Code Qualifier		MI	Member Identification Number
			NM109	Insured's Identifier		###	Other Subscriber's Primary Identifier
		2000B	SBR05	Insurance Type Code (Header Information)		12	Indicator must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43, or 47 if the 2000B SBR01 is "T" or "S".
		2000B or 2320	SBR09	Claim Filing Indicator Code		MB	Indicators – 09, T0, 11, 12, 13, 14, 16, AM, BL, CH, CI, DS, HM, LI, LM, MB, MC, OF, TV, VVC, ZZ.
		2320	SBR05	Insurance Type Code (Detail Line Information)		12	Indicators – 12, 13, 14, 15, 16, 41, 42, 43 or 47.
		2300	CLM01	Claim Submitter's Identifier		#####	Patient Account Number
			CLM02	Monetary Amount		\$\$\$\$\$	Total amount of All Submitted Charges
		2320 (header)	AMT01	Amount Qualifier Code		D	D = Primary Payer PAID Amount
			AB	AB = Non-Covered Amount			
			EAF	EAF = Remaining Patient Liability			
			AMT02	Monetary Amount			
		2400 (detail)	AMT01	Amount Qualifier			
			AMT02	Monetary Amount			
			\$\$\$	Dollar Amount			
			EAF	EAF = Amount owed by patient			
			\$\$\$	Remaining Patient Liability			

11 Cont	Insured's Policy or Group Number <i>Cont.</i> Medicare Secondary Payer (MSP) Information ONLY	2320 or 2430	CAS01	Claim Adjustment Group Codes	CO	CO, CR, OA, PI or PR	
			CAS02	Claim Adjustment Reason Codes		96	Reason Code
			CAS03	Adjustment Amount		\$\$\$\$\$	Monetary amount (03, 06, 09, 12, 15 or 18)
			CAS04	Adjustment Quantity		###	Adjustment Quantity (04, 07, 10, 13, 16 or 19).
		2330B (H) or 2430 (D)	DTP01	Primary Insurance Adjudication Date		573	573 = Date Claim Paid
			DTP02	Date Time Period Qualifier		D8	D8 = Date Expressed in format CCYYMMDD
			DTP03	Date Paid		Date	Adjudication or Payment Date
		2300 or 2400	CN101	Contract Type Code		09	Claim OTAF Amount
			CN102	OTAF Amount		\$\$\$	Monetary Amount
		2430	SVD01	Identification Code		###	Primary Payer Identifier
			SVD02	Primary Payer Paid Amount		\$\$\$	Service Line Paid Amount
			SVD03	Medical Procedure Identifier		Code	Procedure code used to pay this service
			SVD03-1	Service ID Qualifier		HC	HC = HCFA Common procedural coding.
			SVD03-2	Service ID		Code	Procedure Code
			SVD05	Quantity		###	Paid Service Unit count
		2330B	NM101	Entity Identifier Code		PR	PR = Payer
			NM102	Entity Type Code		2	2 = Non-Peron Entity
			NM103	Last Name or Organization		Cigna	Other Payer Last or Organization Name
			NM108	Identification Code Qualifier		PI	PI = Payer Identification
			NM109	Identification Code		###	Other Payer Primary Identification Number

11a	Insured's Date of Birth and Gender	Not Mapped				
11b+	Insured's Employer Name	Not Mapped				
11c+	Insured's Plan or Program Name	2320	SBR04	Other Insured's Group Name	C	Name Required if the Subscriber's Payer Identification Includes a Group or Plan Name.
11d	Leave Blank	Not Mapped				

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Electronic Data Elements Using the Electronic ASC X12 5010 Format

Insured's Name

If the patient has insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word "Same." If Medicare is primary, leave blank. The insured's name information should be submitted in the following loops/segments:

Loop 2330A	NM103	Last name
	NM104	First name
	NM105	Middle name

Patient's Relationship to Insured

Check the appropriate box for patient's relationship to insured when the insured's name is completed.

Loop 2000B SBR02

Or,

For Medicare purposes, indicate: Self=18 *or* Spouse=01

Loop 2320 SBR02

Insured's Address

Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word "Same." Complete this item only when the insured's name is required and the MSP primary insurance information is required and completed.

Loop 2330A	N301	Address line 1
	N302	Address line 2
	N401	City name
	N402	State code
	N403	ZIP code

Is Patient's Condition Related to Employment? Auto Accident? Other Accident?

Indicate whether employment, auto liability or accident applies to one or more of the services described in Loop 2400 (procedures). Enter the state postal code (e.g., Texas = TX) if auto accident is populated. In addition, if this field is populated, this indicates there may be another insurance primary to Medicare. Continue to Loop 2320 to identify primary insurance information.

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Primary Insurance Type Code

Code identifying the type of insurance policy within a specific insurance program. Required when the destination payer is Medicare and Medicare is not the primary payer. Insurance type code should be submitted in the 2000B SBR05 loop/segment *for header reporting or 2320 SBR05 loop/segment for detail line reporting.*

Select the appropriate insurance type code and enter in either 2000B SBR05 loop/segment for header reporting or 2320 SBR05 loop/segment for detail line reporting.

Examples:

- 12 Working Aged
- 13 End Stage Renal Disease (ESRD)
- 14 Auto/Med/No-Fault Liability
- 15 Workers' Compensation
- 16 Federal Agency (Public Health)
- 41 Federal Black Lung
- 42 Veterans Affairs
- 43 Disability
- 47 Other Liability

MSP Type Code Description/Definition

- 12 Working-Aged – Beneficiaries age 65 or older who are insured through their or their spouses' current employment. Employer's group plan has 20 or more employees. **Note:** This type must only be used for beneficiaries who are 65 years old or older on the date the service was rendered.
- 13 End Stage Renal Disease (ESRD) – Beneficiaries enrolled with Medicare solely due to renal failure and are insured through their own, or through a family member's former or current employment. **Note:** This type has no age restrictions.
- 14 Automobile/No-Fault – Insurance coverage (including a self-insured plan) 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.** This insurance includes, but is not limited to automobile, homeowners and commercial plans. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage." **Note:** This type has no age restrictions.
- 15 Workers' Compensation – Insurance that employers are required to provide to cover employees who become sick or are injured on the job. **Note:** This type has no age restrictions.
- 16 Federal Agency (Public Health) – Services that are the direct obligation of another federal, state or local governmental entity. **Note:** This MSP type code should not be used for those patients who are covered under Federal Blue Cross and Blue Shield (FEP BCBS). Medicare benefits should not be paid if the patient has a federal agency paying as primary. This would be an overlap of federal

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- services. Medicare will deny the service when MSP type 16 is billed.
- 41 Federal Black Lung – Coverage due to black lung disease and other respiratory conditions caused by coal mining, where a Medicare beneficiary may be entitled to have services reimbursed by the United States Department of Labor. **Note:** This type has no age restrictions.
- 42 Veterans Affairs – Veterans who are Medicare-eligible may elect whether Medicare or VA benefits will handle their claims. **Note:** This type has no age restrictions.
- 43 Disability – Beneficiaries under the age of 65, who are disabled and insured through their current employment or through the current employment of a family member. The plan has 100 or more employees. **Note:** If the basis of disability is ESRD, the ESRD type should be used when billing Medicare. The disability type should only be used for those beneficiaries who are under age 65 years of age on the date the service was rendered.
- 47 Other Liability – **Insurance** (including self-insured plans) that provides payment based on legal liability for injury, illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowner’s liability insurance, malpractice insurance, product liability insurance and general casualty insurance. **Note:** This type code should not be used to indicate working-aged, disability, ESRD, etc. This type code should only be used in the event the patient was involved in a liability type accident. This type has no age restrictions.

Difference Between Liability Insurance and Other Primary Insurance Plans

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

Reminder: MSP claims must be submitted with accurate primary insurance information to ensure the result is an accurate Medicare payment. Use of an incorrect MSP type code could result in a claim rejection.

Primary Insurance Amount Paid

For **detail line-level** services, physicians and suppliers must indicate the primary payer paid amount for that service line.

Loop *2400 AMT01* *Amount qualifier code* **EAF = Remaining patient liability**
AMT02 *Enter* \$\$\$ for the amount.

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	<i>charge; 119 = benefit maximum for this time period or occurrence has been reached.)</i>
CAS03	Adjustment amount (\$\$\$)
CAS04	Adjustment quantity

To ensure proper payment, providers are encouraged to compare the reason/remark codes that are received via the primary insurance company's Explanation of Benefits (EOB) to the Washington Publishing Company (WPC)-Electronic Data Interchange (EDI) code list. The code list is located at <http://www.wpc-edi.com/reference/>. Some primary insurance codes may differ from the WPC-EDI list and it is a good practice to verify those codes prior to Medicare claim submission.

Reminder: Providers are encouraged to verify the reason/remark code messages to ensure the message is complete. Some messages may require two CAS codes to provide the necessary information needed for claim processing.

The example below reflects a CAS code that would be necessary to use a secondary CAS code for additional information. An additional remark code should be included to indicate why the service was denied as non-covered. The WPC Web site will provide additional comments if more than one reason/remark code should be used.

Example: Adjustment Message 96

Non-covered charge(s). At least one remark code must be provided (may be composed of either the remittance advice remark code or reject reason code.)

Examples: Correct Claim Submission

PR-96 (patient responsible) non-covered charge(s) and PR-119 (patient responsible) benefit maximum for this time period or occurrence has been reached.

Or,

PR-96 (patient responsible) non-covered charge(s) and PR-38 (patient responsible) services rendered by a provider not authorized or designed (network/primary care) providers.
--

Reminders:

- It is important to verify the primary insurance remittance advice reason and remark codes to the WPC Web site to ensure the code and the remittance advice narrative description match the WPC narrative description for that reason/remark code. Inconsistent use of the reason/remark codes could result in incorrect secondary payment or claim rejection.

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- If the primary insurance allowed amount and/or the primary insurance paid amount is 0.00, providers *should* indicate the reason for no allowed amount as well as non-payment of the primary insurance *via CAS codes*.
- CAS codes communicate information about the status of a claim (i.e., paid, denied, rejected, non-covered). The CAS codes inform Medicare of the claim processing decision of the primary insurance company in place of submitting the primary insurance remittance notice.
- Multiple CAS codes can be entered in the CAS area.
- It **is not** acceptable to electronically transmit an MSP claim to Medicare and then routinely fax the primary insurance remittance advice.

Primary Insurance Paid Date

Loop 2330B (header-level) DTP01

Or

2430 (detail-level) DTP02

DTP03

Primary insurance adjudication date

(573 = Date claim paid)

Date time period qualifier

(D8 = Date expressed in format CCYYMMDD)

Adjudication or payment date

Primary Insurance Payment Information

Loop 2300

Or 2400

CN101

CN102

Contract type code (09 = OTAF amount)

\$\$\$ OTAF monetary amount

Obligation to Accept Payment in Full (OTAF)

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

Note: The OTAF amount must be greater than zero.

The OTAF information should *also* be identified by using the CAS group code Contractual Obligation (CO) to identify the CO adjustment amount. The CAS remark code should also be listed in the CAS to identify the amount of the OTAF.

An example of an OTAF CAS code from the primary remittance notice would be:

CO-45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. **Note:** The OTAF amount may not be easily identified on the primary insurance remittance advice. The OTAF is the amount the physician is obligated to accept and may be titled many ways on the primary insurance statement. Some examples might be: Contractual Allowed Amount, Provider Discount, Provider Adjusted Discount, Adjusted Provider Charge, Contracted/Contractual Amount, Negotiated Rate,

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Charges Exceed Contracted/Legislated Fee Arrangement or Provider Write-Off. The OTAF can also be any type of wording that states the patient is not responsible for the amount over the allowed amount or that the provider is prohibited from billing the patient for the difference.

The OTAF or CO, the group code and the amount should be taken from the primary insurance remittance notice to notify Medicare of the CO OTAF amount.

If a provider is obligated to accept, or voluntarily accepts, an amount as payment in full from the primary payer, the provider must use the group code CO to identify the contractual adjustment amount, also known as OTAF.

<i>Loop 2430</i>	<i>SVD01</i>	<i>Identification code (Enter the primary payer identifier)</i>
	<i>SVD02</i>	<i>Primary payer paid amount (Service line paid amount)</i>
	<i>SVD03</i>	<i>Medical procedure identifier (Procedure code used to pay this service)</i>
	<i>SVD03-1</i>	<i>Service ID qualifier (HC = Healthcare Common Procedural Coding)</i>
	<i>SVD03-2</i>	<i>Service ID (Procedure code)</i>
	<i>SVD05</i>	<i>Quantity (Paid service unit count)</i>
<i>Loop 2330B</i>	<i>NM101</i>	<i>Entity identifier code (PR = Payer)</i>
	<i>NM102</i>	<i>Entity type code (2 = Non-person entity)</i>
	<i>NM103</i>	<i>Last name or organization (Other payer/primary payer)</i>
	<i>NM108</i>	<i>Identification code qualifier (PI = Payer identification)</i>
	<i>NM109</i>	<i>Other payer primary identification number (Enter ID number)</i>
<i>Loop 2320</i>	<i>SBR04</i>	<i>Other insured's group name (Required if the subscriber's payer ID includes a group or plan name)</i>

Electronic MSP Claim Rejection Examples

- The Common Working File reflects Medicare is secondary to a disability record and the insurance belongs to the patient's spouse. The provider submitted the claim indicating working-aged information (type 12) reflecting the insured as

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“spouse.” The claim will be rejected by Medicare due to the conflicting MSP information. The conflict is that the CWF record reflects disability; however the claim indicates working-aged.

- The Common Working File reflects Medicare is the primary payer. The provider submitted the claim indicating “other liability” (type 47) indicating there should be an open liability accident record, however, did not indicate the date of the accident and none of the diagnosis codes submitted on the claim appear to be accident-related. The claim will be rejected by Medicare due to the conflicting MSP information. The conflict is the claim type of liability is not consistent with an accident type of diagnosis and no date of accident is provided on the claim.
- The Common Working File reflects Medicare is secondary to an End Stage Renal Disease (ESRD) record. The provider submitted the claim indicating disability (type 43). The claim will be rejected by Medicare due to the conflicting MSP information. The conflict is that the CWF record reflects ESRD; however, the claim indicates disability. The claim is inconsistent with the Common Working File.
- The Common Working File reflects Medicare is secondary to a working-aged record. The provider submitted the claim indicating auto/medical/no-fault liability (type 14) indicating an auto liability accident, however, did not indicate on the claim the date of the accident and none of the diagnosis codes appear to be accident-related. The claim will be rejected by Medicare due to the conflicting MSP information. The conflict is the CWF record indicates a working-aged file; however, the claim indicates the patient was in an auto accident, but adequate information was not submitted to alert Medicare that an auto liability record should be recorded. It is important to submit the correct type.
- The provider submits a secondary claim indicating the patient was the insured. The claim reflected “self” in loop 2000B/SBR02. The patient’s name was listed as the insured in loop 2010BA/NM103. The provider also indicated in a separate section within the electronic claim indicated the primary insurer was the “spouse” in loop 2320/SBR02. The Common Working File reflects Medicare is the primary payer. The claim will be rejected by Medicare due to the conflicting MSP insured information submitted with the claim. All loops/segments populated within the claim should contain a consistent patient relationship for correct processing.

The rejection examples above will reflect similar language on the Medicare Remittance Advice (MRA):

CO-16 Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).

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- MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
- N155 Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.

Reminder: Patient screening is vital in obtaining correct and up-to-date patient insurance information. The *Patient Registration and Screening Guide* offers tips to establish or enhance patient screening procedures within the office:

<http://www.trailblazerhealth.com/publications/trainingManual/patientRegistrationscreening.pdf>

Copayments: What You Need to Know

Participating Medicare providers must not accept from the beneficiary/patient any copayment or coinsurance upon services rendered when the primary payer is an employer Managed Care Organization or any other type of primary insurance. Providers must follow the MSP rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform the provider on the Medicare Remittance Advice (MRA) of the amount that may be collected from the beneficiary/patient. This change was implemented via CR 5488, March 2007.

HMO Secondary Claims Submission

Electronic: Medicare will pay secondary to the HMO's copayment amount. Submitting an electronic claim for HMO insurance does not require the submission of the primary payer's EOB, but does require the submission of five additional data elements as listed above. Once the claim has been processed by Medicare as secondary, the provider will be informed on the MRA of the amount that may be collected from the beneficiary/patient.

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When Medicare Is the Secondary Payer Following Two Primary Insurance Payers (Tertiary)

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

Note: Item 11 or the electronic equivalent should reflect the "first" primary payer and both primary remittance advices should be submitted along with the claim for consideration by Medicare.

Medicare Secondary Payer Calculator

To assist providers in the secondary payment calculations, an online feature has been added to the MSP page as well as the Self-Service Tools page on the TrailBlazer Web site at:

<http://www.trailblazerhealth.com/Tools/MSPPartbCalculator.aspx>

This tool is for providers needing assistance with calculating MSP payment amounts.

Note: This feature should only be used as an estimation to determine if the claim was correctly processed by both the primary payer and Medicare.

Understanding the Medicare Remittance Advice With MSP Claim Information

Several codes have been developed for the provider remittance advice. The three major code sets are:

- Group codes.
- Claim Adjustment Reason Codes (CARCs).
- Remittance Advice Remark Codes (RARCs).

CARCs and RARCs are updated three times a year. The latest codes may be viewed on the Washington Publishing Company's Web site at:

<http://www.wpc-edi.com/reference/>

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Group Codes

Group codes identify the financially responsible party or the general category of payment adjustment. A group code must always be used in conjunction with a CARC.

Group codes will always be shown with a reason code to indicate when a provider may or may not bill a beneficiary for the non-paid balance of the services furnished.

Payment Adjustment Category Description

- PR (Patient Responsibility).
- CO (Contractual Obligation).
- OA (Other Adjustment).
- CR (Correction or Reversal to a prior decision).

Group Code PR

All denials or reductions from the billed amount with group code PR are the financial responsibility of the beneficiary or his supplemental insurer (if it covers that service).

Due to the frequency of their use, separate columns have been set aside for reporting of deductible and coinsurance, both of which are also the patient's responsibility.

PR amounts, including deductible and coinsurance, are totaled in the Patient Responsibility field at the end of each claim.

Group Code OA

Group code OA is used when neither PR nor CO applies, such as with the reason code message that indicates the bill is being paid in full.

Group Code CR

Group code CR is used when there is a change to the decision on a previously adjudicated claim, perhaps as the result of a subsequent reopening.

Reminder: Group code CR explains the reason for change and is always used in conjunction with PR, CO or OA to show revised information.

Group Code CO

Group code CO is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial responsibility, such as:

- Participation agreement violation amounts.
- Limiting charge violations.
- Late filing penalties.

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- Amounts for services not considered being reasonable and necessary.

Claim Adjustment Reason Codes (CARCs)

These codes provide financial information about claim decisions. CARCs communicate an adjustment or why a claim (or service line) was paid differently than it was billed. If there is no adjustment to a claim/service line, then there is no need to use a CARC. The numeric code will appear after the group code. These codes can be found in the ADJ REASON CODES field on the Electronic Remittance Advice (ERA) and the RC field on the Standard Paper Remittance (SPR).

Examples of CARCs:

Code	Financial Information
1	Deductible amount
2	Coinsurance amount
3	Copayment amount

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Below is an example of an MSP claim. The MRA will reflect the primary payer paid amounts along with any Medicare allowed and paid amounts. The glossary at the end of the MRA will provide the claim details to make the necessary claim adjustments for office bookkeeping.

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	SMITH, MARY											
#####	0601 060110	11	1	99213			80.00	60.85	60.85	0.00	CO-45	19.15 0.00
											OA-23	31.89
											PR-23	-31.89
#####	0601 060110	11	1	73140			50.00	27.74	27.74	0.00	CO-45	22.26 0.00
											OA-23	22.31
											PR-23	-22.31
PT RESP	34.39											41.41
							130.00	88.59	88.59	0.00		0.00
											NET	

CLAIMS TOTALS

- MSP

MEDICARE PART B 880000000 1111111111 MEDICARE

PROVIDER #: ##### REMITTANCE

CHECK/EFT # 8800000000 08/21/10 PAGE #: ADVISE

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes

CO Contractual Obligation. Amount from which the provider is financially liable. The patient may not be billed for this amount.

OA Other Adjustments.

PR Patient Responsibility.

CR Correction and Reversals.

FB Forwarding Balance.

WO Withholding.

16 Claim/service lacks information which is needed for adjudication.

23 Payment adjusted due to the impact of prior payer(s) adjudication including payment and /or adjustments.

45 Charges exceed your contracted/legislated fee arrangement.

96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittant Advice Code or NCPDP reject Reason Code.)

109 Claim not covered by this payer/contractor. You must send this claim to the correct payer/contractor.

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

The MRA glossary will provide important details relating to the processed MSP claim.

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MSP claim scenario: Primary payer processed the claim with payment and Medicare processed the claim and applied the allowed amounts to the patient's 2010 Part B deductible.

Primary allowed	\$61.89	Medicare allowed	\$60.85
	<u>\$22.31</u>		<u>\$27.74</u>
	\$84.20		\$88.59
Primary paid	\$31.89 (OA-23)	Part B deductible	
	<u>\$22.31</u> (OA-23)	withheld	\$88.59
	\$54.20		
*Patient responsibility	\$30.00	Medicare paid	\$00.00

*This amount should not be collected up front from the patient. Refer to the MRA for final patient responsibility.

Does the patient have any financial responsibility after the primary payer determination and the Medicare determination?

Medicare allowed	\$88.59
Minus any Medicare payment(s)	- \$00.00
Minus any primary payment(s)	- <u>\$54.20</u>
Patient responsibility	\$34.39

Provider should collect \$34.39 from patient.

Detailed information regarding the MRA can be found in the *Medicare Remittance Advice (MRA)* manual on the TrailBlazer Web site at:

<http://www.trailblazerhealth.com/Publications/Training Manual/MRA.pdf>

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MSP Quick Reference Billing Guide

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

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

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

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

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

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

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REVISION HISTORY

Date	Section	Revision
February 2010	Medicare Advantage Plans	<ul style="list-style-type: none"> • Included MA plans also referenced to Medicare Part C. • Included updated statistics on the number of people on Medicare and enrolled in MA benefits. • Added clarification to the type of services MA plans offer. • Added additional information on Medical Savings Accounts. • Added tips to remember for MA beneficiaries. • Removed references to Medicare+Choice, using Medicare Advantage as primary reference.
	Electronic Claim Submission	<ul style="list-style-type: none"> • Added clarification to mandatory electronic claim submission versus CMS-1500 claim form to those meeting the limited exception requirements. • Changed format of the loops/segments under the following sections: <ul style="list-style-type: none"> ○ Primary insurance amount paid. ○ Primary insurance allowed amount. ○ OTAF. ○ CAS billing requirements. • Added reminder to verify WPC-EDI Web site reason/remark codes to those listed on the primary EOB. • Added detailed electronic billing loops/segments for CAS segment. • Removed requirement to enter the date the primary payer paid/adjudicated the claim. This is not an electronic billing requirement so the entire billing reference was

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Date	Section	Revision
		<p>removed.</p> <ul style="list-style-type: none"> Removed the entire "Patient Screening and Registration" section. This section was removed and a new manual was developed for the Web site, titled Patient Screening and Registration.
April 2010	Veterans' Benefits	Updated language to indicate wording on claim to indicate "the VA has not preauthorized or authorized the claim" versus claim not filed or will not be filed to the VA for consideration.
	Time Limits for Filing Claims	The Patient Protection and Affordable Care Act (PPACA) changed the claim filing time limits. New guidelines included.
	MSP Type Code Description/Definition	Added CMS language to clarify differences between liability insurance and other primary plans.
	All Sections	Updated CMS Web site addresses.
August 2010	Medicare Advantage Plan Listing	Updated CMS Web site link to direct to the current MA plan directory.
	Electronic Claim Submission	Included the electronic equivalent of Items 4, 6 and 7 of the CMS-1500 claim form to the electronic submission requirements.
	When Medicare Is the Secondary Payer Following Two Primary Insurance Payers	Included the word "tertiary" in this section to associate the two meanings together.
	Understanding the Medicare Remittance Advice With MSP Claim Information	Included MRA reason and remark code information along with an excerpt of an MRA that reflects an MSP claim example.
	COBC Contact Information	Data Match Project and MSP Claims Investigation Project address updates.
	MSPRC	Added MSPRC fax number and requirements for information when submitting information in writing.
October 2010	MSPRC	<ul style="list-style-type: none"> MSPRC mailing addresses updated. Added reminders for MSPRC

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Date	Section	Revision
		fax/correspondence.
November 2010	MSP Type Code and Type Code Description/Definition	Added MSP type code 16 along with description and note to indicate proper use.
March 2011	MSP Type Code Description/Definition	Updated definition of MSP types : 14 – Auto Medical/No-Fault 47 – Liability
July 2011	COBC Contact Information	Added additional COBC requirements for incoming calls without complete information.
	Black Lung Disease	Added additional coverage information.
	United Mine Workers Association (UMWA)	Added additional coverage information, updated contact phone numbers, and included address to mail paper claims and Web site link for further research.
	MSP Calculator	New MSP calculator feature added to the TrailBlazer Web site. This section was updated to include link to the new self-service tool.
October 2011	Primary Payer Billing Conflicts With Medicare Billing Requirements	Included billing guidelines for consultation procedure billed to the primary; however, Medicare does not accept consultation CPT codes as of January 2010.
	Electronic Data Elements Using the Electronic v4010 Format	Updated the WPC-EDI Web link for the Companion Guide.
<i>February/March 2012</i>	<i>COBC Contact Information</i>	<ul style="list-style-type: none"> • <i>Included a general address in this section.</i> • <i>Included additional information needed when calling the COBC.</i> • <i>COBC new process effective April 2012. MLN Matters® Number SE1205.</i>
	<i>Important Contacts for MSP Recovery Contractor</i>	<ul style="list-style-type: none"> • <i>New CMS contractor handling MSP recoveries, Group Health Inc.</i> • <i>Fax for MSPRC correspondence updated.</i>
	<i>MSP Reopening for Claims Paid as Secondary</i>	<ul style="list-style-type: none"> • <i>Clarification of MSP claim reopening guidelines.</i>

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Date	Section	Revision
	<i>Medicare Advantage Plans</i>	<ul style="list-style-type: none"> • Updated the various categories of local Medicare Advantage plans. • Included information for additional plans available. • Added disenrollment information to the “Important to Remember” section. • Updated CMS link to Medicare Advantage plan listing.
	<i>CMS-1500 Claim Form Instructions</i>	<ul style="list-style-type: none"> • Included example of the claim form field for each item required. • Added additional information to Item 7 instructions.
	<i>Electronic Claim Submission</i>	<ul style="list-style-type: none"> • Updated required data elements. • Updated examples from the Part B Crosswalk to the CMS-1500 Claim Form that are required for MSP due to the ANSI Version 5010 transition. • Updated the loops/segment section to include the requirements for ANSI Version 5010 electronic billing of MSP claims.