CMS Manual System

Pub. 100-05 Medicare Secondary Payer

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 25 **Date: FEBRUARY 25, 2005**

CHANGE REQUEST 3219

SUBJECT: Update Medicare Secondary Payer (MSP) Manual Publication 100-05 to reflect statutory changes included in the Medicare Modernization Act (MMA).

I. SUMMARY OF CHANGES: This transmittal revises various sections in the Medicare Secondary Payer (MSP) Manual (identified in section II of the transmittal) in order to accurately reflect clarifications to the MSP statutory provisions which were added by Section 301 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

There are also miscellaneous changes that correct errors/omissions made in the compilation of the on-line manual or add further clarifying language regarding existing policy. Additionally, the time frame to appeal has been updated in the model letter in Exhibit 2 as referenced in Chapter 7, Section 50.5.2.1 in accord with previously issued appeal instructions.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 25, 2005
***IMPLEMENTATION DATE: April 25, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/10/ General Provisions
R	1/10.7/Conditional Primary Medicare Benefits
R	1/10.7.1/When Conditional Primary Medicare Benefits May Be Paid
R	1/10.8/When Medicare Secondary Benefits Are Payable and Not Payable
R	1/20/Definitions
R	1/30/Beneficiary's Rights and Responsibility
R	2/40.1/Statutory Provisions
R	2/60/No-Fault Insurance
R	3/10.3/Situations in Which MSP Billing Applies
R	3/10.6/Incorrect GHP Primary Payments

R	3/20.1/General Policy
R	5/40.6/Conditional Primary Medicare Benefits
R	5/40.6.1/Conditional Medicare Payment
D	5/40.6.3/Conditional Primary Payment in Cases Involving a Denied Claim that was Appealed
R	7/20/Medicare Right of Recovery
R	7/20.1/Conflicting Claims by Medicare and Medicaid
D	7/20.5/20.5.1/Third Party Payer Refund Requests Served on Medicare
R	7/50.1/General Operational Instructions
R	7/50.2/50.2.2/Conditional Primary Medicare Benefits
R	7/50.4/50.4.1/Existence of Overpayment
R	7/50.5/Subsection 50.5.2.1/Exhibit 2 – Standard Recovery/Initial Determination Letter to Beneficiary

***III. FUNDING: These instructions shall be implemented within your current operating budget.**

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-05	Transmittal: 25	Date: February 25, 2005	Change Request 3219

SUBJECT: Update Medicare Secondary Payer (MSP) Manual Publication 100-05 to reflect statutory changes included in the Medicare Modernization Act (MMA).

I. GENERAL INFORMATION

A. Background: Medicare Modernization Act amended MSP provisions. Section 301 of the Act clarifies that: (1) conditional Medicare payments made because a no-fault or liability insurance or workers' compensation does not pay promptly are subject to reimbursement; (2) entities that engage in a business, trade or profession are deemed to either have purchased liability insurance or be self-insured; (3) a primary payer's obligation to repay Medicare is established when it is demonstrated that the primary plan has, or had, at the time the services were provided, an obligation to make primary payment; and (4) employers that purchase group health plan coverage from an insurer are responsible for resolving debts to Medicare arising when that group health plan did not make required primary payments.

These clarifications resolve several legal challenges to the manner in which CMS administers the MSP provisions.

There are additional miscellaneous changes that correct errors/omissions made in the compilation of the on-line manual or add clarifying language regarding existing policy. Also, the time frame to appeal has been updated in the model letter in Exhibit 2 as referenced in Chapter 7, Section 50.5.2.1 in accord with previously issued appeal instructions.

B. Policy: The MSP Manual (Pub. 100-05) must accurately reflect the current statutory language. The clarifications to the statute support CMS's existing interpretation of the MSP statutory provisions.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3219.1	Contractors shall be aware of statutory clarifications set forth in Section 301 of the MMA.	X	X	X	X					
3219.2	Contractors shall update their beneficiary recovery demand letter in accord with the changes, which have been made to Exhibit 2 as referenced in Chapter 7, Section 50.5.2.1.	X	X	X	X					
3219.3	Contractors shall review and be aware of all of the miscellaneous clarifying changes made in this transmittal.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: No system changes.

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 25, 2005. **Implementation Date:** April 25, 2005 (Contractors may implement earlier if they are able to do so.) **Pre-Implementation Contact(s):** Karen Ochab at 410-786-6406. **Post-Implementation Contact(s):** Your Regional Office (RO) MSP coordinator.	No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

***Unless otherwise specified, the effective date is the date of service.**

Medicare Secondary Payer (MSP) Manual

Chapter 1 - Background and Overview

10 - General Provisions

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Under the Medicare law, as enacted in 1965, Medicare was the primary payer for 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 third party payers (TPP). The purpose was to shift costs from the Medicare program to private sources of payment. Section 1862(b)(2)(A) of the Social Security Act (the Act) prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made by a third party payer. If payment has not been made or cannot be expected to be made promptly, Medicare may make a conditional payment, *under some circumstances,* subject to Medicare payment rules. At present, the law makes Medicare the secondary payer to insurance plans and programs under certain conditions, for beneficiaries covered for health care benefits through their group health plan (GHP) or a spouse's GHP or a family member's GHP and for auto, no-fault liability, and workers' compensation situations. When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second.

When Medicare is the secondary payer, the provider, physician, 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. Three provisions of the law require Medicare to be secondary payer relating to employer group health insurance plans. Three provisions of the law require Medicare to be secondary payer relating to disease or accidents as a result of employment or coverage available under an automobile, liability insurance policy or plan (including a self-insured plan), or under no-fault insurance. An overview of each insurance type is separately described in the following sections. A detailed description of each insurance type is in Chapter 2 of the MEDICARE SECONDARY MANUAL (MSP).

10.7 - Conditional Primary Medicare Benefits

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

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

NOTE: If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a GHP, the provider bills the automobile medical or no-fault insurer and/or GHP as appropriate, in accordance with §10, §10.2, and §10.6, before requesting conditional Medicare payments. (See §10.9 and Chapter 2, §50.2.)

10.7.1 - When Conditional Primary Medicare Benefits May Be Paid

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Conditional primary Medicare benefits may be paid if:

• The beneficiary or provider, physician, or supplier that has accepted assignment filed a proper claim with a GHP or LGHP and the GHP denied the claim in whole or in part *based on an assertion other than that the GHP or LGHP is the secondary payer to Medicare (i.e., Medicare is primary)*; or

• Because of physical or mental incapacity of the beneficiary, the physician, the supplier or beneficiary failed to file a proper claim with the GHP.

When such conditional Medicare payments are made, they are made on condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the GHP.

10.8 - When Medicare Secondary Benefits Are Payable and Not Payable

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Contractors may pay Medicare secondary benefits when a provider, physician, supplier, or beneficiary submits a claim to a TPP and the TPP 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 TPP payment as full payment. (In the case of liability claims (see Chapter 2, §40), the TPP *must* be billed during the 120-day promptness period by providers and physicians/suppliers who have accepted assignment. The method of calculating the Medicare secondary amount is the same whether the claim is assigned or unassigned.

When a third party payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the third party payment as full payment, then contractors can process Medicare secondary payment in accordance with Chapter 5, §40.8.2, as appropriate.

Secondary benefits are not payable when the:

• TPP pays the provider/physician's/supplier's charges in full; or

• Provider/physician/supplier is either obligated to accept or voluntarily accepts a third party payment as full payment *or as fully satisfying the patients payment responsibility*; or

• The third party payment is equal to or greater than the gross amount payable by Medicare, e.g., providers participating with Blue Cross/Blue Shield are usually required to accept Blue Cross/Blue Shield payment as payment in full.

20 - Definitions

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

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

Active Individual - The term "active individual" means "an employee, the employer, self-employed individual, an individual associated with the employer in a business relationship, or a member of the family of such persons."

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 - The amount that is determined to be owed to the Medicare program. This is the amount that was paid out by Medicare, less any applicable procurement costs.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is 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 effect the goal of ending the dispute. In an MSP situation under the Federal Claims Collection Act, a compromise represents the acceptance by CMS or 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 for services for which another insurer is primary payer. See §10.7 for situations identifying when conditional payment may be made.

Coordination Period - The term "coordination period" means a period of 30 months during which Medicare benefits are secondary to benefits payable under GHPs for individuals who have Medicare because of ESRD. See Chapter 2, §20.

Current Employment Status – See §50 of this chapter.

Eligibility - Eligibility means 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 from an employer payments that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code (IRC).

Employer - Employer means, 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.

Employer Group Health Plan or Employer Plan – This means any health plan that is of, or contributed to by, an employer; and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, and/or their families. It includes the Federal employees health benefits program but not TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). “Employee pay all” plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition. 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 employee offered GHPs. However, coverage under TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is **not** considered to meet the definition of GHP.

Contractors assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of current or former employment of the beneficiary or of a member of the beneficiary’s family meets this definition.

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 - Family member means a person enrolled in a GHP based on another person's enrollment. Family members may include a spouse (including a divorced or common law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

FICA - The term "FICA" stands for 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) - The term "GHP" means 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 full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life 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.

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) - LGHP means 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 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 upon a legally established responsibility 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, including a payment to cover a deductible required by a liability insurer, by any individual or other entity that possesses liability insurance or is covered by a self-insured plan.

Lump Sum Commutation Settlement - 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 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 life long medical treatment for the injury or illness. This may occur when compensability is contested.

MSP - Acronym denoting "Medicare Secondary Payer" provision of the Social Security Act. Medicare has a responsibility to pay for covered medical expenses only after (i.e. secondary to) another insurer who is deemed the primary payer has made payment. The statute intentionally shifts the financial burden for covered medical expenses from Medicare to other insurers whom Congress has determined must be primary payer. Section 1862(b)(2)(A) prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made by a third party payer. If payment has not been made or cannot be expected to be made promptly, Medicare may make a conditional payment, *under certain circumstances,* subject to Medicare payment rules.

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/personal injury protection insurance. In these situations, Medicare's proportionate share of procurement costs is not deducted from this payment unless the claim was contested.

Multi-employer Group Health Plan - The term "multi-employer group health plan" means a plan that is sponsored jointly 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 or on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include automobile no-fault insurance, often referred to as personal injury protection (PIP), and homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage. In these situations, Medicare's proportionate share of procurement costs is not deducted from this payment unless the claim was contested.

Nonconforming Group Health Plan or Large Group Health Plan - A "nonconforming GHP or LGHP" means one that at any time during the calendar year takes into account that an individual is eligible for, or receives, benefits based on disability, e.g., a LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with these instructions.

Partial Waiver - A decision by the Medicare program to relinquish the right to collect 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. The CMS also has the right to grant partial waivers as set forth in 1862(b)(2)(B)(iv) of the Act if it is in the best interests of the Program. Waiver decisions of MSP debts based upon 1862(b)(2)(B)(iv) may not be appealed.

Payment in full – Payment in full is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., 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 - The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to employees. 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.

Proceeds - Money or items of value obtained as a result of a transaction, which are in the possession of the party to whom they were intended to be disbursed.

Procurement Costs - Attorney fees and other costs directly related to securing a settlement or judgment that are borne by the party against which CMS seeks to recover.

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

• The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or

• The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

With regard to *no-fault and 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 TPP (e.g., mandatory second opinion, prior notification before seeking treatment).

Recovery - Proceeds obtained from a judgment, settlement, erroneous or conditional payment. The establishment of a right existing in an individual through a law, formal judgment, or decree of a court.

Secondary – The term "secondary", when used with respect to Medicare payment, means that Medicare is the residual payer to all GHPs under which the Medicare beneficiary is covered and will not pay for expenses that are reimbursable by any such plan. Consider the WC exclusion (§10.4 and Chapter 2 §50) and no fault and liability insurance provisions (Chapter 2 §20 and, §60) in determining the extent of Medicare's liability as a residual payer. If Medicare is secondary payer to more than one primary insurer, e.g., an individual covered under his own GHP as well as under the GHP of his spouse or under automobile insurance, the other primary payer(s) will customarily coordinate benefits. Medicare secondary payment is made only after all primary payers have made proper primary payments.

Self-Employed Person - An individual is considered to be self-employed during a particular tax year only if, during the preceding tax year, the individual's self-employment income, as determined by the IRS, from work related to the employer that offers the group health coverage was at least equal to the amount specified in §211(b)(2) of the Act, which defines self-employment income for Social Security purposes. Self-employed individuals include persons such as consultants, owners of businesses, directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.

Set Aside Arrangement – An administrative mechanism used to set-aside monies for Medicare including a self-administered arrangement (State law permitting). Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. Set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

SSI - Supplemental Security Income for the Aged, Blind and Disabled is 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 reach or 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 – Means any individual who has spousal coverage under the employer plan.

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

Subrogation - Subrogation means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the

responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary.

Third Party Payer (TPP) - A WC law or plan, automobile or non-automobile no-fault insurance, any liability insurance, or a GHP or LGHP that is required to pay primary to Medicare.

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

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

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 - The term "WC agency" means 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 - The term "WC carrier" means 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 WC law or plan is 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.

Working Aged – Medicare is secondary to group health plans (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. Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age. .

Wrongful Death - A death caused by a wrongful act, neglect, or fault, as seen in some liability situations. See also Chapter 7, §50.5.4.1.1.

30 - Beneficiary's Rights and Responsibility

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

A - Beneficiary's Responsibility With Respect to GHPs that are Primary to Medicare

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

The contractor will not make any Medicare payment if the beneficiary has not filed a claim or cooperated fully with the provider, physician or other supplier or the GHP. Also, the contractor will not make any Medicare payments until the beneficiary has exhausted the entire claims process. Conditional benefits are not payable if payment cannot be made under *the GHP* because the beneficiary failed to file a proper claim (See §20 for definition of proper claim) unless the failure to file a proper claim is due to mental or physical incapacity of the beneficiary. A beneficiary need not file any appeal if not inclined to do so.

B - Beneficiary's Right to Take Legal Action Against A GHP

(Rev. 25, Issued: 02-25-2005, Effective: 04-25-05, Implementation: 04-25-05)

Section 1862(b)(3)(A) of the Act provides that any claimant (including a beneficiary, provider, physician, or supplier) has the right to take legal action against, and to collect double damages from a GHP, that fails to pay primary benefits for services covered by the GHP. Any claimant, also, has the right to take legal action against, and to collect double damages from, a no-fault or liability insurer that fails to pay primary benefits for services covered by the no-fault or liability insurer where required to do so under §1862(b) of the Act.

Medicare Secondary Payer (MSP) Manual

Chapter 2 - MSP Provisions

40 - General Effect of Liability Insurance on Medicare Payments

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

40.1 - Statutory Provisions

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Under §1862(b)(1) of the Act, (42 U.S.C. 1395y(b)(1)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan (including a self-insured plan). *Under certain circumstances, Medicare may make conditional payments if the liability insurer will not pay or will not pay promptly*. All Medicare payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan). Medicare is subrogated to the rights of the beneficiary and may also recover its benefits directly from liability insurance companies and self-insured plans, and from any entity, including the beneficiary, that has been paid by a liability insurer. Medicare's right to recover its benefits from liability insurers and from those who have been paid by liability insurers takes precedence over the claims of any other party, including Medicaid.

"Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary. Medicare can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer.

The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against a liability insurer that fails to pay primary benefits for services covered by the insurer and to collect double damages.

60 - No-Fault Insurance

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Payment may not be made under 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 any no-fault insurance (including a self-insured plan). *Under certain circumstances, Medicare may make conditional payments if the no-fault insurer will not pay or will not pay promptly.* Medicare is secondary to no-fault 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. If Medicare payments have been made but should not have been, or if the payments were made on a conditional basis in accordance with the Medicare Secondary Manual (MSP) Manual, Chapter 5, "Contractor Prepayment Processing Requirements," §§40.6, they are subject to recovery.

If services are covered under no-fault insurance, that insurer must be billed first. If the insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted in accordance with Chapter 3, §30.3, to supplement the amount paid by the insurer. Medicare can pay for services related to an accident, if benefits are not currently available under the individual's no-fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on non-medical items such as lost wages. Efforts to ascertain coverage under no-fault insurance are subject to the tolerance in Chapter 7.

The question in each case involving accident related medical expenses is whether no-fault benefits can be paid for these particular services. If so, the no-fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save insurance benefits to pay for future services or for non-covered medical services or non-medical services. Since no-fault insurance benefits would be currently available in that situation, they must be used before Medicare can be billed.

If there is an indication that the individual has filed, or intends to file, a liability claim against a party that allegedly caused an injury, the contractor follows Chapter 5, §10.8.1.

A - Effective Dates

The general rule pertaining to automobile or non-automobile no-fault insurance is that these provisions are effective with respect to injuries that occurred on or after December 5, 1980.
These rules apply to services covered under automobile medical and no-fault insurance furnished on or after June 6, 1983, and services covered under **non**-automobile medical and no-fault insurance furnished on or after November 13, 1989.

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider Billing Requirements

10.3 - Situations in Which MSP Billing Applies

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Medicare secondary billing procedures apply in the following situations:

• Where the VA authorized services, Medicare does not make payment for items or services furnished by a non-Federal provider pursuant to such an authorization. Although certain MSP billing procedures apply, VA is not an MSP provision. (See the Medicare Benefit Policy Manual, Chapter 17, §50.1, for an explanation of this provision.);

• Where services are payable under WC, Medicare does not make payment 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 a State. (See Chapter 1 for an explanation of this provision.) *Under certain circumstances, Medicare may make conditional payments if the WC carrier has not paid or will not pay promptly;*

• Where services are payable under 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 for the items or services under no-fault *or liability* insurance (including a self-insured plan). *Under certain circumstances, Medicare may make conditional payments if the no fault or liability insurer has not paid or will not pay promptly.* Medicare is secondary to no-fault 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. In the case of liability insurance, if CMS has information that services for which Medicare benefits have been claimed are for the treatment of an injury or illness that was allegedly caused by a person who is insured under a liability insurance plan, Medicare benefits *may be paid* conditionally and then recovered. (See Chapter 5, §§40.6);

• Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to Medicare based on ESRD during a Medicare coordination period as described in Chapter 1, §10.2;

• 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 Chapter 1, §10.1, for an explanation of this provision.); and

• 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 Chapter 1, §10.3, 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, 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.

10.6 - Incorrect GHP Primary Payments

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

The contractor may advise claimants that a GHP has incorrectly paid primary benefits, e.g., primary payments made by the GHP of an employer of less than 20 employees. In such cases, the claimant bills Medicare as primary payer if the Medicare timely filing period has not expired and refunds to the GHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for non-covered services.

A GHP may advise a claimant that the GHP believes that Medicare may have been the proper primary payer for services for which the GHP had previously made a primary payment. The GHP may request that the claimant 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.

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

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

20.1 – General Policy

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

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 and 3. 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, "Admission Questions to Ask Medicare Beneficiaries," may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: *P*rovider*s 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. Section 20.2.1 lists the type of questions it must ask of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1 and 3.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF). (See §20.2.) If the provider lacks access to CWF, it will follow the procedures found in §20.2.1.

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., automobile 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.

Instructions to carriers on how to process reference lab claims submitted on Form CMS-1500 are available by clicking on the following hyperlink:
http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf (After you get to chapter 26, click on section 10.2 in the Table of Contents.)

2. Policy for Recurring Outpatient Services
A-02-021

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 + Choice Organization (M+CO) Members

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

4. Policy for Medicare Secondary Payer (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, 1998, if the date of admission is January 4, 2003) 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 intermediary would have nothing to audit submitted claims against. CMS recommends that providers retain MSP information for 10 years.

A - Obtain Auto, Non-Auto Liability or No-Fault Insurance Information

Providers are required to obtain information on possible Medicare Secondary Payer 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 auto, 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 automobile or non-automobile 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 expected 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 Chapter 4, §30.4.2.1, of this MSP manual 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.

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 Chapter 5, §30, for action to take where a claim is received for primary benefits and there is reason to believe that Medicare may be secondary payer.

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Chapter 5 - Contractor Prepayment Processing Requirements

40.6 - Conditional Primary Medicare Benefits

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Conditional primary Medicare benefits may be paid if;

- The beneficiary has appealed or is protesting the GHP denial of the claim for any reason other than that the GHP offers only secondary coverage of services covered by Medicare;

- The GHP denied the claim *(that is, the claim made on behalf of the beneficiary)* because the time limit for filing the claim with the GHP has expired (whether appealed or not);

- The provider*, physician, or other supplier* has filed a proper claim under the employer plan, and the plan denies the claim in whole or in part *based on an assertion other than that the GHP or LGHP is a secondary payer to Medicare (i.e., Medicare is primary)*;

- The provider*, physician, or other supplier* fails to file a proper claim because of mental or physical incapacity of the beneficiary;

- The beneficiary has filed a claim with a WC carrier and the FI or carrier determines that the WC carrier *will not pay or will not pay promptly* (i.e., within 120 days of receipt of claim) for any reason except when the WC carrier claims that its benefits are only secondary to Medicare; or

- The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement of the WC Carrier.

Before making a conditional primary payment in cases involving appealed or protested claims, the FI or carrier notifies the GHP and the beneficiary that the payment is *conditioned upon reimbursement, by the insurer and the beneficiary, to the trust fund if it is demonstrated that the GHP has or had responsibility to make primary payment. The FI or carrier reminds the GHP that it is obligated to reimburse Medicare if it should be later determined that it was the proper primary payer for the services. A 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 or services included in a claim against the primary payer or the primary payer's insured, or by other means.*

40.6.1 - Conditional Medicare Payment

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

There is frequently a long delay between an injury and the decision by a State WC agency, no-fault, or liability insurer in cases where compensability is contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might use their own funds for expenses that are eventually borne by either WC, no-fault or liability insurer or Medicare. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made.

When such conditional payments are made, they are *conditioned upon reimbursement, by the insurer and beneficiary, to the trust fund if it is demonstrated that the WC carrier, no-fault insurer, or liability insurer has or had a responsibility to make payment*. *A 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 or services included in a claim against the primary payer or the primary payer's insured, or by other means.*

When making *conditional* payments, the FI or carrier notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.) It asks the insurer to notify it when the insurer is prepared to pay the claim, so that direct refund can be arranged.

FIs and carriers flag **all** cases for possible follow-up action to recover the conditional payments. Providers of service request conditional payments from FIs via the Form CMS-1450 using the appropriate insurance value code (i.e., value code 14 for no-fault insurance) and zero as the value amount.

Type of Insurance	Value Code	Value Amount	Occurrence Code	Condition Code
No-Fault/Liability	14	0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date	
WC	15	0	04-Accident/Tort Liability & Date	02-Condition is Employment Related
ESRD	13	0	24-Date Insurance Denied	
GHP	12 or 43	0	24-Date Insurance Denied	

The identity of the other payer is shown on line A of item 50, the identifying information about the insured is shown on line A of items 56-62 and the address of the insured is shown in item 38 or Remarks (Item 84). Fiscal Intermediaries and carriers process conditional payment bills following normal procedures.

Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

20 - Medicare Right of Recovery

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Section 1862(b)(2) of the Social Security Act (the Act) gives the Government the right to recover conditional Medicare benefits from entities responsible for or required to make payment on behalf of private insurers that are the primary payers for Medicare beneficiaries. Therefore, primary payers must reimburse Medicare when Medicare mistakenly paid primary benefits.

All Medicare payments are conditioned on reimbursement to the appropriate trust fund, when notice or other information is received that payment with respect to the same items or services has also been made, or could be made by a GHP.

Section 1862(b)(1) as amended, expressly provides that the Government:

- May recover directly from employers, Workers' Compensation (WC) carriers, or GHPs, Medicare benefits paid for services furnished to an individual for whom Medicare is the secondary payer. The Government may recover from WC *regardless of whether or not a specific claim for the services for which recovery is sought was filed as long as the beneficiary filed a WC claim related to the underlying injury or illness.*

- May recover or take legal action to recover erroneous primary benefits paid from any entity that has been paid by an employer, WC carrier or any GHP;

- May join or intervene in any WC claim where the compensability of the injury is at issue or in any legal action against a GHP related to the events that gave rise to the need for the items or services;

- Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from a GHP, an employer or a WC carrier; and

- May bring legal action against any entity that is required to make or is responsible for payment and may collect double damages.

20.1 - Conflicting Claims by Medicare and Medicaid

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Medicare and a State Medicaid agency may conditionally or erroneously pay for services, and the amount payable by a GHP is insufficient to reimburse both. Under the law, (§1862(b)(1)) of the Act, Medicare has the right to recover its benefits from a GHP before any other entity, including a State Medicaid agency. Medicare's recovery rights where a GHP is the primary payer are higher than, and take precedence over, the rights of any other entity. Medicare has the right to recover its benefits from any entity, including a State Medicaid agency that has been paid by a GHP.

If Medicare and Medicaid both have claims against a GHP, Medicare's right to recover its benefits from the GHP or from a beneficiary that has been paid by a GHP, is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort and, therefore, does not pay its benefits until after Medicare has paid.

Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid being payer of last resort. Under §1862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a third party that is primary to Medicare. Where a GHP pays, Medicare makes no payment for any services covered by the GHP. Delay of the GHP payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, where a GHP pays less than the charges, Medicare may be responsible to pay secondary benefits. In addition, where the third party pays the charges, Medicare may not pay at all. Pro rata or other sharing of recoveries with Medicaid would create a Medicare payment where none is authorized under the law or improperly increasing the amount of a Medicare secondary payment.

The right of Medicaid agencies to recover benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than the beneficiary's own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.

Where both Medicare and Medicaid seek reimbursement from the GHP, the FI or carrier informs the GHP and the other parties to the claim that the GHP must reimburse Medicare before it can pay any other entity, including a State Medicaid agency. Where a beneficiary, attorney, provider, or supplier receives payment from a GHP, and the amount paid by the GHP is less than the combined amounts paid by Medicare and Medicaid, the FI or carrier informs the payee that it is obligated to refund the Medicare payment up to the full amount of the GHP payment before paying the State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, attorney, provider, or supplier have the right to reimburse Medicaid or another entity.

If a State Medicaid agency is reimbursed from a GHP payment before Medicare, or if a beneficiary, after receiving a third party payment, has reimbursed a State Medicaid Agency, the FI or carrier asks the State agency or beneficiary to reimburse Medicare from the remainder of the third party payment. If the remainder of the third party payment is insufficient to reimburse Medicare in full, ask the State Agency to reimburse Medicare up to the full amount the Agency received. The FI/carrier explains the legal basis for Medicare's right to recover. If the State refuses to reimburse in full, the FI/carrier refers the case to the RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State. The FI or carrier tells the GHP that in future cases involving claims by Medicare and Medicaid, it must reimburse Medicare first.

50.1 - General Operational Instructions

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

These instructions address the operational aspects of reimbursement to the Medicare program in situations involving settlements to beneficiaries paid by liability insurance, auto liability insurance, no-fault insurance and uninsured, or under-insured motorist insurance. Liability insurance means insurance (including a self-insurance plan) that provides payment based on legal liability for injury or illness or damage to property, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. Since recovering Medicare secondary payer (MSP) liability overpayments involves procedures which vary somewhat from those used for general overpayments, the following recovery instructions are to be used in place of the general overpayment instructions found in the Financial Manual, Chapter 3, **except where specific references to those sections are provided.** Overpayments arising from benefits paid by employer group health plans should be resolved using procedures applicable to general Medicare overpayments, as described in Chapter 3 of the Medicare Financial Management Manual.

Section 1862(b) of the Act grants Medicare a priority right of recovery. Section 1862(b) also gives the Medicare program the right of subrogation for any amounts payable to the program under §1962 of the Act. In order to recover the conditional payment, Medicare may bring direct action in its own right against the entity responsible or required to pay Medicare, or against any other entity that has received payment. In addition, Medicare has, under subrogation law, a right to recover its payment from an individual or other entity that received payment from a third party payer.

Previously, situations and recoveries involving liability settlement claims were referred to generically as "subrogation." This term has caused confusion in the legal community and

implies that Medicare has only a subrogated right when, in fact, Medicare has a priority right of recovery. This priority right of recovery is much stronger than the subrogated right. Medicare's right to recover its benefits takes precedence over the claims of any other party, including Medicaid. (See §10.1.) The FI or carrier refers to these situations as

liability cases or situations, and focuses on Medicare's statutory priority right of recovery when corresponding with the beneficiary and/or the beneficiary's attorney.

The CMS may employ various statutory authorities to waive, compromise, terminate, or suspend its right of recovery. Section 1862(b)(2)(B)(*v*) of the Act provides for waiver of an MSP overpayment when it is in the best interests of the Medicare program. Section 1870(c) of the Act also permits CMS to waive its right to recovery when the beneficiary meets certain criteria. The Federal Claims Collection Act (FCCA) of 1966 (31 U.S.C. 3711) gives CMS the right to compromise claims for less than the full amount on behalf of the Government of the United States, or to suspend or terminate collection action. Contractors have authority to resolve claims under §1870(c) of the Act, but not under FCCA nor §1862(b). Each of these authorities is discussed §50.6.3 - 50.7.2.

It is common for insurance companies to settle claims without admitting liability. Therefore, any payment by a liability insurer, except payments under a no-fault clause in a non-automobile policy, constitutes a liability insurance payment whether there has been a determination of liability. In addition, regardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement.

If a negligent party who carries liability insurance decides to pay a liability claim with his/her own funds rather than submit the claim to the liability insurer, Medicare recovers its benefits for such a payment because it is deemed to be a liability insurance payment. Medicare benefits are also subject to recovery from payments by a self-insured party

50.2.2 - Conditional Primary Medicare Benefits

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Conditional Medicare payments may be made in liability cases under the following circumstances:

- The beneficiary has filed a claim with the liability insurer, and the Medicare contractor determines that the insurer will not pay *or will not pay* promptly (i.e., within 120 days of receipt of the claim) for any reason except when the liability insurer claims that its benefits are only secondary to Medicare; or
- The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement of the liability insurer.

When such conditional Medicare payments are made, they are made on condition that the beneficiary will reimburse the program to the extent that the liability/no-fault insurer subsequently makes payment. When making such payments, the FI or carrier notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve the beneficiary or insurer of the obligation to refund the payments.) The FI or carrier asks the insurer to notify the Medicare contractor when it is prepared to pay the claim, so that direct refund can be arranged, in accordance with §50.5.

The Medicare contractor flags **all** cases for possible follow-up action to recover the conditional payments.

An individual's refusal to file a claim with a liability or no-fault insurer or to cooperate with a provider in filing such a claim is not a basis for making a conditional Medicare payment.

50.4 - Pre-Settlement Issues

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

50.4.1 - Existence of Overpayment

(*Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)*

In MSP liability situations, before a settlement is reached between the beneficiary and the liable party or a court renders a judgment, there is no overpayment. Medicare's claim comes into existence by operation of law (42 U.S.C. 1395y(b)(2)(B)(*ii*)) when payment for medical expenses that Medicare conditionally paid for has been made by a third party payer. Consequently, while Medicare may alert beneficiaries and their attorneys of Medicare's right to recover settlement proceeds in pre-settlement correspondence, no demand for recovery may be made until a settlement has been reached. However, the FI or carrier should send a letter to the beneficiary and attorney giving notice of possible recovery by Medicare. This letter also notifies the beneficiary and attorney that settlement proceeds should not be disbursed until Medicare's claim has been satisfied.

Note that the Coordination of Benefit contractor (COBC) is responsible for initiating MSP development and making MSP determinations. It is the responsibility of the carrier or FI to forward any information identified, in Pre-Pay MSP or other FI/carrier functions to the COBC for further development. Once the COBC has established the MSP record on CWF, the FI, and carrier will continue to be responsible for all activities related to identification and recovery of MSP-related debts.

50.5.2.1 – Issuance of Recovery Letter

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

The contractor initiates recovery from the beneficiary by sending the letter shown in Exhibit 2 - Standard Recovery/Initial Determination Letter to Beneficiary. Use of this letter, not a substitute, is mandatory. The letter contains all pertinent information:

- Medicare's right to recover;

- The amount of the mistaken payment;
- Notice of the beneficiary's right to request a waiver and/or appeal;
- Notice of Medicare's right to collect interest on the debt;
- Notice of the beneficiary's right to request free legal services; and,
- How and when to repay Medicare.

The contractor keeps a dated copy of all correspondence and exhibits forwarded to the beneficiary and the attorney.

Exhibit 2 - Standard Recovery/Initial Determination Letter to Beneficiary

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Dear Mr./Ms. _____

This letter follows our *earlier communication* in which we advised you that you would *be required to repay the Medicare program for the cost of medical care it paid relating to your liability recovery if you received money from a third party payer for a claim related to [insert date] accident/incident/injury. (The term "recovery" includes a settlement, judgment, award or any other type of recovery.)* We have now been advised that you have received such proceeds. This means that Medicare now has a claim against these proceeds in the amount of $_____, which represents Medicare's claim after reduction for procurement costs, in accordance with 42 CFR 411.37.

The Medicare Secondary payer provisions of the statute, 42 *U.S.C.*1395y(b)(2), preclude Medicare from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance." However, Medicare *may* pay for a beneficiary's covered medical expenses when the third party payer does not pay promptly, conditioned on reimbursement to Medicare from proceeds received from a third party liability settlement, award, judgment or recovery. In your case, Medicare made a conditional payment in the amount of $_____. A list of the claims used to arrive at this total is enclosed.

Medicare's regulations require that you pay Medicare back within 60 days of your receipt of settlement or insurance proceeds. It is our understanding that 60 days have passed since you received the insurance proceeds. Therefore, please send a check or money order in the amount of $_____, made payable to (name of contractor) in the enclosed envelope.

Exercising common law authority and consistent with the Federal Claims Collection Act and 45 CFR 30.13, we will assess interest if this debt is not repaid in full within 60 days of the date of this letter. Additionally, 45 CFR 30.14(a) provides that a debtor may either pay the debt, or be liable for interest on the un-collectable debt while a waiver determination, appeal, or a formal or informal review of the debt is pending. Therefore, assessment of interest may not be suspended solely because further review may be requested. Interest will be assessed at an annual rate of _____. It should be noted, however, that you may repay the debt to avoid accruing charges, but retain your right to dispute, appeal, or request waiver of the debt. If you succeed in your appeal or waiver request, Medicare will refund your money.

If you do not repay this overpayment, Medicare has the authority to refer it to the Social Security Administration or Railroad Retirement Board for further recovery action, which may result in the overpayment being deducted from any monthly Social Security or Railroad Retirement benefits to which you may be entitled.

If you are unable to refund this amount in one payment, you may ask us to consider whether to allow you to pay in regular installments.

The law requires that you must repay an overpayment to Medicare unless both of the following conditions are met:

1. This overpayment was not your fault, because the information you gave us with your claim was correct and complete as far as you knew, and, when the Medicare payment was made, you thought that it was the right payment for your claim,

AND

2. Paying back this money would cause financial hardship **OR** would be unfair for some other reason.

If you believe that **BOTH** of the conditions above apply in your case, please let us know, giving a brief statement of your reasons. You will be sent a form asking for information about your income, assets, and expenses, and requesting that you explain why you believe you are entitled to waiver of the overpayment. We will notify you if recovery of this overpayment can be waived.

You may appeal our decision if: you disagree that you received an overpayment; or you disagree with the amount of overpayment; or you disagree with our decision not to waive your repayment of the overpayment.

For Part A *and Part B* services, you must *file an* appeal within *120* days from the date of your receipt of this determination. Appeals should be requested in writing to _____.

If you decide to appeal this determination further, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

If you have any questions about this letter, you may contact either this office or any Social Security office.

Sincerely,

ABC Contractor

Attachments: List of claims