



MEDICARE SECONDARY PAYER (MSP)

Welcome to WPS-Medicare's
Computer Based Training Session
on Medicare Secondary Payer.

Objective

- **Gain a basic understanding of MSP**
- **Understand provider procedures for gathering MSP information**
- **Understand billing requirements in special situations**

Medicare Secondary Payer (MSP)

- **Until 1980, Medicare was the primary payer in all cases (except workers compensation or VA benefits)**
- **Medicare is not primary payer in all instances anymore**
- **All insurance coverages must be identified at admission**
- **MSP questionnaire must be completed on all admissions**
- **Questionnaire should be stored somewhere accessible in case requested**

Employee Group Health Plan

- **Medicare is secondary to benefits payable under EGHP (Working Aged)**
 - **for employees age 65 or over and their spouses**
 - **if the employer has 20 or more employees and pays a portion or all of the group health insurance**
- **Medicare is primary when the employer has less than 20 employees or benefits are exhausted, services not covered, or employee is retired**

Large Group Health Plan Disabled, Under Age 65

- **The determination of primary and secondary payer depends upon the current employment status of the beneficiary or spouse (must be actively working) Medicare is**
 - **Secondary when the group plan covers employees of employers with 100 or more employees**
 - **Primary when group plan covers less than 100 employees, or benefits exhausted, services not covered, or employee not currently working**

End Stage Renal Disease

- **Medicare is secondary to benefits payable under GHP for beneficiaries entitled to Medicare during the coordination period**
- **Coordination period is the period of time during which Medicare benefits are secondary to GHP (begins with first month the person is eligible for Medicare)**
- **Coordination period for ESRD beneficiaries is now 30 months per BBA-97**

ESRD Coordination Period

- For kidney transplant, period begins with date of first treatment**
- For home dialysis, period will start at the beginning of the month in which first dialysis treatment was given**
- For hemodialysis, period begins at the beginning of the fourth month of renal dialysis treatment**

Clarification of MSP Rules in a Temporary Leave of Absence

- When an employee takes a company-approved leave of absence **AND** retains his/her employee status **AND** his/her health insurance coverage through the employer, MSP rules state that Medicare is the secondary payer.

**CMS Pub 100-5, Chapter 1, Section 50B
Transmittal #19 Change Request #3447
Newsletter 11/01/04**

Consolidated Omnibus Budget Act of 1985 (COBRA)

- **States an employer must offer continuation of group insurance coverage for a specified time to employee upon job termination**
- **If beneficiary has COBRA coverage, Medicare would be primary, except for ESRD**
- **If beneficiary is entitled due to ESRD, the COBRA coverage is primary for the coordination period**

Automobile/ No Fault/ Liability

- **Medicare is secondary when the beneficiary has been involved in an automobile accident or in a liability situation in which another party is responsible**
- **Medicare is primary when the beneficiary fell at home or any other situations in which no other party is responsible**
- **When billing Medicare, the provider has the choice to either bill Medicare OR file a claim with the auto, no fault plan, or place a lien with the attorney**

Auto/ No Fault/ Liability Billing

- **The provider cannot bill BOTH Medicare and the insurer or place a lien with the attorney**
- **If Medicare paid the claim and the provider receives a check from another entity, an adjustment should be requested**
- **The Provider is only allowed to keep up to Medicare's approved amount plus deductible, coinsurance and noncovered charges**
- **The Remainder must be refunded to patient**

Workers Compensation

- **If a patient is involved in a work-related accident, the Workers Compensation carrier should be billed prior to Medicare**

Federal Agencies

- **Federal Law states that payment may not be made for items and services furnished by a provider of service when it can be paid directly or indirectly by a Federal, State, or local government entity**

Black Lung

- **Medicare is secondary when the patient is entitled to have the services reimbursed by the Department of Labor (DOL) under the Federal Black Lung Program**
 - **Bill the DOL**
- **Medicare is primary if the services rendered to a Black Lung beneficiary were solely for non-Black Lung condition such as diabetes or a fracture**
 - **Bill the Medicare Intermediary**

Veterans Administration

- **If it is known that a patient is covered by the VA, bill the Veterans Administration prior to submitting the bill to Medicare**
- **VA eligible patients may choose to receive services in a Medicare Certified provider.**

Coordination of Benefits Contractor (COB)

- **CMS awarded the Coordination of Benefits (COB) contract to consolidate MSP development activities**
- **All MSP claims investigations are no longer a function of the FI, i.e., FI's cannot update, close or change any screen information per COB**
- **The COB provides customer service to all callers from any source**
- **The COB initiates a variety of methods and programs to identify MSP situations**

Request for Claims Payment

- **FIs and Carriers process claims for primary or secondary payment**
- **Claims processing is not a function of the COB Contractor**
- **MSP investigations are now done by the COB Contractor, not the FI**

Contacting the COB Contractor

- **Refer all MSP inquiries, MSP situations, changes in insurance, employment and general MSP questions and concerns**
- **COB Contractor's Customer Call Center:**
 - **1-800-999-1118 or**
 - **1-800-318-8782 TDD/TYY**
 - **1-646-458-6761 Fax #**
 - **Available 8:00 a.m. to 8:00 p.m. Monday through Friday, Eastern Standard time**
- **Continue to call the FI regarding claims-related questions**

MSP Admission Questionnaire

- **Providers are required to determine whether Medicare is a primary or secondary payer**
- **They must ask the beneficiary about other insurance coverage for every admission, outpatient encounter, or start of care**
- **The format may be changed, added to an on-line system or hardcopy**
- **All questions on the MSP questionnaire must be answered in full**
- **Beneficiary's signature is not required**

MSP Admission Questionnaire

- **Failure to obtain information listed in the questionnaire is a violation of your provider agreement with Medicare**
- **MSP information with the proper uniform billing codes on the claim will be used to update CWF through the billing process**
- **All MSP questionnaires must be retained on file (hardcopy or on-line) for 10 years in accordance with Dept. of Justice record retention requirements**

MSP Policy for Recurring Outpatient Services

- **Hospitals must collect MSP information from beneficiary/representative for outpatients receiving recurring services.**
- **Following the initial collection, the MSP information should be verified once every 90 days.**
- **If this information is no older than 90 calendar days from the DOS, the information may be used to bill Medicare.**
- **Hospitals must be able to demonstrate compliance.**

Pub. 100-5 Chapter 3, Section 20.1.2

Credit Balance Report

- **CMS requires that providers file a quarterly Credit Balance Report on CMS Form 838 to report these credits**
- **The Credit Balance Certification page must be filed with an original signature**
- **The Credit Balance Report and Certification Page may not be filed via facsimile**
- **Credit Balance Report (CMS 838) may be obtained at:**

www.cms.hhs.gov/forms/cms838.pdf

Credit Balance Report

The Credit Balance Report must be submitted to our office in accordance with the following schedule:

Quarter Ending:

March 31

June 30

September 30

December 31

Due by:

April 30

July 30

October 30

January 30

Credit Balance Line (402) 351-5498

Credit Balance Report

- **When submitting credit balance reports, claim adjustments (UB-04) or a check must accompany the 838 report**
 - **If you are reporting any MSP credit balances, an EOB must be sent with the report to document the date the credit balance was established**
- **Please do not hold adjustments for the Quarterly Credit Balance report**
 - **Send these in as they are identified**
 - **All providers should have a zero report to submit**
- **If there are no adjustments or a check received with the report, a demand letter for the total amount of the report will be issued**

Credit Balance Report

- **Credit Balance Reports are required even if the provider has a “0” balance**
- **The certification form must also be completed and signed to be accepted**
- **Adjustments should not be held for the Credit Balance Report**
- **For Reason Code 2 (MSP) or 3 (Other) you must submit a UB-04**
- **If reports are not received by the due date, suspension of payments will result.**

Pub. 100-5, Chapter 3, Section 10.5

Mailing Addresses

OVERNIGHT

**Wisconsin Physicians Service - Medicare
MSP Department
3333 Farnam Street
Suite 700
Omaha, NE 68131**

REGULAR MAIL

**Wisconsin Physicians Service - Medicare
P. O. Box 1602
Omaha, NE 68101**

Billing Procedures

- **All MSP claims can and should be submitted electronically**
- **If requesting a Conditional Payment, indicate “requesting conditional payments” in remarks screen**

Liability Situations/Double Billing

- **Providers MAY NOT simultaneously bill a beneficiary, Medicare, or another insurer for covered items and services**
- **In liability situations providers may choose to:**
 - **Bill Medicare**
 - **File a lien against the settlement**
 - **Bill the liability insurer directly**
- **Providers may not bill both Medicare and the liability insurer**

Conditional Payment

- **If providers cannot expect prompt payment from a third party (i.e., within 120 days), they may bill Medicare for conditional payment**
 - **Medicare will pay the bill on the condition that we will be reimbursed if the provider receives other payment**
 - **Use a Value Code 14, (no fault) or 47 (liability) showing zero (0) payment amount, complete the insurance and primary payer information using a “C” in the Payer ID field and the comments from above in remarks**

When Choosing to Bill Medicare First:

- Provider must file an amended lien or adjusted bill with the liability insurer for only non-covered services, deductibles, or coinsurance as required by law**
- Providers are not allowed to bill the liability insurer for the difference between the allowed amount or the limiting charge**
- Such action would be considered double billing**
- If Provider bills Medicare first and Medicare denies all or part of a claim, the denied services may be billed to liability insurer**

When Choosing to Bill Liability Insurer/File a Lien

- **After billing the liability insurer, a Provider must wait 120 days before billing Medicare**
- **Once the Provider bills Medicare, the Provider must amend any lien or adjust its bill to the liability insurer for ONLY non-covered services, deductibles and coinsurance**
- **To do otherwise would be considered double billing**
- **Claims for which liability insurer makes only partial payment may be submitted as MSP**
 - **Should be submitted with copy of primary insurer's EOB**

Value Code 44

- Value Code 44 is used when a primary payer pays less than actual charges and less than the amount a provider is contractually obligated to accept as payment in full from an insurance company
- It is used with the amount the provider was obligated to accept
- Also, use the appropriate value code to show the amount actually received from the insurance company
- Value Code 44 amount must always be higher than the value code 12, 13 or 43

Pub. 100-5, Chapter 3, Section 40.2.1

Instructions for Requesting MSP Adjustments

- **Check the MSP screen(s) on CWF to ensure the information is correct before requesting an adjustment.**
- **Providers must include all appropriate documentation to support the MSP adjustment**
- **If these items are missing, the adjustments will not be processed**
- **Mail the information to:**

WPS - Medicare

Medicare Secondary Payer

PO Box 1602

Omaha, NE 68101

Pub. 100-4, Chapter 3, Section 50.2

Medicare Secondary Payer (MSP) References

- **CMS web site**
www.cms.hhs.gov

CMS MSP Manual- Pub. 100-5
**[www.cms.hhs.gov/manuals/105_msp/
msp105index.asp](http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp)**

- **WPS' web site**
www.wpsmedicare.com

◆ This program is presented for informational purposes only. The current Medicare Regulations will prevail.

**Thank you, you have completed
the CBT.**

**Would you like to take a 10 question
knowledge check?**

Yes, let's get started.

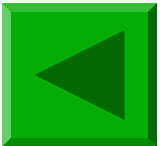
No, please take me back to
WPS Medicare's Provider
Homepage.

Medicare is always primary to other insurance.

True

False

**That is not correct, please try
again.**



**That is correct the answer is
False.**

A Credit Balance Report must be submitted quarterly only if you have a credit balance to report.

True

False

**That is correct the answer is
False.**

When an employee takes a company-approved leave of absence and retains his/her health coverage through the employer, Medicare is the primary payer.

True

False

**That is correct the answer is
False.**

If a patient is involved in a work-related accident, the Worker's Compensation carrier should be billed prior to Medicare.

True

False

**That is correct the answer is
True.**

**There is a 12-month
coordination period for
beneficiaries who have End
Stage Renal Disease.**

True

False

**That is correct the answer is
False.**

**MSP claims and adjustments
can be submitted electronically.**

True

False

**That is correct the answer is
True.**

Updates to the MSP master record can only be made by WPS Medicare.

True

False

**That is correct the answer is
False.**

Credit Balance reports can be faxed to Medicare.

True

False

**That is correct the answer is
False.**

In a liability situation, provider may not bill both Medicare and the liability insurer.

True

False

**That is correct the answer is
True.**

The MSP Questionnaire must be completed for each Medicare admission or outpatient encounter and kept on file (hard copy or on-line) for 10 years in accordance with the Department of Justice requirements.

True

False

**That is correct the answer is
True.**

Thank you, you have completed the Knowledge Check.

Would you like to take another CBT?

Yes, let's get started.

No, please take me back to
WPS Medicare's Provider
Homepage.