CMS Manual System

Department of Health & Human Services

Pub 100-05 Medicare Secondary Payer

Centers for Medicare & Medicaid Services

Transmittal 34

Date: SEPTEMBER 7, 2005

Change Request 4018

SUBJECT: Manualization: Long-Standing MSP Policy in Chapter 1 of the Medicare Secondary Payer (MSP) Internet Only Manual (IOM)

I. SUMMARY OF CHANGES: Updating chapter 1 of the Medicare Secondary Payer (MSP) Internet Only Manual (IOM) to reflect current MSP policy. These changes will assist in ensuring consistent and accurate application of MSP policy among providers, physicians, and other suppliers, current FFS contractors, and future Medicare Administrative Contractors (MACs) (MMA Section 911). No new policy is reflected in these updates; we are merely conforming the IOM to long-standing policy. These updates take into consideration the anticipated usage in the MAC contracting environment, e.g., the IOM will reference contractors versus FIs or carriers.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : N/A
IMPLEMENTATION DATE : N/A

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
	Table of Contents
R	1/10/General Provisions
R	1/10/10.1/Working Aged
R	1/10/10.2/End-Stage Renal Disease (ESRD)

R	1/10/10.4/Workers' Compensation (WC)
R	1/10/10.5/No-Fault Insurance
R	1/10/10.6/Liability Insurance
R	1/10/10.7/Conditional Primary Medicare Benefits
R	1/10/10.7/10.7.1/When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare
R	1/10/10.7/10.7.2/When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare
R	1/10/10.8/When Medicare Secondary Payer Benefits Are Payable and Not Payable
R	1/10/10.9/Multiple Insurers
R	1/20/Definitions
R	1/40/40.1/Crediting Deductible for Non-Inpatient Psychiatric Services
R	1/50/50.1/Clarification of Current Employment Status for Specific Groups
R	1/80/Actions Resulting from GHP or LGHP Nonconformance
R	1/110/Federal Government's Right to Sue and Collect Double Damages

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-05	Transmittal: 34	Date: September 7, 2005	Change Request 4018

SUBJECT: Manualization: Long-Standing MSP Policy in Chapter 1 of the Medicare Secondary Payer (MSP) Internet Only Manual (IOM)

I. GENERAL INFORMATION

A. Background: In preparation of upcoming initiatives, manual changes are necessary to reflect current MSP policy.

B. Policy: As a result of the passage of the Medicare Modernization Act (MMA), creation of Medicare Administrative Contractors (MACs) was enacted. These changes to chapter 1 of the Medicare Secondary Payer (MSP) Internet Only Manual (IOM) will assist in ensuring consistent and accurate application of MSP policy among providers, physicians, and other suppliers, current FFS contractors, and future MACs.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4018.1	Contractors shall implement revised policies cited within the manual sections as written.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: N/A **Implementation Date:** N/A **Pre-Implementation Contact(s)**: Suzanne Ripley and Eve Fisher **Post-Implementation Contact(s):** Suzanne Ripley and Eve Fisher	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Secondary Payer (MSP) Manual

Chapter 1 - Background and Overview

Table of Contents

(Rev. 34, 09-07-05)

Crosswalk to Old Manuals

10 - General Provisions

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Under the Medicare law, as enacted in 1965, Medicare was the primary payer for services except those covered by workers' compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional *primary plans*. The purpose was to shift costs from the Medicare program to private sources of payment. *These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at section 1862(b)* of the Social Security Act (the Act). *These provisions* prohibit Medicare from making payment if payment has been made or can reasonably be expected to be made by *the following primary plans when certain conditions are satisfied: group health plans, workers' compensation plans, liability insurance, or no-fault insurance.* If payment has not been made or cannot be expected to be made promptly *by a workers' compensation plan, liability insurance, or no-fault insurance*, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. *Conditional payments are made subject to repayment when the primary plan makes payment.* 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.

When Medicare is the secondary payer, the provider, physician, *or other* supplier, or beneficiary must first submit the claim to the primary payer. The primary payer 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 the primary payer processes the claim, it does not pay in full for the services, Medicare secondary benefits may be paid for the services as prescribed in §10.8. Generally, the beneficiary is not disadvantaged where Medicare is the secondary payer because the combined payment by a primary payer and by Medicare as the secondary payer is the same as or greater than the combined payment when Medicare is the primary payer.

10.1 - Working Aged

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of:

- Their own current employment status with an employer that has 20 or more employees; or
- The current employment status of a spouse of any age with such an employer. (Section 70.2 of this chapter and §10 of Chapter 2 of the Medicare Secondary Payer (MSP) Manual further defines individuals subject to this limitation on payment.)

Employers are required to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries *who have or whose spouse has* current employment status.

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.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Self-employed individuals who participate in an employer plan are not counted as employees in determining if the 20 or more employees requirement is met. Where an employer does not have 20 or more employees in the preceding year, he is required to offer his employees and spouses age 65 or over, primary coverage when he has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees subsequently drops below 20. The "20 or more employees" requirement must be met when the individual receives the services for which Medicare benefits are claimed. If at that time, the employer has met the "20 or more employees" requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the employer plan.

Employers are not required to provide coverage to individuals. However, any coverage provided to such individuals age 65 or older and age 65 or older spouses of such individuals of any age, by an employer of 20 or more employees must be the same as coverage provided to younger such individuals, that is, coverage primary to Medicare. The employer must also provide primary coverage to older such individuals even if there are no younger such individuals enrolled in the plan.

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid, to supplement the amount it paid for the Medicare covered service. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may **not** be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries.

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

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

Contractors *must* refer a multi-employer plan's (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of few*er* than 20 employees, as a basis for making Medicare primary payer, to the *COB* contractor *(see chapter 2 §10.4 and chapter 5 §50 of this manual for further instructions)*.

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

10.2 - End-Stage Renal Disease (ESRD)

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30 months if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD

The coordination period begins when the individual is eligible for Medicare. Medicare is secondary during this period even if the employer policy or plan contains a provision stating that its benefits are secondary to Medicare, or otherwise excludes or limits its payments to Medicare beneficiaries. Under this provision, the GHP is billed first for services provided to a Medicare ESRD beneficiary. If the GHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with current billing instructions. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in the coordination period.

10.4 - Workers' Compensation (WC)

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

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

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, e.g., coal miners totally disabled due to

pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from nonappropriated Federal funds (such as employees of post-exchanges), and offshore oil field workers. The Federal Employers' Liability Act *(FELA)*, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion. *The FELA and similar State acts are considered liability insurance under the MSP liability provisions.*

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

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

10.5 - No-Fault Insurance

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Medicare is secondary to any no-fault insurance, including *all forms of automobile no-fault insurance,* automobile medical *payments,* and non-automobile no-fault insurance. (See Chapter 2, §60.) No-fault insurance is a form of insurance that *pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident.* MedPay is a form of no-fault insurance *even when included in automobile insurance of any type*. Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under no-fault insurance. *A conditional Medicare payment may be made if the no-fault insurance has not paid and cannot reasonably be expected to make payment promptly.*

10.6 - Liability Insurance

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). (See Chapter 2, §40.) Liability insurance means insurance (including a self-insurance plan) that provides payment based on *the policyholder's alledged* legal liability for injury or illness or damage to property. *It includes, but is not limited to* homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It includes payments under state "wrongful

death" statutes that provide payment for medical damages. *An entity that engages in a business, trade, or profession is considered to be self-insured for liability purposes to the extent that it has not purchased liability insurance.*

10.7 - Conditional Primary Medicare Benefits

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

The Medicare statute stipulates that Medicare may not make payment if WC, no-fault, or liability insurance is the proper primary payer. The statute further authorizes Medicare to make *a conditional* payment if the WC, no-fault, or liability *insurance* will not pay or will not pay promptly. Such payments are conditioned upon reimbursement to the trust fund if it is demonstrated that the WC, no-fault, or liability *insurance* has or had the responsibility to make primary payment. Such responsibility may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured, or by other means.

NOTE: If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a GHP, the provider*, physician, or other supplier* bills the *liability insurer* or no-fault insurer and/or GHP as appropriate before requesting conditional Medicare payments. *Except as delineated below in 10.7.1, Medicare does not make conditional primary payment when there is GHP coverage that is a primary payer to Medicare.*

10.7.1 - When Conditional Primary Medicare Benefits May Be Paid *When a GHP is a Primary Payer to Medicare*

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Conditional primary Medicare benefits may be paid if:

• The beneficiary or provider, physician, or *other* supplier that has accepted assignment filed a proper claim with a GHP or LGHP and the GHP denied the claim in whole or in part based on an assertion other than that the GHP or LGHP is the secondary payer to Medicare (i.e., Medicare is primary); or

• Because of physical or mental incapacity of the beneficiary, the *provider, the* physician *or other* supplier, or beneficiary failed to file a proper claim with the GHP.

When such conditional Medicare payments are made, they are made on condition that the *GHP* and*/or* beneficiary will reimburse *Medicare if* payment is subsequently made by the GHP.

10.7.2 - When Conditional Primary Medicare Benefits May Not Be Paid *When a GHP is a Primary Payer to Medicare*

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Conditional primary Medicare payments may not be made *if the claim is denied for one of the following reasons*:

- It is alleged that the *GHP* is secondary to Medicare;
- The *GHP* limits its payment when the individual is entitled to Medicare;
- The services are covered by the *GHP* for younger employees and spouses but not for employees and spouses age 65 or over; or
- 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.

10.8 - When Medicare Secondary Benefits Are Payable and Not Payable

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Contractors may pay Medicare secondary benefits when a provider, physician, *or other* supplier, or beneficiary submits a claim *that is payable under Medicare's coverage requirements* and the *primary plan* does not pay the entire charge. Medicare will not make a secondary payment if the provider/physician/supplier accepts, or is obligated to accept, the *primary plan* payment as full payment *or full satisfaction of the patient's responsibility*.

When a *primary plan's* payment for Medicare covered services is less than the provider's, *physician's, or other supplier's* charges for those services and less than the gross amount payable by Medicare, and the provider*, physician, or other supplier* does not accept and is not obligated to accept the *primary plan's* payment as full payment, then contractors can process Medicare secondary payment as appropriate.

10.9 - Multiple Insurers

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

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 is covered under his/her own GHP and under the GHP of an employed spouse 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.

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain GHPs for individuals and spouses age 65 or over. Therefore, where the individual has GHP coverage based on current employment status in addition to GHP coverage as a retiree, Medicare is secondary to the GHP coverage based on current employment status and primary to the GHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

Where services are covered in part by WC and also under *liability* or no-fault insurance, or there is primary coverage by a GHP, Medicare is the residual payer only.

Accordingly, whenever *any primary plan* pays in part for provider*, physician, or other supplier* services and the provider*, physician, or other supplier* does not accept, and is not obligated to accept the payment as payment in full, the provider*, physician, or other supplier* assures that a claim is submitted to any other insurer that is primary to Medicare.

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. There are two scenarios to consider.

The first scenario is where an individual has dependent GHP coverage that is primary to Medicare (e.g., coverage based on the employment of the individual's spouse) in addition to nondependent coverage that 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. (See example 2 below.)

The second scenario is 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. (See example 1 below.)

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 2003 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 1977 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. *However, the retirement plan must coordinate benefits with the employed spouse's GHP (i.e., the spouse's GHP will not pay until after the retirement plan pays). Under these circumstances, the combined benefit of the two plans is primary to Medicare.*
- Medicare is secondary payer.

NOTE: If the retirement plan is permitted to pay after the GHP under the private coordination of benefits, the order of payment will be as follows:

- The GHP will be primary,
- Medicare will be secondary, and
- The retirement plan will be tertiary payer.

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 2002 and has GHP coverage through his employer. His wife, Ann, age 62, has been retired from the local police department since 2000 and received retirement health insurance coverage for herself and her husband that is secondary to Medicare. The order of payment for Chris' medical expenses is as follows:

- Chris's GHP, based on current employment status is primary payer.
- Medicare is secondary payer.
- The spouse's retirement plan is the tertiary payer.

20 - Definitions

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Accident - An unintended occurrence outside the normal course of events that causes illness, injury, or damage to a person or property.

Age 65 or older – An individual attains age 65 on the day preceding his or her 65th birthday.

Automobile - Any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

CMS' Claim - *In the context of WC, no-fault, and liability claims,* the amount that is determined to be owed to the Medicare program. This is *the lesser of the total sum of the settlements, judgments, or awards related to the underlying WC, no-fault, or liability claim; or* the amount that was paid out by Medicare, less any applicable *share of* procurement costs.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a Title X provision that provides continuation of GHP coverage if elected. For aged or disabled Medicare beneficiaries, COBRA continuation coverage is secondary to Medicare because the coverage is by virtue of COBRA law rather than by virtue of current employment status. For an ESRD related Medicare beneficiary, COBRA continuation coverage if elected, is primary to Medicare during the 30-month ESRD coordination period. See 42 CFR 411.161(a)(3) and 411.162(a)(3).

Compromise - A settlement of differences by mutual consent or adjustment of matters in dispute by mutual concession; a negotiated settlement between parties who are in essentially equal bargaining positions, wherein neither party admits or concedes that he is entitled to less than he desires, but accepts less to effect the goal of ending the dispute. In an MSP situation under the Federal Claims Collection Act, a compromise represents the acceptance by the Regional Office (RO) of less than the full debt owed to Medicare,

when the amount of the full debt does not exceed $100,000, or by Central Office (CO) when the amount exceeds $100,000. An individual who accepts a compromise has no right to appeal the remaining debt.

Conditional Payment - A Medicare payment*, conditioned upon reimbursement to Medicare,* for services for which another insurer is primary payer.

Coordination Period - The term "coordination period" means a period of 30 months during which Medicare benefits are secondary to benefits payable under GHPs for individuals who *are eligible for* Medicare because of ESRD. See Chapter 2, §20.

Current Employment Status – See §50 of this chapter.

Eligibility - Eligibility means a beneficiary meets the legal requirements for Medicare benefits. It is still necessary to file an application to become entitled. (For example, a Social Security beneficiary is eligible for Medicare upon attaining age 65 but is not entitled until an application is filed and approved).

Employee - 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).

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.

Entitled - An eligible individual becomes entitled to Medicare by filing the appropriate application. Upon approval of the application, the individual is entitled. It may also be necessary to enroll for certain services in order to get them.

Family Member - Family member means a person enrolled in a GHP based on another person's enrollment. Family members may include*, but are not limited to,* a spouse (including a divorced or common law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

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 Internal Revenue Code.

Fiduciary - A person in a position of trust with regard to the affairs of another, who has a duty to act primarily for the benefit of the other, with respect to a particular undertaking.

GHP (Group Health Plan) - 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 insurance agents, the plan is not considered a GHP. However, if the plan includes 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 the TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is not considered to meet the definition of a GHP. It is secondary to Medicare since the law makes Medicare primary to TRICARE.

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

Judgment - The official and authentic decision of a court of justice upon the respective rights of the parties to an action submitted to it for determination.

LGHP (Large Group Health Plan) - LGHP means a GHP that covers employees of either:

• 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.

• It includes individual policies (including Medigap policies) purchased by an or through an employer or former employer of the individual or family member.

Liability - Responsibility or fault for damages arising out of a specified incident.

Liability Insurance - Insurance (including a self-insured plan) that provides payment based *on alleged legal liability* for injury, illness or damage to property. It includes, but is not limited to, automobile liability, uninsured and under-insured motorist, homeowner's liability, malpractice, product liability and general casualty insurance. It includes payments under State "wrongful death" statutes that provide payment for medical damages.

Liability Insurance Payment - A payment by a liability insurer, *or an out-of-pocket payment,* including a payment to cover a deductible required by a liability insurer, by any individual or other entity that *carries* liability insurance or is covered by a self-insured plan.

Lump Sum Commutation Settlement - *A workers' compensation settlement in which t*he beneficiary accepts a lump sum payment that compensates for all future medical expenses and disability benefits related to the work injury or disease.

Lump Sum Compromise Settlement - A *workers' compensation* settlement that provides less in total compensation than the individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. This may occur when compensability is contested.

MSP - Acronym denoting "Medicare Secondary Payer" provision*s* of the Social Security Act.

Med-Pay - A payment made by an insurer intended specifically to pay for medical expenses without regard to the fault of any party to the accident. Med-Pay is a form of no-fault insurance.

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

No-Fault Insurance - Insurance that pays for medical expenses for injuries sustained or on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It *includes* "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage.

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

Partial Waiver - A decision by the Medicare program to relinquish the right to collect *a portion of a debt* from a specific entity. A partial waiver is not to be confused with a compromise. It is different in that it does not arise from negotiation or offer, but under 1870(c) of the Act, which provides the beneficiary the right to request waiver and Medicare the authority to grant or deny waiver based on factual data. Section 1870(c) allows a partial waiver to a person who is without fault or where the adjustment or recovery would defeat the purpose of Title II or XVII of the Act (hardship) or be against equity and good conscience. An individual may appeal a determination based on 1870(c) of the Act if the determination grants only partial waiver of a debt.

Payment in full – Payment in full is an amount that the provider*, physician, or other supplier* is obligated to accept (e.g., contractually) or voluntarily accepts as *full satisfaction of the charges for medical services to an individual* from the insurer (*e.g.*, 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.

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

Primary Payer *- When used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.*

Primary Payment *- When used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.*

Primary Plan *- When used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.*

Proceeds - *Benefits paid under any insurance plan or policy, or annuity contract.*

Procurement Costs - Attorney fees and other costs directly related to securing a settlement or judgment that are borne by the *beneficiary* against *whom* CMS seeks to recover.

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 no-fault and WC insurance, prompt or promptly means payment within 120 days after receipt of the claim.

Proper Claim - A claim that is filed timely and meets all other claims filing requirements specified by *the plan, program, or insurer* (e.g., mandatory second opinion, prior notification before seeking treatment).

Recovery - Proceeds obtained from a judgment, settlement, erroneous or conditional payment. The establishment of a right existing in an individual through a law, formal judgment, or decree of a court.

Secondary – The term "secondary", when used with respect to Medicare payment, means that Medicare is the residual payer to all *plans that are primary plans with respect to services provided to a Medicare beneficiary.*

Self-Employed Person - An individual is considered to be self-employed during a particular tax year only if the individual's self-employment income, as determined by the IRS, was at least equal to the amount specified in §211(b)(2) of the Act, which defines self-employment income for Social Security purposes.

Set Aside Arrangement – An administrative mechanism used to set-aside monies for *specific purposes (such as Medicare expenses)* including a self-administered arrangement (State law permitting).

SSI - Supplemental Security Income for the Aged, Blind and Disabled is the Federal subsistence income maintenance program for eligible individuals. Title XVI of the Social Security Act enacted SSI in 1972 for the purpose of assuring a minimum level of income for people who are age 65 or over, blind, or disabled, and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level.

Self-Insured Plan - 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 a nonprofit 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. An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by failure to obtain insurance or otherwise) in whole or in part. (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.)

Settlement - An adjustment or agreement by which parties having a dispute between them reach or ascertain what each owes the other. In the MSP liability context, settlement refers to a monetary amount from a liability insurer agreed to by a party in satisfaction of a liability dispute.

Spouse – Means *a person of the opposite sex who is a husband or a wife.*

Statute of Limitations - A specific time period after the right to assert a claim begins within which certain claims must be filed, and after which the claim may no longer be enforced.

Subrogation - Subrogation means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary.

Under-insured Motorist Insurance - *Insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the party's policy or plan.*

Uninsured Motorist Insurance - *Insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or carries less than the amount of insurance required by law.*

Waiver - The relinquishing of an established right. In an MSP situation, it is the forgiveness of the party's obligation to satisfy Medicare's claim, in whole or in part, if certain conditions are met.

Workers' Compensation Agency - The term "WC agency" means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal WC programs, the U.S. Department of Labor.

Workers' Compensation Carrier - The term "WC carrier" means any insurance carrier authorized to write WC insurance under the state or federal law, the state compensation fund where the state administers the WC program, and the beneficiary's employer where the employer is self-insured.

Workers' Compensation Law or Plan - A WC law or plan is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

Working Aged – 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. *This provision applies* 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.

Wrongful Death - A death caused by a wrongful act, neglect, or fault, as seen in some *WC, no-fault, and* liability situations.

40.1 - Crediting Deductible for Non-Inpatient Psychiatric Services

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

The Part B deductible for non-inpatient psychiatric services is credited on the basis of 62.5 percent of the Medicare fee schedule amount. This is because incurred expenses for non-inpatient psychiatric services are limited to 62.5 percent of the Medicare fee schedule amount. Accordingly, Medicare pays no more than 50 percent of the Medicare fee schedule amount for non-inpatient psychiatric services (i.e., 80 percent of 62.5 percent of the fee schedule amount). (The unmet Part B deductible reduces the percentage of the fee schedule amount payable by Medicare.) The maximum *primary plan* payment that can be credited to the Part B deductible for non-inpatient psychiatric services is $160: $100 (Part B deductible) divided by .625. There is no annual limit on incurred expenses for non-inpatient psychiatric services.

EXAMPLE 1

An individual received non-inpatient psychiatric services for which a physician charged $120. The $100 Part B deductible had not been met. The GHP allowed $100 and paid $50. The Medicare fee schedule amount is $110. The unmet Part B deductible is credited with $68.75 (62.5 percent of $110 = $68.75). Since this amount is insufficient to meet the Part B deductible, the Medicare secondary benefit calculated is $0.

The beneficiary can be charged $60 (the $110 fee schedule amount minus the sum of the $50 primary payment plus the $0 Medicare payment). The beneficiary still must meet $32.25 of the annual Part B deductible before Medicare benefits become payable.

EXAMPLE 2

An individual received non-inpatient psychiatric services for which the physician charged $250. None of the individual's Part B deductible had been met. The GHP allowed charges in full and paid $250. The Medicare fee schedule amount for the services was $200. No Medicare secondary benefit is payable since the GHP paid charges in full. The $100 Part B deductible is credited in full by the first $160 of the fee schedule amount (62.5 percent x $160 = $100).

The beneficiary cannot be billed by the physician because the sum total of the primary payment ($250) and the Medicare payment ($0) exceeds the fee schedule amount ($200).

EXAMPLE 3

An individual received non-inpatient psychiatric services from a physician for which the physician charged $500. None of the individual's $100 Part B deductible had been met. A GHP allowed charges in full and paid $400 (80 percent of the $500). The Medicare fee schedule amount for the services was also $500. The $100 Part B deductible is credited in full by the first $160 of the fee schedule amount (62.5 percent x $160 = $100). The Medicare secondary benefit calculated is $100.

The physician cannot bill the beneficiary because the sum total of the primary payment ($400) and the Medicare secondary payment ($100) equals the physician's charges.

50.1 - Clarification of Current Employment Status for Specific Groups

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

A - Member of Religious Order

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 section 3121(r) of the Internal Revenue **Member of Religious Order** Code. Thus, Medicare is primary payer to any group health 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 1

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 the 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 2

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.

Contractors 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.

B - Insurance Agents

The following guidelines apply in determining the status of insurance agents. (See §20, definition of GHP to determine when an insurance company's plan meets the definition of a GHP.)

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.

C - 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.

D - Volunteers

Volunteers are considered to have current employment status *when* 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 nonmonetary nature. Benefits, including health benefits that a volunteer receives, are considered remuneration.

E - 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 nonmonetary nature. Benefits, including health benefits that a corporation provides to a board member, are considered remuneration if they are subject to FICA taxes under the IRC.

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

F - 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 2003 receives payments subject to FICA taxes for work performed in 2002 is not considered to be an employee in 2003 solely on the basis of receiving those payments.

G - 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 CMS RO.

H - Re-employed Retirees and Annuitants

If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that is furnished to other employees (i.e., non-retirees). Thus, an employer is required to provide primary coverage for a re-employed retiree if the amount of work the individual performs (based on hours, productivity, etc.) would be sufficient to earn the employee coverage from the employer had the employee not retired. The GHP or LGHP coverage is primary to Medicare because of the current employment status. This rule applies even if the:

- Plan is the same plan that previously provided coverage to the individual retiree or annuitant;
- Premiums for the plan are paid from a retirement pension or fund; or
- Re-employed retiree pays the entire premium.

I - 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).

80 - Actions Resulting from GHP or LGHP Nonconformance

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

A - Determination

A determination of nonconformance is a CMS determination that a GHP or LGHP is a nonconforming plan as provided in this section. The 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 §70.4 above);
- The equal benefits clause for the working aged (see §70.5 above);
- The nondifferentiation clause for individuals with ESRD ((see §70.3 above); or
- The obligation to refund conditional Medicare primary payments.

The 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 §70.4) 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 2000, that plan was nonconforming for 2000. If in 2003 CMS identifies mistaken primary payments attributable to the 2000 violation and the plan refuses to repay, it is also nonconforming for 2003.

B - Starting Dates for Determination of Nonconformance

The CMS's authority to determine nonconformance of GHPs and LGHPs begins on the following dates:

- January 1, 1987, for MSP provisions that affect the disabled;
- December 20, 1989, for MSP provisions that affect ESRD beneficiaries and the working aged; and
- August 10, 1993, for failure to refund mistaken Medicare primary payments.

C - Notice to GHP or LGHP of Determination of Nonconformance

If CMS Central Office determines that a GHP or a LGHP is nonconforming with respect to a particular calendar year, CMS will mail a written notice to the plan with the following:

- The determination;
- The basis for the determination;
- 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.);
- An explanation of the procedure for requesting a hearing;
- The tax that may be assessed by the IRS in accordance with §5000 of the IRC; and
- 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.

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.

D - Notice to Contributing Employers and Employee Organizations

The CMS mails written notice of the determination, including all the information specified in subsection C, above, to all contributing employers and employee organizations already known to CMS or identified by the plan in accordance with subsection C. Employer and employee organizations have 65 days from the date of their notice to request a hearing.

E - Penalties

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.

If CMS Central Office 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. 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. The IRS administers Section 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 §80.

110 - Federal Government's Right to Sue and Collect Double Damages

(Rev. 34, Issued: 09-07-05; Effective/Implementation Dates: 09-07-05)

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover Medicare primary payments from *primary payers that* fail to meet the requirement or the responsibility. The Federal Government may recover double damages in this type of lawsuit pursuant to §1862(b)(2)(B)(ii) of the Act. *Primary payers include:*

- insurers and third party administrators *of group health plans and large group health plans and employers/employee organizations that sponsor or contribute to such plans*;
- *No-fault insurers;*
- Any liability *insurers or entities having plans of self-insurance; and*
- WC *insurers or plans.*

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