

PART B



Medicare Secondary Payer Billing Guide

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NHIC, Corp.

Medicare Secondary Payer Billing Guide

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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Medicare Secondary Payer billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-5, Chapters 1-8 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.hhs.gov/manuals/>

If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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GENERAL INFORMATION

Medicare law supersedes any insurance policy statement regarding primary or secondary coverage. Under Medicare law, primary coverage is provided for a Medicare beneficiary unless he or she is eligible for primary coverage under another health insurance plan. Medicare would then be the secondary payer even if a state law or a private insurance contract stipulates Medicare to be primary. There are several types of insurance plans that would prevent Medicare from paying primary benefits.

Working Aged - Group Health Plan

Medicare is the secondary payer for services provided to a Medicare eligible individual aged 65 or older who is:

- Actively employed (other than a self-employed individual) and elects to be covered by their Group Health Plan (GHP); (Note: the Employer must have 20 or more employees)
- Covered by the spouse's GHP (Excluded: Domestic Partners, Effective 04/01/04)

Note: If you elect not to be covered by your GHP, your employer may not provide you with a supplemental plan.

Disabled Beneficiaries Employer Group Health Plan

Medicare is the secondary payer for an individual who is:

- Entitled to Medicare solely on the basis of disability;
- Under age 65;
- Covered under a Large Group Health Plan (LGHP), which has 100 or more employees through their own active employment or through another family member's current employment.

End-Stage Renal Disease (ESRD) - Employer Group Health Plan

Medicare is the primary payer for all beneficiaries who became eligible based on End Stage Renal Disease (ESRD) regardless of work status. However, if a beneficiary is covered by an Employer Group Health Plan (EGHP) when they became ESRD entitled, the EGHP must continue primary coverage for the first 30 months of Medicare coverage (for coverage starting on or after March 01, 1996). The EGHP is responsible for all medical services, including renal dialysis. Medicare becomes the primary payer after the 30 months even if the beneficiary or family member is still employed and covered by the EGHP.

Federal Black Lung

The Department of Labor's Black Lung program provides for treatment of Black Lung disease, more commonly known as "coal miner's disease". The Black Lung program also provides coverage for other pulmonary/respiratory illnesses associated with the effects of coal mining. Medicare is the primary payer for services rendered for conditions other than Black Lung.

Workers' Compensation

Medicare payments may not be made for any item or services to the extent that payment has been made or can reasonably be expected to be made by a Workers' Compensation plan of the United States or a state. If Medicare does pay for services that should have been paid by a Workers' compensation carrier (including self-insured plans) the Medicare payment constitutes an overpayment due and a debt to the United States Government.

This exclusion is applicable to the workers' compensation plans of the 50 states, the District of Columbia, American Samoa, Guam, the Virgin Islands and Puerto Rico. It also applies to the Federal workers' compensation plans provided under the Federal Employees' Compensation Act and its extensions. Not included in this provision is the Federal Employers' Liability Act and similar State employers' liability acts.

The law makes the beneficiary responsible for taking whatever action is necessary to obtain payment that can reasonably be expected under workers' compensation. If failure to file a proper claim results in a loss of workers' compensation benefits, Medicare benefits are precluded to the extent that payment could reasonably be expected under workers' compensation.

Conditional Medicare payment may be made under either of the following circumstances:

1. The beneficiary has filed a proper claim for workers' compensation benefits, but the intermediary or carrier determines that the workers' compensation carrier will not pay promptly (within 120 days of receipt of the claim). This includes cases in which a Workers' compensation carrier has denied a claim.
2. If failure to file a proper claim was caused by physical or mental incapacitation of the beneficiary.

If future medical was awarded, claims for services for the work related illness or injury must be billed to the workers' compensation carrier.

If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized.

If services were provided as a result of an injury or disease suffered in connection with employment, the workers' compensation policy would assume the primary payer role until all benefits are exhausted. If the services are not payable under a workers' compensation policy, Medicare may make payment for covered services. For future expenses that were not part of the lump sum payment by the Workers' Compensation carrier, Medicare reverts to a primary status. If this is the case, submit a copy of the denial from the Worker's Compensation insurance to Medicare with your claim.

Veterans Administration

Veterans who are entitled to Medicare may choose which program will be responsible for payment for those services that are covered by both programs. However, claims for the same date and service may not be submitted to both programs. When services are authorized by the Veteran's Administration (VA), the authorization binds the VA to pay in full for the items and services provided. No payment is made by Medicare for such authorized services.

If an authorization from the VA was not obtained and given to the party rendering the services, Medicare payment is not excluded even though the individual might have been entitled to have the payment made by the VA had he/she requested the authorization. Medicare can pay for such services where neither the physician/supplier nor beneficiary had claimed benefits from the VA. Medicare may also pay for services for which the VA does not make any payment.

For example, if a veteran is authorized "fee basis" care at the VA's expense for a military service connected injury and receives treatment for a different condition for which the VA does not pay, Medicare can pay for the services that are not reimbursable by the VA. However for this rule to apply, it must be a Medicare covered service.

Third Party Liability

Federal law prohibits payment for services to an extent that payment has been made or can reasonably be expected to be made under certain other types of policies. However, Medicare may pay for a beneficiary's covered medical expenses conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement award, judgment, or recovery. This conditional payment gives Medicare the right to recover its payments when the beneficiary receives proceeds from a third party arising from an incident which generated the medical expenses for which Medicare conditionally paid. If Medicare payments have been made but should not have been because the services are excluded under this provision, they are subject to recovery. The types of policies consist of:

- Automobile
- Medical
- Liability
- No-fault
- Personal Injury Protection
- Third Party Liability (TPL)

Third Party Liability Claims Submission

In TPL cases, the provider should attempt to collect from the liability insurer.

Within the first 120 days after the date of service, bill only the no-fault and liability insurer unless they have documentation that payment will not be received within 120 days.

After 120 days, the provider MUST choose one of the following:

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1. Bill Medicare for conditional payment:
 - Provider must withdraw claims against the primary insurer or a lien placed on a settlement.
 - Medicare may make conditional payment. Once the primary insurer pays, Medicare will recover its conditional payment from the primary insurer.
 - If assignment is accepted on the claims, the provider may only collect the amount of the Medicare payment plus any applicable deductible and coinsurance.
 - If assignment is not accepted on the claim, limiting charges apply.

2. Continue their claim against the primary insurer:
 - Provider may not bill Medicare.
 - Provider may not collect payment from the beneficiary until settlement is reached.
 - If it is found that the insurer is not liable and no monies were paid to the beneficiary, the claim may be submitted to Medicare for payment.

Note: The claim to Medicare will only be considered if it is filed within the Medicare claims' filing time frames. Medicare will not waive the claims' filing deadline.

IMPORTANT NOTE: By submitting an assigned bill to Medicare, the provider/supplier voluntarily gives up its right to collect actual Medicare covered services from the beneficiary (either directly from the beneficiary after settlement of the liability claim or indirectly from the liability insurance payer). Therefore, the provider or supplier no longer has a right to be paid in excess of the Medicare allowed amount and can bill the beneficiary only for the applicable deductible, coinsurance amounts and any non-covered amounts. The provider or supplier, in accord with its assigned claim, must refund the beneficiary any amount collected in excess of the Medicare payment for the services and amounts for which the beneficiary is otherwise liable.

Should a provider or supplier attempt to refund the Medicare program after submitting an assigned claim and subsequently receiving payment from a third party, the payment being refunded will be accepted as being made on behalf of the beneficiary who has the obligation to refund the conditional Medicare payment to Medicare. A notice will be sent to the refunding provider/supplier and the beneficiary regarding the portion of the incorrect collection that the provider or supplier has refunded to Medicare and the amount that it must refund to the beneficiary.

When submitting the TPL claim, please be sure to indicate in Item 10 of the CMS-1500 claim form, whether the patient's condition is related to:

- An auto accident (include the state), or
- Other accident

Additional basic information is available on the CMS website:

- [Medicare Secondary Payer Fact Sheet \(MSP\), for Provider, Physician, and Other Supplier Billing Staff](#)

INSURANCE SCREENING

All providers and practitioners should screen their Medicare patients to obtain correct health insurance information before submitting a primary claim to Medicare. Listed below are some questions that you may ask your patient during your confidential screening that will help you recognize circumstances where Medicare may be the secondary payer:

- Are you currently employed?
- Is your spouse or other family member currently employed?
- Are you covered under an employer or union health plan that should be primary over Medicare?
- Did you sustain an injury/illness while at work?
- Are your injuries accident related?

By using the above questions to initially screen your Medicare patients, you will help reduce administrative costs to your practice as well as to the Medicare Program. When Medicare is found to be secondary and you are submitting a new claim, you must submit the primary insurer's Explanation of Benefits (EOB) or complete the necessary data fields for electronically submitted claims.

When submitting your CMS-1500 claim form or electronic claim, be sure to complete all primary insurance information, including workers compensation carriers and automobile/no fault and liability insurance. The accident and employment indicators will help us identify the insurance information provided.

GATHERING ACCURATE DATA

Providers can save time and money by collecting patient insurance information at each patient visit. Some suggested questions that providers should ask are:

- Is the patient covered by any GHP through his or her current or former employment? If so, how many employees work for the employer providing coverage? insurance, no-fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account from a legal settlement?
- Is the patient covered by any GHP through his or her spouse or other family member's current or former employment? If so, how many employees work for the employer providing the GHP?
- Is the patient receiving Federal Black Lung Program benefits?
- Is the patient receiving Workers' Compensation (WC) benefits?
- Is the patient covered under automobile insurance, no-fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account from a legal settlement?
- Is the patient being treated for an injury or illness for which another party could be held liable?

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If the provider does not furnish Medicare with a record of other insurance that may be primary to Medicare on any claim and there is an indication of possible MSP, the COB Contractor may request that the provider complete a Development Questionnaire.

If the provider of service contacts Medicare regarding beneficiary eligibility as it pertains to MSP situations, any information already provided on the Remittance Advice (RA) notice can be discussed. However, specific information cannot be released pursuant to provisions of the 1974 Privacy Act.

For example:

- Effective date of primary coverage;
- Termination date of primary coverage; or
- Primary plan name.

MSP CLAIM SUBMISSION

In every situation where Medicare is secondary payer, always submit a claim to the primary payer first. Upon receipt of the primary payer's explanation of benefits statement, send a legible copy along with your Medicare claim to the appropriate post office box address. Failure to include the primary payer's explanation of benefits statement or to provide complete information on the claim may cause the claim to be rejected or denied.

Note: Do not enter the amount paid by the primary plan in Item 29 of the CMS-1500 claim form.

In addition to completing all required information fields of the claim form, remember to provide all of the primary insurer's information in Items 4, 7 and 11 of the CMS-1500 claim form as follows:

Information to Enter	CMS-1500 Form Field	ANSI 4010A1 Format
Primary Plan - Complete Name of Insured	**Item 4	Last Name - Loop 2330A NM103 First Name - Loop 2330A NM104 Middle Name - Loop 2330A NM105
Primary Plan - Insured Address	**Item 7	Address - Loop 2330A N301 City - Loop 2330A N401 State - Loop 2330A N402 Zip Code - Loop 2330A N403
Primary Group Policy Number	**Item 11	Loop 2320 SBR03
Primary Payer Organization Name	**Item 11b	Loop 2330B NM103
Primary Insurance Plan Name	**Item 11c	Loop 2320 SBR04

**These fields are mandatory for processing Medicare Secondary Claims submissions.

Electronic Claim Submission

Traditionally, Medicare Secondary Payer claims have been adjudicated based on the explanation of benefits (EOB) from the primary payer attached to paper claims. Now, you may submit the MSP claims and primary payer's explanation of benefits information electronically. To ensure the payments are accurate include the following information in the appropriate fields on each claim submitted electronically:

- Primary payer name and address (If the insured is not the patient, then submit the patient's relationship to the insured and the complete name of the insured.)
- Insured's effective date and termination date with the primary payer
- Primary payer allowed amount
- Paid amount
- Obligated to accept in full (OTAF). This is a field in the MCS System used to limit Medicare's Secondary payment to what the patient is liable in paying the provider. (For additional information, please see <http://www.cms.hhs.gov/manuals/downloads/msp105c03.pdf>)
- Deductible amount
- Coinsurance amount when applicable
- Disallowed amount
- Cost-containment amount when applicable

If the primary payer considered the charges but did not make any payments, the adjudication indicator is crucial. If any of the above information is missing or incomplete, the claim payment will be delayed. Please contact your software vendor to activate the MSP fields or screens and for instructions on how to input the MSP information. Your software vendor or programmer should refer to the American National Standard Institute (ANSI) Health Care Claim 837 Implementation Guide for complete programming instructions.

Information Needed

ANSI Format

PRIMARY GROUP POLICY NUMBER	Loop 2320 SBR03
PRIMARY INSURANCE PLAN NAME	Loop 2320 SBR04
PRIMARY PAYER ALLOWED AMOUNT (TOTAL CLAIM)	Loop 2320 AMT*B6 02
PRIMARY PAID AMOUNT (TOTAL CLAIM)	Loop 2320 AMT*D 02
PRIMARY PLAN INSURED COMPLETE NAME	
Last Name	Loop 2330A NM103
First Name	Loop 2330A NM104
Middle Name	Loop 2330A NM105
PRIMARY PLAN INSURED ADDRESS	
Address	Loop 2330A N301
City	Loop 2330A N401
State	Loop 2330A N402
Zip Code	Loop 2330A N403
PRIMARY PAYER ORGANIZATION NAME	Loop 2330B NM103
PRIMARY PAYER IDENTIFICATION NUMBER	Loop 2330B NM109
PRIMARY PAYER LINE ADJUDICATION INFORMATION	
Full Payment Amount	Loop 2400 CN1*09 02

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Allowed Amount (Total allowed amounts for all lines of service. Must equal amount in Loop 2320 AMT*B6 02)	Loop 2400 AMT*AAE 02
Identification Number (Must equal ID number in Loop 2330B NM109)	Loop 2430 SVD01
Paid Amount (Total paid amounts for all lines of service. Must equal Paid amount in Loop 2320 AMT*D 02)	Loop 2430 SVD02
Adjudication Date	Loop 2430 DTP03
Reason Code	Loop 2430 CAS01
MEDICARE PAYER NAME	Loop 2010BB NM103
MEDICARE PAYER IDENTIFICATION	Loop 2010BB NM09
MEDICARE INSURED HEALTH INSURANCE	
CLAIM NUMBER	Loop 2010BA NM109
MEDICARE INSURED COMPLETE NAME	
Last Name	Loop 2010BA NM103
First Name	Loop 2010BA NM104
Middle Name	Loop 2010BA NM105
MEDICARE INSURED ADDRESS	
Address	Loop 2010BA N301
City	Loop 2010BA N401
State	Loop 2010BA N402
Zip Code	Loop 2010BA N403

COORDINATION OF BENEFITS CONTRACTOR INFORMATION

The Centers for Medicare & Medicaid Services (CMS) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. CMS awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at, the COB contractor. This is no longer the function of your local Medicare intermediary or carrier. Implementation of this single-source development approach greatly reduces the amount of duplicate MSP investigations. This also offers a centralized one-stop customer service approach for all MSP-related inquiries, including those seeking general MSP information (but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds). The COB Contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys, other beneficiary representatives, employers, insurers, providers, and suppliers.

Contacting the COB Contractor

Effective January 1, 2001, all MSP inquiries (the reporting of potential MSP situations, invalid MSP auxiliary files, and general MSP questions/concerns) should be referred to the COB contractor. Continue to call your local intermediary and/or carrier regarding claims-related and recovery questions. The COB Contractor's Customer Call Center toll free number is 1-800-999-1118 or TDD/TYY 1-800-318-8782. Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Standard Time (except holidays).

Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim - Based Crossover Process

Effective with October 1, 2007, the COBC assumes responsibility for the Medigap claim-based crossover process. At that time, it also assumes the foregoing responsibilities associated with invoicing the affected Medigap insurers, collecting the crossover fees from these entities, and distributing these fees to the affected Medicare contractors.

All Part B contractors, including Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACS) shall invoice for the last claims files that they transmit to their associated Medigap insurers.

In addition, these affected contractors shall pursue unpaid balances with the Medigap insurers following the conclusion of the Medigap claim-based crossover transition, which included clearing all residual Medigap claim-based crossover claims from their payment floors no later than October 31, 2007.

For additional information please visit the CMS website at <http://www.cms.hhs.gov/manuals/downloads/clm104c28.pdf>

Provider Requests and Questions Regarding Claims Payment

Intermediaries and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local intermediary or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor. Questions regarding Medicare claims or service denials and adjustments should continue to be directed to your local intermediary and carrier. If a provider submits a claim on behalf of a beneficiary, and there is an indication of MSP (but not sufficient information to disprove the existence of MSP) the claim will be investigated by the COB Contractor. This investigation will be performed in cooperation with the provider or supplier that submitted the claim.

MSP investigations will no longer be a function of your local intermediary or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in CMS' Database

The COB Contractor's sole purpose is to ensure the accuracy and integrity of the MSP information contained in the CMS database (i.e., Common Working File/CWF). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as needed, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB Contractor. CMS also relies on providers and suppliers to ask their Medicare patients about the possible presence of other primary health care coverage, and to report this information when filing claims with the Medicare program.

Termination and Deletion of MSP Auxiliary Records in CMS' Database

MSP records on the CWF that you identify as invalid should be reported to the COB Contractor for investigation and deletion. Termination requests (e.g. cessation of employment, retirement) can also be reported to the COB contractor. However, this information can still be reported directly to your local intermediaries and carriers. Reference: Section 20.1.4

<http://www.cms.hhs.gov/manuals/downloads/msp105c06.pdf>

Information Gathering

Medicare generally uses the term, "Medicare Secondary Payer" or (MSP) when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance plans that are primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary's health care expenses before Medicare. The table below describes a few of these methods and programs.

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Method/Program	Description
Initial Enrollment Questionnaire (IEQ)	Beneficiaries are sent a questionnaire about other insurance coverage.
IRS/SSA/CMS Data Match	Under the Omnibus Reconciliation Act of 1989, employers are required to complete a questionnaire that requests the Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
MSP Claims Investigation	This activity involves the collection of data on health insurance's that may be primary to Medicare, based on information submitted on a medical claim or other sources.
Voluntary MSP Data Match Agreement	Voluntary Agreements allow for the electronic data exchange of Group Health Plan (GHP) eligibility and Medicare information, between CMS and employers or insurers.

Medicare Secondary Payer IRS/SSA/CMS Data Match Project

As required by Federal Law, the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration (SSA), and the Internal Revenue Service (IRS) matched information from their records to determine likely cases in which Medicare should be secondary payer to another insurer. This project, called the IRS/SSA/CMS Data Match Project, was conducted in late 1990. It required CMS to contact employers and determine whether employees and their families who have Medicare, also have group health coverage under the employer plan. Medicare files were then updated with the information.

If the employer confirms the existence of coverage, the employer plan would then be the primary payer and Medicare the secondary payer. If you submit claim(s) for a beneficiary who was identified through this project, the claim will be denied. The denial statement will ask you to submit the claim to the Employer Group Health Plan first. If the plan states that coverage is no longer available, we will need documentation from them indicating the date and reason the coverage ended. In these situations, Medicare's files can only be updated by CMS.

The IRS/SSA/CMS Data Match project is run by the Medicare Secondary Payer Recovery Contractor (MSPRC).

RetroActive Recovery

The IRS/SSA/ RetroActive Recovery project is run by the Medicare Secondary Payer Recovery Contractor (MSPRC). In situations where Medicare has paid a claim as primary and later receives information indicating that the beneficiary has other primary coverage, we will pursue recovery of the funds that were paid in error. Through the efforts of the Retroactive Recovery process, we will refer back to the beneficiary's claims to determine if our payments were made incorrectly. Overpayments discovered during the retroactive recovery process must be refunded to Medicare.

HMO/HCPP Situations

If the employer health plan is a Health Maintenance Organization (HMO) or a Health Care Prepayment Plan (HCPP), Medicare cannot pay for services when the same services are available from the HMO or HCPP. If the plan does not offer the service, Medicare may pay for the claim. You must submit the claim with an explanation of benefits statement from the HMO/HCPP, which states that the services are not offered by the plan.

POSTING MSP REFUNDS

When Medicare receives an unsolicited refund concerning an unknown MSP situation, the contractor will send an inquiry to the Coordination of Benefits Contractor (COBC). The COBC is allowed 100 days to research the MSP situation and update the beneficiary's record.

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services (SSG)
75 William Terry Drive
Hingham, MA 02043
Phone 1-781-741- 3282
Fax 1-781-741-3283
maureen.akhouzine@eds.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

TELEPHONE AND ADDRESS DIRECTORY

Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date**. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, redetermination status (formerly Appeals). Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems. This rule applies even if the caller has obtained the code.

Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Friday

866-801-5304

Dedicated Reopening Requests Only

Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Friday

877-757-7781

MAILING ADDRESS DIRECTORY

Initial Claim Submission Maine	P.O. Box 2323 Hingham, MA 02044
Massachusetts	P.O. Box 1212 Hingham, MA 02044
New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

** Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:

www.medicarenhic.com

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

Medicare Learning Network

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

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

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

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

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

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

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Notice of Exclusion from Medicare Benefits (NEMB) (20007)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.hhs.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

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

CMS Correct Coding Initiative

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

Medicare Secondary Payer Billing Guide

**CMS Physician's Information
Resource for Medicare**

<http://www.cms.hhs.gov/center/physician.asp?>

Evaluation and Management Documentation Guidelines

http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Federal Register

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

HIPAA

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

National Provider Identifier (NPI)

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

NPI Registry

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

U.S. Government Printing Office

<http://www.gpoaccess.gov/index.html>

Medicare Secondary Payer Billing Guide

Revision History:

Version	Date	Reviewed By	Approved By	Summary of Changes
1	10/01/2003	A. Randall	M. Kelly	Original national
2	05/25/2005	A. Randall	B. Bedard/K. Leary	Added Gathering Accurate Data section, updated TPL and WC, deleted MSP questionnaire section; updated telephone directory.
3	7/20/2005	A. Randall	B. Bedard/K. Leary	Added Posting MSP Refund section, other minor edits and updates
4	9/26/2006	A. Randall/ J. Costa	K. Leary/M. Kelly	Annual Update; NHIC name change
5	3/20/2007	A. Randall/ J. Costa	K. Leary/M. Kelly	Annual Review Minor additions and correction. Updated directory and resources.
6	9/27/2007	A. Randall/ J. Costa	K. Leary/M. Kelly	Updated the ESRD section and other minor edits. MSP department reviewed and approved. Also, updated basic template information.
7	4/4/2008	A. Randall/ J. Costa	K. Leary/M. Kelly	Annual Review Updated basic template information. Added section on COBA Medigap Claim - Based Crossover Process. Updated references & hyperlinks.
8	10/01/08	J. Costa	Mylene Clark	ANNUAL REVIEW Update Template and remove California info
9.0	07-15-09	Jainne Costa	Mylene Clark	Annual Review , added J14 template, no other changes

NHIC, Corp.

**75 Sgt. William Terry Drive
Hingham, MA 02044**

Website:

<http://www.medicarenhic.com>

CMS Websites

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

<http://www.medicare.gov>