CMS Manual System

Pub 100-05 Medicare Secondary Payer

Transmittal 49

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: APRIL 7, 2006
Change Request 4024

SUBJECT: Manualizing Long-Standing Medicare Secondary Payer (MSP) Policy in Chapter 2 of the MSP Internet Only Manual (IOM)

I. SUMMARY OF CHANGES: Updating chapter 2 of the MSP 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: May 8, 2006
IMPLEMENTATION DATE: May 8, 2006

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
R	2/10/Medicare Secondary Payer Provisions for Working Aged Individuals
R	2/10/10.1/Individuals Subject to Limitations on Payment
R	2/10/10.2/Individuals Not Subject to the Limitation on Payment
R	2/10/10.4/Working Aged Exception for Small Employers in Multi-Employer Group Health Plans (GHPs)
R	2/20/Medicare Secondary Payer Provisions for End-Stage Renal Disease (ESRD) Beneficiaries

R	2/20/20.1.3/Dual Eligiblity/Entitlement Situations
R	2/30/30.1/Individuals Not Subject to MSP Provision
R	2/30/30.2/The 100 or More Employees Requirement
R	2/30/30.3/Disabled Individuals Who Return to Work
R	2/30/30.4/Dually Entitled Individuals
D	2/30/30.5/Dually Entitled Individuals
R	2/40/Liability Insurance
R	2/40/40.1/Medicare's Recovery Rights
R	2/40/40.2/Billing in Liability Insurance Situations
D	2/40/40.3/Physician and Supplier Billing Rights and Responsibilities
D	2/40/40.3.1/Physician or Supplier Prohibitions Involving Liability Insurance
R	2/50/Workers' Compensation (WC)
R	2/50/50.1/Effect of Payments Under Workers' Compensation Plan
R	2/60/No-Fault Insurance
N	2/60/60.1/Medicare's Recovery Rights

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 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: 49	Date: April 7, 2006	Change Request 4024

SUBJECT: Manualizing Long-Standing Medicare Secondary Payer (MSP) Policy in Chapter 2 of the 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 2 of the MSP 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	
4024.1	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*: May 8, 2006 **Implementation Date:** May 8, 2006 **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 2006 operating budgets.**

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

Medicare Secondary Payer (MSP) Manual

Chapter 2 - MSP Provisions

Table of Contents

(Rev. 49, 04-07-06)

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

10 - Medicare Secondary Payer Provisions for Working Aged Individuals

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

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

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

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

See definitions of employer and employee in Chapter 1.

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

10.1 - Individuals Subject to Limitations on Payment

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

- Is age 65 or over;
- Is entitled to Part A (hospital insurance) on the basis of the individual's own *S*ocial *S*ecurity or *R*ailroad *R*etirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person*;* and
- Is covered on the basis of individual's own current employment status or the current employment status of the individual's spouse.

Re-employed Retirees and Annuitants

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

10.2 - Individuals Not Subject to the Limitation on Payment

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium.
- Anyone who is under age 65. (Medicare is secondary to large group health plans *(LGHPs)* that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than a GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;

- Employees of employers of fewer than 20 employees who are covered by a single employer plan;

- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;

- Individuals enrolled in single employer GHPs of employers *with* fewer than 20 employees; or

- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected (see §10.4) to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.

- Domestic partners who are given "spousal" coverage by the *GHP*. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus*, for this purpose* a domestic partner cannot be recognized as a spouse; and

- Former spouses who have Federal Employees Health Benefit (FEHB) coverage under the Spouse Equity Act.

10.4 – Working Aged Exception for Small Employers in Multi-Employer Group Health Plans

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

A multi-employer GHP having at least one employer participating that has at least one employer with 20 or more employees may **prospectively** request to except employees (and their spouses) of identified employers with fewer than 20 employees from the working aged provision. Such members and their spouses are not subject to the working aged provision once an exception has been granted as long as the employer continues to meet the requirements for the exception.

Be advised that it is the GHP's responsibility to provide written updates of any information that may affect the original exception request (updates should include identification of any employees not previously identified as well as information on any terminated coverage issues, etc.) to the *Coordination of Benefits Contractor (*COBC*)* as soon as any changes take place.

The contractor shall forward any Small Employer Exception inquiry or request *it receives* to the COBC within 14 calendar days of receipt (this includes the previously specified documentation). The contractor shall simultaneously issue the PC generated model interim response shown in Exhibit A. Additionally, if the contractor receives an inquiry or request via telephone, the contractor shall inform the caller that the COBC is responsible for addressing such issues. The contractor *shall* direct the caller to submit the inquiry or request in writing to the COBC*, at the address shown below*.

Exhibit A

[Insert: DATE]

[Insert: Name of Individual/Entity Who Made the Inquiry]

[Insert: Street Address]

[Insert: City, State, Zip]

Re: Procedures for Excepting Small Employers Participating in a Multi-employer Plan for the Working Aged

[Insert: Name of employer and/or GHP if included in the inquiry]

Dear (Sir/Madam)

Thank you for your inquiry on the multi-employer exception to the Medicare Secondary Payer provisions for the working aged employers with less than 20 employees. In order for your inquiry to be appropriately addressed, it will be forwarded to the Coordination of Benefits Contractor (COBC). After reviewing your inquiry, the COBC will respond accordingly.

Please be advised that it is the GHP's responsibility to provide written updates of any information that may affect/change the original exception request. Updates include identification of any employees not previously identified as well as information on any terminated coverage issues, etc. This information must be submitted to the COBC as soon as any change takes place. Updates must be submitted in writing directly to the COBC at the address provided below.

Medicare Coordination of Benefits
Attn: Small Employer Exception Request
P.O. Box *125*
New York, NY 10274-*0125*

If you have any questions concerning this letter, please call the COBC at 1-800-999-1118.

Sincerely,

20 - Medicare Secondary Payer Provisions for *End-Stage Renal Disease (*ESRD*)* Beneficiaries

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

Medicare is secondary payer to GHPs for individuals eligible for, or entitled to Medicare benefits based on ESRD during a coordination period described below. (See Chapter 1,

"Background and Overview," §20, for definitions of eligibility *and* entitled.) This provision applies regardless of the number of employees employed by the employer and regardless of whether the individual *or other family member* has current employment status. The ESRD provision applies to former as well as to current employees. This provision applies where an individual is eligible for Medicare based on ESRD and where an individual is entitled to Medicare based on ESRD. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of §20.1.1 or §20.1.3 if the individual meets the other requirements *in Medicare Pub. 100-1, Medicare General Information, Eligibility and Entitlement, Chapter 2, §10.4*.

Prior to August 10, 1993 (the enactment date of OBRA 1993), if an individual was eligible for, or entitled to Medicare on more than one basis (i.e., ESRD and disability or ESRD and age), Medicare was the primary payer. This is because the ESRD MSP provision only applied with respect to individuals who were eligible for, or entitled to Medicare based solely on ESRD. However, in general, §13561(c)(2) and (3) of OBRA 1993 provided that plans must pay primary benefits during the coordination period regardless of whether the individual is also entitled to Medicare on another basis. (See §20.1.3 for dual entitlement provisions. Specifically, see §20.1.3.B, which discusses the dual entitlement provision under which a GHP remains secondary to Medicare during the 30-month coordination period and litigation challenging that provision.)

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

20.1.3 - Dual Eligibility/Entitlement Situations

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

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

Except as provided in subsection B, GHPs are subject to a 30-month coordination period for any plan enrollee eligible for, or entitled to Medicare based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. The 30-month period coincides with the first 30 months of ESRD-based Part A Medicare eligibility or entitlement. (Under previous law, Medicare automatically became the primary payer at the point of dual Medicare eligibility/entitlement.) As long as dual eligibility/entitlement exists, the ESRD MSP provision applies exclusively. Medicare

becomes the primary payer after the 30th month of ESRD-based eligibility/entitlement even though plan coverage may be in effect by reason of current employment status. That is, the working aged MSP provisions (see §10) and the disability MSP provisions (see §30) do not apply to individuals with ESRD during or after the 30-month coordination period.

Subsection A, below, deals with coordination periods governed by present law *and provides examples*. Subsection B specifies the circumstances under which the ESRD MSP provision does not apply in dual entitlement situations and provides *an* example. Subsection C *deals with circumstances in which Medicare continues to be primary when an individual is entitled to Medicare based on age or disability and then ESRD with no GHP coverage but obtains GHP coverage during the coordination period and provides an example. Subsection D deals with the effect of the cessation of dual entitlement.*

A - Circumstances in Which Medicare Continues to be Secondary After Aged or Disabled Beneficiary Becomes Eligible for, or Entitled to Medicare on the Basis of ESRD

Medicare *is* secondary payer during the first 30 months of ESRD-based eligibility and entitlement and becomes primary payer after the 30th month of ESRD-based eligibility or entitlement *if Medicare was not properly primary prior to ESRD-based eligibility*. *(Refer to subsection B below if Medicare is properly primary.)*

EXAMPLE 1

Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and begins a course of maintenance dialysis on June 27, 2000. Effective September 1, 2000, Mr. C is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 2003, the 30th month of ESRD-based eligibility, and becomes primary payer beginning March 2003.

EXAMPLE 2

Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 2000 at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 30-month coordination period (July 2000), Mr. D turned age 65. The coordination period continues without regard to age-based entitlement with the retirement plan continuing to pay primary benefits through June 2003, the 30th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer beginning July 2003.

EXAMPLE 3

Mr. E retired at age 62 and maintained GHP coverage as a retiree. In July 2000, he simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 2000) and entitled based on age. The retirement plan must pay benefits

primary to Medicare from July 2000 through December 2002, the first 30 months of ESRD-based eligibility. Medicare becomes the primary payer beginning January 2003.

B - Circumstances in Which Medicare Continues to be Primary After Aged or Disabled Beneficiary Becomes Eligible on Basis of ESRD

Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if both of the following conditions are met:

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

- The MSP prohibition against "taking into account" age-based or disability-based entitlement does not apply because plan coverage was not "by virtue of current employment status" or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

The plan may continue to pay benefits secondary to Medicare under this subsection. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

EXAMPLE

Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 2000. She automatically becomes eligible for Medicare based on ESRD effective January 1, 2001. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

C – Circumstances in Which Medicare Continues to be Primary When Individual is Entitled to Medicare Based on Age or Disability and then ESRD with no GHP Coverage but Obtains GHP Coverage During the Coordination Period

If Medicare is the proper primary payer for services when eligibility for Medicare based on ESRD is established, Medicare remains the primary payer (during the coordination period and afterwards). Medicare is considered to be the primary payer when Medicare is the only payer or Medicare is legally obligated to be the primary payer to any GHP coverage.

EXAMPLE

Mr. Z is 67 years old and has Medicare based on age. He has no GHP coverage. Mr. Z develops ESRD and begins a course in maintenance dialysis and becomes eligible for Medicare based on ESRD which triggers the 30-month coordination period. However,

Mr. Z has no GHP coverage and Medicare continues as the primary payer. In the 6th month of the coordination period Mr. Z obtains coverage through his wife's GHP. Since Medicare was the proper primary payer when eligibility for ESRD was established, Medicare remains the primary payer.

D - Dual Eligibility/Entitlement Ceases

If ESRD-based eligibility or entitlement ceases in accordance with the *Medicare Pub. 100-1, Medicare General Information, Eligibility and Entitlement, Chapter 2, §10.4*, Medicare is the primary payer unless plan coverage is in effect by virtue of current employment status, and the provisions of §§10 and 20 or 30 apply.

30.1 - Individuals Not Subject to MSP Provision

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

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

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

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

- Who have FEHB coverage under the Spouse Equity Act*;*

- *Individuals enrolled in Part B only; or*

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

30.2 - The 100 or More Employees Requirement

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

- Medicare is secondary for all employees enrolled in the plan if a plan is a multi-employer plan, such as a union plan which covers employees of some small employers and also employees of at least one employer that meets the 100-or-

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

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

30.3 - Disabled Individuals Who Return to Work

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

30.4 - Dually Entitled Individuals

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

40 - Liability Insurance

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), *Medicare does not make* payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan (including a self-insured plan). Under certain circumstances, Medicare may make conditional payments if the liability *insurance* will not pay or will not pay promptly. *Conditional* payments are conditioned on reimbursement to the Medicare program to the extent that

payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan).

40.1 – Medicare's Recovery Rights

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

Medicare has a statutory direct right of recovery from the liability insurance as well as any entity that has received payment directly or indirectly from the proceeds of a liability insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right *is superior to* other entities including Medicaid *because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation rights.*

In addition to its direct rights of recovery, Medicare has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. *If* Medicare *exercises its* subrogation *rights*, *Medicare* 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 *for services related to claims against the alleged tortfeasor (and the alleged tortfeasor's liability insurance)*. Medicare can be a party to any claim by a beneficiary or other entity against *an alledged tortfeasor and/or his/her* liability *insurance and* can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare.

40.2 – Billing in MSP Liability Insurance Situations

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

A - Difference Between Liability Insurance and Other Primary *Plans*

Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., no-fault insurance, group health plans, and workers' compensation, *the insurance has a contractual obligation to pay for medical services provided to the covered/injured person. Liability insurance, however, has a contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party.*

B – Billing Options and Requirements – Alternative Billing

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) Promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital

services, the date of discharge) rather than bill Medicare. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- *bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or*

- *maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.*

C – Special Rule for Oregon

As a result of a court order, providers, physicians, and other suppliers in Oregon:

- *may either (i.e., double billing is not permitted) bill Medicare or bill liability insurance (the filing of a lien against a beneficiary's liability insurance settlement is considered billing the liability insurance) if the liability insurer pays within 120 days after the earlier of the following dates:*

    - *the date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement; or*

    - *the date the services were provided or, in the case of inpatient hospital services, the date of discharge.*

- *must withdraw claims/liens against the liability insurance/beneficiary's liability insurance settlement following expiration of the 120-day period and bill Medicare.*

However, CMS will not terminate the provider agreement of a provider that does not comply with the court order if that provider is following the procedures outlined in B above.

D – Charges to Beneficiaries

<u>Provider Charges to Beneficiaries for Services Covered By Medicare</u>

The following applies to providers who participate in Medicare, emergency hospitals who do not participate in Medicare, and foreign hospitals with an election to bill Medicare:

- *if the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.*

- *if the provider pursues liability insurance, the provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.*

Physician and Other Supplier Charges to Beneficiaries for Services Covered By Medicare

The following applies to physicians and other suppliers who participate in Medicare:

- *if the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.*

- *if the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.*

The following applies to physicians and other suppliers who do not participate in Medicare and who submit or would be required to submit an assigned claim:

- *if the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.*

- *if the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.*

Physicians and other suppliers who do not participate in Medicare and who submit an unassigned claim may charge beneficiaries no more than the limiting charge and may collect without regard to whether the liability insurance is available to the beneficiary.

Physicians and other suppliers who do not participate in Medicare, do not submit an unassigned claim, and are not required to submit an assigned claim if they submitted a claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services Not Covered by Medicare

- *For services for which there is no Medicare coverage available regardless of who furnishes them, providers, physicians, and other suppliers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.*

- *For services of foreign hospitals that have no election to bill Medicare, providers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.*

- *For services of foreign physicians and other suppliers, the physician or other supplier may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.*

E – Provider, Physician, or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary's Liability Insurance Settlement

As cited above in B, providers, physicians, and other suppliers must withdraw all claims/liens against liability insurance/beneficiary's liability insurance settlement (except for claims related to services not covered by Medicare and for Medicare deductibles and coinsurance) when they bill Medicare. You may learn of a situation where the provider, physician, or other supplier billed Medicare but did not withdraw the claim/lien. In such situations you must:

- *Advise the provider, physician, or other supplier and beneficiary that the act of billing Medicare limits the payment that the provider, physician, or other supplier may receive for the services billed to the Medicare approved amount. This applies even if Medicare did not pay the claim or the provider, physician, or other supplier refunded the Medicare payment to Medicare.*

- *If the provider, physician, or other supplier collected on a claim/lien after billing Medicare, advise the provider, physician, or other supplier and beneficiary that:*

    - *the provider, physician, or other supplier must refund the Medicare payment in instances where the amount collected on the claim/lien is for the full charges of the claim/lien and the Medicare payment is greater than or equal to the full charges of the claim/lien and greater than or equal to the amount collected on the claim/lien (see example one below for an illustration of this policy); or*

    - *the provider, physician, or other supplier must refund the lesser of the amount collected on the claim/lien or the Medicare payment in instances where the amount collected on the claim/lien is less than the full charges of the claim/lien due to policy limits (see example two below for an illustration of this policy); and*

    - *the provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment if the provider, physician, or other supplier received payment for services not covered by Medicare and for Medicare deductibles and coinsurance (see example three below for an illustration of this policy); or*

- *the provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment less any amounts due from the beneficiary for services not covered by Medicare and for Medicare deductibles and coinsurance (see example four below for an illustration of this policy).*

EXAMPLES

Example one: Charges from the facility are $5,000. Medicare is billed. The facility receives $8,000 from Medicare. The facility receives $5,000 from the liability insurance. The facility must repay Medicare $8,000.

Example two: Charges from the facility are $150,000. Medicare is billed. The facility receives $110,000 from Medicare. The facility receives $100,000 (due to policy limits) from the liability insurance. The facility must repay Medicare $100,000.

Example three: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deductible has been satisfied. The Medicare coinsurance of $160.00 has been paid. There are no charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00 and send $360.00 to the Medicare beneficiary.

Example four: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deducible has been satisfied. The Medicare coinsurance of $160.00 has not been paid. There are $50.00 in charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00. The facility may retain $210.00 for the unpaid Medicare coinsurance and charges for the non-covered Medicare services. The facility must send to the Medicare beneficiary the remainder of the liability insurance payment ($150.00).

F – Permissible Liens

The MSP provisions do not create lien rights when those rights do not exist under State law. Where permitted by State law, a provider, physician, or other supplier may file a lien for full charges against a beneficiary's liability settlement. (A lien against a beneficiary will be considered a lien against a liability settlement if there is a binding agreement that the lien will only be enforced if there is a settlement and will be withdrawn otherwise.)

The provider, physician, or other supplier may enforce a permissible lien up to the lesser of the amount of the settlement and charges for the services incorporated in the lien. The provider, physician, or other supplier may not charge interest, lien filing, and administrative fees to the beneficiary or against the lien.

50 - Workers' Compensation (WC)

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

A - General

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

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

These Federal programs provide WC protection for Federal *C*ivil *S*ervice employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, for example:

- Coal miners totally disabled due to pneumoconiosis;
- Maritime workers (with the exception of seamen);
- Employees of companies performing overseas contracts with the United States government;
- Employees of American companies who are injured in an armed conflict;
- Employees paid from nonappropriated Federal funds (such as employees of post-exchanges)*;*
- Offshore oil field workers*; and*
- *Qualified claimants under the Department of Labor's Energy Employees Occupational Illness Compensation Program.*

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

purposes of this exclusion. *However, they are considered liability insurance and the MSP liability rules apply.*

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory. If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

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

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

50.1 - Effect of Payments Under Workers' Compensation Plan

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

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

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

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

A - Secondary Medicare Payments

When a *primary plan's* payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the *primary plan's* payment as full payment, then Medicare secondary payment can be made as appropriate. In general, the Medicare secondary payment is the least of:

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

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

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

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

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

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

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

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

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

B - Workers' Compensation Does Not Pay for All Services

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

C - Charges Included Non-Work Related Items or Services

If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work

related concurrently with services which were work-related, Medicare benefits may be paid to the extent that the services are not covered by any other source which is primary to Medicare. A physician/supplier is permitted under WC law to charge an individual or the individual's insurer for services that are not work related.

D - Workers' Compensation Cases Involving Liability Claims

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

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

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

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

Accordingly, whenever WC pays in part for services, and the physician or *other* supplier does not accept and is not obligated to accept such payment as payment in full, and there is information which indicates that the services may also be reimbursable under no-fault insurance or under a *GHP*, the contractor follows the instructions in the Medicare Secondary *Payer* Manual (MSP) Manual, Chapter 5, "Contractor Prepayment Processing Requirements," §§40.6, or §10.4.

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

insurance, it is assumed that the individual is employed and that the other insurance is *a* GHP.

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

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

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

G - Contested Workers' Compensation Claims

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

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

60 - No-Fault Insurance

(Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)

Under §1862(b)(2) of the Act, (42 U.S.C. 1395y(b)(1)), Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under no-fault insurance. Medicare is secondary to no-fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare

beneficiaries. *Under certain circumstances, Medicare may make conditional payments if the no-fault insurance will not pay or will not pay promptly (i.e., 120 days after receipt of the claim). Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under no-fault insurance.*

If services are covered under no-fault insurance, that *insurance* must be billed first. If the *insurance* does not pay all of the charges, a claim for secondary Medicare benefits can be submitted. Medicare can pay for services related to an accident if benefits are not available under the individual's no-fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on non-medical items such as lost wages.

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

If there is an indication that the individual has filed, or intends to file a liability claim against a party that allegedly caused an injury, the contractor follows *the procedures related to MSP liability insurance situations once the no-fault insurance is exhausted.*

60.1 – Medicare's Recovery Rights

Medicare has a statutory direct right of recovery from the no-fault insurance as well as any entity that has received payment directly or indirectly from the proceeds of a no-fault insurance payment. Medicare's recovery rights take precedence over the claims of any other party, including Medicaid. Medicare's recovery right is superior to other entities including Medicaid because Medicare's direct right of recovery is explicitly prescribed in Federal law and other entities' recovery rights are based on either State law or subrogation rights.

In addition to its direct rights of recovery, Medicare has subrogation rights. "Subrogation" literally means the substitution of one person or entity for another. If Medicare exercises its subrogation rights, Medicare is a claimant against the no-fault insurer to the extent that Medicare has made payments to or on behalf of the beneficiary for services related to claims against the no-fault insurer. Medicare can be a party to any claim by a beneficiary or other entity against no-fault insurance and can participate in negotiations concerning the total no-fault insurance payment and the amount to be repaid to Medicare.