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Medicare Secondary Payer: Don't Deny Services & Bill Correctly

We return information for primary Medicare payers through Medicare eligibility. If Medicare eligibility shows open Medicare secondary payer (MSP) records, don't deny Medicare patients medical services, treatment, or entry to skilled nursing facilities or hospitals. MSP records are identified by these Insurance Type Codes:

Insurance Type	Insurance Type Codes
Working Aged	12
End-Stage Renal Disease	13
Disability	43
Liability (L)	47
No-Fault (NF)	14
Workers' compensation (WC)	15, WC

Continue to see and treat Medicare patients, even if we previously mistakenly denied or rejected a claim you submitted as Medicare primary. You can appeal these claim denials or rejections with your Medicare Administrative Contractor (MAC). Medicare Part A providers can submit adjustments.

Determine the Payer Order

- A Group Health Plan (GHP) is health coverage sponsored by an employer or employee organization. This includes MSP types 12, 13, and 43: When a patient has an employer GHP primary to Medicare, their plan usually covers most health care services and they pay first. Medicare pays second.
    - A Non-Group Health Plan (NGHP) is coverage by a liability insurer (47) (including self-insurance), no-fault insurer (14), and WC (15). When a patient has accident insurance, it usually covers all health care services related to the accident and pays first. We pay second in certain situations. Note: See below how we may mistakenly deny or reject claims related to the accident or injury MSP record when similar diagnosis codes are used, including what actions the provider takes to resolve the issue with the MAC.
- Always bill the employer GHP first before billing the NGHP for accident-related services. Bill Medicare last after you get the GHP and NGHP remittance advice.

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It's important to know the payer order, so you can bill properly. But don't deny services if it takes you some time to figure out who pays first. Review the Medicare eligibility response for information that can help you determine the primary payer of services. You may also ask your patient MSP Questions to verify their MSP status and ask whether any of their insurance status has changed. View the Medicare Questions (IOM Pub 100-05, Chapter 3, Section 20) to find the MSP questions to ask your Medicare patients. We encourage you to read Chapter 3 to become familiar on how to bill Medicare when another primary payer is involved.

Tip for Using Medicare Eligibility

Be sure to check the time periods. We return MSP effective dates and end dates. If the MSP record is still open, a begin date will appear but an end date won't.

How to Bill MSP NGHP Claims with GHP & NGHP Involvement

If the claim's date of service is within an active (open) or closed MSP NGHP record for accident-related claims:

- Bill the primary insurer first. If there's a GHP record that falls during the timeframe for the dates of service, bill the GHP insurer first.
- Bill the NGHP insurer after you get the GHP remittance advice.
- Use the same diagnosis codes found on the NGHP record identified in the eligibility response for those claims related to the accident or injury.
- The NGHP insurer may deny claims if the NGHP case hasn't yet settled or the benefits were exhausted.
- On your Medicare claim, include the reason for claim denial. You can find this on the other payer's remittance advice. Medicare may pay depending on the reason for the NGHP claim denial.

If claim services are unrelated to the MSP NGHP record found on the Medicare eligibility file, but the diagnosis codes match or are related to the diagnosis codes found in the NGHP record:

- Submit these claims to Medicare after you submit them to the appropriate GHP and/or NGHP insurer.
- The NGHP insurer may deny these claims if they're new claim services that are unrelated to the original accident or injury found on the eligibility response.
- When you get a claim denial from the NGHP, include the denial reason on the primary payer remittance advice on your claim to Medicare. We may pay depending on why the NGHP denied the claim.
- After you submit these claims to us, we may not pay the claim service due to the diagnosis codes being related to the diagnosis codes found on the NGHP MSP record on the eligibility response.
- Appeal the mistakenly denied claim with your MAC. Provide an explanation and relevant reason codes to justify the services aren't related to the accident or injury on record.
- Continue to provide services to your patient.

How to Bill When There's a Workers' Compensation Medicare Set-Aside (WCMSA)

A WCMSA is an agreement between CMS and a Medicare patient. It determines how much of the settlement funds the WCMSA will spend for care related to all settled WC injuries or illnesses before we become the primary payer.

Use the Medicare eligibility transaction if there's an open or closed WCMSA MSP record:

- Ask your patient if they have other insurance that may be primary to Medicare. View the Medicare Questions to learn which questions to ask.
- If the patient has an active WCMSA record that pays for services related to the accident, bill the patient directly. If the remittance advice shows the primary insurer rejected the claim with reason code P3 (Workers' Compensation case settled), the patient is responsible to pay the claim. Contact the WC insurer if this information isn't accurate.
- If the WCMSA pays for some services but doesn't pay for all of the services because benefits are exhausted, bill Medicare and show, on the claim, the amount WCMSA paid and that the residual payment wasn't made because of benefits exhaustion.
- We'll then pay as a primary or secondary payer, depending on the WCMSA status and how much it paid on the claim.

To bill:

- Use regular billing procedures to submit a bill indicating occurrence code 24 (insurance denied) and the date of denial in FL 31-36 (Part A UB-04) or Loop 2300 HI Segment on the X12 837 electronic claim.
- Submit a supplementary statement that WCMSA denied payment or annotate FL 80 (Part A UB-04), remarks, with the reason for denial. The 837 electronic claim shows Adjudication and Payment Date: Date of payment or denial determination by previous payer is found in the following loops and segments: D | 2330B | DTP03 or D | 2430 | DTP03.
- Use the CMS 1500 form or the X12 837 Professional Form to submit Medicare Part B claims

How to Bill Accident Insurance for Ongoing Responsibility for Medicals (ORM) & Non-ORM Claims

When NF, L, or WC is primary to Medicare, Medicare eligibility returns the MSP information including the diagnosis codes (ICD-10). Review the MSP records and respective diagnosis codes to determine who pays first. If the MSP record on the Medicare eligibility response includes both an open GHP and an open NGHP record, bill the GHP insurer first, even before you bill the NGHP for both ORM and non-ORM claims. Bill the NGHP after the GHP insurer sends you the remittance advice.

When you treat a patient, with dates of service that overlap an open or closed MSP NGHP record found in the eligibility response:

- If the NGHP record shows an open MSP period identifying there's ORM, bill the NGHP first when the dates of service overlap with the MSP dates found on the record. They're the primary payer for claims related to the accident or injury. Don't bill Medicare, as we won't pay for services related to the open ORM NGHP MSP record.
- If the NGHP record shows a closed MSP period, bill the NGHP first for dates of service that overlap with the MSP period. If the NGHP denies the claim and identifies the reason for the denial on the remittance advice, add the denial on your Medicare claim. This will help us determine whether to make a conditional payment during the promptly payment period.

For More Information

- Medicare Secondary Payer
- Medicare Secondary Payer (PDF)
- Checking Medicare Eligibility (PDF)
- MSP Manual
- CR13085: Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5