Medicare
Carriers Manual
Part 3 – Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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THIS TRANSMITTAL MANUALIZES CHANGE REQUEST 817.

HEADER SECTION NUMBERS	PAGES TO INSERT	CHANGE REQUEST 817 PAGES TO DELETE
2306 – 2306 (Cont.)	2-109.2 - 2-109.3 (2 pp.)	2-109.2 - 2-109.3 (2 pp.)
3328 – 3328 (Cont.)	3-87 - 3-87.1 (2 pp.)	3-87 - 3-87.1 (2 pp.)
3328.25 (Cont.) - 3329.3 (Cont.)	3-87.22 - 3-87.25 (4 pp.)	3-87.22 - 3-87.25 (4 pp.)
3329.6 - 3329.6 (Cont.)	3-87.30 - 3-87.31 (2 pp.)	3-87.30 - 3-87.31 (2 pp.)
3335.2 - 3335.5	3-90.5 - 3-90.10 (6 pp.)	3-90.5 - 3-90.10 (6 pp.)
4301.1 (Cont.) - 4302	4-68.7 - 4-68.8 (2 pp.)	4-68.7 - 4-68.8 (2 pp.)
7012 (Cont.) – 7012 (Cont.)	7-9.10 - 7-9.11 (2 pp.)	7-9.10 - 7-9.11 (2 pp.)

MANUALIZATION--*EFFECTIVE DATE: September 1997*
IMPLEMENTATION DATE: Not Applicable.

The Medicare Carrier Manual sections listed below are being updated to reflect the 30-month coordination period for individuals entitled to benefits on the basis of End Stage Renal Disease (ESRD) who are covered by Group Health Plans (GHPs).

Section 2306, No Legal Obligation To Pay For Or Provide Services, updates the coordination periods to reflect the new 30-month coordination period.

Section 3328, Medicare Secondary Payer (MSP) General Provisions, updates the coordination periods to reflect the new 30-month coordination period.

Section 3329, MSP - General Provisions Applicable To Individuals Covered By Group Health Plans (GHP) and Large Group Health Plans (LGHP), updates the coordination periods to reflect the new 30-month coordination period.

Section 3335, Limitation On Payment For Services To Individuals Eligible For Or Entitled To Benefits On Basis Of End Stage Renal Disease Who Are Covered By GHPs, updates the coordination periods to reflect the new 30-month coordination period.

Section 4303, Paying Secondary Benefits Where EGHP Has Paid Primary Benefits For ESRD Beneficiary, updates the coordination periods to reflect the new 30-month coordination period.

Section 7012, Explanatory And Denial Messages, updates the coordination periods to reflect the new 30-month coordination period.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

2303.1 Devices Not Approved by FDA.--Medical devices which have not been approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures or services performed using devices which have not been approved for marketing by the FDA.

2306. NO LEGAL OBLIGATION TO PAY FOR OR PROVIDE SERVICES

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies when items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a physician or supplier waives the charges in the case of a particular patient or a group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services other than those paid for directly or indirectly by a governmental entity. (For a discussion of the latter, see §2309.)

A. Indigency.--This exclusion does not apply when items and services are furnished an indigent individual without charge because of his inability to pay, if the physician or supplier bills other patients to the extent that they are able to pay.

B. Physician or Supplier Bills Only Insured Patients.--Some physicians and suppliers waive their charges for individuals of limited means, but they also expect to be paid if the patient has insurance which covers the items or services they furnish. In such a situation, because it is clear that a patient would be charged if insured, a legal obligation to pay exists and benefits are payable for services rendered to patients with medical insurance if the physician or supplier customarily bills all insured patients--not just Medicare patients--even though noninsured patients are not charged.

Individuals with conditions which are the subject of a research project may receive treatment financed by a private research foundation. The foundation may establish its own clinic to study certain diseases or it may make grants to various other organizations. In most cases, the patient is not expected to pay for his treatment out-of-pocket, but if he has insurance, the parties expect that the insurer will pay for the services. In this situation, a legal obligation is considered to exist in the case of a Medicare patient even though other patients may not have insurance and are not charged.

C. Medicare Patient Has Other Health Insurance.--Except as provided in §§3335ff., 3336ff., and 3340ff., payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. This plan may be the type which pays money toward the cost of the services, such as a health insurance policy, or it may be the type which organizes and maintains its own facilities and professional staff. Examples of this latter type are employer and union sponsored plans which furnish services to special groups of employees or retirees or to union members and group practice prepayment plans.

The exceptions to this rule are services covered by automobile medical or no-fault insurance (§§3338ff.), services rendered during a specified period of up to 30 months to individuals entitled solely on the basis of end stage renal disease who are insured under an employer group health plan (§§3335ff.), services rendered employed individuals age 65 or

over and spouses age 65 or over of employed individuals of any age who are insured under an employer group health plan (§§3336ff.), and services covered by workers' compensation (§§3330ff.). In these cases the other plan pays primary benefits and if the other plan doesn't pay the entire bill, secondary Medicare benefits may be payable. Medicare is also secondary to the extent that services have been paid for by a liability insurer (§§3340ff.).

D. Items Covered Under a Warranty.--When a defective medical device such as a cardiac pacemaker is replaced under a warranty, hospital or other provider services rendered by parties other than the warrantor are covered despite the warrantor's liability. However, consider recovering Medicare payment for such services under the liability insurance provisions in §§3340ff.

With respect to payment for the device itself, in the case of services reimbursed on the basis of cost, the following rules apply: If the device is replaced free of charge by the warrantor, no program payment may be made, since there was no charge involved. If, however, a replacement device from another manufacturer had to be substituted because the replacement device offered under the warranty was not acceptable to the beneficiary or his physician, payment may be made for the replaced device. Also, if the warrantor supplied the replaced device, but some charge or pro rata payment was imposed, program payment may be made for the partial payment imposed for the device furnished by the warrantor.

If a provider could have obtained an acceptable device free of charge under a warranty but chose to purchase one instead, payment cannot be made for the purchased device under the prudent buyer rules. (See Provider Reimbursement Manual Part 1, §2103.) Also, if an acceptable device could have been purchased at a reduced price under a warranty but the provider did not take advantage of the warranty (i.e., it paid the full price to the original manufacturer or purchased the replacement device from a different manufacturer), the most the provider can receive as reimbursement for the purchased device is the amount it would have had to pay if it had pursued the warranty.

E. Ambulance Services.--There are numerous methods of financing ambulance companies. For example, some volunteer organizations do not charge the patient or any other person but ask the recipient of services for a donation to help offset the cost of the service. Although the recipients may be under considerable moral and social pressure to donate, they are not required to do so, and there is no enforceable legal obligation on the part of the individual or anyone else to pay for the services. Thus, Medicare benefits would not be payable. However, services of volunteer ambulance corps are not categorically excluded. Many such companies regularly charge for their services and these services are covered by Medicare.

Some ambulance companies provide services without charge to residents of specific geographical areas but charge non-residents to the extent they are able to pay (e.g., through private health insurance). Under those circumstances, the free services provided the residents would be excluded from coverage, while the services furnished non-residents would be covered.

Ambulance companies which charge membership fees generally do not charge additional fees for services covered under the membership plan, although they may charge for certain other services (e.g., additional trips or mileage). Services furnished by such ambulance companies including services for which prepayment is made under the membership plan, are considered to be services for which there is a legal obligation to pay. Therefore such services are reimbursable provided the ambulance company bills all third party payers. The ambulance company's charges to nonmembers and to other third parties would be considered in determining the reasonable charge. Membership fees and insurance premiums are not incurred expenses under Medicare (see §2000) and are not reimbursable.

3328. MEDICARE SECONDARY PAYER (MSP) GENERAL PROVISIONS

A. Introduction.--Under the Medicare law, as enacted in 1965, Medicare was the primary payer for Medicare covered services except for services covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare secondary payer to certain additional third party payers (TPP). The purpose was to shift costs from the Medicare program to private sources of payment. The MSP provisions are found in §1862(b) of the Act. At present, the law makes Medicare secondary payer to insurance plans and programs in the following situations:

1. Working Aged.--Medicare is secondary to group health plans (GHPs) of employers and employee organizations, including multiemployer and multiple employer plans which have at least one participating employer that employs 20 or more employees. Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age. (See §§3336ff.)

2. Working Disabled.--Medicare is secondary to large group health plans (LGHPs), i.e., plans of employee organizations and employers when at least one of the employers employs at least 100 employees. Medicare is secondary for Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and are covered under the plan by virtue of their own or a family member's current employment status with an employer. (See §§3337ff.)

3. End Stage Renal Disease (ESRD).--Medicare is secondary to GHPs (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in §3335.4E, GHPs are always primary payers throughout the first 30 months of ESRD-based Medicare eligibility or entitlement. (See §§3335ff.)

4. Workers Compensation.--Medicare is secondary to WC plans (including black lung benefit programs) of the States and the United States. (See §§3330ff.)

5. No-Fault.--Medicare is secondary to any no-fault insurance, including automobile medical and nonautomobile no-fault insurance. (See §§3338ff.)

6. Liability.--Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). (See §§3340ff.)

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. This means that the provider, supplier, or beneficiary must first submit the claim to the primary payer, which 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 processing the claim in this manner, the primary payer does not pay in full for the services. Medicare secondary benefits may be paid for the services as prescribed in §3328.18. Generally, the beneficiary is not disadvantaged where Medicare is secondary payer because the combined payment by a primary payer and by Medicare as secondary payer is the same as or greater than the combined payment where Medicare is primary payer.

B. Definitions.--

1. COBRA stands for Consolidated Omnibus Budget Reconciliation Act of 1985.

2. Conditional payment means a Medicare payment for services for which another insurer is primary payer.

3. GHP means 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 multiemployer 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 full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life 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 that are under the auspices of one or more employers or employee organizations but do not receive any contribution from the employer). However, coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is secondary to Medicare since the law makes Medicare primary to CHAMPUS.

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

4. LGHP means a GHP that covers employees of either:

- o 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

- o 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.

5. Prompt or promptly with regard to liability insurance means payment within 120 days after the earlier of the following:

- o The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or

- o The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

With regard to all other primary payers, prompt or promptly means payment within 120 days after receipt of the claim.

6. Proper claim means a claim that is filed timely and meets all other claims filing requirements specified by the TPP. (See §3328.1.)

while incurred expenses are equal to 100 percent of the Medicare fee schedule amount. Therefore, in order to properly determine the incurred expenses which are to be applied to the $750 annual limit on incurred expenses, Medicare payment amounts, including secondary payment amounts, must be multiplied by a factor of 1.25 (1.00 (100 percent of fee schedule amount) divided by .8 (80 percent payable by Medicare after deduction for coinsurance) = 1.25).

EXAMPLE: An individual received services from an independently practicing physical therapist for which the therapist charged $500. None of the individual's $100 Part B deductible had been met. A TPP allowed the charges in full and paid $400 (80 percent of $500). The Medicare fee schedule amount for the services was also $500. The first $100 in charges paid by the TPP is applied to the Part B deductible. The secondary Medicare benefit calculated in accordance with §3328.20 is $100. The $750 fee schedule limit on incurred expenses for services by independently practicing physical therapists is charged with the $100 credited to the Part B deductible plus $125 (1.25 x the $100 Medicare payment). Thus, $525 of the $750 limit is still unmet.

3329. MSP - GENERAL PROVISIONS APPLICABLE TO INDIVIDUALS COVERED BY GROUP HEALTH PLANS (GHP) AND LARGE GROUP HEALTH PLANS (LGHP)

3329.1 General.--

A. Working Aged.--In general, Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage by virtue of:

1. Their own current employment status with an employer that has 20 or more employees; or

2. The current employment status of a spouse of any age with such an employer. (Section 3336.3 further defines individuals subject to this limitation on payment.)

B. ESRD.--Medicare benefits are secondary to benefits payable under a GHP for individuals entitled to benefits on the basis of ESRD (see §1020) during a coordination period of 30 months, as determined in accordance with §§3335.3 or 3335.4.

C. Disabled.--In general, Medicare benefits are secondary to benefits payable under an LGHP for individuals under 65 entitled to Medicare on the basis of disability who are covered under a LGHP by virtue of the:

1. Individual's current employment status with an employer that has 100 employees (see §3337.3); or

2. Current employment status of a family member with such employer.

Special rules apply in the case of multiple employers and multiemployer plans. (See §3337.3.)

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.

3329.2 Definitions.--

A. Employee.--Employee means an individual who is working for an employer or an individual who, although not actually working for an employer, is receiving from an employer payments 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).

B. Employer.--Employer means, 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.

C. Family Member.--Family member means a person enrolled in an LGHP based on another person's enrollment. Family members may include a spouse (including a divorced or common-law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

D. FICA.--The term "FICA" stands for the Federal Insurance Contributions Act, the law that imposes Social Security taxes on employers and employees under '21 of the IRC.

E. GHP.--The term "GHP" means 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 multiemployer 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 full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life 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). However, coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is secondary to Medicare since the law makes Medicare primary to CHAMPUS.

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

F. LGHP.--The term "LGHP" means a GHP that covers employees of either:

1. 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

2. 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.

G. Multiemployer Group Health Plan.--The term "multiemployer group health plan" means a plan that is sponsored jointly by two or more employers (sometimes called a multiple employer plan) or by employers and unions (as under the Taft-Hartley law).

H. Self-Employed Person.--An individual is considered to be self-employed during a particular tax year only if, during the preceding tax year, the individual's self-employment income, as determined by the IRS, from work related to the employer that offers the group health coverage was at least equal to the amount specified in '211(b)(2) of the Act, which defines self-employment income for Social Security purposes. At present, this amount is $400. Self-employed individuals include persons such as consultants, owners of businesses, directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.

3329.3 Current Employment Status.--

A. General.--An individual has current employment status if the individual is:

1. Actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or

2. Not actively working but meets all of the following conditions:

- Retains employment rights in the industry;

- Has not had his/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.)

B. Persons Who Retain Employment Rights.--Persons who retain employment rights include but are not limited to:

1. Those who are furloughed, temporarily laid off, or who are on sick leave;

2. Teachers and seasonal workers who normally do not work throughout the year; and

3. Those who have health coverage that extends beyond or between active employment periods (e.g., based on an hour's bank arrangement). (Active union members in certain trades and industries (e.g., construction) often have hours' bank coverage.)

C. Coverage by Virtue of Current Employment Status.--An individual has coverage by virtue of current employment status with an employer if the individual has:

1. 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

2. Current employment status with that employer, as defined in subsection A.

D. Member of Religious Order Who Has Not Taken Vow of Poverty.--A member of a religious order who has not taken a vow of poverty is considered to have current employment status with the order if the:

1. Religious order pays FICA taxes on behalf of that member; or

2. Individual is receiving from the religious order remuneration for services furnished whether or not the religious order pays FICA taxes on behalf of that member.

E. Member of Religious Order Who Has Taken Vow of Poverty.--A member of a religious order whose members are required to take a vow of poverty is not considered to have current employment status if the services he/she performs as a member of the order are considered

C. Referral of Cases To Regional Office.--If you suspect that a prohibited incentive has been offered, develop the case fully and refer it to the regional office.

3329.6 Nondiscrimination.--

A. Prohibitions Against Taking Into Account Medicare Entitlement When Medicare Is Secondary.--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:

o 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 §§3336ff.);

o 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 §§3335ff.); or

o Beneficiaries under age 65 who are entitled to Medicare on the basis of disability and who are covered under an 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 §§3337ff.)

B. Equal Benefits for Older and Younger Employees and Spouses.--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.

C. Nondifferentiation for ESRD.--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 are listed in §3335.2.B.)

D. Examples of Actions That Constitute Taking Into Account.--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:

o Failing to pay primary benefits;

o Offering to individuals entitled to Medicare coverage that is secondary to Medicare;

o Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (see 26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. §1162.(2)(D); and 42 U.S.C. 300bb-2 (2)(D));

o 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;

- o 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;

- o Charging the Medicare-entitled individual higher premiums;

- o Requiring a Medicare-entitled individual to wait longer for coverage to begin;

- o 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;

- o 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.);

- o 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

- o 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.

E. Permissible Distinctions.--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 1 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 1 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.

Medicare Secondary Payer Provisions for ESRD Beneficiaries

3335. LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ELIGIBLE FOR OR ENTITLED TO BENEFITS ON BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY GHPs

3335.1 General.--Except as provided in §3335.4:

- Medicare is secondary payer to GHPs for individuals eligible for or entitled to Medicare benefits based on ESRD during a coordination period of 30 months.

- This provision applies regardless of the number of employees employed by the employer and regardless of whether the individual 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 §§3335.3 or 3335.4 if the individual meets the other requirements of §1020.

Prior to August 10, 1993 (the enactment date of OBRA 1993), if an individual was eligible for or entitled to Medicare on more than one basis (i.e., ESRD and disability or ESRD and age), Medicare was the primary payer. This is because the ESRD MSP provision only applied with respect to individuals who were eligible for or entitled to Medicare based solely on ESRD. However, in general, §§13561(c)(2) and (3) of OBRA 1993 provides that GHPs must pay primary benefits during the coordination period regardless of whether the individual is also entitled to Medicare on another basis. (See §3335.4 for dual entitlement provisions. Specifically, see §3335.4.B, which discusses the dual entitlement provision under which a GHP remains secondary to Medicare during the first 30 months of ESRD-based eligibility or entitlement and litigation challenging that provision.)

This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in a 30-month coordination period. Consider the possible application of this limitation when processing claims for items or services furnished to ESRD beneficiaries who are in their first 30 months of ESRD-based eligibility or entitlement. No Medicare benefits are payable on behalf of an individual who is eligible for but not yet entitled to Medicare solely on the basis of ESRD.

3335.2 Prohibition Against Taking Into Account Medicare Eligibility or Entitlement and Benefit Differentiation During Coordination Period.--

A. Taking Medicare Into Account Prohibited.--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 in §§3335.3 or 3335.4. Examples of actions that constitute taking into account Medicare entitlement are listed in §3329.6.D.

B. Differentiation in Benefits Prohibited.--A GHP may not differentiate in the benefits it provides to individuals who have ESRD and individuals who do not have ESRD on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner.

GHP 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:

1. Terminating coverage of individuals with ESRD for reasons that would not be a basis for terminating individuals who do not have ESRD;

2. 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;

3. Charging individuals with ESRD higher premiums;

4. 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

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

C. Uniform Limitations on Particular Services Permissible.--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.

D. Paying Benefits Secondary To Medicare.--The nondifferentiation provision does not prohibit a plan from paying benefits secondary to Medicare after the coordination period described in §§3335.3 or 3335.4. However, a plan may not otherwise differentiate, as described in subsection B, in the benefits it provides.

EXAMPLE: 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.

3335.3 Determining Period During Which Medicare May Be Secondary Payer.--

A. Duration of Coordination Period.--The coordination period is a period of 18 months 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.

Prior to enactment of the Balanced Budget Act (BBA) of 1997, Medicare benefits were secondary to benefits payable under a GHP in the case of individuals eligible for or entitled to benefits on the basis of ESRD during an 18-month coordination period. The BBA extended the coordination period to 30- months for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who have not completed an 18-month coordination period by July 1, 1997, will have a 30-month coordination period.

EXAMPLE: Coordination Period Ended on or Before July 31, 1997.

An individual began a course of maintenance dialysis in October 1995. He became entitled to Medicare based on ESRD effective January 1, 1996. The GHP must pay primary to Medicare through June 1997, the end of the 18-month period.

EXAMPLE: Coordination Period Began on or After March 1, 1996.

EXAMPLE: An individual began dialysis on November 17, 1996, and thus becomes entitled to Medicare effective February 1, 1997. Medicare is secondary payer from February 1, 1997, through July 1999, a total of 30 months.

B. Determination for Subsequent Periods of ESRD Eligibility.--If an individual has more than one period of Part A eligibility or entitlement based on ESRD, a coordination period is determined for each period of eligibility in accordance with subsection A.

3335.4 Dual Eligibility/Entitlement Situations.--When an individual is eligible for or entitled to Medicare based on ESRD and also entitled on the basis of age or disability, coordination of benefits is in accordance with this section instead of §3335.3.

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 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 (see §§3336ff.) and the disability MSP provisions (see §§3337ff.) do not apply to individuals with ESRD during or after the 30-month coordination period.

Subsection A deals with coordination periods governed by present law. Subsection B specifies the circumstances under which the ESRD MSP provision does not apply in dual entitlement situations and provides examples. Subsection C 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.--

1. Medicare 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.

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 on June 27, 1996. Effective September 1, 1996, 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 March 1999, the 30th month of ESRD-based eligibility, and becomes primary payer beginning April 1999.

EXAMPLE 2: Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 1997 at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 30-month coordination period (July 1997), 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 July 2000, the 30th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer beginning August 2000.

EXAMPLE 3: Mr. E retired at age 62 and maintained GHP coverage as a retiree. In July 1996, he simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 1996) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 1996 through December 1998, the first 30 months of ESRD-based eligibility. Medicare becomes the primary payer beginning January 1999.

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:

1. The individual is already entitled on the basis of age or disability when he/she becomes eligible on the basis of ESRD.

2. 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.

A law suit was filed in United States District Court for the District of Columbia on May 5, 1995, (National Medical Care, Inc. v. Shalala, Civil Action No. 95-0860), challenging the implementation of this aspect of the OBRA 1993 provision with respect to GHPs' retirement coverage. The court issued a preliminary injunction order on June 6, 1995, that enjoins the Secretary from applying the rule contained in this subsection B for services furnished on or after August 10, 1993, but before April 24, 1995, pending the court's decision on the merits. HCFA will modify the rule, if required, based on the final ruling by the court. Please note that the court injunction does not apply to services furnished on or after April 24, 1995. Therefore, this subsection B applies with respect to such services.

EXAMPLE: 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 1995. She automatically becomes eligible for Medicare based on ESRD effective January 1, 1996. 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. Dual Eligibility/Entitlement Ceases.--If ESRD-based eligibility or entitlement ceases in accordance with §1020, Medicare is the primary payer unless plan coverage is in effect by virtue of current employment status and the provisions of §§3336ff. or 3337ff. apply.

3335.5 Effect of ESRD MSP on Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage.--

A. General.-- 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 the 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 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 his/her 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:

1. Is required to keep in effect under the COBRA continuation requirements where Medicare entitlement occurs first, or

2. 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); or

3. 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.

subsequent claim from this beneficiary as possibly involving the working aged provisions. If you reject the claim at the front end, the letter to the beneficiary must show that it appears that the beneficiary has EGHP which pays first, and that a claim must be sent to the employer's plan before the claim is resubmitted to Medicare. Also state that after the claim has been processed by the employer plan, the beneficiary must resubmit the claim with the bills and the explanation of benefits notice which the employer's plan sent, if the bill had not been paid in full.

F. Determining Medicare Payment.--Review the claims form, a copy of the primary insurance company's explanation of benefits, and the bills.

- o Determine the amount of the reimbursement as shown in §3336.9.

- o If the explanation of benefits does not give the EGHP allowed charge, in the absence of evidence to the contrary, assume that the actual charge is the plan's allowable charge. However, if there is a low employer plan payment in relation to the charge, assume that the Medicare reasonable charge is higher than the EGHP allowable charge in determining the amount payable under §3336.9.

- o Do not attempt to keep complete and detailed information on the reimbursement amounts and the coverage offered by each employment related insurance plan in the area. Process each claim based upon the information submitted with that claim.

- o Record the primary insurer's submitted and allowed charge and indicate if assumptions were made about these charges for pricing purposes so that you can answer any inquiries.

G. Development of Claims Upon Receipt of a "Y" Trailer.--When you receive a "Y" trailer with a code "A" (see §6l30.4), develop where:

- o There is no indication on the Health Insurance Claim Form (HCFA-l500) or Patient's Request for Medicare Payment (HCFA-l490S) that the beneficiary or the beneficiary's spouse is employed and that the beneficiary is covered by an EGHP; and

- o Claims on which the cumulative total amount payable equals $50 or more have been submitted.

Develop to determine if the beneficiary is employed or is the spouse of an employed individual and has coverage with an EGHP. If development indicates that there is primary EGHP coverage for the services, process it in accordance with §3336.5. If you determine that the primary insurer has paid its share, determine Medicare's liability and process the claim in accordance with §3336.9.

When you receive a claim for secondary benefits, search your records for any claims (independent of dollar amount) for services furnished during the 30-month period prior to the month the current claim is processed on:

o Which you paid primary benefits; and

o Which have not been annotated in accordance with §3336.l0 to indicate a valid prior EGHP denial which would apply to subsequent claims.

Where such prior claims are identified and the cumulative total amount of Medicare is $50 or more, follow §3336.ll.

4302. REVIEWING CLAIMS INVOLVING AUTOMOBILE MEDICAL, AUTOMOBILE NO-FAULT, AND ANY LIABILITY INSURANCE

Where item l0b of the HCFA-l500 indicates automobile or other third party liability insurance, Medicare may be the secondary payer. If automobile medical or automobile no-fault insurance is involved, develop the claim. (See §3340.3B.) If any type of liability insurance is involved, including automobile liability, pay the claim and attempt to recoup any overpayment when the other insurance company settles. Process the claim according to §2340 and §3340. When processing these claims, remember:

o Insurance payments do not count toward the deductible. (See §3340.1B.)

o Consider other indicators of insurance coverage in addition to checking box 10(b) of the HCFA-l500. (See §3340.3A.)

4303. PAYING SECONDARY BENEFITS WHERE EGHP HAS PAID PRIMARY BENEFITS FOR ESRD BENEFICIARY

General provisions for processing claims involving ESRD benefits paid with Medicare as a secondary payer are in §§3335.1-3335.5. To process claims under these provisions:

o Determine the 30- month period based upon information supplied by the ESRD facility or hospital. (See §3335.5.)

o Coordinate your determinations of the 30-month period with any other contractor(s) involved.

4304. REVIEWING MEDICARE CLAIMS WHERE VA LIABILITY MAY BE INVOLVED

Under certain circumstances, the VA may authorize a veteran to receive care on a fee-for-service basis from a non-VA physician/supplier. Generally, this authorization is related to a specific condition; Medicare payment for all other services is appropriate. Since no payment may be made under Medicare for services authorized by the VA, you must assure that Medicare funds are not used to supplement or duplicate VA benefits. See §2309.2 for an explanation of Medicare policy in relation to VA authorized services.

26.4. Medicare does not pay for eyeglasses or contact lenses except after cataract surgery or if the natural lens of your eye is missing.

26.5. Medicare pays for only one pair of glasses after cataract surgery with lens insertion.

26.6. Medicare does not pay the extra charge for deluxe frames.

26.7. Medicare does not make separate payment for intraocular lenses implanted after cataract surgery performed in an ambulatory surgical care facility.

26.8. Medicare can pay for only one pair of contact lenses after cataract surgery. Our records show that Medicare has already paid for one pair of contact lenses.

26.9. Medicare does not pay for this service when provided by an optometrist. (Services that are not covered, i.e., surgery, X-rays, laboratory services.)

26.10. Medicare does not pay for this service unless done in conjunction with cataract surgery.

26.11. Medicare has reduced payment 50% for this service because it was prematurely terminated. If this procedure is for insertion of an intraocular lens, the Medicare allowance is first reduced for the unused lens.

26.12. The Medicare allowance for this terminated procedure has been reduced for the unused lens.

26.13. Medicare does not pay for more than one lens after cataract surgery with implant or intraocular lens.

27.0. HOSPICE.--

27.1. Medicare does not pay for these services because you are enrolled in a hospice.

28.0. MANDATORY ASSIGNMENT FOR PHYSICIAN SERVICES FURNISHED MEDICAID PATIENTS.--

28.1. Your Request for Medicare Payment form shows that you receive state medical assistance--Medicaid. Your doctor must file the claim and agree to accept assignment.

29.0 Medicare Secondary Payer/Department Of Veterans Affairs/Workers Compensation/Black Lung.--

GENERAL

29.1. Medicare is the secondary payer for these services. (NOTE: Add if information accessible: Your primary payer is (DVA/WC/BL.)

29.2. Medicare is the secondary payer for this claim. (NOTE: Add if information accessible: Your primary payer is (DVA/WC/BL.)

29.3. Medicare secondary payment cannot be considered without the name of the primary insurer. This information was either not provided or illegible for this claim.

29.30. Medicare cannot pay for these services because the payment made by your primary payer satisfies the provider's bill. The primary payer is ______ (the Department of Veterans Affairs, the Federal Black Lung Program, Worker's Compensation, your Employer Group Health Plan, your auto or other no-fault or liability insurance.)

29.31. Medicare benefits are reduced because some of these expenses have been paid by ______ (the Department of Veterans Affairs, the Federal Black Lung program, Worker's Compensation, your Employer Group Health Plan, your auto or other no-fault or liability insurance.)

29.32. In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).

29.33. Your original claim was denied because we were provided with incorrect Medicare secondary payer information. Now that we have the correct information, we have reprocessed this claim.

WORKING AGED/DISABLED

29.4. Our records show that you are a member of an employer sponsored group health plan. A claim must be sent to your group health plan first. After the claim has been processed by that plan, and if the bill has not been paid in full, resubmit this claim along with your bills and a copy of the notice you received from the other insurance company. The services will then be considered toward meeting your deductible and for possible Medicare payment.

29.5. Our records show that you are a member of an employer sponsored prepaid health plan. Therefore, Medicare is secondary payer for you and services from sources outside your health plan are not covered. However, since you were not previously notified of this, we will pay this time. In the future, payment will not be made for nonplan services.

29.6. Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.

29.40. Since you are covered under an employer group health plan, and the plan has denied your claim, Medicare benefits are being paid on the condition that, if you receive payment from the employer plan, you must repay Medicare.

29.41. If your employer group health plan has processed other claims for you, submit a Medicare claim with copies of bills and that health plan's explanation of benefits notice if you would like these services considered toward meeting your deductible and possible Medicare payment.

END-STAGE RENAL DISEASE

29.7. Our records show that you are a member of an employer sponsored group health plan. During the 30-month coordination period, your employer group health plan must pay for these end-stage renal disease (ESRD) services first. After the claim has been processed by that plan, and if the bill has not been paid in full, resubmit this claim along with your bills and a copy of the notice you receive from the other insurance company.