CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 85	**Date: May 3, 2012**
	Change Request 7355

NOTE: Change Request 7355, Transmittal 84, dated May 02, 2012, was erroneously sent out with the wrong transmittal number. The Transmittal number should have been Transmittal 85. This instruction has been revised to correct the transmittal number only. All other information remains the same.

SUBJECT: Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims.

I. SUMMARY OF CHANGES: The purpose of this instruction is to clarify, for all Medicare contractors, the process and procedures to follow when processing L, NF or WC claims when the L, NF, or WC insurer does not make prompt payment. The instructions also include definitions of the promptly payment rules and how contractors shall identify conditional payment requests on MSP claims received from physicians, providers and other suppliers.

EFFECTIVE DATE: MCS, October 1, 2012
VMS, October 1, 2012 - Analysis and Design
VMS, January 1, 2013 - Coding and Implementation
FISS and CWF, January 1, 2013

IMPLEMENTATION DATE: MCS, October 1, 2012
VMS, October 1, 2012 - Analysis and Design
VMS, January 7, 2013 - Coding and Implementation
FISS and CWF, January 7, 2013

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	1/10/10.7/Conditional Primary Medicare Benefits
R	1/10/10.7.1/When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare
R	1/10/10.7.2/When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare
R	3/30/30.2.1.1/No-Fault Insurance Does Not Pay
R	3/30/30.2.2/Responsibility of Provider Where Benefits May Be Payable Under Workers" Compensation
R	5/40/40.6/Conditional Primary Medicare Benefits
R	5/40/40.6.1/Conditional Medicare Payment
R	5/40/40.6.2/When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 85	Date: May 3, 2012	Change Request: 7355

NOTE: Change Request 7355, Transmittal 84, dated May 02, 2012, was erroneously sent out with the wrong transmittal number. The Transmittal number should have been Transmittal 85. This instruction has been revised to correct the transmittal number only. All other information remains the same.

SUBJECT: Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims

Effective Date: MCS, October 1, 2012
VMS, October 1, 2012 - Analysis and Design
VMS, January 1, 2013 - Coding and Implementation
FISS & CWF, January 1, 2013

Implementation Date: MCS, October 1, 2012
VMS, October 1, 2012 - Analysis and Design
VMS, January 7, 2013 - Coding and Implementation
FISS & CWF, January 7, 2013

I. GENERAL INFORMATION

A. Background: Some Medicare Contractors expressed concern that the promptly period and conditional payment instructions found in the MSP Internet Only Manuals (IOM) are not consistent and need clarification for purposes of processing liability insurance (including self-insurance), no-fault insurance and workers' compensation MSP claims correctly. The purpose of this instruction is to clarify, for all Medicare claims processing contractors and shared systems, the process and procedures to follow when systematically, or manually, processing liability insurance (including self-insurance), no-fault insurance, and workers' compensation claims when the liability insurer (including the self-insurer), no-fault insurer, or workers' compensation entity does not make prompt payment or cannot reasonably be expected to make prompt payment. The instructions also include definitions relevant to the promptly payment rules and how contractors shall identify situations which Medicare may make conditional payments on MSP claims received from physicians, providers and other suppliers.

B. Policy: When specified conditions are met the MSP statute prohibits Medicare from making payment where payment has been made or can reasonably be expected to be made by group health plans (GHPs), a workers' compensation law or plan, liability insurance (including self-insurance), or no-fault insurance. If payment has not been made or cannot be reasonably be expected to be made promptly by workers' compensation, liability insurance (including self-insurance), or no-fault insurance, Medicare may make conditional payments. Medicare contractors and shared systems shall continue to follow instructions found in the updated IOM 100-05, Chapter 1, section 10, Chapter 2, section 60, Chapter 3, section 30.2, and Chapter 5, section 40.6 and to determine when to pay conditionally on incoming claims.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7355.1	The shared systems shall determine the promptly period for no-fault insurance and workers' compensation situations.						X	X	X		
7355.1.1	Prompt or promptly, with regard to no-fault insurance and workers' compensation situations, shall mean payment from the no-fault insurer or workers' compensation entity within 120 days after receipt of the claim, for specific items and services, by the no-fault insurer or workers' compensation entity.	X	X	X	X	X	X	X	X		
7355.1.2	In no-fault insurance or workers' compensation situations, in the absence of evidence to the contrary, Medicare claims processing contractors and shared systems shall treat the date of service, for specific items and services, as the claim date, for the purposes of determining the promptly period.	X	X	X	X	X	X	X	X		
7355.1.3	In no-fault insurance or workers' compensation situations, with respect to Part A inpatient services, contractors shall treat the date of discharge as the date of service, for purposes of determining the promptly period.	X		X		X	X				
7355.1.4	The Part A shared systems shall systematically inform the Part A Medicare claims processing contractors whether a claim is within or outside of the 120 promptly period as identified in 7355.1 and sub-requirements.	X		X		X	X				
7355.1.4.1	The Part A Medicare claims processing contractors shall pay conditionally on the no fault, or workers' compensation claim, based on requirements in 7355.2 if the Part A service date, or for a Home Health, Skilled Nursing Facility or Inpatient stay date of discharge, is less than 120 days and Medicare contractors receive information, including claim information, stating the no-fault insurer or workers' compensation entity will not make payment.	X		X		X	X				
7355.1.4.2	The Part B and DME shared systems shall systematically inform their Medicare claims processing contractors whether a claim is within or outside of the 120 promptly period as identified in 7355.1.2.	X	X		X			X	X		
7355.1.4.3	The Medicare claims processing contractors shall pay conditionally on the claim based on requirements in 7355.2 if the Part B or DME date of service date is less than 120 days and/or Medicare contractors receive information, including claim information, stating the no-	X	X		X			X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	fault insurer or workers' compensation entity will not make payment.										
7355.1.4.4	The Part B and DME claims processing contactors and MCS and VMS shared systems shall identify the GHP, the liability insurer (including self-insurance), no-fault insurer or workers' compensation entity that received the claim, before Medicare, in the 2320 SBR.	X	X		X			X	X		
7355.1.4.5	The Part B and DME claims processing contactors and MCS and VMS shared systems shall determine whether the previous payer(s), identified in the 2320 SBR and respective 2330 loops, made payment on the claim.	X	X		X			X	X		
7355.1.4.6	Taking into consideration the CAS and whether an insurer, or insurers, made payment on the claim shall assist the Part B contractors, the DME contactors and the MCS and VMS shared system in determining if a MSP payment for GHP claims, or a conditional payment for a liability, no-fault, workers' compensation related services, shall be made on the claim.	X	X		X			X	X		
7355.2	Medicare claims processing contractors and shared systems shall make conditional payments for claims for specific items and service where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that no-fault insurance or workers' compensation is involved for that specific item or service, (2) there is/was no open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the physician, provider or other supplier sent the claim to the no-fault insurer or workers' compensation entity first, and (4) there is information on the claim that indicates that the no-fault insurer or workers' compensation entity did not pay the claim during the promptly period.	X	X	X	X	X	X	X	X		
7355.2.1	Medicare claims processing contractors shall use remittance advice remark code RARC M32 to indicate a conditional payment is being made.	X	X	X	X	X					
7355.3	Medicare claims processing contractors and shared systems shall deny claims, reject claims for Part A, where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that no-fault insurance or workers' compensation is involved for that specific item or	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	service, (2) there is/was an open GHP record on the MSP auxiliary file as of the date of service, (3) there is no information on the claim that indicates that the claim was sent to the GHP, (4) there is information on the claim that indicates that the physician, provider, or supplier sent the claim to the no-fault insurer or workers' compensation entity, and (5) there is information on the claim that indicates that the no-fault insurer or workers' compensation entity did not pay the claim during the promptly period.										
7355.3.1	Medicare claims processing contractors and shared systems shall use claim adjustment reason code (CARC) CO 22 and remittance advice remark code (RARC) MA04 to indicate in their denials that claims meeting these criteria need to be submitted to the GHP for payment Medicare Summary Notice (MSN) Message 29.5 shall also be used on beneficiary MSNs.	X	X	X	X	X	X		X		
7355.4	Medicare claims processing contractors and shared systems shall deny claims, reject claims for Part A, where the following conditions are met: (1) there is a information on the claim that indicates that no-fault insurance or workers' compensation is involved for that specific item or service, (2) there is/was an open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the GHP denied the claim because the GHP asserted that the no-fault insurer or workers' compensation entity should pay first, (4) there is information on the claim that indicates that the physician, provider, or supplier sent the claim to the no-fault insurer or workers' compensation entity; and (5) there is information on the claim that indicates that the no-fault or worker's compensation entity did not pay the claim during the promptly period.	X	X	X	X	X	X	X	X		
7355.4.1	Medicare claims processing contractors and share systems shall use CARC CO 22 and remittance advice remark code RARC MA04 to indicate in their denials that claims meeting these criteria need to be submitted to the GHP for payment. Medicare Summary Notice (MSN) Message 29.5 shall also be used on beneficiary MSNs.	X	X	X	X	X	X		X		
7355.5	Medicare claims processing contractors and shared	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	systems shall process no-fault insurance and workers' compensation claims conditionally after the promptly period has expired.										
7355.6	Medicare claims processing contractors and shared systems shall pay primary if services are not related to the accident or incident and no other GHP record exists as stated in CR 7605.	X	X	X	X	X	X	X	X		
7355.7	Medicare claims processing contractors/shared systems shall determine the promptly period for liability insurance (including self-insurance) situations.	X	X	X	X	X	X	X	X		
7355.7.1	Prompt or promptly, with regard to liability insurance (including self-insurance), shall mean payment within 120 days after the earlier of the following: (1) The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; (2) the date the service was furnished or, in the case of inpatient services, the date of discharge.	X	X	X	X	X	X	X	X		
7355.7.2	Medicare claims processing contractors and shared systems shall consider the date of accretion, listed on the liability MSP auxiliary record on CWF, to be the date the general liability claim was filed for the purposes of determining the promptly period.	X	X	X	X	X	X	X	X		
7355.7.3	The Part B and DME Medicare claims processing contractors shall pay conditionally on the liability claim, based on requirements in 7355.9, if the Part B or DME service date, or the date of accretion listed on the liability MSP auxiliary record on CWF if earlier, is less than 120 days and Medicare Contractors receive information, including claim information, stating the liability insurer (including self insurance) will not make payment.	X	X		X						
7355.7.4	The Part A Medicare claims processing contractors shall pay conditionally on the Liability claim, based on requirements in 7355.9 if the Part A serviced date, or for a Home Health, Skilled Nursing Facility or Inpatient stay date of discharge, or the date of accretion listed on the liability MSP auxiliary record on CWF if earlier, is less than 120 days and Medicare Contractors receive information, including claim information, stating the liability insurer will not make payment.	X		X		X					
7355.8	CWF shall inform the shared systems when there is an open liability, no-Fault and workers compensation									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	record on CWF and an open GHP MSP record so claims can be processed accordingly.										
7355.9	Medicare claims processing contractors and shared systems shall make conditional payments for claims for specific items and services where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that liability insurance (including self-insurance) is involved for that specific item or service, (2) there is/was no open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and (4) there is information on the claim that indicates that the liability insurer (including the self insurer) did not make payment on the claim during the promptly period.	X	X	X	X	X	X	X	X		
7355.9.1	Medicare claims processing contractors shall use remittance advice remark code RARC M32 to indicate a conditional payment is being made.	X	X	X	X	X					
7355.10	Medicare claims processing contractors and shared systems shall deny claims, reject claims for Part A, where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that liability insurance (including self-insurance) is involved for that specific item or service, (2) there is/was an open GHP record on the MSP auxiliary file as of the date of service, (3) there is no information on the claim that indicates that the claim was sent to the GHP, (4) there is information on the claim that indicates that the physician, provider, or supplier sent the claim to the liability insurer (including the self-insurer), (5) there is information on the claim that indicates that the liability insurer (including the self-insurer) did not pay the claim during the promptly period.	X	X	X	X	X	X	X	X		
7355.10.1	Medicare claims processing contractors shall use CARC CO 22 and remittance advice remark code RARC MA04 to indicate in their denials that claims meeting these criteria need to be submitted to the GHP for payment. Medicare Summary Notice (MSN) Message 29.5 shall also be used on beneficiary MSNs.	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7355.11	Medicare claims processing contractors and shared systems shall deny claims, reject claims for Part A, where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that liability insurance(including self-insurance) is involved for that specific item or service, (2) there is/was an open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the GHP denied the claim because the GHP asserted that liability insurer (including the self-insurer) should pay first, (4) there is information on the claim that indicates that the physician, provider, or supplier sent the claim to the liability insurer (including the self-insurer), and (5) there is information on the claim that indicates that the liability insurer (including self-insurer) did not pay the claim.	X	X	X	X	X	X	X	X		
7355.11.1	Medicare claims processing contractors shall use (CARC) 22 and remittance advice remark code (RARC) MA04 to indicate in their denials that claims meeting these criteria need to be resubmitted to the GHP for payment. Medicare Summary Notice (MSN) Message 29.5 shall also be used on beneficiary MSNs.	X	X	X	X	X					
7355.12	Medicare claims processing contractors and shared systems shall pay liability insurance (including self-insurance) claims conditionally after the promptly period has expired.	X	X	X	X	X	X	X	X		
7355.13	All systems and Medicare claims processing contractors shall take into consideration the DX code on the incoming claim as applicable when processing liability, no-fault, workers' compensation claims as identified in CR 7605.	X	X	X	X	X	X	X	X	X	
7355.13.1	If there is no GHP insurance CWF shall send the 6819 error code and the shared systems shall deny the claim, reject for Part A, if the diagnosis is considered a match (exact or match within family of diagnosis codes), the claim shows no evidence it was sent to the Liability insurer (including self-insurer), no- Fault or Workers' Compensation insurer, and the service is within the 120 day promptly period, utilizing the appropriate audit/denial code based on the MSP type.						X	X	X	X	
7355.13.2	If there is no GHP insurance the CWF shall send the						X	X	X	X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	6819 error code and shared systems shall bypass the applicable error code and pay the claim conditionally if the diagnosis is considered a match (exact or match within family of diagnosis codes) and the claim is outside the 120 day promptly period.										
7355.13.3	If there is no GHP insurance the shared systems¸ or DME Contractor, shall pay the claim primary if the diagnosis is not considered a match (exact or match within family of diagnosis codes), regardless of the 120 day period.		X				X	X		X	
7355.14	CWF shall update HUSC transaction to include the CWF accretion date.									X	
7355.15	CWF shall send the CWF accretion date to Medicare contractors on the MSP HUSC transaction.									X	
7355.15.1	CWF shall continue to send the '03' trailer with the Date Entry Added (CWF accretion date).									X	
7355.16	Medicare claims processing contractors and shared systems shall upload the 03 trailer found and HUSC transaction, including the CWF accretion date, to their internal systems when received from CWF.	X	X	X	X	X	X	X	X	X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7355.17	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, Richard.Mazur2@cms.hhs.gov, (410) 786-1418

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: ***For Medicare Administrative Contractors (MACs)*****, include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Secondary Payer (MSP) Manual
Chapter 1 - Background and Overview

10.7 - Conditional Primary Medicare Benefits

(Rev.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

When specified conditions are met, the MSP statute prohibits Medicare from making payment where payment has been made or can reasonably be expected to be made by group health plans (GHPs), a workers' compensation law or plan, liability insurance (including self-insurance), or no-fault insurance. If payment has not been made or cannot be reasonably be expected to be made promptly by workers' compensation, liability insurance (including self-insurance), or no-fault insurance, Medicare may make conditional payments.

In order to adhere to the provisions in the MSP statute, all Medicare claims processing contractors shall follow 42 CFR 411.20, reflected in Chapter 1, section 20, for the definition of prompt or promptly. Prompt or promptly, with regard to no-fault insurance and workers' compensation, means payment within 120 days after receipt of the claim for specific items and services by the no-fault insurer or workers' compensation entity. In the absence of evidence to the contrary, Medicare claims processing contractors shall treat the date of service, for specific items and services, as the claim date, for the purposes of determining the promptly period. Further, with respect to inpatient services, in the absence of evidence to the contrary, Medicare claims processing contractors shall treat the date of discharge as the date of service, for purposes of determining the promptly period, with respect to no-fault insurance and workers' compensation situations.

Additionally, Medicare claims processing contractors shall follow 42 CFR 411.50, also reflected in Chapter 1, section 20, for the definition of prompt or promptly, with regard to liability insurance (including self-insurance). Prompt or promptly, with regard to liability insurance (including self-insurance), means payment within 120 days after the earlier of the following: (1) The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; and (2) the date the service was furnished or, in the case of inpatient services, the date of discharge. Generally, the MSP auxiliary record for the liability situation is posted to CWF after the beneficiary files a claim against the alleged tortfeasor and the associated liability insurance (including self-insurance) Accordingly, in the absence of evidence to the contrary, the date the general liability claim is filed against liability insurance (including self-insurance) is no later than the date that the record was posted on CWF. Therefore, Medicare claims processing contractors shall consider the date of accretion listed on liability MSP auxiliary record on CWF to be the date the general liability claim was filed, for the purposes of determining the promptly period, with regard to liability insurance (including self-insurance) situations.

Subject to Medicare payment rules and other stipulations, primary payers (GHP, liability insurance, including self-insurance, no-fault insurance, and workers' compensation) are obligated to reimburse Medicare if they were properly primary to Medicare, but have not paid as primary. A primary plan's responsibility for such payment 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 and services included in a claim against the primary plan or the primary plan'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/ GHP as appropriate before requesting conditional Medicare payments. Except as delineated below in *sub-section* 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.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

Conditional primary Medicare benefits may be paid if:

The beneficiary has GHP coverage primary to Medicare and conditions in 10.7.2 are not present;

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.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

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;

- *Medicare does not pay if the GHP asserts it is secondary to the liability, no-fault or workers' compensation insurer.*

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.

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

30.2.1.1 - No-Fault Insurance Does Not Pay

(Rev.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

If the services are related to an accident and the no-fault insurance has been billed but does not make payment because the individual's no-fault benefits are exhausted or, the individual's coverage expired, and no other primary payers to Medicare have been identified, the provider may bill Medicare. *Medicare claims processing contractors will need to look at the statements from the no-fault insurer or the CAS segment and paid amount loop for electronic claims (paid amount loop on the 837 should show zero dollars paid by the NGHP insurer), or attached RA for hardcopy claims, to determine whether benefits were exhausted, coverage expired or services were not related to the accident/incident to process the claim appropriately. Medicare contractors may send an ECRS request to the COBC to close the MSP record as deem necessary.*

When billing Medicare where no-fault insurance has been billed but does not make payment, annotate the date on which the other payer denied the claim and the reason for denial. If the provider later receives payment from no-fault insurance, it refunds the Medicare payment by submitting an adjustment bill *for Part A and/or a reopening, or appeal request, for Part B.*

Providers notify the contractor of a No-Fault denial using occurrence code 24 (Date Insurance Denied) and indicate the date on which the other payer denied the claim. The reason for denial is indicated in remarks. In addition, the following occurrence codes are used to identify the date of the accident:

01 - Auto Accident and Date

02 - No-Fault Insurance Involved-Including Auto Accident/Other and Date

If the conditions described in Chapter 7, §50.2.2, are met, conditional payments may be made. To request a conditional payment, providers enter value code 14 with zero value in form locator (FL) 39-41 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of FL 50, and the identifying information about the insured is shown on line A of FL 58-62. The provider enters the proper occurrence code in FL *31*-36 and the address of the insurer in FL 38 or Remarks (FL *80*). In addition, an explanation of why the conditional payment is justified is shown in Remarks (FL *80*). (See Chapter 7, §50.2.2, for an explanation of policy and procedures for conditional payment situations for contested, delayed, or no-fault claims.)

30.2.2 - Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation

(Rev.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

Information supplied by the provider is one of the means of alerting the Medicare contractor to actual or potential *workers' compensation* coverage. A condition is work-related if it resulted from an accident that occurred on the job or from an occupational disease. The billing form is completed in accordance with Pub 100-04, *Medicare Claims Processing Manual, Chapter 25*, "Completing and Processing *the Form CMS 1450* Data Set" when any of the following apply:

- The provider or the patient states that the condition is work-related;
- The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;
- The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis, and "black lung" disease in the case of a coal miner); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;
- The beneficiary previously received *workers' compensation* for the same condition;
- There is indication that a *workers' compensation* claim is pending; or
- There is other indication that the condition arose on the job.

Where there is an indication that *workers' compensation* may pay for the services, the provider bills the *workers' compensation* carrier. If *workers' compensation* pays for all of the services (whether at the provider's customary charge rate or at a special *workers' compensation* rate) the provider submits a Medicare bill indicating the insurer paid in full. The beneficiary's Medicare deductible will be credited, however no payment will be made.

If the provider's *workers' compensation* claim is denied, the provider determines whether any other MSP provisions apply and bills accordingly. If no other primary payers are available, the provider submits:

• A bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in FL *31*-36; and

• A supplementary statement calling attention to the fact that *workers' compensation* has denied payment or annotates FL *80*, remarks, with the reason.

Providers, Physicians and other suppliers must follow the appropriate billing requirements to bill Medicare in Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations, and also as identified in 100-05, Chapter 5, section 40.6.1.

Medicare Secondary Payer (MSP) Manual
Chapter 5 - Contractor Prepayment Processing Requirements

40.6 - Conditional Primary Medicare Benefits

(Rev.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

Conditional primary Medicare benefits may be paid if;

- The beneficiary has appealed or is protesting the GHP denial of the claim for any reason other than that the GHP offers only secondary coverage of services covered by Medicare;
- The GHP denied the claim (that is, the claim made on behalf of the beneficiary) because the time limit for filing the claim with the GHP has expired (whether appealed or not);
- The provider, physician, or other supplier fails to file a proper claim because of mental or physical incapacity of the beneficiary;
- The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement of the *workers' compensation* carrier.
- *Medicare claims processing contractors and shared systems shall make conditional payments for claims for specific items and service where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that no-fault insurance or workers' compensation is involved for that specific item or service, (2) there is/was no open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the physician, provider or other supplier sent the claim to the no-fault insurer or workers' compensation entity first, and*

(4) there is information on the claim that indicates that the no-fault insurer or workers' compensation entity did not pay the claim during the promptly period for any reason except when the workers' compensation carrier claims that its benefits are only secondary to Medicare.

- *Medicare claims processing contractors and shared systems shall make conditional payments for claims for specific items and services where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that liability insurance (including self-insurance) is involved for that specific item or service, (2) there is/was no open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and (4) there is information on the claim that indicates that the liability insurer (including the self insurer) did not make payment on the claim during the promptly period.*

Before making a conditional primary payment in cases involving appealed or protested claims, the *Medicare claims processing contractor* notifies the GHP, and the beneficiary that the payment is conditioned upon reimbursement, by the insurer and the beneficiary, to the trust fund if it is demonstrated that the GHP has or had responsibility to make primary payment. The *Medicare claims processing contractor* reminds the GHP that it is obligated to reimburse Medicare if it should be later determined that it was the proper primary payer for the services. A responsibility for such payment 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.

40.6.1 - Conditional Medicare Payment

(Rev.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

There is frequently a long delay between an injury and the decision by a State *Workers' Compensation* agency, no-fault *insurance*, or liability insurer *(including self-insurance)* in cases where compensability is contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might use their own funds for expenses that are eventually borne by either *Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations* or Medicare. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made *if there is no other GHP that is primary to Medicare. Note: if there is a primary GHP and the physician, provider or other supplier did not send the claim to the GHP first Medicare will not pay conditionally on the Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation claim.*

When such conditional *Medicare* payments are made, they are conditioned upon reimbursement, by the insurer and beneficiary, to the trust fund if it is demonstrated that the *Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation Carrier* has or had a responsibility to make payment. A responsibility for such payment 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.

When making conditional *notify* the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.) It asks the insurer to notify it when the insurer is prepared to pay the claim, so that direct refund can be arranged.

For Part A Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations, if there is no primary payer GHP to Medicare that will pay for services and the promptly period has expired then the Medicare claims processing contractor shall make a conditional payment. Providers of service may request Medicare conditional non-GHP payments via the hardcopy Form CMS-1450, or the 837 Institutional electronic Claim, using the appropriate insurance value code (i.e., value code 14, 15 or 47) and zero as the value amount.

Type of Insurance	***CAS***	***Part A Value Code*** *(2300 HI)*	***Value Amount*** *(2300 HI)*	***Occurrence Code*** *(2300 HI)*	***Condition Code*** *(2300 HI)*
No-Fault/Liability	*2320 - valid information why NGHP or GHP did not make payment*	*14 or 47*	*$0*	*01-Auto Accident & Date* 02-No-fault Insurance Involved & Date *24 – Date Insurance Denied*	
Workers' Compensation	*2320 - valid information why NGHP or GHP did not make payment*	*15*	*$0*	*04-Accident/Tort Liability & Date* *24 – Date Insurance Denied*	02-Condition is Employment Related

Institutional provider (e.g. hospital) Medicare claims processing contractors are required to look for the zero value code paid amount and occurrence code in the 2300 HI when claims are received electronically in the 837 Institutional Claims format. The appropriate Occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), and the CAS segment (see previous CMS MSP change requests on processing MSP claims utilizing the CAS) may be used in billing situations in cases where the provider has attempted to bill a primary payer in non-GHP (i.e., Liability, No-Fault and Workers' Compensation) situations, but the primary payer is not expected to pay in the promptly period. A conditional payment by Medicare may be made. For hardcopy claims, the identity of the other payer is shown on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65 and the address of the insured is shown in FL38 or Remarks (FL 80). Medicare claims processing contractors process conditional payment bills following normal procedures.

In determining conditional payments for physician and other Supplier electronic claims it is known that the 837 4010 professional claims does not include Value Codes nor Condition Codes. To determine whether conditional payment should be granted for Part B electronic claims the following fields must be completed and defined as follows: The physician/supplier must complete the 2320AMT02 = $0 if whole claim is a non-GHP claim and conditional payment is being requested for the whole claim, or 2430 SVD02 is completed for line level conditional payment requests if the claim contains other service line activity not related to the accident or injury. The CAS shall be taken into consideration when processing NGHP claims and determining if a conditional payment should be made. For 4010, the 2320 SBR05 it is acceptable to receive and include CP Medicare Conditionally Primary, AP for auto insurance policy or OT for other. The 2320 SBR09 may contain the claim filing indicator code of AM (automobile medical); LI (Liability), LM (Liability Medical) or WC (Workers' Compensation Health Claim). Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types. The 2300 DTP identifies the date of the accident with appropriate Value. The accident "related causes code" is found in 2300 CLM 11-1 through CLM 11-3. NOTE: There is no occurrence code for electronic Part B claims so the following conditional payment policy is being implemented. For Part B Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations, if there is no primary payer GHP to Medicare that will pay for services and the promptly period has expired then the Medicare claims processing contractor shall make a conditional payment for Medicare payable and covered services. A conditional payment may be made by Medicare where the physician or other supplier has attempted to bill a primary payer in non-GHP (i.e., Liability, No-Fault and Workers' Compensation) situations, but the NGHP insurer is not expected to pay in the promptly period. The Medicare claims processing contractors and shared systems shall take into consideration the CAS segment on the 837 to also determine if conditional payment shall be made.

The graph below explains what the MSP 4010 Professional claim should look like when a physician/supplier is requesting conditional payments:

Type of Insurance	***CAS***	***Insurance Type Code (2320 SBR05)***	***Claim Filing Indicator (2320 SBR09)***	***Paid Amount (2320 AMT or 2430 SVD02)***	***Insurance Type Code (2000B SBR05)***	*Date of Accident*
No-Fault/Liability	*2320 or 2430 valid information why NGHP or GHP did not make payment*	*AP or CP*	*AM, LI, or LM*	*$0.00*	*14*	*2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AB, AP or OA*
Workers' Compensation	*2320 or 2430 valid information why NGHP or GHP did not make payment*	*OT*	*WC*	*$0.00*	*15*	*2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM*

For 5010 Professional claims the insurance codes change and the acceptable information for Medicare conditional payment request is modified to look like the following:

Type of Insurance	***CAS***	***Insurance Type Code 2320 SBR05 from previous payer(s)***	***Claim Filing Indicator (2320 SBR09)***	***Paid Amount (2320 AMT or 2430 SVD02)***	***Condition Code (2300 HI)***	*Date of Accident*
No-Fault/Liability	*2320 or 2430 – valid information why NGHP or GHP did not make payment*	*14 / 47*	*AM or LM*	*$0.00*		*2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA*
Workers' Compensation	*2320 or 2430 – valid information why NGHP or GHP did not make payment*	*15*	*WC*	*$0.00*	*02-Condition is Employment Related*	*2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM*

40.6.2 - When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable

(Rev.85, Issued: 05-03-12, Effective :MCS,10-01-12,VMS, 10-01-12-Analysis and Design,VMS,01-01-13-Coding and Implementation, FISS and CWF,01-01-13,Implementation:MCS,10-01-12,VMS 10-01-12-Analysis and Design VMS,01-07-13-Coding and Implementation, FISS and CWF, 01-07-13)

Neither primary nor conditional primary Medicare payments may be made where a GHP denies payment for particular services because:

- The services are not covered by the plan, and there is reason to believe the plan does cover the services;
- The plan offers only secondary coverage of services covered by Medicare. Conditional primary benefits may not be paid in this situation even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, the *Medicare claims processing contractor* denied the claim for Medicare primary benefits and follows the instructions in §10.7;
- The plan limits its payments when the individual is entitled to Medicare;
- The services are covered under the *GHP* for younger employees and spouses but not for employees and spouses age 65 or over;
- The provider fails to file a proper claim for any reason other than the physical or mental incapacity of the beneficiary; or,
- When the employer plan fails to furnish information that is requested by CMS and that is necessary to determine whether the employer plan is primary to Medicare.

In addition to the bullet points stated above, Medicare primary or conditional primary Medicare benefits are not payable for the following reasons:

A) For no-fault insurance or workers' compensation situations, Medicare claims processing contractors shall deny claims where the following conditions are met: (1) the claim is a no-fault insurance or workers' compensation claim; (2) there is a GHP record on the MSP auxiliary file; (3) the claim was not sent to the GHP; (4) and the physician, provider, or supplier sent the claim to the no-fault or workers' compensation entity, but the no-fault or workers' compensation entity did not pay the claim.

Medicare claims processing contractors shall deny claims where the following conditions are met: (1) the claim is a no-fault insurance or workers' compensation claim; (2) there is a GHP record on the MSP auxiliary file; (3) the GHP denied the claim because the GHP asserted that

the no-fault insurer or workers' compensation entity should pay first; (4) and the physician, provider, or supplier sent the claim to the no-fault insurer or workers' compensation entity, but the no-fault or workers' compensation entity did not pay the claim.

B) For Liability insurance claims (including self insurance), Medicare claims processing contractors shall deny claims where the following conditions are met: (1) the claim is a liability claim; (2) there is a GHP record on the MSP auxiliary file; (3) the claim was not sent to the GHP; (4) and the physician, provider, or other supplier sent the claim to the liability insurer (including the self-insurer), but the liability insurer (including the self-insurer) did not pay the claim.

Medicare claims processing contractors shall deny claims where the following conditions are met: (1) the claim is a liability insurance (including self insurance) claim; (2) there is a GHP record on the MSP auxiliary file; (3) the GHP denied the claim because the GHP asserted that liability insurer (including the self-insurer) should pay first; (4) and the physician, provider, or other supplier sent the claim to the liability insurer (including the self-insurer), but the liability insurer (including self-insurer) did not pay the claim.

Note: Individuals are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim. However, beneficiaries are required to cooperate in the filing of no-fault and workers' compensation claims. If the beneficiary refuses to cooperate in filing of no-fault or workers' compensation claims Medicare does not pay.

Conditional benefits are not payable if payment cannot be made under no-fault insurance because the provider or the beneficiary failed to file a proper claim. (See Chapter 1, §20, for definition.) Exception: When failure to file a proper claim is due to mental or physical incapacity of the beneficiary, and the provider could not have known that a no-fault claim was involved, this rule does not apply.