# mln
## BOOKLET

# Medicare Secondary Payer

# Table of Contents

# What's Changed?

- Added clarification for situations where a Group Health Plan (GHP) is the primary payer but doesn't pay in full for a service (page 5)
- The Benefits Coordination & Recovery Center (BCRC) and the Commercial Repayment Center (CRC) are now referred to as the Medicare Secondary Payer (MSP) contractor (throughout)
- Added clarification for situations where Medicare Administrative Contractors (MACs) incorrectly deny claims because the services performed for an accident or injury aren't related to the liability, no-fault, or Workers' Compensation MSP occurrence found on Medicare patient records (page 9)
- Added the address of where to send Federal Black Lung Program claims (page 11)
- Added clarification about where to find the claim adjustment segment and identifying the correct claim adjustment reason code or we may deny the claim (page 12)
- Added clarification about Ongoing Responsibility for Medicals (ORM), no-fault insurance denials, and Medicare conditional payments (page 14)
- Added clarification about provider responsibilities if they discover an MSP record for a patient and how to bill appropriately (page 16)

Substantive content changes are in dark red.

Medicare Secondary Payer (MSP) provisions protect Medicare from paying when another entity should pay first. Any entity providing items and services to Medicare patients must determine if Medicare is the primary payer.

> **Stay Informed**
>
> To sign up for automatic updates regarding MSP or Coordination of Benefits (COB) issues, enter your email address at the bottom of the Coordination of Benefits & Recovery Overview webpage.

## MSP Provisions

The MSP provisions prevent Medicare from paying for items and services when patients have other primary health insurance coverage. In these cases, the MSP provisions contribute to:

- **National program savings:** MSP provisions saved the Medicare Program nearly $9.17 billion in FY 2022.
- **Increased provider, physician, and other supplier revenue:** Billing a primary plan before Medicare means you may get better payment rates. Coordinated health coverage may speed up the payment process and reduce administrative costs.
- **Avoiding Medicare recovery efforts:** Filing claims correctly the first time prevents future Medicare claim recovery efforts.

To get these benefits, it's important to get correct and current patient health insurance coverage information during the registration or admissions process. Medicare provisions require providers to determine the primary or secondary payer of benefits for patient items or services before submitting claims.

## When Medicare Pays First

We (Medicare) pay first for patients who don't have other primary insurance or coverage primary to Medicare. In certain situations, we may pay first when the patient has other primary insurance coverage. Situations where we pay first include, but aren't limited to:

- The patient hasn't met their primary payer deductible
- The insurer doesn't cover the service
- The patient exhausted their insurance benefits

Primary payers and settlement funds designed to cover all future services related to a settled injury or illness (for example, Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)) must pay a claim first.

In Table 1 we list common situations when a patient has Medicare and other health insurance. For each situation, we list which entity pays first (primary payer) and the entity that pays second (secondary payer).

**Table 1. Common MSP Coverage Situations**

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| 65 or older and has Group Health Plan (GHP*) coverage through current employment or spouse's current employment | Entitled to Medicare<br><br>Employer has **less** than 20 employees | **Medicare** | **GHP** |
| 65 or older and has GHP coverage through current employment or spouse's current employment | Entitled to Medicare<br><br>Employer has 20 or **more** employees or is part of a multiple or multi-employer group with at least 1 employer employing 20 or **more** people | GHP | **Medicare**<br><br>**Note:** If the GHP is the primary payer but doesn't pay in full, we may pay secondary to cover the remaining amount the GHP doesn't pay if it's a service Medicare covers. If the GHP denies payment because the plan doesn't cover the service, we may pay primary if it's a service Medicare covers. |
| 65 or older, has employer retirement GHP coverage, and isn't working | Entitled to Medicare | **Medicare** | Retiree coverage |
| Under 65, disabled, and has GHP coverage through their current employment or a family member's current employment | Entitled to Medicare<br><br>Employer has **less** than 100 employees | **Medicare** | GHP |

Medicare Learning Network®

**Table 1. Common MSP Coverage Situations (cont.)**

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| Under 65, disabled, and has GHP coverage through their current employment or a family member's current employment | Entitled to Medicare<br><br>Employer has 100 or **more** employees or is part of a multiple or multi-employer group with at least 1 employer employing 100 or **more** people | GHP | **Medicare** |
| Federal Black Lung Program (FBLP) coverage | Entitled to FBLP coverage<br><br>Medicare covers services or items **not** related to the Black Lung diagnosis | FBLP | **Medicare** |
| ESRD and GHP coverage was primary before the person became eligible or entitled to Medicare based on ESRD diagnosis | Before 30 months of Medicare eligibility or entitlement | GHP | **Medicare** |
| ESRD and has GHP coverage | After 30 months of Medicare eligibility or entitlement | **Medicare** | GHP |
| ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage before the person became eligible or entitled to Medicare | First 30 months of Medicare eligibility or entitlement | COBRA | **Medicare** |
| ESRD and has COBRA coverage | After 30 months of Medicare eligibility or entitlement | **Medicare** | COBRA |

**Table 1. Common MSP Coverage Situations (cont.)**

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| Parts A and B coverage under a Medicare Advantage (MA) Plan | Also has a GHP Health Reimbursement Account (HRA) | Contact MA Plan for billing guidance. | None (employer pays person from HRA for out-of-pocket expenses) |
| **Workers' Compensation (WC) coverage because of job-related illness or injury | Entitled to Medicare | WC pays health care items or job-related illness or injury services first (see the Conditional Payments section).<br><br>When a WC case settles, a WCMSA may substitute for WC coverage. | **Medicare** |
| **In an accident or other incident, including auto accidents, where there's no-fault or liability insurance | Entitled to Medicare | No-fault or liability insurance pays accident- or other incident-related health care services first (see the Conditional Payments section).<br><br>WC, liability, or no-fault pays first when the Responsible Reporting Entities (RREs) report  Ongoing Responsibility for Medicals (ORM).<br><br>Medicare doesn't pay.<br><br>**Accident** | **Medicare**<br><br>**Note:** For ORM, Medicare doesn't pay until ORM funds exhaust. |

Medicare
Learning
Network®

**Table 1. Common MSP Coverage Situations (cont.)**

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| **In an accident or other incident where there's no-fault or liability insurance | Patient has no-fault or liability insurance but refuses to give the information | Determination happens after submitting the claim to Medicare. The MSP contractor works with the patient to determine who's the primary payer. We also find out who's primary through Section 111 reporting. | To be determined |
| 65 or older, **or** disabled and has Medicare and COBRA coverage | Entitled to Medicare | **Medicare** | COBRA |
| Dually eligible patient regardless of eligibility reason | Enrolled in Medicare and Medicaid | **Medicare** | Medicaid |
| Has Medicare coverage **and** a Medicare supplement insurance (Medigap) plan | Entitled to Medicare | **Medicare** | Medigap |
| Active-duty status military member | Entitled to Medicare and TRICARE | TRICARE | **Medicare** |

**Table 1. Common MSP Coverage Situations (cont.)**

| Patient | Situation | Pays First | Pays Second |
|---|---|---|---|
| Inactive status military member treated by civilian providers | Entitled to Medicare and TRICARE | **Medicare** | TRICARE |
| Inactive status military member treated at a military hospital or by other federal providers | Entitled to Medicare and TRICARE | TRICARE | **Medicare** |

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

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

Medicare Administrative Contractors (MACs) may incorrectly deny claims because the services performed for an accident or injury aren't related to the liability, no-fault, or WC MSP occurrence found on the patient's eligibility file. Although claim services aren't related to the accident or injury, the provider may use diagnosis codes on the claim that are within the family of diagnosis codes found on the Medicare eligibility file.

You may appeal these incorrectly denied claims. If you appeal the claim, you must provide information that proves the services didn't relate to the accident or injury. Continue providing services to the patient during your appeal period if there's an open MSP record found on the Medicare eligibility file or if you're still waiting for payment on previous submitted claims.

# ESRD-MSP Rules & Dually Entitled Patients

A patient meets dual entitlement when they're eligible or entitled to Medicare based on ESRD, age, or disability.

If we're the primary payer based on entitlement due to age or disability and the patient doesn't have GHP coverage, we remain the primary payer during and after the 30-month ESRD coordination period.

We pay first when we're the only payer upon the patient's entitlement to ESRD or if we're legally required to pay primary to any GHP coverage. Otherwise, we pay secondary to any GHP coverage that may exist during the ESRD coordination period.

**Table 2. ESRD-MSP Rules**

| Basis of Medicare Eligibility & Group Health Plan Coverage | Application of Rule |
|---|---|
| ESRD only | Medicare pays **secondary** to any GHP coverage |
| Age or disability entitlement and GHP coverage comes before ESRD eligibility with Medicare being primary | Medicare pays **primary** to any GHP coverage |
| Age or disability entitlement and GHP coverage comes before ESRD eligibility with Medicare being secondary | Medicare pays **secondary** to any GHP coverage |
| Age or disability entitlement and ESRD eligibility occur on the same day | Medicare pays **secondary** to any GHP coverage at the time of ESRD eligibility or after the patient gets ESRD eligibility |
| ESRD eligibility comes before entitlement based on age or disability | Medicare pays **secondary** to any GHP coverage |
| Age or disability entitlement and **no** GHP coverage comes before ESRD eligibility | Medicare pays **primary** to any GHP coverage |

# When We Don't Pay Primary, Secondary, or Other

## Veterans Benefits

We don't pay (primary, secondary, or otherwise) for services authorized under Veterans Health Administration (VHA) benefits. However, we may cover and pay for services not authorized under VHA benefits. Both Medicare and and the U.S. Department of Veterans Affairs (VA) may recover duplicate payments in situations where both agencies made payments on the same claim services. Return Medicare's payment for services that the VA paid, as this is considered a duplicate payment.

The VA is a government-run military system that administers veterans' benefits and provides veterans' health care coverage through the VHA. The program offers people who serve or formerly served in the Armed Forces primary care, specialized care, and related medical and social support services.

## Federal Black Lung Program Benefits

We don't pay (primary, secondary, or otherwise) for FBLP-covered services. If a patient has an illness or injury unrelated to Black Lung, we may pay claims. Under rare circumstances, we may pay on Black Lung claims if the FBLP denies the service or the Department of Labor denies full Black Lung payments. We may make Medicare payments on a case-by-case basis. We can recover duplicate claims.

> **Mailing FBLP Claims**
>
> U.S. Department of Labor OWCP/DCMWC
> P.O. Box 8307
> London, KY 40742-8307

# MSP Provision Exceptions

There aren't exceptions to the MSP provisions. Section 1862(b)(2)(A)(i) of the Social Security Act and 42 United States Code 1395(y)(b)(2)(A)(i) prohibit accepting patient service payments on admission if they have another primary insurance. If you do this, you must stop immediately.

Participating Medicare providers, physicians, and other suppliers must not accept any copayment, coinsurance, or other payments from the patient when the primary payer is an employer Managed Care Organization insurance or any other type of primary insurance, like an employer GHP.

You must follow the MSP rules and bill Medicare as the secondary payer after the primary payer makes payment. Your remittance advice will show how much you can collect from the patient.

**Note:** In situations where patients made payment, they have a right to a refund and you must reimburse them.

Medicare Learning Network®

# If the Primary Payer Denies the Claim

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

- The no-fault or liability insurer doesn't pay during the paid promptly period or denies the medical bill. We don't pay for services that relate to an accident when there's an open ORM or set-aside record for services that relate to an accident.
- The WC program doesn't pay during the paid promptly period or denies payment (for example, when the WC claim excludes a medical condition or certain services). Providers must give the reason for denial on Medicare claims.
- The patient gets services that don't relate to the accident or injury.
- WCMSA funds or the ORM benefits terminate or exhaust.
- The GHP denies service payment because:
  - The patient hasn't met their GHP deductible
  - The patient exhausted certain plan benefit services
  - The patient isn't enrolled for GHP benefits
  - The patient needs services the GHP doesn't cover

When submitting an MSP claim, explain why the other payer denied the claim, made an exhausted benefits determination, didn't pay the claim in full, or another reason why the primary payer didn't pay the claim. You can find the claim adjustment segment on ASC X12 835 remittance advice or ASC X12 837 professional claim. You need to identify the correct claim adjustment reason code or we may deny the claim.

We can't pay claims that were already paid or if we can reasonably expect the no-fault insurance, liability insurance (including self-insurance), WC plan, or GHP primary plan to make payment. Medicare and federal laws, including the MSP provisions, take priority over state law or an insurance policy's contents. Section 1862(b) of the Social Security Act establishes payment order and takes priority over state laws and private contracts.

# Conditional Payments

In contested compensation cases, there's often a long delay between an injury and the primary payer decision. We **may** make pending case conditional payments, for non-ORM situations, to avoid imposing a financial hardship on you and the patient while awaiting a contested case decision. We won't make conditional Medicare payments when ORM applies and there's an open ORM record on the patient's Medicare record.

We can make conditional covered service payments even if we aren't the primary payer. We may make conditional covered service payments in non-ORM liability (including self-insurance), no-fault, and WC situations if the following apply:

- Liability, including self-insurance, no-fault, or WC has payment liability and responsibility
- We don't expect a prompt payment

When a patient has non-ORM liability, no-fault, or WC coverage, we **may** make conditional claims payments when:

- The claim information or the Common Working File (CWF) shows liability, no-fault insurance, or a specific item or service with WC involvement
- There's no open GHP CWF MSP file record for the service date
- The claim information shows the physician, provider, or supplier sent the claim to the liability, no-fault insurer, or WC entity first
- The claim information shows the liability, no-fault insurer, or WC entity didn't pay the claim during the 120-day paid promptly period for identified reasons

Always send the claim to the primary payer first. If the primary payer denies the claim because of liability, the no-fault or WC insurer must place the reason for denial on the claim, which you can find on your remittance advice that you'll send to Medicare. Without this reason, Medicare will deny the claim. If this is a non-ORM situation and the claim is less than 120 days past the date of service, Medicare may make a payment on the claim. You can find electronic remittance advices and reasons for claim denial in the claim adjustment segment. We can recover any conditional payments. The MSP contractor recovers conditional payments from the patient or that person's attorney if the patient gets a settlement, judgment, award, or other payment.

We may pay for conditional primary benefits if the provider, physician, supplier, or patient doesn't file a proper claim with the GHP (or Large Group Health Plan (LGHP)) due to the patient's physical or mental incapacity. The provider, physician, or other supplier must prove the patient's physical or mental incapacity prevented them from providing other payer information, which led to the failure to file a proper claim.

If the patient has a primary GHP and the provider doesn't bill the primary GHP first, we won't pay conditionally on the liability (including self-insurance), no-fault, or WC claim. Providers must bill the GHP before billing Medicare. We won't pay for conditional primary benefits for non-ORM claims in other situations where the:

- GHP says it's secondary to Medicare
- GHP limits its payment when the patient is entitled to Medicare
- GHP covers the services for younger employees and spouses, but not for employees and spouses 65 and older
- GHP says it's secondary to liability, no-fault, or WC insurance
- The provider doesn't file a proper and timely claim with Medicare

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

## Paid Promptly

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

For non-ORM liability insurance (including self-insurance), **paid promptly** means payment within 120 days of the:

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

Find more information on conditional payments in:

- Section 20.7 of the Medicare Secondary Payer Manual, Chapter 1
- Sections 40 and 60 of the Medicare Secondary Payer Manual, Chapter 2
- Sections 30 and 40.3.1 of the Medicare Secondary Payer Manual, Chapter 3
- Section 40.6 of the Medicare Secondary Payer Manual, Chapter 5
- Sections 40.3 and 60 of the Medicare Secondary Payer Manual, Chapter 6

## Ongoing Responsibility for Medicals (ORM)

We can't pay claims that are already paid or when payment can reasonably be expected from liability insurance (including self-insurance), no-fault insurance, WC, or plan.

When a primary plan reports ORM to Medicare, it assumes payment responsibility, on an ongoing basis, for certain accident- or injury-related medical care. We won't pay for a patient's injury care without documentation the ORM terminated or exhausted.

If there's not an ORM open record and the liability, no-fault insurance, or WC insurer won't pay promptly, you must bill the no-fault insurer first to get the denial. You may bill Medicare for conditional payment after first getting a denial on a remittance advice. Medicare may pay depending on the reason for denial.

The Medicare Secondary Payer: Don't Deny Services & Bill Correctly fact sheet has more information to help you determine the payer order, how to bill MSP NGHP, how to bill a WCMSA claim, and how to bill accident insurance for ORM and non-ORM claims.

## Collecting Patient Health Insurance Information

COB allows plans to determine their payment responsibilities. The MSP contractor collects, manages, and reports other patient insurance coverage to the CWF. Providers, physicians, and other suppliers must collect accurate MSP information from the patient to ensure claims are filed properly.

The MSP contractor relies on health insurance program stakeholders, including:

- Federal and state programs
- Plans that offer health insurance, prescription coverage, or both
- Pharmacy networks
- Variety of assistance programs

Some reporting methods we use to get MSP and COB information include:

- **Voluntary Data Sharing Agreement (VDSA):** VDSA allows CMS and an employer to electronically exchange GHP eligibility and Medicare information. The VDSA includes Medicare Part D information, allowing VDSA partners to submit primary or secondary (retiree) records with Part D prescription drug coverage.

- **MSP Mandatory Reporting Process:** Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) requires mandatory MSP data sharing requirements for GHP insurance arrangements, liability insurance (including self-insurance), no-fault insurance, and WC to report patient MSP information.

- **MSP Claims Investigation:** The MSP contractor investigates when it learns another insurance plan may have primary responsibility for paying a patient's Medicare claims. The MSP contractor determines if information is missing from MSP records or MSP cases. Single-source investigations, which offer a centralized MSP-related inquiries location, involve collecting other health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or other sources like correspondence, accident and injury cases, or phone calls.

- **Electronic Correspondence Referral System (ECRS):** ECRS is a web-based application that allows MAC representatives and CMS Regional Office MSP staff to electronically send possible MSP lead information or questions about existing MSP records to the MSP contractor. ECRS allows our authorized contractors and CMS Regional Offices to complete various online forms, electronically transmit change requests to existing CWF MSP information, and inquire about possible MSP coverage. The COB contractor automatically stores transactions in their system. Each evening, a batch process reads the transactions and processes the requests.

- **Coordination of Benefits Agreement (COBA) Program (non-MSP process; this involves Medigap-type plans only):** The COBA Program establishes a national standard contract between the MSP contractor and other health insurance organizations to send enrollee eligibility data and Original Medicare paid claims data. This means Medigap plans, employer supplemental plans, Medicaid, and others rely on a national information repository with unique identifiers to get and cross over Medicare-paid claims data. The COBA data exchange processes include prescription drug coverage former employers provide to people after they retire.

  **Note:** Medicare is usually always primary for patient claims exchanged as part of COBA.

# Provider & Supplier Responsibilities

- Gather accurate MSP data by asking patients or their representatives questions about other (potential) health insurance coverage that could be primary to Medicare. Do this at each visit before providing services. Check eligibility to verify whether other primary insurance information exists. It's important for providers to maintain an admissions process that identifies primary payers, other than Medicare, to prevent incorrect billing and overpayments. Based on this requirement, hospitals must document and maintain patient MSP information.

- Identify all known primary payers to Medicare on the claim. Bill any primary payer before billing Medicare.

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

- It's important to note that you can't deny medical services or entry to a skilled nursing facility or hospital if you discover an open or closed GHP or NGHP, no-fault, WC MSP record, or a claim Medicare mistakenly denies due to an MSP occurrence in the patient's Medicare eligibility file. Doing so is against Medicare laws and policies.

If you're an institutional provider, you should:

- Ask patients to update their insurance profiles at each visit. The updates include MSP information, like GHP information or NGHP coverage resulting from an injury or illness, before providing services.

- Incorporate patient responses to MSP questions and eligibility verification from the HETS 271 response transaction in your health records.

- Review or administer the MSP questions each time you treat or admit the patient.

- Identify all known primary payers to Medicare on the claim.

- Submit claims to the appropriate primary payer first.

- Submit MSP information to the MAC using proper claim condition, occurrence, and value codes (for providers using Form CMS-1450 or its electronic equivalent).

- Submit an explanation of benefits or remittance advice from any other insurers with all appropriate MSP information to the MAC on the hard copy claim. Provide the necessary information in the appropriate fields, loops, and segments required to process an 837I electronic MSP claim.

- Provide updated information to government agencies as appropriate.

## Part B Providers (Physicians, Practitioners, & Suppliers)

- Gather accurate MSP data. Determine if we're the primary payer by asking patients or their representative for MSP information.
- Bill the primary payer before billing us.
- Submit an explanation of benefits or remittance advice from the primary payer with all MSP information on your hardcopy claim. If you're submitting an electronic claim, include the necessary information in the appropriate fields, loops, and segments required to process an 837P electronic claim.
- Provide updated information to government agencies as appropriate.

Section 70 of the Medicare Claims Processing Manual, Chapter 1 has more information on Medicare-covered services timely filing requirements.

## Gathering Accurate Data

Providers must keep responses to completed MSP questions and other MSP information for 10 years after the service date. You may keep hard copy files or store them electronically. Keep negative and positive question responses.

Once you collect information about other patient payers, report it on the claim. Our billing claim forms (CMS-1450 and CMS-1500, and their electronic equivalents) have several MSP information fields. Complete the necessary fields to identify other payers and other payer payment information.

## Calculating Payment

Once the primary payer pays a claim, we use that information (with any applicable patient deductible and coinsurance) to calculate our secondary payment. Section 40.8.3 of the Medicare Secondary Payer Manual, Chapter 5 details specific formulas and payment calculations.

The calculation uses claim information and the primary payer's explanation of benefits or remittance advice data for hard-copy claims.

## MSP Contractor Claims Investigation

If you don't provide records of other health insurance or coverage that may be primary to Medicare on a claim, the MSP contractor may request the patient or their representative complete a Secondary Claim Development Questionnaire. The MSP contractor may send this questionnaire when the:

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

The Reporting Other Health Insurance webpage has more information on secondary claim development.

## Submit Claims With Other Insurer Information

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

If a MAC doesn't have complete information about other primary insurance on the claim, they'll send a request to the MSP contractor to get additional information. The MSP contractor may request the patient, employer, insurer, or attorney complete a Secondary Claim Development Questionnaire for the additional information. After the MSP contractor gets the completed form, they'll review the questionnaire responses and take necessary action.

The Medicare Secondary Payer Manual, Chapter 3 has more information on MSP billing.

## File Proper & Timely Claims

File a proper and timely claim with the primary payer. Check with the payer for their specific policies.

Federal law allows Medicare to recover incorrect payments. We require you to return any payment we incorrectly paid as the primary payer. Generally, for MSP GHP situations, we recover improper payments. We can fine providers, physicians, and suppliers for knowingly, willfully, and repeatedly giving inaccurate information about other health insurance coverage.

We may recover incorrect payments directly from a primary payer, other entity, or third payer. Medicare's right to recover payments takes priority over any other party, including Medicaid.

A primary payer, or entity paid by a non-Medicare primary payer, has 60 days to reimburse Medicare. This 60-day period begins on the date we get information that payment was, or could be made, by a primary payer.

If you don't reimburse us before the period's expiration, we may charge interest for the violation. We may also bring legal action to recover our primary payments, which may include double damages recovery (twice the payment amount).

# MSP Contact Information

**Table 3. Who to Contact with MSP Questions**

| Contact | Question |
|---|---|
| Benefits Coordination & Recovery Center (BCRC) Customer Service Representatives<br>Monday–Friday (except holidays)<br>8 am–8 pm, ET<br>Toll free lines:<br>1-855-798-2627<br>Text Telephone (TTY) or Telecommunication Device for the Deaf (TDD): 1-855-797-2627 | • Ask about Medicare development letters and questionnaires<br>• Report a patient's accident or injury on the claim you submit to your MAC<br>• Report a patient's employment or health insurance coverage changes on your claim to Medicare<br>• Verify Medicare's primary or secondary status<br><br>The Provider Services webpage has guidance on reporting a patient's health insurance changes.<br><br>Request patient MSP information before billing. To protect patients' rights and information, the BCRC MSP contractor can't disclose this information. |
| MAC | • Ask general questions, including how to bill<br>• Ask about processing specific claims<br>• Ask about Medicare claim or service denials, adjustments, and claim appeals<br>• Ask about voluntary refunds<br>• Ask about returning inappropriate Medicare payments |

- The Commercial Repayment Center (CRC) MSP contractor is responsible for GHP recoveries and activities related to recovering improper payments
- The BCRC MSP contractor is responsible for liability, no-fault, and WC recoveries
- The BCRC and CRC MSP contractor manages all COB and recovery activities except for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 demonstration recovery demand letters that MSP recovery auditors issue

The GHP Recovery and NGHP Recovery webpages have more information regarding MSP recoveries.

Medicare Learning Network®

## Resources

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

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](#).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).