Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1943

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter V	4-5 - 4-6 (2 pp.)	4-5 - 4-6 (2 pp.)
3490.1 – 3490.16 (Cont.)	4-565 – 4-573 (9 pp.)	4-565 – 4-579 (15 pp.)
3491.1 - 3492 (Cont.)	4-585 - 4-616 (32 pp.)	4-585 - 4-618 (28 pp.)
3496 – 3496 (Cont.)	4-618.3 – 4-618.5 (3 pp.)	----------

CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: Not Applicable*
IMPLEMENTATION DATE: Not Applicable

THE CHANGES LISTED BELOW DO NOT REQUIRE ANY SYSTEM CHANGES. THE CHANGES ARE INCLUSIVE OF DIRECTIVES ISSUED 1996 AND BEFORE. DIRECTIVES AND PROGRAM MEMORANDUMS ISSUED IN 1997 WILL BE MANUALIZED SHORTLY, BUT REMAIN IN EFFECT.

Section 3490, Limitation on Payment for Services to Individuals Entitled to Benefits on the Basis of ESRD Who Are Covered by GHP's, changes title and EGHP to GHP. This change applies through out this revision. Also, updates the coordination period 12 months to reflect the 30 months coordination period.

Section 3490.1, Definitions, changes the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to TRICARE adds to the end of the paragraph, "If Medicare is secondary payer to more than…..

Section 3490.2, Retroactive Implementation, deletes prior information.

Section 3490.3, Processing Claims, revises E and F and changes 30 month period from 12 month period.

Section 3490.4, Determining the 30-Month Coordination Period During Which Medicare May be Secondary Payer, changes title to "Determining the 12-Month Period During Which Medicare May be Secondary Payer". Also adds the statement, "If Medicare was not the proper primary payer….", adds the bullet 'If the patient undergoes a course of….." Also, adds a statement NOTE; "In the rare case of an untimely application….". Also, adds the statement "When the 30-month period begins before the month….."

Section 3490.5, Effect of Dual Entitlement, changes title from Effect of Changed Basis for Medicare Entitlement. Also this entire section was revised.

Section 3490.6, Subsequent Periods of ESRD Eligibility or Entitlement, changes title from Subsequent Periods of ESRD Entitlement. This section was revised.

Section 3490.7, Amount of Secondary Medicare Payments Where GHP Pays in Part for Items and Services, adds statement of Payment in Full.

Section 3490.11, Limitation on Right of Provider or Facility to Charge a Beneficiary, changes the GHP coverage from 1987 to 2003 and the inpatient deductible from $520 to $840.

Section 3490.12, Responsibility of Providers of Service and Renal Dialysis Facilities, The 30 months period was changed from 12 months.

Section 3490.13, Action When GHP Erroneously Pays Primary Benefits, adds statement "instruct the provider to bill Medicare as primary payer if the Medicare timely filing period has not expired.

Section 3490.14, Referral to RO of Cases Involving Taking into Account Medicare Eligibility or Entitlement and Benefit Differentiation During Coordination Period, changes title from Prohibition Against Taking Into Account Medicare Eligibility or Entitlement and Benefit Differentiation During Coordination Period and explains the nondifferentiation requirement where Medicare is secondary for ESRD beneficiaries.

Section 3490.15, Claimant's Right to Take Legal Action Against an GHP, updated the section to reflect current policy.

Section 3490.16, Medical Services Furnished to ESRD Beneficiaries by Source Outside GHP Managed Care Plan, changes title. The coordination period was changed from 12-month coordination period to 30-month coordination period. Also, changes reference from MSP Regional Data Exchange System to the MSP Auxiliary File.

Section 3491, Limitations on Payment for Services to Aged Beneficiaries Who Are Covered by an GHP on the Basis of Current Employment Status, title changed and reflects the statement of "who are covered by GHPs by virtue of current employment status. (See §3491.2.) A paragraph was also added stating that "Employers are required to offer to their employees age 65 or over…. Followed by another paragraph change that included the statement "Employers may not sponsor or contribute to individual Medigap or Medicare Supplement policies for beneficiaries with current employment status.

Section 3491.1, Definitions, adds the individual is not actively working and is receiving disability benefits from an employer for up to 6 months, adds employers are not required to provide coverage to individuals associated with the employer in a business relationship (including self-employed individuals). Also, adds a NOTE: That the request to exempt is done on a prospective basis.

Section 3491.2, Individuals Subject to Limitation on Payment, General, was revised with the current definition of age 65.

Section 3491.3, Individuals Not Subject to the Limitation on Payment, revisions are contained throughout the entire section.

Section 3491.4, Identification of Cases by Providers of Services, revised to explain how providers are trying to determine whether to bill a GHP as primary payer.

Section 3491.5, Identification of Cases and Action Where There is Indication of Possible GHP Coverage, title change. Also, this section was revised to state §3686 for development of claims where there may be other payer involvement.

Section 3491.6, Action by Providers Where Medicare is Secondary to GHP, adds the statement of payment in full.

Section 3491.7, Limitation on Right of Provider or Facility to Charge a Beneficiary, updated the example to reflect the current deductible amount.

Section 3491.9, Employer Plan Denies Claim for Primary Benefits, revised to include the single employer GHP or a multiple employer plan.

Section 3491.10, Referral of Cases to RO, adds items and services covered by the GHP for this individual., and adds the RO advises officials contacted of Medicare rights to recover from any parties.

Section 3491.13, Recovery of Mistaken Primary Medicare Payments, title change. Also, revised to show current processes.

Section 3491.14, Advice to Providers, Physicians, and Beneficiaries, revised to include where there is primary GHP coverage.

Section 3491.15, Mistaken GHP Primary Payments, title change and revisions throughout the section.

Section 3492.16, Claimant's Right to Take Legal Action Against a GHP, corrects typographical error in previous manual.

Section 3491.17, Special Rules for Services Furnished by Source Outside GHP Managed Care Health Plan, title change. Also, the period of up to 30 months was changed from 12 months.

Section 3492, Medicare as Secondary Payer for Disabled Individuals, the LGHP coverage was redefined. Also, this section was revised to reflect current employment status for services provided on or after August 10, 1993, and to include individual policies (including Medigap policies). The definition of LGHP was revised.

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

These instructions should be implemented within your current operating budget.

CHAPTER V
SPECIAL PROVISIONS RELATED TO PAYMENT

Section

No-Fault Insurance

Services Reimbursable Under No-Fault Insurance 3489
Definitions 3489.1
Provider Actions 3489.2
Processing of Claims Indicating Possibility of Payments Under No-Fault Insurance 3489.3
No-Fault Insurance Does Not Pay All Charges Because of Deductible or Coinsurance Provision in Policy 3489.4
State Law or Contract Provides That No-Fault Insurance Is Secondary to Other Insurance 3489.5
Services Covered Under No-Fault Insurance and Liability Claim Also Filed 3489.6
Allocation of Recovered Medicare Payments 3489.7
Provider's and Beneficiary's Responsibility With Respect to No-Fault Insurance 3489.8
Claimant's Right to Take Legal Action Against No-Fault Insurer 3489.9

Limitation on Payment for Services to ESRD Beneficiaries

Limitation on Payment for Services to Individuals Entitled to Benefits on the Basis of ESRD Who Are Covered by GHPs 3490
Definitions 3490.1
Retroactive Implementation 3490.2
Processing Claims 3490.3
Determining the 30-Month Coordination Period During Which Medicare May be Secondary Payer 3490.4
Effect of Dual Entitlement 3490.5
Subsequent Periods of ESRD Eligibility or Entitlement 3490.6
Amount of Secondary Medicare Payments Where GHP Pays in Part for Items and Services 3490.7
GHP Pays in Full 3490.8
Effect of Secondary Payments on Part A Utilization 3490.9
Effect of GHP Payments on Deductible and Coinsurance 3490.10
Limitation on Right of Provider or Facility to Charge a Beneficiary 3490.11
Responsibility of Providers of Services and Renal Dialysis Facilities 3490.12
Action When GHP Erroneously Pays Primary Benefits 3490.13
Referral to RO of Cases Involving Taking into Account Medicare Eligibility or Entitlement and Benefit Differentiation During Coordination Period 3490.14
Claimant's Right to Take Legal Action Against a GHP. 3490.15
Medical Services Furnished to ESRD Beneficiaries by Source Outside GHP Managed Care Plan 3490.16

Limitation on Payment for Services to Aged Beneficiaries

Limitations on Payment for Services to Aged Beneficiaries Who Are Covered by a GHP on the Basis of Current Employment Status 3491
Definitions 3491.1
Individuals Subject to Limitation on Payment 3491.2
Individuals Not Subject to the Limitation on Payment 3491.3

Section

Identification of Cases by Providers of Services 3491.4
Identification of Cases and Action Where There Is Indication of Possible GHP Coverage 3491.5
Action by Providers Where Medicare Is Secondary to GHP 3491.6
Limitation on Right of Provider or Facility to Charge a Beneficiary 3491.7
Effect of GHP Payments on Deductible and Coinsurance 3491.8
Employer Plan Denies Claim for Primary Benefits 3491.9
Referral of Cases to RO 3491.10
Amount of Secondary Medicare Payments Where GHP Pays in Part for Items and Services 3491.11
Effect of Secondary Payments on Part A Utilization 3491.12
Recovery of Mistaken Primary Medicare Payments 3491.13
Advice to Providers, Physicians, and Beneficiaries 3491.14
Mistaken GHP Primary Payments 3491.15
Claimant's Right to Take Legal Action Against a GHP 3491.16
Special Rules For Services Furnished By Source Outside GHP Managed Care Health Plan 3491.17

Medicare as Secondary Payer for Disabled Individuals

Medicare as Secondary Payer for Disabled Individuals 3492
Federal Government's Right to Sue and Collect Double Damages 3495
Excise Tax Penalties for Contributors to Nonconforming Group Health Plans 3496

Telehealth Services

Payment for Medicare Telehealth Services 3497

Limitation on Payment for Services to ESRD Beneficiaries

3490. LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS ON THE BASIS OF ESRD WHO ARE COVERED BY GHPs

Medicare benefits are secondary to benefits payable under a GHP in the case of individuals eligible for or entitled to benefits on the basis of ESRD (see §3001.3), during a period of up to 30 months if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD. (See §§3490.4 and 3490.5.) Medicare is secondary during the period even though the employer's policy or plan contains a provision stating that its benefits are secondary to Medicare or otherwise excludes, or limits its payments to Medicare beneficiaries.

Pay secondary benefits in accordance with §3490.7 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. (See §3178.5.) Consider this limitation when processing claims for items or services furnished to ESRD beneficiaries who are in their 30-months of eligibility or entitlement on the basis of ESRD.

In these instructions, the term provider includes dialysis facilities and other facilities which provide Medicare covered services.

3490.1 Definitions.--

A. Employer.--The term "employer" means, not only individuals and organizations engaged in a trade or business, but organizations exempt from income tax, such as religious, charitable, and educational institutions as well as the governments of the United States, the individual States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands and the District of Columbia, including their agencies, instrumentalities and political subdivisions. For purposes of the ESRD secondary payer provision the term "employer" is defined without regard to the number of employees.

B. Employer Group Health Plan or Employer Plan.--This means any health plan that is of, or contributed to by, an employer; and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, and/or their families. It includes the Federal employees health benefits program but not TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). "Employee pay all" plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition. Individual policies (including Medigap policies) purchased by or through an employee organization, employer or former employer of the individual or family member of the individual are considered employee offered GHPs.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of current or former employment of the beneficiary or of a member of the beneficiary's family meets this definition.

C. Secondary--The term "secondary," when used with respect to Medicare payment, means that Medicare is the residual payer to all GHPs under which the Medicare beneficiary is covered and will not pay for expenses that are reimbursable by any such plan. Consider the WC exclusion (§3407) and no fault and liability insurance provisions (§§3419 and 3489) in determining the extent of Medicare's liability as a residual payer. If Medicare is secondary payer to more than one primary insurer, e.g., an individual covered under his own GHP as well as under the GHP of his spouse or under automobile insurance, the other primary payer(s) will customarily coordinate benefits.

Medicare secondary payment is made only after all primary payers have made proper primary payments.

D. Coordination Period--The term "coordination period" means a period of up to 30 months determined in accordance with §§3490.4 and 3490.5 during which Medicare benefits are secondary to benefits payable under GHPs.

3490.2 Retroactive Implementation.--If cases come to your attention in which you paid primary benefits for services rendered during a coordination period and GHP benefits may be payable, send an ECRS MSP inquiry to the COBC for initial or additional development.

3490.3 Processing Claims.--

A. Provider Bills Medicare for Primary Benefits.--Where the provider has indicated Medicare as the primary payer in accordance with §3681A, assume in the absence of evidence to the contrary, that it has correctly determined that there is no primary GHP coverage and process the claim. Pay primary Medicare benefits only if the services were not rendered during a coordination period, or if the GHP denies a claim because the beneficiary is not entitled to benefits under the plan, or benefits under the plan are exhausted for the particular services, or the services are not covered by the GHP, and the beneficiary is not appealing the GHP denial. Do not pay primary benefits if you have reason to believe that the GHP covers the services. (See subsection F.) If you pay primary Medicare benefits and later learn that the beneficiary is appealing the GHP denial, treat the payment as a conditional primary payment and take action in accordance with subsection E.

If you believe that a GHP may be the primary payer, return the bill to the provider with the information you have. Ask the provider to ascertain whether primary GHP benefits are payable, and if so, to bill for primary benefits. Instruct the provider that if a GHP has denied its claim for primary benefits, the provider must annotate Item 84 "Remarks" of the Medicare claim form with the reason for the denial and enter occurrence code 24 and the date of denial in Items 32 - 35. No attachment is needed.

A GHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on you. Evaluate claims under existing guidelines to assure that the services are covered by the program regardless of any GHP involvement.

Refer to subsections E and F if the claim is for conditional primary Medicare benefits.

B. Medicare Claim is for Secondary Benefits.--Where a GHP has paid primary benefits, and Medicare is billed for secondary benefits, calculate the amount payable in accordance with §3490.7.

If a GHP payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare (as defined in §3490.7A) in the absence of GHP payment, and the provider does not accept and is not obligated to accept the plan's payment as payment in full, determine the amount of secondary Medicare benefits due in accordance with §3490.7. In this situation, and where the employer plan paid an amount which equals or exceeds the amount that Medicare would have paid in the absence of GHP payment, follow the instructions in §3681 for processing claims from providers on cost reimbursement, and §3685 for providers on prospective payment.

C. Intermediary File On Cases in Which Medicare May Be Secondary.--Based upon the information you obtain from providers and renal dialysis facilities in accordance with §3490.l2A, from other contractors, or from your own development, maintain a file containing information concerning ESRD beneficiaries on whose behalf claims have been filed. Include the first and last months of the 30-month period, whether the individual is covered by a GHP during that period, and, if so, its name and address. If this information is not available, request the provider to obtain it.

D. GHP Claims That Its Benefits Are Secondary to Medicare's.--If a provider bills a GHP and the plan refuses to pay primary benefits because it claims that its benefits are secondary to Medicare's, do not pay conditional benefits. Refer the case to the RO in accordance with subsection G. If you have paid conditional benefits in such a case, seek recovery in accordance with subsection G.

E. Conditional Primary Medicare Benefits.--Conditional primary Medicare benefits may be paid if (1) the beneficiary has appealed or is protesting the GHP denial of the claim for any reason other than that the GHP offers only secondary coverage of services covered by Medicare, or (2) the GHP denied the claim because the time limit for filing the claim with the GHP has expired (whether appealed or not). Before making a conditional primary payment in cases involving appealed or protested claims, notify the GHP and the beneficiary that the payment is being made on condition that both the insurer and the beneficiary are responsible for reimbursing the program up to the amount it has paid, if the GHP subsequently approves the claim. Also notify the GHP that if it pays the beneficiary, it is still liable to reimburse Medicare for the amount of the conditional benefits (up to the GHP primary payment). (However, your failure to notify the parties does not relieve them of the obligation to refund the payment.) Follow up periodically with the insurer to determine the outcome of the disputed claim. If the GHP allows the claim, recover the Medicare payment directly from the GHP. (See subsection G.) Where a GHP has denied payment because its claim filing deadline has expired, promptly notify the GHP that it must reimburse Medicare the amount of conditional benefits Medicare paid. Follow the recovery instructions in subsection G.

F. When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable.--Neither primary nor conditional primary Medicare payments may be made where a GHP denies payment for particular services on the grounds that they are not covered by the plan, and you have reason to believe the plan does cover the services. Do not pay conditional benefits if a plan offers only secondary coverage of services covered by Medicare. Conditional primary benefits may not be paid in this situation even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, reject the claim for Medicare primary benefits.

G. Recovery of Mistaken Primary Medicare Benefits.--Follow the recovery instructions at §3491.13.

3490.4 Determining the 30-Month Coordination Period During Which Medicare May Be Secondary Payer.-- 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 §3001.3A 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, contact the SSO.

When the 30-month period begins before the month the individual becomes eligible for or entitled to Medicare, pay secondary benefits for the portion of the period during which the individual is eligible or entitled. The latter is the coordination period (see §3490.1D). Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis.

3490.5 Effect of Dual Entitlement.--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.

3490.6 Subsequent Periods of ESRD Eligibility or Entitlement.--If an individual has more than one period of eligibility or entitlement based solely on ESRD, a coordination period is determined for each period in accordance with §§3490.4 and 3490.5.

3490.7 Amount of Secondary Medicare Payments Where GHP Pays In Part for Items and Services.--

A. General.--If a GHP's payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare (as defined below), and the provider does not accept, and is not obligated to accept, the payment as payment in full, Medicare secondary payment can be made. "Payment in full is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation."

The Medicare secondary payment is the lower of:

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

- The gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is:

- The current Medicare interim reimbursement amount (as defined in §3683) for providers reimbursed on a reasonable cost basis;

- The Medicare payment rate (as defined in §3685) for providers reimbursed on a prospective payment basis;

- The composite rate for maintenance dialysis services;

- The reasonable charge for separately billable items furnished by independent renal dialysis facilities (see §3644.1).

The gross amount payable by Medicare includes applicable deductible and coinsurance amounts. If a provider furnishes services that are reimbursable under more than one payment method (e.g., composite rate for dialysis treatments and reasonable cost for separately billable items associated with dialysis) the gross amount payable is the combined amount of Medicare reimbursement for the services (without regard to the effect of the deductible or coinsurance or the payment by the GHP). For detailed billing and reimbursement instructions, see §3681 (for reasonable cost reimbursement) and §3685 (for prospective payment).

B. Special Rules for Dialysis Equipment for Which Medicare Paid the Full Reasonable Cost.- Where a provider or renal dialysis facility is paid its full reasonable costs for the purchase of dialysis equipment pursuant to an agreement with CMS, instruct it to bill the GHP based on the usual rates in the area for the same or similar equipment. Any amounts received from the GHP should be refunded to you or used to adjust future payment as you determine to be appropriate. There is no secondary Medicare payment because Medicare has paid the provider or facility 100 percent of its reasonable costs for the equipment. (The 100 percent reimbursement option for dialysis equipment is no longer in effect. However, any equipment already purchased under a full reasonable cost reimbursement agreement will be handled under the pertinent regulations and terms of the agreement.)

3490.8 GHP Pays in Full.--If a GHP's payment for Medicare covered services equals or exceeds the provider's charges for those services or the gross amount payable by Medicare (as defined in §3490.7A), or if the provider accepts or is obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the GHP's payment over the gross amount payable by Medicare is not subtracted from the provider's Medicare reimbursement. The provider submits a no payment bill in accordance with §3681 or §3685 as appropriate.

3490.9 Effect of Secondary Payments on Part A Utilization.--Where no Medicare secondary benefit is payable, no utilization is charged the beneficiary. Where a Medicare secondary payment is made, charge the beneficiary with utilization in accordance with §3681C3 for providers reimbursed on a reasonable cost basis or §3685A3 for providers reimbursed on a prospective payment basis. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

3490.10 Effect of GHP Payments On Deductible and Coinsurance.--GHP payments are credited to the Part A and Part B deductible amounts. Thus, expenses that would be credited to a beneficiary's Part A or Part B cash or blood deductibles if Medicare were primary payer, are credited to the deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no Medicare benefit payable. GHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance. (See §3681.)

3490.11 Limitation on Right of Provider or Facility to Charge a Beneficiary.--A provider of services, renal dialysis facility or other facility that receives direct payment from the Medicare program may not charge a beneficiary or any other party, other than an insurer that is primary under §1862(b) of the Act, for Medicare covered services, if it has been or could be paid by a GHP at least an amount equal to any applicable deductible or coinsurance. This limitation applies to situations where an insurer is primary under §1862(b) but offers only secondary benefits.

EXAMPLE: A Medicare beneficiary with GHP coverage was a hospital inpatient for 20 days in 2003. The hospital's charges for Medicare covered services were $5,000. The inpatient deductible had not been met. The gross amount payable by Medicare for the stay in the absence of GHP coverage is $4,000. The employer plan paid $4,500, $840 of which was credited to the inpatient deductible. Medicare will make no payment, since the plan's payment was greater than the gross amount payable by Medicare of $4,000. No part of the $500 difference between the hospital's charges and the employer plan's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the employer plan's payment. The provider files a no-payment bill reflecting a fully satisfied deductible.

3490.12 Responsibility of Providers of Service and Renal Dialysis Facilities.--

A. Identification of Cases in Which Medicare May be Secondary to GHPs .--Providers of services investigate cases in which information available to them (e.g., the beneficiary's Medicare card) indicates that the beneficiary is eligible for or entitled to Medicare based on ESRD for 30-months or less at the time the services were rendered. They ascertain whether the services were rendered during the 30-month period described in §§3490.4 and 3490.5. Providers determine whether the services were rendered in the 30-month period by checking their own records; e.g., information contained on Form CMS- 2728 or, if the potential Medicare payment is $50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant). If the individual is in the 30-month period, the provider asks the beneficiary if he/she is insured under any health insurance plan which provides coverage through the employer or through a union. If the response is yes, the provider asks for the name and address of the plan and the beneficiary's identification number.

If the information obtained does not indicate GHP coverage, the provider annotates the bill to that effect (e.g., GHP coverage lapsed, benefits exhausted). If the information indicates that GHP coverage exists, the provider obtains the information indicated above from the beneficiary or the beneficiary's representative.

B. Action by Provider Where Medicare May be Secondary to GHP.--

1. Submittal of Bill for Primary Benefits to GHP.--If providers determine, based on their development, conducted in accordance with subsection A , that Medicare may be secondary to a GHP, they must bill the GHP for primary benefits. When a provider bills a GHP as primary payer, the bill itemizes the services rendered even though they are services for which Medicare reimburses on a composite rate basis.

2. Submittal of Bill to Medicare After GHP Has Processed Claim.--After a GHP has processed a claim for primary benefits, the provider submits a bill for secondary payment or a no payment bill as appropriate, in accordance with §3681 for providers reimbursed on a reasonable cost basis, or §3685 for providers reimbursed on a prospective payment basis. If a GHP denies a claim for primary benefits, the provider submits a bill for conditional primary benefits with an explanation of any reason given by the plan for its denial, in accordance with §3681A.

3490.13 Action When GHP Erroneously Pays Primary Benefits.--Cases may come to your attention where a GHP has inappropriately paid primary benefits. In such cases, advise the party who calls this to your attention, that the GHP may bill Medicare as primary payer if the Medicare timely filing period has not expired.

3490.14 Referral to RO of Cases Involving 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.

The following are examples of potential taking into account the Medicare eligibility or entitlement of ESRD patients:

- The plan does not cover routine maintenance dialysis services or kidney transplants;

- The plan excludes benefits, makes itself secondary to government benefits, or charges a higher premium for individuals with ESRD;

- The plan imposes limitations on benefits for persons with ESRD which are not applicable to others , e.g., a higher deductible or coinsurance, a longer waiting period or a lower annual or lifetime benefit limit.

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 enrolled 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. 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.

3490.15 Claimant's Right to Take Legal Action Against a GHP.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against, and to collect double damages from, a GHP that fails to pay primary benefits for services covered by it where required to do so under §1862(b) of the Act.

3490.16 Medical Services Furnished to ESRD Beneficiaries by Source Outside GHP Managed Care Plan.--

A. Services By Outside Sources Not Covered.--If an ESRD beneficiary is in a 30-month coordination period as defined in §3490.4 and is enrolled in an employer sponsored managed care health plan (e.g., health maintenance organization (HMO)/competitive medical plan (CMP)), Medicare does not pay for services obtained from a source outside the managed care employer health plan if:

o The same type of services could have been obtained as covered services through the managed care GHP, or

o The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded under these circumstances even if the individual receives services outside of the managed care health plan's service area, e.g., while the individual is away from home. At the time of admission, providers are to ask beneficiaries that are enrolled in GHPs whether the plan is a managed care health plan. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required per §§3624 and 3679B.) Any request for payment is made to the GHP.

NOTE: This restriction only affects Medicare beneficiaries enrolled in employer sponsored managed care health plans which either do not have a Medicare contract or have a Medicare cost contract. Beneficiaries in HMO/CMPs that have Medicare risk contracts are not affected because beneficiaries enrolled in a risk-basis HMO/CMP are locked into the plan in all instances except for emergency or urgently needed services.

B. Exception.--If a beneficiary obtains services from a source outside the managed care GHP, and has not yet been notified in writing of this special rule, Medicare pays for the services, provided the plan will not pay for legitimate reasons. In general, it is assumed that written notification has not been given in the absence of evidence to the contrary, e.g., your internal system indicates that the beneficiary is a working aged, ESRD, or disabled beneficiary who belongs to a managed care GHP and that the beneficiary has been notified that Medicare will not pay. (See subsection C.) Where payment is made for services from a source outside the managed care health plan, the Medicare Benefits Notice (CMS-1533), or the EOMB, where applicable, states:

"Our records show that you are a member of an employer sponsored managed care health plan. Since Medicare is secondary payer for you, 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 non-plan services which could have been obtained from or through the managed care health plan."

C. Notice to Beneficiary.--Deny any bills received for Medicare payment from, or on behalf of, a beneficiary enrolled in a GHP managed care Health Plan who has previously been notified in writing. Advise that the reason for the denial is that Medicare's records show that you are a member of an employer sponsored managed care health plan. Because Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from, or through, the managed care health plan are not payable. Medicare's records show that you were previously informed of this rule. Therefore, payment cannot be made for the non-plan services you received.

LIMITATION ON PAYMENT FOR SERVICES TO AGED BENEFICIARIES

3491. LIMITATIONS ON PAYMENT FOR SERVICES TO AGED BENEFICIARIES WHO ARE COVERED BY AN GHP ON THE BASIS OF CURRENT EMPLOYMENT STATUS

If Medicare mistakenly made primary payment for services furnished by virtue of current employment status to an individual who meets the criteria in §3491.2, recover the mistaken Medicare payment in accordance with §3491.13. Billing instructions are in §3682 for providers reimbursed on a cost reimbursement basis and in §3685 for hospitals reimbursed on a prospective payment basis.

In general, providers are instructed that, where an individual meets the criteria in §3491.2, they should bill the GHP first and, 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, Medicare secondary benefits may be payable in accordance with §3491.11.

Employers are required 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, i.e., coverage that is primary to Medicare. This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

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 for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries with current employment status.

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in §3491.12, to supplement the amount it paid for the Medicare covered service. 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 you. Evaluate claims under existing guidelines derived from the law and regulations to assure that services are covered by the program regardless of any employer plan involvement.

3491.1 Definitions.--

A. Employer.--The term "employer" means not only individuals and organizations engaged in a trade or business, but also organizations exempt from income tax, such as religious, charitable, and educational institutions. Included are the governments of the United States, the individual States, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, Puerto Rico and the District of Columbia.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. 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. Self-employed individuals who participate in an employer plan are not counted as employees in determining if the 20 or more employees requirement is met. Where an employer does not have 20 or more employees in the preceding year, he is required to offer his employees and spouses age 65 or over, primary coverage when he 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 subsequently drops below 20.

The "20 or more employees" requirement must be met when 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 employer plan.

Employers are not required to provide coverage to individuals associated with the employer in a business relationship (including self-employed individuals). However, any coverage provided to such individual age 65 or older and age 65 or older spouses of such individuals of any age, by an employer of 20 or more employees must be the same as coverage provided to younger such individuals, that is coverage primary to Medicare. The employer must also provide primary coverage to older such individuals even if there are no younger such individuals enrolled in the plan.

Assume for developing claims and the requirement that GHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. Refer an employer's allegation that the 20-employee requirement is not met to the COB contractor.

Refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of fewer than 20 employees, as a basis for making Medicare primary payer, to the contractor in the State in which the multi-employer plan is located for development as a prospective exemption request.

NOTE: That the request to exempt is done on a prospective basis.

B. Current Employment Status.--

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

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

b. The individual is not actively working and is receiving disability benefits from an employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or not actively working but meets all of the following conditions:

- o Retains employment rights in the industry;
- o 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;

o Is not receiving disability benefits from an employer for more than 6 months;

o Is not receiving Social Security disability benefits; and

o Has employment-based GHP coverage that is not COBRA continuation coverage. (See 29 U.S.C. 1161-1168.)

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

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

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

b. 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.)

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

a. 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

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

4. 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:

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

b. 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.

5. 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 with the religious order if the services he/she performs as a member of the order are considered employment by the order for Social Security purposes only. This is because the religious order elected Social Security coverage for its members under §3121(r) of the Internal Revenue Member of Religious Order Code. Thus, Medicare is the primary payer to any group health plan coverage provided by the religious order.

This exception applies only to members of religious orders who have taken a vow of poverty. It does not apply to clergy or to any member of a religious order who has not taken a vow of poverty or to lay employees of the order. This exception applies not only to services performed for the order itself (such as administrative, housekeeping, and religious services), but also to services performed at the direction of the order for employers outside of the order provided that the outside employer does

not provide the member of the religious order with its own group health plan coverage. A member of a religious order has current employment status with the outside employer as a result of providing services on behalf of the outside employer (an ongoing business relationship exists). If the outside employer provides group health plan coverage to the member of the religious order on the basis of that current employment status relationship, the usual Medicare Secondary Payer rules apply.

Medicare is the secondary payer to the group health plan of the outside employer if the outside employer has the requisite number of employees.

EXAMPLE: Sister Mary Agnes is a member of a religious order where members are required to take a vow of poverty. Sister Mary Agnes was assigned to teach at a church school in the Diocese of Metropolis. The Diocese does not provide group health plan coverage to Sister Mary Agnes. The only group health coverage available to Sister Mary Agnes is provided by the religious order. Medicare is the primary payer for services provided to sister Mary Agnes.

EXAMPLE: Sister Mary Teresa is a member of a religious order whose members are required to take a vow of poverty. Sister Mary Teresa was assigned to teach at a church school in the Diocese of Smallville. On the basis of her teaching relationship with the Diocese of Smallville, the Diocese provides group health plan coverage to sister Mary Teresa. The group health plan provided by the Diocese of Smallville is the primary payer and Medicare is the secondary payer for services provided to sister Mary Teresa.

Carriers should note that the exemption only applies to the working aged and disability provisions that base a group health plan's obligation to be a primary payer, on a current employment status relationship. The exception does not apply to the ESRD, workers' compensation or liability and no-fault provisions.

6. Insurance Agents.--Apply the following guidelines in determining the status of insurance agents.

o A self-employed insurance agent is considered to have coverage based on current employment status if the agent: (1) has an "active agent" relationship with the company; or (2) has a "retired agent" relationship with the company and has reached the "earning threshold" of $400 or more pursuant to §211(b) of the Act. The fact that a self-employed insurance agent is authorized to represent the company; e.g., to write policies on behalf of the company, does not itself imply current employment status.

7. Senior Federal Judges.--Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the remuneration they receive as senior judges is not considered wages for Social Security retirement offset purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the working aged and disability provisions.

8. Volunteers.--Volunteers are not considered to have current employment status unless they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) of the Act, VISTA volunteers are considered to have current employment status since they receive remuneration from the Federal Government. Also, remuneration may be of a monetary or non-monetary nature. Benefits, including health benefits, that a volunteer receives, is considered to be remuneration.

9. Directors of Corporations.--Directors of corporations (i.e., persons serving on a Board of Directors of a corporation who are not officers of the corporation) are self- employed. (Officers of a corporation are employees.) Directors who receive remuneration for serving on a board are considered to have current employment status. Remuneration may be of a monetary or non-monetary nature. Benefits, including health benefits, that a corporation provides to a board member is considered to be remuneration.

Directors who receive no remuneration for serving on the Board (unpaid directors) are not considered to have current employment status. However, remuneration may consist of deferred compensation (i.e., amounts earned but not payable until some future date usually when the individual reaches age 70 and is no longer subject to the Social Security retirement test). A director receiving deferred compensation is considered to have current employment status only while he/she is serving as a director. (See subsection K.)

C. Plan.--The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to employees. An arrangement by more than one employer is a single plan if the arrangement provides for common administration of the health benefits, for example, by the employers directly, by a benefit administrator, by a multi-employer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

D. Group Health Plan or (GHP).--These terms mean any health plan (including individual Medigap policies) that is of, or contributed to by, an employer of 20 or more employees which provides medical care, directly or through other methods such as insurance or reimbursement, to current or former employees, or to current or former employees and their families. This includes a multi-employer group health plan that has at least one employer with 20 or more employees.

The Federal employees health benefits program meets the definition of a GHP. Employee-pay-all plans, i.e., group health plans which are under the auspices of an employer and which do not receive any contributions from the employer, also meet the definition of GHP. Coverage by TRICARE is not considered to meet the definition of a GHP.

Assume, in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the beneficiary's spouse's employment, meets this definition.

E. Secondary.--The term "secondary" with respect to Medicare payment, means that Medicare is the residual payer to all GHPs under which the Medicare beneficiary is covered by reason of current employment status and will not pay for any expenses reimbursable by any such plan(s). Consider the workers' compensation and automobile and liability insurance exclusions (§§3407-3416, 3419, and 3489) in appropriate cases in determining the extent of Medicare's payment obligations.

(Also refer to §3491.6C regarding claims in which there is a GHP and another primary and/or secondary payer involved, e.g., a GHP, an automobile insurer and a retirement plan.)

F. Age 65 or Older.--An individual attains age 65 on the day preceding his or her 65th birthday.

G. Spouse.--Means any individual who has spousal coverage under the employer plan.

3491.2 Individuals Subject to Limitation on Payment.--

A. General.--Medicare is secondary payer for Part A and Part B benefits under this provision for an individual who:

o Is age 65 or over,

o 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

o Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

B. 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.

3491.3 Individuals Not Subject to the Limitation on Payment.--This Medicare secondary provision does not apply to:

o Individuals entitled, or who could upon application become entitled, to Medicare under the ESRD provisions, i.e., individuals who meet the requirements for ESRD entitlement even though their current Medicare entitlement is on the basis of age 65 if Medicare was properly the primary payer prior to eligibility for Medicare due to ESRD.

o Individuals enrolled in Part B only.

o Individuals enrolled in Part A on the basis of a monthly premium.

o 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.)

o Individuals covered by a health plan other than a 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.

o Employees of employers of fewer than 20 employees who are covered by a single employer plan.

o 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.

o 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.

3491.4 Identification of Cases by Providers of Services.--To obtain the information needed to ascertain whether to bill a GHP as primary payer, providers ask beneficiaries age 65 or over admitted for inpatient care or receiving outpatient care, or their representatives, selected questions. These include but are not limited to the age of the beneficiary, the employment status of the beneficiary and the spouse, whether the beneficiary is covered under a GHP because of the beneficiary's or the spouse's current employment, and the patient's identification number and the name and address of the GHP.

3491.5 Identification of Cases and Action Where There Is Indication of Possible GHP Coverage.--See §3686 for development of claims where there may be other payer involvement.

3491.6 Action by Providers Where Medicare Is Secondary to GHP.--

A. General.--Providers are obligated to seek payment from the GHP before billing Medicare when there is an indication that a GHP is primary payer, i.e., where the services were rendered to an individual who meets the criteria in §3491.2, and there is no evidence that the definitions in §3491.1 are not met. They bill the GHP as primary payer even where there may be GHP coverage for only part of the stay (e.g., split stays where the beneficiary terminated employment during the stay and GHP coverage terminated concurrently).

B. Submittal of Bill to Medicare After Employer Plan Has Made Payment.--If a GHP pays primary benefits, secondary Medicare benefits may be payable in accordance with §3491.11 to supplement the amount paid by the GHP. If the GHP primary payment for a particular stay or particular services is less than the provider's charges for Medicare covered services, and is less than the gross amount payable by Medicare (as defined in §3491.12) and the provider does not accept and is not obligated to accept the GHP payment as payment in full, the provider submits a bill for secondary benefits in accordance with §3682 or §3685 as appropriate. "Payment in full is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation."

If the GHP's payment equals or exceeds the gross amount payable by Medicare (as defined in §3491.11), or equals or exceeds the provider's charges for Medicare covered services or the provider accepts or is obligated to accept the GHP payment as payment in full, it submits a no payment bill in accordance with §3682 or §3685 as appropriate.

Any excess of the GHP payment over the gross amount payable by Medicare is not subtracted from the provider's Medicare reimbursement at final cost settlement. If the GHP denies a provider's claim for primary benefits, the provider submits a claim for primary Medicare benefits or conditional primary benefits as provided for in §3491.9.

C. Multiple Insurers.--There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual who meets the criteria in §3491.2 is covered under his own GHP and under the GHP of an employed spouse who meets the criteria in §3491.2 or under automobile insurance. In such cases, the other primary payers customarily coordinate benefits. If a portion of the charges remains unpaid after the other insurers have paid primary payments, a secondary Medicare payment may be made.

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain GHPs for individuals and spouses age 65 or over. Therefore, where the individual has GHP coverage based on

current employment status in addition to GHP coverage as a retiree, Medicare is secondary to the GHP coverage based on current employment status and primary to the GHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

Where a plan's payment would normally be secondary to Medicare, but under coordination of benefit provisions, the payment is primary to a primary payer under §1862(b), the combined payment of both plans constitutes the primary payment to which Medicare is secondary.

EXAMPLE: John Jones, age 67, is a Medicare beneficiary with coverage under Part A and Part B. He retired from the Acme Tool Company in 1986 and received retirement health insurance coverage which is secondary to Medicare. His wife Mary, age 62, has been employed continuously with the local police department since 1960 and since that time has received coverage for herself and her husband under the department's GHP. The priority of payment for John's medical expenses is as follows:

- o The employed spouse's GHP is primary payer.
- o Medicare is secondary payer.
- o The retirement plan is either tertiary payer or the retirement plan may choose to coordinate benefits with the employed spouse's GHP so that the combined benefit of the two plans is primary to Medicare.

3491.7 Limitation on Right of Provider or Facility to Charge a Beneficiary.--A participating provider or any other facility that receives direct payment from the Medicare program may not charge a beneficiary or any other party other than an insurer which is primary under §1862(b) of the Act for Medicare covered services if the provider or facility has been paid or could have been paid by a GHP an amount which equals or exceeds any applicable deductible or coinsurance amount. This applies where an insurer is made primary under §1862(b) but offers only secondary benefits.

EXAMPLE: A Medicare beneficiary who had GHP coverage was hospitalized for 20 days in 1997. The hospital's charges for covered services were $5000. The inpatient deductible had not been met. The gross amount payable by Medicare (as defined in §3419.12) would have been $4000 for the stay if there had been no GHP coverage. The GHP paid $4500 (of which $520 was credited to the Medicare deductible). Medicare will make no payment, since the plan's payment was greater than Medicare's gross amount payable of $4000 would have been. No part of the $500 difference between the hospital's charges and the GHP's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the GHP payment. The provider files a no-payment bill reflecting the $760 credited to the deductible.

3491.8 Effect of GHP Payments on Deductible and Coinsurance.--Expenses that serve to meet the beneficiary's Part A or Part B cash and blood deductibles, if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no Medicare benefit payable. Also, GHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance.

3491.9 Employer Plan Denies Claim for Primary Benefits.--

A. Primary Medicare Benefits.--Primary Medicare benefits may be paid if a single employer GHP or a multiple employer plan for which CMS has approved the plan's multi-employer exemption request denies a claim for primary benefits because the employer does not employ 20 or more

employees; the beneficiary is not entitled to benefits under the plan; benefits under the GHP are exhausted for the services involved; or, the services are not covered by the GHP under any circumstances for any covered individual, and the beneficiary is not appealing the GHP denial. (Do not pay primary Medicare benefits if you believe that the GHP covers the particular service and the plan asserts that the services are not covered for "primary payment" when provided to Medicare beneficiaries. See subsection C.) If you pay primary Medicare benefits and later learn that the beneficiary is appealing the GHP denial, treat the payment as a conditional primary payment and take action in accordance with subsection B.

B. Conditional Primary Medicare Benefits.--Conditional primary Medicare benefits may be paid if:

o The beneficiary has appealed or is protesting the GHP denial of the claim for any reason other than that the GHP offers only secondary coverage of services covered by Medicare, or

o The GHP denied the claim because the time limit for its filing had expired (whether appealed or not).

Before making a conditional primary payment in cases involving appealed or protested claims, notify the GHP and the beneficiary that the payment is being made on condition that both the insurer and the beneficiary are responsible for reimbursing the program up to the amount it has paid, if the GHP subsequently approves the claim. Notify the GHP that if it pays the beneficiary, it is still liable to reimburse Medicare for the amount of the conditional benefits (up to it primary payment). (However, your failure to notify the parties does not relieve them of the obligation to refund the payment.) Follow-up periodically with the insurer to determine the outcome of the disputed claim.

Where a GHP has denied payment because its claim filing deadline has expired, promptly notify the GHP that it must reimburse Medicare the amount of conditional benefits Medicare paid. Follow the recovery instructions in §3491.13.

C. When Primary Benefits and Conditional Primary Medicare Benefits Not Payable.--Neither primary benefits nor conditional primary Medicare payments may be made where a GHP denies payment for particular services on the grounds they are not covered by the plan, and you believe the plan does cover them. Do not pay conditional benefits if a plan offers only secondary coverage for services covered by Medicare, and the GHP does not allege that the employer has fewer than 20 employees. Do not pay conditional primary benefits even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, deny the claim for Medicare primary benefits unless the single employer GHP or multi-employer plan with an approved multiple employer plan exemption alleges that the employer has fewer than 20 employees. Send written notification to the GHP explaining that:

o It is obligated to pay primary benefits under §1862(b)(3) of the Social Security Act,

o Medicare payment cannot be made for services that are covered by the plan until the plan has paid primary benefits in accordance with its policy, and

o If the employer plan primary payment does not pay the full charge, then a claim for secondary benefits can be submitted to Medicare.

Send a denial letter to the beneficiary including similar information and a statement that the beneficiary may not be charged more than the deductible and coinsurance amounts and charges for non-covered services. (Services that are or could have been paid for by the GHP are not considered

"non-covered.") Include an appeals paragraph. Advise the beneficiary to consult his employer and the State Insurance Commissioner or other official having jurisdiction if necessary. Advise him of the private right of legal action to collect double damages. (See §3491.16.) See §3491.10 for further action to take after you have denied the claim and notified the GHP of its obligation to pay primary benefits.

Notify the provider of your actions.

D. Annotation of Claims Denied by GHP's.--Whenever a GHP denies a claim for primary benefits, the provider annotates in item 94 "Remarks" of Medicare claim the reason and enters occurrence code 24 and date of denial in items 29 - 32. No attachment is needed. The annotation is needed to avoid needless recoupment efforts under §3491.13.

3491.10 Referral of Cases to RO.--Refer all cases where recovery is not made to the RO. When referring a case subsequent to the first case involving a particular GHP, advise the RO of the total number of cases which have been referred, involving the GHP and the total dollar amount of Medicare overpayments involved. Whenever you paid primary benefits that should have been paid by a GHP and the GHP refuses to reimburse you, or it comes to your attention that a beneficiary (who meets the criteria in 3491.2) is covered on a secondary basis by a GHP for Medicare covered services (see §3491), refer the case to the RO. Include documentation of the recovery attempt specified in §3491.13F.

The RO notifies the State Insurance Commissioner, or other official having jurisdiction over the GHP, that evidence suggests that the GHP has violated Federal law. It requests that the GHP's actions be investigated, and that it be ordered to comply with Federal law and to make appropriate refund to Medicare. The RO also advises the responsible official that the Medicare beneficiary is placed at risk by the GHP's actions and that Medicare will not make future primary payments for items and services covered by the GHP for this individual.

The RO advises officials contacted of Medicare rights to recover from any parties to whom it has made improper payments. The RO considers possible legal action against the GHP or employer and/or referral of the case to the Equal Employment Opportunity Commission.

3491.11 Amount of Secondary Medicare Payments Where GHP Pays in Part for Items and Services.--If a GHP payment for Medicare covered services is less than the provider's charges for them and less than the gross amount payable by Medicare (as defined below), and the provider does not accept and is not obligated to accept the payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment is the lower of:

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

- The gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

NOTE: The gross amount payable by Medicare is:

(1) The current Medicare interim reimbursement amount (as defined in §3683) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the GHP,

(2) Or the Medicare payment rate (as defined in §3685) for providers reimbursed on a prospective payment basis without considering the effect of the Medicare deductible or coinsurance or the payment by the GHP.

Detailed reimbursement and billing instructions are in §3682C, F, H and J for providers reimbursed on a cost reimbursement basis and §3685 for hospitals reimbursed on a prospective payment basis.

3491.12 Effect of Secondary Payments on Part A Utilization.--Where the conditions in §3491.11 are met and a Medicare secondary benefit is payable, utilization is charged the beneficiary as specified in §3682C3 for providers reimbursed on a cost reimbursement basis and §3685A3 for hospitals reimbursed on a prospective payment basis. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

3491.13 Recovery of Mistaken Primary Medicare Payments.--If you receive information that a GHP should have been the primary payer for services provided to an identified beneficiary, take the following actions:

A. IRS/SSA/CMS Data Match (Data Match) Identified Cases.--Within the time period specified in CMS's current fiscal year intermediary budget and performance requirements (BPR) take the following actions:

Search your claims history for the time period specified in the BPR to determine if the payments you made with respect to any report ID (or group of report IDs) equals or exceeds the recovery tolerance for Data Match cases specified in the BPR. Prior to mailing out a demand, Medicare contractors must validate the MSP record on the Common Working File (CWF); include a screen print of the CWF information in the case file. If the case is valid, send the employer demand letter found at the end of this section to the identified employer. Include claims facsimiles (showing the amount Medicare paid) for the claims for which Medicare seeks payment and the other identified enclosures to the letter. (Examples are provided with the demand letter.) Aggregate all Data Match letters with respect to report IDs on any Data Match cycle linked to a single employer.

NOTE: If a contractor's systems will recognize an existing termination date on an MSP record prior to the generation of a demand, that contractor will not be required to check CWF prior to the mailing of the demand. If a contractor's systems did not recognize an existing termination date on an MSP record, that contractor is required to check CWF prior to mailing.

The employer or other entity acting on the employer's behalf may respond with a full or partial payment. If the employer or other entity repays Medicare in full (including any applicable interest), close the case. If the employer or other entity provides a full payment for certain services and provides a valid documented defense for all other services, close the case. (A valid documented defense consists of evidentiary material demonstrating that the GHP was not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is not a valid documented defense.) If the employer or other entity makes less than a full payment or provides less than a valid documented defense, adjust the recovery claim as appropriate and keep the case open.

To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, adjust the claim accordingly. If the valid documented defense is that the GHP made primary payment to a provider or beneficiary, recover from the provider or beneficiary as explained in subsection D.

If an employer or other entity requests specific information or asks a specific question about the recovery claim, provide the information or answer the questions. If you are unsure how to proceed in a specific situation, consult with your RO.

Data Match cases are tracked in a special tracking system, the Mistaken Primary Payment Recovery Tracking System (MPaRTS), which is maintained by CMS. You are required to update this system and keep the information in the system current as specified in the systems documentation and the current year BPR.

B. Other than Data Match Identified Cases.--Within the time period specified in CMS's current fiscal year intermediary BPR, take the following actions:

Search your claims history for the time period specified in the BPR to determine if payments you made with respect to the case equals or exceeds the recovery tolerance for non-Data Match cases specified in the BPR.

Contractors need to check the CWF MSP Auxiliary File. If the CWF MSP Auxiliary File identifies the employer with sufficient specificity (name and address) or you otherwise know the identity of the employer (notify the COB contractor through an ECRS CWF MSP Inquiry Transaction to add the employment information to the MSP Auxiliary File), send the employer demand letter found at the end of this section to the identified employer. Include claims facsimiles (showing the amount Medicare paid) for the claims for which Medicare seeks repayment and the other identified enclosures to the letter. (Examples are provided with the demand letter.) Aggregate employer demand letters to the extent possible for the purpose of bulk mailing.

If the CWF MSP Auxiliary File does not identify the employer with sufficient specificity and you otherwise do not know the identity of the employer, but the CWF MSP Auxiliary File does identify the "insurer," send the insurer/TPA/Plan (insurer) demand letter to the insurer. Include claims facsimiles (showing the amount Medicare paid) for the claims for which Medicare seeks repayment and other identified enclosures to the letter. (Examples are provided with the demand letter.)

The employer or other entity acting on the employer's behalf may respond with a full or partial payment. If the employer or other entity repays Medicare in full (including any applicable interest), close the case. If the employer or other entity provides a full payment for certain services and provides a valid document defense for all other services, close the case. (A valid documented defense consists of evidentiary material demonstrating that the GHP was not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is not valid documented defense.) If the employer or other entity makes less than a full payment or provides less than a valid documented defense, adjust the recovery claim as appropriate and keep the case open.

To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, adjust the claim accordingly. If the valid documented defense is that the GHP made primary payment to a provider or beneficiary, recover from the provider or beneficiary as explained in subsection D.

If an employer or other entity requests specific information or asks a specific question about the recovery claim, provide the information or answer the questions. If you are unsure how to proceed in a specific situation, consult with your RO.

C. GHP Acknowledges Specific Debt.--If a group health plan (or insurer, TPA or employer) specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make primary payment, recover the Medicare primary payment from the appropriate entity.

D. Recovery From the Provider.--If both Medicare and the GHP made primary payment to the provider, recover from the provider.

E. Recovery From the Beneficiary.--If both Medicare and the GHP made primary payment to the beneficiary, recover from the beneficiary .

F. Recovery When a State Medicaid Agency Has Also Requested a Refund From the GHP.-Situations may arise in which both Medicare and another insurer or a State Medicaid agency have conditionally or mistakenly paid for services and the amount payable by a GHP is insufficient to

reimburse both programs. Under the law, Medicare has the right to recover its benefits from a GHP before any other entity does, including a State Medicaid agency. Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by a GHP.

The superiority of Medicare's recovery right over other entities including Medicaid derives from the Medicare statute. It states that where Medicare is secondary to another insurer:

- Medicare may recover benefits from the responsible insurer,

- Medicare is subrogated to the right of the beneficiary and the right of any other entity to payment by the responsible insurer, and

- Medicare may recover its payments from any entity that has been paid by the responsible insurer. Medicare's right to recover from a GHP or from a beneficiary that has been paid by a GHP is higher than Medicaid notwithstanding the fact that Medicaid is the payer of last resort, and therefore does not pay until after Medicare. Medicare priority right of recovery from insurance plans that are primary to Medicare does not violate the concept of Medicaid's being payer of last resort. Under §1862(b)(2) of the Act, Medicare's statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a GHP which is primary to Medicare. Where the GHP pays right away, Medicare makes no payment to the extent of the GHP payment. A delay of GHP payment does not change Medicare obligation to pay the correct amount, if any, regardless of any conditional payments made. Thus, if the GHP pays less than the charges, Medicare may be responsible to pay secondary benefits. And, if a third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would create a Medicare payment where none is authorized under the law, or improperly increase the amount of a Medicare secondary payment.

The right of Medicaid agencies to recover benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. The beneficiary can assign a right no higher than his/her own, and since Medicare statutory right is higher than the beneficiary's, Medicare right is higher than the State.

Where both Medicare and Medicaid are seeking reimbursement, inform the GHP that it must first reimburse you before it can pay any other entity, including a State Medicaid agency.

Where a beneficiary, provider or supplier receives payment from a GHP, inform the payee that it is obligated to refund your payment up to the full amount of the GHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount does the beneficiary, provider, or supplier have the right to reimburse Medicaid or another entity.

If a State Medicaid agency is reimbursed from a GHP payment before Medicare, ask it to reimburse you up to the full amount it received. Explain the legal basis for Medicare's right to recover. If the State refuses, refer the case to the RO.

G. Contractor Recovery Case Files (Audit Trails).--Maintain a recovery case file for all cases (Data Match and others) in which you have attempted recovery. Each case file is to be organized as follows:

- Place the label on the outside of the folder where it can be readily seen, preferably at the upper left hand corner of the file folder with the name of the third party payer;

- Label the upper right hand corner of the file folder with the name and HICN of the beneficiary;

- o The following documents should be inside the file folder;
- o Copies of all demand letters
- o A copy of the accountability worksheet (see example at the end of this section)
- o Copies of the return receipt mail card;
- o Copies of any responses from the third party payer;
- o Copies of all claims for which a recovery is being sought;
- o Copies of the IRS/SSA/CO Data Match report (where applicable);
- o Any other materials related to the case.
- o All these materials should be fastened to the right hand side of the file folder.

3491.14 Advice to Providers, Physicians, and Beneficiaries.--In your professional and public relations activities, inform providers, physicians, and beneficiaries to direct claims to the GHP where there is primary GHP coverage for the services involved.

3491.15 Mistaken GHP Primary Payments.-- Cases may come to your attention where a GHP has inappropriately paid primary benefits. In such cases, advise the party who calls this to your attention, that the GHP may bill Medicare as primary payer if the Medicare timely filing period has not expired.

3491.16 Claimant's Right to Take Legal Action Against a GHP.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to:

- o Take legal action against a GHP that fails to pay primary benefits for services covered by the GHP, and
- o Collect double damages.

3491.17 Special Rules For Services Furnished By Source Outside GHP Managed Care Health Plan.--

A. Services By Outside Sources Not Covered.--Where Medicare is secondary payer for a person enrolled in an employer sponsored managed care health plan (e.g., HMO/CMP), Medicare does not pay for services obtained from a source outside the managed care employer health plan if:

- o The same type of services could have been obtained as covered services through the managed care employer health plan, or
- o The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded even if the individual received services outside of the managed care health plan's service area, e.g., while away from home.

At admission, providers ask beneficiaries that are enrolled in GHPs whether the plan is a managed care health plan. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required per §§3624 and 3679B.) Any request for payment is made to the GHP.

This applies to ESRD beneficiaries during the period of up to 30 months in which Medicare is secondary.

B. Exception.--If a beneficiary obtains services from a source outside the managed care employer health plan, and has not been notified in writing of this special rule, Medicare pays, provided the plan will not pay for legitimate reasons. In general, assume that written notification has not been given in the absence of evidence to the contrary. Where payment is made for services from a source outside the managed care health plan, the Medicare Benefits Notice (CMS-1533), or the EOMB, where applicable, states the following:

"Our records show that you are a member of an employer sponsored managed care health plan. Since Medicare is secondary payer for you, 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 non-plan services which could have been obtained from, or through, the managed care health plan."

C. Notice to Beneficiary.--Deny any bills received for Medicare payment from, or on behalf of, a beneficiary enrolled in a managed care GHP who has previously been notified in writing. Advise that the reason for the demand is that Medicare's records show that you are a member of an employer sponsored managed care health plan. Because Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from, or through, the managed care health plan are not payable. Medicare's records show that you were previously informed of this rule. Therefore, payment cannot be made for the non-plan services you received.

(There are standard EOMB messages that convey this information.)

Employer Letter

Dear Employer:

We are writing to advise you that your organization either has sole liability or shares liability for a debt to the Medicare program. The following explains how this happened and what you must do to resolve this matter.

How This Happened

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to the Medicare beneficiaries identified below that should have been the primary payment responsibility of a group health plan that you sponsor or to which you financially contribute. The Medicare Secondary Payer (MSP) provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (42 U.S.C. 1395y(b)) and regulations (42 CFR 411.20ff) are satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers, other plan sponsors, and insurers.[1] We are sending this letter to you because you are an entity responsible for payment under the Medicare law and are subject to an excise tax under the Internal Revenue Service if any group health plan that you sponsor, or to which you contribute, fails to comply with the MSP requirements. We want to afford you every opportunity to resolve this matter. We also encourage you to contact other entities, such as the plan itself or the plan's insurer (if any), that are also entities responsible for payment, for assistance in resolving this matter. An enclosure entitled, "Important Information for Employers" explains how your obligations arise and what happens if you do not satisfy your obligations.

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How to Resolve This Matter

Within 60 days of the date of this letter, you or someone acting on your behalf, e.g., your insurer or plan administrator, must provide one of the following response.

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Please provide the report identification number, which is found in the upper right corner of the enclosed summary sheet, with the repayment. If the amount repaid for any item or service is less

[1] In 1994, a Federal court in District of Columbia ruled that Medicare could not seek recovery from third party administrators of plans. However, a recent statutory enactment provides that, effective for services provided on or after August 5, 1997, Medicare may seek recovery from third party administrators under certain circumstances.

than the amount that Medicare paid, provide an explanation of how the amount repaid was determined. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, please provide a copy of the Explanation of Benefits and proof of payment;

2. If the group health plan is not obligated to make primary payment under any circumstances for services provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan and, if applicable, other plan sponsors, insurers and third party administrators.

   - If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the Medicare Secondary Payer provisions is that the plan's claims filing requirements have not been met[2], submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide copy of the applicable plan provisions.

   - If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would had the appeal or waiver request been made by the identified individual. Notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Please include the Medicare report identification number from the summary sheet on all correspondence. This enables Medicare to reconcile its records.

Your failure to respond within sixty (60) days of this date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures.

If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 C.F.R. 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

[2] In 1994, a Federal court in District of Columbia ruled that in making demands on a group health plan, Medicare must comply with a plan's filing requirements. However, a recent statutory enactment provides that, notwithstanding, any plan claims filing requirements to the contrary, Medicare has at least 3 years from the date the service was rendered to make a demand upon the plan. The statutory provision is effective for services furnished on or after August 5, 1997.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 C.F.R. 411.110 et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (§5000 of Internal Revenue Code). Moreover, 31 U.S.C. 3720A provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal Agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, see 42 U.S.C. 1395y(b) and regulations found at 42 CFR 411.20-37, 411.100-206.

If you have any questions concerning this matter, please write or call _____ at _____.

Sincerely,

MSP Supervisor

Enclosures:

MSP Summary Data Sheet
Summary of Medicare Payments
Claims Facsimiles
Important Information for Employers

Enclosure

Important Information for Employers

Employers often ask us to explain why an employer, especially one who purchases insurance from an insurance company, has or shares liability for this debt and to explain the potential consequences if the employer fails to resolve this matter. We provide these explanations in this enclosure.

Congress has created a statutory framework in the Medicare statute and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. One of Medicare's regulations, 42 CFR 411.24(e), provides that "CMS has a direct right to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan or program…" Accordingly, Medicare may seek recovery from the employer.

The MSP provisions generally require group health plans to make payments primary to Medicare for: (1) individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and (2) individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a thirty-month coordination period if the individual is covered under a group health plan on any basis. A group health plan is defined in the Internal Revenue Code at 26 U.S.C. §5000(b) as "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, other associated or formerly associated with the employer in a business relationship, or their families." Taken together, the MSP provisions and the Internal Revenue Code definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's compliance with the MSP rules.

Employer accountability is also reflected by Internal Revenue Code provisions allowing the employer to claim health plan expenditures as a deductible business expense (26 U.S.C. 162), and subjecting the employer to an excise tax if a plan to which it contributes does not conform to the MSP provisions (26 U.S.C. 5000(a) and (b)). Employers create, direct, authorize and control their health plans. Where an employer establishes a plan to provide health benefits indirectly through insurance, the employer determines the nature of the coverages and has the right to enforce its insurance contract to assure compliance with applicable laws.

Courts have also recognized that an employer is an entity responsible for payment. In Provident Life and Accident Insurance Co. v. United States, 740 F. Supp. 492 504 (E.D. Tenn. 1990), the court concluded "that the Government must look to the employer or other entity who actually insures the employee" to recover Medicare overpayments in MSP situations. Also, in United States v. Blue Cross and Blue Shield of Michigan, 726 F. Supp. 1517, 1521 (E.D. Mich. 1989), the court agreed that "the employer at all times is the entity which undertakes full 'financial responsibility for payments' under the plan, i.e., the employer is the one who bears the cost of administering and financing the plan." In 1994, a court held that, if a group health plan is administered by a third party administrator, Medicare must seek to recover its mistaken payment from the employer or plan itself. In Health Insurance Association of America v. Shalala, 23 F.3d 412, 416 (D.C. Cir. 1994), the court of appeals held that third party administrators could not be subjected to recovery actions because they "assume no financial responsibility for paying a plan's benefits.[3]" Because the employer or the plan are the entities that have financial responsibility, they are the entities from which Medicare must seek payment.

[3] Portions of this decision, limiting the Government's ability to collect from TPAs and subjecting the Government to a plan's time limits for filing claims, were reversed by recent legislation effective for services furnished on or after August 5, 1997.

Regulations under the Federal Claims Collection Act establish that all entities responsible for paying a debt to the Federal Government are jointly and severally liable for payment of the debt. As previously explained, the employer is one of potentially several entities responsible for making primary payment under the MSP provisions. If the United States must take legal action to recover this debt, the Government may take action against any or all entities responsible for payment, including the insurer, the plan and the employer (See 42 U.S.C. 1395y(b)(2)(B)(ii); and 42 CFR 401.623.) If the Government is unable to recover the total debt from one of the entities responsible for payment, it may then pursue recovery from another.

If an employer does not repay Medicare or arrange for Medicare to be paid in full, any tax refunds that may be due the employer under the Internal Revenue Code may be applied toward satisfaction of the MSP debt (31 U.S.C. 3720A). In addition, the MSP provisions state that a plan that does not repay Medicare may be held to be a "nonconforming" plan (See 42 U.S.C. 1395y(b)(3)(B) and 42 CFR 411.110 et seq.) The Internal Revenue Code at §5000 imposes a 25 percent excise tax on all employers, except government entities, on all health plan expenditures of employers and employee organizations that contribute to a nonconforming group health plan. A plan may be found to be nonconforming both in the year that it failed to repay Medicare and in the year in which it was originally obligated to have made primary payment. In addition, the Debt Collection Improvement Act of 1996 (Chapter 10 of P.L. 104-134) requires Federal agencies to collect debts by offset from any monies otherwise payable to the debtor by the United States.

INSURER LETTER

Dear Sir or Madam:

It has come to our attention that Medicare has made payment for services, under the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)(1)), when payment may be or is the responsibility of a group health plan for which you are/were the insurer, underwriter, sponsor, or claims processor.

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How This Happened

The MSP provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (2 U.S.C. 1395(y)(b)) and regulations (42 CFR411.20ff) are satisfied. Medicare did not know that these conditions were satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers, other plan sponsors, and insurers.[1]

How to Resolve This Matter

Within 60 days of the date of this letter, you must provide one of the following responses:

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Provide the report identification number, which is found in the upper right corner of the enclosed summary data sheet, with the repayment. If the amount repaid for any item or service is less than the mount that Medicare paid, provide an explanation of how the amount repaid was determined. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, provide a copy of the explanation of benefits and proof of payment;

2. If the group health plan is not obligated to make primary payment under any circumstances for service provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan.

[1] In 1994, a Federal court in the District of Columbia ruled that Medicare could not seek recovery from third party administrators of plans. However, a recent statutory enactment provides that, effective for services provided on or after August 5, 1997, Medicare may seek recovery from third party administrators under certain circumstances.

- If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the MSP provision is that the plan's claims filing requirements have not been met,[2] submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provision.

- If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would have the appeal or waiver request been made by the identified individual. Notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary data sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Include the report identification number from the summary sheet on all correspondence. This enables Medicare to reconcile its records. Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures.

If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110 et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (§5000 of Internal Revenue Code). Moreover, 31 U.S.C 3720A provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

If you have any questions concerning this matter, please write to _____ at or call our customer service representatives at _____.

[2] In 1994, a Federal court in the District of Columbia ruled that in making demands on group health plan, Medicare must comply with a plan's filing requirements. However, a recent statutory enactment provides that, notwithstanding any plan claims filing requirements to the contrary, Medicare has at least 3 years from the date the service was rendered to make a demand upon the plan. The statutory provision is effective for services furnished on or after August 5, 1997.

When you are enclosing payments, please make the check payable to Medicare. Mail the check and any information concerning this matter to _____.

Sincerely,

XXXXXXXXXXX
Title
Contractor Name

Enclosure:
MSP Summary Data Sheet
Summary of Medicare Payment
Requested Reimbursement Summary Report
Summary of Medicare Reimbursement Key
Claims Facsimiles

ACCOUNTABILITY WORKSHEET

Data Match Report (if applicable): _____

Data Match Report Date (if applicable): _____

Beneficiary Name: _____

Beneficiary HICN: _____

Third Party Payer: _____

First Demand Sent: _____

Second Demand Sent: _____

Recovery Status: _____

Recovery Status Date: _____

Total Potential Mistaken
Payment Identified:

_____

Additions

_____

Total Recovered

_____

Difference Between Identified
Amount and Amount Recovered (1)

_____

Briefly Explain Above Entry:

If the identified third party payer paid primary list entities from whom you were required to recoup duplication payment and amount recovered on an attachment.

MSP SUMMARY DATA SHEET | | REPORT ID:
TYPE OF MSP SITUATION: WORKING AGED
DATE OF ACTUAL NOTICE:
BENEFICIARY NAME:
HEALTH INSURANCE CLAIM NUMBER (HICN):
DATE OF BIRTH:
THIRD PARTY PAYER NAME:
THIRD PARTY PAYER ADDRESS:
COVERAGE BEGIN DATE: | COVERAGE END DATE:
GROUP IDENTIFICATION:
PATIENT POLICY IDENTIFICATION:
SUBSCRIBER NAME:
EMPLOYEE ID NUMBER:
EMPLOYER NAME:
EMPLOYER ADDRESS:
REPAYMENT AMOUNT REQUESTED | *SEE ATTACHED DOCUMENTATION |
ACCRUED INTEREST/RATE/DATE
TOTAL REPAYMENT AMOUNT | REQUESTED INCLUDING INTEREST |
MAKE YOUR CHECK OUT TO: THE MEDICARE PROGRAM MEDICARE SECONDARY PAYER UNIT AT TAX EIN: PLEASE INSURE THAT THE REPORT ID AND HICN LISTED ON THE SUMMARY SHEET IS REFERENCED ON YOUR CHECK.
X | CHECK BOX IF CASE WAS IDENTIFIED THROUGH THE IRS/SSA/CMS DATAMATCH

PAYMENT RECORD SUMMARY

BENEFICIARY NAME: HICN: REPORT ID NBR:

PROVIDER NAME: PROVIDER ID NBR:

DOC CNTL NBR:

SERVICE DATES: FROM: THRU: TOTAL CHARGES:

AMOUNT REQUESTED: ACCRUED INTEREST:

TOTAL AMOUNT REQUESTED:
TOTAL MEDICARE CHARGES:
TOTAL ACCRUED INTEREST:

TOTAL AMOUNT DUE:

Medicare as Secondary Payer
for Disabled Individuals

3492. MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

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 definition below.) 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 §§3491.6 - 3491.10 and §§3491.12 -3491.16 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 subsection C1, to apply them to disabled individuals.

A. Effective Date.-- 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.

B. Definitions.--

1. Large Group Health Plan.--A LGHP means any health plan of, or contributed to by, an employer or by an employee organization (including a self-insured plan) that provides health care directly or through other methods such as insurance or reimbursement, to employees or former employees, the employer, others associated, or formerly associated with, the employer in a business relationship, or their families. It includes individual policies (including Medigap policies) purchased by an or through an employer or former employer of the individual or family member. The plan covers employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year. The term employer has the same meaning as the term has for purpose of the working aged provision. See §3491.1A. It includes the Federal and other governmental entities. The tax penalty for nonconforming LGHPs does not apply to Federal and other governmental entities. (See subsection H.)

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceding calendar year is considered to meet this definition. If the 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 employees requirement, Medicare is secondary for all employees enrolled in the plan, including those that work for small employers. This differs from the rule for multi-employer plans under the working aged. (See §3491.1C.)

2. Nonconforming Large Group Health Plan.--A "nonconforming LGHP" means one that at any time during the calendar year takes into account that an individual is eligible for, or receives, benefits based on disability, e.g., a LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with subsection C.3.

3. Current Employment Status.--

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

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

o Not actively working but meets all of the following conditions:

o Retains employment rights in the industry.

o 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;

o Is not receiving disability benefits from an employer for more than 6 months;

o Is not receiving social security disability benefits; and

o Has employment-based GHP coverage that is not COBRA continuation coverage. (See 29 USC 1161-1168.)

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

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

o Teachers and seasonal workers who normally do not work throughout the year, and

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

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:

o 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

o 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:

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

o 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 with the religious order if the services he/she performs as a member of the order are considered employment by the order for Social Security purposes only. This is because the religious order elected Social Security coverage for its members under §3121(r) of the Internal Revenue Member of Religious Order Code. Thus, Medicare is the primary payer to any group health plan coverage provided by the religious order.

This exception applies only to members of religious orders who have taken a vow of poverty. It does not apply to clergy or to any member of a religious order who has not taken a vow of poverty or to lay employees of the order. This exception applies not only to services performed for the order itself (such as administrative, housekeeping, and religious services), but also to services performed at the direction of the order for employers outside of the order provided that the outside employer does not provide the member of the religious order with its own group health plan coverage. A member of a religious order has current employment status with the outside employer as a result of providing services on behalf of the outside employer (an ongoing business relationship exists). If the outside employer provides group health plan coverage to the member of the religious order on the basis of that current employment status relationship, the usual Medicare Secondary Payer rules apply. Medicare is the secondary payer to the group health plan of the outside employer if the outside employer has the requisite number of employees.

EXAMPLE: Sister Mary Agnes is a member of a religious order where members are required to take a vow of poverty. Sister Mary Agnes was assigned to teach at a church school in the Diocese of Metropolis. The Diocese does not provide group health plan coverage to Sister Mary Agnes. The only group health coverage available to Sister Mary Agnes is provided by the religious order. Medicare is the primary payer for services provided to sister Mary Agnes.

EXAMPLE: Sister Mary Teresa is a member of a religious order whose members are required to take a vow of poverty. Sister Mary Teresa was assigned to teach at a church school in the Diocese of Smallville. On the basis of her teaching relationship with the Diocese of Smallville, the Diocese provides group health plan coverage to sister Mary Teresa. The group health plan provided by the Diocese of Smallville is the primary payer and Medicare is the secondary payer for services provided to sister Mary Teresa.

Carriers should note that the exemption only applies to the working aged and disability provisions that base a group health plan's obligation to be a primary payer, on a current employment status relationship. The exception does not apply to the ESRD, workers' compensation or liability and no-fault provisions.

f. Insurance Agents.--The following guidelines apply in determining whether agents have current employment status. (See §3329.2.E to determine when an insurance company's plan meets the definition of a GHP.)

An insurance agent, including a self-employed insurance agent or a part-time agent, but not a retired agent, is considered to have current employment status without regard to the extent to which the agent is selling policies on behalf of the company; or

A retired agent has current employment status if the agent meets, the earnings threshold (i.e, $400 or more) of §211(b) of the Act.

g. Senior Federal Judges.--Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the remuneration they receive as senior judges is not considered wages for Social Security retirement test purposes. Since they are considered retired for Social Security purposes, they are not considered to have current employment status for purposes of the working aged and disability provisions.

h. Volunteers.--Volunteers are not considered to have current employment status unless they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) of the Act, VISTA volunteers are considered to have current employment status since they receive remuneration, the Federal Government. Also, remuneration may be of a monetary or non-monetary nature. Benefits, including health benefits, that a volunteer receives is considered to be remuneration if the benefit is subject to FICA taxes under the IRC.

i. Directors of Corporations.--Directors of corporations (i.e., persons serving on a Board of Directors of a corporation who are not officers of the corporation) are self-employed. (Officers of a corporation are employees.) Directors who receive remuneration for serving on a board are considered to have current employment status. Remuneration may be of a monetary or non-monetary nature. Benefits, including health benefits, that a corporation provides to a board member is considered to be remuneration if the benefit is subject to FICA taxes under the IRC.

Directors who receive no remuneration for serving on the Board (unpaid directors) are not considered to have current employment status. However, remuneration may consist of deferred compensation (i.e., amounts earned but not payable until some future date usually when the individual reaches age 70 and is no longer subject to the Social Security retirement test). A director receiving deferred compensation is considered to have current employment status only while he/she is serving as a director.

4. 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).

5. 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.

6. Family Member.--Family member means a person enrolled in a 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.

7. 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.

8. Payment in full.--"Payment in full is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation."

C. Individuals Not Subject to this Limitation on Payment.--Medicare is not secondary under the MSP for the disabled provision for:

o Individuals eligible or entitled to Medicare under the ESRD provision, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability. Medicare is secondary payer for persons under age 65 with ESRD under the MSP ESRD provision if Medicare was not properly the primary payer prior to eligibility or entitlement to Medicare based on ESRD.

o Individuals who are covered by a GHP of employer(s) of fewer than 100 employees, unless the GHP is a multi-employer plan in which there is at least one employer of 100 or more employees.

o Individuals whose coverage by a LGHP is not based on either their own or a family member's current employment status.

D. Action by Providers to Identify Individuals Subject to This MSP Provision.--Providers are to identify individuals who meet the conditions in this section by asking every Medicare beneficiary under age 65 if the individual is an employee, a self-employed individual, or a member of the family of an employee or self-employed individual and, if so, whether the individual has group health coverage through their own or a family member's current employment status. If the individual responds affirmatively, the provider requests the name and address of the employer plan and the individual's identification number and bills the plan for primary benefits. If the individual responds negatively, the provider bills Medicare for primary benefits.

For audit purposes, and to ensure that the provider has developed for other primary payer coverage, the provider retains a record of the development or other information on which it based its determination that Medicare is primary payer. See §3686 for action to take where a claim is received for primary benefits and you have reason to believe that Medicare may be secondary payer.

E. When Medicare Can Pay Secondary Benefits.--If the provider bills the employer plan first, Medicare may pay secondary benefits in accordance with §3491.12, to supplement the employer plan payment, only if the following conditions are met:

o The plan payment is less than the provider's charges for Medicare covered services,

o The plan payment is less than the gross amount payable by Medicare (as defined in §3491.12), and

o The provider does not accept, and is not obligated to accept, the plan's payment as payment in full. Refer to §3682 (cost reimbursement) and §3685 (PPS reimbursement) as appropriate.

F. Recovery of Mistaken Primary Medicare Payments.--Follow the recovery instructions at §3491.13.

G. Claimants' Right to Take Legal Action Against Large Group Health Plan .--Any claimant including an individual who received services, and the provider or supplier, has the right to take legal action against a LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare, and to collect double damages.

H. Tax Penalty for Noncompliance.--An excise tax is imposed by §5000 of the Internal Revenue Code on any employer or employee organization that contributes to a nonconforming LGHP (see subsection C2 for definition) during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to LGHPs during that year. This tax penalty does not apply to Federal and other governmental entities.

I. Identification of Cases and Action Where There Is Indication of LGHP Coverage In Prior Claims.--Consider the possible application of this limitation on benefits when processing claims for items or services furnished on or after August 10, 1993 to beneficiaries for whom Medicare is secondary.

J. Referral of Cases to RO.--Refer to the RO any cases of a nonconforming LGHP which come to your attention which either offers secondary coverage for individuals for whom Medicare is secondary or which refuses to reimburse you for any primary benefits you have paid to, or on behalf of, such individuals. Include, in addition to the individual's name and HICN, the name and address of the employer and the LGHP, the individual's group health plan identification number, and a full explanation of the reasons for the referral.

The RO will investigate further and refer the case to CO.

3495. FEDERAL GOVERNMENT'S RIGHT TO SUE AND COLLECT DOUBLE DAMAGES

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover Medicare primary payments from entities that are required or responsible to pay benefits primary to Medicare but which fail to do so. The Federal Government may recover double damages in this type of lawsuit pursuant to §1862(b)(2)(B)(ii) of the Act. Entities that are required or responsible to pay primary to Medicare include:

- A group health plan, including insurers, employers and third party administrators of such plans,
- A large group health plan, including insurers, employers and third party administrators of such plans,
- An automobile medical insurance plan,
- Any liability insurance policy or plan, including a self-insured plan,
- A workers' compensation plan, and
- An automobile or non-automobile no-fault insurance plan.

Refer any case in which an entity is required or responsible to make primary payment but refuses to do so to the RO servicing your area. Include, in addition to the beneficiary's name, address and SSN or HICN, the formal name and address of the insurer or plan; the employee brochure that describes health benefits and coverage; the name and address of the entity required or responsible for making payment on behalf of the plan (e.g., the employer, an insurer or a third party administrator (TPA)); a copy of the employer's agreement with the TPA; the name of the sponsoring or contributing employer or employee organization; the provider's name, address and identification number; the specific amount of mistaken primary benefits Medicare paid; the specific date(s) of service; the specific procedure or diagnosis code(s); the MSP type (e.g., ESRD, disabled or working aged); and a full explanation of the reasons for the referral. The RO reviews the case file for completeness and obtains any needed additional information. When the file is complete, the RO refers the case to central office (CO). The CO considers possible legal action to collect double damages from that entity.

The government's right to sue and collect double damages is effective for items and services furnished on or after December 20, 1989 under all MSP provisions except the MSP for the disabled provision. The Government's right to sue and collect double damages under the MSP for the disabled provision is effective for items and services furnished on or after January 1, 1987.

3496. EXCISE TAX PENALTIES FOR CONTRIBUTORS TO NONCONFORMING GROUP HEALTH PLANS

Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations which contribute to "nonconforming group health plans." They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each group health plan (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers.

The term "nonconforming group health plan" means a group health plan or large group health plan that at any time during a calendar year fails to comply with any of the following provisions of the working aged, disability or ESRD Medicare secondary laws.

A. Working Aged.--Section 1862(b)(1)(A)(i)(I) of the Act provides that a group health plan may not take into account that a currently employed individual age 65 or over (or a spouse age 65 or over of an employed individual of any age) is entitled to Medicare. Further, §1862(b)(1)(A)(i)(II) of the Act states that a group health plan must provide the same benefits under the same conditions to employees and employees' spouses age 65 or over as it provides to employees and employees' spouses under age 65.

B. Disability.--Section 1862(b)(1)(B)(i) of the Act provides that a large group health plan may not take into account that a disabled "active individual" is entitled to Medicare based on disability. (See §3492B.3.) The term "active individual" means an employee, the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any of such persons.

C. ESRD.--Section 1862(b)(1)(C) of the Act provides that a group health plan may not take into account that an individual is entitled to Medicare solely on the basis of ESRD during the period when Medicare is secondary payer. Further, a group health plan may not differentiate on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner in the benefits it provides between individuals having ESRD and other individuals covered by such plan.

Examples of discriminatory actions by a group health plan or large group health plan which constitute noncompliance with the Medicare secondary provisions include:

o Failure to make primary payment on behalf of an individual for whom Medicare is secondary,

o Providing secondary or complementary coverage to such an individual,

o Refusal to allow such an individual to enroll or reenroll in the group health plan or large group health plan because of Medicare entitlement,

o Providing a different level of benefits for individuals for whom Medicare is secondary than it provides for other persons enrolled in the plan,

o Imposing limitations on benefits, exclusions of benefits, reductions in benefits, higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations, for persons for whom Medicare is secondary payer, that are not applicable to others enrolled in the plan,

o Terminating coverage because a person has become entitled to Medicare, or

o Failure to cover routine maintenance dialysis services or kidney transplants.

Refer any case of a nonconforming group health plan to the RO servicing your area. Include, in addition to the beneficiary's name, address and SSN or HICN, the formal name and address of the nonconforming group health plan; the name and address of the entity required or responsible for making payment on behalf of the plan (e.g., the employer, an insurer or a third party administrator (TPA)); a copy of the employer's agreement with the TPA; the name of the sponsoring or contributing employer or employee organization; the employer or employee organization taxpayer identification number; year(s) of violation; the provider's name, address and identification number; the specific amount of

Medicare payments associated with the nonconformance; the specific date(s) of service; the specific procedure or diagnosis code(s); the MSP type (e.g., ESRD or working aged); and a full explanation of the reasons for the referral. The RO reviews the case file for completeness and obtains any needed additional information. When the file is complete, the RO refers the case to the Bureau of Program Operations in CMS Central Office (CO). CMS CO reviews the case and refers it to the Internal Revenue Service to impose the excise tax on employers and employee organizations that have contributed to the plan.

The excise tax penalty for nonconformance with the working aged and ESRD MSP provisions can be imposed for acts of discrimination occurring on or after December 20, 1989. The excise tax penalty for nonconformance with the disability MSP provision can be imposed for acts of discrimination occurring on or after January 1, 1987.