

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



FACT SHEET

Medicare Secondary Payer Fact Sheet
for Provider, Physician, and Other Supplier Billing Staff

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

Maintaining the viability and integrity of the Medicare Trust Fund becomes critical as the Medicare Program matures and the “baby boomer” generation moves toward retirement. Providers, physicians, and other suppliers can contribute to the appropriate use of Medicare funds by complying with all Medicare requirements, including those applicable to the Medicare Secondary Payer (MSP) provisions. The purpose of this fact sheet is to provide a general overview of the MSP provisions for individuals involved in the admission and billing procedures for health care providers, physicians, and other suppliers.

WHAT IS MEDICARE SECONDARY PAYER (MSP)?

Since 1980, the MSP provisions have protected Medicare Trust Funds by ensuring that Medicare does not pay for services and items that certain health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not the beneficiary’s primary health insurance coverage. The MSP requirement provides the following benefits for both the Medicare Program and providers, physicians, and other suppliers:

- **National program savings** – Medicare saves more than \$8 billion annually on claims processed by insurances that are primary to Medicare.
- **Increased provider, physician, and other supplier revenue** – Providers, physicians, and other suppliers that bill a primary plan before billing Medicare may receive more favorable reimbursement rates. Providers, physicians, and other suppliers can also reduce administrative costs when health insurance or coverage is properly coordinated.
- **Avoidance of Medicare recovery efforts** – Providers, physicians, and other suppliers that file claims correctly the first time may prevent future Medicare recovery efforts on that claim.

To realize these benefits, providers, physicians, and other suppliers must have access to accurate, up-to-date information about all health insurance or coverage that Medicare beneficiaries may have. Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items.

<input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <small>(Sponsor's SSN)</small> <input type="checkbox"/> CHAMPVA <small>(Member ID#)</small> <input type="checkbox"/> GROUP HEALTH PLAN <small>(SSN or ID)</small>	Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD
		6. PATIENT RELATIONSHIP Self <input type="checkbox"/> Spouse <input type="checkbox"/>
STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/>	
7. IS PATIENT'S CURRENT EMPLOYMENT? (CHECK ONE) <input type="checkbox"/> YES <input type="checkbox"/> NO		

WHEN DOES MEDICARE PAY FIRST?

Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries in the absence of other primary insurance or coverage. Medicare is also the primary payer in certain instances, provided several conditions are met. Table 1 lists some common situations when Medicare and other health insurance or coverage may be present and which entity will be the primary or secondary payer for a Medicare patient's claims.

TABLE 1. LIST OF COMMON SITUATIONS WHEN MEDICARE MAY PAY FIRST OR SECOND

If the patient...	And this condition exists...	Then this program pays first...	And this program pays second
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment...	The employer has less than 20 employees...	Medicare	Group Health Plan
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment...	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals...	Group Health Plan	Medicare
Has an employer retirement plan and is age 65 or older...	The patient is entitled to Medicare...	Medicare	Retiree coverage
Is disabled and covered by a Group Health Plan through his or her own current employment or through a family member's current employment...	The employer has less than 100 employees...	Medicare	Group Health Plan
Is disabled and covered by a Group Health Plan through his or her own current employment or through a family member's current employment...	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	Group Health Plan	Medicare
Has End-Stage Renal Disease and Group Health Plan Coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	Group Health Plan	Medicare
Has End-Stage Renal Disease and Group Health Plan Coverage...	After 30 months...	Medicare	Group Health Plan
Has End-Stage Renal Disease and COBRA coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	Medicare
Has End-Stage Renal Disease and COBRA coverage...	After 30 months...	Medicare	COBRA
Is covered under Workers' Compensation because of a job-related illness or injury...	The patient is entitled to Medicare...	Workers' Compensation (for health care items or services related to job-related illness or injury) claims	Medicare
Has been in an accident or other situation where no-fault or liability insurance is involved...	The patient is entitled to Medicare...	No-fault or liability insurance for accident or other situation related health care services claimed or released	Medicare
Is age 65 or older OR is disabled and covered by Medicare and COBRA...	The patient is entitled to Medicare...	Medicare	COBRA

ARE THERE ANY EXCEPTIONS TO THE MSP REQUIREMENTS?

Federal law takes precedence over state laws and private contracts. Even if an entity believes that due to state law or because its insurance policy states it is the secondary payer to Medicare, the MSP provisions would apply when billing for services.

WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

In the following situations, Medicare **may** make payment assuming the services are covered and a proper claim has been filed.

- A Group Health Plan (GHP) denies payment for services because the beneficiary is not covered by the health plan;
- A no-fault or liability insurer does not pay, or denies the medical bill;
- A Workers' Compensation (WC) program denies payment, as in situations where WC is not required to pay for a given medical condition; or
- A WC Medicare Set-aside Arrangement (WCMSA) is exhausted.

In these situations, providers, physicians, and other suppliers should include documentation from the other payer stating that the claim has been denied and/or benefits have been exhausted when submitting the claim to Medicare.

WHEN MAY MEDICARE MAKE A CONDITIONAL PAYMENT?

Medicare may make a conditional payment for Medicare covered services in liability, no-fault, and WC situations where another payer is responsible for payment and the claim is not expected to be paid promptly (i.e., up to 120 days after receipt of the claim). However, Medicare has the right to recover any conditional payments.

Medicare will not make conditional payments in association with WCMSAs.

HOW IS BENEFICIARY HEALTH INSURANCE OR COVERAGE INFORMATION COLLECTED AND COORDINATED?

The Centers for Medicare & Medicaid Services (CMS) established the Coordination of Benefits Contractor (COBC) to collect, manage, and maintain information regarding other health insurance or coverage for Medicare beneficiaries. Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the COBC to coordinate the information.

To support the goals of the MSP provisions, the COBC manages several data gathering programs.

WHAT ARE SOME OF THE ACTIVITIES MANAGED BY THE COBC?

The COBC provides a centralized, one-step customer service approach for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries.

Activities that the COBC performs to collect MSP data include:

- **Pre-Enrollment Questionnaire** – About three months before entitlement to Medicare, enrolling beneficiaries receive a letter explaining enrollment. New Medicare enrollees are automatically registered to use the MyMedicare.gov website, which is Medicare's **secure** online service. After receiving the letter, the enrolling beneficiary can access the website and answer questions on other insurance or coverage (including prescription coverage) that may be primary to Medicare.
- **Internal Revenue Service/Social Security Administration/CMS (IRS/SSA/CMS) Data Match Project** – Federal law requires the IRS, SSA, and CMS to share information they have regarding employment of Medicare beneficiaries or their spouses. This information helps determine whether a beneficiary may be covered by a GHP that pays primary to Medicare. This information is sent to the COBC, and is used by the contractor to send the IRS/SSA/CMS Data Match Questionnaire notification to employers. This notification directs the employers to go to the COBC Secure Website to complete the questionnaire identifying employees and family members covered by the health plan that may be primary to Medicare.
- **The Voluntary Data Sharing Agreement (VDSA)** – The VDSA program allows for the electronic data exchange of GHP eligibility and Medicare information among CMS, employers, and prescription drug plans. To meet the mandatory reporting requirements, employers can enter into a VDSA in lieu of completing and submitting the IRS/SSA/CMS Data Match Questionnaire. CMS has also developed a data exchange process similar to the VDSA program for use by Supplemental Drug Plans such as State Pharmaceutical Assistance Programs (SPAPs) and AIDS Drug Assistance Programs (ADAPs) to coordinate their benefits with Medicare Part D.
- **MSP Mandatory Reporting Process** – Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) adds mandatory MSP reporting requirements for GHP insurance arrangements, liability insurance (including self-insurance), no-fault insurance, and WC (Non-Group Health Plans [NGHPs]) to the existing MSP provisions. Responsible Reporting Entities (RREs) are now mandated to submit GHP and NGHP information to strengthen the MSP coordination of benefits process.
- **MSP Claims Investigation** – The COBC investigates missing information on MSP cases. The single-source investigation offers a centralized approach for MSP-related inquiries. The investigation involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.

- **Electronic Correspondence Referral System (ECRS) is now a web-based application** – The ECRS allows contractor MSP representatives and the Regional Office MSP staff to fill out various forms online and electronically transmit them to the COBC.

WHAT IS SECTION 111 MSP MANDATORY REPORTING?

Section 111 of MMSEA adds to existing MSP provisions of the Social Security Act to provide for mandatory reporting for GHP arrangements, liability insurance (including self-insurance), no-fault insurance, and WC (NGHPs). The provisions were implemented January 1, 2009, for information about GHP arrangements and July 1, 2009, for liability insurance (including self-insurance), no-fault insurance, and WC. The purpose of the reporting process is to enable CMS to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer. Under the new Section 111 requirements, enrollment and settlement data will be submitted electronically to the COBC. These requirements do not change or eliminate any existing obligations under the MSP statutory provisions or regulations.

For more information and official instructions for Section 111 MSP reporting, visit the Mandatory Insurer Reporting web page at <http://www.cms.gov/MandatoryInsRep> on the CMS website.

WHAT IS THE PROVIDER'S, PHYSICIAN'S, OR OTHER SUPPLIER'S ROLE IN THE MSP PROVISIONS?

Providers, physicians, and other suppliers must aid in the collection and coordination of beneficiary health insurance or coverage information by:

- Asking the beneficiary or his/her representative questions concerning the beneficiary's MSP status. Providers, physicians, and other suppliers may use a model questionnaire published by CMS as a guide concerning the kinds of information to collect from beneficiaries. This tool is available online in the MSP Manual in Chapter 3, Section 20.2.1, at <http://www.cms.gov/manuals/downloads/msp105c03.pdf> on the CMS website. A commonly used method is to incorporate the MSP questionnaire elements into all health records.
- Billing the primary payer before billing Medicare, as required by the Social Security Act.

HOW DO PROVIDERS, PHYSICIANS, AND OTHER SUPPLIERS GATHER ACCURATE DATA FROM THE BENEFICIARY?

Providers, physicians, and other suppliers can save time and money by collecting beneficiary health insurance or coverage information at each visit. Some questions that providers, physicians, and other suppliers should ask include, but are not limited to:

- Is the beneficiary covered by any GHP through his or her current or former employment? If so, how many employees work for the employer providing coverage?



- Is the beneficiary covered by a 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 beneficiary receiving Workers' Compensation (WC) benefits?
- Does the beneficiary have a Workers' Compensation Medicare Set-aside Arrangement (WCMSA)?
- Is the beneficiary filing a claim with a no-fault insurance or liability insurance?
- Is the beneficiary being treated for an injury or illness for which another party has been found responsible?

If the provider, physician, or other supplier does not furnish Medicare with a record of other health insurance or coverage that may be primary to Medicare on any claim and there is an indication of possible MSP considerations, the COBC may request that the beneficiary, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire.

WHY GATHER ADDITIONAL BENEFICIARY HEALTH INSURANCE OR COVERAGE INFORMATION?

The goal of MSP information-gathering activities is to quickly identify possible MSP situations, thus ensuring correct primary and secondary payments by the responsible parties. This effort may require that the beneficiary, employer, insurer, or attorney complete SCD Questionnaires to collect accurate beneficiary health insurance or coverage information. Many of the questions on the SCD Questionnaires are similar to the questions that providers, physicians, and other suppliers might ask a beneficiary during a routine visit. This similarity provides another good reason to routinely ask beneficiaries about their health insurance or coverage. If a provider, physician, or other supplier gathers information about a beneficiary's other health insurance or coverage and uses that information to complete the claim properly, an SCD Questionnaire may not be necessary. Accurate submittal of claims may accelerate the processing of the provider's, physician's, or other supplier's claims.

An SCD Questionnaire may be sent to the beneficiary, employer, insurer, or attorney to collect information on the existence of other insurance that may be primary to Medicare. The COBC may send an SCD Questionnaire for the following situations:

- A claim is submitted to Medicare with an Explanation of Benefits (EOB) attached from an insurer other than Medicare;
- A self-report is made by the beneficiary or the beneficiary's attorney identifying an MSP situation; or
- The third party payer submitted MSP information to a contractor or the COBC.

For more information, see the "Medicare Secondary Claim Development Questionnaire" at http://www.cms.gov/InsurerServices/04_medicaresecclaimdevquest.asp on the CMS website.



WHAT HAPPENS IF THE PROVIDER, PHYSICIAN, OR OTHER SUPPLIER SUBMITS A CLAIM TO MEDICARE WITHOUT PROVIDING THE OTHER INSURER'S INFORMATION?

The claim may be erroneously paid by Medicare as primary if it meets all Medicare requirements, including Medicare coverage and medical necessity guidelines. However, if the beneficiary's Medicare record indicates that another insurer should have paid primary to Medicare, the claim will be denied, unless Medicare may rightly pay conditionally. If the Medicare Contractor does not have enough information, they may forward the information to the COBC and the COBC may send the beneficiary, employer, insurer, or attorney an SCD Questionnaire to complete for additional information. Medicare will review the information on the questionnaire and determine the proper action to take.

WHAT HAPPENS IF THE PROVIDER, PHYSICIAN, OR OTHER SUPPLIER FAILS TO FILE CORRECT AND ACCURATE CLAIMS WITH MEDICARE?

Federal law permits Medicare to recover its conditional payments. Providers, physicians, and other suppliers can be fined up to \$2,000 for knowingly, willfully, and repeatedly providing inaccurate information related to the existence of other health insurance or coverage.

HOW DOES THE PROVIDER, PHYSICIAN, OR OTHER SUPPLIER CONTACT THE COBC?

Providers, physicians, and other suppliers may contact the COBC at 1-800-999-1118 (TTY/TDD: 1-800-318-8782), Monday - Friday, 8 a.m. to 8 p.m. Eastern Time (excluding holidays). Providers, physicians, and other suppliers may contact the COBC to:

- Verify Medicare's primary/secondary status;
- Report changes to a beneficiary's health coverage;
- Report a beneficiary's accident/injury;
- Report potential MSP situations; or
- Ask questions regarding Medicare development letters and questionnaires.

NOTE: Insurer information will not be released. The provider must request information on payers primary to Medicare from the beneficiary prior to billing. Since the rights and information of our beneficiaries must be protected, the COBC cannot disclose this information.

Specific claim-based issues (including claim processing) should still be addressed to the provider's, physician's, or other supplier's Medicare claims processing contractor.

RESOURCES

For more information about the Medicare Coordination of Benefits, visit the Medicare Coordination of Benefits web page at <http://www.cms.gov/COBGeneralInformation> on the CMS website.

For more information about contacting the COBC, visit the Contacting the COBC web page at http://www.cms.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp on the CMS website.

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