

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

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(Rev. 11874, 02-23-23)

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10 - General

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs) are required in professional and public relations activities to inform providers, physicians, other suppliers, and beneficiaries about the MSP provisions and that claims for services to beneficiaries for which Medicare is the secondary payer must be directed first to the primary plan where there is primary coverage for the services involved. The Medicare law and/or provider agreement require the submitter to identify on the claim all known payers obligated to pay primary to Medicare.

10.1- Limitation on Right to Charge a Beneficiary Where Services Are Covered by a *Group Health Plan (GHP)*

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A provider, physician, or other supplier that receives direct payment from the Medicare program may not charge a beneficiary if the provider, physician, or other supplier has been paid or could have been paid by a GHP an amount which equals or exceeds any applicable deductible or coinsurance amount.

EXAMPLE

A Medicare beneficiary who had GHP coverage was hospitalized for 20 days. The hospital's charges for covered services were \$5000. The inpatient deductible had not been met. The gross amount payable by Medicare (as defined in *Pub. 100-05*, Chapter 2) for the stay if there had been no GHP coverage is \$4,000. The GHP paid \$4,500 (\$840 of which was credited to the Medicare deductible). Medicare will make no payment, since the plan's payment was greater than Medicare's gross amount payable of \$4,000. No part of the \$500 difference between the hospital's charges and the GHP's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the GHP payment. The provider submits a bill to Medicare reflecting the appropriate amount paid by the primary payer.

10.1.1 - Right of Providers to Charge Beneficiary Who Has Received Primary Payment from a GHP

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

When a primary plan has paid a beneficiary, the amounts the provider (including renal dialysis facilities or facilities that receive direct payment from the Medicare program) may collect for Medicare covered services from the beneficiary are limited to the following:

- The amount paid or payable by the primary plan to the beneficiary. If this amount exceeds the amount which would have been payable by Medicare as primary payer (without regard to deductible or coinsurance), the provider may retain the primary payment in full without violating the terms of the provider agreement;
- The amount, if any, by which the applicable Medicare deductible and coinsurance amounts exceed any primary payment made or due the beneficiary or due the provider for medical services; and

- The amount of any charges made to the beneficiary for the noncovered component of a partially covered service, e.g., the charge differential for a private room that is not medically necessary but that is requested by the beneficiary. However, such a charge may not be collected from the beneficiary to the extent that the primary plan pays it directly to the provider.

EXAMPLE

A Medicare beneficiary with GHP coverage was a hospital inpatient for 20 days. The hospital's charges for Medicare covered services were \$16,000. The inpatient deductible had not been met. The gross amount payable by Medicare for the stay in the absence of GHP coverage is \$11,500. The GHP paid \$14,000, a portion of which was credited to the entire inpatient deductible. Medicare makes no secondary payment, since the GHP's payment was greater than the gross amount payable by Medicare of \$11,500. No part of the \$2,000 difference between the hospital's charges and the GHP's payment can be billed to the beneficiary, since the beneficiary's obligation, the deductible, was met by the GHP's payment. The provider files a non-payment bill reflecting the applicable deductible for purposes of crediting the deductible.

10.1.2 - Right of Physicians and Other Suppliers to Charge Beneficiary Who Has Received Primary Payment from a GHP

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

When a beneficiary has been paid by a primary plan, the amount a physician or other supplier who accepts assignment may collect for Medicare covered services from the beneficiary is limited to the following:

- The amount paid or payable by the primary plan to the beneficiary. (If this amount exceeds the amount that *is* Medicare *would pay* as primary payer (without regard to deductible or coinsurance), the physician or other supplier may retain the primary payment in full without violating the conditions of assignment.); or
- If the primary payment is less than the applicable Medicare deductible and coinsurance amounts, the difference between the fee schedule amount (or the amount the physician is obligated to accept as payment in full, if less), and the sum of the primary plan's payment *is* the Medicare secondary payment.

EXAMPLE

A physician charges \$362 for a service. The GHP allows \$362 but pays a primary payment of only \$212 because of a \$150 plan deductible. The Medicare fee schedule amount is \$300. The amount that Medicare pays as secondary payer is \$53.60 since the Medicare secondary payment amount cannot exceed the amount Medicare would pay primary payer (\$300 fee schedule amount minus the \$233 Part B deductible equals \$67 x 80 percent = \$53.60). The combined primary payment and Medicare secondary payment is \$265.60 (\$212 + \$53.60).

The physician may charge the beneficiary \$34.40, the difference between the Medicare fee schedule amount (\$300) and the sum of the primary payment (\$212) plus the Medicare secondary payment (\$53.60). The \$34.40 charge to the beneficiary represents the portion of the Part B deductible and coinsurance amounts in excess of the GHP's payment. The \$233 Part B deductible is credited in full. The remaining GHP's payment is applied to the beneficiary's Part B

coinsurance obligation, leaving the beneficiary responsible for the remaining coinsurance obligation of \$34.40.

In the case of non-inpatient psychiatric services, *the Part B deductible is credited on the basis of the Medicare fee schedule amount. There is no annual limit on incurred expenses for non-inpatient psychiatric services.* (See *Pub. 100-05*, Chapter 2.)

10.1.3 - Payment When a Proper Claim is Not Filed

(Rev.11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If a provider, physician, or other supplier receives from a payer, that is primary to Medicare, a payment that is reduced because the provider, physician, or other supplier failed to file a proper claim, the provider, physician, or other supplier must include this information on the claim for secondary payment that is submitted to Medicare. Medicare's secondary payment will be based on the full payment amount (before the reduction for failure to file a proper claim) unless the provider, physician, or other supplier demonstrates that the failure to file a proper claim is attributable to a physical or mental incapacity of the beneficiary that precluded the beneficiary from being able to provide other payer information.

For example, a physician's charges are \$1,000. The primary plan's allowable charges without reduction for failure to file a proper claim are \$800.00. The Medicare allowable was \$700.00. The primary plan would have paid \$640.00 if a proper claim had been filed. The primary plan reduced its payment to \$500.00 because the physician had not filed a proper claim. Medicare's secondary payment would be based on a primary plan payment of \$640.00 rather than the reduced amount of \$500.00. The beneficiary may not be billed for the reduction in the primary plan's payment due to the physician's failure to file a proper claim.

10.2 - Situations in Which MSP Billing Applies

(Rev.11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

Medicare secondary billing procedures apply in the following situations:

- Where the *Veterans Affairs (VA)* authorized services, Medicare does not make payment for items or services furnished by *the VA or other* non-Federal provider pursuant to such an authorization. *Note, although certain MSP billing procedures apply, VA is not an MSP provision. Rather, it represents a Medicare payment exclusion.*
- Where services are payable under *Workers' Compensation (WC)*, no-fault or liability insurance, Medicare does not make payment for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made. Under certain circumstances, Medicare may make conditional payments, subject to reimbursement, if the WC, no-fault, or liability insurer has not paid or will not pay promptly. Medicare is secondary to WC, no-fault, and liability insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.
- Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to Medicare *Part A* based on ESRD during a Medicare coordination period as described in *Pub. 100-05*, Chapter 2, §20.

- Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of their own current employment status or the current employment status of a spouse of any age. (See *Pub. 100-05*, Chapter 2§10, for an explanation of this provision.)
- Medicare benefits are secondary to benefits provided by GHPs for certain disabled individuals under age 65 (entitled to Medicare on the basis of disability) who have coverage based on their own current employment status or the current employment status of a family member, e.g., a spouse or other family member of a disabled beneficiary. (See *Pub. 100-05*, Chapter 21, §30, for an explanation of this provision.)
- Payment made by any of these primary payers can be used to satisfy unmet deductibles and the individual's coinsurance. Inpatient, psychiatric hospital, *Skilled Nursing Facility (SNF)*, or Religious Non-medical Institution care that is paid for by a primary payer is not counted against the number of lifetime psychiatric days available to the beneficiary.

10.3 - Provider, Physician, and Other Supplier Responsibility When a Request is Received from an Insurance Company or Attorney

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (*Mbi*) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The provider, physician, or other supplier notifies the *MSP Contractor, the entity responsible for coordination of benefits (formerly known as the Benefits Coordination & Recovery Center or the Coordination of Benefits Contractor and hereafter termed the “MSP contractor”)*, promptly if a request is received from an attorney or an insurance company for a copy of a medical record or a bill concerning a Medicare patient. The *MSP Contractor* is given a copy of the request or, if it is unavailable, details of the request, including:

- The name and Medicare beneficiary identifier of the patient;
- Name and address of the insurance company and/or attorney; and,
- Date(s) of services for which Medicare has been or will be billed.

A/B MACs and DME MACs receiving MSP information from providers, physicians, and other suppliers should follow the procedures outlined in *Pub. 100-05*, Chapter 5.

10.4 – Provider, Physician, and Other Supplier Responsibility When Duplicate Payments Are Received

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

In any case in which a provider, physician, or other supplier has received a primary payment from Medicare and a duplicate primary payment from a primary plan, the *A/B MACs and DME MACs* instruct the provider, physician, or other supplier to refund to the beneficiary any Medicare deductible and coinsurance amounts paid by the beneficiary that were duplicated by the primary payment. If the primary payment exceeds the deductible and coinsurance amounts, the excess constitutes a debt to Medicare because it duplicates all or part of the amount Medicare has paid and, therefore, must be collected from the provider, physician, or other supplier. Medicare must be reimbursed within 60 days of the receipt of the duplicate payment. A copy of the letter to the provider, physician, or other supplier is sent to the beneficiary. Interest is applicable if repayment is not made to Medicare within 60 days.

The MSP regulations at 42 CFR § 489.20 require providers to pay Medicare within 60 days from the date a payment is received from another payer (primary to Medicare) for the same service for which Medicare paid. A provider refunds the Medicare payment within 60 days by submitting an adjustment bill or via the Medicare Credit Balance Report. The MSP regulations at 42 § CFR 411.24(h) and § 411.25 require all entities that receive a primary payment from both Medicare and a primary plan to repay Medicare. A physician or other supplier submits a refund check to Medicare. This refund is due Medicare, regardless of which payment the provider, physician, or other supplier received first and even if the insurance payment was refunded to the beneficiary or the insurer.

Providers report credit balances resulting from MSP payments on the Form CMS-838 if the overpayment has not been repaid by the last day of the reporting quarter. If the provider identifies and repays an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, it is not reported on the Form CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in the provider records.

If an MSP credit balance occurs late in a reporting quarter, and the Form CMS-838 is due prior to expiration of the 60-day requirement, the overpayment must be included in the credit balance report. However, payment of the credit balance does not have to be made at the time the Form CMS-838 is submitted, but within the 60 days allowed.

10.5 - Incorrect GHP Primary Payments

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

A GHP may advise a provider, physician, or other supplier that the GHP believes that Medicare *may be* the proper primary payer for services for which the GHP had previously made a primary payment. The GHP may request that the provider, physician, or other supplier either submit an initial claim to Medicare or request that Medicare reopen its determination on previously submitted claims for the services. The normal Medicare timely filing and reopening rules apply to these situations. The initial claim must be submitted within the timely filing period. An initial determination on a previously adjudicated claim may be reopened for any reason for 1 (one) year from the date of that determination. After 1 (one) year and prior to 4 (four) years from the date of determination, “good cause” is required for Medicare to reopen the claim. 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.

10.6 - Retroactive Application

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If *A/B MACs and DME MACs*, including the *MSP Contractor* notify the provider, physician, or other supplier, or the provider, physician, or other supplier learns from other sources that an employer plan may be primary payer for services for which Medicare paid primary benefits, the provider, physician, or other supplier takes the following actions:

- *Determines* whether there is GHP coverage and, if so, the name and address of the GHP, if that information is not annotated on the claim;
- Checks its records to *confirm* whether Medicare paid primary benefits for other services rendered during a coordination period for which a GHP may be primary; and
- Notifies the *MSP Contractor* of the results of the development efforts according to *Pub. 100-05, Chapter 5 Contractor MSP Claims Processing Requirements*.

This information is necessary for Medicare to determine its proper payment. If the GHP pays or has already paid the provider, physician, or other supplier for all or part of the services, the provider, physician, or other supplier submits a corrected bill to the *A/B MACs and DME MACs* along with the GHP’s explanation of benefits (EOB) *or remittance advice if the claim is submitted hardcopy*. The *A/B MACs and DME MACs* recoups from the provider, physician, or other supplier the amount of Medicare benefits paid in excess of any amount it is obligated to pay as secondary payer.

20 - Obtain Information from Patient or Representative at Admission or Start of Care

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

20.1 - General Policy

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

Based on the law and regulations, providers, physicians, and other suppliers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Act, (42 USC 1395y(b)(6)), requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR § 489.20(g) requires that all providers must agree “to bill other primary payers before billing Medicare.”

Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Exceptions to this requirement are discussed

below in 1, 3 and 6. If providers, physicians or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, [42 CFR § 411.24](#) permits Medicare to recover its conditional or mistaken payments.

Section [20.2.1 of this chapter](#), "*Model Admission Questions to Ask Medicare Beneficiaries*," is a *set of questions* that may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: Providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. The model *admission questions* in [section 20.2.1 of this chapter represent](#) the types of questions that should be asked of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1, 3 and 6.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF) or the X12 270 transmission and the X12 271 response. (See [Section 20.2](#).) If the provider lacks access to CWF, or does not have a copy of the 271 response, it will follow the procedures found *below* in [section 20.2.1](#). The X12 270 Transaction Set is used to transmit Health Care Eligibility Benefit Inquiries from health care providers, insurers, clearinghouses and other health care adjudication processors. The X12 270 Transaction Set can be used to make an inquiry about the Medicare eligibility of an individual. The X12 271 Transaction Set is the appropriate response mechanism for Health Care Eligibility Benefit Inquiries.

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., liability insurer and GHP). The provider, physician, or other supplier must identify all possible payers.

This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming that the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred

1. Policy for Hospital Reference Lab Services and Independent Reference Lab Services

Background

Section 943 (TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYER (MSP) PROVISIONS) of the Medicare

Prescription Drug, Improvement & Modernization Act of 2003 states:

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

“(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.”

Policy

The Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above. Therefore, pursuant to section 943 of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above. This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.

A/B MACs shall instruct hospital and independent labs, which have already collected and retained MSP information for beneficiaries, that they may use that information for the billing of non-face-to-face reference lab services. However, in situations when there is a face-to-face encounter with the beneficiary, *A/B MACs* shall instruct hospitals and independent labs that they are required to collect MSP information from the beneficiary when billing for lab services.

Instructions to *A/B MACs* on how to process reference lab claims submitted on Form CMS-1500 are available by clicking on the following hyperlink: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf>. (After you get to chapter 26, go to section 10.2 *which discusses reference lab services*.)

2. Policy for Recurring Outpatient Services

Hospitals must collect MSP information from the beneficiary or his/her representative for hospital outpatients receiving recurring services. Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his/her representative. Following the initial collection, the MSP information should be verified once every 90 days. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for recurring outpatient services furnished by hospitals. This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.

NOTE: A Medicare beneficiary is considered to be receiving recurring services if he/she receives identical services and treatments on an outpatient basis more than once within a billing cycle.

Hospitals must be able to demonstrate that they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy.

3. Policy for Medicare Advantage (MA) Members

If the beneficiary is a member of an MA plan, hospitals are not required to ask the MSP questions or to collect, maintain, or report this information.

4. Policy for MSP Retirement Dates

During the intake process, when a beneficiary cannot recall his/her precise retirement date as it relates to coverage under a group health plan as a policyholder or cannot recall the same information as it relates to his/her spouse, as applicable, hospitals must follow the policy below.

When a beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, hospitals report his/her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, hospitals report the beneficiary's Medicare entitlement date as his/her retirement date.

If the beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but the hospital determines it has been at least five years since the beneficiary retired, the hospital enters the retirement date as five years retrospective to the date of admission. (Example: Hospitals report the retirement date as January 4, *2016*, if the date of admission is January 4, *2021*) As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission. If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the hospital must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

5. Policy for Provider Records Retention of MSP Information

Title *42 CFR § 489.20(f)* states that the provider agrees to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. Based on this regulation, hospitals must document and maintain MSP information for Medicare beneficiaries.

Without this documentation, the *A/B MACs and DME MACs* would have nothing to audit submitted claims against. CMS recommends that providers retain MSP information for 10 years.

A. Obtain Liability or No-Fault Insurance Information

Providers are required to obtain information on possible *MSP* situations. Medicare patients, or their representatives, at admission or start of care, are asked if the services are for treatment of an injury or illness which resulted from an automobile accident or other incident, for which liability or no-fault insurance may pay, or for which another party is held responsible. This includes an incident

that occurs on the provider's premises. The provider obtains the name, address, and policy number of any liability or no-fault insurance company or any other party that may be responsible for payment of medical expenses that resulted from the accident or illness.

B. Obtain Workers' Compensation (WC) Information

Providers are *required* to inquire of the beneficiary or representative at the time hospitalization is ordered, at admission, or when the service is rendered, whether the condition is work-related. When the patient or the patient's physician indicates that the condition is work-related or there is other indication that it is work-related, the provider is required to ask the patient or the patient's physician, wherever possible, whether WC is expected to pay. (Generally, where hospital services are covered under a WC program, the WC carrier or the employer will authorize the services in advance.)

If the patient denies that WC benefits are payable for a condition which the provider believes may be covered by WC, a supplementary statement is attached to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

C. Obtain GHP Data from Working Aged Beneficiaries

To obtain the information needed to ascertain whether to bill a GHP as primary payer, providers ask beneficiaries age 65 or over admitted for inpatient care or receiving outpatient care, or their representatives, selected questions. See *section 20.2.1* of this *chapter* for the model questionnaire. These include the age of the beneficiary, the employment status of the beneficiary and the spouse, whether the beneficiary is covered under a GHP because of the beneficiary's or the spouse's current employment, and the patient's identification number and the name and address of the GHP.

D. Obtain GHP Data from Disabled Beneficiaries

Providers are required to identify individuals who meet the disability provisions by asking every Medicare beneficiary under age 65 if the individual has group health coverage based on their own current employment status or the current employment status of a family member. If the individual has such coverage, the provider requests the name and address of the employer plan and the individual's identification number and bills the plan for primary benefits, except where the provider has information that clearly shows that the employer plan is not primary payer. If the individual responds negatively to either question, or the provider has otherwise determined that the employer plan is not primary payer, the provider bills Medicare for primary benefits.

E. Obtain GHP Data from ESRD Beneficiaries

Health care providers identify beneficiaries who are entitled to Medicare based on ESRD through information available to them (e.g., the beneficiary's Medicare card) and to ascertain whether the services may be payable under a GHP during the 30-month coordination period. Providers determine whether the services were rendered in the coordination period by checking their own records, e.g., information contained on Form CMS-2728 or, if the potential Medicare payment is \$50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant) or the date an individual began a course of home dialysis. If the individual is in the 30-month coordination period, the provider asks if the beneficiary is insured under a group health insurance plan of his or her own, or as a family member. If the response is yes, the provider asks for the name and address of the plan and the beneficiary's identification number. A coordination of benefits (COB) period may be applicable even if an ESRD beneficiary or his (her) spouse is not currently employed throughout the COB period. The beginning date of a COB period is different when an individual receives a kidney transplant or receives home dialysis than when an individual receives regular (outpatient) dialysis (3-month waiting period).

If the information obtained does not indicate GHP coverage, the provider annotates the bill to that effect (e.g., GHP coverage lapsed, benefits exhausted). If the information indicates that GHP coverage exists, the provider obtains the information indicated above from the beneficiary or the beneficiary's representative.

6. Policy for Provider Based and Non-Provider Based Services, such as Ambulance Services

Some hospitals offer provider-based services, such as a transfer ambulance service that is affiliated with the hospital. The affiliated provider-based service does not need to repeat the MSP questions if the beneficiary has already had their information verified by the provider. In the above example, the hospital-affiliated ambulance provider does not need to ask the MSP questions if the beneficiary is seen by the hospital admissions staff. The admissions staff shall verify the beneficiary's insurance information and it bills the appropriate insurer for the ambulance service.

However, if the provider is an independent provider (such as if the ambulance provider above were not affiliated with the hospital), then the independent provider is responsible for verifying the correct information prior to billing for services.

For audit purposes, and to ensure that the provider has developed for other primary payer coverage, the provider retains a record of the development or other information on which it based its determination that Medicare is primary payer. See *Pub. 100-05*, Chapter 5 for action to take where a claim is received for primary benefits and there is reason to

believe that Medicare may be secondary payer.

20.2 - Verification of Medicare Secondary Payer (MSP) Online Data and Use of Admission Questions

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

Physicians, providers and suppliers shall not deny medical services or entry to a SNF or hospital after you discover that there is:

- an open or closed GHP (whether the beneficiary is entitled due to age, disability, or End Stage Renal Disease) or NGHP (Liability (L), No-Fault (NF) or Workers' Compensation (WC), MSP record found in the HIPAA Eligibility Transaction System (HETS) 270/271, or on CWF; or,*
- a claim that was previously mistakenly denied by Medicare due to an MSP occurrence.*

Information about the 270/271 HETS transaction can be found on the following link:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/About-HETS> .

MSP Online Data Elements

Providers with online capability may now access the following MSP information via *the HETS 270/271* or from the CWF MSP auxiliary file:

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information: Name, group number, address, city, State, and ZIP code;
- MSP type;
- Remarks code;
- Employer information: Name, address, city, State, and ZIP code; and
- Employee data: ID number, and information.

At the provider's discretion, these data may be viewed during either the admission or the billing process. However, the data must be viewed before a bill is submitted to Medicare, and should ideally be viewed before the patient leaves the hospital.

If the model *questions are* used during the admissions process, the provider will verify each data element by using the questions, found in *section 20.2.1 of this chapter*, to help identify other payers that may be primary to Medicare. It will comply with any instructions that follow a particular question. Note: If the provider has the ability to submit and receive a X12 270/271 transaction, the admission staff shall ask the beneficiary if any insurance information found on CWF, or the X12 271 response, has changed in lieu of asking all the MSP questions. When submitting the X12 270 transaction the provider must include the beneficiary entitlement date to be sure all MSP periods are received on the X12 271 response. If there are no changes or updates to the beneficiary's insurance then there is no need to ask the questions. However, having

access to CWF or the X12 270/271 transaction does not absolve the provider of its responsibility from asking the MSP questions as necessary. If there are changes to the insurance information, or if there is uncertainty regarding information based on conversation, then the provider must ask the MSP questions. Providers must make a notation for auditing purposes that all the questions were not asked upon admission, or during the telephone interview/screening, based on the beneficiary's statement that their insurance information has not changed or does not require updating. The Medicare *A/B MACs* shall request this notation and confirmation during its hospital review. If the provider lacks access to CWF or it does not utilize the X12 270/271 transaction the provider shall follow the procedures found under *section 20.2.1 of this chapter*.

This means the provider shall ask the beneficiary the necessary MSP questions to determine the correct primary payer. The providers are held liable to obtain the correct MSP information so claims are billed to the correct primary payer accordingly per the CMS regulations 42 CFR § 489.20.

20.2.1 - Model Admission Questions to Ask Medicare Beneficiaries *(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)*

The following outline of questions provides *important* points of data to gather from Medicare beneficiaries that are helpful for providers to determine who has primary payment responsibility for a claim or set of claims by asking the questions upon each inpatient and outpatient admission. The information assists in the proper coordination of benefits to ensure adherence to MSP provisions as outlined in section 1862(b) of the Social Security Act.

Part I. INFORMATION ABOUT BLACK LUNG, WORKERS' COMPENSATION (WC), NO-FAULT AND LIABILITY

1. Are you receiving benefits under the Black Lung Benefits Act (BL)?
2. If yes, the following BL information is required to submit claims appropriately:
 - Date Black Lung Benefits began

Note: BL is the primary payer for claims related to BL.
3. Was the illness/injury due to a work-related accident/condition?
4. If yes, the following WC information is required to submit claims appropriately:
 - Name and address of employer
 - Name and address of insurance carrier
 - Policy or claim number
 - Date of the workplace illness or the injury

Note: WC is the primary payer only for services related to work-related injuries or illness.

5. Are you receiving treatment for an injury or illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?

6. If yes, the following no-fault/auto insurance information is required to submit claims appropriately:
 - Name and address of insurance carrier
 - Policy or claim number
 - Date of illness or injury

Note: No-fault insurance is the primary payer only for services related to the accident.

7. Are you receiving treatment for an injury, or illness, which another party may be liable?

8. If yes, the following liability information is required to submit claims appropriately:
 - Name and address of insurance carrier
 - Policy or claim number
 - Date of illness or injury

Note: Liability insurance is the primary payer only for services related to the liability settlement, judgment, or award.

Part II. INFORMATION ABOUT MEDICARE ENTITLEMENT AND GROUP HEALTH PLANS

1. Are you entitled to Medicare based on Age, Disability or ESRD?

Note: If entitlement is based solely on ESRD, skip Part II and complete Part III. Stop after completing Part II if you are entitled to Medicare based on Age or Disability.

2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member?

If yes, the employer GHP may be primary to Medicare. Continue below. If no, stop here as Medicare is primary.

3. How many employees, including yourself or spouse, work for the employer from whom you have GHP coverage? (1-19, 20 – 99 or 100 or more)

Note: If you are aged and there are 20 or more employees, your GHP is primary. If you are disabled and your employer, spouse, or family member employer, has 100 or more employees, your GHP is primary.

4. The following employer GHP information is required to submit claims appropriately:
 - Name and address of the employer (your own or your spouse's/family member's) through which you receive GHP coverage
 - Name and address of GHP
 - Policy number (sometimes referred to as the health insurance benefit package number)
 - Group number
 - Date the GHP coverage began
 - Name of policyholder (if coverage is through your spouse/other family member)
 - Relationship to patient (if other than self)

**Part III. INFORMATION ABOUT THE PATIENT IF ESRD
MEDICARE ENTITLEMENT APPLIES (INCLUDING DUAL
ENTITLEMENT: AGE AND ESRD OR DISABILITY AND ESRD)**

1. Do you have employer group health plan (GHP) coverage through yourself, a spouse, or family member if dually entitled based on Disability and ESRD?

If yes, the employer GHP may be primary to Medicare. Continue below.

2. Have you received a kidney transplant?
 - Date of transplant
3. Have you received maintenance dialysis treatments?
 - Date dialysis began

4. Are you within the 30-month coordination period?

Note: the 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis) regardless of entitlement due to age or disability. If the individual is participating in a self-dialysis training program, or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.

5. Were you receiving GHP coverage prior to and on the date of Medicare entitlement due to ESRD (or simultaneous entitlement due to ESRD and Age or ESRD and Disability)?

Note: If yes, the GHP is primary during the 30-month coordination period.

6. The following information is required to submit claims appropriately:
 - Name and address of the employer (your own or your spouse's/family member's)

- through which you receive GHP coverage
- Name and address of GHP
- Policy number (sometimes referred to as the health insurance benefit package number)
- Group number
- Name of policyholder (if coverage is through your spouse/other family member)
- Relationship to patient (if other than self)

20.2.2 - Documentation to Support the Admission Process

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

The provider retains a copy of completed admission questions, the CWF print out or copy of the 271 responses including all notations, in its files (or online) for audit purposes to demonstrate that development for primary payer coverage takes place. It is not necessary that the beneficiary sign the completed questions. However, providers may identify the date when the questions are asked. Medicare permits providers to retain hard copy questions and responses on paper, optical image, microfilm, or microfiche. Hard copy and data described in this paragraph must be kept for at least 10 years after the date of service that appears on the claim. (See *Pub. 100-05*, Chapter 5 for information about the documentation to be used in a review.) Medicare requires it to retain **negative** and **positive** responses to admission questions for 10 years with DOJ's record retention requirements, after the date of service. Online data cannot be purged before then.

30 - Provider, Physician, and Other Supplier Billing

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If services are covered under an open GHP or related to an NGHP MSP accident or injury incident, bill the primary insurer first.

There are situations where providers bill for services related to a new accident or injury that are not related to an existing NGHP MSP record found on HETS or CWF. Physicians, providers and suppliers may need to use the same diagnosis codes that are found on the NGHP record in HETS and CWF. You may submit these claims to Medicare after you submit these claims to the appropriate GHP and/or NGHP insurer. The NGHP insurer may deny these claims if the claim is not related to the original accident or injury or the case has not been settled. After you submit these claims to Medicare, Medicare may mistakenly deny these services because the diagnosis codes on the claim are related to the diagnosis codes found on the NGHP MSP record on HETS and CWF. Physicians, providers and suppliers may appeal the denied claim with your MAC. Physicians, providers and other suppliers must provide an explanation, or a reason code, to justify why the services are not related to the accident or injury on record. Nonetheless, physicians, providers and other suppliers must continue to see or provide services to the beneficiary if claims are mistakenly denied.

30.1 - Provider Billing Where Services *are* Covered by a GHP

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

Providers *may* seek reimbursement from a GHP insurer before billing Medicare when there is an indication the insurer is primary payer. A GHP is billed first as primary payer even where there may be primary coverage for only part of the stay or services (e.g., split stays where the beneficiary terminated employment during the stay and the GHP coverage terminated concurrently.)

When a provider bills a GHP as primary payer, the bill itemizes the services rendered even though they are services for which Medicare reimburses on a fee schedule or other reimbursement methodology.

30.2 - Provider Billing Where Services *are* Accident Related and No-Fault Insurance May Be Available

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If a provider learns that no-fault insurance may pay for covered services, it must bill the insurance company as the primary insurer during the promptly period. *If Ongoing Responsibility for Medicals (ORM) exists and is not closed, then Medicare will not make a payment.*

30.2.1 - Provider Bills No-Fault Insurance First

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If the services are related to an automobile accident, the provider ascertains whether coverage under no-fault insurance is available. If a provider learns that no-fault insurance may pay for otherwise covered services, *or if the beneficiary has an open ORM record*, it must bill the insurance company as primary insurer during the promptly period. If *there is not an ORM open record and if* the no-fault insurance will not pay promptly, the provider *shall bill the no-fault insurer first to get the denial. Once the denial is received on the remittance advice, the provider* may bill Medicare for conditional payment.

If no-fault insurance does not pay or does not pay in full and there is indication of primary GHP coverage under *Pub. 100-05*, Chapter 2, the provider must bill the GHP for the services not paid in full. It may bill Medicare for secondary benefits only after all primary payers to Medicare have been billed.

30.2.1.1 - No-Fault Insurance Does Not Pay

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If the services are related to an accident and the no-fault insurance has been billed but does not make payment because the individual's no-fault benefits are exhausted or, the individual's coverage expired, *the beneficiary does not have an ORM record*, and no other primary payers to Medicare have been identified, the provider may bill Medicare. *A/B MACs and DME MACs* will need to look at the statements from the no-fault insurer or the CAS segment and paid amount loop for electronic claims (paid amount loop on the 837 should show zero dollars paid by the NGHP insurer), or attached RA for hardcopy claims, to determine whether benefits were exhausted, coverage expired or services were not related to the accident/incident to process the claim appropriately. *A/B MACs and DME MACs* may send an ECRS request to the *MSP Contractor* to close the MSP record as deem necessary.

When billing Medicare where no-fault insurance has been billed but does not make payment, annotate the date on which the other payer denied the claim and the reason for denial. If the provider later receives payment from no-fault insurance, it refunds the Medicare payment by submitting an adjustment bill for Part A and/or a reopening, or appeal request, for Part B.

Part A providers notify the *A/B MACs (Part A)* of a No-Fault denial using occurrence code 24

(Date Insurance Denied) and indicate the date on which the other payer denied the claim. The reason for denial is indicated in remarks. In addition, the following occurrence codes are used to identify the date of the accident:

01 - Auto Accident and Date

02 - No-Fault Insurance Involved-Including Auto Accident/Other and Date

If the conditions described in *Pub. 100-05*, Chapter 7 are met, conditional payments may be made. To request a conditional payment, providers enter value code 14 with zero value in form locator (FL) 39-41 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of FL 50, and the identifying information about the insured is shown on line A of FL 58-62. The provider enters the proper occurrence code in FL 31-36 and the address of the insurer in FL 38 or Remarks (FL 80). In addition, an explanation of why the conditional payment is justified is shown in Remarks (FL 80). (See *Pub. 100-05*, Chapter 7 for an explanation of policy and procedures for conditional payment situations for contested, delayed, or no-fault claims.)

30.2.1.2 - Liability Claim Also Involved

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If the individual files a claim against a third party for injuries suffered in an accident, the provider may bill Medicare conditionally for otherwise covered expenses to the extent that payment has not been made, or cannot be made promptly by a no-fault insurer or liability insurer. For example, a *Medicare beneficiary* incurs \$20,000 in medical expenses due to an automobile accident. The individual receives \$5,000 in no-fault insurance benefits and also has a liability claim pending against the driver of the other car. Medicare does not pay benefits for the \$5,000 in expenses paid for by the no-fault insurer but does pay benefits based on the additional \$15,000 in expenses. Medicare recovers from the liability insurer or the beneficiary when the liability claim is settled.

30.2.1.3 - No-Fault Payment is Reduced Because Proper Claim Not Filed

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

When a provider receives a reduced no-fault payment because of failure to file a proper claim, (see *Pub. 100-05*, Chapter 1 for definition), the Medicare secondary payment may not exceed the amount that would have been payable if the no-fault insurer had paid on the basis of a proper claim.

The provider must inform the *A/B MACs and DME MACs* that a reduced payment was made and notify it of the amount that would have been paid if a proper claim had been filed. Failure to notify Medicare of the latter amount would constitute the filing of a false claim against the United States and could result in prosecution.

30.2.2 - Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation (*WC*)

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

Information supplied by the provider is one of the means of alerting the *A/B MACs (Part A)* to actual or potential *WC* coverage. A condition is work-related if it resulted from an accident that occurred on the job or from an occupational disease. The billing form is completed in accordance with Pub 100-04, Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the Form CMS 1450 Data Set" when any of the following apply:

- The provider or the patient states that the condition is work-related;
- The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;
- The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis, and "black lung" disease in the case of a coal miner); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;
- The beneficiary previously received workers' compensation for the same condition;
- There is indication that a workers' compensation claim is pending; or
- There is other indication that the condition arose on the job.

Where there is an indication that workers' compensation may pay for the services, the provider bills the *WC* carrier. If *WC* pays for all of the services (whether at the provider's customary charge rate or at a special *WC* rate) the provider submits a Medicare bill indicating the insurer paid in full. The beneficiary's Medicare deductible will be credited, however no payment will be made.

If the provider's *WC* claim is denied, the provider determines whether any other MSP provisions apply and bills accordingly. If no other primary payers are available, the provider submits:

- A bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in FL 31-36; an
- A supplementary statement calling attention to the fact that workers' compensation has denied payment or annotates FL 80, remarks, with the reason.

Providers, Physicians and other suppliers must follow the appropriate billing requirements to bill Medicare in Liability insurance (including self-insurance), No Fault insurance or Workers'

Compensation situations, and also as identified in *Pub.* 100-05, Chapter 5.

30.2.2.1 Responsibility of Provider Where Benefits May be Payable Under a Workers' Compensation Medicare Set-Aside Agreement (WCMSA) ***(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)***

A WCMSA is an agreement between the CMS and the CMS beneficiary about what value of settlement funds must be spent for care related to all settled WC injuries or illnesses before Medicare begins primary payment for those settled injuries or illnesses.

Indicators that a WCMSA may exist include:

- The condition was claimed as work-related and received full-and-final settlement that included funds for future care;*
- The beneficiary previously filed a workers' compensation claim for the same condition;*
- The beneficiary indicates that a WCMSA exists; or*
- The HETS 270/271 transaction shows that a "W" MSP WC record exists.*

An MSP record is not a reason to deny services, but information as to who is the appropriate primary payer for that situation. Providers must first verify via the HETS 270/271 transaction whether a "W" record exists. Where there is an indication showing a "W" MSP WCMSA record exists, the patient should have a WCMSA that may pay for services, and the provider bills the patient, directly. If the WCMSA does not pay for all of the services due to total exhaustion the provider may submit a Medicare bill indicating what the WCMSA paid. Medicare may then pay as a primary or secondary payer, dependent upon the WCMSA status. The provider should determine whether any other MSP provisions apply and bill accordingly. If no other primary payers are available, the provider submits:

- A bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in FL 31-36; and*
- A supplementary statement calling attention to the fact that WCMSA denied payment or annotates FL 80, remarks, with the reason.*

30.2.3 - Responsibility of Provider Where Benefits May be Payable Under the Federal Black Lung (BL) Program ***(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)***

Providers are to identify beneficiaries who may be entitled under the Federal Black Lung (BL) Program. Where it appears that a beneficiary may be entitled to receive medical benefits under the Federal BL Program administered by DOL, the provider bills DOL in the following situations:

- Diagnosis Is BL Related (which includes a diagnosis that is related to BL within*

the family of ICD diagnosis codes) - The provider bills **all** services to DOL, and includes its DOL assigned provider number on the billing form.

- Diagnosis Is Not BL Related - The bill is for an inpatient stay during which some BL covered procedures were furnished. The provider bills all services to DOL.
- The bill is for outpatient services that include one or more BL related procedures. The provider bills DOL only for those procedures that are reimbursable under the BL program.
- DOL Does Not Pay for All of the Services - If a provider bills DOL, but DOL doesn't pay for the services in full, the provider bills Medicare as provided in Pub. 100-04, Chapter 25, "Completing and Processing *the Form CMS 1450* Data Set," attaching a copy of DOL's denial notice which gives the specific reason for nonpayment. If a claim is denied because of the provider's failure to obtain a DOL provider number or to furnish documentation needed by DOL, payment may not be made under Medicare.

30.3 - Provider Billing Medicare for Secondary Benefits Where Services Are Covered by a GHP

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If a GHP pays primary benefits, secondary Medicare benefits may be payable to supplement the amount paid by the GHP. Medicare secondary benefits may be payable if the following situations apply:

- The plan payment is less than the provider's charges for Medicare covered services;
- The plan payment is less than the gross amount payable by Medicare; and,
- The provider does not accept and is not obligated to accept the GHP primary payment as payment in full.

When a provider bills Medicare for secondary benefits, the primary payment amounts are reported according to *sections* 40.1.1 - 40.1.2 *below*. If a GHP denies a claim for primary benefits, the provider submits a bill for conditional primary benefits with an explanation of any reason given by the plan for its denial. For an inpatient hospital or SNF stay, if the GHP's payment equals or exceeds the gross amount payable by Medicare, or equals or exceeds the provider's charges for Medicare covered services or the provider accepts or is obligated to accept the GHP payment as payment in full, a no payment bill is submitted in accordance with *Pub. 100-05*, Chapter 5.

Any excess of the GHP payment over the gross amount payable by Medicare is not deducted from the provider's Medicare reimbursement at final cost settlement. If the GHP denies a

provider's claim for primary benefits, the provider submits a claim for primary Medicare benefits or conditional primary benefits as provided for in *Pub. 100-05*, Chapter 5.

30.4 - Instructions to Providers: How to Submit Claims to *A/B MACs* (*Part A*) When There Are Multiple Primary Payers *(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)*

There are situations where there is more than one primary payer that pays on a Medicare Part A electronic claim and Medicare may still make a secondary payment on the claim. When there are multiple primary payers, providers must do the following when sending the claim to Medicare for secondary payment.

- Comply with Section 1.4.2, titled “Coordination of Benefits,” found in the 837 Institutional Implementation Guide regarding the submission of Medicare beneficiary claims to multiple payers for payment. Follow *the* model that discusses the “provider to payer to provider” methodology of submitting electronic claims.
- After receiving the electronic remittance advice from the primary payers, the provider sends the other payers’ claim information to Medicare using the 837 format. For MSP claims, they place the primary payer paid amounts, in loop 2300, qualifier HIXX-1 = BE. They place the value codes in HIXX-2 and the (value code) monetary amounts in HIXX-5. **NOTE:** In regard to Value Code 44, Obligated to Accept as Payment in Full (OTAF) amount, indicate a value of “Y” in loop 2320, segment OI03. This will inform Medicare that an OTAF amount is present on the claim and the amount can be found in the 2300 loop HI segment.
- If, for any reason, providers must send a hardcopy MSP claim, they must place the MSP Value codes and Value code amounts in FL 39-41 of the Form UB04/CMS-1450.

30.5 - Instructions to Physicians and Other Suppliers: How to Submit Claims to *A/B MACs* (*Part B*) and *DME MACs* When There Are One or More Primary Payers *(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)*

A. When Medicare is the Secondary Payer Following One Primary Payer There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. Physicians and other suppliers must comply with *the* Section titled “Coordination of Benefits,” found in the 837 version Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims. Physicians and other suppliers must follow *the* section that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Physicians and other suppliers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837 as identified below:

Primary Payer Paid Amount:

For line level services, physicians and other suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and other suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount:

For line level services, physicians and other suppliers must indicate the primary payer allowed amount *by identifying the adjustment amount in the CAS segment using the CO 45* for that service line of the 837.

For claim level information, physicians and other suppliers must indicate the primary payer allowed amount *by identifying the adjustment amount in the CAS segment using the CO 45 for the 837 claim.*

Obligated to Accept as Payment in Full Amount (OTAF):

The OTAF amount for Part A and Part B claims is identified in the CAS segment as group code CO (usually associated with Claim Adjustment Reason Code 45) with the associated dollar adjustment amount. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

B. When Medicare is the Secondary Payer Following Multiple Primary Payers

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, a group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500. Physicians and other suppliers must attach the other payers' EOB, or remittance advice, to the claim when sending it to Medicare for processing.

C. Submission of MSP Claims with Multiple Primary Payers Where There is More Than One Insurance Type Code for Part B Claims

When *A/B MACs (Part B) and DME MACs* receive claims with more than one insurance type code, the *A/B MACs (Part B) and DME MACs* must send the shared system and CWF the insurance type code associated with the highest other payer total claim payment amount. For example, a Medicare beneficiary sustains injury in a car accident. Five services were performed on the beneficiary. Since the services performed were related to the accident, the no-fault insurer (referred to as insurance type code 14) makes a \$500.00 payment on each line of the claim totaling \$2,500.00. The beneficiary also has coverage through the spouse's group health plan. The spouse's plan (referred to as insurance type code 12) makes a \$400.00 payment on each line of the claim totaling \$2000.00. The *A/B MACs (Part B) and DME MACs* must send insurance type code 14 (not insurance type code 12) to the shared system and CWF.

D. Amounts *A/B MACs (Part B) and DME MACs* and Part B Shared Systems must send MSPPAY on electronic and paper claims with one or more Primary Payers

There are situations with MSP Part B claims when the 1) the primary payer allowed amount(s) are greater than the billed amount; 2) the primary paid amount(s) are greater than the primary payer contractual amounts (a.k.a. the obligated to accept as payment in full (OTAF) amounts); and 3) the primary paid amount(s) are in excess of the primary allowed amount. When MSP claims of these types are received and processed it causes the outbound remittance advice (RA) to be out of balance. To prevent this from occurring the following actions must be taken:

When the other insurer paid amount, or combined paid amount exceeds the physician or other supplier billed amount, the shared systems shall send the billed amount in place of the primary payer's paid amount to MSPPAY and CWF.

When the primary payer allowed amount exceeds the physician or other supplier's billed amount, the shared systems shall send the billed amount in place of the primary payer allowed amount to MSPPAY.

When the primary paid amount is greater than the primary allowed amount, and less than billed charges, the shared systems shall send the primary payer paid amount instead of the primary allowed amount to MSPPAY.

When the primary payer paid amount exceeds the primary payer contractual amount, the shared system shall send the primary payer contractual amount instead of the primary payer paid amount to MSPPAY.

The remittance advice must show the billed amount, the Medicare payment amount, and the

“impact amounts” from the primary payer(s) on which the Medicare payment is based, and all Medicare adjustments. The impact amount, as found in *section 2.2.13* of the 835 Implementation Guide, is defined as the amount on which Medicare’s payment is based. This amount will depend on the payment methodology followed in the above business requirements.

Shared Systems shall no longer use reason code 35 on the outbound remittance advice unless the life time benefit has been reached is the reason the claim is being adjusted. Shared systems instead shall use Group Code “CO” with Reason Code “45” on the outbound remittance advice when the OTAF amount minus the other payer’s payment is the lowest of the three MSP calculations and is used to identify Medicare’s Secondary payment.

NOTE: In regards to the outbound 837, when the primary payment is equal to or exceeds the billed amount, and Medicare’s payment is equal to zero, the outbound 837 shall show Medicare’s zero payment in the 2320 AMT segment. The shared systems shall identify in the CAS segment of the outbound 837 the amount that exceeds the billed amount and the reason why Medicare is making a zero payment by using group code and claims adjustment reason code CO 94 (processed in excess of charges), with an accompanied negative dollar amount, and OA 23 (payment adjusted because charges have been paid by another payer) with an accompanied negative dollar amount.

E. - When *A/B MACs (Part B) and DME MACs* receive a hard copy Part B claim with multiple primary payer amounts

A/B MACs (Part B) and DME MACs must take into consideration instructions found in *section 30.5.D* above when sending the correct amounts to MSPPAY for payment calculation.

Primary Payer Paid Amounts: For line level service claims, the *A/B MACs (Part B) and DME MACs* must add all primary payer paid amounts for that service line and send the total line level payment amount to MSPPAY. If only claim level information is sent to Medicare, the *A/B MACs (Part B) and DME MACs* add all other payer paid amounts for that claim and sends the total claim payment amount to MSPPAY. Note: If the payment amount is greater than the billed amount, send the billed amount to MSPPAY instead of the other payer paid amount.

Primary Payer Allowed Amount: For line level services, *A/B MACs (Part B) and DME MACs* use one of the two fields as follows:

- Either the higher of the allowed amount for that service line, or
- The total of the other payer paid amounts, whichever is higher, and send it to MSPPAY.

If only claim level information is sent to Medicare, *A/B MACs (Part B) and DME MACs* use one of the two fields as follows:

- Take the total claim level allowed amount, or
- The total of the paid amount, if less than the billed amount, whichever is higher, and send it to MSPPAY.

Obligated to Accept as Payment in Full Amount (OTAF): For line level services, the carrier takes the lowest OTAF amount for that service line, which must be greater than zero, and sends that amount to MSPPAY. If only claim level information is sent to Medicare, the *A/B MACs (Part B) and DME MACs* take the lowest claim level OTAF amount, which must be greater than zero, and send it to MSPPAY. **(NOTE:** If submitted charges are lower than the OTAF amount, then send the lowest Medicare covered charge for that service line to MSPPAY.

Claim Example:

Below is an example of a hard copy Part B MSP claim, with more than one primary payer, sent to *A/B MACs (Part B) and DME MACs*. All services are Medicare covered services.

Payer 1	Submitted Covered Charges	Other Payer Allowed Amount (Medicare Part B only)	OTAF	Other Payer Paid Amount
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Line 1	\$60.00	\$60.00	\$50.00	\$40.00
Line 2	\$40.00	\$30.00	\$30.00	\$30.00
Total	\$100.00	\$90.00	\$80.00	\$70.00

	Payer 2	Submitted Covered Charges	Other Payer Allowed Amount (Medicare Part B only)	OTAF	Other Payer Paid Amount
The A/B MACs (Part B) and DME	Line 1	\$60.00	\$50.00	\$50.00	\$40.00
	Line 2	\$40.00	\$30.00	\$0	\$30.00
	Total	\$100.00	\$80.00	\$50.00	\$70.00

MACs must send the following line level other payer amounts to MSPPAY based on the instructions cited above.

Line 1:	Other Payer Allowed Amount (Part B):	\$60.00	Based on the
	OTAF:	\$50.00	
	Other Payer Paid Amount:	\$50.00 (the OTAF amount is substituted for line1)	
Line 2	Other Payer Allowed Amount (Part B)	\$40.00	
	OTAF:	\$30.00	
	Other Payer Paid Amount	\$30.00 (the billed amount is substituted for line1)	

example above, since Payer 2 had no OTAF amount on service line 2 and Payer 1 had an OTAF amount greater than zero on service line 2, Payer 1's OTAF of \$30.00 is used and sent to MSPPAY. Since the combined payment amount is higher than the primary payer OTAF amount for Line 1 and line 2, the OTAF amounts are sent to MSPPAY in place of the paid amounts.

30.6 - MSP Situations Under *the Competitive Acquisition Program (CAP)* *(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)*

Drugs Obtained Through the CAP for Beneficiaries with Insurance Primary to Medicare

Providers *that* elect into the CAP voluntarily agree to obtain CAP drugs for Medicare beneficiaries exclusively through an approved CAP vendor. In situations where participating CAP providers obtain a drug from the CAP vendor for a beneficiary who is incorrectly determined to have Medicare as their primary insurer, but the provider and the CAP vendor must first bill the appropriate primary insurer for the drug and the administration service.

Upon receipt of the primary insurer's payment, MSP claims should then be submitted by the physician to their local carrier for the administration service and by the approved CAP vendor to the CAP designated carrier for the drug. Providers are required to submit MSP claims even if they believe there is no outstanding balance due. Such claims must adhere to CAP guidelines and include the drug HCPCS code, the prescription number provided by the approved CAP vendor and an appropriate CAP no-pay modifier.

Approved CAP vendor claims must also adhere to CAP requirements and include the assigned prescription number.

All participating CAP providers to submit MSP claims for drug administration services where the drug was obtained from the approved CAP vendor. Failure to submit an MSP claim for the drug administration prevents the processing of the vendor's MSP claim by the CAP designated carrier.

Drugs Obtained Outside of the CAP for Beneficiaries *with* Medicare

In certain rare situations, participating CAP providers may mistakenly obtain drugs for Medicare beneficiaries outside of the CAP vendor because they had determined that the beneficiary had another insurer that was primary to Medicare. In order to make an appropriate payment for drugs administered under these unusual circumstances, we are allowing temporary use of the J3 modifier to bypass CAP edits and pay the participating CAP provider at the current ASP rate.

We have requested a modifier for use in this rare situation. Local carriers will be notified through the usual quarterly update process when a new modifier is available. At that time, the J3 modifier will no longer be accepted for this purpose.

As we expect the situations that require this modifier to be infrequent, local carriers have the ability to review claims with this modifier to monitor for proper use and educational opportunities.

MSP Claims *for* Drugs Present on the Provider's CAP Drug List

In order to prevent processing errors for MSP claims where the drug billed on the provider's claim is present on the selected CAP drug list, local carriers are to implement a SCF rule allowing an override of the CAP claims processing edits. This SCF rule will allow claims to be identified as MSP and not require the CAP modifiers or prescription number.

40 - Completing the Form CMS-1450 in MSP Situations by Providers

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

Where Medicare is determined to be the primary payer, Medicare is shown on line A of FL 50. Where Medicare is *the* secondary *payer*, Medicare is shown on line B. All bills where Medicare is secondary because of primary payer coverage are prepared in accordance with the following instructions.

40.1- Full Payment by the Primary Payer

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

See below inpatient and outpatient processes.

40.1.1- Inpatient Services

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

If payment by the primary payer for Medicare covered services (as determined by the formula in [section 40.2.2 below](#)) equals or exceeds the provider's charge for those services or the current Medicare interim payment amount (without regard to deductible or coinsurance), or the provider accepts or is obligated to accept the primary payer payment as payment in full and receives at least this amount, no payment is due from Medicare, and no utilization is charged to the beneficiary. However, the provider submits a no-payment bill for determining the benefit period. In addition, primary payer payments are used to satisfy unmet deductibles. The *A/B MACs (Part A)* shall process the bill in accordance with *Pub. 100-5*, Chapter 5 and as follows:

- The provider completes the total and noncovered charges columns as if there had been no other payment;
- Where blood is involved, the provider completes the blood items. (This data is for the beneficiary's utilization records only and is not to be used for the Provider Statistical & Reimbursement [PS&R] Report);
- The provider does not complete the coinsurance amount (no days are charged). However, inpatient deductible and total deductions are completed when applicable. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R Report.);
- The provider shows total covered and noncovered days in the usual manner. The *A/B MACs (Part A)* count days paid by the primary payer as covered days;
- The provider enters the appropriate value code to identify the primary payer;
- The provider enters the amount paid by the primary payer in the Value Amount field;
- The provider enters condition code 77 in the condition code field when it receives an amount it is obligated to accept from the primary payer as payment in full;
- The *A/B MACs (Part A)* do **not** complete the nonpayment code;
- The *A/B MACs (Part A)* enter the additional MSP data elements that may apply to the bill based on the applicable MSP provision according to [section 50](#) below.

40.1.2 - Outpatient Bills, Part B Inpatient Services, and *Home Health Agency*

(HHA) Bills

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

No bill is submitted if:

- Payment by the primary payer for Medicare covered services equals or exceeds:
 - The provider's charges for those services, or
 - The current Medicare interim payment amount (without regard to the deductible or coinsurance), or the provider accepts (or is obligated to accept) the primary payer's payment as payment in full (and it receives at least this amount) and the provider knows the individual has already met the deductible.
- A GHP payment for an ESRD beneficiary equals or exceeds the *Medicare* rate (without regard to the deductible or coinsurance) and the hospital-based renal dialysis facility knows the individual has **met the deductible**; and
- Where *an* HHA is billing for DME or orthotic/prosthetic devices and the patient is not under a plan of treatment and the provider knows the individual has met the deductible.

A bill is submitted to:

- Inform Medicare of charges where the deductible may not yet be met. Although Medicare can make no payment, it can apply the expenses to the beneficiary's deductible. A bill is required for crediting the deductible.

The provider completes the bill in the usual manner and determines the charges including those covered by the primary payer's payment. The amount paid by the primary payer for Medicare covered services is reported in the appropriate value code and amount. See *section* 50 below for additional MSP data elements that may apply to the bill based on the applicable MSP provision. The provider enters condition code 77 when it receives the amount it is obligated to accept from the primary payer as payment in full.

40.2 - Partial Payment by Primary Payer

(Rev.11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

See partial payment processes and procedures below.

40.2.1 - Partial Payment by Primary Payer for Inpatient Services, Outpatient Services, Part B Inpatient Services, and HHA Bills

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

A modified bill will be submitted if payment by the primary payer for Medicare covered services is less than the provider's charges for those services and the current Medicare interim payment amount (without regard to the deductible or coinsurance) and the provider does not accept (and is not obligated to accept) the primary payer's payment as payment in full, or the primary payment is less than the *Medicare* rate (without regard to the deductible and coinsurance),

The bill will be submitted in accordance with Chapter 25, "Completing and Processing *the Form CMS 1450* Data Set," of the Medicare Claims Processing Manual, with the following modifications:

- The provider completes the total and noncovered charges as if there had been no other payment;
- For inpatient hospital or SNF services, the provider completes total covered and non-covered days in the usual manner. It counts days paid by the primary payer as covered days;
- The primary payer is identified on the first payer line in FL 50. Medicare is identified as the secondary or tertiary payer by completing the second or third payer line;
- The appropriate primary payer value code and amount paid is shown in value code and amount fields;
- The amount the provider is obligated to accept as payment in full from the primary payer when the primary payer pays a lesser amount is shown as value code 44;
- The address of the primary payer is shown in Remarks (FL 84); and
- If the primary payer is a GHP for an ESRD beneficiary, the provider enters occurrence code 33 and the first day of the first month of the Medicare coordination period. In addition, the provider enters the appropriate occurrence/condition codes in *section* 50 below.

40.2.2 - Partial Payment by Primary Payer That Applies to Medicare Covered Services

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

The provider indicates the primary payer's allocation of its payment between covered and non-covered Medicare services, by entering the amount the primary payer paid toward Medicare covered services in value codes (FLs 39 - 41) and value amount fields on the Form CMS-1450. Where the provider cannot determine those services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes/amounts (FLs 39-41). It treats all services (other than those for which the beneficiary may be charged, such as a private room that is not medically necessary) furnished on any day for which benefits are payable as covered. It must be able to validate its ratio of covered and non-covered charges if requested.

If a benefit exhausted case is also a day outlier, Medicare covered charges cannot be determined until the impact of the primary payment on utilization is determined.

EXAMPLE 1

Total charges were \$110. Medicare covered charges were \$90. The primary payer's payment was \$88. Since the provider cannot determine the actual allocation of the primary payer's payment, it uses the following calculation to determine the allocation shown below:

$$(\$90 \text{ divided by } \$110) \times \$88 = \$72$$

The provider enters \$72 in value code/amounts (FLs 39-41).

EXAMPLE 2

Total charges were \$5,000. Medicare covered charges were \$4,000. The primary payer's payment was \$3,000. Since the non-PPS provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$(\$4,000 \text{ divided by } \$5,000) \times \$3,000 = \$2,400$$

The non-PPS provider enters \$2,400 in the value code amount.

EXAMPLE 3

Total charges were \$550. Medicare covered charges were \$500. The primary payer's payment was \$330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$(\$500 \text{ divided by } \$550) \times \$330 = \$300$$

The HHA enters \$300 in the value code amount.

40.3 - Annotation of Claims Denied by GHP's, Liability or No-Fault Insurers *(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)*

Primary Medicare benefits *that* are paid (if the beneficiary is not appealing the GHP denial) when a single or a multiple employer plan for which CMS has approved the plan's multi-employer exemption request denies a claim for primary benefits because:

- The beneficiary is age 65 or over and is enrolled in a single employer plan of an employer who does not employ 20 or more employees;
- The beneficiary is age 65 or over and is enrolled in a multi-employer plan by virtue of employment with an employer that does not employ 20 or more employees and the plan has elected the small employer exception;
- The beneficiary is not entitled to primary benefits under the plan;
- The beneficiary is under age 65 and disabled and the employer does not employ 100 or more employees and the employer is not a member of a multiple employer GHP which has at least one employer that employs 100 or more employees;
- The beneficiary is not entitled to benefits under the plan on the basis of rules that apply equally to all participants without regard to age or Medicare entitlement;
- Benefits under the GHP are exhausted for the services involved;
- The services are not covered by the GHP under any circumstances for any covered individual;
- The beneficiary has Medicare based on ESRD (under age 65 and eligible based on ESRD) and not in a Medicare coordination period.

Medicare does not pay primary Medicare benefits if it is believed that the GHP covers the particular service and the plan asserts that the services are not covered for "primary payment" when provided to Medicare beneficiaries.

Where a GHP denies payment for any of these reasons, the provider shows occurrence code 24 or 25 (insurance denied) and the date of denial in FLs 32-35 (occurrence codes). In addition, it provides the reason for the denial in Remarks (FL 84).

Medicare primary benefits cannot be paid when a GHP offers only secondary coverage of services covered by Medicare and it does not allege that the employer has fewer than 20 employees (or 100 employees in the case of disabled beneficiaries). The provider enters occurrence code 24 (insurance denied) and the date of denial in FLs 32-35 (occurrence codes). In addition, it enters the annotation "Plan offers secondary coverage of services covered by Medicare."

40.3.1 - Annotation of Claims to Request Conditional Payments

(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

When a liability or no-fault insurer does not make payment e.g., the services are not covered under no-fault insurance or the individual's insurance coverage expired, the provider bills Medicare as usual. In addition, the proper occurrence code is shown in FLs 32-35. Occurrence code 24 is completed to show the date the other payer denied the claim, and the reason for denial is shown in Remarks (FL 84).

A conditional primary payment may be requested if conditional payment criteria are met.

The provider enters value code 14 with a zero-value amount in FLs 39-41 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of FL 50, and the identifying information about the insured is shown on line A of FLs 58-60. The provider enters the proper occurrence code in FLs 32-35 and the address of the insurer in FL 38 or Remarks (FL 84). In addition, an explanation of why the conditional payment is justified is shown in Remarks (FL 84). (See *Pub. 100-05*, Chapter 7 for an explanation of policy and procedures for conditional payment situations for contested, delayed, or no-fault claims.)

When a GHP does not make payment for the reasons described below, a conditional Medicare payment can be requested. Conditional payments may be requested where:

- The provider has filed a proper claim under the plan and the plan denies the claim in whole or in part; or
- The provider fails to file a proper claim because of the physical or mental incapacity of the beneficiary.

The provider requests conditional primary payment by entering the appropriate value code to indicate the type of other insurer. Applicable GHP value codes are 12, 13 or 43. The value amount is completed with zero value in FLs 39-41. In addition, it includes occurrence code 24 (insurance denied) and the date of denial by the GHP. The identity of the GHP is entered on line A of FL 50, the identifying information about the insured is entered on line A of FLs 58-62, and the address of the GHP is entered on FL 38 or Remarks (FL 84). In addition, the provider enters the annotation "Beneficiary has

appealed or is protesting GHP denial" in Remarks, FL 84.

Neither primary benefits nor conditional primary Medicare payments may be made where a GHP denies payment for particular services on the grounds they are not covered by the plan, and the *A/B MACs (Part A)* believe the plan does cover them. Conditional benefits are not paid if a plan offers only secondary coverage for services covered by Medicare, and the

GHP does not allege that the employer has fewer than 20 employees. Conditional primary benefits are not paid even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, the *A/B MACs (Part A)* denies the claim for Medicare primary benefits unless the single employer GHP or multi-employer plan with an approved multiple employer plan exemption alleges that the employer has fewer than 20 employees.

50 - Summary of MSP Data Elements for *the Form CMS-1450 (UB-04)*
(Rev. 11874, Issued: 02-23-23, Effective: 03-24-23; Implementation: 03-24-23)

The following table identifies the data elements that are submitted on bills to communicate the status of the primary payer and payment where Medicare is the secondary payer. See Medicare Claims Processing Manual *100-04*, Chapter 25, "Completing and Processing *the Form CMS -1450* Data Set," for a crosswalk to the electronic data elements or segment names.

Data Element	Value for MSP	MSP Situation
Condition Code		
	02-Employment Related	Workers' Compensation and Black Lung
	05-Lien has been filed	WC, No-fault, Liability,
	06-ESRD Patient within coordination period and covered by GHP	End Stage Renal Disease and covered by a GHP
	08-Beneficiary would not furnish information concerning other insurance coverage	All MSP situations
	09-Neither patient nor spouse is employed	Working Aged, Disability, or ESRD
	11-Disabled Beneficiary but no GHP exists	Disability

Data Element	Value for MSP	MSP Situation
	28-Patient and/or Spouse's GHP is Secondary to Medicare	Working Aged
	29-Disabled Beneficiary and/or Family Member's GHP is Secondary to Medicare	Disability
	77-Provider Accepts Payment by a Primary Payer as Payment in Full	All MSP Situations
	D7-Claim Change Reason Code for Adjustment Requests to Make Medicare the Secondary Payer	All MSP Situations
	D8-Claim Change Reason Code for Adjustment Requests to Make Medicare the Primary Payer	All MSP Situations

Occurrence Code and Date

01-Auto Accident	No-Fault or Liability
02-No-fault Insurance including Auto accident/Other	No-Fault
03-Accident/Tort Liability	Liability
04-Accident/Employment Related	WC or BL
05-Other Accident	Liability
18-Date of Retirement	Working Aged, Disability, or ESRD
19-Date of Retirement Spouse	Working Aged, Disability, or ESRD
24-Date Insurance Denied	All MSP Situations
25-Date Benefits Terminated by Primary Payer	All MSP Situations
33-First day of the Medicare coordination period for ESRD beneficiaries covered by GHP	ESRD
A1-Birth date -Insured A	Working Aged, Disability, or ESRD
A2-Effective Date-Insured A Policy	Working Aged, Disability, or ESRD

Data Element Value for MSP**MSP Situation**

A3- Benefits Exhausted for Payer A	Working Aged, Disability, or ESRD
B1-Birth date -Insured B	Working Aged, Disability, or ESRD
B2-Effective Date-Insured B Policy	Working Aged, Disability, or ESRD
B3- Benefits Exhausted for Payer B	Working Aged, Disability, or ESRD
C1-Birth date -Insured C	Working Aged, Disability, or ESRD
C2-Effective Date-Insured C Policy	Working Aged, Disability, or ESRD
C3- Benefits Exhausted for Payer C	Working Aged, Disability, or ESRD

Value Codes and Amounts

12- Working Aged Beneficiary/Spouse Group Health Plan	Working Aged
13-ESRD Beneficiary in a Medicare Coordination Period with an Employer Health Plan	ESRD
14-No-fault, including auto/other.	No-Fault
15-Workers' Compensation Six zeros in the amount field indicates a request for a conditional Medicare payment.	WC
16-PHS, Other Federal Agency	Other Federal Agency, VA
41-Black Lung Six zeros in the amount field indicates a request for a conditional Medicare payment.	Black Lung
42-Veterans Affairs	VA
43-Disabled Beneficiary Under Age 65 with GHP	Disability
44-Amount Provider Agreed to Accept from Primary Payer as Payment in Full	All MSP Provisions
47- Any Liability Insurance	Liability Provisions

Insured's Name

Data Element Value for MSP

For Primary Payer Information

MSP Situation

All MSP Provisions

Patient's Relationship to Insured

01-Patient is Insured

All MSP Provisions

02-Spouse

All MSP Provisions

03- Natural Child/Insured has Financial
Responsibility

Disability, ESRD

08- Employee

Working Aged, ESRD, Disability

15-Injured Plaintiff

Liability

Certificate/Social Security Number/Medicare beneficiary identifierThe involved claim number for the
primary coverage is shown

All MSP Provisions

Insurance Group Number

Identification number

All MSP Provisions

Employment Status Code

1-Employed Full Time

Working Aged, ESRD, Disability

2-Employed Part-Time

Working Aged, ESRD, Disability

3-Not Employed

Working Aged, ESRD, Disability

4-Self-employed

Working Aged, ESRD, Disability

5-Retired

Working Aged, ESRD, Disability

Employer Name

WC, Working Aged, ESRD, Disability

Employer Location

WC, Working Aged, ESRD, Disability

Payer ID

Data Element Value for MSP

MSP Situation

All MSP Provisions

60 - Completing the Form CMS-1500 in MSP Situations by Physicians and Other Suppliers of Services

(Rev. 11874, Issued: 02-23-23; Effective: 03-24-23; Implementation: 03-24-23)

Instructions for completing the Form CMS-1500 can be found in Pub 100-4, Chapter 26, "Completing and Processing Form CMS-1500 Data Set," of the Medicare Claims Processing Manual. Specific data elements used to report MSP information are listed below. In addition, each claim must have an EOB *or remittance advice* from the primary payer attached that identifies the amount allowed, paid, or denied by the primary payer.

Item	Data Element Name	Instruction to Physician or Other Supplier
Item 4	Insured's Name	If the patient has insurance primary to Medicare, either through the patient's or the spouse's employment or any other source, the biller lists the name of the insured here. When the insured and the patient are the same, the biller enters the word SAME. If Medicare is primary this item is left blank.
Item 7	Insured Address	The insured's address and telephone number. When the address is the same as the patients, the biller uses the word SAME. It completes this item only when items 4 and 11 are completed.
Item 8	Patient Status	The patient's marital status and whether employed or a student.
Item 9	Other Insured Name;	The last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, the biller uses the word SAME. If no Medigap benefits are assigned, the biller leaves this item

Item	Data Element Name	Instruction to Physician or Other Supplier
		blank. This field may be used in the future for supplemental insurance plans. Participating physicians and other suppliers taking assignment under a MEDIGAP policy complete this item. Other supplemental claims are not listed here because they are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.
9a	Other Insured's Policy or Group Number	Item 9a. The policy and/or group number of the Medigap insured preceded by: MEDIGAP, MG, or MGAP.
9b	Other Insured's Date of Birth	Item 9b. The Medigap insured's 8-digit birth date (MMDDCCYY) and sex.
9c	Employer's Name or School Name;	Item 9c. Blank if a Medigap PayerID is in item 9d. Otherwise, the claims processing address of the Medigap insurer.
9d	Insurance Plan Name or Program Name	Item 9d. The 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then the Medigap insurance program or plan name is shown.
Item 10a	Is Patient's Condition Related to Employment?	Items 10a thru 10c. "YES" or "NO" must be checked to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. The State postal code must be shown. Any item checked "YES" indicates there may be other insurance primary to Medicare. Primary insurance information must then be shown in item 11.
Item 10b	Is Patient's Condition Related to Auto Accident?	
Item 10c	Is Patient's Condition Related to Other Accident?	
Item 11	Insured's Policy Group or FECA Number	If there is insurance primary to Medicare, the biller enters the insured's policy or group number.
Item 11a	Insured's Date of Birth	Insured's 8-digit birth and sex if different from item 3

Item Data Element Name Instruction to Physician or Other Supplier

- Item 11b Employer's Name or School Name The name of the insured's employer is shown here. If there is a change in the insured's insurance status, e.g., retired, this contains a retirement date preceded by the word "RETIRED".
- Item 11c Insurance Plan or Program Name The 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, the complete primary payer's program or plan name. If the primary payer's EOB does not contain the claim processing address, this contains the primary payer's claims processing address as shown on the EOB.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R11874MSP</u>	02/23/2023	Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 3	03/24/2023	13085
<u>R10359MSP</u>	09/15/2020	Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries	12/07/2020	11945
<u>R10342MSP</u>	09/04/2020	Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries - Rescinded and replaced by Transmittal 10359	12/07/2020	11945
<u>R125MSP</u>	03/22/2019	Update to Publication (Pub.) 100-05 to Provide Language-Only Changes for the New Medicare Card Project	04/22/2019	11193
<u>R123MSP</u>	08/17/18	Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual	11/20/18	10863
<u>R87MSP</u>	08/03/2012	Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims	10/01/2012	7355
<u>R86MSP</u>	05/25/2012	Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims Rescinded and replaced by Transmittal 87	01/07/2013	7355

<u>R85MSP</u>	05/03/2012	Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims – Rescinded and replaced by Transmittal 86	10/01/2012	7355
<u>R57MSP</u>	10/27/2006	Instructions for the Coordination of Medicare Secondary Payer (MSP) Claims for the Competitive Acquisition Program (CAP)	01/02/2007	5332
<u>R53MSP</u>	06/09/2006	Modifications to Online Medicare Secondary Payer Questionnaire. This CR Rescinds and Replaces CR 4098	09/11/2006	5087
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