

Chapter 5: Medicare Secondary Payer

When Medicare is Secondary

Under the Medicare law, as enacted in 1965, Medicare was the primary payer for Medicare-covered services except for services covered by workers' compensation. 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. If payment has not been made or cannot be expected to be made promptly by a workers' compensation plan, liability insurance, or no-fault insurance, Medicare may make conditional payment, under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment.

Any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. The information from the primary insurance company's explanation of benefits (EOB) must be included with each claim when it is submitted to Medicare. If providers, physicians, or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second.

When Medicare is the secondary payer, the provider, physician, 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. 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.

Group Health Plans

Three provisions of the law require Medicare to be secondary payer relating to group health plans (GHPs).

Working Aged

Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of:

- Their own current employment status with an employer that has 20 or more employees
- The current employment status of a spouse of any age with such an employer

Employers are required 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 (i.e., coverage that is primary to Medicare). This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

End-Stage Renal Disease (ESRD)

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30 months if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

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

Medicare benefits are 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 result of the:

- Individual's current employment status with an employer that has 100 employees or more
- Current employment status of a family member with such employer

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 for services provided on or after August 10, 1993.

Workers' Compensation (WC)

Medicare is secondary to WC plans (including black lung benefit programs). 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 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, e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the U.S. 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.

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 the 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.

No-Fault Insurance

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. 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. Payment may not be made under Medicare for otherwise

covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under 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.

Liability Insurance

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). 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.

For additional information on MSP provisions, refer to the following in Pub. 100-05, *Medicare Secondary Payer (MSP) Manual*:

- Chapter 1 <http://www.cms.hhs.gov/manuals/downloads/msp105c01.pdf>
- Chapter 2 <http://www.cms.hhs.gov/manuals/downloads/msp105c02.pdf>

Government Program Health Plans

Medicare law contains three separate exclusions applicable to items and services furnished, paid for, or authorized by governmental entities. In general, payment may **not** be made for items and services:

- Furnished by a provider (governmental or non-governmental) or other person at public expense pursuant to an authorization issued by a federal agency
- Furnished by a provider of services or agency of the federal government
- Paid for directly or indirectly by a federal, state, or local governmental entity

Veterans' Administration (VA)

As a general rule, an authorization issued by the VA binds the VA to pay in full for the items and services provided. No payment is made under Medicare for such authorized services. (**Note:** Medicare can reimburse veterans for (or credit toward Medicare deductible or coinsurance amounts) VA co-payment amounts charged for VA-authorized services furnished by non-VA sources.) Where an authorization from the VA was not given to the party rendering the services, Medicare payment is not precluded even though the individual might have been entitled to have payment made by the VA had they requested the authorization.

Generally, it is advantageous for Medicare beneficiaries who are veterans to have items and services paid for by the VA where possible, since in most cases the VA has no deductible or coinsurance requirements. However, Medicare can pay for such services where neither the physician/supplier nor beneficiary has claimed benefits from the VA. Medicare may also pay for (covered) services for which the VA does not make any payment.

Other Government Programs

Typically, federal providers are excluded from participation in the Medicare program. Even so, the law provides exceptions to this exclusion which permits the following categories of federal providers to participate in Medicare:

- Hospitals and skilled nursing facilities (SNFs) of Indian Health Service (IHS), and
- A federal provider which is determined to be providing services to the public generally as a community institution or agency. This exception does not apply to federal clinics or other federal health facilities which are not “providers of services” as defined in the Medicare law. CMS is responsible for processing claims for services furnished directly by federal providers.

Medicare payment may **not** be made for items or services paid for directly or indirectly by a federal, state, or local governmental entity. However, the law specifies that this exclusion does not prohibit payment for:

- Items or services furnished under a health benefits or insurance plan established for employees of the governmental entity
- Items or services furnished under one of the titles of the Social Security Act (such as medical assistance under Title XIX)
- Rural health clinic services

Payment may **not** be made for items or services furnished by a non-governmental provider, physician, or supplier if the charges have been paid for by a government program other than Medicare, or if the

provider, physician, or supplier intends to look to another government program for payment, unless the payment by the other program is limited to Medicare deductible and coinsurance amounts.

For additional information on government program health plans, refer to Chapter 16 of Pub. 100-02, *Medicare Benefit Policy Manual* <http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf>

Medicare Secondary Payments

Based on the law and regulations, providers, physicians, and other suppliers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Act (42 USC 1395y(b)(6)) requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR 489.20(g) requires that **all** providers must agree “to bill other primary payers before billing Medicare.” Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries **must** determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary’s MSP status. If providers, physicians, or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

Section 20.2.1, “Admission Questions to Ask Medicare Beneficiaries,” may be used to determine the correct primary payers of claims for all beneficiary services furnished at every admission, outpatient encounter, or start of care.

For additional information on MSP provider billing requirements, refer to Chapter 3 of Pub. 100-05, *Medicare Secondary Payer (MSP) Manual* <http://www.cms.hhs.gov/manuals/downloads/msp105c03.pdf>

Overpayments and Denials

If a provider, physician, or supplier receives an overpayment that is a result of Medicare paying primary on a claim when the beneficiary has primary insurance coverage, refer to the following guidelines:

- Refund the entire Medicare payment amount for the MSP beneficiary, along with a copy of the Medicare remittance advice and the primary insurance company's explanation of benefits (EOB)
- Personal/business checks should be made payable to NHIC, Corp. DME MAC
- These items should be mailed to NHIC, Corp. DME MAC, Accounting (MSP Refund Checks) (refer to Chapter 1 of this manual for the mailing address)

If a provider, physician, or supplier feels a claim was improperly denied, send a copy of the Medicare remittance advice and the primary insurance company's explanation of benefits (EOB) for adjustment to NHIC, Corp. DME MAC, MSP Correspondence unit (refer to Chapter 1 of this manual for the mailing address). If the claim was denied incorrectly, please do not resubmit a new claim as it would be denied as a duplicate.

Coordination of Benefits

Coordination of benefits (COB) arrangements between private plans, whether based on state law or private agreements, **cannot** supersede federal law that makes Medicare secondary 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 non-dependent coverage that is secondary to Medicare (e.g., coverage based on the individual's retirement); Medicare is secondary to the dependent coverage and primary to the non-dependent coverage. In other words, the dependent coverage pays first and the non-dependent coverage pays second even though under private COB agreements, the non-dependent coverage would be expected to pay before the dependent coverage.
- 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 Section 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.

For additional information on COB rules conflict with MSP rules, refer to Chapter 1 of Pub. 100-05, *Medicare Secondary Payer (MSP) Manual* <http://www.cms.hhs.gov/manuals/downloads/msp105c01.pdf>

Coordination of Benefits Contractor

CMS has established a centralized COB operation by consolidating under a single contractor entity, the Coordination of Benefits Contractor (COBC), the performance of all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. In addition, CMS has a centralized COB operation that provides quality customer service to Medicare providers, suppliers, and beneficiaries by streamlining the payment process while ensuring the integrity of the Medicare Trust Funds. To further that goal, CMS requires the COBC to maintain a comprehensive health care insurance profile on all Medicare beneficiaries and carry out other activities necessary to meet these objectives.

CMS awarded the COB contract to Group Health Inc. (GHI) Medicare. The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and federal and state insurance programs.

For additional information on COBC requirements, refer to Chapter 4 of Pub. 100-05, *Medicare Secondary Payer (MSP) Manual* (<http://www.cms.hhs.gov/manuals/downloads/msp105c04.pdf>).

Further information on COB is available via CMS' Web site at:

<http://www.cms.hhs.gov/COBGeneralInformation/>

Contacting the COBC

The COBC's toll-free number is **800-999-1118**, or **TTY/TDD 800-318-8782** for the hearing and speech impaired. Customer service representatives are available Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays. General written MSP inquiries should be mailed to:

MEDICARE - Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232-5847

Provider Requests and Questions Regarding Claims Payment

Claims processing is **not** a function of the COBC. Questions concerning how to bill for payment should continue to be directed to the DME MAC A supplier toll-free line (refer to Chapter 1 of this manual for the toll-free number). In addition, continue to return inappropriate Medicare payments to DME MAC A. Checks should **not** be sent to the COBC. Questions regarding Medicare claim or service denials and adjustments should continue to be directed to the DME MAC A supplier toll-free line.

For additional information regarding MSP, refer to the “*Medicare Second Payer and You*” section on the CMS Web site <http://www.cms.hhs.gov/MedicareSecondPayerandYou/>