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2022 NGS Medicare Spring Virtual Conference **Medicare for You**

Medicare Secondary Payer Overview for Part B Providers

5/11/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education
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Objectives

- Here's what you will learn today!
  - This session will take you through the relationship of the Medicare Secondary Payer provisions that covers two broad categories of MSP, group health plan (GHP) and nongroup health plan (NGHP), addressing benefits coordination and recovery, submitting claims appropriately, calculating MSP claims, and the final topic of the MSP overpayment process.

Agenda

- MSP types provisions
- Identifying primary payers
- BCRC responsibilities
- Claim and billing requirements
- Payment and calculations
- MSP overpayments
- Interactive MSP scenarios

MSP Types and Provisions

MSP Types and Provisions

- 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)
- MLN® Booklet: *Medicare Secondary Payer*
  - for providers, physicians, other suppliers, and billing staff

Group Health Plan Provisions

- Working Aged
  - Beneficiary aged 65 or older, enrolled in Medicare Part A, beneficiary or spouse (of any age) employed and actively working, and covered by EGHP through that employer
  - Individual employer GHP = 20 or more employees
- Disability
  - Beneficiary under age 65, enrolled in Medicare Part A, beneficiary or family member (of any age) employed and actively working and covered by LGHP through that employer
  - Individual/multiple employer LGHP = 100 or more employees

ESRD Provision

- 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

Nongroup Health Plan Provisions

- MSP 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
- MSP auto/no-fault liability insurance
  - Auto/No-fault insurance/Liability 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

Government Program

- Federal Black Lung Program
  - Program designed for individuals diagnosed with black lung disease caused by coal mining
    - Black lung benefits are considered WC benefits
    - Administered by U.S. Department of Labor
  - If diagnosis is not related to black lung, submit to Medicare
- Veterans Administration
- To receive VA services, beneficiary must
  - Go to VA facility or
  - Have VA authorize services in non-VA facility
- Uniform Services Family Health Plan
  - HMO government program in place of Medicare

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Medicare Supplement or Medigap

- Private Medigap insurance and MSP law regulations are not the same
- Supplement/Medigap: private health insurance policy fills gaps in Medicare's coverage when Medicare is primary
  - Medigap is not Medicare program benefit
  - Typically pay for expenses Medicare does not such as
    - Deductibles and coinsurance

Identifying Primary Payers

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

Primary Payer Identification Methods

- Collect information
  - CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 3
    - Verification of Medicare Secondary Payer Online Data and Use of Admission Questions
- Check Medicare's records
  - IVR
    - NGS Website > Contact Us > Interactive Voice Response System
  - NGSConnex
    - NGSConnex

Benefits Coordination and Recovery Center

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When to Contact BCRC

- Report employment changes, or any other insurance coverage information
- Report a liability, auto/no-fault, or workers' compensation case
- BCRC does not process claims and does not answer claim inquiries
- Benefits Coordination & Recovery Center (BCRC)

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Updating Beneficiary Information

- BCRC undertaking to maintain most up-to-date and accurate beneficiary MSP information on Medicare's CWF Providers may call to update
- Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time
  - Toll-free lines
    - 855-798-2627
    - 855-797-2627 for the hearing and speech impaired

MSP Claim and Billing Requirements

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 Publication100-04, *Medicare Claims Processing Manual,* Chapter 1, Section 70
  - 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

ASCA

- Most providers required to submit MSP claims electronically due to ASCA regulations
  - If submit all other claims electronically, must also submit MSP claims electronically
- Ten ASCA exceptions include
  - Medicare tertiary (third) payer claims
  - Providers submitting < ten claims per month
  - Physician/practitioner/supplier with < ten FTE employees
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 24, Section 90-90.6

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MSP Paper Claim Line Items

- Item 4
  - If insurance primary to Medicare, list name of insured
  - When insured and patient are same, enter “SAME”
- Item 6
  - Check appropriate box for patient’s relationship to insured
- Item 7
  - Enter insured’s address and telephone number
  - When address is same as patient’s, enter “SAME”
- Item 10a, b and c
  - Is patient’s condition related to employment, auto accident or other accident? Yes/No
- Item 11
  - Enter insured’s policy or group number
- Item 11a
  - Enter insured’s eight-digit birth date and sex if different from Item 3
- Item 11c
  - Enter nine digit payer ID for primary insurer or complete primary payer’s program/plan name

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Same

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
Same

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
XYZ 987654321

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX
Same M X F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME
Anthem BC/BS

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

CARRIER

PATIENT AND INSURED INFORMATION

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MSP Electronic Claims

- Electronic 837P
  - Different claim submission methods
    - Directly to Medicare (PC-ACE or NGSConnex)
    - Through clearinghouse or vendor via HIPAA-compliant software
  - Required items on paper claim have electronic equivalents
- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

MSP Electronic Claims

- Required MSP data for electronic claim
  - 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

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Conditional Payment Data Requirements

- 837 5010 Professional Claims

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		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0	02-Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

MSP Payment and Calculations

Obligated To Accept Full Payment

- OTAF amount will indicate discount
- Beneficiary is not responsible for OTAF
- Calculate OTAF using primary explanation of benefits
- Take billed amount and minus any discounts or adjustments

MSP Payment Calculation

- Determine three possible payment amounts
  - A. Actual charge by physician/supplier or Obligated to Accept (OTAF) minus amount paid by primary
  - B. Usual Medicare payment determination
    - Fee Schedule amount (minus any deductible 2022 - $233)
    - Multiply results by 80% (or other as appropriate)
  - C. Highest allowed amount minus amount paid by primary
    - MPFS or amount payable under Medicare (not including deductible or coinsurance)
    - Primary payer's allowed amount
- Medicare Secondary Payer Payment Calculator
  - Medicare pays the lesser of the three amounts

Patient Responsibility Formula

- Add amount primary payer paid to Medicare paid amount
- Subtract that amount from Medicare allowed charge for claim
- If total equals $0 or negative
  - Beneficiary does not have any financial responsibility

MSP Overpayment Process

MSP Overpayments

- Multiple primary payments received?
  - If Medicare should be secondary
    - Medicare must be repaid within 60 days of receiving payment from primary plan
    - Repay difference between
      - Amount Medicare actually paid
      - Amount Medicare should have paid (if any)
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapter 3, Section 10.4

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MSP Overpayments

- Providers **not on** automatic immediate recoupment
  - Complete MSP Part B Voluntary Refund Form
    - Attach your check
    - Include EOB from primary plan
- Providers **on** automatic immediate recoupment
  - Complete Medicare Part B MSP Overpayment Request Form
    - Include EOB from primary plan
- JK and J6 MSP Post-Pay Overpayment Forms

MSP Claims Issue Protocol

What To Do When

- MSP denials for working aged, disability, or ESRD
  - If the Common Working File and Multi-Carrier System are updated to show as primary, you have a claim that initially denied and now you need claim reopened
  - Reopening versus Redetermination
    - Part B Reopening Request via Telephone Reopening Unit
      - MSP pricing issues cannot be conducted in NGSConnex; therefore, request via TRU or Part B Reopening Request

What To Do When

- MSP denials for auto no fault (14), workers' compensation (15), or liability (47)
  - If the Common Working File and Multi-Carrier System show an open record **or** updated record and you have a claim that initially denied and you need the claim processed by Medicare
    - If denial is correct and you have documentation, submit a redetermination

What To Do When

- MSP denials for working aged, disability, or ESRD, because claim was **not** submitted with MSP data on initial claim submission and Medicare is secondary payer
  - Resubmit claim with appropriate loops and segments populated
    - Refer to: Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

What To Do When

- MSP claim processed and paid as primary, but records now show Medicare is secondary payer and you have an overpayment
  - If Medicare paid primary, but should have paid as secondary
  - Use MSP Post-Pay Overpayments form and attach a copy of the primary explanation of benefits

Interactive MSP Scenarios

Scenario One

- Model MSP questionnaire was completed by beneficiary in office and when accessing eligibility records in NGSConnex, there is a conflict. What do you do?
  - **Contact BCRC to report employment changes, or any other insurance coverage information**

  OR

  - Contact NGS

Scenario Two

- True or False
- Correct group health insurance type codes are required on electronic claims
  - Insurance type codes
    - Working aged (type 12)
    - Disability (type 43)
    - ESRD (type 13)
- **True**

Scenario Three

- True or False
- For group health plans Medicare is always either primary or secondary for all services
  - Working Aged
  - Disability
  - ESRD
- **True**

Scenario Four

- True or False
- Nongroup health plans are responsible for injury related conditions only
  - Auto/no-fault
  - Liability
  - Workers' Compensation
- **True**

Scenario Five

- Before submitting claims, providers should always do what?
  - **Conduct screening using the MSP model questionnaire and check eligibility records via IVR or NGSConnex**

  OR

  - Submit the claim and wait for the remittance advice notice

Scenario Six

- Claim was submitted as primary to Medicare and denied. Provider received payment from primary insurer. What are next steps for Medicare reimbursement?
  - **Submit claim with MSP data in loops and segments**
  - Submit redetermination
  - Submit reopening

Scenario Seven

- You received primary payment from Medicare, but recently received payment from another primary insurer. You learn that Medicare is secondary and Medicare records now show secondary for the services you provided. What do you do next?
  - **Submit Part B MSP Overpayment Request form**
  - Submit Redetermination

Scenario Eight

- Physician's charges = $175
- Primary payer's allowed charge = $150
- Primary payer paid 80% of allowed charge = $120
- Medicare fee schedule amount = $125
- Patient’s Part B deductible met

MSP Payment Calculation

- Determine three possible payment amounts
  - A. Actual charge by physician/supplier or Obligated to Accept (OTAF) minus amount paid by primary
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    - Fee Schedule amount (minus any deductible 2022 - $233)
    - Multiply results by 80% (or other as appropriate)
  - C. Highest allowed amount minus amount paid by primary
    - MPFS or amount payable under Medicare (not including deductible or coinsurance)
    - Primary payer's allowed amount
- Medicare Secondary Payer Payment Calculator
  - Medicare pays the lesser of the three amounts

Scenario Eight: MSP Methodology

- A. Actual charge by physician minus primary payer's payment
  - $175 - $120 = $55
- B. Usual Medicare payment determination
  - 80% x $125 = $100
- C. Highest allowed amount minus amount paid by primary
  - $150 - $120 = $30
- What would Medicare pay?

Scenario Eight: Patient Responsibility

- Primary payer paid amount plus Medicare paid amount
  - $120 + $30 = $150
- Medicare allowed charge minus result from first step
  - $125 - $150 = - $25
- What is patient responsibility?

References

Electronic MSP Claims

- NGS Website
  - Under Resources > Claims and Appeals > Medicare Secondary Payer (MSP) > Prepare and Submit an MSP Claim > Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P

CMS References and Materials

- MLN® Booklet: *Medicare Secondary Payer*
  - For providers, physicians, other suppliers, and billing staff
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16
- CMS IOM Publication 100-05 *Medicare Secondary Payer Manual*
- CMS IOM Publication 100-05 *Medicare Secondary Payer (MSP) Manual*, Chapter 3
  - Verification of Medicare Secondary Payer (MSP) Online Data and Use of Admission Questions

Government Program References

- Federal Black Lung Program
- Veterans Administration
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapter 3
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapter 5

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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