Medicare Secondary Payer (MSP) Manual

Chapter 2 - MSP Provisions

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(Rev 2. 10-17-03)

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The purpose of this chapter is to provide more detailed information concerning MSP provisions and the relationship of MSP to other laws. Detail provided here assists contractors with responses to questions from providers, physicians, suppliers, attorneys, employers, and other payers.

10 - Medicare Secondary Payer Provisions for Working Aged Individuals

A3-3491, B3-3336, B3-3329, HO-263, HO-263.1, SNF-336, SNF-336.1, HH-253, HH-253.1

(Rev. 1, 10-01-03)

Medicare pays secondary to GHP coverage for individuals age 65 or over if the GHP coverage is by virtue of the individual's current employment status or the current employment status of the individual's spouse. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. The Age Discrimination in Employment Act (ADEA), administered by the Equal Employment Opportunity Commission, requires employers (as defined in the Medicare Secondary Payer Manual, Chapter 1, "Background and Overview," §20) to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65. For example, a plan may not provide benefits that are less for individuals age 65 or over or charge policyholders premiums that are higher for individuals age 65 or over since this would create an incentive for these individuals to reject the GHP coverage and make Medicare the primary payer. This provision applies whether or not the individual age 65 or over is entitled to Medicare. This equal benefit rule applies to coverage offered to full-time and part-time employees.

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage of items and services covered by Medicare. The requirements for employer compliance with the Medicare secondary payer provisions may differ in some respects from the requirements for compliance with the ADEA. For example, the ADEA law applies only to employees, while the Medicare provision applies also to self-employed individuals.

Where an GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in Chapter 1, §40, to supplement the amount

it paid for Medicare covered services. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may NOT be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries.

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. Contractors evaluate claims under existing guidelines derived from the law and regulations to assure that Medicare covers the services regardless of any employer plan involvement.

See definitions of employer and employee in Chapter 1.

An individual attains a particular age on the day preceding his or her birthday.

10.1 - Individuals Subject to Limitations on Payment

(Rev. 1, 10-01-03)

A3-3491.2, B3-3336.1, B3-4301, HO-263.3, SNF-336.3, HH-253.3 - Sections deleted from original manual because they were outdated and no longer apply.

Medicare pays secondary for Part A and Part B benefits for an individual who:

- Is age 65 or over;
- Is entitled to Part A (hospital insurance) on the basis of the individual's own social security or railroad retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person, and
- Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that he furnishes to other employees (i.e., non-retirees). Medicare is secondary payer to the GHP that the employer provides to the re-employed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for individuals associated with the employer in a business relationship such as consultants who are former employees, if the employer provides coverage for other such individuals.

10.2 - Individuals Not Subject to the Limitation on Payment

(Rev. 2, 10-17-03)

A3-3491.3, B3-3336.1, B3-3336.9, HO- 253.4, SNF-336.4, HH-253.4

The Medicare secondary provision for working aged does not apply to:

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium. Anyone who is under age 65. (Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than an GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;
- Employees of employers of fewer than 20 employees who are covered by a single employer plan. Members of multi-employer plans, which have been approved by CMS for the "multi-employer exemption", whom the plan identified as employees of employers with fewer than 20 employees;
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;
- Individuals enrolled in single employer GHPs of employers of fewer than 20 employees; or
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected (see §10.4) to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.
- *Domestic partners who are given "spousal" coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus a domestic partner cannot be recognized as a spouse.*

10.3 - The 20-or-More Employees Requirement

(Rev. 1, 10-01-03)

B3-3336.1, B3-3336.4

The working aged MSP provision applies only to GHPs of employers with 20 or more employees and to multi-employer and multiple employer GHPs in which at least one employer employs 20 or more employees. This requirement is met if an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full-time or part-time employees on its employment rolls each working day of that week. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals participating in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if the employee does not work on a particular day. An employer may not have different employment rolls for different days reflecting those scheduled.

Where an employer does not have 20 or more employees in the preceding year, it is required to offer its employees and spouses age 65 or over primary coverage beginning with the point in time at which the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year even if the number of employees drops below 20 after the employer has met the requirement.

The 20-or-more employees requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. If at that time the employer has met the 20-or- more employees requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the GHP. (See Chapter 1, §60, for determining the size of employers.)

10.4 - Exception for Small Employers in Multi-Employer and Multiple Employer GHPs

(Rev. 1, 10-01-03)

B3-3336.5

A multi-employer or multiple employer GHP that has at least one employer with 20 or more employees may request to exempt employees of identified employers with fewer than 20 employees from the working aged provision. Such members and their spouses are not subject to this provision. If a GHP wishes to exempt such employees of a

particular employer from the working aged provision because the employer does not meet the 20-or-more employee requirement, the plan must submit the following documentation to the Medicare contractor:

- A letter from the employer that specifies the number of employees that the employer employs and a statement that the employer does not meet the requirements of the 20-or-more employee provision described in §10.3;

- A copy of a letter that the plan has sent to the affected employees notifying them and their spouses covered by the plan that the plan has elected to exempt their employer, and Medicare is, therefore, the primary payer; and

- A letter that identifies the individual as an employee of a small employer that participates in the plan. The letter should include the Medicare number for each affected employee and spouse.

If the above information is provided and there is no evidence to the contrary, the contractor may approve the request. Advise COB of any updates to CWF that may be needed.

20 - Medicare Secondary Payer Provisions for ESRD Beneficiaries

(Rev. 1, 10-01-03)

B3-3335, B3-3335.1, A3-3490, AB 97-14, B3-3329, HO-264, HO-264.1, SNF-335, SNF-335.1, HH-252, HH-252.1

Medicare is secondary payer to GHPs for individuals eligible for or entitled to Medicare benefits based on ESRD during a coordination period described below. (See Chapter 1, "Background and Overview," §20, for definition of eligibility, entitled, and enrolled.) 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 §20.1.1 or §20.1.3 if the individual meets the other requirements the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 2, "Hospital Insurance and Medical Insurance," §10.4.

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 provided that plans must pay primary benefits during the coordination period regardless of whether the individual is also entitled to Medicare on another basis. (See

§20.1.3 for dual entitlement provisions. Specifically, see §20.1.3.B, which discusses the dual entitlement provision under which a GHP remains secondary to Medicare during the 30-month coordination period and litigation challenging that provision.)

Medicare secondary benefits are payable in accordance with Chapter 5, §40.8.1 if:

- The plan payment is less than the provider's charges for Medicare covered services,
- The plan payment is less than the gross amount payable by Medicare, and
- The provider does not accept, and is not obligated to accept, the GHP payment as payment in full.

This provision applies to all Medicare covered items and services furnished to beneficiaries who are in the 30-month period, including services for non-ESRD treatment and services required by kidney donors in cases of transplantation. This limitation applies for claims processing for items or services furnished to ESRD beneficiaries who are in their 30-months of eligibility or entitlement on the basis of ESRD.

20.1 - Determining the 30 Month Coordination Period During Which Medicare May Be Secondary Payer

(Rev. 1, 10-01-03)

B3-3335.3, AB-97-14, A3-3490.4, HO-264.4, SNF-335.4, HH-252.4

If Medicare was not the proper primary payer for an individual on the basis of age or disability at the time the individual became eligible for or entitled to Medicare on the basis of End Stage Renal Disease, Medicare is secondary payer to GHPs for items and services furnished during a period of up to 30 consecutive months which begins with the earlier of:

- The month in which a regular course of renal dialysis is initiated, or
- If the patient undergoes a course of self-dialysis training the first day of the month in which the training occurred, or
- If an individual who received a kidney transplant, the first month in which the individual became entitled.

NOTE: In the rare case of an untimely application by an individual who receives a transplant, the 30-month period could begin with the first month in which the individual would have been eligible for or entitled to Medicare benefits if a timely application had been filed. (See Medicare Pub 100-1, Medicare General Information, Eligibility and Entitlement, Chapter 2, §10.4, for the earliest possible month of eligibility or entitlement in transplant cases.) It is not necessary to consider this possibility absent a specific

indication, e.g., information that the transplant occurred before the first month of eligibility or entitlement. If further development is required, the contractor should contact the SSO.

When the 30-month period begins before the month the individual becomes eligible for or entitled to Medicare, contractors pay secondary benefits for the portion of the period during which the individual is eligible or entitled. The latter is the coordination period (See Chapter 1, §20). Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis.

20.1.1 - Duration of Coordination Period

(Rev. 1, 10-01-03)

B3-3335.3, AB-97-14, HO-264.4, HO-264.5, SNF-335.4, SNF-335.5, HH-252.4, HH-252.5

The coordination period is a period 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.

Immediately 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. Prior to OBRA 90, the ESRD coordination period was 9 to 12 months. 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 1

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 2

Coordination Period Began on or After March 1, 1996:

An individual began maintenance 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.

Eligibility refers to the first month the individual would have become entitled to Medicare Part A on the basis of ESRD if an application were filed for such benefits. In the rare case of an untimely application by an individual, the coordination period could begin with the first month in which the individual would have been entitled to Medicare benefits if a timely application had been filed. (See Pub 100-1, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 2, §§10.4.2 and 10.4.3, for the earliest possible month of entitlement in self-dialysis training or transplant cases.) It is not necessary to consider this possibility absent a specific indication, e.g., information that the transplant occurred before the first month of entitlement. If further development is required, contractors contact the RO.

When the coordination period begins before the month the individual becomes entitled to Medicare, the contractor pays secondary benefits for the portion of the period during which the individual is entitled. (See §20.1.1.) Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis. However, for individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 30 months of the individual's entitlement.

Individuals eligible for Medicare on the basis on ESRD cannot enroll for Part B in a SEP but can defer entitlement to both Part A and B and file an initial application later, usually at the end of the coordination period.

A - 30-Month Coordination Period as a Result of the BBA of 1997

Section 4631(b) of the BBA of 1997 permanently extends 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 31, 1997, will have a 30-month coordination period under the new law. This provision does not apply to individuals who would reach the 18-month point on or before July 31, 1997. These individuals would continue to have an 18-month coordination period.

20.1.2 - Determination for Subsequent Periods of ESRD Eligibility

(Rev. 1, 10-01-03)

A3-3490.6, B3-3335.3, HO-264.6, SNF-335.6, HH-252.6

If an individual has more than one period of eligibility or entitlement based solely on ESRD, a coordination period is determined for each period of eligibility in accordance with §20.1.1, subsection A. If Medicare entitlement is not correctly terminated three years after a successful transplant, it is still considered a new period of eligibility and consequently a new coordination period begins.

20.1.3 - Dual Eligibility/Entitlement Situations

(Rev. 1, 10-01-03)

B3-3335.4 B3-3335.4.A, A3-3490.5, B3-3336.9, HO-264.5, SNF-335.5, HH-252.5

If an individual also becomes entitled to Medicare based on age 65 or disability, the coordination period continues for the remainder of the 30-months if Medicare was properly the secondary payer at the time of the dual entitlement.

When an individual is eligible for or entitled to Medicare based on ESRD and also entitled on the basis of age or disability, the coordination of benefits is described below.

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

Subsection A below 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

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, 2000. Effective September 1, 2000, 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 February 2003, the 30th month of ESRD-based eligibility, and becomes primary payer beginning March 2003.

EXAMPLE 2

Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 2000 at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 30-month coordination period (July 2000), 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 June 2003, the 30th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer beginning July 2003.

EXAMPLE 3

Mr. E retired at age 62 and maintained GHP coverage as a retiree. In July 2000, he simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 2000) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 2000 through December 2002, the first 30 months of ESRD-based eligibility. Medicare becomes the primary payer beginning January 2003.

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:

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

- 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.

EXAMPLE 1

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 2000. She automatically becomes eligible for Medicare based on ESRD effective January 1, 2001. 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

B3-3335.4

If ESRD-based eligibility or entitlement ceases in accordance with the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 2, "Hospital Insurance and Medical Insurance," §§10.4, Medicare is the primary payer unless plan coverage is in effect by virtue of current employment status, and the provisions of §§10 and 20 or 30 apply.

20.2 - Effect of ESRD MSP on Consolidated Omnibus Budget Reconciliation Act (COBRA)

(Rev. 1, 10-01-03)

B3-3335.5

A - General

The 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 "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 the individual's 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:

- Is required to keep in effect under the COBRA continuation requirements where Medicare entitlement occurs first; or

- 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 above); or

- 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.

30 - Medicare Secondary Payer Provision for Disabled Beneficiaries

(Rev. 1, 10-01-03)

B3-3337, A3-3492 (revised), HO-259.A, B3-3329, SNF-337, HO IM-259, SNF IM-336, HH IM-253

Medicare is secondary payer to "large group health plans" (LGHPs) for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member. (See Chapter 1, §50, for definition.) Under the law, a LGHP may not "take into account" that such an individual is eligible for, or receives, Medicare benefits based on disability. Apply the instructions in chapter 1 in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to a GHP of 20 or more employees, substitute the term "large group health plan" as defined in Chapter 1, §20, to apply them to disabled individuals.

Medicare is secondary payer to LGHP coverage based on an individual's or family members current employment status for services provided on or after August 10, 1993.

30.1 - Items and Services Furnished Prior to October 1, 1998

A - Items and Services Furnished On or After August 10, 1993, and Before October 1, 1998

(Rev. 1, 10-01-03)

B3-3337.1, A3-3492

Under §1862(b)(4) of Social Security Act (the Act), Medicare is secondary payer to LGHP coverage for individuals under age 65 entitled to Medicare based on disability and whose LGHP coverage is based on the individual's current employment status or the

current employment status of a family member. (See §40 for definition of current employment status.) An LGHP may not take into account that such individuals receive benefits based on disability. (See Chapter 1, §70.5, for guidelines pertaining to this prohibition.)

B - Items and Services Furnished On or After January 1, 1987 and Before August 10, 1993

(Rev. 1, 10-01-03)

B3-3337.6, HO-IM 263.4, SNF-IM 337, HH-IM 254

Medicare is secondary payer to LGHP coverage for active individuals under age 65 entitled to Medicare on the basis of disability. The term "active individual" means any of the following:

- An employee;
- An employer (e.g., a proprietor or a partner);
- An individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees), or
- A member of the family of any of these persons, such as the spouse, parent, or child of such an individual.

Medicare is secondary payer under this provision for active individuals entitled to Medicare based on disability who have coverage under an LGHP.

In some cases, the disabled individual may be the employee, employer, or individual associated with the employer in a business relationship. In other cases, the disabled person may be the family member of the employee, employer, or individual associated with the employer in a business relationship. This means that a disabled person who is not an employee, as defined below, but who is covered under an LGHP of a spouse, parent, or any other family member is considered to be an active individual.

For these purposes, an employee is an individual who is actively working for an employer or (since disabled persons are not usually working) a person whose relationship to an employer is indicative of employee status. Whether or not such a person is an employee is established by the unique facts applicable to the person's relationship to the employer. The question to be decided is whether the employer treats a disabled individual who is not working as an employee in light of commonly accepted indicators of employee status rather than whether the person is categorized in any particular way by the employer. In general, an individual who is not actively working may be considered to have employee status if the relationship is such that the:

- Individual is receiving, from an employer, payments which are subject to taxes under FICA or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the Internal Revenue Code;

- Individual is termed an employee under State or Federal law or in accordance with a court decision;

- Employer pays the same taxes for the individual that it pays for actively working employees;

- Individual continues to accrue vacation time or receives vacation pay;

- Individual participates in an employer's benefit plan in which only employees may participate;

- Individual has rights to return to duty if the individual's condition improves; or

- Individual continues to accrue sick leave.

OBRA 93 abolished the concept of "active individual" and replacing it with the definition of "Current Employment Status" discussed in §30.1 of this chapter and Chapter 1, §50.

30.2 - Individuals Not Subject to MSP Provision

(Rev. 1, 10-01-03)

B3-3337.2, A3-3492.C

Medicare is **not** secondary under the MSP for the disabled provision for individuals:

- Who work for employers of fewer than 100 employees unless the GHP is a multi-employer plan in which at least one employer of 100 or more employees participates;

- Covered by an LGHP as a result of past employment (e.g., as a retired former employee or as the spouse of a retired former employee) and whose coverage is not also based on current employment status of their own or a family members current employment status (see Chapter 1, §50); or

- Covered by a health plan other than an LGHP (e.g., one that is purchased by the individual privately and not through an employer).

30.3 - The 100 or More Employees Requirement

(Rev. 1, 10-01-03)

B3-3337.3

- The Medicare as secondary for the disabled provision applies only to LGHPs that cover employees of at least one employer that employed 100 or more full-time and/or part-time employees on 50 percent or more of its business days during the previous calendar year.

- Medicare is secondary for all employees enrolled in the plan if a plan is a multi-employer plan, such as a union plan which covers employees of some small employers and also employees of at least one employer that meets the 100-or-more employee requirement, including those that work for small employers. The exception discussed in §10.4 with respect to the working aged provision does not apply to the Medicare as secondary for the disabled provision. An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on his/her employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 100 regardless of the number of employees who work or who are expected to report for work on that day.

- Self-employed individuals who participate in an LGHP are not counted as employees for purposes of determining if the 100-or-more employee requirement is met. If an employer does not meet the 100-or-more employees requirement in a particular year, the employer may offer employees coverage that is secondary to Medicare during the following year. If the employer meets the 100-or-more employee requirement at any time during the current year, the employer is required to provide employees with coverage that is primary to Medicare during the following year.

30.4 - Disabled Individuals Who Return to Work

(Rev. 1, 10-01-03)

B3-3337.4

If a disabled individual who has LGHP coverage based on prior service to the employer returns to work, the coverage is considered to be by virtue of current employment status if the employer provides coverage to similarly situated individuals who are not disabled. Similarly situated individuals are individuals who work in the same category of employment and who perform the same amount of work. Such services may be based, for example, on the number of hours worked or the amount of earnings.

30.5 - Dually Entitled Individuals

(Rev. 1, 10-01-03)

B3-3337.5

If a disabled individual is also eligible for or entitled to Medicare under the ESRD provisions, follow the rules in §20.1.3 under which Medicare is secondary payer for the applicable 30-month coordination period.

40 - General Effect of Liability Insurance on Medicare Payments

(Rev. 1, 10-01-03)

40.1 - Statutory Provisions

(Rev. 1, 10-01-03)

B3-3340, A3-3418, HO-262, SNF-332, HH-251

Under §1862(b)(1) of the Act, (42 U.S.C. 1395y(b)(1)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan). All Medicare payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan). Medicare is subrogated to the rights of the beneficiary and may also recover its benefits directly from liability insurance companies and self-insured plans, and from any entity, including the beneficiary, that has been paid by a liability insurer. Medicare's right to recover its benefits from liability insurers and from those who have been paid by liability insurers takes precedence over the claims of any other party, including Medicaid.

"Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer to the extent that Medicare has made payments to or on behalf of the beneficiary. Medicare can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer.

The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against a liability insurer that fails to pay primary benefits for services covered by the insurer and to collect double damages.

40.2 - Conflicting Claims by Medicare and Medicaid

(Rev. 1, 10-01-03)

B3-3340, A3-3418, HO-262, SNF-332, HH-251, B3-3340.B, B3-3340.3.C

Under the law, Medicare has the right to recover its benefits from a liability insurer before any other entity, (including a State Medicaid agency) or from any entity that has been paid by a liability insurer. The superiority of Medicare's recovery right over that of other entities including Medicaid derives from the Medicare statute, which provides that where Medicare is secondary to another insurer CMS:

- May recover Medicare benefits from the responsible insurer;
- Is subrogated to the right of the Medicare beneficiary and the right of **any other** entity to payment by the responsible insurer; and
- May recover its payments from **any** entity that has been paid by the responsible insurer.

40.3 - Physician and Supplier Billing Rights and Responsibilities

(Rev. 1, 10-01-03)

B3-3340.3, HO-262.3, SNF-332.3, HH-251.3, B3-3340.3.A, B3-3340.3.B

A - Difference Between Liability Insurance and Other Primary Insurers

Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., automobile medical and no-fault insurance, employer group health plans, and workers' compensation, there is a contractual relationship between the injured party and the third party payer, and a physician or supplier has the right to bill the third party payer.

In the case of liability insurance, unlike the other policies or plans, there is no direct or indirect contractual or quasi-contractual relationship between a physician or supplier and the liability insurer of the alleged tortfeasor. A party alleging injury has a relationship to the liability insurer only through the tortfeasor and must try to prove negligence by the tortfeasor. Physicians and suppliers, in contrast, have no standing to sue the tortfeasor; their relationship is solely to the injured party whom they have furnished Medicare covered services.

B - Services Payable by Liability Insurance Are Considered Covered

The rights and responsibilities of physicians and suppliers regarding services for which liability insurance payments have been made, or can reasonably be expected, are governed by the provisions of §1862(b) (the Medicare secondary provision) and

§1842(b)(3)(B)(ii) (the assignment agreement) of the Act. Section 1862(b) is a limitation of payment provision rather than a noncoverage provision. Therefore, when Medicare is secondary under this provision, the services do not lose their identity as Medicare covered services. If the services were not covered, Medicare could not pay secondary benefits for them. In the case of liability insurance, primary Medicare benefits are paid conditionally and then recovered. Payment could not be made for services (even on a conditional basis) if they were not considered covered services.

Section 1842 prohibits physicians and suppliers who accept assignment from charging a beneficiary or any other person for covered services except to collect applicable deductibles and coinsurance. While §1862(b) requires billing third parties that are primary to Medicare, §1842 does not permit such billing where the billing would take money from the beneficiary, since that would be equivalent to billing the beneficiary for Medicare covered services.

Even without reference to §1842, the right of a physician or supplier who accepts assignment to bill a liability insurer or to file a lien against a beneficiary's liability settlement is quite limited. Section 1862(b)(1) does not allow billing primary payers unless payment can be expected to be made promptly. Since that would rarely occur in liability insurance cases because liability settlements are usually made only after protracted negotiations between the injured party and insurer, in the vast majority of cases Medicare payment could not be limited, and the physician or supplier would be obliged by the assignment agreement to file a Medicare claim on the beneficiary's behalf. In the rare case where payment could be expected to be made promptly under liability insurance and Medicare payment might justifiably be limited, it is a violation of §1842 for a physician or supplier to bill the liability insurer or to file a lien against a beneficiary's liability insurance proceeds. The reason is that either action has the effect of charging the beneficiary for more than the permitted deductibles and coinsurance.

It has that effect because:

- The liability insurer owes nothing to the physician or supplier, neither of whom has rights against the insured (the tortfeasor) or the company from which the insured has bought insurance - the insurer's only obligation is to the beneficiary that has been harmed by the insured; and

- Payment to the physician or supplier directly reduces the amount the beneficiary recovers from the liability insurer.

For the same reasons, a physician or supplier who accepts assignment may not bill a beneficiary who has received a liability insurance payment, except to collect any applicable deductibles and coinsurance. Thus, if a beneficiary has filed or is contemplating a liability claim, it is immaterial to such a physician or supplier whether payment under liability insurance could or could not be expected to be made promptly. In either event, their only recourse is to bill Medicare.

In summary, since services for which Medicare is secondary are covered services, the beneficiary is protected by the assignment agreement, i.e., a physician or supplier that accepts assignment may not bill an insurer or beneficiary for such services, if the effect would be to reduce the amount the beneficiary can recover. That effect could occur when liability insurance is primary. Payment to a physician or supplier by the beneficiary or liability insurer would directly reduce the amount the beneficiary recovers from that insurer.

C - Medicare Must Be Billed

Even though services are needed because of an accident (as defined in Chapter 1, §20), providers, physicians, or suppliers who accept assignment must bill Medicare for conditional primary payments even if it is believed that there is a reasonable likelihood that a liability insurer will pay promptly. However, before billing Medicare for primary benefits, providers, physicians, or suppliers must first attempt to determine whether there are potential primary payers other than a liability insurer, e.g., an automobile no-fault insurer or an employer group health plan. Such payers must be billed before Medicare.

40.3.1 - Physician or Supplier Prohibitions Involving Liability Insurance

(Rev. 1, 10-01-03)

B3-3340.3.D, HO-262.3, SNF-332.3, HH-251.3, B3-3340.3.E, B3-3340.3.F

A - Prohibition Against Billing Liability Insurer

Physicians and suppliers who accept assignment may not bill liability insurers instead of Medicare.

B - Prohibition Against Charging Beneficiary

A physician or supplier who has received assigned benefits may not return the Medicare payment to the carrier and bill full charges to a beneficiary who has received a liability award or settlement. Nor may a physician or supplier who has accepted assignment but not yet received the Medicare payment decline on similar grounds to accept Medicare payment and bill the patient full charges. Under the terms of the assignment, the physician or supplier may bill only for the applicable deductible and coinsurance amounts. The beneficiary's receipt of a liability award or settlement does not permit rescission of the assignment agreement. (See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §30.2.2.D.)

C - Prohibition Against Filing a Lien Against Liability Settlements

A physician or supplier who accepts assignment may not file a lien against a beneficiary's liability insurance proceeds. To do so is tantamount to billing the beneficiary and is a violation of the assignment agreement.

50 - Workers' Compensation (WC)

(Rev. 1, 10-01-03)

B3-2370, A3-3407, A3-IM-3497.3, B3-2340, HO-262.8, HO-289, SNF-280.13, SNF-325, HH-232.14, HH-250

A - General

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation (WC) law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program).

These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, for example:

- Coal miners totally disabled due to pneumoconiosis;
- Maritime workers (with the exception of seamen);
- Employees of companies performing overseas contracts with the United States government;
- Employees of American companies who are injured in an armed conflict;
- Employees paid from nonappropriated Federal funds (such as employees of post-exchanges); and
- Offshore oil field workers.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of

medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory. If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

See Chapter 1, §20, for the definition of a "set aside arrangement" under workers' compensation and its affect on Medicare payments.

50.1 - Effect of Payments Under Workers' Compensation Plan

(Rev. 1, 10-01-03)

B3-2370.2, B3-2370.3, B3-2370.4, B3-2370.5, B3-2370.6, A3-3407.2, A3-IM 3497.3 replaced A3-3407.3, A3- 3407.4, A3-3407.5, A3-3407.6, HO-289.2, SNF-325.2, HH-250.2

No Medicare payment may be made if WC has paid an amount:

- Which equals or exceeds the gross amount payable by Medicare;
- Which equals or exceeds the provider's charges for Medicare covered services; or
- The provider, physician or supplier is either obligated to accept, or voluntarily accepts, a third party payment as full payment.

NOTE: In general, WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for services. In such cases, providers are obligated to accept the WC payment as payment in full, and no secondary Medicare benefits are payable. If WC pays for Medicare covered services **and** under the WC law or plan the provider is not obligated to accept the payment as payment in full, Medicare secondary benefits may be payable as described in Chapter 5, §40.8.1.

A - Secondary Medicare Payments

B3-2370.2.B, A3-3407.3.A, A3-IM-3497.4, HO-289.2, HO-289.3, SNF-325.3, HH-250.3

When a third party payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the third party payment as full payment, then Medicare secondary payment can be made in accordance with Chapter 5, §40.8.1, as appropriate. In general, the Medicare secondary payment is the least of:

- The Medicare gross payable amount minus the amount paid by the TPP for Medicare covered services; or,

- The gross amount payable by Medicare minus the applicable deductible and/or coinsurance amount; or

- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full) minus any applicable deductible or coinsurance amounts; or

- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full), minus the amount paid by the third party payer for Medicare covered services.

NOTE: Medicare uses the amount the provider is obligated to accept as payment in full when:

1. The provider is obligated to accept an amount that is less than its charges (e.g., under the terms of a preferred provider agreement), and

2. The primary payer pays less than charges and less than the amount the provider is obligated to accept as payment in full for reasons other than failure to file a proper claim (e.g., because of the imposition of a primary payer deductible and/or copayment).

In the absence of a lower amount that the provider is obligated to accept as payment in full, the amount of the provider's actual charges is used in determining Medicare's secondary payment.

If WC pays a physician's or supplier's full charges for medical services or pays a lesser amount based on their reasonable charge screen or fee schedule which must be accepted as payment in full, secondary Medicare benefits may not be paid to supplement the amount paid by WC. In addition, the physician or supplier cannot charge the beneficiary or any other party for the services. This is because WC medical benefits constitute a service benefit, i.e., the payment constitutes full discharge of the patient's liability for the services.

B - Workers' Compensation Does Not Pay for All Services

B3-2370.C, A3-3407, HO-289

Where WC does not pay for all services furnished to a beneficiary, Medicare benefits may be paid for those services not covered under WC. For example, the services of a physician not authorized to furnish medical care under WC, may be reimbursed under Medicare. (See §50.1.)

C - Charges Included Non-Work Related Items or Services

A3-3407.3.C

If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work-related (see Chapter 5, §30.2.1), Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare. A physician/supplier is permitted, under WC law, to charge an individual or the individual's insurer for services that are not work related.

D - Workers' Compensation Cases Involving Liability Claims

B3-2370.3, A3-3407.4, HO 289.4, SNF-325.4, HH-250.4

Most State laws provide that, if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. If the individual is covered by a GHP and is age 65 or over, or is eligible or entitled to Medicare based on ESRD and covered by a GHP, or is under age 65 and has LGHP coverage and entitled to Medicare based on disability, the GHP may also be primary to Medicare. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, Medicare is not secondary under this provision, to the extent of the nonpayment or recovery by WC. However, Medicare may be secondary for services covered under the liability insurance provision. Consider these cases under the policies in §§40 and Chapter 7, §§50.8.

E - Possible Coverage of Work Related Services Under Automobile Medical or No-Fault Insurance or Group Health Plan

B3-2370.4, A3-3407.5, HO-289.5, SNF-325.5, HH-250.5

Where services are covered in part by WC and also under automobile medical or no-fault insurance, WC pays first, the automobile medical or no-fault insurance pays second and Medicare would be the residual payer. (See §§60.) If the individual is covered by an GHP and is age 65 or over; or is under age 65 and entitled to Medicare solely because of ESRD, or is entitled as an active individual, including the member of the family of such individual, who is entitled to benefits on the basis of disability, the employer plan coverage may also be primary to Medicare. (See §§10, §§20, and §§30 respectively.)

Accordingly whenever WC pays in part for services, and the physician or supplier does not accept and is not obligated to accept such payment as payment in full, and there is information which indicates that the services may also be reimbursable under automobile

medical or no-fault insurance, or under an employer group health plan, the contractor follows the instructions in the Medicare Secondary Manual (MSP) Manual, Chapter 5, "Contractor Prepayment Processing Requirements," §§40.6, or §10.4.

If there is no coverage under automobile medical or no-fault insurance, but another insurer is shown on the bill, and there is indication of primary GHP coverage under §10, §20, or §30, the other insurer is to be billed for the services not paid for by WC. The other insurer is billed because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is GHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident (see §60) and there is no indication of primary employer group health plan coverage under §10 or §20, Medicare may pay benefits for the services not covered under WC.

F - Workers' Compensation Pays Only for Services of Certain Physicians

B3-2370.5

In some States, physicians' services are covered under WC only if furnished by a physician selected by the employer or the WC carrier or if furnished by a member of a panel of physicians authorized to furnish care in WC cases. In such cases, if the individual engages the services of another physician (for whose services the individual is not entitled to receive WC benefits), Medicare payment for such services is not precluded.

G - Contested Workers' Compensation Claims

B3-2370.6, A3-3407.6, HO-289.6, SNF-325.6, HH-250.6

An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits to an employee by the WC agency. Such appeals are generally heard by a hearing officer or judge of the agency, with further appeal from their decision to the WC agency or appeals board and from there to the courts. Sometimes contested claims are settled by compromise agreement between the parties with the approval of the WC agency.

In general, a decision by a State WC agency on a contested claim, or a compromise settlement that has been approved by the agency should be accepted as a basis for applying the WC exclusion, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, the contractor allows claims for treatment of that condition, unless the decision or settlement is clearly inconsistent with the medical facts and applicable State law and has the effect of shifting to the Medicare program, liability for medical expenses which are the responsibility of the State WC program. Where it is clear that an attempt was made to shift responsibility to the Medicare program, the contractor denies the Medicare claim. The conclusions

should be explained in detail in the denial notice and state that the beneficiary may wish to request a reopening under the WC law.

60 - No-Fault Insurance

(Rev. 1, 10-01-03)

A3-3489, B3-3338, HO-262.8, SNF-334, HH-248

Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, for the items or services under any no-fault insurance (including a self-insured plan). Medicare is secondary to no-fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. If Medicare payments have been made but should not have been, or if the payments were made on a conditional basis in accordance with the Medicare Secondary Manual (MSP) Manual, Chapter 5, "Contractor Prepayment Processing Requirements," §§40.6, they are subject to recovery.

If services are covered under no-fault insurance, that insurer must be billed first. If the insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted in accordance with Chapter 3, §30.3, to supplement the amount paid by the insurer. Medicare can pay for services related to an accident, if benefits are not currently available under the individual's no-fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on non-medical items such as lost wages. Efforts to ascertain coverage under no-fault insurance are subject to the tolerance in Chapter 7.

The question in each case involving accident related medical expenses is whether no-fault benefits can be paid for these particular services. If so, the no-fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save insurance benefits to pay for future services or for non-covered medical services or non-medical services. Since no-fault insurance benefits would be currently available in that situation, they must be used before Medicare can be billed.

If there is an indication that the individual has filed, or intends to file, a liability claim against a party that allegedly caused an injury, the contractor follows Chapter 5, §10.8.1.

A - Effective Dates

A3-3489.A, B3-3338.A

The general rule pertaining to automobile or non-automobile no-fault insurance is that these provisions are effective with respect to injuries that occurred on or after December 5, 1980.

These rules apply to services covered under automobile medical and no-fault insurance furnished on or after June 6, 1983, and services covered under **non**-automobile medical and no-fault insurance furnished on or after November 13, 1989.