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Medicare Secondary Payer Provisions Group and Nongroup Health Plans

10/8/2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

After this session you will have a better understanding of the MSP group and nongroup health plan provision guidelines to ensure your claims are being submitted to the Medicare program appropriately.

Agenda

- MSP General
- MSP Group Health Plans (GHP)
  - Working Aged (type 12)
  - Disability (type 43)
  - ESRD (type 13)
- MSP Nongroup Health Plans (NGHP)
  - Liability
  - Workers' Compensation
- Conditional Claims
- Claim Denials
- Government Programs
  - Federal Black Lung
  - Veterans Administration
  - U.S. Family Health Plans
- Resources

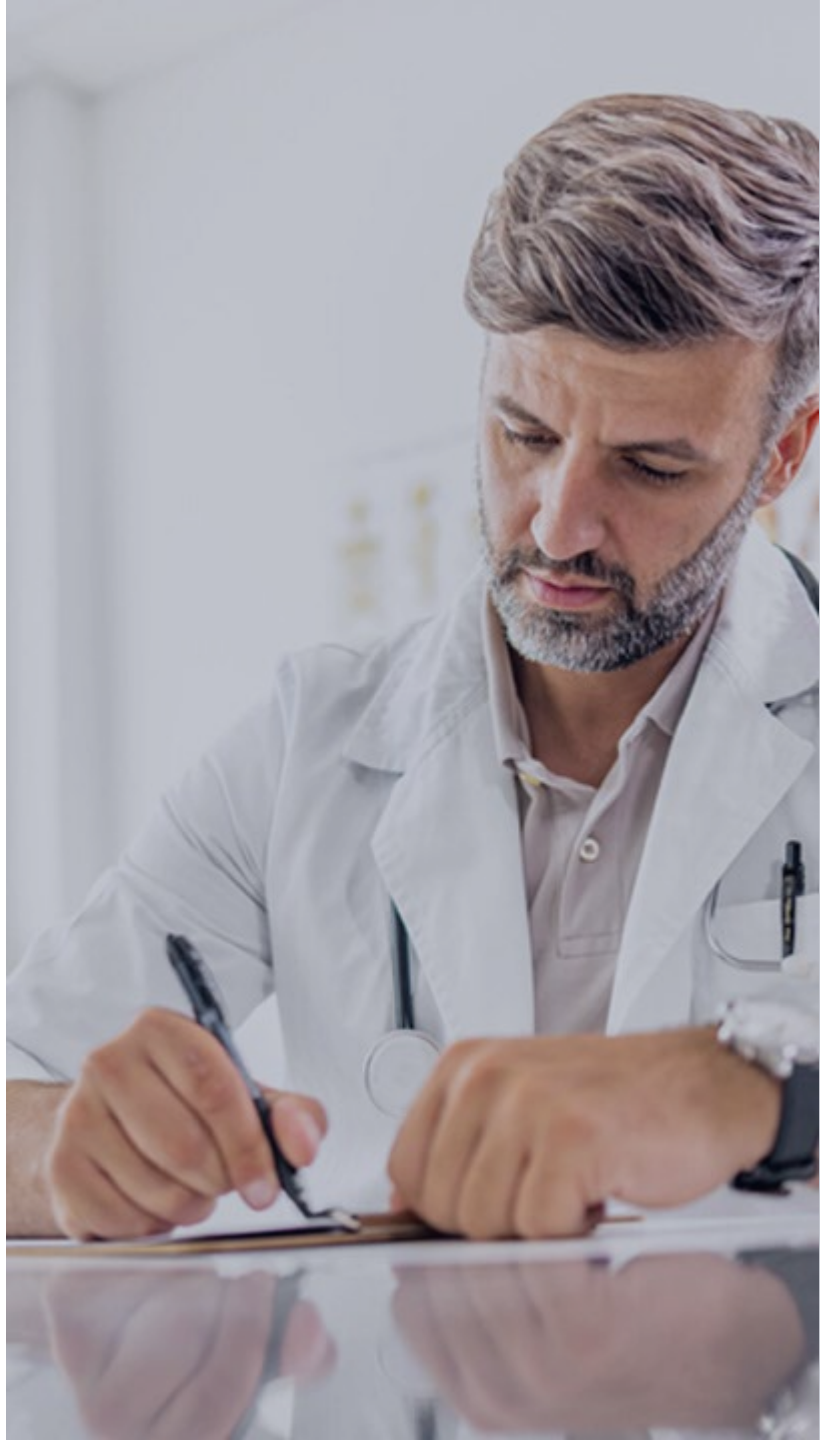
MSP General

MSP Categories and Type Codes

- Group Health Plans
  - Working aged (12)
  - Disabled (43)
  - ESRD (13)
- Nongroup Health Plans
  - Workers' Compensation (15)
  - Automobile or other no-fault insurance (14)
  - Liability (47)
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapters 1–8

Provider Responsibilities

- Determine if Medicare is primary payer for services rendered
  - Maintain office procedures to identify primary payer other than Medicare at each visit
  - Bill other payers before billing Medicare
  - Submit MSP claims when required even if primary payer made payment in full
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Sections 20.2.1



Submit MSP Electronic Claims Requirements

- Required MSP data for electronic claims
  - Indication of Medicare as the secondary payer
  - Insurance type code
  - COB payer paid amount claim level
  - Claim contract information (OTAF) – claim level
    - OTAF = obligated to accept as payment in full
  - Claim adjudication date – claim level
  - Service line information
    - Line adjudication information
    - Line adjustments
    - Line adjudication date
- Electronic Data Interchange: Medicare
- Secondary Payer ANSI Specifications for 837P

Claim Submission Timeliness

- Limit is one calendar year from date of service
  - Claims not submitted timely are provider-liable
    - Beneficiary cannot be charged
- Exceptions: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70.7
  - Administrative error
  - Retroactive Medicare entitlement, including when state Medicaid agencies involved
  - Retroactive disenrollment from Medicare
  - Advantage Plan or Program of All-Inclusive Care of the Elderly (PACE) Provider Organization

MSP Group Health Plans (GHP)

GHP Steps to Take

Provider Responsibilities

- Ask Medicare patients if there's other insurance
- Your Billing Responsibilities

Defining Terms and Eligibility

- MSP: Medicare Secondary Payer
- Situations when Medicare is not primary claim payer
- GHP: Group Health Plan is health coverage based on employment benefits of beneficiaries and/or spouse
- Check eligibility records IVR/NGSConnex

Who Pays First?

- GHP insurance may be primary
  - Working Aged (12)
  - Disabled (43)
  - ESRD (13)
- Medicare will process as secondary
- Submit MSP claims with the required data
- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

MSP Working Aged (12)

- Five criteria must be met
  - Beneficiary aged 65 or older
  - Beneficiary enrolled in Medicare Part A
  - Beneficiary or spouse (of any age) employed and actively working
  - Beneficiary covered by EGHP through that employer
  - Size of employer (full- and/or part-time employees)
    - Individual employer GHP = 20 or more employees
    - Multi-employer or multiple employer GHPs = at least one employer employs 20 or more employees

MSP Working Aged Scenario

- Betty, widowed age 68 works full time at Stone and Company and has elected EGHP benefits for herself. Betty also has Medicare Parts A and B original/ traditional/ fee-for-service.

- Aged 65 or older
- Enrolled in Medicare Part A
- Employed and actively working
- Elected covered through employer
- Size of employer
  - Employer GHP = 20 or more employees

MSP Disability (Type 43)

- Five criteria must be met
  - Beneficiary under age 65
  - Beneficiary enrolled in Medicare Part A
  - Beneficiary or family member (of any age) employed and actively working
  - Beneficiary covered by LGHP through that employer
  - Size of employer (full- and/or part-time employees)
    - Individual/multiple employer LGHP - 100 or more employees
    - Multi-employer plan – at least one employer employs 100 or more employees

MSP Disability Scenario

- Fred, age 58 is a paraplegic and does not work. Fred has Medicare Parts A and B. Fred is married to Wilma that works full time for Slate Rock Co. that employees over 3,000 people.

- Under age 65
- Enrolled in Medicare Part A
- Has family member (Wilma) employed and actively working
- Covered by LGHP through that employer
- Size of employer
  - Individual/multiple employer LGHP - 100 or more employees

MSP ESRD (Type 13)

- Beneficiary of any age diagnosed with permanent kidney failure
- Two criteria must be met
  - Beneficiary eligible for or entitled to Medicare based on ESRD
    - Usually, third month after month started regular course of maintenance dialysis
  - Beneficiary enrolled in GHP through current/former employer of self or family member
- 30-month coordination period
  - Begins earlier of
    - Regular course renal dialysis initiated
    - Self-dialysis training occurred
    - Entitlement based on kidney transplant
  - Also based on
    - Date Part A became effective based on ESRD
    - Date Part A would have become effective based on ESRD had individual applied for Medicare when eligible
  - Ends last date of 30th month from date began
    - Earlier if GHP ends prior to end of 30th month

MSP ESRD Scenario

- Pebbles diagnosed with kidney failure in January 2024 goes on Medicare in March 2024, as she receives a regular course of dialysis treatments. Pebbles works for Rockwood Estates and has employer group coverage.
- Diagnosed with permanent kidney failure and eligible for Medicare based on ESRD
  - Third month after month started regular course of maintenance dialysis
- Pebbles is enrolled in GHP through current employer, Rockwood Estates; therefore, the EGHP plan is primary payer for 30 months

MSP Nongroup Health Plans (NGHP)

NGHP Steps to Take

Provider Responsibilities

- Ask Medicare patients if there's other insurance
- Your Billing Responsibilities
- 20.2.1 - Admission Questions to Ask Medicare Beneficiaries

Defining Terms and Eligibility

- MSP: Medicare Secondary Payer
- Situations when Medicare is not primary claim payer
- NGHP: Non-Group Health Plan is a health insurance plan that is purchased directly from an insurance company, rather than through an employer
- Check eligibility records IVR/NGSConnex

Who Pays First?

- NGHP insurance may be primary
  - WC
  - Auto/No Fault
  - Liability
- Medicare will may process conditionally if primary does not make payment
- Submit MSP claims with the required data
  - See slide 31

Auto/No-Fault (Type 14)

- Medicare may be secondary payer to auto/no-fault insurance
  - Primary payment made for medical expenses for injuries sustained on property or premises of insured, or in use, occupancy, or operation of an auto, regardless of who was responsible for causing accident
  - Auto/No-fault insurance includes
    - Automobile
    - Homeowners'
    - Commercial
  - Medicare will pay conditional when auto/no-fault insurer will not pay promptly
    - Promptly means payment within 120 days after receipt of claim
- Example of auto/no-fault insurance
  - Individual or driver has $5,000 medical payments coverage on policy
  - $5,000 is considered auto/no-fault insurance and primary to Medicare

MSP Auto/No-Fault Scenario

- Barney was on his way to work at Slate Rock when he was hit by another vehicle causing Barney bodily injuries to his head and neck
- Primary payment for medical expenses for automobile injuries (head and neck) sustained by the other driver's insurance
- Medicare will pay conditionally if auto/no-fault insurer will not pay promptly
  - Promptly means payment within 120 days after receipt of claim

Liability (Type 47)

- Medicare may be secondary payer to liability insurance
  - Primary payment based on legal liability for injuries, or damages to property
    - Auto liability and uninsured/underinsured motorist
    - Homeowners'
    - Product/Malpractice
    - Wrongful death
- Medicare will pay conditional when liability insurer will not pay promptly
  - Promptly means payment within 120 days after the earlier of
    - Date claim is filed with insurer, or the lien is filed; or
    - Date service was furnished or date of discharge for inpatient hospital
- Example of liability insurance
  - Beneficiary injured in an auto accident and files claim against alleged responsible party and receives payment
  - Medicare is secondary to liability insurance payment

MSP Liability Scenario

- Bam Bam falls at Rock Furniture Store while walking downstairs to the basement to price furniture
- The stair that Bam Bam walked on was cracked causing him to fall fracturing Bam Bam's hip
- Primary payment for medical expenses for liability injuries (hip fracture) sustained at Rock Furniture Store is responsible
- Medicare will pay conditionally if liability insurer will not pay promptly
  - Promptly means payment within 120 days after receipt of claim

Workers' Compensation (Type 15)

- Medicare is secondary payer to workers' compensation (WC) benefits
  - When services rendered are related to injury, illness or disease sustained at work
    - Either under current or past employment
  - Medicare will pay conditional when a WC insurer will not pay promptly
    - Promptly means payment within 120 days after receipt of the claim
- Example of WC
  - Warehouse worker suffers a back injury while working
  - All related medical bills are the primary payment responsibility of the WC insurer

MSP Workers' Compensation Scenario

- Fred was at work (Rockhead and Quarry Cave Construction Company), and as Fred pick-up a bolder, his back went out and he went tumbling over
- Primary payment for medical expenses for the WC injuries (back) sustained at Rockhead and Quarry Cave Construction Company
- Medicare will pay conditionally if WC insurer will not pay promptly
  - Promptly means payment within 120 days after receipt of claim

Workers' Compensation Medicare Set Aside Arrangements

- WC-related settlement, judgment or award used to pay for future medical, prescription drug or expenses related to WC injury, illness or disease
- Amount determined on case-by-case basis by CMS
- Medicare may not pay until
  - Set-aside amount is exhausted
  - Set-aside amount is accurately accounted for by administrator of WC set-aside arrangement
- Medicare will not pay conditionally for related diagnosis
- After Workers' Compensation Medicare Set-Aside Arrangements amount is properly exhausted, Medicare will reimburse treatment related to WC
- CMS References
  - Workers' Compensation Medicare Set Aside Arrangements
  - CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 3 - MSP Provider, Physician, and Other Supplier Billing, Section 30.2.2.1

Medicare Set-Aside

- Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is an agreement between Medicare and a beneficiary to set aside a portion of a workers' compensation settlement to cover future medical expenses
- Some examples of WCMSAs include
  - Lump sum: A single payment to fund the WCMSA
  - Fixed amount paid annually: A set amount of funds paid each year for a set number of years
- If beneficiary does not properly manage MSA account, they severely jeopardize Medicare paying for your future medical care
- Consequences include denial of future bills from Medicare if funds exhaust and being required to repay MSA account for expenses that were paid for that are not covered by Medicare

Conditional Claims

Conditional Payment

- Conditional payment is payment made by Medicare when there is evidence that payment has not been made or cannot reasonably be expected to be made promptly
- Avoid imposing financial hardship on provider/beneficiary while awaiting decision in contested case
- Payments are made “on condition” that Medicare will be refunded if payment is made
  - Medicare has right to recover any conditional payments
- Conditional payment may be made if both are true
  - Liability (including self-insurance), auto/no-fault, or WC insurer is responsible for payment; and
  - Claim is not expected to be paid promptly

Prompt Period

- Liability insurance (including self-insurance) payment is not made within 120 days after earlier of
  - Date liability claim is filed with insurer/or lien is filed against potential liability settlement
  - Date service was furnished
    - Date of discharge for inpatient hospital claims
- Claim not paid promptly by liability, auto/no-fault or workers' compensation
  - You may submit claim to Medicare conditionally
- Auto/no-fault and workers' compensation claims means payment within 120 days after receipt of claim, or when there is no evidence to contrary, date of service or discharge date

Conditional Payment Data Requirements

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 Data	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

Claim Denials

GHP Claim Denials

- If provider submits claim as primary payer, but Medicare records/CWF shows MSP, claim will deny
- If provider submits MSP claim, but Medicare records/CWF is primary, claim will deny
- If provider submits incomplete or missing MSP claim information, claim will deny
- References
  - CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual,* Chapter 3 - MSP Provider, Physician, and Other Supplier Billing
  - Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

Steps To Take

- Provider shall ask beneficiary necessary MSP questions to determine correct primary payer
- Providers are held liable to obtain the correct MSP information, so claims are billed to correct primary payer
- Obtain name and address of the employer, name and address of GHP, policy number, group number, date GHP coverage began, name of policyholder and relationship to
- CMS Internet-Only Manual Publication 100-05, *Medicare Secondary Payer (MSP) Manual,* Chapter 3 - MSP Provider, Physician, and other Supplier Billing Requirements, Section 20.2.1
- Submit claim(s) to other insurer before submitting claim(s) to Medicare

NGHP Claim Denials

- If auto/no-fault, liability, or WC insurance denies payment
  - Proof that claim was denied
  - Medicare will pay for Medicare-covered items and services as appropriate
    - Submit claim with request for conditional Medicare payment
    - Conditional payment policy and billing procedures for liability, auto/no-fault and WC MSP Claims
- References
  - CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 3 - MSP Provider, Physician, and Other Supplier Billing
  - CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 5 – Contractor MSP Claims Prepayment Processing

Steps You Take

- Ask Medicare patient if service(s) related to injury or illness that resulted from accident or other incident which another party is responsible
- Obtain name, address and policy number of auto/no-fault, liability/WC insurance or other insurance responsible for payment of medical expenses
  - CMS Internet-Only Manual Publication 100-05, *Medicare Secondary Payer (MSP) Manual,* Chapter 3 - MSP Provider, Physician, and other Supplier Billing Requirements, Section 20.2.1
- Submit accident-related claim(s) to other insurer before submitting claim(s) to Medicare

Diagnosis Codes

- Is it related or not?
  - Diagnosis may be related even if code is not an exact match, because it may be in same range or family of diagnosis codes
    - Family of diagnosis means first three digits are same
    - Refer to current coding manuals for more details

Government Programs

Federal Black Lung Program

- Beneficiary entitled to medical benefits under FBLP
  - Program designed for individuals diagnosed with black lung disease caused by coal mining
    - Black lung benefits are considered WC benefits
    - U.S. Department of Labor
- If diagnosis is related to black lung
  - Submit claim to DOL
- If diagnosis is not related to black lung
  - Submit claim to Medicare
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapter 3 and Chapter 5
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16

Veterans Administration (VA)

- Veterans VA benefits for service members who have Medicare and VA benefits may choose Medicare or VA for covered benefits
  - Decision must be made each time beneficiary receives health care services
- To receive VA services, beneficiary must
  - Go to VA facility or
  - Have VA authorize services in non-VA facility

US Family Health Plans

- US Family Health Plan is a contracted TRICARE program under which the TRICARE Prime benefit is offered to eligible military beneficiaries
- Requires beneficiaries to enroll and is offered through six participating non-profit plans in different regions of the country

- US Family Health Plan of Southern New England (Brighton Marine)
  - Serving CT-MA-RI
- Martin's Point Health Care US Family Health Plan
  - Serving ME-NH-NY-VT
- USFHP Saint Vincent
  - Serving Western CT- NY (Nassau and Suffolk Counties)

Government Programs Protocol

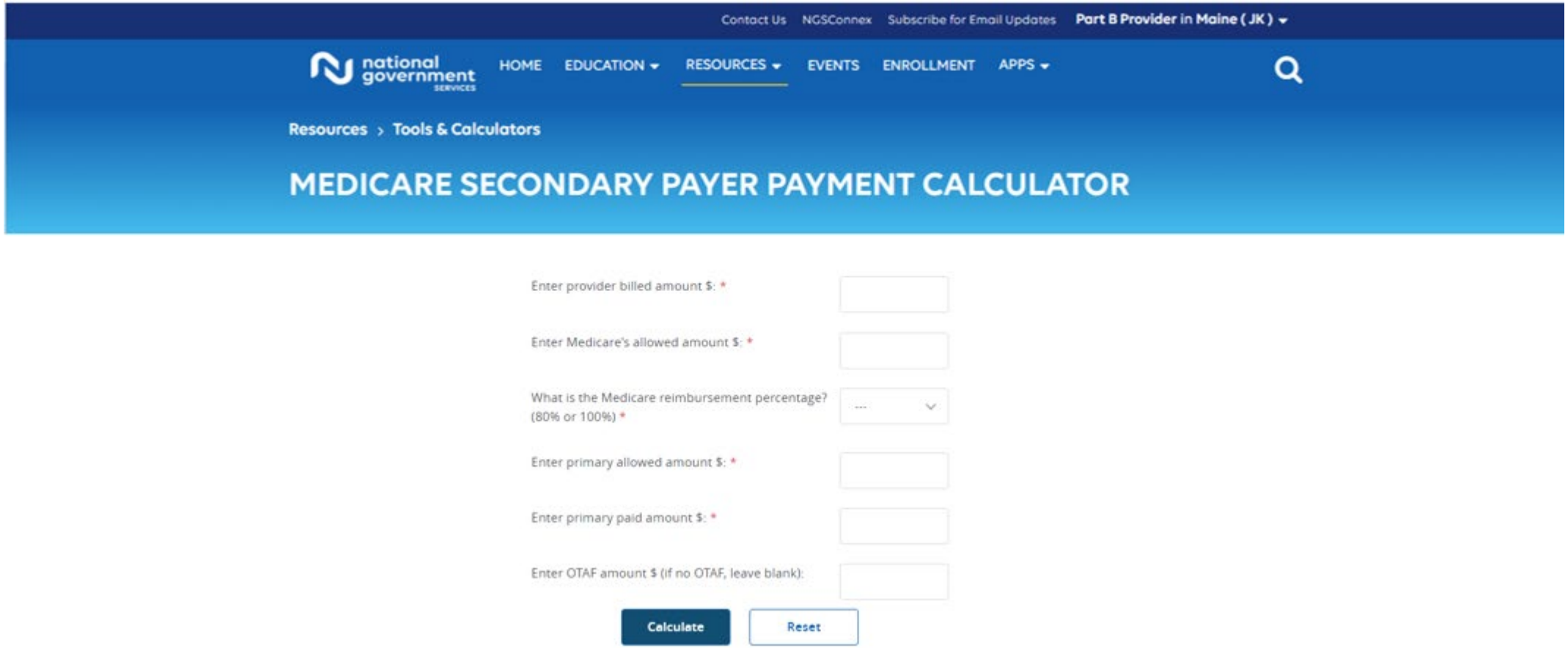
- If you were paid by both NGS Medicare and another government program, such as, Federal Black Lung Program, Veterans Administration or US Family Health Plan
- In NGSConnex, Initiate Clerical Error Reopening

- When NGSConnex asks, “Is this overpayment because Medicare paid as the primary payer, but another insurer is primary?”
- Select NO, because government programs are not MSP claims
- You will be directed to Reopening Details screen to proceed with your reopening request
- At claim line Click the drop-down arrow in “Claim Line Action” field and select “Initiate Overpayment”
- If claim line was billed in error, this will result in claim line being denied and recoupment of payment

Resources

NGS MSP Resources

MSP Payment Calculator

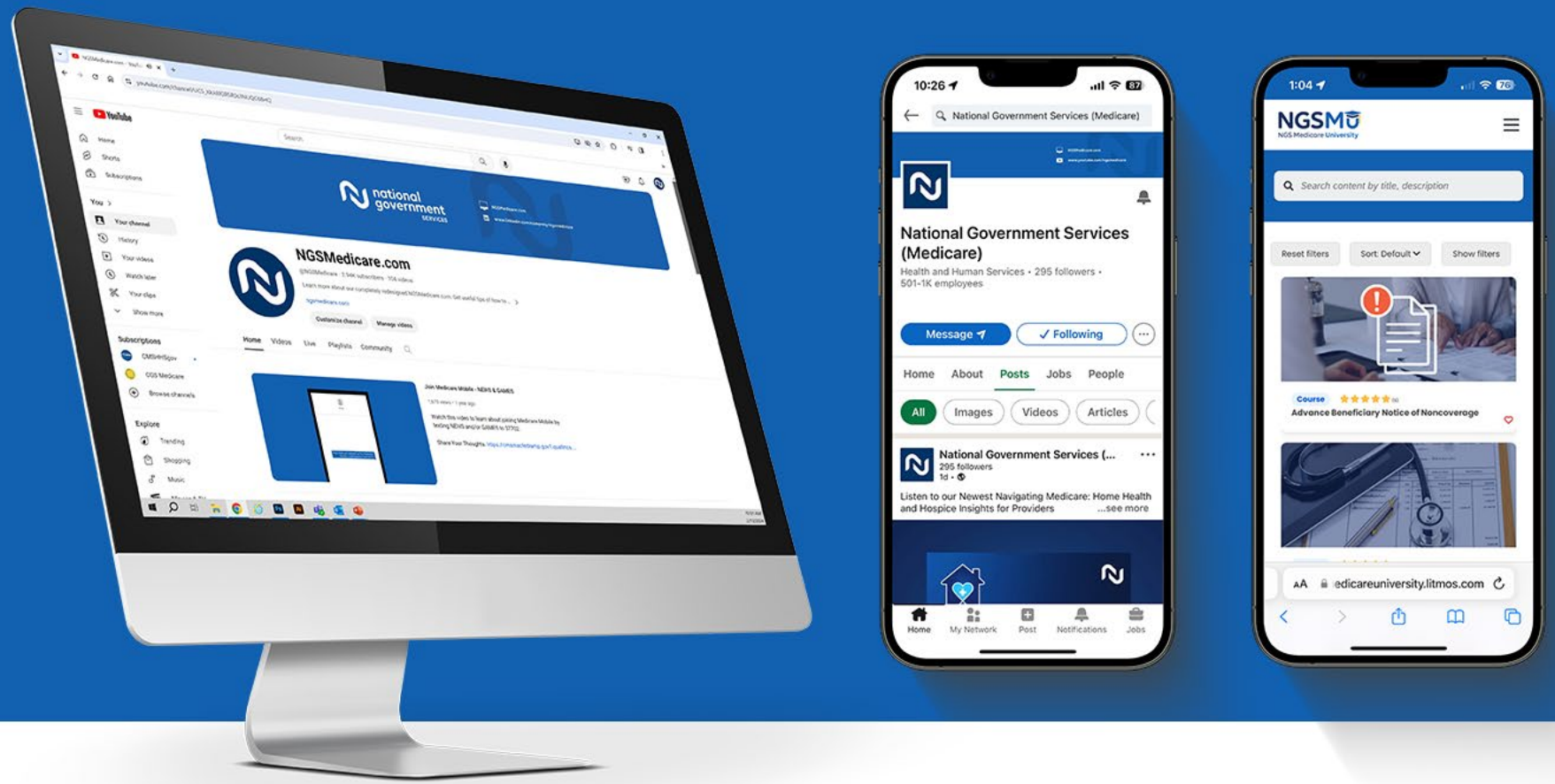


CMS Resources

- CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 1 – General MSP Overview
- CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 2 – MSP Provisions
  - Section 10: Working Aged
  - Section 20: End-Stage Renal Disease
  - Section 30: Disabled
  - Section 40: Liability Insurance
  - Section 50: Workers' Compensation
  - Section 60: No-Fault Insurance
- CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 3, Section 20.2.1- Model Admission Questions to Ask Medicare Beneficiaries

Questions?

Thank you!



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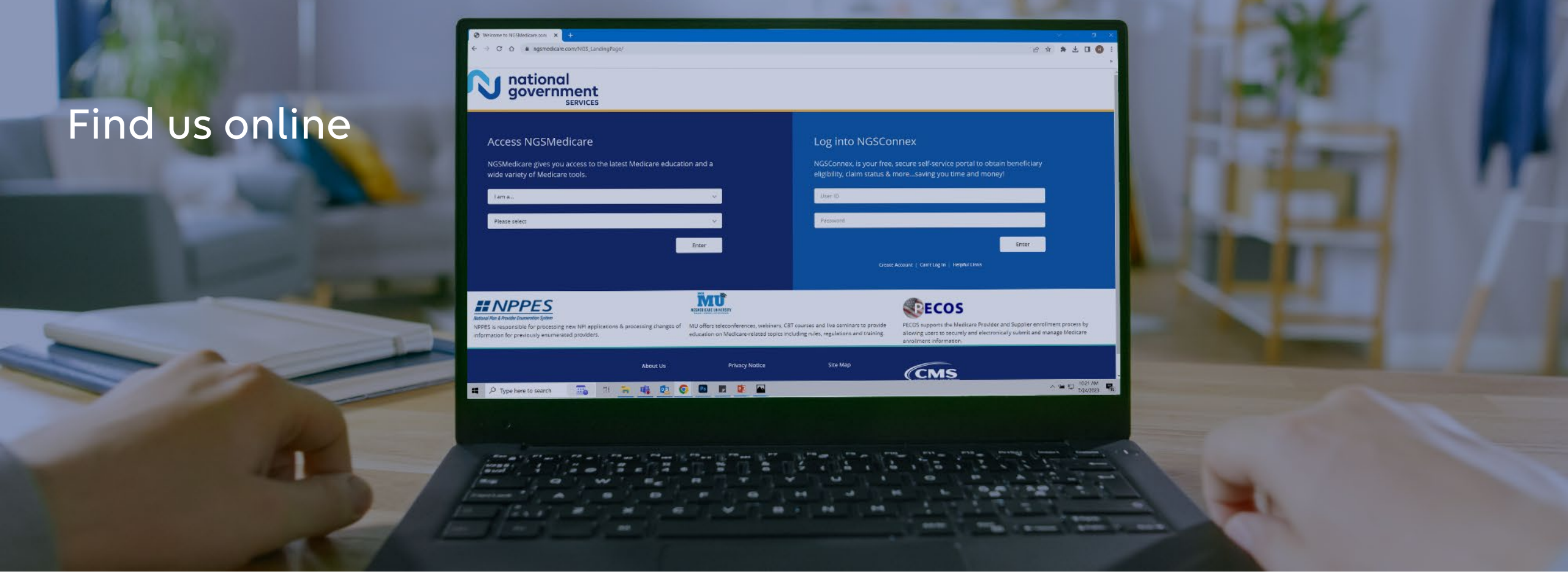

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