

Medicare Secondary Payer (MSP) Manual

Chapter 1 - *General MSP* Overview

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10 - *Understanding MSP: Definitions and Important Terminology*
(Rev. 11755, Issued:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The following section provides the most commonly used MSP definitions and terms. These definitions and terms will be frequently referenced throughout this chapter of the IOM as well as the remaining Pub. 100-05.

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

Age 65 or older – An individual attains age 65 on the day preceding his or her 65th birthday.

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

CMS' Claim - In the context of Workers' Compensation (WC), no-fault, and liability claims, the amount that is determined to be owed to the Medicare program. This is the lesser of the total sum of the settlements, judgments, or awards related to the underlying WC, no-fault, or liability claim; or the amount that was paid out by Medicare, less any applicable share of procurement costs.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - A Title X provision that provides continuation of GHP coverage if elected. For aged or disabled Medicare beneficiaries, COBRA continuation coverage is secondary to Medicare because the coverage is by virtue of COBRA law rather than by virtue of current employment status. For an ESRD related Medicare beneficiary, COBRA continuation coverage, if elected, is primary to Medicare during the 30-month ESRD coordination period. See 42 CFR 411.161(a)(3) and 411.162(a)(3).

Compromise - A settlement of differences by mutual consent or adjustment of matters in dispute by mutual concession; a negotiated settlement between parties who are in essentially equal bargaining positions, wherein neither party admits or concedes that he is entitled to less than he desires, but accepts less to affect the goal of ending the dispute. In an MSP situation under the Federal Claims Collection Act, a compromise represents the acceptance by the Regional Office (RO) of less than the full debt owed to Medicare, when the amount of the full debt does not exceed \$100,000, or by Central Office (CO) when the amount exceeds \$100,000. An individual who accepts a compromise has no right to appeal the remaining debt.

Conditional Payment - A Medicare payment, conditioned upon reimbursement to Medicare, for items or services for which another insurer is the primary payer.

Coordination Period - A period of 30 months during which Medicare benefits are secondary to benefits payable under GHPs for individuals who are eligible for Medicare because of ESRD.

Current Employment Status - *An individual that is:*

- *Actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or*
- *The individual is not actively working and is receiving disability benefits from an employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or not actively working but meets **all** of the following conditions:*
 - *Retains employment rights in the industry;*
 - *Has not had their employment terminated by the employer if the employer provides the coverage or has not had his/her membership in the employee organization terminated if the employee organization provides the coverage;*
 - *Is not receiving disability benefits from an employer for more than 6 months;*
 - *Is not receiving Social Security disability benefits, and*
- *Has employment-based GHP coverage that is not COBRA continuation coverage. [See 29 U.S.C. 1161-1168.]*

Note, A person aged 65 or older and receiving disability payments from an employer is considered to have current employment status if such payments are subject to taxes under FICA. Employer disability payments are subject to FICA tax for the first six months of disability after the last calendar month in which the employee worked for that employer.

Eligibility - A beneficiary meets the legal requirements for Medicare benefits. It is still necessary to file an application to become entitled. (For example, a Social Security beneficiary is eligible for Medicare upon attaining age 65 but is not entitled until an application is filed and approved).

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

Employer - In addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions. Included are the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the District of Columbia, and foreign governments.

Entitled - An eligible individual becomes entitled to Medicare by filing the appropriate

application. Upon approval of the application, the individual is entitled. It may also be necessary to enroll for certain services in order to get them.

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

FICA - The Federal Insurance Contributions Act, the law that imposes Social Security taxes on employers and employees under §21 of the Internal Revenue Code.

Fiduciary - A person in a position of trust with regard to the affairs of another, who has a duty to act primarily for the benefit of the other, with respect to a particular undertaking.

GHP (Group Health Plan) - Any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than insurance agents, the plan is not considered a GHP. However, if the plan includes insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State, and local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs which are under the auspices of one or more employers or employee organizations but which do not receive any contribution from the employer). Individual policies (including Medigap policies) purchased by or through an employee organization, employer or former employer of the individual or family member of the individual are considered employer offered GHPs. However, coverage under the TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is not considered to meet the definition of a GHP. It is secondary to Medicare since the law makes Medicare primary to TRICARE *unless the individual is under active duty status*.

Any health plan (including a union plan) in which a beneficiary is enrolled because his/her employment or a family member's employment meets this definition.

Judgment - The official and authentic decision of a court of justice upon the respective rights of the parties to an action submitted to it for determination.

LGHP (Large Group Health Plan) - A GHP that covers employees of either:

- A single employer or employee organization that employed at least 100 full-time

or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

- Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.
- It includes individual policies (including, in rare circumstances, Medigap policies) purchased by an or through an employer or former employer of the individual or family member.

Liability - Responsibility or fault for damages arising out of a specified incident.

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

Liability Insurance Payment - A payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurer, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

Lump Sum Commutation Settlement - A workers' compensation settlement in which the beneficiary accepts a lump sum payment that compensates for all future medical expenses and disability benefits related to the work injury or disease.

Lump Sum Compromise Settlement - A workers' compensation settlement that provides less in total compensation than the individual would have received if he or she had received full reimbursement for lost wages and lifelong medical treatment for the injury or illness. This may occur when compensability is contested.

MSP - The "Medicare Secondary Payer" provisions of the Social Security Act, also used to describe situations where those provisions apply.

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

Multi-employer Group Health Plan - A plan that is sponsored jointly or contributed to by two or more employers (sometimes called a multiple employer plan) or by employers and unions (as under the Taft-Hartley law).

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

Nonconforming Group Health Plan or Large Group Health Plan - *A plan that at any time during the calendar year takes into account that an individual is eligible for, or receives, benefits based on working aged or disability, e.g., a plan fails to pay primary benefits for Medicare entitled individuals for whom Medicare is secondary payer in accordance with the MSP provisions and regulations as found in 42 CFR §411.10 and 42 CFR §411.130.*

Partial Waiver - A decision by the Medicare program to relinquish the right to collect a portion of a debt from a specific entity. A partial waiver is not to be confused with a compromise. It is different in that it does not arise from negotiation or offer but under 1870(c) of the Act, which provides the beneficiary the right to request waiver, and Medicare the authority to grant or deny waiver, based on factual data. Section 1870(c) allows a partial waiver to a person who is without fault or where the adjustment or recovery would defeat the purpose of Title II or XVII of the Act (hardship) or be against equity and good conscience. An individual may appeal a determination based on 1870(c) of the Act if the determination grants only partial waiver of a debt.

Payment in full – An amount that the provider, physician, or other supplier is obligated to accept (e.g., contractually), or voluntarily accepts, for medical services to an individual from the insurer (e.g., the GHP) in full satisfaction of the patient’s payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient’s payment obligation satisfies any Medicare payment obligation.

Plan - Any arrangement by an employer, more than one employer, or an employee organization to provide health benefits or medical care to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is a single plan if the arrangement provides for common administration of the health benefits. An arrangement may be administered by the employers directly, by a benefit administrator, by a multi-employer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

Primary Payer - When used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary Payment - *Payment for an item or service that is made, or reasonably expected to be made, by the entity that has primary payment responsibility.* When used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

Primary Plan - When used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers’ compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

Proceeds - Benefits paid under any insurance plan or policy, or annuity contract.

Procurement Costs - Attorney fees and other costs directly related to securing a settlement

or judgment that are borne by the beneficiary against whom CMS seeks to recover.

Prompt or Promptly - With regard to liability insurance means payment within 120 days after the earlier of:

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

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

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

Recovery - Proceeds obtained from a judgment, settlement, erroneous or conditional payment.

Secondary – *With respect to Medicare payment*, means that Medicare is the residual payer to all plans that are primary plans with respect to services provided to a Medicare beneficiary.

Self-Employed Person - An individual is considered to be self-employed during a particular tax year only if the individual's self-employment income, as determined by the IRS, was at least equal to the amount specified in §211(b)(2) of the Act, which defines self-employment income for Social Security purposes.

Set-Aside Arrangement – An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set-aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).

SSI (Supplemental Security Income for the Aged, Blind and Disabled) - The Federal subsistence income maintenance program for eligible individuals. Title XVI of the Social Security Act enacted SSI in 1972 for the purpose of assuring a minimum level of income for people who are age 65 or over, blind, or disabled, and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level.

Self-Insured Plan - A plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a nonprofit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay for liability claims under the Federal Tort Claims Act. An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by failure to obtain insurance or otherwise) in whole or in part. (With regard to FTCA claims, CMS attempts to collect its mistaken payment from the Federal agency that is settling the claim. If a resolution cannot be reached, CMS must submit the conflict to the Department of Justice for resolution.)

Settlement - An adjustment or agreement by which parties having a dispute between them ascertain what each owes the other. In the MSP liability context, settlement refers to a monetary amount from a liability insurer agreed to by a party in satisfaction of a liability dispute.

Spouse – (on or before December 31, 2014) means a person of the opposite sex who is a husband or a wife.

Spouse - (effective on January 1, 2015) for purposes of the working aged provisions means a person who is entitled to Medicare as a spouse based upon the Social Security Administration's rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction.

Statute of Limitations - A specific time period within which certain claims must be filed and after which the claim may no longer be enforced.

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

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

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

Waiver - The relinquishing of an established right. In an MSP situation, it is the forgiveness of the party's obligation to satisfy Medicare's claim, in whole or in part, if certain conditions are met.

Workers' Compensation Agency - Any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal WC programs, the U.S. Department of Labor.

Workers' Compensation Carrier - Any insurance carrier authorized to write WC insurance under the state or federal law, the state compensation fund where the state administers the WC program, and the beneficiary's employer where the employer is self-insured.

Workers' Compensation Law or Plan - A government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) - The recommended method to protect Medicare's interests in workers' compensation (WC) settlements, judgments, or awards which allocate funds from the settlement for future medical and/or prescription drug expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate.

Working Aged – Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under a GHP by virtue of their own current employment status or the current employment status of a spouse of any age. This provision applies to GHPs of employers and employee organizations, including multi- employer and multiple employer plans which have at least one participating employer that employs 20 or more employees.

Wrongful Death - A death caused by a wrongful act, neglect, or fault.

20 - *General Provisions*

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Under the Medicare law, as enacted in 1965, Medicare was the primary payer for *all* services except those covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional primary plans. The purpose was to shift costs from the Medicare program to private sources of payment. These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at section 1862(b) of the Social Security Act (the Act), *and implemented by 42 CFR § 411.20 and following*. These provisions prohibit Medicare from making payment if payment has been made or can reasonably be expected to be made by the following primary plans: *employer-sponsored* group health plans (*GHPs*), workers' compensation plans, liability insurance (*including self-insurance*), or no-fault insurance (*collectively known as Non-GHPs or NGHPs.*) If payment has not been made or cannot be

expected to be made promptly by a workers' compensation *law or policy of the United States*, liability insurance (*including self-insurance*), or no-fault insurance, Medicare may make a conditional payment under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment. *When Medicare is the secondary payer, any and all payers primary to Medicare are expected to pay before Medicare. Medicare does not determine primacy between or among other payers when multiple payers are primary to Medicare for a given item or service.*

When Medicare is the secondary payer, the provider, physician, or other supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. The primary payer may **not** decline to make primary payment on the grounds that its contract calls for Medicare to pay first. If, after the primary payer processes the claim, it does not pay in full for the services, Medicare secondary benefits may be paid for the services as prescribed in §10.8. Generally, the beneficiary is not disadvantaged where Medicare is the secondary payer because the combined payment by a primary payer and by Medicare as the secondary payer is the same as or greater than the combined payment when Medicare is the primary payer.

20.1 - Working Aged

(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

Pursuant to 1862(b)(1)(A) of the Social Security Act, Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have Medicare Part A and who have GHP coverage as a result of either:

- Their own current employment status with an employer that has 20 or more employees; or*
- The current employment status of a spouse of any age with an employer that has 20 or more employees. (Section 70.2 of this chapter and Pub. 100-05, Chapter 2 §10 further defines individuals subject to this limitation on payment.)*

NOTE: *Effective January 1, 2015, for purposes of the working aged provisions, the definition of spouse was changed. Where, at any time, an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse for the purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the individual in question. If such an individual is reported as a spouse through Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) (MMSEA), Medicare will pay accordingly and pursue recovery, as applicable.*

Employers are required to offer to their employees who are age 65 or over, and to the age 65 or over spouses of employees of any age, the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare, regardless of entitlement to Medicare. This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

Medicare beneficiaries have the option to reject the employer plan coverage, in which case they retain Medicare as their primary coverage. Employers cannot offer such employees, or

their spouses, secondary coverage for items and services covered by Medicare. Additionally, employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have, or whose spouse has, current employment status. Further guidance pertaining to the MSP provisions for working aged individuals can be found in Pub. 100-05, Chapter 2, §10.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. This requirement applies if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Self-employed individuals who participate in an employer plan are not counted as employees in determining if the 20 or more employees requirement applies. Where an employer does not have 20 or more employees in the preceding year, he is required to offer his employees, and spouses age 65 or over, primary coverage when he has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees subsequently drops below 20. The "20 or more employees" requirement applies when the individual (employee) receives the services for which Medicare benefits are claimed. If at that time, the "20 or more employees" requirement in the current year or in the preceding calendar year applies, the GHP is primary payer. An employer for which this requirement applies must provide primary coverage even if less than 20 employees participate in the employer plan.

The MSP provisions do not obligate employers to provide coverage to individuals, nor do they speak to the benefits provided under such coverage with the exception of ensuring that individuals eligible for or entitled to Medicare receive the same coverage as individuals who are not eligible for or entitled to Medicare.

NOTE: *Where, at any time, an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of "spouse" for the purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the individual in question. If such an individual is reported as a spouse through MMSEA Section 111, Medicare will pay accordingly and pursue recovery, as applicable. The employer must also provide primary coverage to older such individuals even if there are no younger such individuals enrolled in the plan. See all parts under 42 CFR § 411.100.*

Where a GHP is the primary payer, but does not pay in full for the services, Medicare may pay secondary benefits to supplement the amount the GHP paid for the service if it is a Medicare covered service. If a GHP denies payment for services because they are not covered by the plan as a plan benefit available to all covered individuals, Medicare may pay primary benefits if the services are covered by Medicare.

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. 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) must evaluate claims under existing guidelines derived from the law and regulations to assure that services are covered by the program regardless of any employer plan involvement.

A/B MACs and DME MACs assume, for the purpose of processing claims, that because of the requirement that GHPs be billed before Medicare, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled by nature of employment meets the definition of employer and employs at least 20 people. The A/B MACs and DME MACs refers an employer's allegation that the 20-employee requirement does not apply to the MSP Contractor.

A/B MACs and DME MACs must refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of fewer than 20 employees, as a basis for making Medicare primary payer, to the MSP Contractor (see Pub. 100-05, Chapter 2 §10 for further instructions).

NOTE: *The request to exempt is done on a prospective basis.*

20.2 - End-Stage Renal Disease (ESRD)

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Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for, or entitled to, Medicare Part A on the basis of ESRD during a period of up to 30 months if Medicare was not already the proper primary payer for the individual on the basis of entitlement due to age or disability at the time that this individual became eligible or entitled to Medicare Part A on the basis of ESRD, pursuant to 42 CFR § 411.162. (See Section 1862(b)(1)(C) of the Act.)

The coordination period begins when the individual is eligible for Medicare Part A. Medicare is secondary during this period even if the employer policy or plan contains a provision stating that its benefits are secondary to Medicare, or otherwise excludes or limits its payments to Medicare beneficiaries. Under this provision, the GHP is billed first for services provided to a Medicare ESRD beneficiary. If the GHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with current billing instructions. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in the coordination period.

20.3 - Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP)

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Medicare is secondary to LGHPs for individuals under age 65 entitled to Medicare Part A on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member, pursuant to 42 CFR § 411.204. Under the law, a LGHP may not "take into account" that such an individual is eligible for, or receives, Medicare benefits based on disability. The instructions in §10.1 and throughout this manual that are applicable to GHPs are also applicable to LGHPs in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to a GHP with 20 or more employees, substitute the term "large group health plan" as defined in Pub. 100-05, Chapter 1, §40, to apply them to disabled individuals.

Medicare is secondary to benefits payable under a LGHP for individuals under age 65 entitled to Medicare on the basis of disability who are covered under a LGHP as a result of the:

- i. Individual's current employment status with an employer that has 100 employees or more (see Pub. 100-05, Chapter 2, §30.3); or*
- ii. Current employment status of a family member with such employer (42 CFR 411.200).*

Special rules apply in the case of multiple employers and multi-employer plans. (See Pub. 100-05, Chapter 2, §30.3.) Medicare is secondary for these Medicare beneficiaries even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare benefits or otherwise excludes or limits its payments to Medicare beneficiaries.

Medicare is secondary payer to LGHP coverage based on an individual's or family members current employment status.

20.4 - Workers' Compensation (WC)

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Medicare is secondary to WC plans (including black lung benefit programs), pursuant to 42 CFR § 411.40. Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid under WC, the Medicare payment constitutes mistaken payment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the

Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from non-appropriated Federal funds (such as employees of post-exchanges), and offshore oil field workers. The Federal Employers' Liability Act (FELA), which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion. The FELA and similar State acts are considered liability insurance under the MSP liability provisions.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC. See 42 CFR § 411.43.

20.4.1 - Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) (Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

WC insurers, agencies, and attorneys have significant responsibilities under the MSP provisions of the Social Security Act to protect Medicare's interests when resolving WC cases. Because Medicare does not pay for an individual's WC-related medical services and/or prescription drugs when the individual receives a WC settlement, judgment, or award that includes funds for future medical and/or prescription drug expenses, it is in the best interest of the individual to consider Medicare at the time of settlement, as required in 1395y(b)(2). For this reason, CMS recommends that parties to a WC settlement set aside funds, known as WC Medicare Set-Aside Arrangements (WCMSAs) for all future medical and/or prescription drug services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare.

See Pub. 100-05, Chapter 1, §20, for the definitions of a "Set- Aside Arrangement," "Workers' Compensation Medicare Set-Aside Arrangement."

20.5 - No-Fault Insurance

(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

Medicare is secondary to any no-fault insurance, including all forms of automobile no-fault insurance, automobile medical payments, and non-automobile no-fault insurance. pursuant to 42 CFR § 411.50. (See Pub. 100-05, Chapter 2, §60.) No-fault insurance is a form of insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident. MedPay is a form of no-fault insurance even when included in automobile insurance of any type. Payment may not be made by Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under no-fault insurance. A conditional Medicare payment may be made if the no-fault insurance has not paid and cannot reasonably be expected to make payment promptly. See 42 CFR § 411.53.

20.6 - Liability Insurance

(Rev.11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance), pursuant to 42 CFR § 411.50. (See Pub. 100-05, Chapter 2, §40.) (See Pub. 100-05, Chapter 2, §40.) Liability insurance means insurance (including a self-insurance plan) that provides payment based on the policyholder's alleged legal liability for injury or illness or damage to property. It includes, but is not limited to, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It includes payments under state "wrongful death" statutes that provide payment for medical damages. An entity that engages in a business, trade, or profession is considered to be self-insured for liability purposes to the extent that it has not purchased liability insurance.

20.7 - Conditional Primary Medicare Benefits

(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

When specified conditions are met, the MSP statute prohibits Medicare from making payment where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance. If payment has not been made or cannot be reasonably be expected to be made promptly by WC, liability insurance (including self-insurance), or no-fault insurance, Medicare may make conditional payments. (See 42 CFR § 411.52.)

In order to adhere to the provisions in the MSP statute, all A/B MACs and DME MACs shall follow 42 CFR § 411.21, reflected in Pub. 100-05, Chapter 1, §40, for the definition of prompt or promptly. Prompt or promptly, with regard to no-fault insurance and workers' compensation, means payment within 120 days after receipt of the claim for specific items and services by the no-fault insurer or WC entity. In the absence of evidence to the contrary, A/B MACs and DME MACs shall treat the date of service for specific items and services as the claim date for the purpose of determining the promptly period. Further, with respect to inpatient services, in the absence of evidence to the contrary, A/B MACs and

DME MACs shall treat the date of discharge as the date of service with respect to no-fault insurance and WC situations for the purpose of determining the promptly period.

Additionally, A/B MACs and DME MACs shall follow 42 CFR §411.50, also reflected in Pub. 100-05, Chapter 2, for the definition of prompt or promptly with regard to liability insurance (including self-insurance). Prompt or promptly, with regard to liability insurance (including self-insurance), means payment within 120 days after the earlier of the following: (1) The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; and (2) the date the service was furnished or, in the case of inpatient services, the date of discharge. Generally, the MSP auxiliary record for the liability situation is posted to CWF after the beneficiary files a claim against the alleged tortfeasor and the associated liability insurance (including self-insurance) Accordingly, in the absence of evidence to the contrary, the date the general liability claim is filed against liability insurance (including self-insurance) is no later than the date that the record was posted on CWF. Therefore, A/B MACs and DME MACs shall consider the date of accretion listed on liability MSP auxiliary record on CWF to be the date the general liability claim was filed, for the purposes of determining the promptly period, with regard to liability insurance (including self-insurance) situations.

Subject to Medicare payment rules and other stipulations, primary payers (GHP, liability insurance, including self-insurance, no-fault insurance, and WC) are obligated to reimburse Medicare if they were properly primary to Medicare, but have not paid as primary, pursuant to 42 CFR 411.22. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items and services included in a claim against the primary plan or the primary plan's insured, or by other means.

NOTE: *If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a GHP, the provider, physician, or other supplier bills the liability insurer or no-fault insurer and/ GHP as appropriate before requesting conditional Medicare payments. Except as delineated in in Pub.100-05, Chapter 2, Medicare does not make conditional primary payment when there is GHP coverage that is a primary payer to Medicare until the claim has been sent to the primary payer first for payment.*

**20.7.1- When Conditional Primary Medicare Benefits May Be Paid
When a GHP is a Primary Payer to Medicare**
(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

Conditional primary Medicare benefits may be paid if the conditions in the following subsection 20.7.2 do not apply **and** if one (1) of the following reasons apply [See 42 CFR § 411.175]:

- The beneficiary, the provider, or their supplier that has accepted assignment has filed a proper claim under the GHP and the plan has denied the claim in whole or in part, **or**
- The beneficiary, because of physical or mental incapacity, failed to file proper claim.

When such conditional Medicare payments are made, they are made on condition that the GHP, and/or beneficiary, will reimburse Medicare if payment is subsequently made by the GHP.

**20.7.2 - When Conditional Primary Medicare Benefits May Not Be Paid
When a GHP is a Primary Payer to Medicare**
(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

Conditional primary Medicare payments may not be made if the claim is denied for one of the following reasons [See 42 CFR § 411.175(c)]:

- It is alleged that the GHP is secondary to Medicare;
- The GHP limits its payment when the individual is entitled to Medicare;
- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over;
- The GHP asserts it is secondary to a liability, no-fault or WC insurer, or other coverage also primary to Medicare.
- Failure to file a proper claim (including failure to file timely) if that failure is for any reason other than physical or mental incapacity of the beneficiary.

20.8 - When Medicare Secondary Benefits Are Payable and Not Payable
(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

A/B MACs and DME MACs may pay Medicare secondary benefits when a provider, physician or other supplier, or beneficiary submits a claim that is payable under Medicare's coverage requirements and the primary plan does not pay the entire charge. Medicare will not make a secondary payment if the provider/physician/supplier accepts, or is obligated to accept, the primary plan payment as full payment or full satisfaction of the patient's responsibility.

When a primary plan's payment for Medicare covered services is less than the provider's, physician's, or other supplier's charges for those services and less than the gross amount payable by Medicare, and the provider, physician, or other supplier does not accept and is not obligated to accept the primary plan's payment as full payment, then A/B MACs and DME MACs can process Medicare secondary payment as appropriate. See 42 CFR § 411.32, 411.33, 411.162, 411.172 and 411.204.

20.9 - Multiple Insurers

(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

A. More Than One Primary Insurer

There may be instances where Medicare is secondary payer to more than one primary insurer (e.g., an individual who is covered under his/her own GHP and under the GHP of an employed spouse or under no-fault insurance). In such cases, the other primary payers will customarily coordinate benefits. If a portion of the charges remains unpaid after the other insurers have paid primary benefits, a secondary Medicare payment may be made. See 42 CFR § 411.24.

Coordination of benefits (COB) arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain GHPs for individuals and spouses age 65 or over. Therefore, where the individual has GHP coverage based on current employment status in addition to GHP coverage as a retiree, Medicare is secondary to the GHP coverage based on current employment status and primary to the GHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

Where services are covered in part by WC and also under liability or no-fault insurance, or there is primary coverage by a GHP, Medicare is the residual payer only.

Accordingly, whenever any primary plan pays in part for provider, physician, or other supplier services and the provider, physician, or other supplier does not accept, and is not obligated to accept the payment as payment in full, the provider, physician, or other supplier ensures that a claim is submitted to any other insurer that is primary to Medicare.

B. COB Rules Conflict With MSP Rules

COB arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to GHPs and LGHPs in certain situations. There are two scenarios to consider.

The first scenario is where an individual has dependent GHP coverage that is primary to Medicare (e.g., coverage based on the employment of the individual's spouse) in addition to nondependent coverage that is secondary to Medicare (e.g., coverage based on the individual's retirement). In this instance, Medicare is secondary to the dependent coverage and primary to the nondependent coverage. In other words, the dependent coverage pays first and the nondependent coverage pays second even though under private COB agreements, the nondependent coverage would be expected to pay before the dependent coverage. (See example 2 below.)

The second scenario is where a plan's payment would normally be secondary to Medicare but, under COB provisions, the payment is primary to a primary payer under §1862(b) of the Act, the combined payment of both plans constitutes the primary payment to which Medicare is a secondary payer. In other words, both plans pay first. (See example 1 below.)

EXAMPLE 1:

John Jones, age 75, is a Medicare beneficiary with coverage under Part A and Part B. He retired from the Acme Tool Company in 2021 and received retirement health insurance coverage that is secondary to Medicare. His wife, Mary, age 64, has been employed continuously with the local police department since 1977 and since that time has received coverage for herself and her husband under the department's GHP. The priority of payment for John's medical expenses is as follows:

- *The GHP will be primary,*
- *Medicare will be secondary, and*
- *The retirement plan will be tertiary payer.*

EXAMPLE 2:

Chris Thomas, age 67, is a Medicare beneficiary with coverage under Part A and Part B. He has been employed continuously by XYZ Bolt Company since 2002 and has GHP coverage through his employer. His wife, Ann, age 62, has been retired from the local police department since 2015 and received retirement health insurance coverage for

herself and her husband that is secondary to Medicare. The order of payment for Chris' medical expenses is as follows:

- Chris's GHP, based on current employment status is primary payer.*
- Medicare is secondary payer.*
- The spouse's retirement plan is the tertiary payer.-*

30 - Overview of Pub. 100-05, the MSP Manual **(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)**

In addition to the General MSP Overview content provided within this chapter, subsequent chapters of the MSP Manual are available for access at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017>. These chapters offer a variety of information ranging from general MSP provisions and the relationship to other laws to specific guidance concerning MSP prepayment processing requirements, MSP Recovery activities, and the MSP Common Working File (CWF) process.

The MSP Manual also includes a chapter outlining information that should be collected from beneficiaries, instances where MSP billing should be applied, and the requirements among providers, physicians, or other suppliers. The Electronic Correspondence Referral System (ECRS) User Guide and ECRS Quick Reference Card are MSP Manual chapters as well, intended to provide technical guidance to A/B MACs, DME MACs, and CMS regional office (RO) staff attempting to transmit change requests to existing CWF MSP information or submit MSP coverage inquiries.

30.1 – MSP Provisions

(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

Pub. 100-05, known as the MSP Manual, includes a more in-depth description of the MSP provisions outlined in the Act. These explanations serve to clarify and provide more detailed information concerning the MSP provisions and how they are implemented by CMS daily. They also provide information about the relationship of MSP to other laws. Detail provided here assists A/B MACs and DME MACs, and the MSP Contractors with responses to questions from providers, physicians, and other suppliers, attorneys, employers, and other payers. This information is found in chapters 2, 3, 5 and 7 of the MSP manuals.

30.2 – MSP Provider, Physician, and Other Supplier Billing Requirements **(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)**

Chapter 3 of the Medicare Secondary Payer Manual, an outline of the provider's responsibility to gather information sufficient to identify primary payers and to bill them before billing Medicare, if MSP provisions state Medicare should be secondary payer. Identifying commensurable information upon beneficiary admission can help prevent incorrect billing and Medicare overpayments.

A/B MACs, DME MACs and the MSP Contractors 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. See 42 CFR § 489.20.

30.3 – A/B MACs and DME MACs Prepayment Processing Requirements (Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

The MSP Manual provides a technical guide for A/B MACs and DME MACs to process any prepayment activities that allow MSP provisions to occur appropriately and by statute. These instructions and processes are outlined in Chapter 5 of the Medicare Secondary Payer Manual with the ECRS Web User Guide and ECRS Quick Reference Card as separate documents for easy reference.

30.4 – MSP CWF Process (Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

The CWF holds all Medicare beneficiaries' Part A and Part B data. All beneficiaries have a master record in CWF. CMS uses the MSP Auxiliary file within CMS to identify MSP occurrences in order to ensure accurate Coordination of Benefits. Currently in Chapter 6 of the Medicare Secondary Payer Manual, the CWF process as it pertains to MSP and Coordination of Benefits is explained. It gives A/B MACs and DME MACs an idea of how to use the CWF when their role requires it and how it is used by CMS for MSP activities.

30.5 – MSP Recovery (Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

The MSP Manual outlines Medicare's right to recover payments it has made on behalf of private insurers that are the primary (or "first") payers for Medicare beneficiaries. This information is currently found in Chapter 7 of the Medicare Secondary Payer Manual. In situations where Medicare is a "secondary" payer, the primary payer must

reimburse Medicare for any benefits that Medicare has mistakenly paid as primary on behalf of a beneficiary.

The MSP program ensures that Medicare is aware of situations where it should not be the primary (the first) payer of claims. If a beneficiary has Medicare and other health insurance, Medicare COB) rules decide which entity pays first. Medicare may make conditional payments on behalf of beneficiaries so that beneficiaries can maintain continual Medicare coverage throughout the COB period. Any such payments are conditioned on reimbursement to the appropriate Medicare trust fund.

40 - Referral to the Regional Office

(Rev. 11755, Issued:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

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 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.

Since the CMS is responsible for enforcement of the age anti-discrimination provisions for coverage under group health plans, all complaints received that may reflect such discrimination by GHPs must be treated as possible violations of the Medicare law. This includes complaints that a GHP is "taking into account" that an individual is entitled to Medicare benefits and complaints that a GHP is not providing equal benefits under the same conditions for older and younger workers and spouses.

A/B MACs and DME MACs must refer any cases to the RO where a GHP or LGHP is a nonconforming plan. Cases are referred as a result of the GHP or LGHP refuses to make payment as the primary payer or performing the following actions:

- *Offers secondary coverage for individuals for whom Medicare is secondary; or*
- *Refuses to reimburse Medicare for any primary benefits paid to, or on behalf of, a Medicare beneficiary.*

In all potential discrimination cases, the contractor obtains documentation of the alleged discrimination, such as:

- *A notice from the GHP and/or a copy of the plan policy;*
- *A written description of the alleged discriminatory action(s) by the GHP from the party or parties involved;*
- *The name and address of the individual's employer;*

- *The individual's name and Medicare beneficiary identifier;*
- *The name and address of the GHP or LGHP;*
- *The individual's group health plan identification number; and*
- *A full explanation of the reasons for the referral.*

All available information concerning the matter must be sent to the RO, along with an analysis of the facts. If the RO believes that the GHP may have committed a discriminatory act, the case is referred to the Central Office (CO) for facts, for consideration of whether the plan is a nonconforming group health plan, (i.e. a group health plan which at any time during a calendar year does not comply with the anti-discrimination provisions of the Act). The RO considers possible legal action to collect double damages from the nonconforming LGHP/GHP. The CO also refers nonconforming group health plans to the Internal Revenue Service for imposition of an excise tax penalty to assure compliance with the anti-discrimination provisions of the law.

If the GHP, LGHP, or employer has agreed to discontinue offering secondary coverage to Medicare individuals for whom it is primary payer or has agreed to reimburse Medicare the amount of incorrect Medicare primary benefits that should have been paid by the plan, the CO includes this information in its referral.

Once the CO refers a nonconforming LGHP/GHP to the IRS, it does not withdraw the referral solely because the plan has discontinued offering improper secondary coverage or has reimbursed Medicare the amount of incorrect primary benefits Medicare paid.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R11755MSP</u>	12/21/2022	Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapters 1 and 2	01/23/2023	13000
<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>R106MSP</u>	10/10/2014	Medicare Secondary Payer (MSP) Group Health Plan (GHP) Working Aged Policy -- Definition of "Spouse"; Same-Sex Marriages	01/01/2015	8875
<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>R65MSP</u>	03/20/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments	04/06/2009/ 07/06/2009	5371

<u>R64MSP</u>	01/09/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments - Rescinded and replaced by Transmittal 65	04/06/2009/ 07/06/2009	5371
<u>R34MSP</u>	09/07/2005	Manualization of Long-Standing MSP Policy	N/A	4018
<u>R25MSP</u>	02/25/2005	Changes Included in the Medicare Modernization Act (MMA)	04/25/2005	3219
<u>R19MSP</u>	09/24/2004	Clarification of MSP Rules in Relation to a Temporary Leave of Absence	10/25/2004	3447
<u>R01MSP</u>	10/01/2003	Initial Issuance of Manual	N/A	N/A

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