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

Medicare Learning Network®
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Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff

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The Medicare Secondary Payer (MSP) provisions protect the Medicare Trust Fund. Compliance with the MSP provisions contributes to the appropriate use of Medicare funds. This publication provides a general overview of the MSP provisions and outlines your responsibilities. When "you" is used in this publication, we are referring to providers, physicians, other suppliers, and billing staff, unless stated otherwise.

Please note: The information in this publication applies only to the Medicare Fee-For Service Program (also known as Original Medicare).

Table 4. Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Stay Up to Date

To sign up for automatic updates, select the "Subscription Sign-up for COB&R Overview Web Page Update Notification" link on the Coordination of Benefits & Recovery Overview webpage.

What Is MSP?

The MSP provisions protect the Medicare Trust Fund by ensuring Medicare does not pay for items and services when other health insurance coverage is primary to Medicare. The MSP provisions apply to situations where Medicare is not the primary or first payer of claims. In these cases, the MSP requirements provide the following benefits for you and the Medicare Program:

- **National program savings** – The Centers for Medicare & Medicaid Services (CMS) enforcement of the MSP provisions saved the Medicare Program roughly $8.5 billion in Fiscal Year (FY) 2015.
- **Increased provider, physician, and other supplier revenue** – If you bill a primary plan before billing Medicare, you may get more favorable reimbursement rates. Also, properly coordinated health coverage may expedite the payment process and reduce your administrative costs.
- **Avoidance of Medicare recovery efforts** – If you file claims correctly the first time, you prevent future Medicare recovery efforts on claims.

To get these benefits, you must access accurate, up-to-date information about your Medicare beneficiary's health insurance coverage. Medicare regulations require anyone submitting Medicare claims to determine whether Medicare is the primary payer for items or services provided to the beneficiary.

When Does Medicare Pay First?

Primary payers have first responsibility to pay a claim first. Medicare pays first for beneficiaries in the absence of other primary insurance or coverage. Medicare may also pay first when the beneficiary has other insurance coverage but a special condition exists. Table 1 lists some common situations where a beneficiary has both Medicare and other health plan coverage and lists which entity pays first (primary payer) and pays second (secondary payer).

Definition of "Spouse"

"Spouse," under the MSP Working Aged provisions, includes both same-sex and opposite-sex marriages. Find more information in MLN Matters® Article MM8875 about the definition of spouse.

Table 1. Analysis of Common MSP Coverage Situations

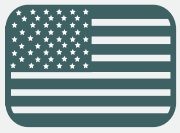
Individual	Condition	Pays First	Pays Second
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment	The individual is entitled to Medicare The employer has less than 20 employees	 Medicare	 GHP
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The individual is entitled to Medicare The employer has 20 or more employees, or the employer is part of a multi-employer group with at least one employer employing 20 or more individuals	 GHP	 Medicare
Is age 65 or older, has an employer retirement GHP, and is not working	The individual is entitled to Medicare	 Medicare	 Retiree Coverage
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has less than 100 employees	 Medicare	 GHP
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has 100 or more employees, or the employer is part of a multi-employer group with at least one employer employing 100 or more individuals	 GHP	 Medicare

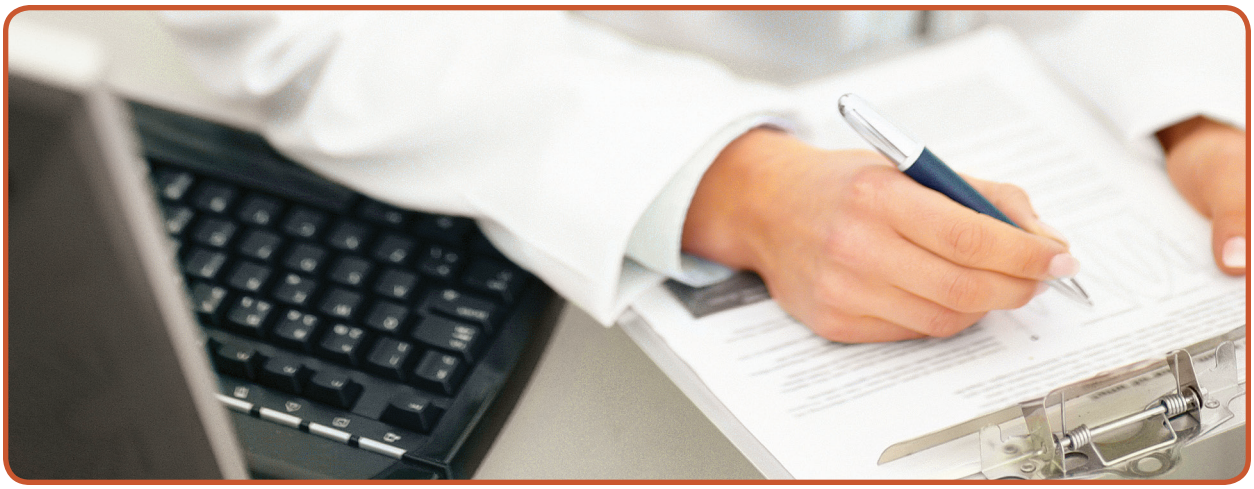
Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Has End-Stage Renal Disease (ESRD) and GHP coverage was the primary plan prior to the individual becoming eligible and entitled to Medicare based on ESRD	First 30 months of Medicare eligibility or entitlement	 GHP	 Medicare
Has ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage prior to becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement	 COBRA	 Medicare
Has ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury	The individual is entitled to Medicare	WC for health care items or services related to job-related illness or injury  Workers' Compensation * See section titled, "When May Medicare Make a Conditional Payment?"	 Medicare

Table 1. Analysis of Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Was in an accident or other situation where no-fault or liability insurance is involved	The individual is entitled to Medicare	1) No-fault or liability insurance for accident- or other situation-related health care services claimed or released  **Accident** * See section titled, "When May Medicare Make a Conditional Payment?" 2) WC, Liability, or No-Fault where ongoing responsibility for medicals (ORM) is reported. Medicare does not make a payment	 **Medicare** **Note**: For ORM, Medicare does not make a payment until ORM funds are exhausted
Is age 65 or older **or** is disabled and covered by Medicare and COBRA	The individual is entitled to Medicare	 **Medicare**	 **COBRA**

NOTE: For more instances of how Medicare works with other government payers, take the Medicare Learning Network® (MLN) Web-Based Training Course "Medicare Secondary Payer Provisions."



Are There Exceptions to the MSP Provisions?

There are no exceptions to the MSP provisions. Federal law takes precedence over State laws and private contracts. Even if an entity believes it is the secondary payer to Medicare due to State law or the contents of its insurance policy, the MSP provisions apply when billing for services.

What Happens if the Primary Payer Denies a Claim?

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

- A no-fault or liability insurer does not pay during the "paid promptly" period or denies the medical bill
- A WC program does not pay during the "paid promptly" period or denies payment (for example, where WC excludes a particular medical condition)
- Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) or the ORM benefits terminate or exhaust
- A GHP denies payment for services because:
  - The beneficiary exhausted plan benefits for particular services
  - The beneficiary is not entitled to benefits under the GHP
  - The beneficiary needs services not covered by the GHP

When submitting a claim to Medicare in these situations, you should include information showing why the other payer denied the claim, made an exhausted benefits determination, or did both.

When May Medicare Make a Conditional Payment?

Frequently, there is a long delay between an injury and the decision by the primary payer in a contested compensation case. Medicare may make conditional payments to avoid imposing a financial hardship on you and the beneficiary while awaiting a decision in a contested case.

Medicare can make conditional payments on behalf of beneficiaries for Medicare-covered services even if it is not the primary payer. Medicare may make conditional payments for covered services in liability (including self-insurance), no-fault, and WC situations if both the following are true:

- Liability (including self-insurance), no-fault, or WC insurer is responsible for payment
- The claim is not expected to be **paid promptly**

NOTE: Medicare has the right to recover any conditional payments. The Benefits Coordination & Recovery Center (BCRC) recovers conditional payments when the Medicare beneficiary receives a settlement, judgment, award, or other payment.

If there is a primary GHP and the provider does not bill the GHP first, Medicare may not pay conditionally on the liability (including self-insurance), no-fault, or WC claim. Providers must bill the GHP before billing Medicare, and the primary payer payment information that appears on all primary payer remittance advices **must appear on the claim submitted to Medicare**.

Medicare will not make conditional payments associated with WCMSAs and/or where there is ORM.

"Paid Promptly" Definition

For no-fault insurance and WC claims, "paid promptly" means payment within 120 days after the no-fault insurance or WC carrier received the claim for specific items and/or services. Without contradicting information, the date of service for specific items and services must be treated as the claim date when determining the "paid promptly" period. Furthermore, regarding inpatient services, without contradicting information, the date of discharge must be treated as the date of service when determining the "paid promptly" period.

For liability insurance (including self-insurance), "paid promptly" means payment within 120 days after whichever of the following occurs first:

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

For more information on conditional payments, refer to the following sections of the Medicare Secondary Payer Manual:

- Chapter 1, Section 10.7
- Chapter 3, Sections 30 and 40
- Chapter 5, Section 40
- Chapter 6, Sections 40.3 and 60

All Non-Group Health Plan (NGHP) claims must first be sent to the liability insurance (including self-insurance), no-fault insurance, or a WC insurer. Refer to MLN Matters® Article MM7355 for instructions on submitting a claim for conditional payment.

Ongoing Responsibility for Medicals (ORM)

Pursuant to Section 1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a WC law or plan, hereafter, referred to as NGHP. Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted. All NGHP claims must first go to the liability insurance (including self-insurance), no-fault insurance, or a WC insurer.

How Is Beneficiary Health Insurance or Coverage Information Collected and Coordinated?

Coordination of Benefits (COB) allows plans that provide coverage for a person with Medicare to determine their respective payment responsibilities. The BCRC collects, manages, and reports other insurance coverage for Medicare beneficiaries. **Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the BCRC to coordinate the information.**

COBA Program

The COB Agreement (COBA) program establishes a national standard contract between the BCRC and other health insurance organizations for transmitting enrollee eligibility data and Medicare-paid claims data. This means Medigap plans, Part D plans, employer supplemental plans, and others rely on a national repository of information with unique identifiers to receive Medicare-paid claims data for the purpose of calculating their secondary payment. The COBA data exchange processes include prescription drug coverage.

COB relies on many databases maintained by stakeholders, including Federal and State programs; plans that offer health insurance, prescription coverage, or both; pharmacy networks; and a variety of assistance programs. Some of the methods to obtain COB information are:

- **IRS/SSA/CMS Data Match Project** – Federal law requires the Internal Revenue Service (IRS), Social Security Administration (SSA), and CMS to share information about Medicare beneficiaries and their spouses. Employers complete an online Data Match Questionnaire that requests GHP information on identified employees entitled to Medicare or married to a Medicare beneficiary where the GHP may be primary to Medicare. As an alternative to the Data Match Questionnaire, employers may enter into an employer Voluntary Data Sharing Agreement (VDSA).
- **VDSA** – The VDSA allows CMS and an employer to electronically exchange GHP eligibility and Medicare information. The VDSA includes Medicare Part D information enabling VDSA partners to submit primary or secondary records with prescription drug coverage to Part D.
- **MSP Mandatory Reporting Process** – Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) adds mandatory MSP reporting requirements for GHP insurance arrangements, liability insurance (including self-insurance), no-fault insurance, and WC (NGHPs) to report beneficiary MSP information. For more information, visit Mandatory Insurer Reporting for GHPs or Mandatory Insurer Reporting for NGHPs.
- **MSP Claims Investigation** – The BCRC initiates an investigation when it learns another insurance plan may have primary responsibility for paying the beneficiary's Medicare claims. The BCRC determines if there is missing information on MSP records or MSP cases. Single-source investigations offer a centralized location for MSP-related inquiries. Investigations involve collecting data on other health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources.
- **ECRS** – The Electronic Correspondence Referral System (ECRS) is a web-based application that allows Medicare contractor representatives and the CMS Regional Office MSP staff to electronically transmit MSP information to the BCRC.

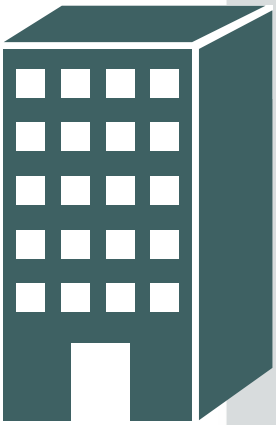
IEQ Update

In the past, the Initial Enrollment Questionnaire (IEQ) gathered COB information from beneficiaries enrolling in Medicare. The law enforcing the IEQ was repealed, and the IEQ is no longer included in Medicare's initial enrollment package.

For more information on the BCRC, refer to the Medicare Secondary Payer Manual, Chapter 4.

What Are Your Responsibilities under the MSP Provisions?

Part A Institutional Provider (that is, Hospitals)



Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information such as group health coverage through employment or non-group health coverage resulting from an injury or illness.

Bill the primary payer before billing Medicare, as required by the Social Security Act.

Submit any MSP information on your Medicare claim using proper payment information, value codes, condition and occurrence codes, etc. (If submitting an electronic claim, provide the necessary fields, loops, and segments to process an MSP claim.)

Part B Provider (that is, Physicians and Suppliers)

Gather accurate MSP data to determine whether or not Medicare is the primary payer by asking Medicare beneficiaries, or their representatives, for information such as group health coverage through employment or non-group health coverage resulting from an injury or illness.

Bill the primary payer before billing Medicare, as required by the Social Security Act.

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

NOTE: Normal timely filing requirements apply for Medicare-covered services. For more information, refer to the Medicare Claims Processing Manual, Chapter 1, Section 70.

How Do You Gather Accurate MSP Data from the Beneficiary?

As a Medicare provider, you must determine whether Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter prior to submitting a claim to Medicare. You can do this by asking Medicare beneficiaries about other coverage. The questions you ask can help you verify the Common Working File (CWF) information is correct and up to date.

Tip for Providers

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

CMS developed an MSP questionnaire for providers to help identify other payers that may be primary to Medicare. This questionnaire models the type of questions that help identify MSP situations. Refer to the MSP questionnaire in the Medicare Secondary Payer Manual, Chapter 3, Section 20.2.1. Your Medicare Administrative Contractor (MAC) may also offer questionnaire tools.

You should retain a copy of completed MSP questionnaires for at least 10 years after the date of service. You may keep hard copy files, optical images, microfilms, or microfiches. If you store these files online, you must keep both negative and positive responses to questions.

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

- The MAC receives a claim with an EOB attached, or remittance advice, from an insurer other than Medicare
- The beneficiary self-reports or beneficiary's attorney identifies an MSP situation
- The third-party payer submitted MSP information to a MAC or the BCRC

For more information on "Secondary Claim Development," visit the CMS Reporting Other Health Insurance webpage.

What Happens if You Submit a Claim to Your MAC without Providing the Other Insurer's Information?

Medicare may erroneously pay the claim as primary if it meets all Medicare requirements, including coverage and medical necessity guidelines. However, if the beneficiary's MSP record in the CWF indicates another insurer should have paid primary to Medicare, Medicare will deny the claim. If the MAC does not have enough information on the claim or correspondence, it may forward the information to the BCRC, and the BCRC may send the beneficiary, employer, insurer, or attorney an SCD Questionnaire for additional information. The BCRC will review the response information on the questionnaire and take the proper action.

For more information on proper MSP billing, refer to the Medicare Secondary Payer Manual, Chapter 3.

What Happens if You Fail to File Correct and Accurate Claims?

You must file a proper and timely claim with the appropriate primary payer. Not filing a proper and timely claim with the appropriate primary payer may result in a claim denial by that payer. Policies vary depending on the payer; please check with the payer to learn about its specific policies.

Federal law permits Medicare to recover its erroneous payments. Medicare will require the return of any payment it erroneously paid as the primary payer. Also, Medicare can fine providers, physicians, and other suppliers up to $2,000 for knowingly, willfully, and repeatedly providing inaccurate information related to the existence of other health insurance or coverage.

Who Do You Contact with MSP Questions?

Table 2 provides information about who to contact for specific MSP-related questions or situations.

Table 2. Who to Contact for MSP Questions

Contact	Question
BCRC Customer Service Representatives Monday through Friday (except holidays) 8 am to 8 pm, ET Toll free lines: 1-855-798-2627 Text Telephone (TTY) or Telecommunication Device for the Deaf (TDD) 1-855-797-2627 for the hearing and speech impaired	• Questions about Medicare development letters and questionnaires • Report a beneficiary's accident/injury • Report changes to a beneficiary's health coverage • Report potential MSP situations • Verify Medicare's primary/secondary status • Contact Medicare's Commercial Recovery Center (CRC) For guidance on reporting changes to a beneficiary's health coverage, refer to MLN Matters Article SE1416. **NOTE**: The BCRC will not release insurer information. The provider must request MSP information from the beneficiary prior to billing. To protect the rights and information of our beneficiaries, the BCRC cannot disclose this information.
MAC For contact information for your MAC, visit the Review Contractor Directory – Interactive Map.	• Questions about Medicare claim or service denials and adjustments • Questions concerning how to bill • Questions about the processing of a specific claim • Return inappropriate Medicare payments

See the BCRC contacts webpage for specific mailing addresses within the BCRC and CRC.

GHP recoveries are the responsibility of Medicare's CRC, and liability, no-fault, and WC recoveries are the responsibility of the BCRC. Two exceptions to this rule are:

- Recovery demand letters issued by the MSP Recovery Auditors under the demonstration authorized by the Medicare Modernization Act of 2003
- MSP recovery demand letters issued by MACs to providers, physicians, and other suppliers

Resources

Table 3 provides resources about MSP provisions.

Table 3. Resources

Resource	Location
CMS MSP Website	CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html
"Medicare & Other Health Benefits: Your Guide to Who Pays First"	Medicare.gov/pubs/pdf/02179.pdf
MLN Matters Article SE1217 "Guidance for Correct Claims Submission When Secondary Payers Are Involved"	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1217.pdf
MLN Guided Pathways	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/ Downloads/Guided_Pathways_Provider_ Specific_booklet.pdf

Table 4. Hyperlink Table

Embedded Hyperlink	Complete URL
BCRC Contacts	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html
Coordination of Benefits & Recovery Overview	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html
Mandatory Insurer Reporting for GHPs	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html
Mandatory Insurer Reporting for NGHPs	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html
Medicare Claims Processing Manual, Chapter 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
Medicare Learning Network® (MLN) Web-Based Training Course	https://learner.mlnlms.com

Table 4. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Medicare Secondary Payer Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html
Medicare Secondary Payer Manual, Chapter 3	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf
Medicare Secondary Payer Manual, Chapter 4	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c04.pdf
MLN Matters® Article MM7355	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf
MLN Matters® Article MM8875	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8875.pdf
MLN Matters Article SE1416	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf
Reporting Other Health Insurance	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Reporting-Other-GHP-Insurance/Reporting-Other-Health-Insurance.html
Review Contractor Directory – Interactive Map	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Section 1862(b)(2)(A)(ii) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1862.htm#act-1862-b

Check out CMS on: