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Medicare Secondary Payer: Don't Deny Services & Bill Correctly

What's Changed?

- Added ORM indicator information (page 5)
- Added new Billing in Liability Insurance Situations section (pages 5–7)

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

We return information for primary Medicare payers through Medicare eligibility. If Medicare eligibility shows open Medicare Secondary Payer (MSP) records, don't deny Medicare patients medical services, treatment, or entry to skilled nursing facilities or hospitals. MSP records are identified by these Insurance Type Codes:

Insurance Type	Insurance Type Codes
Working Aged	12
ESRD	13
Disability	43
Liability (L)	47
No-Fault (NF)	14
Workers' Compensation (WC)	15, WC

Continue to see and treat patients, even if we previously mistakenly denied or rejected a claim you submitted as Medicare primary. You can appeal these claim denials or rejections with your Medicare Administrative Contractor (MAC). Medicare Part A providers can submit adjustments.

Determine the Payer Order

- A Group Health Plan (GHP) is health coverage sponsored by an employer or employee organization. This includes MSP types 12, 13, and 43: When a patient has an employer GHP primary to Medicare, their plan usually covers most health care services and they pay first. Medicare pays second.
- **A Non-Group Health Plan (NGHP) is coverage by a liability insurer (47) (including self-insurance), no-fault insurer (14), and WC (15)**. When a patient has accident insurance, it usually covers all health care services related to the accident and pays first. We pay second in certain situations. Note: See below how we may mistakenly deny or reject claims related to the accident or injury MSP record when similar diagnosis codes are used, including what actions the provider takes to resolve the issue with the MAC.
- Always bill the employer GHP first before billing the NGHP for accident-related services. Bill Medicare last after you get the GHP and NGHP remittance advice.

It's important to know the payer order so you can bill properly. But don't deny services if it takes you some time to figure out who pays first. Review the Medicare eligibility response for information that can help you determine the primary payer of services. You may also ask your patient MSP Questions to verify their MSP status and ask whether any of their insurance status has changed. View the Medicare Questions (IOM Pub 100-05, Chapter 3, Section 20.2.1) to find the MSP questions to ask your Medicare patients. We encourage you to read Chapter 3 to become familiar with how to bill Medicare when another primary payer is involved.

Tips for Using Medicare Eligibility

Be sure to check the time periods. We return MSP effective dates and end dates. If the MSP record is still open, a begin date will appear but an end date won't.

How to Bill MSP NGHP Claims with GHP & NGHP Involvement

If the claim's date of service is within an active (open) or closed MSP NGHP record for accident-related claims:

- Bill the primary insurer first. If there's a GHP record that falls during the timeframe for the date of service, bill the GHP insurer first.
- Bill the NGHP insurer after you get the GHP remittance advice.
- Use the same diagnosis codes found on the NGHP record identified in the eligibility response for those claims related to the accident or injury.
- The NGHP insurer may deny claims if the NGHP case hasn't yet settled, or the benefits were exhausted.
- On your Medicare claim, include the reason for claim denial. You can find this on the other payer's remittance advice. Medicare may pay depending on the reason for the NGHP claim denial.

If claim services are unrelated to the MSP NGHP record found on the Medicare eligibility file, but the diagnosis codes match or are related to the diagnosis codes found in the NGHP record:

- Submit these claims to Medicare after you submit them to the appropriate GHP and/or NGHP insurer.
- The NGHP insurer may deny these claims if they're new claim services that are unrelated to the original accident or injury found on the eligibility response.
- When you get a claim denial from the NGHP, include the denial reason on the primary payer remittance advice on your claim to Medicare. We may pay depending on why the NGHP denied the claim.
- After you submit these claims to us, we may not pay the claim service due to the diagnosis codes being related to the diagnosis codes found on the NGHP MSP record on the eligibility response.
- Appeal the mistakenly denied claim with your MAC. Provide an explanation and relevant reason codes to justify the services aren't related to the accident or injury on record.
- Continue to provide services to your patient.

How to Bill When There's a Workers' Compensation Medicare Set-Aside Agreement

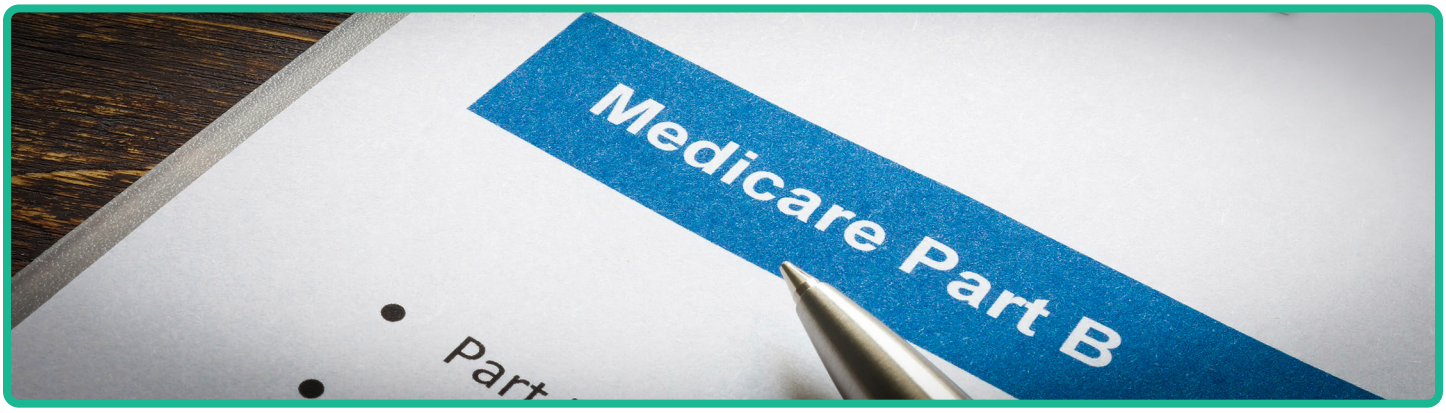
A Workers' Compensation Medicare Set-Aside (WCMSA) is an agreement between CMS and a patient. It determines how much of the settlement funds the WCMSA will spend for care related to all settled WC injuries or illnesses before we become the primary payer.

Use the Medicare eligibility transaction if there's an open or closed WCMSA MSP record:

- Ask your patient if they have other insurance that may be primary to Medicare. View the Medicare Questions to learn which questions to ask.
- If the patient has an active WCMSA record that pays for services related to the accident, bill the patient directly. If the remittance advice shows the primary insurer rejected the claim with reason code P3 (Workers' Compensation case settled), the patient is responsible to pay the claim. Contact the WC insurer if this information isn't accurate.
- If the WCMSA pays for some services but doesn't pay for all the services because benefits are exhausted, bill Medicare and show, on the claim, the amount WCMSA paid, and that the residual payment wasn't made because of benefit exhaustion.
- We'll then pay as a primary or secondary payer, depending on the WCMSA status and how much it paid on the claim.

To bill:

- Use regular billing procedures to submit a bill indicating occurrence code 24 (insurance denied) and the date of denial in FL 31–36 (Part A UB-04) or Loop 2300 HI Segment on the X12 837 electronic claim.
- Submit a supplementary statement that WCMSA denied payment, or annotate FL 80 (Part A UB-04) remarks with the reason for denial. The 837 electronic claim shows Adjudication and Payment Date: Date of payment or denial determination by previous payer is found in these loops and segments: D | 2330B | DTP03 or D | 2430 | DTP03.
- Use the CMS 1500 form or the X12 837 Professional Form to submit Medicare Part B claims.



Billing Accident Insurance for Ongoing Responsibility for Medicals Claims

When NF, L, or WC is primary to Medicare, Medicare eligibility returns the MSP information, including the ICD-10 diagnosis codes. Review the MSP records and respective diagnosis codes to determine who pays first. If the MSP record on the Medicare eligibility response includes both an open GHP and an open NGHP record, bill the GHP insurer first, before you bill the NGHP for both Ongoing Responsibility for Medicals (ORM) and non-ORM claims. Bill the NGHP after the GHP insurer sends you the remittance advice.

> If a record only has an ICD-9 diagnosis code, you don't need to update any records we received before October 1, 2015.

When you treat a patient with dates of service that overlap an open or closed MSP NGHP record found in the eligibility response:

- If the NGHP record shows an open MSP period and the ORM indicator is Y, bill the NGHP first when the dates of service overlap with the MSP dates found on the record. They're the primary payer for claims related to the accident or injury. Don't bill Medicare, as we won't pay for services related to the open ORM NGHP MSP record.
- If the NGHP record shows a closed MSP period and there isn't an ORM indicator, bill the NGHP first for dates of service that overlap with the MSP period. If the NGHP denies the claim and identifies the reason for the denial on the remittance advice, add the denial on your Medicare claim. This helps us determine whether to make a conditional payment during the promptly payment period.

Billing in Liability Insurance Situations

Our regulations and policies for liability insurance billing are different than those for NF insurance and WC benefits. Because the liability insurance billing rules are different and place distinct obligations on providers, physicians, and other suppliers, be sure to review these rules in detail.

View IOM Pub 100-05, Chapter 2, Section 40.2 to learn the options about receiving payment from the liability insurer, and the accompanying obligations and restrictions.

Promptly Period & Timely Filing

- The "promptly period" is 120 days after the earlier of 1 of these dates:
  - You file the claim with an insurer
  - You file a lien against a potential liability settlement
  - You furnish the service
  - The date of discharge for inpatient hospital services

- The promptly period applies even when you're aware liability insurance may end up indirectly funding the defendant's settlement. However, you can bill Medicare or maintain a claim or lien against the liability insurance or patient's liability insurance settlement if 1 of these occurs:
  - The 120-day "promptly period" expires
  - You can show liability insurance won't pay during the promptly period (for example, a submitted bill or claim isn't paid)
- When the promptly period expires, you may bill **either** Medicare (if the Medicare timely filing period hasn't expired), the liability insurer, or the beneficiary's liability insurance settlement. You can't bill both Medicare and maintain a claim against the liability insurance or beneficiary's liability insurance settlement. After you bill Medicare, you're limited to the Medicare-approved amount or the limiting charge if the claim isn't assigned, even if you subsequently return any payment we make.
- For Oregon, there are very specific alternative billing rules due to a court order. You may bill **either** Medicare or the liability insurance if the liability insurer pays within 120 days. View IOM Pub 100-05, Chapter 2, Section 40.2 for more information.
- Liability insurance or a potential liability insurance situation doesn't change or extend our timely filing requirements. If you don't bill Medicare within the applicable timely filing period, we'll deny the claim. You can still maintain a claim or lien against the liability insurance or patient's liability insurance settlement.

Properly Billing Liability Insurance or Patient's Settlement

- If we have a recovery claim, we have the priority right of recovery. In most cases, you:
  - Are limited to the Medicare-approved amount (limiting charge when not assigned) once you've billed Medicare, even if you return any payment you got from us.
  - May charge actual charges but are limited to the amount available from the settlement less applicable procurement costs, like attorney fees and litigation costs.
  - May only bill for non-covered services, coinsurance, or deductibles if Medicare timely filing has expired before payment or settlement. In this case, non-covered services, like measuring of eye refractions or services rendered to family members, are program exclusions. Medical necessity denials aren't included or billable in this example.
  - May not collect from the patient until the proceeds are available to them.

Other Considerations When Billing Liability Insurance

- If you're not a Medicare provider or supplier and don't submit an assigned claim, you can pursue liability insurance, but the amount may not exceed the limiting charge.
- If you don't file a Medicare claim once the "promptly period" has expired, and before timely filing has expired, insurance proceeds may not be available or may be less than our payment would've been if you had billed us.

- If the patient gets help from the state, additional regulations govern provider billing. If a Medicare patient got Medicaid benefits at the time you rendered services, contact their state Medicaid office to get the state's policy on provider billing.
- If you provide items or services not covered by Medicare, you may bill and collect actual charges even if the patient receives the liability insurance proceeds. In this case, non-covered services, like measuring eye refractions or services rendered to family members, are program exclusions. Medical necessity denials aren't included or billable in this example.

Resources

- Medicare Secondary Payer
- Medicare Secondary Payer booklet
- MSP Manual, Chapter 5

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