

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11755	Date: December 21, 2022
	Change Request 13000

SUBJECT: Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapters 1 and 2

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise, Pub. 100-05 Medicare Secondary Payer Manual, Chapters 1 and 2, which are out of date specific to verbiage, policy, and operational procedures.

EFFECTIVE DATE: January 23, 2023

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

IMPLEMENTATION DATE: January 23, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
R	1/10/Understanding MSP: Definitions and Important Terminologies
D	1/10/10.1/Working Aged
D	1/10/10.2/End-Stage Renal Disease (ESRD)
D	1/10/10.3/Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP)
D	1/10/10.4/Workers' Compensation (WC)
D	1/10/10.4/10.4.1/Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)
D	1/10/10.5/No-Fault Insurance
D	1/10/10.6/Liability Insurance
D	1/10/10.7/Conditional Primary Medicare Benefits
D	1/10/10.7/10.7.1/When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare
D	1/10/10.7/10.7.2/When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare
D	1/10/10.8/When Medicare Secondary Benefits Are Payable and Not Payable
D	1/10/10.9/Multiple Insurers
R	1/20/General Provisions
N	1/20/20.1/Working Aged
N	1/20/20.2/End-Stage Renal Disease (ESRD)
N	1/20/20.3/Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP)
N	1/20/20.4/Workers' Compensation (WC)
N	1/20/20.4/20.4.1/Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)
N	1/20/20.5/No-Fault Insurance
N	1/20/20.6/Liability Insurance
N	1/20/20.7/Conditional Primary Medicare Benefits
N	1/20/20.7/20.7.1/When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare
N	1/20/20.7/20.7.2/When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare
N	1/20/20.8/When Medicare Secondary Benefits Are Payable and Not Payable

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R	1/30/Overview of Pub. 100-05, the MSP Manual
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N	1/30/30.3/A/B MACs and DME MACs Prepayment Processing Requirements
N	1/30/30.4/Medicare Secondary Payer (MSP) Common Working Files (CWF)
N	1/30/30.5/MSP Recovery
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D	1/50/Rules Defining Employees Covered by GHPs and LGHPs
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D	1/70/70.1/Financial Incentives
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D	1/70/70.3/Differentiation for ESRD
D	1/70/70.3/70.3.1/Paying Benefits Secondary to Medicare
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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N	2/90/Actions Resulting from GHP or LGHP Nonconformance
N	2/100/GHP or LGHP Actions to Document Conformance

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-05	Transmittal: 11755	Date: December 21, 2022	Change Request: 13000
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I. GENERAL INFORMATION

A. Background: 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 primary plans. The purpose was to shift costs from the Medicare program to private sources of payment. These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at section 1862(b) of the Social Security Act (the Act). These provisions prohibit Medicare from making payment, if payment has been made or can reasonably be expected to be made by the following primary plans when certain conditions are satisfied: group health plans, workers' compensation plans, liability insurance, or no-fault insurance.

B. Policy: When Medicare is the secondary payer, the provider, physician, or other supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. Although Chapters 1 and 2 explains MSP policy and operational procedures, there are no MSP policy or operational changes being made to this chapter.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC		D M E M A C	Shared- System Maintainers				Other		
		A	B		H H H	F I S S	M C S	V M S		C W F	
13000.1	The A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME) MACs shall review and provide comments, in the echimp forums, for the attached updated Pub. 100-05 Medicare Secondary Payer Manual, Chapters 1 and 2.	X	X	X	X						BCRC, CMS, CRC, ECRS
13000.2	The A/B MACs and DME MACs shall not take the IOM update found in this change request as final and should not be used by the A/B MACs, DME MACs and down stream systems until the IOM is issued as final.	X	X	X	X						BCRC, CMS, CRC, ECRS

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, 410-786-1418 or richard.mazur2@cms.hhs.gov , Sheila Alston, 410-786-8334 or Sheila.Alston@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Secondary Payer (MSP) Manual

Chapter 1 - *General MSP* Overview

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40 – *Referral to the Regional Office*

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

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

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

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

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

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

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

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

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

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

Current Employment Status - *An individual that is:*

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

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

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

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

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

Entitled - An eligible individual becomes entitled to Medicare by filing the appropriate application. Upon approval of the application, the individual is entitled. It may also be necessary to enroll for certain services in order to get them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No-Fault Insurance - Insurance that pays for medical expenses for injuries sustained 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 includes "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage.

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

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

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

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

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

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

Primary Plan - When used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an

automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 - General Provisions

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

Under the Medicare law, as enacted in 1965, Medicare was the primary payer for *all* services except those covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional primary plans. The purpose was to shift costs from the Medicare program to private sources of payment. These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at section 1862(b) of the Social Security Act (the Act), *and implemented by 42 CFR § 411.20 and following*. These

provisions prohibit Medicare from making payment if payment has been made or can reasonably be expected to be made by the following primary plans: *employer-sponsored group health plans (GHPs), workers' compensation plans, liability insurance (including self-insurance), or no-fault insurance (collectively known as Non-GHPs or NGHPs.)* If payment has not been made or cannot be expected to be made promptly by a workers' compensation *law or policy of the United States*, liability insurance *(including self-insurance)*, or no-fault insurance, Medicare may make a conditional payment under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment. *When Medicare is the secondary payer, any and all payers primary to Medicare are expected to pay before Medicare. Medicare does not determine primacy between or among other payers when multiple payers are primary to Medicare for a given item or service.*

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

20.1 - Working Aged

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

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

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

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

Employers are required to offer to their employees who are age 65 or over, and to the age 65 or over spouses of employees of any age, the same coverage as they offer to

employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare, regardless of entitlement to Medicare. This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

Medicare beneficiaries have the option to reject the employer plan coverage, in which case they retain Medicare as their primary coverage. Employers cannot offer such employees, or their spouses, secondary coverage for items and services covered by Medicare. Additionally, employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have, or whose spouse has, current employment status. Further guidance pertaining to the MSP provisions for working aged individuals can be found in Pub. 100-05, Chapter 2, §10.

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

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

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

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

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs) must evaluate claims under existing guidelines derived from the law and regulations to assure that services are covered by the program regardless of any employer plan involvement.

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

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

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

20.2 - End-Stage Renal Disease (ESRD)

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

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

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

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

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

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

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

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

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

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

20.4 - Workers' Compensation (WC)

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

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

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

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

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

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

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

20.4.1 - Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)

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

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

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

20.5 - No-Fault Insurance

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

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

20.6 - Liability Insurance

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

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

20.7 - Conditional Primary Medicare Benefits

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

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

In order to adhere to the provisions in the MSP statute, all A/B MACs and DME MACs shall follow 42 CFR § 411.21, reflected in Pub. 100-05, Chapter 1, §40, for the definition of prompt or promptly. Prompt or promptly, with regard to no-fault insurance

and workers' compensation, means payment within 120 days after receipt of the claim for specific items and services by the no-fault insurer or WC entity. In the absence of evidence to the contrary, A/B MACs and DME MACs shall treat the date of service for specific items and services as the claim date for the purpose of determining the promptly period. Further, with respect to inpatient services, in the absence of evidence to the contrary, A/B MACs and DME MACs shall treat the date of discharge as the date of service with respect to no-fault insurance and WC situations for the purpose of determining the promptly period.

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

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

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

make conditional primary payment when there is GHP coverage that is a primary payer to Medicare until the claim has been sent to the primary payer first for payment.

***20.7.1- When Conditional Primary Medicare Benefits May Be Paid
When a GHP is a Primary Payer to Medicare***

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

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

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

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

***20.7.2 - When Conditional Primary Medicare Benefits May Not Be Paid
When a GHP is a Primary Payer to Medicare***

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

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

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

20.8 - When Medicare Secondary Benefits Are Payable and Not Payable

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

A/B MACs and DME MACs may pay Medicare secondary benefits when a provider,

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

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

20.9 - Multiple Insurers

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

A. More Than One Primary Insurer

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

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

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

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

B. COB Rules Conflict With MSP Rules

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

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

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

EXAMPLE 1:

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

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

EXAMPLE 2:

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

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

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

30 – Overview of Pub. 100-05, the MSP Manual

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

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

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

30.1 – MSP Provisions

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

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

30.2 – MSP Provider, Physician, and Other Supplier Billing Requirements

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

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

A/B MACs, DME MACs and the MSP Contractors are required in professional and public relations activities to inform providers, physicians, other suppliers, and beneficiaries about the MSP provisions and that claims for services to beneficiaries for which Medicare is the secondary payer must be directed first to the primary plan where there is primary coverage for the services involved. The Medicare law and/or provider agreement require the submitter to identify on the claim all known payers obligated to pay primary to Medicare. See 42 CFR § 489.20.

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

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

30.4 – MSP CWF Process

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

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

30.5 – MSP Recovery

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

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The MSP Manual outlines Medicare's right to recover payments it has made on behalf of private insurers that are the primary (or "first") payers for Medicare beneficiaries. This

information is currently found in Chapter 7 of the Medicare Secondary Payer Manual. In situations where Medicare is a “secondary” payer, the primary payer must reimburse Medicare for any benefits that Medicare has mistakenly paid as primary on behalf of a beneficiary.

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

40 - Referral to the Regional Office (Rev.11755, Issuance:12-21-22, Effective: 01-23-23, Implementation: 01-23-23)

The term Medicare beneficiary identifier (MBI) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the MBI during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

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

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

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

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

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

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

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

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

Medicare Secondary Payer (MSP) Manual

Chapter 2 - MSP Provisions

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The purpose of *Pub. 100-05, Chapter 2* is for the Centers for Medicare & Medicaid Services (CMS) to provide detailed information regarding the MSP provisions, and the relationship of MSP to other laws. *This information can assist the A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs)* with responses to questions from providers, physicians and other suppliers, attorneys, employers, and other payers.

10 - MSP Provisions for Working Aged Individuals

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.100, and further specified in § 411.170 and § 411.172, Medicare pays secondary to GHP coverage for individuals age 65 or over if the GHP coverage is by virtue of the individual's current employment status or the current employment status of the individual's spouse. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. The law requires employers (as defined in *Pub. 100-05, Chapter 1*) to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65. For example, a plan may not provide benefits that are less for individuals age 65 or over or charge policyholders premiums that are higher for individuals age 65 or over since this would create an incentive for these individuals to reject the GHP coverage and make Medicare the primary payer. This provision applies whether or not the individual age 65 or over is entitled to Medicare. This equal benefit rule applies to coverage offered to full-time and part-time employees. *CMS accepts that an individual attains a particular age on the day preceding his or her birthday.*

Medicare beneficiaries *who have current employment status* are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage *in accordance with 42 CFR § 411.172. If the employee or spouse refuses the plan Medicare is primary payer for that individual; and the plan may not offer that individual coverage complementary to Medicare.* The requirements for employer compliance with the MSP provisions may differ in some respects from the requirements for compliance with the Age Discrimination in Employment Act (ADEA). For example, the ADEA law applies only to employees, while the Medicare provision applies also to self-employed individuals. *Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have or whose spouse has current employment status, as outlined in 42 CFR § 411.108.*

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid to supplement the amount it paid for Medicare-covered services. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may NOT be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries. *(See 42 CFR § 411.108.)*

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. *A/B MACs and DME MACs* evaluate claims under existing guidelines derived from the law and regulations to assure that Medicare covers the services regardless of any employer plan involvement.

A/B MACs and DME MACs assume for developing claims and the requirement that GHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. The A/B MACS or DME MAC refers an employer's allegation that the 20-employee requirement is not met to the MSP contractor for coordination of benefits.

A/B MACs and DME MACs must refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of fewer than 20 employees, as a basis for making Medicare primary payer, to the MSP contractor for coordination of benefits. Refer to the Employer Exception (SEE) provisions process on the following link: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception>

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

10.1 - Individuals Subject to Limitations on Payment

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare pays secondary for Part A and Part B benefits for an individual who:

- Is age 65 or over;
- Is entitled to Part A (hospital insurance) on the basis of the individual's own Social Security or Railroad Retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person; and
- Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that the employer furnishes to other similarly situated employees (i.e., non-retirees). Medicare is *the* secondary payer to the GHP that the employer provides to the re-employed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for individuals associated with the employer in a business relationship such as consultants who are former employees, if the employer provides *insurance* coverage for other such individuals. *(See 42 CFR §411.172(d))*

10.2 - Individuals Not Subject to the Limitation on Payment

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The *MSP* provision for working aged does not apply to:

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium;
- Anyone who is under age 65. (Medicare is secondary to LGHPs that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than a GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;

- Employees of employers of fewer than 20 employees who are covered by a single employer plan;
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;
- Individuals enrolled in single employer GHPs of employers with fewer than 20 employees;
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees;
- Domestic partners who are given “spousal” coverage by the GHP; *or*
- Former spouses who have Federal Employees Health Benefit (FEHB) coverage under the Spouse Equity Act.

10.3 - The 20-or-More Employees Requirement

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The working aged MSP provision applies only to GHPs of employers with 20 or more employees and to multi-employer and multiple employer GHPs in which at least one employer employs 20 or more employees. *See 42 CFR § 411.100(a)(1)(i). 42 CFR § 411.170(a)(2)(i) which specifies* this requirement is met if an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if the employee does not work on a particular day. An employer may not have different employment rolls for different days reflecting those scheduled.

Where an employer does not have 20 or more employees in the preceding year, it is required to offer its employees and spouses age 65 or over primary coverage beginning with the point in time at which the employer had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year

even if the number of employees drops below 20 after the employer has met the requirement.

The 20-or-more employees requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. *During the* time the employer has met the 20-or-more employees requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the GHP.

10.4 – Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A multi-employer GHP having at least one employer participating that has at least one employer with 20 or more employees may **prospectively** request to except employees (and their spouses) of identified employers with fewer than 20 employees from the working aged provision. *The small employer provision of the MSP statute can be found at 42 U.S.C. 1395y(b)(1)(A)(iii) and 42 CFR 411.172(b). Under this provision, multi-employer GHPs may elect Medicare as the primary payer for services provided to working aged Medicare beneficiaries covered through qualified employers participating in the plan that have fewer than 20 employees. These employees* and their spouses are not subject to the working aged provision once an exception has been granted as long as the employer continues to meet the requirements for the exception.

Be advised that it is the GHP's responsibility to provide written updates of any information that may affect the original exception request (updates should include identification of any employees not previously identified as well as information on any terminated coverage issues, etc.) to the *MSP Contractor* as soon as any changes take place.

All requests for exceptions from the multi-employer plan/administrator of the small employer shall be submitted to the MSP Contractor. A/B MACs and DME MACs having received a request or an update to a previous request shall forward these requests within 14 calendar days of receipt to the MSP Contractor. Please refer to the following link to identify the appropriate contact: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page>.

The MSP contractor shall not make an exception for beneficiaries entitled to Medicare based on permanent kidney failure (End-Stage Renal Disease) or Disability.

The MSP Contractor shall only grant requests on a prospective basis. Detailed information regarding the Small Employer Exception and requirements for requesting an exception can be found on the CMS Web site at: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception>

10.5 - Rules Defining Employees Covered by GHPs and Large Group Health Plans (LGHPs)
(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

[See 42 CFR § 411.104 regarding current employment status]

A. Current Employment Status

An individual has current employment status if the individual is:

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

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

EXAMPLE: *Adam Green stopped working because of disability in December 2021 at age 63. His employer began paying him disability payments January 2022. Since disability payments are taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 2022. Beginning with July 2022, Medicare becomes the primary payer as the disability payments are no longer considered wages under FICA.*

B. Retain Employment Rights [See 42 CFR § 411.104(b)]

Persons who retain employment rights include but are not limited to:

- *Those who are furloughed, temporarily laid off, or who are on sick leave;*
- *Teachers and seasonal workers who normally do not work throughout the year;*
- *Those who have health coverage that extends beyond or between active employment periods (e.g., based on an “hours bank” arrangement). (Active union members in certain trades and industries (e.g., construction) often have “hours bank” coverage); and*
- *Those who take an employer-approved temporary leave of absence for any reason. Temporary leaves of absence include, but are not limited to, periods when an individual qualifies for short-term or long-term medical disability.*

C. Coverage by Virtue of Current Employment [See 42 CFR § 411.104(c)]

An individual has coverage as a result of current employment status with an employer if the individual has:

- *GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and*
- *Current employment status with that employer, as defined above.*

10.5.1 - Clarification of Current Employment Status for Specific Groups (Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

[See 42 CFR § 411.104 for references to employment status of specific groups]

A. Member of Religious Order [See 42 CFR § 411.104(e)]

*A member of a religious order whose members are required to take a vow of poverty is not considered to have current employment status with the religious order if the services he/she performs as a member of the order are considered employment by the order for Social Security purposes only. This is because the religious order elected Social Security coverage for its members under section 3121(r) of the Internal Revenue **Member of Religious Order Code**. Thus, Medicare is primary payer to any group health coverage provided by the religious order.*

This exception applies only to members of religious orders who have taken a vow of poverty. It does not apply to clergy or to any member of a religious order who has not taken a vow of poverty or to lay employees of the order. This exception applies not only to services performed for the order itself (such as administrative, housekeeping, and religious services), but also to services performed at the direction of the order for employers outside of the order, provided that the outside employer does not provide the member of the religious order with its own GHP coverage. A member of a religious order has current employment status with the outside employer as a result of providing services on behalf of the outside employer (an ongoing business relationship exists). If the outside employer provides GHP coverage to the member of the religious order on

the basis of that current employment status relationship, the usual MSP rules apply.

Medicare is the secondary payer to the GHP of the outside employer if the outside employer has the requisite number of employees.

EXAMPLE 1:

Sister Mary Agnes is a member of a religious order where members are required to take a vow of poverty. Sister Mary Agnes was assigned to teach at a church school in the Diocese of the Metropolis. The Diocese does not provide GHP coverage to

Sister Mary Agnes. The only group health coverage available to Sister Mary Agnes is provided by the religious order. Medicare is the primary payer for services provided to Sister Mary Agnes.

EXAMPLE 2:

Sister Mary Teresa is a member of a religious order whose members are not required to take a vow of poverty. Sister Mary Teresa was assigned to teach at a church school in the Diocese of Smallville. On the basis of her teaching relationship with the Diocese of Smallville, the Diocese provides GHP coverage to Sister Mary Teresa. The GHP provided by the Diocese of Smallville is the primary payer and Medicare is the secondary payer for services provided to Sister Mary Teresa.

A/B MACs and DME MACs should note that the exemption only applies to the working aged and disability provisions that base a GHP's obligation to be a primary payer on a current employment status relationship. The exception does not apply to the ESRD, workers compensation, or liability and no-fault provisions.

B. Insurance Agents

The following guidelines apply in determining the status of insurance agents.

A self-employed insurance agent is considered to have coverage based on current employment status if the agent:

- 1. Has an "active agent" relationship with the company; or*
- 2. Has a "retired agent" relationship with the company and has reached the "earning threshold" of \$400 or more pursuant to §211(b) of the Act. The fact that a self-employed insurance agent is authorized to represent the company, e.g., to write policies on behalf of the company, does not itself imply current employment status.*

C. Senior Federal Judges

Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the remuneration they receive as senior judges is not considered wages for Social Security retirement offset purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the working aged and disability provisions.

D. Volunteers

Volunteers are considered to have current employment status when they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) of the Act, AmeriCorps members in the Volunteers In Service To America program (VISTA) are considered to have current employment status since they receive remuneration from the Federal Government. Also, remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a volunteer receives, are considered remuneration.

E. Directors of Corporations

Directors of corporations (i.e., persons serving on a Board of Directors of a corporation who are not officers of the corporation) are self-employed. (Officers of a corporation are employees.) Directors who receive remuneration for serving on a board are considered to have current employment status. Remuneration may be of a monetary or nonmonetary nature. Benefits, including health benefits that a corporation provides to a board member, are considered remuneration if they are subject to FICA taxes under the IRC.

Directors who receive no remuneration for serving on the Board (unpaid directors) are not considered to have current employment status. However, remuneration may consist of deferred compensation (i.e., amounts earned but not payable until some future date usually when the individual reaches age 70 and is no longer subject to the Social Security retirement test). A director receiving deferred compensation is considered to have current employment status only while serving as a director. (See subsection F.)

F. Individuals Receiving Delayed Compensation Payments Subject to FICA Taxes [See 42 CFR § 411.104(f)]

An individual who is not working is not considered to have current employment status solely on the basis of receiving delayed compensation payments for previous periods of work even though those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working and in 2021 receives payments subject to FICA taxes for work performed in 2020 is not considered to be an employee in 2021 solely on the basis of receiving those payments.

G. Leased Employees

Leased employees (as defined in §414(n)(2) of the IRC) are treated as employees of the recipient. The term "leased employee" means any person who is not an employee of the recipient of the services but who provides services to the recipient if the:

- Services are provided based on an agreement between the recipient and any other person (i.e., the leasing organization);*
- Person has performed such services for the recipient on a substantially full-time basis for at least 1 year. (In general, an employee who works 30 hours or more is considered to be full time.); and*

- *Services are of a type historically performed in the business field of the recipient by employees. An example of a leased employee is an employee of a temporary agency who is assigned to work full time for at least one year doing bookkeeping for an accounting firm.*

In implementing these provisions, CMS relies on the regulations and decisions made by the Secretary of the Treasury. Specific questions relating to application of these provisions may be directed to CMS.

H. Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that is furnished to other employees (i.e., non-retirees). Thus, an employer is required to provide primary coverage for a re-employed retiree if the amount of work the individual performs (based on hours, productivity, etc.) would be sufficient to earn the employee coverage from the employer had the employee not retired. The GHP or LGHP coverage is primary to Medicare because of the current employment status. This rule applies even if the:

- *Plan is the same plan that previously provided coverage to the individual retiree or annuitant;*
- *Premiums for the plan are paid from a retirement pension or fund; or*
- *Re-employed retiree pays the entire premium.*

I. Coverage for Self-Employed Individuals [See 42 CFR § 411.104(d)]

When Medicare is secondary payer, the employer is not required to provide GHP coverage to self-employed individuals. However, if an employer subject to the MSP provisions provides coverage to a self-employed individual (including owners, a consultant, or a contractor), the employer may not take into account the individual's Medicare entitlement (i.e., the GHP must pay primary to Medicare). Also see 42 CFR § 411.104(d).

10.6 - Aggregation Rules Applicable to Determine the Employer Size (Rev.11755, Issuance:12-21-2022, ,Effective: 01-23-2023, Implementation: 01-23-23)

The size of the employer is a factor in determining whether Medicare is secondary or primary payer under the working aged and disability provisions of the law. For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. Ordinarily, the identity of that entity is clear.

There are situations, however, when it is not clear which corporation or individual is the employing entity for MSP purposes. For example, when a corporation is owned or controlled by another corporation, it must be decided which corporation is the employer.

Similarly, when related individuals each have businesses and each claim to be a separate employer with either fewer than 20 or fewer than 100 employees, it must be decided whether the individuals are separate employers or a single employer.

The MSP law contains the following rules for determining the size of the employer under the MSP for the aged and disabled provisions. [See 42 CFR § 411.106]

A. Single Employers

Single employers under Section §52 of the IRC are defined as follows:

- All employers that are treated as single employers under subsections (a) or (b) of §52 of the IRC are treated as single employers;*
- Section 52(a) of the IRC provides that all employees of all corporations that are members of the same controlled group of corporations are treated as if employed by a single employer; and,*
- Section 52(b) of the IRC provides that all employees of trades or businesses (whether or not incorporated), e.g., employees of partnerships or proprietorships that are under common control, shall be treated as employed by a single employer.*

In general, two or more individuals or corporations are considered to be separate employers under §52(a) or (b) of the IRC if they file separate income tax returns. Two or more individuals are considered to be a single employer if they file a consolidated tax return.

When there is a question about the tax status of a particular employer that claims to have fewer employees than the 20 or 100 employee thresholds, A/B MACs and DME MACs must request the employer to submit copies of its most recent tax return to resolve the question.

B. Affiliated Service Groups

All employees of the members of an affiliated service group (as defined in Section 414(m) of the IRC) are treated as employed by a single employer.

C. Treatment of Religious Organizations

CMS does not aggregate religious organizations for MSP purposes. Incorporated parishes and churches that are part of a church-wide organization, such as a diocese or synod, are considered to be individual employers. A GHP or LGHP for employees of such parishes or churches is considered to be a multi-employer GHP. (See §10.3 and §10.4 of this chapter, for policies regarding multi-employer GHPs in which at least one participating employer employs 20 or 100 or more employees respectively.)

10.7 - Effect of GHPs Payments on Deductible, Coinsurance, and Utilization

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Expenses that serve to meet the beneficiary's Part A or Part B cash and blood deductibles, if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no secondary Medicare benefit payable. If a GHP paid for Medicare covered expenses in whole or in part, the Part B deductible is credited on the basis of the Medicare fee schedule amount rather than the amount paid by the GHP. Also, GHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance.

Where no Medicare secondary benefit is payable, no utilization is charged the beneficiary. Where a Medicare secondary payment is made, the A/B MAC charges the beneficiary with utilization. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

Expenses for which payments are made and Medicare conditional payments are recovered from no-fault or liability insurance are credited toward the deductible amounts for both Parts A and B. Also, no-fault and liability payments are applied to satisfy a beneficiary's obligation to pay Part A or Part B coinsurance amounts. No-fault and liability payments are credited to deductibles before being used to satisfy the coinsurance. For services provided prior to November 13, 1989, payments by the primary payer are not counted toward the Medicare deductible. The discharge date is used for determining when a provider furnished the services.

Services for which Medicare conditional payments are recovered from liability or no-fault insurance are not counted against the number of inpatient care days available to the beneficiary. If an individual is hospitalized twice in the same benefit period and Medicare recovers its payment from a no-fault or liability insurance for the first hospitalization, the first hospitalization would not be charged to the beneficiary. See CFR 42 § 411.30 and 411.33

EXAMPLE 1:

An individual who previously had not met any of the \$233 Part B deductible incurred \$233 in charges for which the GHP paid \$200. The Medicare fee schedule amount was \$233. No Medicare benefits are payable. The individual is credited with \$233 toward the Part B cash deductible.

The beneficiary can be charged \$33. (The \$233 fee schedule amount minus the sum of the \$200 primary payment plus the \$0 Medicare payment).

EXAMPLE 2:

An individual who previously had met \$100 of the \$233 Part B deductible incurred \$150 in charges that were paid in full by the GHP. The Medicare fee schedule amount was \$150. No Medicare benefits are payable. The individual is credited with an additional \$150 toward the Part B cash deductible and now has satisfied the Medicare deductible.

The physician cannot bill the beneficiary because the sum total of the primary payment (\$150) and the Medicare payment (\$0) meets the fee schedule amount of (\$150).

10.7.1 - Crediting Deductible for Non-Inpatient Psychiatric Services

The Part B deductible for non-inpatient psychiatric services is credited on the basis of the Medicare fee schedule amount. There is no annual limit on incurred expenses for non-inpatient psychiatric services.

EXAMPLE 1:

An individual received non-inpatient psychiatric services for which a physician charged \$250. The \$233 Part B deductible had not been met. The GHP allowed \$100 and paid \$100. The Medicare fee schedule amount is \$210.

- A. Actual charge by the physician minus the third-party payment: $\$250 - \$100 = \$150$.*
- B. The Medicare payment is determined in the usual manner: $\$210 - \$233 = 0 \times .80 = \$0$.*
- C. Medicare's allowable charge of \$210 (which is higher than GHP's allowed amount of \$200) minus GHP's payment of \$100 equals \$110.*

Medicare pays \$0 (lowest of amounts in steps A, B, or C).

The beneficiary can be charged \$110 (the \$210 fee schedule amount minus the sum of the \$100 primary payment plus the \$0 Medicare payment). The unmet Part B deductible is credited with \$210. The beneficiary still must meet \$13 of the annual Part B deductible before Medicare benefits become payable.

EXAMPLE 2:

An individual received non-inpatient psychiatric services for which the physician charged \$250. None of the individual's Part B deductible had been met. The GHP allowed charges in full and paid \$250. The Medicare fee schedule amount for the services was \$200. No Medicare secondary benefit is payable since the GHP paid charges in full. The \$233 Part B deductible is credited by the first \$200 of the fee schedule amount.

The beneficiary cannot be billed by the physician because the sum total of the primary payment (\$250) and the Medicare payment (\$0) exceeds the fee schedule amount (\$200).

EXAMPLE 3:

An individual received non-inpatient psychiatric services from a physician for which the physician charged \$500. None of the individual's \$233 Part B deductible had been met. A GHP allowed charges in full and paid \$400 (80 percent of the \$500). The Medicare fee schedule amount for the services was also \$500. The \$233 Part B deductible is credited in full. The Medicare secondary benefit calculated is \$100.

The physician cannot bill the beneficiary because the sum total of the primary payment (\$400) and the Medicare secondary payment (\$100) equals the Medicare fee schedule

amount.

10.8 - Beneficiary's Rights and Responsibility (Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. Beneficiary's Responsibility with Respect to GHPs that are Primary to Medicare

The A/B MACs and DME MACs shall 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 A/B MACs and DME MACs 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 §100 of this chapter for definition of proper claim) unless the failure to file a proper claim is due to mental or physical incapacity of the beneficiary. [See CFR 42 § 411.165, 411.175 and 411.206]. A beneficiary need not file any appeal if not inclined to do so.

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

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.

20 - MSP Provisions for End-Stage Renal Disease (ESRD) Beneficiaries (Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

*Pursuant to 42 CFR § 411.162, Medicare is secondary payer to GHPs for individuals eligible for, or entitled to Medicare **Part A** based on ESRD during a coordination period described below. This provision applies regardless of the number of employees employed by the employer and regardless of whether the individual or other family member has current employment status. The ESRD provision applies to former as well as to current employees. This provision applies where an individual is eligible for Medicare based on ESRD and where an individual is entitled to Medicare based on ESRD. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of §20.1.1 or §20.1.3 if the individual meets the other requirements.*

In general, §13561(c)(2) and (3) of OBRA 1993 provided that plans must pay primary benefits during the coordination period regardless of whether the individual is also entitled to Medicare on another basis. (See §20.1.3 for dual entitlement provisions. Specifically, see §20.1.3.B, which discusses the dual entitlement provision under which a GHP remains secondary to Medicare during the 30-month coordination period and litigation challenging that provision.)

This provision applies to all Medicare-covered items and services furnished to beneficiaries who are in the 30-month period, including services for non-ESRD treatment

and services required by kidney donors in cases of transplantation. This limitation applies for claims processing for items or services furnished to ESRD beneficiaries who are in their 30-months of eligibility or entitlement on the basis of ESRD.

20.1 - Determining the 30 Month Coordination Period During Which Medicare May Be Secondary Payer

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If Medicare was not the primary payer for an individual on the basis of age or disability at the time the individual became eligible for or entitled to Medicare on the basis of *ESRD*, Medicare is secondary payer to GHPs for items and services furnished during a period of up to 30 consecutive months, which begins with the earlier of:

- The month in which a regular course of renal dialysis is initiated, or
- If the patient undergoes a course of self-dialysis training the first day of the month in which the training occurred, or
- If an individual who received a kidney transplant, the first month in which the individual became entitled.

NOTE: In the rare case of an untimely application by an individual who receives a transplant, the 30-month period could begin with the first month in which the individual would have been eligible for or entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of eligibility or entitlement. If further development is required, the contractor should contact the SSO.

When the 30-month period begins before the month the individual becomes eligible for or entitled to Medicare, *A/B MACs and DME MACs* pay secondary benefits for the portion of the period during which the individual is eligible or entitled. The latter is the coordination period

. Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis.

20.1.1 - Duration of Coordination Period

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The coordination period is a period that begins with the earlier of the first month of entitlement to or eligibility for Medicare Part A based on ESRD. Eligibility refers to the first month the individual would have become entitled to Medicare Part A on the basis of ESRD if he/she had filed an application for such benefits.

The Balanced Budget Act (BBA) of 1997, extended the coordination period *from 18 months* to 30 months.

Eligibility refers to the first month the individual would have become entitled to Medicare Part A on the basis of ESRD if an application were filed for such benefits. In the rare case of an untimely application by an individual, the coordination period could begin with the first month in which the individual would have been entitled to Medicare benefits if a timely application had been filed. It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of entitlement. If further development is required, *A/B MACs and DME MACs* contact the RO.

When the coordination period begins before the month the individual becomes entitled to Medicare, the *A/B MACs and DME MACs* pay secondary benefits for the portion of the period during which the individual is entitled. Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis. However, for individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 30 months of the individual's entitlement.

Individuals eligible for Medicare on the basis on ESRD cannot enroll for Part B *during a Special Enrollment Period (SEP)* SEP, but can defer entitlement to both Part A and B and file an initial application later, usually at the end of the coordination period.

More examples illustrating when Medicare pays secondary in cases of ESRD entitlement and eligibility are found at 42 CFR § 411.162(d).

20.1.2 - Determination for Subsequent Periods of ESRD Eligibility *(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)*

20.1.3 - Dual Eligibility/Entitlement Situations *(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)*

If an individual also becomes entitled to Medicare based on age 65 or disability after being entitled based on ESRD, the coordination period continues for the remainder of the 30-months if Medicare was properly the secondary payer at the time of the dual entitlement. *See 42 CFR § 411.163.*

When an individual is eligible for, or entitled to Medicare *Part A* based on ESRD and also entitled on the basis of age or disability, the coordination of benefits is described below.

Except as provided in subsection B, GHPs are subject to a 30-month coordination period for any plan enrollee eligible for, or entitled to Medicare *Part A* based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. The 30-month period coincides with the first 30 months of ESRD-based Part A Medicare eligibility or entitlement. (Under previous law, Medicare automatically became the primary payer at the point of dual Medicare eligibility/entitlement.) As long as dual eligibility/entitlement exists, the ESRD MSP provision applies exclusively. Medicare becomes the primary payer after the 30th month of ESRD-based eligibility/entitlement even though plan coverage may be in effect by reason of current employment status.

That is, the working aged MSP provisions and the disability MSP provisions do not apply to individuals *who are entitled on the basis of* ESRD during or after the 30-month coordination period.

Subsection A, below, deals with coordination periods governed by present law and provides examples. Subsection B specifies the circumstances under which the ESRD MSP provision does not apply in dual entitlement situations and provides an example. Subsection C deals with circumstances in which Medicare continues to be primary when

an individual is entitled to Medicare based on age or disability and then ESRD with no GHP coverage, but obtains GHP coverage during the coordination period and provides an example. Subsection D deals with the effect of the cessation of dual entitlement.

A - Circumstances in Which Medicare Continues to be Secondary After Aged or Disabled Beneficiary Becomes Eligible for, or Entitled to Medicare on the Basis of ESRD

Medicare is secondary payer during the first 30 months of ESRD-based eligibility and entitlement and becomes primary payer after the 30th month of ESRD-based eligibility or entitlement if Medicare was not properly primary prior to ESRD-based eligibility. (Refer to subsection B below if Medicare is properly primary.)

EXAMPLE 1

Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and begins a course of maintenance dialysis *at an ESRD facility* on June 27, 2020. Effective September 1, 2020, Mr. C is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 2023, the 30th month of ESRD-based eligibility, and becomes primary payer beginning March 2023.

EXAMPLE 2

Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 2020 at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 30-month coordination period (July 2020), Mr. D turned age 65. The coordination period continues without regard to age-based entitlement with the retirement plan continuing to pay primary benefits through June 2023, the 30th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer beginning July 2023.

EXAMPLE 3

Mr. *Edwards* retired at age 62 and maintained GHP coverage as a retiree. In July 2020, he simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 2020) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 2020 through December 2022, the first 30 months of ESRD-based eligibility. Medicare becomes the primary payer beginning January 2023.

B - Circumstances in Which Medicare Continues to be Primary After Aged or Disabled Beneficiary Becomes Eligible on Basis of ESRD

Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if both of the following conditions are met:

- The individual is already entitled *to Medicare* on the basis of age or disability when he/she becomes eligible on the basis of ESRD, *and*
- The MSP prohibition against "taking into account" age-based or disability-based entitlement does not apply because plan coverage was not "by virtue of current employment status" or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

The plan may continue to pay benefits secondary to Medicare under this subsection. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

EXAMPLE 1

Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 2020. She automatically becomes eligible for Medicare based on ESRD effective January 1, 2021. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

C – Circumstances in Which Medicare Continues to be Primary When Individual is Entitled to Medicare Based on Age or Disability and then ESRD with no GHP Coverage but Obtains GHP Coverage During the Coordination Period

If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage.

EXAMPLE 1

Mr. Z is 67 years old and has Medicare based on age. He has no GHP coverage. Mr. Z develops ESRD and begins a course in maintenance dialysis and becomes eligible for Medicare based on ESRD which triggers the 30-month coordination period. However, Mr. Z has no GHP coverage and Medicare continues as the primary payer. In the 6th month of the coordination period Mr. Z obtains coverage through his wife’s GHP. Since Medicare was the proper primary payer when eligibility for ESRD was established, Medicare remains the primary payer.

D - Dual Eligibility/Entitlement Ceases

If ESRD-based eligibility or entitlement ceases in accordance with the Medicare Pub. 100-01, Medicare General Information, Eligibility and Entitlement, Chapter 2, §10.4, Medicare is the primary payer unless plan coverage is in effect by virtue of current employment status, and the provisions of §§10 and 20 or 30 apply.

More examples illustrating the coordination of benefits in cases of dual entitlement are found at 42 CFR § 411.163(c).

20.1.4 – Summary Chart for ESRD-MSP Rules and Dually Entitled Medicare Beneficiaries

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Rule: If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage. Otherwise, Medicare is secondary to any GHP coverage that may exist during the ESRD coordination period.

BASIS OF MEDICAL ELIGIBILITY AND GHP COVERAGE	APPLICATION OF RULE
<i>ESRD Only</i>	<i>Medicare <u>secondary</u> to any GHP coverage.</i>
<i>Age or Disability entitlement and GHP coverage precede ESRD eligibility with Medicare primary</i>	<i>Medicare <u>primary</u> to any GHP coverage.</i>
<i>Age or Disability entitlement and GHP coverage precede ESRD eligibility with Medicare secondary</i>	<i>Medicare <u>secondary</u> to any GHP coverage.</i>
<i>Age or Disability entitlement and ESRD eligibility occur on same day</i>	<i>Medicare <u>secondary</u> to any GHP coverage at time of ESRD eligibility or obtained later.</i>
<i>ESRD eligibility precedes entitlement based on Age or Disability</i>	<i>Medicare <u>secondary</u> to any GHP coverage.</i>
<i>Age or Disability entitlement and <u>NO</u> GHP coverage precedes ESRD eligibility</i>	<i>Medicare <u>primary</u> to any GHP coverage.</i>

20.2 - Effect of ESRD MSP on Consolidated Omnibus Budget Reconciliation Act (COBRA)

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. General

The COBRA requires that certain GHPs offer continuation of plan coverage for 18 to 36 months after the occurrence of certain qualifying events, including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of GHP coverage unless the individual is given the opportunity to elect and does elect to continue plan coverage at his/her own expense.

On June 8, 1998, the Supreme Court in "Geissal v. Moore Medical Corp." invalidated the COBRA continuation of health care coverage regulations with respect to when a GHP may terminate COBRA coverage. The court ruled that individuals who obtain other coverage (including Medicare) on or before the COBRA election date are permitted to continue this coverage along with COBRA. Thus, where ESRD-based Medicare *Part A* entitlement predates the COBRA qualifying event, the plan is obligated to offer COBRA coverage for a qualifying event such as termination of employment. To the extent the period of COBRA coverage overlaps the ESRD MSP coordination period, COBRA is primary and the employer plan has no discretion to terminate COBRA because of the ESRD-based Medicare entitlement. Those individuals who obtain other coverage (including Medicare) after the COBRA election date can be terminated from COBRA coverage. This means that where COBRA coverage came first, the employer may terminate existing COBRA coverage under its health plan when Medicare entitlement occurs. Where COBRA expressly permits termination of continuation coverage upon entitlement to Medicare there is one exception. The exception is that the plan may not terminate continuation coverage of an individual (and the individual's qualified dependents) if the individual retires on or before the date the employer substantially

eliminates regular plan coverage by filing for Chapter 11, Bankruptcy. (See 26 U.S.C. 4980B(g)(1)(D), 29 U.S.C. 1162(2)(D), and 1167(3)(C).)

B. Medicare is Secondary to COBRA Coverage

To the extent COBRA coverage overlaps the 30-month ESRD MSP coordination period, Medicare is secondary payer for benefits that a GHP:

- Is required to keep in effect under the COBRA continuation requirements where Medicare entitlement occurs first; or
- Is required to keep in effect under the COBRA continuation requirements even after the individual becomes entitled to Medicare based on ESRD (i.e., the bankruptcy situation as described in subsection A above); or
- Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD even though not obligated to do so under the COBRA provisions. [*See 42 CFR § 411.162(a)(3)*]

30 - MSP Provision for Disabled Beneficiaries

Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.204, Medicare is secondary payer to LGHPs for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member. (See *Pub. 100-05*, Chapter 1 for definition.)

Under the law, a LGHP may not "take into account" that such an individual is eligible for, or receives, Medicare benefits based on disability. Apply the instructions in *this chapter when* processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to a GHP of 20 or more employees, substitute the term "large group health plan" as defined in *Pub. 100-05, Chapter 1* to apply them to disabled individuals.

30.1 - Individuals Not Subject to MSP Provision

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare is **not** secondary under the MSP *provision* for disabled individuals:

- Who work or whose family member works for employers *having* fewer than 100 employees unless the GHP is a multi-employer plan in which at least one employer of 100 or more employees participates;
- Covered by an LGHP as a result of past employment (e.g., as a retired former employee or as the spouse of a retired former employee) and whose coverage is not also

based on current employment status of their own or a family members current employment status;

- Covered by a health plan other than an LGHP (e.g., one that is purchased by the individual privately and not through an employer);
- Who have FEHB coverage under the Spouse Equity Act;
- *Enrolled* in Part B only; or
- *Enrolled* in Part A on the basis of a monthly premium.

30.2 - The 100 or More Employees Requirement

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The Medicare as secondary for the disabled provision applies only to LGHPs that cover employees of at least one employer that employed 100 or more full-time and/or part-time employees on 50 percent or more of its business days during the previous calendar year.

Medicare is secondary for all employees enrolled in the plan if a plan is a multi- employer plan, such as a union plan which covers employees of some small employers and also employees of at least one employer that meets the 100-or- more employee requirement, including those that work for small employers. The exception discussed in *this chapter*, with respect to the working aged provision, does not apply to the Medicare as secondary for the disabled provision. An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on his/her employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 100 regardless of the number of employees who work or who are expected to report for work on that day.

Self-employed individuals who participate in an LGHP are not counted as employees for purposes of determining if the 100-or-more employee requirement is met. If an employer does not meet the 100-or-more employees requirement in a particular year, the employer may offer employees coverage that is secondary to Medicare during the following year. If the employer meets the 100-or-more employee requirement at any time during the current year, the employer is required to provide employees with coverage that is primary to Medicare during the following year.

30.3 - Disabled Individuals Who Return to Work

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If a disabled individual who has LGHP coverage based on prior service to the employer returns to work, the coverage is considered to be by virtue of current employment status if the employer provides coverage to similarly situated individuals who are not disabled. Similarly situated individuals are individuals who work in the same category of employment and who perform the same amount of work. Such services may be based, for example, on the number of hours worked or the amount of earnings. *[See 42 CFR § 411.104 for current employment status regulations.]*

30.4 - Dually Entitled Individuals

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

If a disabled individual is also eligible for, or entitled to Medicare under the ESRD provisions, follow the rules in §20.1.3 under which Medicare is *the* secondary payer for the applicable 30-month coordination period.

40 - Liability Insurance

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Under (42 U.S.C. 1395y(b)(2)), *and outlined in 42 CFR § 411.50*, Medicare does not make payment 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 insurance will not pay or will not pay promptly. Conditional 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).

40.1 - Medicare's Recovery Rights

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Pursuant to 42 CFR § 411.24 and with reference to 42 CFR Subpart D, Medicare has a statutory direct right of recovery from the liability insurance as well as any entity that has received payment directly or indirectly from the proceeds of a liability insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation rights.

In addition to its direct rights of recovery, Medicare has subrogation rights.

"Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare 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 for services related to claims against the alleged tortfeasor (and the alleged tortfeasor's liability insurance). Medicare can be a party to any claim by a beneficiary or other entity against an alleged tortfeasor and/or his/her liability insurance and can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare.

40.2 - Billing in MSP Liability Insurance Situations

Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A - Difference Between Liability Insurance and Other Primary Plans

Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., no-fault insurance, *GHPs*, and *WC*, the insurance has a contractual obligation to pay for medical services provided to the covered/injured person. Liability insurance, however, has a contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment “has been made, or can reasonably be expected to be made...” under liability insurance (including self-insurance), no-fault insurance, or a workers’ compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted. See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

B – Billing Options and Requirements – Alternative Billing

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary’s liability insurance settlement is considered billing the liability insurance.) *As specified in 42 CFR § 411.50*, promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge) rather than bill Medicare. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid *and the liability insurer indicates, on the claim, the reason why the claim is not being paid. Note: If the reason for primary payer denial is not identified on the claim, the A/B MAC or DME MAC denies/rejects the claim*). If liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- *Bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary’s liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or*
- *Maintain all claims/liens against the liability insurance/beneficiary’s liability insurance settlement.*

C – Special Rule for Oregon *[See 42 CFR § 411.54(d)(2)]*

As a result of a court order, providers, physicians, and other suppliers in Oregon:

- *May* either (i.e., double billing is not permitted) bill Medicare or bill liability insurance (the filing of a lien against a beneficiary's liability insurance settlement is considered billing the liability insurance) if the liability insurer pays within 120 days after the earlier of the following dates:
 - *The* date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement; or

- *The date the services were provided or, in the case of inpatient hospital services, the date of discharge.*
- *Must withdraw claims/liens against the liability insurance/beneficiary's liability insurance settlement following expiration of the 120-day period and bill Medicare.*

However, CMS will not terminate the provider agreement of a provider that does not comply with the court order if that provider is following the procedures outlined in B above.

D – Charges to Beneficiaries

Provider Charges to Beneficiaries for Services Covered By Medicare

The following applies to providers *that* participate in Medicare, emergency hospitals *that* do not participate in Medicare, and foreign hospitals with an election to bill Medicare:

- *If the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.*
- *If the provider pursues liability insurance, the provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.*

Physician and Other Supplier Charges to Beneficiaries for Services Covered By Medicare

The following applies to physicians and other suppliers who participate in Medicare:

- *If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.*
- *If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.*

The following applies to physicians and other suppliers who do not participate in Medicare and who submit or would be required to submit an assigned claim:

- *If* the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.
- *If* the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

Physicians and other suppliers (*with the exception of DMEPOS suppliers*) who do not participate in Medicare and who submit an unassigned claim may charge beneficiaries no more than the limiting charge and may collect *payment* without regard to whether the liability insurance is available to the beneficiary.

Physicians and other suppliers who do not participate in Medicare, do not submit an unassigned claim, and are not required to submit an assigned claim if they submitted a claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services Not Covered by Medicare

- For services for which there is no Medicare coverage available regardless of who furnishes them, providers, physicians, and other suppliers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.
- For services of foreign hospitals that have no election to bill Medicare, providers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.
- For services of foreign physicians and other suppliers, the physician or other supplier may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

E – Provider, Physician, or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary’s Liability Insurance Settlement

As cited above in B, providers, physicians, and other suppliers must withdraw all claims/liens against liability insurance/beneficiary’s liability insurance settlement (except for claims related to services not covered by Medicare and for Medicare deductibles and coinsurance) when they bill Medicare. *A/B MACs and DME MACs* may learn of a situation where the provider, physician, or other supplier billed Medicare but did not withdraw the claim/lien. In such situations, *A/B MACs and DME MACs* must:

- Advise the provider, physician, or other supplier and beneficiary that the act of billing Medicare limits the payment that the provider, physician, or other supplier

may receive for the services billed to the Medicare approved amount. This applies even if Medicare did not pay the claim or the provider, physician, or other supplier refunded the Medicare payment to Medicare.

- If the provider, physician, or other supplier collected on a claim/lien after billing Medicare, advise the provider, physician, or other supplier and beneficiary that:
 - *The provider, physician, or other supplier must refund the Medicare payment in instances where the amount collected on the claim/lien is for the full charges of the claim/lien and the Medicare payment is greater than or equal to the full charges of the claim/lien and greater than or equal to the amount collected on the claim/lien (see example one below for an illustration of this policy); or*
 - *The provider, physician, or other supplier must refund the lesser of the amount collected on the claim/lien or the Medicare payment in instances where the amount collected on the claim/lien is less than the full charges of the claim/lien due to policy limits (see example two below for an illustration of this policy); and*
 - *The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment if the provider, physician, or other supplier received payment for services not covered by Medicare and for Medicare deductibles and coinsurance (see example three below for an illustration of this policy); or*
 - *The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment less any amounts due from the beneficiary for services not covered by Medicare and for Medicare deductibles and coinsurance (see example four below for an illustration of this policy).*

EXAMPLES

EXAMPLE 1: Charges from the facility are \$5,000. Medicare is billed. The facility receives \$8,000 from Medicare. The facility receives \$5,000 from the liability insurance. The facility must repay Medicare \$8,000.

EXAMPLE 2: Charges from the facility are \$150,000. Medicare is billed. The facility receives \$110,000 from Medicare. The facility receives \$100,000 (due to policy limits) from the liability insurance. The facility must repay Medicare \$100,000.

EXAMPLE 3: Charges from the facility are \$1,000. Medicare is billed. The Medicare allowable is \$800.00. The Medicare deductible has been satisfied. The Medicare coinsurance of \$160.00 has been paid. There are no charges for non-covered Medicare services. The facility receives \$640.00 from Medicare. The facility receives \$1,000 from the liability insurance. The facility must repay Medicare \$640.00 and send \$360.00 to the Medicare beneficiary.

EXAMPLE 4: Charges from the facility are \$1,000. Medicare is billed. The Medicare allowable is \$800.00. The Medicare deductible has been satisfied. The Medicare coinsurance of \$160.00 has not been paid. There are \$50.00 in charges for non-covered Medicare services. The facility receives \$640.00 from Medicare. The facility receives \$1,000 from the liability insurance. The facility must repay Medicare \$640.00. The facility may retain \$210.00 for the unpaid Medicare coinsurance and charges for the non-covered Medicare services. The facility must send to the Medicare beneficiary the remainder of the liability insurance payment (\$150.00).

F – Permissible Liens

The MSP provisions do not create lien rights when those rights do not exist under State law. Where permitted by State law, a provider, physician, or other supplier may file a lien for full charges against a beneficiary's liability settlement. (A lien against a beneficiary will be considered a lien against a liability settlement if there is a binding agreement that the lien will only be enforced if there is a settlement and will be withdrawn otherwise.)

- The provider, physician, or other supplier may enforce a permissible lien up to the lesser of the amount of the settlement and charges for the services incorporated in the lien. The provider, physician, or other supplier may not charge interest, lien filing, and administrative fees to the beneficiary or against the lien.

50 - Workers' Compensation (WC)

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A - General

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(2)), and outlined in 42 CFR § 411.40, payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC

plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program).

These Federal programs provide WC protection for Federal Civil Service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, for example:

- Coal miners totally disabled due to pneumoconiosis;
- Maritime workers (with the exception of seamen);
- Employees of companies performing overseas contracts with the United States government;
- Employees of American companies who are injured in an armed conflict;
- Employees paid from non-appropriated Federal funds (such as employees of post- exchanges);
- Offshore oil field workers; and
- Qualified claimants under the Department of Labor's Energy Employees Occupational Illness Compensation Program.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion. However, they are considered liability insurance and the MSP liability rules apply.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory. If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

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

B. - Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

A WCMSA is an *agreement between CMS and the CMS beneficiary surrounding the allocation of funds from a workers' compensation (WC) settlement, judgment or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. A WCMSA identifies the conditions that must be met before Medicare will resume primary payment of all settled WC injuries or illnesses.* Where a WC settlement specifies that a portion of the settlement is for *future medical care*, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA *allocated funds* provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for as set forth in the following sections, Medicare will pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease. *For additional information on WCMSAs, please visit the following website on CMS.gov: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview>. The WCMSA Reference Guide, located in the Downloads section, details the CMS WCMSA approval process used by CMS while serving as a reference for those choosing to submit a WCMSA for CMS approval.*

NOTE: There are situations where WCMSA benefits may terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit and a residual payment is due. Under these circumstances Medicare may make a residual Medicare secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The shared systems, the A/B MACs, and DME MACs may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

50.1 - Effect of Payments Under *WC* Plan

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

No Medicare payment may be made if WC has paid an amount:

- Which equals or exceeds the gross amount payable by Medicare;
- Which equals or exceeds the provider's charges for Medicare covered services; or
- The provider, physician or other supplier is either obligated to accept, or voluntarily accepts, a primary plan's payment as full payment.

NOTE: In general, WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for services. In such cases, providers are obligated to accept the WC payment as payment in full, and no secondary Medicare benefits are payable. If WC pays for Medicare covered services and under the WC law or plan the provider is not obligated to accept the payment as payment in full, Medicare

secondary benefits may be payable as described in *Pub. 100-05, Chapter 5. If the beneficiary has an open WCMSA on CWF, Medicare will not make any payment related to the WC accident or injury.*

A - Secondary Medicare Payments

When a primary plan's 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 primary plan's payment as full payment, then Medicare secondary payment can be made as appropriate. In general, the Medicare secondary payment is the least of:

- The Medicare gross payable amount minus the amount paid by the primary plan for Medicare covered services; or,
- The gross amount payable by Medicare minus the applicable deductible and/or coinsurance amount; or
- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full) minus any applicable deductible or coinsurance amounts; or
- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full), minus the amount paid by the primary plan for Medicare covered services.

NOTE: Medicare uses the amount the provider is obligated to accept as payment in full when:

1. The provider is obligated to accept an amount that is less than its charges (e.g., under the terms of a preferred provider agreement), and
2. The primary payer pays less than charges and less than the amount the provider is obligated to accept as payment in full for reasons other than failure to file a proper claim (e.g., because of the imposition of a primary payer deductible and/or copayment).

In the absence of a lower amount that the provider is obligated to accept as payment in full, the amount of the provider's actual charges is used in determining Medicare's secondary payment.

If WC pays a physician's or other supplier's full charges for medical services or pays a lesser amount based on its reasonable charge screen or fee schedule which must be accepted as payment in full, secondary Medicare benefits may not be paid to supplement the amount paid by WC. In addition, the physician or other supplier cannot charge the beneficiary or any other party for the services. This is because WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for the services.

B - Workers' Compensation Does Not Pay for All Services

As stated in 42 CFR § 411.40(b)(2), where WC does not cover and therefore pay for all services furnished to a beneficiary, Medicare benefits may be paid for those services. For example, the services of a physician not authorized to furnish medical care under WC, may be reimbursed under Medicare. However, where a WCMSA exists, CMS may not pay for any treatments, services or medications related to the settled injury or illness until the fund administrator demonstrates complete and total exhaustion of the WCMSA funds, regardless of whether the treatment, service or medication might not have been covered under the WC plan.

C - Charges Included Non-Work Related Items or Services

If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work-related, Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare. A physician/supplier is permitted under WC law to charge an individual or the individual's insurer for services that are not work related. *(See 42 CFR § 411.43(d)).*

D - WC Cases Involving Liability Claims

Most State laws provide that, if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. If the individual is covered by a GHP and is age 65 or over, or is eligible or entitled to Medicare based on ESRD and covered by a GHP, or is under age 65 and has LGHP coverage and entitled to Medicare based on disability, the GHP may also be primary to Medicare. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, Medicare is not secondary under this provision, to the extent of the nonpayment or recovery by WC. However, Medicare may be secondary for services covered under the liability insurance provision. Consider these cases under the policies *within this chapter and Pub. 100-05, Chapter 7.*

E - Possible Coverage of Work Related Services Under No-Fault Insurance or Group Health Plan

Where services are covered in part by WC and also under no-fault insurance, WC pays first, the no-fault insurance pays second and Medicare would be the residual payer. If the individual is covered by a GHP and is age 65 or over; or is under age 65 and entitled to Medicare solely because of ESRD, or is entitled as an active individual, including the member of the family of such individual, who is entitled to benefits on the basis of disability, the employer plan coverage may also be primary to Medicare.

Accordingly, whenever WC pays in part for services, and the physician or other supplier does not accept and is not obligated to accept such payment as payment in full, and there

is information which indicates that the services may also be reimbursable under no-fault insurance or under a GHP, the *A/B MAC or DME MAC* follows the instructions in *Pub. 100-05, Chapter 5*.

If there is no coverage under no-fault insurance, but another insurer is shown on the bill, and there is indication of primary GHP coverage under §10, §20, or §30, the other insurer is to be billed for the services not paid for by WC. The other insurer is billed because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is a GHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident (see §60) and there is no indication of primary group health plan coverage under §10 or §20, Medicare may pay benefits for the services not covered under WC.

F - Workers' Compensation Pays Only for Services of Certain Physicians

In some States, physicians' services are covered under WC only if furnished by a physician selected by the employer or the WC carrier or if furnished by a member of a panel of physicians authorized to furnish care in WC cases. In such cases, if the individual engages the services of another physician (for whose services the individual is not entitled to receive WC benefits), Medicare payment for such services is not precluded.

G - Contested Workers' Compensation Claims

An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits to an employee by the WC agency. Such appeals are generally heard by a hearing officer or judge of the agency, with further appeal from such decision to the WC agency or appeals board and from there to the courts. Sometimes contested claims are settled by compromise agreement between the parties with the approval of the WC agency.

In general, a decision by a State WC agency on a contested claim, or a compromise settlement that has been approved by the agency should be accepted as a basis for applying the WC exclusion, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, the *A/B MAC or DME MAC* allows claims for treatment of that condition unless the decision or settlement is clearly inconsistent with the medical facts and applicable State law and has the effect of shifting to the Medicare program liability for medical expenses which are the responsibility of the State WC program. Where it is clear that an attempt was made to shift responsibility to the Medicare program, the *A/B MAC or DME MAC* denies the Medicare claim. The conclusions should be explained in detail in the denial notice and state that the beneficiary may wish to request a reopening under the WC law.

60 - No-Fault Insurance

Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under no-fault insurance. 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. Under certain circumstances, Medicare may make conditional payments if the no-fault insurance will not pay or will not pay promptly (i.e., 120 days after receipt of the claim). Conditional 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 no-fault insurance.

If services are covered under no-fault insurance, that insurance must be billed first. If the insurance does not pay all of the charges, a claim for secondary Medicare benefits can be submitted. Medicare can pay for services related to an accident if benefits are not 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.

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 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 *A/B MAC or DME MAC* follows the procedures related to MSP liability insurance situations once the no-fault insurance is exhausted.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment “has been made, or can reasonably be expected to be made...” under liability insurance (including self-insurance), no-fault insurance, or a workers’ compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted. See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

60.1 – Medicare’s Recovery Rights

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Medicare has a statutory direct right of recovery from the no-fault insurance as well as any entity that has received payment directly or indirectly from the proceeds of a no-fault insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare’s direct right of recovery is explicitly prescribed in Federal law and other entities’ recovery rights are based on either State law or subrogation rights.

In addition to its direct rights of recovery, Medicare *also* has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the no-fault insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the no-fault insurer. Medicare can be a party to any claim by a beneficiary or other entity against no-fault insurance and can participate in negotiations concerning the total no-fault insurance payment and the amount to be repaid to Medicare.

70 – Interest on MSP Recovery Claims

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Section 1862(b)(2)(B)(i) of the Social Security Act (the Act) and 42 C.F.R. 411.24(m) provide express authority to assess interest on MSP debts. Interest is calculated on *the* MSP debts using the method applicable to Non-MSP Medicare overpayments and underpayments as stated in 42 C.F.R. 405.378. For Medicare overpayments and underpayments and MSP debts, interest is calculated in full 30-day periods. Interest instructions for Medicare overpayments and underpayments are found in Chapter 4, Pub. 100-06, Medicare Financial Management Manual.

80 – Prohibitions Applicable to Employers Offering GHP Coverage

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

80. 1- Financial Incentives

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

An employer or other entity is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in or to terminate enrollment in a GHP or LGHP that is or would be primary to Medicare, pursuant to 42 CFR § 411.103. This prohibition precludes the offering of benefits to Medicare beneficiaries that are alternatives to the employer's primary plan (e.g., prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary plan coverage through his/her own or a spouse's employer. This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan. It is a violation of the Medicare law every time a prohibited offer is made regardless of whether it is oral or in writing. Any entity that violates the prohibition is subject to a civil money penalty of up to \$5,000 for each violation

80.2 - Discrimination in Offering Equal Benefits for Older and Younger Employees and Spouses

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Section 1862(b)(1)(A)(i)(II) of the Act provides that GHPs of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits under the same conditions that they provide to employees and spouses under 65 if those 65 or older are covered under the plan on the basis of the individual's current employment status or the current employment status of a spouse of any age. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare. (See 42 CFR § 411.100 and 102.)

80.3 - Differentiation for ESRD

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during a coordination period described earlier in this chapter. The following are examples of potential taking into account the Medicare eligibility or entitlement of ESRD patients:

- The plan does not cover routine maintenance dialysis services or kidney transplants;*
- The plan excludes benefits, makes itself secondary to government benefits, or charges a higher premium for individuals with ESRD;*
- The plan imposes limitations on benefits for persons with ESRD which are not applicable to others, e.g., a higher deductible or coinsurance, a longer waiting period or a lower annual or lifetime benefit limit.*

Section 1862(b)(1)(C)(ii) of the Act provides that GHPs may not differentiate in the benefits they provide between individuals who do not have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute differentiation in plan benefits (and that may also constitute "taking into account" Medicare eligibility or entitlement) include, but are not limited to, the following:

- Terminating coverage of individuals with ESRD for reasons that would not be a basis for terminating individuals who do not have ESRD;*
- Imposing benefit limitations (such as less comprehensive health plan coverage, reductions in benefits, exclusion of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations) on persons who have ESRD but not on others enrolled in the plan;*
- Charging individuals with ESRD higher premiums;*
- Paying providers/suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such*

as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable, and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD; and

- *Failing to cover routine maintenance dialysis or kidney transplants when a plan covers other dialysis services or other organ transplants.*

A plan is not prohibited from limited covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

80.3.1- Paying Benefits Secondary to Medicare

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

The nondifferentiation provision does not prohibit a plan from paying benefits secondary to Medicare after the coordination period. However, a plan may not otherwise differentiate, as described in §70.2 and §70.3, in the benefits it provides.

EXAMPLE 1:

Mr. Smith works for employer A and he and his wife are covered through employer A's GHP (Plan A). Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services, such as prescription drugs, which Plan B does not cover. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs. Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 30 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplemental policy. That policy pays Medicare's deductible and coinsurance amounts but does not pay for items and services not covered by Medicare which Plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones who has ESRD than it provides for Mrs. Smith who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

80.4 - Taking Into Account Medicare Entitlement

(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

Sections 1862(b)(1)(A), (B), and (C) of the Act provide that GHPs and LGHPs may not take into account that an individual is entitled to Medicare in any of the following situations:

- *Beneficiaries age 65 or older who are covered by a GHP (of employers who employ at least 20 employees) by virtue of the individual's current employment status or the current employment status of a spouse of any age (see Chapter 2, §10);*
- *Beneficiaries who are eligible for or entitled to Medicare on the basis of ESRD and who are covered by a GHP (without regard to the number of individuals employed and regardless of current employment status) during the first 30 months of ESRD-based Medicare eligibility or entitlement (See Pub. 100-05, Chapter 2, §20); or*
- *Beneficiaries under age 65 who are entitled to Medicare on the basis of disability and who are covered under a LGHP (i.e., a plan of an employer who employs at least 100 employees) and are covered under the plan by virtue of the individual's or a family member's current employment status. (See Pub. 100-05, Chapter 2, §30)*

A. Examples of Actions that Constitute "Taking Into Account" Medicare Entitlement

Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

- *Failing to pay primary benefits;*
- *Offering to individuals entitled to Medicare coverage that is secondary to Medicare;*
- *Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (see 26 U.S.C. Section 4980B(f)(2)(B)(iv); 29 U.S.C. Section 1162(2)(D); and 42 U.S.C. Section 300bb-2 (2)(D));*
- *In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated disabled individuals who do not meet the Social Security definition of disability;*
- *Imposing limitations (such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, or providing for lower annual or lifetime benefit limits or more restrictive preexisting illness limitations) on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan;*
- *Charging the Medicare-entitled individual higher premiums;*
- *Requiring a Medicare-entitled individual to wait longer for coverage to begin;*
- *Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare;*

- *Providing misleading or incomplete information that could have the effect of inducing a Medicare-entitled individual to reject the employer plan, thereby making Medicare the primary payer. (An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that if he/she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.);*

- *Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer; and*

- *Refusing to enroll an individual for whom Medicare would be secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.*

80.5 - Permissible Distinctions in Coverage Allowed a GHP or LGHP (Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

If a GHP or LGHP makes benefit distinctions between various categories of individuals (distinctions unrelated to the fact that an individual is entitled to Medicare but based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP plan may make the same distinctions between the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are not entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who are entitled to Medicare on the basis of disability or age.

- *A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the employer employs fewer than 20 or 100 employees, respectively.*

- *A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he/she has current employment status, the GHP or LGHP coverage is by reason of the COBRA law rather than by virtue of current employment status.*

- *A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD when permitted under the COBRA provisions. The only exception in the COBRA law (see 29 U.S.C.1162(2)(D)(ii)) prohibits GHPs from terminating COBRA coverage for retirees and dependents who*

are entitled to Medicare when the employee retired before the employer effectively terminated the regular plan coverage by filing for bankruptcy.

90 - Actions Resulting from GHP or LGHP Nonconformance
(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)

A. Determination [See 42 CFR § 411.110]

A determination of nonconformance is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section. The CMS may make a finding of nonconformance for any GHP or LGHP that at any time during a calendar year fails to comply with any of the following statutory provisions:

- *The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability or eligible on the basis of ESRD (see [§70.4](#) above);*
- *The equal benefits clause for the working aged (see [§70.5](#) above);*
- *The non-differentiation clause for individuals with ESRD (see [§70.3](#) above); or*
- *The obligation to refund conditional Medicare primary payments.*

The CMS may make a finding of nonconformance for a GHP or LGHP that fails to provide correct, complete, and timely information, either voluntarily or in response to a CMS request, on the plan's primary payment obligation with respect to a given beneficiary if that failure contributes to:

- *Medicare mistakenly making a primary payment; or*
- *A delay or foreclosure of CMS's ability to recover a mistaken primary payment.*

If CMS determines that a GHP fails to comply with the provision that prohibits taking into account entitlement to Medicare (see [§70.4](#) above) in a particular year, the GHP is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments, the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 2019, that plan was nonconforming for 2019. If in 2022 CMS identifies mistaken primary payments attributable to the 2019 violation and the plan refuses to repay, it is also nonconforming for 2022.

B. Starting Dates for Determination of Nonconformance [See 42 CFR § 411.114]

The CMS's authority to determine nonconformance of GHPs and LGHPs begins on the following dates:

- *January 1, 1987, for MSP provisions that affect the disabled;*
- *December 20, 1989, for MSP provisions that affect ESRD beneficiaries and the working aged; and*
- *August 10, 1993, for failure to refund mistaken Medicare primary payments.*

C. Notice to GHP or LGHP of Determination of Nonconformance [See 42 CFR § 411.115(a)]

If central office determines that a GHP or a LGHP is nonconforming with respect to a particular calendar year, CMS will mail a written notice to the plan with the following:

- *The determination;*

- *The basis for the determination;*
- *The right of the parties to request a hearing. (The Parties are the GHP or LGHP for which CMS determined the nonconformance and any employers or employee organizations that contributed to the plan during the calendar year for which CMS determined nonconformance.);*
- *An explanation of the procedure for requesting a hearing;*
- *The tax that may be assessed by the IRS in accordance with §5000 of the IRC; and*
- *The fact that, if none of the parties requests a hearing within 65 days from the*

date on the notice, the determination is binding on all parties unless it is reopened.

The notice also states that the plan must submit to CMS, within 30 days from the date on its notice, the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which CMS has determined nonconformance.

D. Notice to Contributing Employers and Employee Organizations [See CFR 42 § 411.115(b)]

The CMS mails written notice of the determination, including all the information specified in subsection C, above, to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with subsection C. Employer and employee organizations have 65 days from the date of their notice to request a hearing.

E. Penalties

Any entity that violates the prohibition described in subsection A is subject to a civil money penalty of up to \$5,000 for each violation.

If CMS Central Office determines that a plan has been a nonconforming GHP in a particular year, it refers its determination, including the identity of the contributors that it has identified, to the IRS, but only after the parties have exhausted all appeal rights with respect to the determination. Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations that contribute to nonconforming GHPs. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each GHP (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers. The IRS administers Section 5000 of the IRC, which imposes the tax on employers (other than governmental entities) or employee organizations that contribute to a nonconforming GHP mentioned in §80.

***100 - GHP or LGHP Actions to Document Conformance
(Rev.11755, Issuance:12-21-2022, Effective: 01-23-2023, Implementation: 01-23-23)***

A GHP or LGHP may be required to demonstrate that it has complied with the MSP prohibitions and requirements, set forth in §70 of this chapter, and to submit supporting documentation. If the GHP or LGHP fails to provide acceptable documentation, the GHP or LGHP could be found to be nonconforming. The A/B MAC or DME MAC must notify the RO and furnish complete information.

A. Examples

The following are examples of acceptable documentation:

- A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, and benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability for whom Medicare is secondary payer, as compared to the provisions applicable to other enrollees and potential*

enrollees; and

- An explanation of the plan's allegation that it does not owe CMS any amount CMS claims the plan owes as refund for conditional or mistaken Medicare primary payments. The plan must include all information requested by the A/BMAC or DME MAC.*

