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Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims

Note: This article was revised on November 16, 2017, to add a reference to MLN Matters® Article [SE17018](#) which contains FAQs intended to remind providers, physicians, and other suppliers of the fundamental guidance governing billing where liability insurance (including self-insurance) is involved. All other information is unchanged.

Provider Types Affected

This MLN Matters® article is intended for physicians, hospitals, Home Health Agencies, and other providers who bill Medicare Carriers, Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B/MACs); and suppliers who bill Durable Medical Equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self insurance), no-fault insurance, and WC Medicare Second Payer (MSP) claims.

Provider Action Needed

This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC Medicare Secondary Payer (MSP) claims. Not following the procedures identified in this article may impact your reimbursement. Change Request (CR) 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-

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insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background

CR7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

The term Group Health Plan (GHP) as related to this MLN article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term Non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key Points

Conditional Medicare Payment Procedures

Medicare may not make payment on a MSP claim 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.

Medicare can make **conditional payments** for both Part A and Part B WC, or no-fault, or liability insurance (including self insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self insurance) and the promptly period has expired. **Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.**

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as 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 for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

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“Promptly” Definition

No-fault Insurance and WC “Promptly” Definition

For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

Liability Insurance “Promptly” Definition

For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability 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.

The "Medicare Secondary Payer (MSP) Manual" (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c01.pdf>), Chapter 1 (Background and Overview), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: For the liability situation, the MSP auxiliary record is usually posted to the Medicare’s Common Working File (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort (civil wrong)) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare’s CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the Liability record was created on Medicare’s CWF to be the date the general liability claim was filed.

How to Request a Conditional Payment

The following summarizes the technical procedures that Part A, and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A Conditional Payment Requests

Providers of **Part A** services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 Institutional Electronic Claim, using the appropriate insurance value code (i.e., value code 14, 15 or 47) and zero as the value amount. Again, you must bill

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the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, Providers must identify the other payer's identity on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or Remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 Institutional Claims, Providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate Occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., Liability, no-fault and Workers' Compensation) situations, but the primary payer did not make a payment in the promptly period). Note: Beginning July 1, 2012 Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is requesting conditional payments.

Table 1
Data Requirements for Conditional Payment for Part A Electronic Claims

Type of Insurance	CAS	Part A Value Code (2300 HI)	Value Amount (2300 HI)	Occurrence Code (2300 HI)	Condition Code (2300 HI)
No-Fault/Liability	2320 - valid information why NGHP or GHP did not make payment	14 or 47	\$0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date 24 - Date Insurance Denied	
WC	2320 - valid information why NGHP or GHP did not make payment	15	\$0	04-Accident/Tort Liability & Date 24 - Date Insurance Denied	02-Condition is Employment Related

Part B Conditional Payment Requests (Table 2)

Since the electronic Part B claim (837 4010 professional claim) does not contain Value Codes or Condition Codes, the physician or supplier must complete the: 1) 2320AMT02 = \$0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor

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can determine if conditional payment should be granted for Part B services related to the accident or injury.

For Version 4010, Physicians and other suppliers may include CP- Medicare Conditionally Primary, AP-auto insurance policy, or OT- other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM - automobile medical, LI - Liability, LM - Liability Medical or WC - Workers' Compensation Health Claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. Note: Beginning July 1, 2012 Medicare contractors will no longer accept 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 2 displays the required information for a MSP 4010 Professional in which a physician/supplier is requesting conditional payments.

Table 2
Data Requirements for Conditional Payments for MSP 4010 Professional Claims

Type of Insurance	CAS	Insurance Type Code (2320 SBR05)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2000B SBR05)	Date of Accident
No-Fault/Liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	\$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	\$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Please note that for 837 5010 Professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in Table 3.

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Table 3

Data Requirements for Conditional Payment for 837 5010 Professional Claims

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/Liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	\$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	\$0.00	02-Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Note: Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.

Situations Where a Conditional Payment Can be Made for No-Fault and WC Claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service;
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service;

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- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first; and
- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

Situations Where a Conditional Payment Can be Made for Liability (including Self Insurance) Claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service;
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self insurer) did not make payment on the claim during the promptly period.

Conditional Primary Medicare Benefits Paid When a GHP is a Primary Payer to Medicare

Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are **NOT** present:

- 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;
- If the GHP asserts it is secondary to the liability (including self insurance), no-fault or workers' compensation insurer.

Situations Where Conditional Payment is Denied

Liability, No-Fault, or WC Claims Denied

1. Medicare will deny claims when:

- There is an employer GHP that is primary to Medicare; and
- You did not send the claim to the employer GHP first; and
- You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.

2. Medicare will deny claims when:

- There is an employer GHP that is primary to Medicare; and

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- The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first; and
- You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial Codes

To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim Adjustment Reason Code 22 - "This care may be covered by another payer per coordination of benefits" and
- Remittance Advice Remark Code MA04 -Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Additional Information

You can find official instruction, CR7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R87MSP.pdf> on the CMS website.

You will find the following revised Chapters of the "Medicare Secondary Payer Manual," as an attachment to that CR:

Chapter 1 (Background and Overview):

- Section 10.7 (Conditional Primary Medicare Benefits),
- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements):

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

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Document History

Date of Change	Description
November 16, 2017	This article was revised to add a reference to MLN Matters® Article SE17018 which contains FAQs intended to remind providers, physicians, and other suppliers of the fundamental guidance governing billing where liability insurance (including self-insurance) is involved.
December 15, 2015	The article was changed to add a reference to MLN Matters® Article MM8984 which outlines the Medicare claims processing requirements that are specific to the Ongoing Responsibility for Medicals for liability insurance, no fault insurance and workers' compensation in MSP situations.
May 21, 2015	Initial article released

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