Medicare
Carriers 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 III	3-1.2 - 3-2.2 (4 pp.)	3-1.2 - 3-2.2 (4 pp.)
3328 - 3328.11	3-87 - 3-87.7 (8 pp.)	3-87 - 3-87.7 (8 pp.)
3328.17 - 3328.18	3-87.10 - 3-87.11 (2 pp.)	3-87.10 - 3-87.11 (2 pp.)
3328.24 - 3329.13 (Cont.)	3-87.20 - 3-87.49 (30 pp.)	3-87.20 - 3-87.36 (17 pp.)
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3336.3 - 3337.2	3-90.11 - 3-90.14 (4 pp.)	3-90.11 - 3-90.15 (5 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 3328, Medicare Secondary Payment (MSP) General Provisions, changes EGHP to GHP. This change applies through out this manual. Changes worked disabled to disabled. Updates first 18 months of ESRD to first 30 months of ESRD. Changes the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to TRICARE. Adds the definition of payment in full. Updates to "physician/supplier is obligated to accept, or the physician /supplier voluntary accepts and added HMP/PPO arrangements."

Section 3328.2, TPP Pays Charges in Full, adds, "or the physician/supplier voluntarily accepts and added HMP/PPO arrangements."

Section 3328.7, Physician, Supplier, or Beneficiary Bills Medicare for Primary Benefits, adds the sentence However, the primary insurer…..

Section 3328.10, Multiple Insurers, adds number 2 of the examples, "The GHP of the spouse…", within the **NOTE**: add "private coordination of benefits between the two plans"

Section 3328.16, TPP Pays Primary Benefits When Not Required, changes incorrectly paid primary to mistakenly paid primary, add "permit and if requested by physician/supplier or beneficiary. Deleted "Instruct him/her to refund to the TPP or beneficiary….. Also, delete "However, you cannot require the beneficiary. 3328.16 second paragraph changed from it is the responsibility of the beneficiary to it is the responsibility of the physician/supplier.

Section 3328.24, Right of Physician or Supplier to Charge Beneficiary, changes "the excess constitutes an overpayment to constitutes a debt".

Section 3329.1, General, changes a coordination of 18 months to a coordination of 30 months.

Section 3329.2, Definitions, adds, "Individual policies (including Medigap policies) purchased by or through an employer or former employer of the individual or family member of the individual are considered employer offered GHPs.

Section 3329.3, Current Employment Status, adds disability benefits from an employer for up to 6 months, adds guidelines on how to address member of religious order who has taken vow of poverty and adds guidelines on how to address self-employed insurance agent.

Section 3329.4 Employer Sponsored Managed Care Health Plan, changes title and how to address updating your internal system.

Section 3329.6, Nonconforming Group Health Plan, was changed from nondiscrimination. Changes "during the first 18 months of ESRD to during the first 30 months of ESRD".

Section 3329.9, Recovery of Mistaken Primary Medicare Payments, adds a new section on how to address Data Match Identified cases.

Section 3329.10, Advice to Physicians/Suppliers and Beneficiaries, adds a new section on how to address advice to Physicians/Suppliers and Beneficiaries.

Section 3329.11, Mistaken GHP Primary Payments, adds a new section on how to address Mistaken GHP primary payments.

Section 3329.12, Claimant's Right to Take Legal Action Against a GHP, adds a new section how to address claimant's rights.

Section 3329.13, Special Rules for Services Furnished by Source Outside GHP Managed Care Health Plan, adds a new section on GHP Managed Care.

Section 3336, Medicare Secondary Payer Provisions for Working Aged Individuals, changes title from Limitation on Payment for Services to Employed Beneficiaries and Spouses.

Section 3336.1, Individual Not Subject to MSP Provision, deletes "effective for items and services furnished.

Section 3336.5, Exception for Small Employers in Multi-Employer and Multiple Employer GHPs, changes with 20 or more employees may request to exempt employees of ….. Also added a NOTE. Also, added "If the above information is provided and there is no evidence to the contrary you may approve the request. Advise COB of any updates to CWF than may be needed.

Section 3336.9, Dually Entitled Individuals, changes 18 month coordination period to 30 month coordination period.

Section 3337.1 General, changes title from Items and Services Furnished On or After August 10, 1993 and Before October 1, 1998.

Section 3337.2, Individuals Not Subject to MSP Provision, changes last bullet item to Covered by a health plan other than a LGHP (e.g., one that is purchased by the individual privately and not through an employer.

Section 3337.5, Dually-Entitled Individuals, changes 18-month coordination period to 30-month coordination period.

Section 3337.6, Items and Services Furnished On or After January 1, 1987 and Before August 10, 1993 (Date of Enactment of OBRA 1993), is being **deleted.**

These instructions should be implemented within your current operating budget.

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.

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

Medicare as Secondary Payer for Coverage Under Workers' Compensation

Medicare Secondary Payer Provisions for ESRD Beneficiaries

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

Section

Limitation on Payment for Services to Employed
Aged Beneficiaries and Aged Spouses of Employee of Any Age

Medicare Secondary Payer for Disabled Beneficiaries

No-Fault Insurance

Services Reimbursable Under Liability Insurance

3328. MEDICARE SECONDARY PAYER (MSP) GENERAL PROVISIONS

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

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

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

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

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

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

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

When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second. This means that the physician/supplier or beneficiary must first submit the claim to the primary payer, which is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. The primary payer may not decline to make primary payment on the grounds that its contract calls for Medicare to pay first. If, after processing the claim in this manner, the primary payer does not pay in full for the services, Medicare secondary benefits may be paid for the services as prescribed in §3328.18. Generally, the beneficiary is not disadvantaged where Medicare is secondary payer because the combined payment by a primary payer and by Medicare as secondary payer is the same as or greater than the combined payment where Medicare is primary payer.

B. Definitions.--

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

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

3. GHP means any arrangement of, or contributed to by, one or more employers, or employee organizations, to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP, and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State and, local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs that are under the auspices of one or more employers or employee organizations but do not receive any contribution from the employer). Individual policies (including Medigap policies) purchased by or through an employer or former employer of the individual or family member of the individual are considered employer offered GHPs. However, coverage under TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is not considered to meet the definition of GHP.

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

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

o A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

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

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

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

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

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

7. 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.

8. Secondary, when used to characterize Medicare benefits, means benefits that are payable only to the extent that payment has not been made and cannot reasonably be expected to be made by a TPP that is primary to Medicare.

9. Self-insured plan is a plan under which an individual or a private or governmental entity carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession; a plan of an organization such as a social, fraternal, labor, educational, religious, or professional organization; and the plan established by the Federal Government to pay for liability claims under the Federal Tort Claims Act (FTCA). (With regard to FTCA claims, CMS attempts to collect its mistaken payment from the Federal agency that is settling the claim. If a resolution cannot be reached, CMS must submit the conflict to the Department of Justice for resolution.)

10. TPP means a WC law or plan, automobile or non-automobile no-fault insurance, any liability insurance, or a GHP or LGHP that is required to pay primary to Medicare.

C. Conditional Primary Medicare Benefits.--Except in the situations described in subsection 2, conditional primary Medicare benefits may be paid if:

o The beneficiary, the physician, or the supplier has filed a proper claim with a TPP in the case of services for which payment under WC, liability or no-fault insurance can reasonably be expected, and you determine that the insurer will not pay promptly (see subsection B for definition);

o The beneficiary, the physician or supplier that has accepted assignment filed a proper claim with a GHP or LGHP and the TPP denied the claim in whole or in part; or

o Because of physical or mental incapacity of the beneficiary, the physician, supplier, or beneficiary failed to file a proper claim with the TPP.

1. Appealed or Protested Claims.--Before making a conditional primary payment in cases involving a denied claim that was appealed, notify the TPP 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 TPP subsequently approves the claim. Follow up periodically with the insurer to determine the outcome of the disputed claim. If the TPP allows the claim, recover the Medicare payment directly from the TPP.

2. Exceptions.--Conditional primary Medicare payments may not be made under either of the following circumstances:

a. The claim is denied for one of the following reasons:

o It is alleged that the TPP plan is secondary to Medicare;

o The plan limits its payment when the individual is entitled to Medicare;

o The services are covered by the TPP for younger employees and spouses but not for employees and spouses age 65 or over; or

o Failure to file a proper claim (including failure to file timely) if that failure is for any reason other than physical or mental incapacity of the beneficiary.

b. The TPP fails to furnish information requested by CMS as necessary to determine whether the employer plan is primary to Medicare.

Where a TPP has denied the claim because the plan provides only secondary coverage, deny the claim for Medicare primary benefits unless the TPP alleges that the employer has fewer than 20 employees in the case of a GHP (unless the GHP is part of a multi-employer plan (see §3336.5)) or 100 employees in the case of a LGHP or 100 employees in the case of a LGHP (unless the employer belongs to a multi-employer plan with at least one employer that has 100 employees). (See §3337.3.) Contact the TPP to explain that:

o It is obligated to pay primary benefits under §1862(b) of the Social Security Act (see 42 U.S.C. 1395y (b)), and

o Medicare payment cannot be made for services that are covered by the plan until the plan has processed a claim for services in accordance with the Medicare law and the coverage provisions of its policy.

Send the beneficiary a denial letter including similar information and state that if the TPP does not pay the full charge, then a claim for secondary benefits including a copy of the TPP's Explanation of Benefits (EOB) can be submitted to Medicare. If the physician/supplier accepted assignment, notify the physician/supplier and the beneficiary that the beneficiary may not be charged more than the Medicare deductible and coinsurance amounts and charges for non-covered services. (Services that are or could have been paid for by the TPP are not considered "non-covered.")

Include an appeals paragraph in the letter of denial. Advise the beneficiary to consult with his/her employer and/or the state insurance commissioner or other official having jurisdiction (such as the U.S. Department of Labor) if he/she believes that the TPP should have paid for the services. Advise him/her of the private right of legal action to collect double damages. (See §3328.11.)

3328.1 Beneficiary's Responsibility With Respect to TPPs That Are Primary to Medicare.--The beneficiary or his/her representative is responsible for taking whatever action is necessary to obtain any primary payment that can reasonably be expected. Therefore, unless conditional payment can be made under §§3328.C.1 or C.2, do not make any Medicare payment if the beneficiary has not filed a claim or cooperated fully with the physician or other supplier or the TPP. A beneficiary need not file any appeal if he/she is not inclined to do so.

3328.2 TPP Pays Charges in Full.--If the TPP pays the physician's/supplier's charges in full, the physician/supplier is obligated to accept, or the physician/supplier voluntarily accepts, the TPP's approved amount as full payment, do not make any Medicare payment. (Physicians and other suppliers that participate in Blue Shield plans or HMO/PPO arrangements typically must accept the Blue Shield plan's, or HMO/PPO arrangement's approved amount as payment in full.)

3328.3 TPP Pays Portion of Charges.--If a TPP pays an amount less than the physician's/supplier's charges for the services, secondary Medicare benefits may be paid for Medicare covered services, as prescribed in §3328.18, to supplement the amount paid by the TPP.

3328.4 TPP Denies Payment.--If the TPP denies payment for particular services because they are not covered by the plan under any circumstances or they are covered under the plan but not available to a particular Medicare beneficiary because, for example, the individual has not met the plan deductible, has exhausted plan benefits for the services, or is not enrolled in the plan, primary Medicare benefits may be paid for the services if covered by Medicare.

3328.5 Notification When Claims for Primary Medicare Benefits Are Denied.--When a primary Medicare claim is denied, inform the beneficiary and, in assigned claims, the physician/supplier that, after the TPP has processed the claim for primary benefits, a claim for secondary Medicare benefits may be filed and that a copy of the TPP's explanation of benefits (EOB) must be included.

3328.6 Carrier Action When There Is Indication That Medicare May Be Secondary Payer.--

A. Identification of Claims.--Use the following guidelines to identify claims for otherwise covered services when there is a possibility that payment has been made or can be made by an insurer that is primary to Medicare.

You receive information from a physician/supplier, the beneficiary, your own operations (e.g., medical or utilization review), your own non-Medicare counterpart, or any other source indicating Medicare has been billed for services when there is a possibility of payment by an insurer that is primary to Medicare.

The health insurance claim form shows that the services were related to an accident (i.e., the diagnosis is due to trauma) or occupational illness (e.g., black lung disease) or were furnished while the beneficiary was covered by a GHP or a LGHP which is primary to Medicare.

The Common Working File indicates a "Y" validity indicator showing the presence of MSP coverage.

There is an indication that the beneficiary previously received benefits or had a claim pending for insurance that is primary to Medicare. Assume, in the absence of information to the contrary, that this coverage continues. It is not necessary to repeat the development for future claims unless contradictory information is obtained.

You have not made payment and are asked to endorse a check from another insurer payable to Medicare and some other entity. Return the check to the submitter and request it to pay primary benefits to the full extent of the TPP's primary obligation. (Follow the recovery instructions in §§7100ff. if the check relates to services for which Medicare paid primary.) As necessary, follow up with the physician, supplier, beneficiary, and/or attorney to find out if the beneficiary receives payment from the TPP.

You receive or are informed of a request from an insurance company or attorney for copies of bills or medical records.

Where a TPP's primary coverage is established because the individual forwards a copy of the TPP's EOB and the individual meets the conditions in §3328.A, process the claim for secondary benefits per §§4300ff. Develop in accordance with subsection B below if the information about the TPP's payment is insufficient.

B. Development Required With Claim for Secondary Benefits.--Obtain the insurer's address and insured's identification from the beneficiary. Instruct the beneficiary to file a claim (if this has not already been done) with the primary payer or arrange for the supplier to file a claim. If a claim has already been filed, request a copy of the EOB or denial from the beneficiary, physician or supplier, if necessary, from the insurer. Do not accept the beneficiary's allegations about the primary payment.

An assigned or unassigned claim can be processed as a claim for secondary Medicare benefits if it is accompanied by a primary insurer's EOB which indicates that the insurer has paid in part for services for which Medicare benefits have been claimed. If the Medicare claim is not accompanied by an EOB, return the claim to the claimant with instructions that an EOB from the primary insurer must be submitted for a secondary Medicare claim to be processed.

If you find that the other insurer is not the primary payer, process the claim for primary Medicare benefits. The EOB and Medicare claim must agree with respect to the physician's/supplier's name or code, the dates of services (or the period of time over which the services were furnished), and the actual charges for the services. The TPP's EOB must show the amount the plan paid for each service.

If the EOB does not include needed information or contains information that is inconsistent with the Medicare claim, contact the primary insurer. If a claim for secondary benefits is complete in all respects except that it does not show the primary insurer's allowable charge, process the claim without that information. Use the assumptions in §3328.20.A to determine the allowable charge.

If the TPP does not furnish the information you request, ask the beneficiary to furnish it. If the beneficiary's efforts to obtain the information from the TPP are unsuccessful, ask the beneficiary, physician, or supplier to help you match up the items on the EOB and the Medicare claim based on their understanding of the EOB. If the beneficiary's, physician's, or supplier's interpretation of the EOB is reasonable, it can be accepted as a basis for paying secondary Medicare benefits in the absence of evidence to the contrary.

If a primary insurer's EOB is received without a Medicare claim form and an itemization of the services for which benefits are claimed, return the EOB to the claimant and indicate what additional items and/or information must be submitted in order to complete the claim for secondary Medicare benefits.

3328.7 Physician, Supplier, or Beneficiary Bills Medicare for Primary Benefits.--

A. General.--If Medicare is billed as primary payer but there is an indication of possible coverage by a TPP, deny the claim. Advise the claimant to bill the primary payer. Unless the claimant submits a satisfactory explanation (preferably a copy of the insurer's notice) why full or partial payment under primary insurance cannot be made or there is evidence that a decision on a claim dealing with WC, no-fault, or liability insurance will not be made promptly, deny the claim for primary Medicare benefits. Medicare is primary only if payment cannot be made by an insurer that is primary to Medicare. Examples of acceptable reason why the primary insurer cannot pay are (1) a deductible applies (see §3328.8), (2) the beneficiary is not entitled to benefits, (3) benefits under the plan are exhausted for particular services, or (4) the services are not covered under the plan. However, the primary insurer cannot assert that the beneficiary is not entitled to primary benefits or the services are not covered for primary payment under the plan.

If the beneficiary does not furnish information needed to determine if another payer is primary to Medicare or to determine the amount of the other payer's primary payment, follow up in 60 days.

If no response is received, send a follow-up letter. After the time specified in §3319, deny the claim for lack of sufficient information. Also see §13450 for criteria that must be met in order to count any amounts from such claims as MSP savings on the Form CMS-1564.

If you pay primary benefits and later learn that the beneficiary is appealing the TPP's denial, treat the payment as a conditional primary payment. When a primary Medicare claim is denied, the denial notice informs the physician, supplier, and/or beneficiary that, after the primary insurer has processed the claim for primary benefits, a claim for secondary Medicare benefits may be filed and that a copy of the TPP's EOB must be included.

B. Processing Claims Denied By TPPs.--When it appears that a TPP should be primary payer, a claim for Medicare primary benefits may not be processed unless accompanied by an EOB from the insurer indicating that the TPP has previously processed a claim for the services and denied primary benefits for reasons other than it makes payment after Medicare for services provided to the beneficiary.

If the claim is not accompanied by a TPP's EOB, ask the claimant to provide one.

Unless the claimant submits a satisfactory explanation (preferably a copy of the TPP's notice) of why full or partial payment under primary insurance cannot be made, or in WC, liability, or no-fault claims, there is evidence that a decision will not be made promptly, deny the claim for primary Medicare benefits. Medicare is primary only if payment cannot be made by an insurer that is primary to Medicare. Examples of acceptable reasons why the TPP cannot pay are (1) a deductible applies (see §3328.8), (2) the beneficiary is not entitled to benefits, (3) benefits under the plan are exhausted for particular services, or (4) the services are not covered under the plan.

3328.8 TPP Does Not Pay Because of Deductible or Coinsurance Provision.--A TPP may reduce benefits by deductible and coinsurance amounts. If such provisions apply to all policyholders, Medicare pays secondary benefits with respect to Medicare covered expenses that are not reimbursable under the TPP contract. Therefore, if a TPP has been billed and has made no payment or only partial payment because of a deductible or coinsurance, Medicare may pay. Before you pay such a claim, require submittal of an EOB or similar notice issued by the TPP showing the status of the deductible or coinsurance after taking into account the expenses for which Medicare is being billed.

3328.9 TPP Gives Medicare Beneficiary Choice of Using Preferred Provider.--If a Medicare beneficiary is given the choice by the TPP whether to choose a preferred provider or to obtain medical services from a non-preferred provider, the beneficiary may choose the non-preferred provider and Medicare makes secondary payments based on the amount paid by the TPP. However, see §3329.4 for rules governing employer-sponsored HMO/CMPs when Medicare cannot make primary payments.

3328.10 Multiple Insurers.--

A. More Than One Primary Insurer.--There may be instances where Medicare is secondary payer to more than one primary insurer (e.g., an individual who meets the criteria in §3336.3 is covered under his/her own GHP and under the GHP of an employed spouse (who also meets the criteria in §3336.3) or under no-fault insurance). In such cases, the other primary payers will customarily coordinate benefits. If a portion of the charges remains unpaid after the other insurers have paid primary benefits, a secondary Medicare payment may be made.

B. Coordination of Benefits Rules Conflict With MSP Rules.--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 GHPs and LGHPs in certain situations. Therefore, where the individual has dependent GHP coverage which is primary to Medicare (e.g., coverage based on the employment of the individual's spouse) in addition to nondependent coverage which is secondary to Medicare (e.g., coverage based on the individual's retirement), Medicare is secondary to the dependent coverage and primary to the nondependent coverage. In other words, the dependent coverage pays first and the nondependent coverage pays second even though under private coordination of benefits agreements, the nondependent coverage would be expected to pay before the dependent coverage. However, 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) of the Act, the combined payment of both plans constitutes the primary payment to which Medicare is a secondary payer. In other words, both plans pay first.

EXAMPLE 1: John Jones, age 75, 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 that is secondary to Medicare. His wife Mary, age 64, 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:

- The GHP of the spouse who has current employment status is primary payer. Medicare will not pay until GHP of the spouse has made a full primary payment.

  The GHP of the spouse may not assert that, under its private COB rules, it would only be liable for deductible and coinsurance and thus only pay the estimated deductible and coinsurance. It must make a full primary payment.

EXAMPLE 2: Chris Thomas, age 67, is a Medicare beneficiary with coverage under Part A and Part B. He has been employed continuously by XYZ Bolt Company since 1986 and has GHP coverage through his employer. His wife Ann, age 62, has been retired from the local police department since 1960 and received retirement health insurance coverage for herself and her husband which is secondary to Medicare. The order of payment for Chris' medical expenses is as follows:

1. The GHP of the spouse who has current employment status is primary payer.

2. Medicare is secondary payer.

3. The retirement plan is the tertiary payer.

3328.11 Recovery of MSP Mistaken Payments.--Section 1862(b)(2) of the Act gives the Government the right to recover conditional Medicare benefits from entities responsible for or required to make payment on behalf of private insurers which are the primary payers for Medicare beneficiaries. Therefore, such entities must reimburse Medicare when it mistakenly paid primary benefits.

If the reimbursement is not made, CMS:

o May bring legal action against any entity required to make or responsible for payment and collect double damages;

o May take legal action to recover its benefits from any entity that has received primary payment from the TPP for items and services furnished to an individual for whom Medicare is the secondary payer;

o May join or intervene in any legal action against the TPP related to the events that gave rise to the need for the items or services; and

When you deny a claim for Medicare conditional primary or secondary benefits in insolvency cases because the receiver has not completed the determination of final payment, notify the physician or supplier of the possible 6-month extension on filing claims as described above.

3328.15 Advice to Physician/Suppliers and Beneficiaries.--In your professional and public relations activities, inform physicians/suppliers and beneficiaries about the MSP provisions and that claims from beneficiaries for which Medicare is the secondary payer must be directed first to the TPP where there is primary coverage for the services involved. Advise them that the Medicare law requires the submitter to identify on the claims form all known payers obligated to pay primary to Medicare.

3328.16 TPP Pays Primary Benefits When Not Required.--Cases may come to your attention in which a TPP has mistakenly paid primary benefits for the services of a physician/supplier (e.g., the GHP of an employer of less than 20 employees has paid primary benefits). If the time limits for reopening in §§12000ff. permit and if requested by the physician/supplier or beneficiary, reopen the Medicare secondary claim, pay any additional amount due as primary benefits, and notify the TPP of any such Medicare payments. If the Medicare secondary claim was submitted on an assignment basis, pay the additional amount to the physician/supplier. If the Medicare secondary claim was submitted on an unassigned basis, pay the additional amount to the beneficiary.

When a TPP has mistakenly paid primary benefits for the services of a physician/supplier and no Medicare claim was submitted for those services, it is the responsibility of the physician/supplier to submit an assigned or unassigned Medicare claim, as appropriate. (The time limit on filing may be extended if failure to file timely resulted from error or misrepresentation by an employee, intermediary, carrier, or agent of the DHHS. For this purpose, the Social Security Administration is considered an agent of the DHHS.) (See §3004.1.)

3328.17 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, although are required to or responsible for, fail to pay benefits primary to Medicare. 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:

- GHPs, including insurers, employers, and third party administrators (TPAs) on behalf of such plans; LGHPs, including insurers, employers, and TPAs on behalf of such plans;
- Any automobile and non-automobile no-fault insurers;
- Any liability insurance policy or plan, including a self-insured plan; and
- A WC plan.

Refer any case in which an entity is required or responsible to make primary payment and to repay Medicare for mistaken primary payments but refuses to do so to the CMS 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 TPA); a copy of the employer's agreement with the TPA; the name of the sponsoring or contributing employer or employee organization; the physician's/supplier'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 the Office of Financial Management in central office (CO). CO considers possible legal action to collect double damages from that entity.

The Government's right to collect double damages in a lawsuit 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 in a lawsuit under the MSP for the disabled provision is effective for items and services furnished on or after January 1, 1987.

3328.18 When Medicare Secondary Benefits Are Payable.--Medicare may pay secondary benefits when a physician, supplier, or beneficiary submits a claim to a TPP and the TPP does not pay the entire charge. Medicare will not make a secondary payment if the physician/supplier accepts, or is obligated to accept, the TPP payment as full payment. The method of calculating the Medicare secondary amount is the same whether the claim is assigned or unassigned.

3328.19 When Medicare Secondary Benefits Are Not Payable.--Secondary benefits are not payable when the:

- o TPP pays the physician's/supplier's charges in full; or
- o Physician/supplier is either obligated to accept or voluntarily accepts a third party payment as full payment.

3328.20 Calculating Medicare Secondary Payments for Services Reimbursed on Reasonable Charge or Other Basis Under Part B.--

A. General.--When a proper claim has been filed (i.e., a claim that is filed in a timely manner and meets all other filing requirements of the TPP), the amount of secondary benefits payable is the lowest of the:

- o Actual charge by the physician/supplier (or the amount he/she is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the TPP;
- o Amount Medicare would pay if services were not covered by a TPP. (The payment limitations in §2470 and 2472 for non-inpatient psychiatric services and in §2480 for physical therapy services apply in determining this amount.); or
- o Higher of the Medicare fee schedule or other amount that would be payable under Medicare (without regard to any Medicare deductible and/or coinsurance amounts) or the TPP's allowable charge (without regard to any co-payment imposed by the policy or plan) minus the amount actually paid by the TPP.

The Medicare allowable amount for the nonparticipating physician was $55. The Medicare secondary payment is calculated as follows:

1. Determine the Medicare payment in the usual manner: .80 x $440 ($55 per visit x 8 visits) = $352.

2. The co-payment for the 8 visits total $200 ($25 x 8).

3. Pay $200, the total co-payment, since that amount is lower than the amount Medicare would pay as primary payer.

EXAMPLE 2: Mr. Blue belongs to an employer-sponsored HMO that is primary to Medicare. He had 2 visits with a doctor for which he paid a $10 co-payment per visit. He has not met his Medicare deductible. He wishes Medicare to make secondary payments to reimburse him for these co-payments.

The Medicare allowable amount for each of Mr. Blue's visits was $32 giving a total of $64 for the 2 visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

1. Determine the Medicare payment in the usual manner: .80 x $64 ($32 per visit x 2 visits) = $51.20.

2. The co-payments for the 2 visits totals $20.

3. If the deductible had been met, the lowest of steps 1 or 2 would be payable. Since it was not met, the amount credited toward the deductible is:

- The Medicare allowable amount for the covered services if they had been furnished on a fee-for-service basis ($32 x 2 = $64).

- To this amount, add the total co-payments for those covered services: $64 + ($10 x 2) = $84.

Mr. Blue is credited with $84 toward his deductible. Since Mr. Blue has not met the Medicare deductible, no MSP amount is payable.

3328.24 Right of Physician or Supplier to Charge Beneficiary.--

A. Basic Rule.--When a beneficiary has been paid by a TPP, the amount a physician/supplier who accepts assignment may collect for Medicare covered services from the beneficiary is limited to the following:

- The amount paid or payable by the TPP to the beneficiary. (If this amount exceeds the amount that would be payable by Medicare as primary payer (without regard to deductible or coinsurance), the physician or supplier may retain the third party payment in full without violating the conditions of assignment.); or

- If the third party payment is less than the applicable Medicare deductible and coinsurance amounts, the difference between the fee schedule amount (or the amount the physician is obligated to accept as payment in full, if less) and the sum of the third party primary payment and the Medicare secondary payment.

EXAMPLE: A physician charges $262 for a service. The plan allows $262 but pays a primary payment of only $112 because of a $150 plan deductible. The Medicare fee schedule amount is $200. The amount that Medicare pays as secondary payer is $80 since the Medicare secondary payment amount cannot exceed the amount Medicare would pay as primary payer ($200 fee schedule amount minus the $100 Part B deductible equals $100 x 80 percent = $80). The combined primary plan payment and Medicare secondary payment is $192 ($112 +$80).

The physician may charge the beneficiary $8, the difference between the Medicare fee schedule amount ($200) and the sum of the primary payment ($112) plus the Medicare secondary payment ($80). The $8 charge to the beneficiary represents the portion of the Part B deductible and coinsurance amounts in excess of the plan payment. The $100 Part B deductible is credited in full. The remaining $12 of the plan payment is applied to the beneficiary's Part B coinsurance obligation of $20, leaving him/her responsible for the remaining coinsurance obligation of $8.

In the case of non-inpatient psychiatric services, the amount the beneficiary can be charged is the difference between the Medicare fee schedule amount and a lesser third party payment amount. (The 50-percent cost sharing rule applies.) The beneficiary is responsible for that portion of the fee schedule amount not paid by Medicare (i.e., no less than 50 percent). (See §3328.22.B.)

B. Right To Charge Beneficiary When Physician or Supplier Has Failed To File Proper Claim.--If a physician/supplier receives from a payer that is primary to Medicare a payment that is reduced because the physician/supplier failed to file a proper claim, he/she may charge the beneficiary an amount equal to any third party payment reduction attributable to failure to file a proper claim if the beneficiary was the sole cause of the failure. The physician/supplier may charge the beneficiary this amount only if the physician/supplier can show that he/she failed to file a proper claim due to the beneficiary's action or inaction and the beneficiary is not mentally or physically incapacitated. (See §3328.21.)

C. Duplicate Payments.--In any case in which a physician/supplier has received a primary payment from Medicare and a duplicate primary payment from a TPP, instruct the physician/supplier to refund to the beneficiary any Medicare deductible and coinsurance amounts paid by the beneficiary that were duplicated by the third party payment. If the third party payment exceeds the deductible and coinsurance amounts, the excess constitutes a debt to Medicare because it duplicates all or part of the amount Medicare has paid and, therefore, must be collected from the physician/supplier. Medicare must be reimbursed within 60 days of the receipt of the duplicate payment. A copy of the letter to the physician/supplier is sent to the beneficiary.

3328.25 Charging Expenses Against Annual Limit on Incurred Expenses for Services of Independently Practicing Physical Therapists.--When services are provided by an independently practicing physical therapist, Medicare pays based on 80 percent of the fee schedule amount (incurred expenses). There is a $750 annual limit on incurred expenses for outpatient physical therapy services and a separate $750 limit for outpatient occupational therapy services. (See §2480.) Any portion of the Medicare fee schedule amount paid for by a TPP and credited toward the deductible is charged against the $750 limit on incurred expenses for services furnished by independently practicing physical therapists. However, amounts paid by a TPP after the Part B deductible has been met do not count toward the $750 that is recognized as incurred expenses.

An amount equal to 1.25 times the amount paid by Medicare is charged against the $750 limit on incurred expenses for physical therapy services furnished by independently practicing physical therapists. This is because Medicare pays 80 percent of the fee schedule amount for such services, while incurred expenses are equal to 100 percent of the Medicare fee schedule amount. Therefore, in order to properly determine the incurred expenses which are to be applied to the $750 annual limit on incurred expenses, Medicare payment amounts, including secondary payment amounts, must be multiplied by a factor of 1.25 (1.00 (100 percent of fee schedule amount) divided by .8 (80 percent payable by Medicare after deduction for coinsurance) = 1.25).

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

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

3329.1 General.--

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

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

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

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

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

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

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

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

Medicare is secondary for these Medicare beneficiaries even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare benefits or otherwise excludes or limits its payments to Medicare beneficiaries.

3329.2 Definitions.--

A. Employee.--Employee means an individual who is working for an employer or an individual who, although not actually working for an employer, is receiving from an employer payments that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code (IRC).

B. Employer.--Employer means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions. Included are the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the District of Columbia, and foreign governments.

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

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

E. GHP.--The term "GHP" means any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than full-time life insurance agents, the plan is not considered a GHP. However, if the plan includes full-time life insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State, and local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs which are under the auspices of one or more employers or employee organizations but which do not receive any contribution from the employer). 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 employer offered GHPs. However, coverage under TRICARE formerly known as the civilian health and medical program of the uniform services (CHAMPUS) is not considered to meet the definition of a GHP.

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

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

1. A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

2. Two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

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

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

3329.3 Current Employment Status.--

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

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

2. 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.)

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

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

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

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

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

1. GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and

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

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

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

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

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

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 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.

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 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.

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.

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.)

J. Determining Size of Employers.--

1. General.--The size of the employer is a factor in determining whether Medicare is secondary or primary payer under §§3336ff. and 3337ff. In general, for MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. Ordinarily, the identity of that entity is clear.

There are situations, however, when it is not clear which corporation or individual is the employing entity for MSP purposes. For example, when a corporation is owned or controlled by another corporation, it must be decided which corporation is the employer. Similarly, when related individuals each have businesses and each claims to be a separate employer with either fewer than 20 or fewer than 100 employees, it must be decided whether the individuals are separate employers or a single employer.

2. Aggregation Rules.--The MSP law contains the following rules for determining the size of the employer under the MSP for the aged and disabled provisions.

a. Single Employers Under §52 of the IRC.--All employers that are treated as single employers under subsections (a) or (b) of §52 of the IRC are treated as single employers.

Section 52(a) of the IRC provides that all employees of all corporations that are members of the same controlled group of corporations are treated as if employed by a single employer.

§52(b) of the IRC provides that all employees of trades or businesses (whether or not incorporated), e.g., employees of partnerships or proprietorships that are under common control, shall be treated as employed by a single employer.

In general, two or more individuals or corporations are considered to be separate employers under §52(a) or (b) of the IRC if they file separate income tax returns. Two or more individuals are considered to be a single employer if they file a consolidated tax return.

When there is a question about the tax status of a particular employer that claims to have fewer employees than the 20 or 100 employee thresholds, request the employer to submit copies of its most recent tax return to resolve the question.

b. Affiliated Service Groups.--All employees of the members of an affiliated service group (as defined in §414(m) of the IRC) are treated as employed by a single employer.

c. Leased Employees.--Leased employees (as defined in §414(n)(2) of the IRC) are treated as employees of the recipient.

The term "leased employee" means any person who is not an employee of the recipient of the services but who provides services to the recipient if the:

- Services are provided based on an agreement between the recipient and any other person (i.e., the leasing organization);

- Person has performed such services for the recipient on a substantially full-time basis for at least 1 year. (In general, an employee who works 30 hours or more is considered to be full time.); and

- Services are of a type historically performed in the business field of the recipient by employees. An example of a leased employee is an employee of a temporary agency who is assigned to work full time for at least one year doing bookkeeping for an accounting firm.

In implementing these provisions, CMS relies on the regulations and decisions made by the Secretary of the Treasury. Specific questions relating to application of these provisions may be directed to the appropriate RO.

3. Treatment of Religious Organizations.--CMS does not aggregate religious organizations for MSP purposes. Incorporated parishes and churches that are part of a church-wide organization, such as a diocese or synod, are considered to be individual employers. A GHP or LGHP for employees of such parishes or churches is considered to be a multi-employer GHP. (See §§3336.5 and 3337.3 for policies regarding multi-employer GHPs in which at least one participating employer employs 20 or 100 or more employees respectively.)

K. Individuals Receiving Delayed Compensation Payments Subject To FICA Taxes.--An individual who is not working is not considered to have current employment status solely on the basis of receiving delayed compensation payments for previous periods of work despite the fact that those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working and in 1997 receives payments subject to FICA taxes for work performed in 1996 is not considered to be an employee in 1997 solely on the basis of receiving those payments.

3329.4 Employer Sponsored Managed Care Health Plan.--

A. Services By Outside Sources Not Covered.--When Medicare is secondary payer for a person enrolled in an employer-sponsored managed care health plan (e.g., health maintenance organization/competitive medical plan (HMO/CMP)), Medicare does not pay for services obtained from a source outside the employer-sponsored managed care health plan if the same type of services could have been obtained as covered services through, or paid for by, the employer sponsored managed care health plan.

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).

NOTE: This restriction affects only Medicare beneficiaries enrolled in employer sponsored managed care health plans that either do not have a Medicare contract or have a Medicare cost contract. Beneficiaries in HMOs/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 employer health plan and has not yet been notified in writing of this rule, Medicare pays for the services if the plan will not pay for the services for legitimate reasons. In general, in the absence of evidence to the contrary (e.g., when CWF indicates that the beneficiary has been notified), it is assumed that written notification has not been given. (See subsection D.) When payment is made for services from a source outside the employer sponsored managed care health plan, the Explanation of Medicare Benefits (EOMB) 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 that could have been obtained from, or through, the managed health care plan."

C. Notice To Beneficiary.--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 are denied. The physician/supplier can then bill the beneficiary. In these cases, the EOMB includes 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 that could have been obtained from or through the managed care health plan are not covered. Our records show that you were previously informed of this rule. Therefore, payment cannot be made for the non-plan services you received."

D. Update CWF.--When you have identified a beneficiary under subsection A and either you have notified him/her in writing that Medicare does not pay for services obtained outside of the managed care plan or you have information that he/she was previously notified of this, you must update your internal system to show 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 §4307.) This is accomplished by entering the following information in remarks:

"Working aged, ESRD, or disabled beneficiary belongs to a managed care GHP. Notified that Medicare will not pay."

3329.5 Prohibition Against Financial and Other Incentives.--

A. General.--An employer or other entity is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in or to terminate enrollment in a GHP or LGHP that is or would be primary to Medicare. This prohibition precludes the offering of benefits to Medicare beneficiaries that are alternatives to the employer's primary plan (e.g., prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary plan coverage through his/her own or a spouse's employer. This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan. It is a violation of the Medicare law every time a prohibited offer is made regardless of whether it is oral or in writing.

B. Penalty for Violation.--Any entity that violates the prohibition described in subsection A is subject to a civil money penalty of up to $5,000 for each violation.

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

3329.6 Nonconforming Group Health Plan.--

A. Prohibitions Against Taking Into Account Medicare Entitlement When Medicare Is Secondary.--Sections 1862(b)(1)(A), (B), and (C) of the Act provide that GHPs and LGHPs may not take into account that an individual is entitled to Medicare in any of the following situations:

- Beneficiaries age 65 or older who are covered by a GHP (of employers who employ at least 20 employees) by virtue of the individual's current employment status or the current employment status of a spouse of any age (see §§3336ff.);

- Beneficiaries who are eligible for or entitled to Medicare on the basis of ESRD and who are covered by a GHP (without regard to the number of individuals employed and regardless of current employment status) during the first 30 months of ESRD-based Medicare eligibility or entitlement (see §§3335ff.); or

- Beneficiaries under age 65 who are entitled to Medicare on the basis of disability and who are covered under a LGHP (i.e., a plan of an employer who employs at least 100 employees) and are covered under the plan by virtue of the individual's or a family member's current employment status. (See §§3337ff.)

B. Equal Benefits for Older and Younger Employees and Spouses.--Section 1862(b)(1)(A)(i)(II) of the Act provides that GHPs of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits under the same conditions that they provide to employees and spouses under 65 if those 65 or older are covered under the plan on the basis of the individual's current employment status or the current employment status of a spouse of any age. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare.

C. Non-differentiation for ESRD.--Section 1862(b)(1)(C)(ii) of the Act provides that GHPs may not differentiate in the benefits they provide between individuals who do not have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. (Actions that constitute differentiation are listed in §3335.2.B.)

D. Examples of Actions That Constitute "Taking Into Account".--Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

o Failing to pay primary benefits;

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

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

o In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated disabled individuals who do not meet the Social Security definition of disability;

o Imposing limitations (such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, or providing for lower annual or lifetime benefit limits or more restrictive preexisting illness limitations) on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan;

o Charging the Medicare-entitled individual higher premiums;

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

o Paying physicians and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare;

o Providing misleading or incomplete information that could have the effect of inducing a Medicare-entitled individual to reject the employer plan, thereby making Medicare the primary payer. (An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that if he/she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.);

o Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, physicians and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer; and

o Refusing to enroll an individual for whom Medicare would be secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

E. Permissible Distinctions.--If a GHP or LGHP makes benefit distinctions between various categories of individuals (distinctions unrelated to the fact that an individual is entitled to Medicare but based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP plan may make the same distinctions between the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than 1 year and who are not entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than 1 year and who are entitled to Medicare on the basis of disability or age.

A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the employer employs fewer than 20 or 100 employees, respectively.

A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he/she has current employment status, the GHP or LGHP coverage is by reason of the COBRA law rather than by virtue of current employment status.

A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD when permitted under the COBRA provisions. The only exception in the COBRA law (see 29 U.S.C.1162(2)(D)(ii)) prohibits GHPs from terminating COBRA coverage for retirees and dependents who are entitled to Medicare when the employee retired before the employer effectively terminated the regular plan coverage by filing for bankruptcy.

F. Determination of Nonconformance.--A determination of nonconformance is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section. CMS may make a finding of nonconformance for any GHP or LGHP that at any time during a calendar year fails to comply with any of the following statutory provisions:

- The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability or eligible on the basis of ESRD (see subsection A above);
- The equal benefits clause for the working aged (see subsection B above);
- The non-differentiation clause for individuals with ESRD (see subsection C above); or
- The obligation to refund conditional Medicare primary payments. (See §3328.11.)

CMS may make a finding of nonconformance for a GHP or LGHP that fails to provide correct, complete, and timely information, either voluntarily or in response to a CMS request, on the plan's primary payment obligation with respect to a given beneficiary if that failure contributes to:

- Medicare mistakenly making a primary payment; or
- A delay or foreclosure of CMS's ability to recover a mistaken primary payment.

If CMS determines that a GHP fails to comply with the provision that prohibits taking into account entitlement to Medicare (see 3329.6.D) in a particular year, the GHP is nonconforming for that year.

If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments, the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 1994, that plan was nonconforming for 1994. If in 1997 CMS identifies mistaken primary payments attributable to the 1994 violation and the plan refuses to repay, it is also nonconforming for 1997.

G. Documentation of Conformance.--

1. General.--A GHP or LGHP may be required to demonstrate that it has complied with the MSP prohibitions and requirements set forth in subsections A through E and to submit supporting documentation. If the GHP or LGHP fails to provide acceptable documentation, the GHP or LGHP could be found to be nonconforming. Notify the RO and furnish it complete information.

2. Examples.--The following are examples of acceptable documentation:

o A copy of the employer's plan or policy that specifies the services covered, Conditions of coverage, and benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability for whom Medicare is secondary payer, as compared to the provisions applicable to other enrollees and potential enrollees; and

o An explanation of the plan's allegation that it does not owe CMS any amount CMS claims the plan owes as refund for conditional or mistaken Medicare primary payments. The plan must include all information requested by the contractor.

H. Referral of Nonconforming Plan Cases To Regional Office.--Refer any cases to the RO in which you feel that a GHP or LGHP is a nonconforming plan. Include a full explanation of the reasons for the referral.

I. Starting Dates for Determination of Nonconformance.-- CMS's authority to determine nonconformance of GHPs and LGHPs begins on the following dates:

1. January 1, 1987 for MSP provisions that affect the disabled;

2. December 20, 1989 for MSP provisions that affect ESRD beneficiaries and the working aged; and

3. August 10, 1993 for failure to refund mistaken Medicare primary payments.

J. Notice of Determination of Nonconformance.--

1. Notice To GHP or LGHP.--

a. If CMS determines that a GHP or a LGHP is nonconforming with respect to a particular calendar year, CMS mails to the plan written notice of the following:

o The determination;

o The basis for the determination;

o The right of the parties to request a hearing. (The parties are the GHP or LGHP for which CMS determined the nonconformance and any employers or employee organizations that contributed to the plan during the calendar year for which CMS determined nonconformance.);

o An explanation of the procedure for requesting a hearing;

o The tax that may be assessed by the IRS in accordance with §5000 of the IRC; and

o The fact that, if none of the parties requests a hearing within 65 days from the date on the notice, the determination is binding on all parties unless it is reopened.

b. The notice also states that the plan must submit to CMS, within 30 days from the date on its notice, the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which CMS has determined nonconformance.

2. Notice To Contributing Employers and Employee Organizations.--CMS mails written notice of the determination, including all the information specified in subsection J.1.a., to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with subsection J.1.b. Employer and employee organizations have 65 days from the date of their notice to request a hearing.

3329.7 Tax Imposed On Contributors To Nonconforming GHPs.--Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations that contribute to nonconforming GHPs. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each GHP (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers.

3329.8 Referral To Internal Revenue Service (IRS).--

A. CMS Responsibility.--If CMS determines that a plan has been a nonconforming GHP in a particular year, it refers its determination, including the identity of the contributors that it has identified, to the IRS but only after the parties have exhausted all appeal rights with respect to the determination.

B. IRS Responsibility.--The IRS administers §5000 of the IRC, which imposes the tax on employers (other than governmental entities) or employee organizations that contribute to a nonconforming GHP mentioned in §3329.7).

3329.9 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 carrier 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.

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 evident 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 physician/supplier or beneficiary, recover from the physician 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 regional office.

Data Match cases are tracked in a special tracking system, the Mistaken Primary Payment Recovery and 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 carrier 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 the sufficient specificity (name and address) or you otherwise know the identity of the employer (notify the COB contractor through an ECRS CWF assistance request 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 provided with the demand letter.) Aggregate employer demand letters to the extent possible and do 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 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 physician/supplier or beneficiary, recover from the physician/supplier or beneficiary as explained in subsection D.

If an employer or other entity requests specific information or checks 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 from the appropriate entity.

D. Recovery From the Physician/Supplier.--If both Medicare and the GHP made primary payment to the physician/supplier, recover from the physician/supplier.

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 Medicare benefits from the responsible insurer,
- Medicare is subrogated to the right of the Medicare 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.

G. Contractor Recovery Case Files (Audit Trails).--Maintain a recovery case file for all cases 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;
- The following documents should be inside the file folder;
- Copies of all demand letters
- A copy of the accountability worksheet (see example at the end of this section)
- Copies of the return receipt mail card;
- Copies of any responses from the third party payer;
- Copies of all claims for which a recovery is being sought;

- Copies of the IRS/SSA/CO Data Match Report (where applicable);
- Any other material related to the case.
- All these materials should be fastened to the right hand side of the file folder.

Medicare's right to recover from a GHP or from a beneficiary that has been paid by a GHP is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore does not pay until after Medicare. Medicare's 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's 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's statutory right is higher than the beneficiary's, Medicare's right is higher than the State's.

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, physician 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, physician 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.

3329.10 Advice to Suppliers, Physicians, and Beneficiaries.--In your professional and public relations activities, inform suppliers, physicians, and beneficiaries to direct claims to the GHP where there is primary GHP coverage for the services involved.

3329.11 Mistaken GHP Primary Payments.--Cases may come to your attention in which a GHP has mistakenly paid primary benefits, e.g., primary payments by the GHP of an employer of less than 20 employees. Advise the physician/supplier and beneficiary of the situation and inform them that an initial Medicare claim may be filed if the time period for filing such claims has not expired and an initial claim had not previously been adjudicated. If an initial determination on a claim had been previously made, the physician/supplier or beneficiary may request that the determination be reopened in accordance with Medicare rules.

3329.12 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.

3329.13 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., health maintenance organization (HMO)/competitive Medicare plan (CMP)), it does not pay for services obtained from a source outside the managed care 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, physicians/suppliers ask beneficiaries that are enrolled in GHPs whether the plan is a manage 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 GHP managed care health plan who has previously been notified in writing. Include in the Medicare Benefit Notice or the EOMB 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 that could have been obtained from, or through, the managed care health plan are not covered. Our records show that you were previously informed of this rule. Therefore, payment cannot be made for the non-plan services you received."

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 C.F.R. 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:

[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.

How to Resolve This Matter

Within 60 days of the date of this letter, you or someone acting on you behalf, e.g., your insurer or plan administrator, 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). 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 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 physician/supplier 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. Please 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.

[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.

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.

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 C.F.R. 411.20-37, 411.100-206.

If you have any questions concerning this matter, 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 C.F.R. 411.24(e), provides that "Medicare 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. section 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.

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 C.F.R. 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 C.F.R. 411.110 et seq.) The Internal Revenue Code at Section 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.

[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.

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 (42 U.S.C. 1395(y)(b)) and regulations (42 C.F.R.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]

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). Please 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 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 physician/supplier of the services shown in the enclosures, please provide a copy of the Explanation of Benefits and proof of payment;

[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.

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.

o 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.

o 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. Please 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. Please 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 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 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.

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.

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

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)

_____

(1) Briefly Explain Above Entry:

(2) 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 Coverage Under Workers' Compensation

3330. CARRIER ACTION WHERE THERE IS INDICATION OF WORKERS' COMPENSATION COVERAGE

3330.1 Identification of Cases Requiring Investigation To Determine Whether Services Are Covered Under Workers' Compensation (WC).--Where you receive information that items or services (for which benefits are claimed or for which benefits have been paid) may be covered under WC, identify those cases which require investigation. (See §§2370-2370.12 for policy instructions dealing with the WC exclusion.) Investigate any claim if the following conditions exist:

- The "work-related" question on the request for payment or billing form is answered affirmatively;
- The diagnosis is one that is commonly associated with employment, e.g., pneumoconiosis (including silicosis and asbestosis and Black Lung disease in the case of coal miners); radiation sickness; anthrax; undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;
- There is indication that the injury or illness arose on the job;
- The beneficiary previously received WC for the same condition;
- There is indication that a WC claim is pending;
- The Common Working File's MSP auxiliary record contains a "Y" validity indicator and an MSP code "E" or an MSP code of "H" showing that the beneficiary is entitled to Black Lung benefits (see §§4307ff.); or
- There are other reasons to believe that the services may be covered under WC.

3330.2 Sources of Information for Investigating Possible Workers' Compensation Coverage.--Identify potential WC cases as well as any ensuing investigation as promptly as possible. A delayed determination that WC payment can reasonably be expected, coupled with failure by the patient to file under that system, may result in delay or even loss of benefits under both WC and Medicare.

A. General.--The primary sources indicating WC coverage may be involved are the beneficiary (e.g., on Form HCFA-1490S), the supplier, the physician, or his/her employer. When the information obtained from these initial sources indicates that further information is needed, contact the employer's compensation carrier or the State WC agency. (Although in most jurisdictions the WC program is administered by a State commission or board, there often is no central record of WC cases until a hearing is requested or some action taken to docket a proceeding.) In some cases, it is necessary to obtain copies of any decisions made by the WC agency or settlements approved by the agency.

B. Data Exchange From Workers' Compensation Agencies.--Transfers of information on claimants, who also may be Medicare beneficiaries, for WC benefits have been negotiated with many State WC agencies. Information from such data transfers provide a valuable source for identifying beneficiaries who may be entitled to WC benefits. If you are not receiving information either directly

from the State agency or from the lead contractor, contact your RO to determine the possibility of such a data transfer in your State.

3330.3 Investigation and Evaluation Guides.--The following are general guidelines for investigating and evaluating the likelihood of WC coverage in various situations in which the condition appears to be work-related, but the beneficiary has not filed a claim for WC benefits. If the investigation indicates that such benefits could be paid for the services in question, deny the claim and notify the beneficiary that Medicare benefits are not payable for services covered under WC. Advise the beneficiary to file for WC if he/she has not already done so and that, in the event a WC claim is filed and denied, the Medicare claim may be reopened. Further, advise the beneficiary that, if the reason for denial of WC benefits is due to the beneficiary's failure to timely file a claim, Medicare payment will not be made. Document your determination with the facts obtained in your investigation.

A. Beneficiary States He/She Does Not Wish To Report Condition To Employer.--Deny benefits when a beneficiary states that he/she is not requesting payment under WC for expenses incurred in connection with an on-the-job injury because he/she does not wish to report his/her injury to his/her employer.

B. Beneficiary States He/She Is In Non-covered Employment.--A beneficiary's statement that he/she is in a category of employment which is clearly not covered under WC can be accepted in the absence of any reason to doubt its accuracy. (See §2370.1.A for categories of employees not generally covered under WC.)

C. Beneficiary States Employer or Carrier Denies Condition Is Work-Related or States He/She Has Exhausted Workers' Compensation Benefits.--Obtain confirmation of the beneficiary's statement from the employer, the WC carrier, or the State WC agency. If such confirmation is obtained, pay the claim.

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Limitation on Payment for Services To Employed Aged Beneficiaries and Aged Spouses of Employee of Any Age

3336. MEDICARE SECONDARY PAYER PROVISIONS FOR WORKING AGED INDIVIDUALS

Medicare pays secondary to GHP coverage for individuals age 65 or over if the GHP coverage is by virtue of the individual's current employment status or the current employment status of the individual's spouse. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare.

Medicare beneficiaries are free to reject GHP coverage in which case they retain Medicare as the primary coverage. When Medicare is primary payer, employers cannot offer employees or their spouses secondary coverage of items and services covered by Medicare.

3336.1 Individuals Not Subject To MSP Provision.--This MSP provision does not apply to:

- o Individuals who are 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;
- o Individuals enrolled in single employer GHPs of employers of fewer than 20 employees;
- o Individuals covered by a health plan other than a GHP as defined in §3329.2.E (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) (see §3329.5 for prohibition against incentives);
- o Members of multi-employer plans who are employees of employers with fewer than 20 employees, provided the plan formally requested to elect (see §3336.5) to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees and CMS approved the request; and
- o Retired beneficiaries (other than those covered as a spouse of a person with current employment status) who are covered by GHPs as a result of past employment and who do not have GHP coverage as a result of current employment status. (See §3336.7 regarding reemployed retirees.)

3336.2 Prohibition Against Taking Into Account Medicare Entitlement.--Section 1862(b)(1)(A)(I) of the Act provides that GHPs may not take into account the Medicare entitlement of a working aged individual for whom Medicare is the secondary payer. (See §3329.6.D for examples of actions which constitute taking into account Medicare entitlement.)

3336.3 Requirement to Provide Equal Benefits Under Same Conditions To Older and Younger Employees.--Section 1862(b)(1)(A)(i)(II) of the Act requires employers to offer to their full-time and part-time employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage they offer to employees and employees' spouses under age 65. For example, a plan may not provide benefits that are less for individuals age 65 or over or charge policyholders premiums that are higher for individuals age 65 or over since this would create an incentive for these individuals to reject the GHP coverage and make Medicare the primary payer. This provision applies whether or not the individual age 65 or over is entitled to Medicare.

3336.4 The 20-or-More Employees Requirement.--The working aged MSP provision applies only to GHPs of employers with 20 or more employees and to multi-employer and multiple employer GHPs in which at least one employer that employs 20 or more employees participate. This requirement is met if an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full- time or part-time employees on his/her employment rolls each working day of that week. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 20 regardless of the number of employees who work or who are expected to report for work on a particular day. Self-employed individuals who participate in a GHP are not counted as employees for purposes of determining if the 20-or-more employee requirement is met. An individual is considered to be on the employment rolls even if he/she does not work on a particular day. An employer may not have different employment rolls for different days reflecting those scheduled.

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

The 20-or-more employees requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. If at that time the employer has met the 20-or-more employees requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the GHP. (See §3329.3.J for determining the size of employers.)

3336.5 Exception for Small Employers in Multi-Employer and Multiple Employer GHPs.--A multi-employer or multiple employer GHP that has at least one employer with 20 or more employees may request to exempt employees of identified employers with fewer than 20 employees from the working aged provision. Such members and their spouses are not subject to this provision.

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

If a GHP wishes to exempt such employees of a particular employer from the working aged provision because the employer does not meet the 20-or-more employee requirement, the plan must submit the following documentation:

- o A letter from the employer that specifies the number of employees that the employer employs and a statement that the employer does not meet the requirements of the 20-or-more employee provision described in §3336.4;

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

- o A letter that identifies the individual as an employee of a small employer that participates in the plan.

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

If the above information is not included, contact the plan and ask that it provide such information before the claim can be processed.

3336.6 Coverage for Self-Employed Individuals.--When Medicare is secondary payer, the employer is not required to provide GHP coverage to self-employed individuals. However, if an employer subject to the MSP provisions provides coverage to a self-employed individual (including owners, a consultant, or a contractor), the employer may not take into account the individual's Medicare entitlement (i.e., the GHP must pay primary to Medicare).

3336.7 Reemployed Retirees and Annuitants.--If a retiree or annuitant returns to work, the employer is required to provide the same coverage under the same conditions as he/she furnishes to active employees in the same category (i.e., employees who have not retired). Thus, an employer is required to provide primary coverage for a reemployed retiree if the amount of work the individual performs (based on hours, productivity, etc.) would be sufficient to earn him/her coverage from the employer had he/she not retired. The GHP or LGHP coverage is considered to be by reason of current employment status and, therefore, primary to Medicare. This rule applies even if the:

- Plan is the same plan that previously provided coverage to the individual when he/she was a retiree or annuitant;
- Premiums for the plan are paid from a retirement pension or fund; or
- Reemployed retiree pays the entire premium.

3336.8 Individuals Age 65 or Older Who Receive Disability Payments.--An individual who is age 65 or older and is receiving disability payments from an employer is considered to have current employment status if such payments are subject to taxes under FICA. Employer disability payments are subject to the FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of a disability in December 1994 at age 66. His employer began paying him disability payments as of January 1995. Since disability payments are taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 1995. Beginning with July 1995, Medicare becomes the primary payer as the disability payments are no longer considered wages under FICA.

3336.9 Dually Entitled Individuals.--If a working aged individual is also eligible for or entitled to Medicare under the ESRD provisions follow the rules in §3335.4, which state that Medicare may be secondary for a 30 -month coordination period.

Medicare Secondary Payer for Disabled Beneficiaries

3337. MEDICARE SECONDARY PAYER PROVISION FOR DISABLED BENEFICIARIES

3337.1 General.-- Medicare is secondary payer to LGHP coverage for individuals under age 65 entitled to Medicare based on disability and whose LGHP coverage is based on the individual's current employment status or the current employment status of a family member. (See §3329.3 for definition of current employment status.)

A LGHP may not take into account that such individuals receive benefits based on disability. (See §3329.6D for guidelines pertaining to this prohibition.)

3337.2 Individuals Not Subject to MSP Provision.--Medicare is not secondary for individuals:

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

o Covered by a LGHP as a result of past employment (e.g., as a retired former employee or as the spouse of a retired former employee) and whose coverage is not also based on current employment status (see §3329.3B.3); or

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

3337.3 The 100-or-More Employees Requirement.--The Medicare as secondary for the disabled provision applies only to LGHPs that cover employees of at least one employer that employed 100 or more full-time and/or part-time employees on 50 percent or more of its business days during the previous calendar year. If a plan is a multi-employer plan, such as a union plan which covers employees of some small employers and also employees of at least one employer that meets the 100-or-more employee requirement, Medicare is secondary for all employees enrolled in the plan, including those that work for small employers. The exception discussed in §3336.5 with respect to the working aged provision does not apply to the Medicare as secondary for the disabled provision. An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on his/her employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls adds up to at least 100 regardless of the number of employees who work or who are expected to report for work on that day.

Self-employed individuals who participate in a LGHP are not counted as employees for purposes of determining if the 100-or-more employee requirement is met.

If an employer does not meet the 100-or-more employees requirement in a particular year, he/she may offer his/her employees coverage that is secondary to Medicare during the following year. If he/she meets the 100-or-more employee requirement at any time during the current year, he/she is required to provide his/her employees with coverage that is primary to Medicare during the following year.

3337.4 Disabled Individuals Who Return To Work.--If a disabled individual who has LGHP coverage based on his/her prior service to the employer returns to work, the coverage is considered to be by virtue of current employment status if the employer provides coverage to similarly situated individuals who are not disabled. Similarly situated individuals are individuals who work in the same category of employment and who perform the same amount of work. Such services may be based, for example, on the number of hours worked or the amount of earnings.

3337.5 Dually Entitled Individuals.--If a disabled individual is also eligible for or entitled to Medicare under the ESRD provisions follow the rules in §3335.4 under which Medicare is secondary payer for a 30-month coordination period.