

# MEDICARE SECONDARY PAYER FACT SHEET

FOR PROVIDER, PHYSICIAN, AND  
OTHER SUPPLIER BILLING STAFF

## BACKGROUND

Maintaining the viability and integrity of the Medicare Trust Fund becomes critical as the Medicare Program matures and the “baby boomer” generation moves toward retirement. Providers, physicians, and other suppliers can contribute to the appropriate use of Medicare by complying with all Medicare requirements, including those applicable to the Medicare Secondary Payer (MSP) provisions. The purpose of this fact sheet is to provide a general overview of the MSP provisions for individuals involved in the admission and billing procedures at provider, physician, and other supplier settings.

## WHAT IS MEDICARE SECONDARY PAYER (MSP)?

Since 1980, the Medicare Secondary Payer (MSP) provisions have protected Medicare funds by ensuring that Medicare does not pay for services and items that certain health insurance or coverage has primary responsibilities for paying. The MSP provisions apply to situations when Medicare is not the beneficiary’s primary insurance. It provides the following benefits for both the Medicare Program and providers, physicians, and other suppliers:

- National program savings – Medicare saves more than \$6 billion annually on claims processed by insurers that are primary to Medicare.
- Increased provider, physician, and other supplier revenue – Providers, physicians, and other suppliers that bill a liability insurer *before* billing Medicare may receive more favorable payment rates. Providers, physicians, and other suppliers can also reduce administrative costs when health insurance or coverage is properly coordinated.
- Avoidance of Medicare recovery efforts – Providers, physicians, and other suppliers that file claims correctly the first time may prevent future Medicare recovery efforts on that claim.

To realize these benefits, providers, physicians, and other suppliers must have access to accurate, up-to-date information about all health insurance or coverage that Medicare beneficiaries may have. Current law and regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items.



## WHEN DOES MEDICARE PAY FIRST?

Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage. Medicare is also the primary payer in other instances, provided several conditions are met. Table 1 lists some common situations when Medicare may be the primary or secondary payer for a patient's claims.

**Table 1. List of Common Situations When Medicare May Pay First or Second**

If the patient...	And this condition exists...	Then this program pays first...	And this program pays second
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment...	The employer has less than 20 employees...	<b>Medicare</b>	Group Health Plan
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment...	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals...	Group Health Plan	<b>Medicare</b>
Has an employer retirement plan and is age 65 or older or disabled and age 65 or older...	The patient is entitled to Medicare...	<b>Medicare</b>	Retiree coverage
Is disabled and covered by a Large Group Health Plan through his or her own current employment or through a family member's current employment...	The employer has less than 100 employees...	<b>Medicare</b>	Large Group Health Plan
Is disabled and covered by a Large Group Health Plan through his or her own current employment or through a family member's current employment...	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	Large Group Health Plan	<b>Medicare</b>
Has End Stage Renal Disease and Group Health Plan Coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	Group Health Plan	<b>Medicare</b>
Has End Stage Renal Disease and Group Health Plan Coverage...	After 30 months...	<b>Medicare</b>	Group Health Plan
Has End Stage Renal Disease and COBRA coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	<b>Medicare</b>
Has End Stage Renal Disease and COBRA coverage...	After 30 months...	<b>Medicare</b>	COBRA
Is covered under Workers' Compensation because of a job-related illness or injury...	The patient is entitled to Medicare...	Workers' Compensation (for health care items or services related to job-related illness or injury)	<b>Medicare</b>
Has been in an accident or other situation where no-fault or liability insurance is involved...	The patient is entitled to Medicare...	No-fault or liability insurance for accident or other situation related health care services	<b>Medicare</b>
Is age 65 or older OR is disabled and covered by Medicare and COBRA...	The patient is entitled to Medicare...	<b>Medicare</b>	COBRA

## ARE THERE ANY EXCEPTIONS TO THE MSP REQUIREMENTS?

In most cases, Federal law takes precedence over state laws and private contracts. Even if a state law or insurance policy states that they are a secondary payer to Medicare, the MSP provisions should be followed when billing for services.

## WHAT HAPPENS IF THE PRIMARY PAYER DENIES A CLAIM?

In the following situations, Medicare may make payment assuming the services are covered and a proper claim has been filed.

- The Group Health Plan (GHP) denies payment for services because the beneficiary is not covered by the health plan;
- The no-fault or liability insurer does not pay, or denies the medical bill;
- The Workers' Compensation (WC) program denies payment, as in situations where WC is not required to pay for a given medical condition; or
- The WC Medicare Set-aside Arrangement (WCMSA) is exhausted.

In these situations, providers, physicians, and other suppliers should include documentation from the primary payer stating that the claim has been denied and/or benefits have been exhausted when submitting the claim to Medicare.

## WHEN WILL MEDICARE MAKE A CONDITIONAL PAYMENT?

Medicare will make a conditional payment for Medicare covered services in liability, no-fault, and WC situations where another payer is responsible for payment and the claim is not expected to be paid within the promptly period. Medicare makes conditional payments to prevent the beneficiary from using his or her own money to pay the claim. However, Medicare has the right to recover any conditional payments.

## HOW IS BENEFICIARY HEALTH INSURANCE OR COVERAGE INFORMATION COLLECTED AND COORDINATED?

The Centers for Medicare & Medicaid Services (CMS) established the Coordination of Benefits Contractor (COBC) to collect, manage, and maintain information on Medicare's Common Working File (CWF) regarding other health insurance or coverage for Medicare beneficiaries. Providers, physicians, and other suppliers must

collect accurate MSP beneficiary information for the COBC to coordinate the information.

To support the goals of the MSP provisions, the COBC manages several data gathering programs. These programs were implemented in three phases, as discussed in the next section.

## WHAT ARE SOME OF THE ACTIVITIES MANAGED BY THE COBC?

Activities that the COBC performs to collect MSP data include:

- **Initial Enrollment Questionnaire (IEQ)** – The COBC sends out the IEQ approximately three months before an individual is eligible for Medicare. This questionnaire asks the beneficiary if he or she has other health insurance or coverage (including prescription drug coverage) that may be primary to Medicare.
- **Internal Revenue Service/Social Security Administration/CMS (IRS/SSA/CMS) Data Match Project Coordination** – The Omnibus Budget Reconciliation Act of 1989 requires each agency to share information it has regarding employment of Medicare beneficiaries or their spouses. This information helps determine whether a beneficiary may be covered by a GHP that pays primary to Medicare. This information is sent to the COBC, which coordinates the Data Match Project.
- **Data Match Project** – The Voluntary Data Sharing Agreement (VDSA) program allows for the electronic data exchange of GHP eligibility and Medicare information between CMS, employers, and prescription drug plans. Employers, to meet the mandatory reporting requirements, can sign a VDSA in lieu of completing and submitting the IRS/SSA/CMS Data Match Questionnaire. CMS has also developed a new data exchange, similar to the VDSA program, for Supplemental Drug Plans [Non-Qualified State Pharmaceutical Assistance Programs (SPAPs)] to coordinate with Medicare Part D.

- **MSP Claims Investigation Process** – The COBC is responsible for all initial MSP development activities previously performed by Medicare contractors<sup>1</sup>. The COBC provides a one-stop customer service approach for all MSP-related inquiries. However, the COBC does not process claims, nor does it handle any mistaken payment recoveries or claim-specific inquiries. Each provider, physician, or other supplier should continue to call the Medicare contractor that processes their claims regarding specific claim-based issues.

- **MSP Mandatory Reporting Process** – Section 111 of the Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) adds new mandatory reporting requirements for GHP arrangements and for liability insurance (including self-insurance), no-fault insurance, and WC (Non-Group Health Plans). Responsible Reporting Entities (RREs) are now mandated to submit GHP and Non-Group Health Plan information to strengthen the MSP coordination of benefits process.

### WHAT IS SECTION 111 MSP MANDATORY REPORTING?

Section 111 of MMSEA adds to existing MSP provisions of the Social Security Act to provide for mandatory reporting for GHP arrangements, liability insurance (including self-insurance), no-fault insurance, and WC. The provisions were implemented January 1, 2009, for information about GHP arrangements and July 1, 2009, for liability insurance (including self-insurance), no-fault insurance, and WC. The purpose of the reporting process is to enable CMS to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer. Under the new Section 111 requirements, enrollment and settlement data will be submitted

electronically to the COBC. These requirements do not change or eliminate any existing obligations under the MSP statutory provisions or regulations. The new Section 111 requirements add reporting rules to the existing MSP requirements.

For more information and official instructions for Section 111 MSP reporting, please visit the Mandatory Insurer Reporting Web Page at <http://www.cms.hhs.gov/MandatoryInsRep/> on the CMS website.

### WHAT IS THE PROVIDER’S, PHYSICIAN’S, OR OTHER SUPPLIER’S ROLE IN THE MSP PROVISIONS?

Providers, physicians, and other suppliers must aid in the collection and coordination of beneficiary health insurance or coverage information by:

- Asking the patient or his/her representative questions concerning the patient’s MSP status. A suggested method is to incorporate an MSP questionnaire into all patient health records.
- Billing the primary payer before billing Medicare, as required by the Social Security Act.

### HOW DO PROVIDERS, PHYSICIANS, AND OTHER SUPPLIERS GATHER ACCURATE DATA FROM THE BENEFICIARY?

Providers, physicians, and other suppliers can save time and money by collecting patient health insurance or coverage information at each patient visit. Some suggested questions that providers, physicians, and other suppliers should ask include, but are not limited to:

- Is the patient covered by any GHP through his or her current or former employment? If so, how many employees work for the employer providing coverage?

---

<sup>1</sup> **Medicare Contracting Reform (MCR) Update** – In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare’s administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/> on the CMS website.



- Is the patient covered by a GHP through his or her spouse or other family member's current or former employment? If so, how many employees work for the employer providing the GHP?
- Is the patient receiving WC benefits?
- Does the patient have a WCMSA?
- Is the patient covered under no-fault insurance or liability insurance?
- Is the patient being treated for an injury or illness for which another party could be held liable?

Providers, physicians, and other suppliers may also use a model questionnaire published by CMS to collect patient information. This tool is available online in the MSP Manual in Chapter 3, Section 20.2.1 at <http://www.cms.hhs.gov/manuals/downloads/msp105c03.pdf> on the CMS website.

If the provider, physician, or other supplier does not furnish Medicare with a record of other health insurance or coverage that may be primary to Medicare on any claim and there is an indication of possible MSP considerations, the COBC may request that the provider, physician, or other supplier complete a Development Questionnaire.

### WHY GATHER ADDITIONAL BENEFICIARY HEALTH INSURANCE OR COVERAGE INFORMATION?

The goal of MSP information-gathering activities is to quickly identify possible MSP situations, thus ensuring correct primary and secondary payments by the responsible parties. This effort may require that providers, physicians, and other suppliers complete Development Questionnaires to collect accurate beneficiary health insurance or coverage information. Many of the questions on the Development Questionnaires are similar to the questions that providers, physicians, and other suppliers might ask a beneficiary during a routine visit. This similarity provides another good reason to routinely ask patients about their health insurance or coverage. If a provider, physician, or other supplier gathers information about a beneficiary's other health insurance or coverage and uses that information to complete the claim properly, a Development Questionnaire may not be necessary. Accurate submittal of claims



may accelerate the processing of the provider's, physician's, or other supplier's claim.

The COBC may submit a Secondary Claim Development (SCD) Questionnaire to providers, physicians, and other suppliers.

### WHAT IS A SECONDARY CLAIM DEVELOPMENT (SCD) QUESTIONNAIRE?

An SCD Questionnaire may be sent to the provider, physician, or other supplier when a claim is submitted with an Explanation of Benefits (EOB) attached from an insurer other than Medicare, and relevant information was not submitted to properly adjudicate the submitted claim. The COBC provides the names and Health Insurance Claim Number (HICN) of each individual for which the provider, physician, or other supplier must complete an SCD Questionnaire. The provider, physician, or other supplier must complete and submit the SCD Questionnaire to the COBC.

### WHAT HAPPENS IF THE PROVIDER, PHYSICIAN, OR OTHER SUPPLIER SUBMITS A CLAIM TO MEDICARE WITHOUT PROVIDING THE OTHER INSURER'S INFORMATION?

The claim may be paid if it meets all Medicare requirements, including Medicare coverage and medical necessity guidelines. However,

if the beneficiary's Medicare record indicates that another insurer should have paid primary to Medicare, the claim will be either returned unprocessed to the provider or denied or suspended for development. If the Medicare contractor has enough information, they may forward the information to the COBC and the COBC may send the provider, physician, or other supplier a SCD Questionnaire to complete for additional information if they were the informant. Medicare will review the information on the questionnaire and determine the proper action to take.

### WHAT HAPPENS IF THE PROVIDER, PHYSICIAN, OR OTHER SUPPLIER FAILS TO FILE CORRECT AND ACCURATE CLAIMS WITH MEDICARE?

Federal law permits Medicare to recover its conditional payments. Providers, physicians, and other suppliers can be fined up to \$2,000 for knowingly, willfully, and repeatedly providing inaccurate information relating to the existence of other health insurance or coverage.

### HOW DOES THE PROVIDER, PHYSICIAN, OR OTHER SUPPLIER CONTACT THE COBC?

Providers, physicians, and other suppliers may contact the COBC at 1-800-999-1118 (TTY/TDD: 1-800-318-8782), Monday - Friday, 8 a.m. to 8 p.m. Eastern Time (excluding holidays). Providers, physicians, and other suppliers may contact the COBC to:

- Report potential MSP situations;
- Report incorrect insurance information; or
- Address general MSP questions/concerns.

Specific claim-based issues (including claim processing) should still be addressed to the provider's, physician's, or other supplier's Medicare claims processing contractor.

### WHERE CAN I FIND MORE INFORMATION ON THE PROVIDER'S, PHYSICIAN'S, OR OTHER SUPPLIER'S ROLE IN MSP AND COB?

CMS offers several online references for information about MSP, COB, and the Medicare Program:

- **The Medicare Learning Network Home Page**

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

- **The Medicare Coordination of Benefits Home Page**

<http://www.cms.hhs.gov/COBGeneralInformation/>

The Medicare Coordination of Benefits Home Page features materials related to the MSP provisions.

- **The Contacting the COBC Web Page**

[http://www.cms.hhs.gov/COBGeneralInformation/03\\_ContactingtheCOBContractor.asp](http://www.cms.hhs.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp)

The Contacting the COBC Web Page contains the contact information and specific addresses for submitting COBC-requested materials.

---

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

April 2009

ICN# 006903