# Table of Contents

- What’s Changed? ................................................................................................................................ 3
- MSP Provisions ................................................................................................................................... 4
- When Medicare Pays First .................................................................................................................. 4
- When We Don’t Pay Primary, Secondary, or Other ....................................................................... 10
- MSP Provision Exceptions ............................................................................................................... 10
- If Primary Payer Denies Claim ...........................................................................................................11
- Conditional Payments ........................................................................................................................11
- Collecting Patient Health Insurance Information ........................................................................... 13
- Provider & Supplier Responsibilities .............................................................................................. 14
- Submit Claims with Other Insurer Information ............................................................................... 17
- File Proper & Timely Claims ............................................................................................................. 17
- MSP Contact Information .................................................................................................................. 18
- Resources .......................................................................................................................................... 19
What’s Changed?

Note: No substantive content updates.
Medicare Secondary Payer (MSP) provisions protect the Medicare Trust Funds from paying when another entity is responsible for paying first. Any entity providing items and services to Medicare patients must determine if Medicare is the primary payer. This booklet gives an overview of the MSP provisions and explains your responsibilities.

MSP Provisions

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

- **National program savings**: MSP provisions saved the Medicare Program about $9.7 billion in fiscal year (FY) 2021.
- **Increased provider, physician, and other supplier revenue**: Billing a primary plan before us means we may offer you better payment rates. Coordinated health coverage may speed up the payment process and reduce administrative costs.
- **Avoiding Medicare recovery efforts**: Filing claims correctly the first time prevents future claim recovery efforts.

To get these benefits, it’s important to get correct and current patient health insurance coverage information. Our regulations require providers submitting claims to determine if we’re the primary or secondary payer for patient items or services.

When Medicare Pays First

Primary payers and settlement funds designed to cover all future care related to a settled injury or illness (for example, Workers’ Compensation Medicare Set-Aside Arrangement [WCMSA]) must pay a claim first. We pay first for patients who don’t have other primary insurance or coverage. In certain situations, we pay first when the patient has other insurance coverage.

In Table 1 we list common situations when a patient has Medicare in addition to other health plan coverage. For each situation we list which entity pays first (primary payer) and which pays second (secondary payer).
<table>
<thead>
<tr>
<th>Patient</th>
<th>Situation</th>
<th>Pays First</th>
<th>Pays Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 or older and has Group Health Plan (GHP*) coverage through current employment or spouse’s current employment</td>
<td>Entitled to Medicare</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>65 or older and has GHP coverage through current employment or spouse’s current employment</td>
<td>Entitled to Medicare</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>65 or older, has employer retirement GHP coverage, and isn’t working</td>
<td>Entitled to Medicare</td>
<td>Medicare</td>
<td>Retiree Coverage</td>
</tr>
<tr>
<td>Under 65, disabled, and has GHP coverage through their current employment or a family member’s current employment</td>
<td>Entitled to Medicare</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>Under 65, disabled, and has GHP coverage through their current employment or a family member’s current employment</td>
<td>Entitled to Medicare</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

* A GHP is any arrangement of, or contribution from, 1 or more employers or employee organizations providing insurance to current or former employees or their families.
Table 1. Common MSP Coverage Situations (cont.)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Situation</th>
<th>Pays First</th>
<th>Pays Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Black Lung Program (FBLP) coverage</td>
<td>Entitled to FBLP coverage&lt;br&gt;Medicare covers services or items not related to black lung diagnosis</td>
<td></td>
<td>FBLP</td>
</tr>
<tr>
<td>ESRD and GHP coverage was primary before individual became eligible and entitled to Medicare based on ESRD diagnosis</td>
<td>Before 30 months of Medicare eligibility or entitlement</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>ESRD and has GHP coverage</td>
<td>After 30 months of Medicare eligibility or entitlement</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage before becoming eligible or entitled to Medicare</td>
<td>First 30 months of Medicare eligibility or entitlement</td>
<td>COBRA</td>
<td>Medicare</td>
</tr>
<tr>
<td>ESRD and has COBRA coverage</td>
<td>After 30 months of Medicare eligibility or entitlement</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Parts A and B coverage under Medicare Advantage (MA) Plan</td>
<td>Also has a GHP Health Reimbursement Account (HRA)</td>
<td>Contact MA Plan for billing guidance</td>
<td>None (employer pays individual from HRA for out-of-pocket expenses)</td>
</tr>
<tr>
<td>Patient</td>
<td>Situation</td>
<td>Pays First</td>
<td>Pays Second</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Workers’ Compensation (WC) coverage because of job-related illness or injury</td>
<td>Entitled to Medicare</td>
<td>WC pays health care items or job-related illness or injury services first (see Conditional Payments section)</td>
<td>Medicare</td>
</tr>
<tr>
<td>In an accident or other incident, including auto accidents, where there’s no-fault or liability insurance</td>
<td>Entitled to Medicare</td>
<td>No-fault or liability insurance pays accident- or other incident-related health care services first (see Conditional Payments section)</td>
<td>Medicare</td>
</tr>
<tr>
<td>In an accident or other incident, where there’s no-fault or liability insurance</td>
<td>Patient has no-fault or liability insurance but refuses to give the information</td>
<td>Will determine when the claim is submitted to Medicare</td>
<td>To be determined</td>
</tr>
</tbody>
</table>
Table 1. Common MSP Coverage Situations (cont.)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Situation</th>
<th>Pays First</th>
<th>Pays Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 or older <strong>or</strong> disabled and has Medicare and COBRA coverage</td>
<td>Entitled to Medicare</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Dually eligible patient regardless of eligibility reason</td>
<td>Enrolled in Medicare and Medicaid</td>
<td>Medicare</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Has Medicare coverage <strong>and</strong> a Medicare supplement insurance (Medigap) plan</td>
<td>Entitled to Medicare</td>
<td>Medicare</td>
<td>Medigap</td>
</tr>
<tr>
<td>Active-duty status military member</td>
<td>Entitled to Medicare and TRICARE</td>
<td>TRICARE</td>
<td>Medicare</td>
</tr>
<tr>
<td>Inactive status military member treated by civilian providers</td>
<td>Entitled to Medicare and TRICARE</td>
<td>Medicare</td>
<td>TRICARE</td>
</tr>
<tr>
<td>Inactive status military member treated at a military hospital or by other federal providers</td>
<td>Entitled to Medicare and TRICARE</td>
<td>TRICARE</td>
<td>Medicare</td>
</tr>
</tbody>
</table>
**ESRD-MSP Rules & Dually Entitled Patients**

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

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

We pay first when we’re the only payer or legally obligated to pay primary to any GHP coverage. Otherwise, we pay secondary to any GHP coverage that may exist during the ESRD coordination period.

**Table 2. ESRD-MSP Rules**

<table>
<thead>
<tr>
<th>Basis of Medicare Eligibility &amp; Group Health Plan Coverage</th>
<th>Application of Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESRD only</td>
<td>Medicare pays <strong>secondary</strong> to any GHP coverage</td>
</tr>
<tr>
<td>Age or disability entitlement and GHP coverage precedes ESRD Medicare primary eligibility</td>
<td>Medicare pays <strong>primary</strong> to any GHP coverage</td>
</tr>
<tr>
<td>Age or disability entitlement and GHP coverage precedes ESRD Medicare secondary eligibility</td>
<td>Medicare pays <strong>secondary</strong> to any GHP coverage</td>
</tr>
<tr>
<td>Age or disability entitlement and ESRD eligibility occur on same day</td>
<td>Medicare pays <strong>secondary</strong> to any GHP coverage at time of ESRD eligibility or gotten later</td>
</tr>
<tr>
<td>ESRD eligibility precedes entitlement based on age or disability</td>
<td>Medicare pays <strong>secondary</strong> to any GHP coverage</td>
</tr>
<tr>
<td>Age or disability entitlement and <strong>no</strong> GHP coverage precedes ESRD eligibility</td>
<td>Medicare pays <strong>primary</strong> to any GHP coverage</td>
</tr>
</tbody>
</table>
When We Don’t Pay Primary, Secondary, or Other

Veterans Benefits

We don’t pay (primary, secondary, or otherwise) for services authorized under Veterans Health Administration (VHA) benefits. However, we may cover and pay for services not authorized under VHA benefits. Either Medicare or the VA may recover duplicative payments. Section 1862(a)(3) of the Social Security Act prevents Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

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

VA website has more information on veterans’ benefits.

Federal Black Lung Program Benefits

We don’t pay (primary, secondary, or otherwise) for FBLP-covered services. If a patient has an illness or injury unrelated to Black Lung, we may pay claims. Under rare circumstances, we may pay on Black Lung claims if FBLP denies the service, or the Department of Labor denies full Black Lung payments. We have the right to recover duplicative claims. Section 1862(a)(3) of the Social Security Act prevents Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

MSP Provision Exceptions

There aren’t MSP provision exceptions. Section 1862(b)(2)(A)(i) of the Social Security Act and 42 USC 1395(y)(b)(2)(A)(i) prohibit accepting patient service payments upon admission if they have another primary insurance. If you do this, you must stop immediately.

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

You must follow the MSP rules and bill us as the secondary payer after the primary payer makes payment. We’ll inform you on your Remittance Advice (RA) how much you can collect from the patient.

Note: In situations where patients made payment, they have a right to a refund and you must reimburse them.
If Primary Payer Denies Claim

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

- No-fault or liability insurer doesn’t pay during the paid promptly period or denies the medical bill
- WC program doesn’t pay during the paid promptly period or denies payment (for example, when WC excludes a medical condition or certain services)
- Patient gets services not directly related to the condition when they got WC benefits
- WCMSA funds or the ORM benefits terminate or exhaust
- GHP denies service payment because:
  - Patient exhausted certain plan benefit services
  - Patient isn’t enrolled for GHP benefits
  - Patient needs services the GHP doesn’t cover

When submitting an MSP claim, explain why the other payer denied the claim, made an exhausted benefits determination, or give another reason that may apply.

We can’t pay if the claims were already paid or if we can reasonably expect no-fault insurance, liability insurance (including self-insurance), or a WC plan, law, or policy of the U.S. to make payment. MSP provisions apply even if an entity believes it’s the secondary payer to Medicare due to state law or an insurance policy’s contents. Section 1862(b) of the Social Security Act establishes payment order and takes priority over state laws and private contracts.

Conditional Payments

In contested compensation cases, there’s often a long delay between an injury and the primary payer decision. We may make pending case conditional payments to avoid imposing a financial hardship on you and the patient while awaiting a contested case decision.

We can make conditional covered services payments even if we aren’t the primary payer. We may make conditional covered services payments in liability (including self-insurance), no-fault, and WC situations, if these are true:

- Self-insurance, no-fault, or WC holds payment liability and responsibility
- We don’t expect a prompt payment

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

- Claim information or the Common Working File (CWF) shows there’s liability, no-fault insurance, or specific item or service with WC involvement
- There’s no open GHP CWF MSP file record for the service date
Claim information shows the physician, provider, or supplier sent the claim to the liability, no-fault insurer, or WC entity first

Claim information shows the liability, no-fault insurer, or WC entity didn’t pay the claim during the 120-day paid promptly period for identified claim reasons

We can recover any conditional payments. The Benefits Coordination & Recovery Center (BCRC) recovers conditional payments from the patient or that individual’s attorney if the patient gets a settlement, judgment, award, or other payment.

We may pay for conditional primary benefits if the provider, physician, supplier, or patient doesn’t file a proper claim with the GHP (or Large Group Health Plan [LGHP]) due to the patient’s physical or mental incapacity.

If there’s a primary GHP and the provider doesn’t bill the GHP first, we won’t pay conditionally on the liability (including self-insurance), no-fault, or WC claim. Providers must bill the GHP before billing us, and the primary payer information that appears on all primary payer RAs must appear on all Medicare-submitted claims. We won’t pay for conditional primary benefits in other situations where:

- GHP says it’s secondary to Medicare
- GHP limits its payment when the patient is entitled to Medicare
- GHP covers the services for younger employees and spouses, but not for employees and spouses 65 and older
- GHP says it’s secondary to liability, no-fault, or WC insurance

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

**Paid Promptly**

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

For liability insurance (including self-insurance), “paid promptly” means payment within 120 days after 1 of these occur:

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

[Conditional Payment Information](#) webpage has more information.

Get more information on conditional payments at:

- Section 10.7 of the **Medicare Secondary Payer Manual, Chapter 1**
A Non-Group Health Plan (NGHP) is liability insurance coverage (including self-insurance), no-fault insurer, and WC carrier. Submit all NGHP claims to the NGHP insurer before submitting to Medicare.

### Ongoing Responsibility for Medicals (ORM)

We can’t pay when claims are already paid or can reasonably be expected to be made under liability insurance (including self-insurance), no-fault insurance, or a WC law or plan of the U.S., called a primary plan.

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

### Collecting Patient Health Insurance Information

Coordination of Benefits (COB) allows plans to determine their payment responsibilities. The BCRC collects, manages, and reports other patient insurance coverage to the CWF. **Providers, physicians, and other suppliers must collect accurate patient MSP information to ensure claims are filed properly.**

BCRC relies on health insurance maintained by stakeholders, including federal and state programs; plans that offer health insurance, prescription coverage, or both; pharmacy networks; and a variety of assistance programs. Some of the reporting methods we use to get MSP and COB information include:

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

- **MSP Mandatory Reporting Process:** Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory MSP data sharing requirements for GHP insurance arrangements, liability insurance (including self-insurance), no-fault insurance, and WC to report patient MSP information. **Mandatory Insurer Reporting for GHP** and **Mandatory Insurer Reporting for NGHP** webpages have more information.
• **MSP Claims Investigation**: The BCRC investigates when it learns another insurance plan may have primary responsibility for paying a patient’s Medicare claims. The BCRC determines if information is missing from MSP records or MSP cases. Single-source investigations offer a centralized MSP-related inquiries location. Investigations involve collecting other health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or other sources like correspondence, accident and injury cases, or phone calls.

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

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

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

*Medicare Secondary Payer Manual, Chapter 4* has more information on BCRC.

## Provider & Supplier Responsibilities

### Part A Institutional Providers (Hospitals)

• Ask the patient if they have insurance primary to Medicare. You can find a list of MSP questions in section 20.2.1 of the *Medicare Secondary Payer Manual, Chapter 3*. Be sure to get correct MSP data and find out if we pay primary by asking patients or their representative(s) for MSP information. You may use the HETS 270/271 transaction to verify whether other primary insurance information exists for the patient.

• Bill primary payer before billing us.

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

- Ask patients to update their insurance profiles at each visit. The updates include MSP information, like GHP information or NGHP coverage resulting from an injury or illness, before providing services.
- Incorporate patient responses to MSP questions and eligibility verification from the HETS 271 response transaction in your health records.
- Review or administer the MSP questions each time you treat or admit the patient.
- Identify all known primary payers to Medicare on the claim.
- Submit claims to the appropriate primary payer first.
- Submit MSP information to the MAC using proper claim condition, occurrence, and value codes (for providers using Form CMS-1450 or its electronic equivalent).
- Submit an Explanation of Benefits (EOB) or RA from any other insurer(s) with all appropriate MSP information to the MAC on the hard copy claim. Provide the necessary information in the appropriate fields, loops, and segments required to process an 837I electronic MSP claim.
- Provide updated information to government agencies as appropriate.

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

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

Section 70 of the [Medicare Claims Processing Manual, Chapter 1](https://www.cms.gov) has more information on Medicare-covered services timely filing requirements.

It’s important for providers to maintain an admissions process system that identifies primary payers, other than Medicare, to prevent incorrect billing and overpayments. Based on this requirement, hospitals must document and maintain patient MSP information. Without this documentation, we would have nothing to audit claims against.

**Gathering Accurate Data**

You must determine if we’re the primary or secondary payer for each inpatient admission or outpatient encounter before submitting a claim. Ask patients about other coverage. Your questions help update patient insurance information and verify correct and current information in the patient’s CWF record.
We developed tools, including an **MSP model list of questions**, to help providers verify primary payers for hospital service claims. CMS electronic tools help identify and verify MSP situations. Section 20 of the [Medicare Secondary Payer Manual, Chapter 3](#) has more information or find your MAC’s website.

Providers must keep responses to completed MSP questions and other MSP information for 10 years after the service date. You may keep hard copy files, optical images, microfilms, or microfiches. When storing these files online, keep negative and positive question responses.

Once you collect information about other patient payers, report the information appropriately when you submit the claim. Our billing claim forms ([Form CMS-1450](#) and [Form CMS-1500](#), and their electronic equivalents) have several MSP information fields. Complete the necessary fields to identify other payers.

Once the primary payer pays a claim, use that information with patient deductible and coinsurance information to calculate our secondary payment. You may also calculate the amount using formulas specific to per diem payments, prospective payments, percentage of charge, or Periodic Interim Payments (PIPs). Section 40.8.3 of the [Medicare Secondary Payer Manual, Chapter 5](#) details these formulas and payment calculations. Your MAC can answer Medicare-related payment questions.

We calculate secondary payments using specific, standardized software called **MSP Payment (MSPPAY) module**. It’s organized into distinct modules that calculate MSP amounts. The calculation uses claim information and the primary payer’s RA or EOB data for hard-copy claims.

MACs use MSPPAY to ensure consistent MSP payment calculations. MACs send this data to MSPPAY modules to calculate these MSP amounts:

- Applicable adjustments
- Submitted charges
- Other payer allowed amount (Part B claims only)
- Other payer paid amount
- Obligated-to-Accept-in-Full (OTAF) amount (contractual amount)
- Medicare’s fee schedule amount, including deductible and coinsurance, as applicable

**BCRC Claims Investigation**

If you don’t provide records of other health insurance or coverage that may be primary to Medicare on a claim, the BCRC may request the patient or their representative complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire when the:

- MAC gets a claim with EOB or RA from an insurer other than Medicare
- MAC gets an electronic claim with other insurance payment information in loops and segments
- Patient self-reports or patient’s attorney identifies an MSP situation
- Third-party payer submits MSP information to the MAC or BCRC

[Reporting Other Health Insurance](#) webpage has more information on Secondary Claim Development.
Submit Claims with Other Insurer Information

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

If a MAC doesn’t have complete information on the claim about other primary insurance, they’ll forward the information to the BCRC. The BCRC may send the patient, employer, insurer, or an attorney the SCD Questionnaire for additional information. Once complete, the BCRC reviews the questionnaire responses and takes action.

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

File Proper & Timely Claims

File a proper and timely claim with the appropriate primary payer. Not filing a proper and timely claim with the appropriate primary payer may result in claim denial. Policies vary depending on the payer; check with the payer to learn its specific policies.

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

We may recover incorrect payments directly from the primary payer or other entity that got paid. We also have a right to recover payments from an individual or other entity that got paid from a third payer. Our right to recover payments takes priority over the claims of any other party, including Medicaid.

A primary payer, or entity that gets paid from a non-Medicare primary payer, has 60 days to reimburse us. This 60-day period begins on the date we get a notice or other information that payment was, or could be made, under a primary payer. If you don’t reimburse us before the period’s expiration, we may charge interest for the violation. We may bring legal action to recover our primary payments, which may include double damages recovery (twice the payment amount).
# MSP Contact Information

## Table 3. Who You Contact With MSP Questions

<table>
<thead>
<tr>
<th>Contact</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCRC Customer Service Representatives</strong></td>
<td>• Ask about Medicare development letters and questionnaires</td>
</tr>
<tr>
<td></td>
<td>• Report a patient's accident or injury</td>
</tr>
<tr>
<td></td>
<td>• Report a patient's employment or health insurance coverage changes</td>
</tr>
<tr>
<td></td>
<td>• Report potential MSP situations</td>
</tr>
<tr>
<td></td>
<td>• Verify Medicare's primary or secondary status</td>
</tr>
<tr>
<td></td>
<td>• Contact Medicare's Commercial Recovery Center (CRC)</td>
</tr>
<tr>
<td></td>
<td><strong>Provider Services</strong> webpage has guidance on reporting a patient's health insurance changes.</td>
</tr>
<tr>
<td></td>
<td>Request patient MSP information before billing. To protect patients’ rights and information, the BCRC can't disclose this information.</td>
</tr>
<tr>
<td><strong>MAC</strong></td>
<td>• Ask general questions, including how to bill</td>
</tr>
<tr>
<td></td>
<td>• Ask about processing specific claims</td>
</tr>
<tr>
<td></td>
<td>• Ask about Medicare claim or service denials and adjustments</td>
</tr>
<tr>
<td></td>
<td>• Ask about voluntary refunds</td>
</tr>
<tr>
<td></td>
<td>• Ask about return of inappropriate Medicare payments</td>
</tr>
</tbody>
</table>
• **BCRC contacts** webpage has specific BCRC and CRC mailing addresses
• We hold CRC responsible for GHP recoveries and activities related to recovering improper payments
• We hold BCRC responsible for liability, no-fault, and WC recoveries
• CRC and BCRC manage all Coordination of Benefits & Recovery (COB&R) activities except:
  • [Medicare Modernization Act of 2003](#) demonstration recovery demand letters that MSP recovery auditors issue
  • MSP recovery demand letters that MACs issue providers, physicians, and other suppliers

GHP Recovery and NGHP Recovery webpages have the most current information.

**Resources**

• [Billing for Services When Medicare is a Secondary Payer](#)
• [CMS MSP webpage](#)
• [Medicare & Other Health Benefits: Your Guide to Who Pays First](#)
• [Medicare Secondary Payer Manual](#)