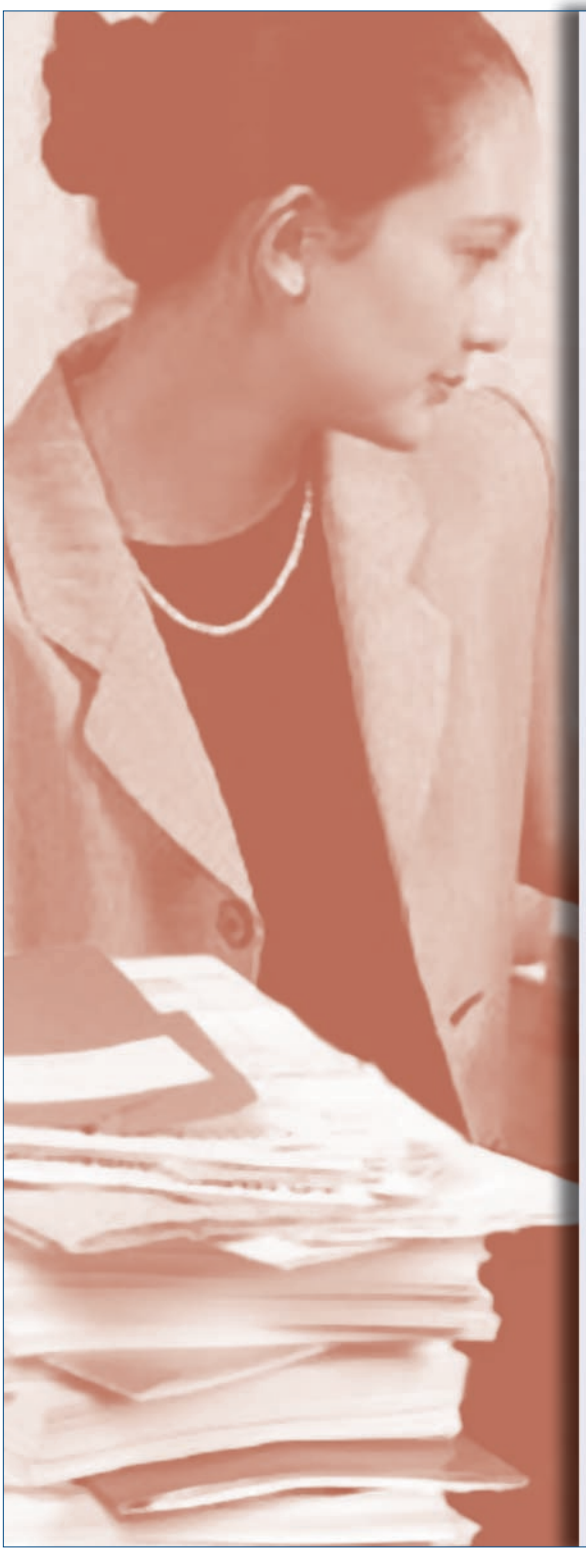
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Fact Sheet

FOR PHYSICIANS AND PROVIDER ADMINISTRATORS

COMPLYING WITH MEDICARE SECONDARY PAYER REQUIREMENTS



Background

As the Medicare program matures and the "baby boomer" generation moves towards retirement, it becomes critical to maintain the viability and integrity of the Medicare Trust Fund. Providers can contribute to the appropriate use of Medicare by complying with all Medicare requirements, including those applicable to Medicare Secondary Payer (MSP). The purpose of this Fact Sheet is to provide a general overview of the MSP Program for physicians and provider administrators.

What Is Medicare Secondary Payer (MSP)?

"Medicare Secondary Payer" is the term used by Medicare when Medicare is not responsible for paying a claim first. When Medicare began on July 1, 1966, it was the primary payer for all beneficiaries, except for those who received benefits from the Federal Black Lung Program and Workers' Compensation (WC) and for those who receive all covered health care services through the Veterans Health Administration (VHA) programs. Beginning in 1980, changes to Medicare laws increased the number of coverage and benefit programs that are primary to Medicare. The additions to the MSP requirements included:

- Automobile, liability, and no-fault insurance that may provide benefits for an accident or injury;
- Group Health Plans (GHPs) made available to working Medicare beneficiaries age 65 or older, or Medicare beneficiaries of any age with a spouse who is working and covered by a GHP;
- Large Group Health Plans (LGHPs) made available to disabled Medicare beneficiaries under the age of 65 through their current employment, or the current employment of a family member; and
- GHPs made available to persons with end-stage renal disease (ESRD)/permanent kidney failure (including beneficiaries directly covered, or covered as a dependent).

With the increase in additional insurance plans and payment programs that are primary to Medicare, the provider's responsibility to maintain accurate, up-to-date information about Medicare beneficiaries is critical. Fulfilling the data gathering responsibilities required by the MSP Program can benefit providers, as well as help Medicare remain viable for future beneficiaries. The

Centers for Medicare & Medicaid Services (CMS) estimates that the MSP Program has resulted in an annual savings in excess of $4.5 billion.

How Does MSP Benefit Providers?

Providers have several valid reasons to comply with MSP data gathering requirements:

- Providers are required to comply with all Medicare laws and regulations. Failure to comply could result in fines and penalties, including, but not limited to, the return of payments made by Medicare.
- Providers may receive more favorable reimbursement rates by billing both primary *and* secondary payers, as appropriate.
- Providers may reduce the number of Development Questionnaires they receive by spending a few minutes at the beginning of each patient visit to collect current insurance information. The few minutes spent with each patient may take less time than responding to a Development Questionnaire.

What Are the MSP Requirements for Providers?

Providers are responsible for maintaining a system that identifies any primary payer other than Medicare for each beneficiary. To fulfill this responsibility, providers must determine if Medicare is the primary or secondary payer for each service.

How Do Providers Determine Who Pays First?

To determine if Medicare is the primary payer, providers must ask the beneficiary about any additional health insurance coverage that he or she may have. To obtain the most updated information, providers should ask about any other health insurance coverage at each patient visit. Some suggested questions that providers should ask are:

- Is the patient covered by any GHP based on his or her current or former employment? If so, how many employees work for the employer providing coverage?
- Is the patient covered by any GHP based on a 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 illness or injury due to a work-related accident or condition, and is it being covered by WC?
- Is the illness or injury 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?

Answers to these questions will help providers complete the claim form and submit it to the correct primary payer. If providers do not submit the correct information to Medicare, Medicare retains the right to recover any mistaken payments made to the provider.

Are There Any Exceptions to MSP Requirements?

In most cases, Federal law takes precedence over state laws and private contracts. Even if a state law or insurance policy states that they are a secondary payer to Medicare, the MSP regulations should be followed when billing for services.

What Is Medicare Coordination of Benefits (COB)?

Coordination of Benefits (COB) is a CMS effort to identify additional health benefits available to a Medicare beneficiary, and coordinate the payment process to prevent and minimize mistaken Medicare payments. The COB Contractor collects, manages, and maintains information on Medicare's Common Working File (CWF) regarding other health insurance coverage for Medicare beneficiaries. The COB Contractor also initiates all MSP claims investigations. The COB Contractor does not process claims and cannot provide information regarding specific, ongoing cases. Questions about claims and specific, ongoing cases should be directed to the local Medicare claims processing contractor.

What Is an MSP Claims Investigation?

The COB Contractor initiates an MSP claims investigation when there is an indication that a beneficiary has other health insurance. This investigation may occur if a provider submits a claim that contains new health insurance information or information that conflicts with what currently exists on Medicare's beneficiary records. This investigation determines if Medicare or the other health insurance is the primary payer for a beneficiary's claims. MSP claims investigations usually begin with Development Questionnaires.

What Types of Development Questionnaires Are Sent to Providers?

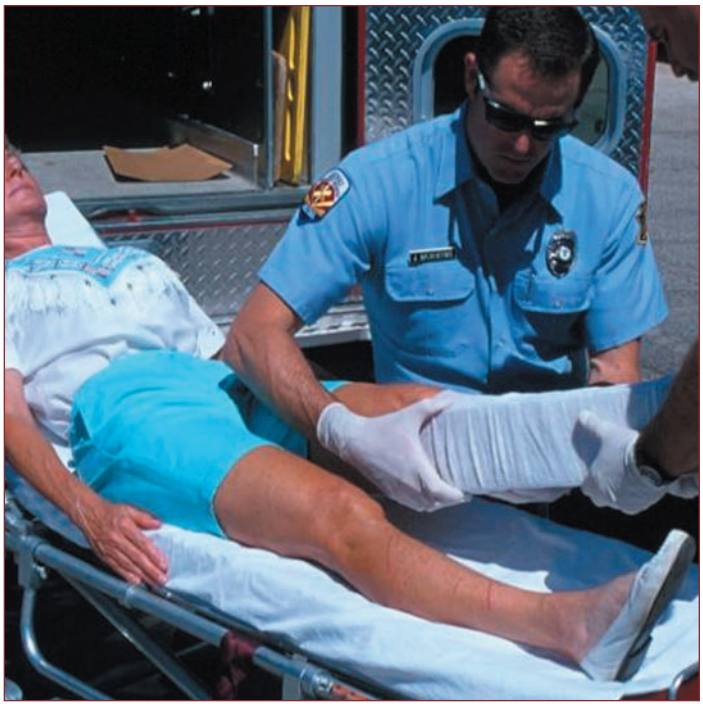
Two types of Development Questionnaires are sent to providers:

- **Secondary Claim Development (SCD) Questionnaire** –

  An SCD Questionnaire may be sent to the provider, when a claim is submitted with an Explanation of Benefits (EOB) attached from an insurer other than Medicare, and pertinent information was not submitted to properly adjudicate the submitted claim. The COB Contractor provides the name and Health Insurance Claim Number (HICN) of each beneficiary for which the provider is requested to complete an SCD Questionnaire. The provider should complete and return the SCD Questionnaire to the COB Contractor.

- **Trauma Development (TD) Questionnaire** –

  A TD Questionnaire may be sent when information regarding an accident, illness, or injury is received and/or a diagnosis appears on a claim that indicates an accident, illness, or injury has occurred. This incident may be related to a WC, automobile accident, or other liability situation. The TD Questionnaire may be sent to the beneficiary, provider, attorney, or insurer to collect information on the existence of other insurance that may be primary to Medicare. If an MSP situation is identified after Medicare pays the claim, Medicare has the right to recover any conditional payments made on behalf of the beneficiary.



If a provider gathers information about a beneficiary's other insurance and uses that information to complete the claim properly, Development Questionnaires may not be necessary. Accurate submittal of claims may accelerate the processing of the provider's claim.

How Do Providers Contact the COB Contractor?

Providers can contact the COB Contractor 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 may contact the COB Contractor to:

- Report potential MSP situations;
- Report incorrect insurance information; or
- Address general MSP questions/concerns.

Specific claim-based issues (including claim processing) should still be addressed to Intermediaries and/or Carriers.

Where Can I Find More Information on the Provider's Role in MSP and COB?

CMS offers several online references for information about MSP, COB, and the Medicare program:

- **The Medicare Learning Network Home Page**

  www.cms.hhs.gov/medlearn/

  The Medlearn Home Page features CMS provider education materials for COB and MSP issues, including a link to the Physicians Information Resource for Medicare Home Page.

- **The Medicare Secondary Payer and You Home Page**

  www.cms.hhs.gov/medicare/cob/msp/msp_home.asp

  The Medicare Secondary Payer and You Home Page contains many useful resources for the MSP Program, including information on data gathering for providers, claims investigations, and contact information for the COB Contractor.

- **The Medicare Coordination of Benefits Home Page**

  www.cms.hhs.gov/medicare/cob

  The Medicare Coordination of Benefits Home Page features MSP Program materials for providers such as the *COB Contractor MSP Claims Investigation Fact Sheet for Providers* and quarterly newsletters.

Written inquiries or requests for hardcopy COB newsletters can be sent to:

Medicare – COB
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New York, NY 10274-0125