CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12436	**Date: December 28, 2023**
	Change Request 13475

SUBJECT: Update to Internet Only Manual 100-05, Chapter 2, Section 40.2 to Clarify the Liability Insurance Settlement Provisions

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Internet Only Manual 100-05, Chapter 2, Section 40.2, paragraph E, and clarify that a provider, physician, or other supplier, may maintain a claim, or lien, against the liability insurance or beneficiary's liability insurance settlement once the Medicare timely filing period has lapsed.

EFFECTIVE DATE: January 29, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 29, 2024

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	2/40/40.2/Billing in MSP Liability Insurance Situations

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 12436	Date: December 28, 2023	Change Request: 13475

SUBJECT: Update to Internet Only Manual 100-05, Chapter 2, Section 40.2 to Clarify the Liability Insurance Settlement Provisions

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update Internet Only Manual 100-05, Chapter 2, Section 40.2, paragraph E, and clarify that a provider, physician, or other supplier, may maintain a claim, or lien, against the liability insurance or beneficiary's liability insurance settlement once the Medicare timely filing period has lapsed.

B. Policy: Medicare Secondary Payer policy and provisions are to provide detailed information regarding the MSP provisions, and the relationship of MSP to other laws. This information can assist the A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs) with responses to questions from providers, physicians and other suppliers, attorneys, employers, and other payers.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13475.1	The Medicare Contractors shall be aware of the policy clarifications in 100-05, Chapter 2, section 40.2, which clarifies policy that allows a provider, physician, or other supplier, to maintain a claim or lien against the liability insurance or beneficiary's liability insurance settlement once the Medicare timely filing period has lapsed.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Secondary Payer (MSP) Manual
Chapter 2 - MSP Provisions

40.2- Billing in MSP Liability Insurance Situations
(Rev. 12436: Issued: 12-28-23: Effective: 01-29-24; Implementation: 01-29-24)

A - Difference Between Liability Insurance and Other Primary Plans

Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Act, are primary to Medicare. In the case of other types of insurance that are primary to Medicare, i.e., no-fault insurance, GHPs, and WC, the insurance has a contractual obligation to pay for medical services provided to the covered/injured person. Liability insurance, however, has a contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party.

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made..." under liability insurance (including self- insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where Ongoing Responsibility of Medicals (ORM) has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted. See IOM 100-05, Chapter 5, Section 20.4 for detailed instructions regarding ORM.

B – Billing Options and Requirements – Alternative Billing

Generally, providers, physicians, and other suppliers must bill liability insurance prior to the expiration of the promptly period rather than bill Medicare. (The filing of an acceptable lien against a beneficiary's liability insurance settlement is considered billing the liability insurance.) As specified in 42 CFR § 411.50, promptly means payment within 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge) rather than bill Medicare. Following expiration of the promptly period, or if demonstrated (e.g., a bill/claim that had been submitted but not paid and the liability insurer indicates, on the claim, the reason why the claim is not being paid. Note: If the reason for primary payer denial is not identified on the claim, the A/B MAC or DME MAC denies/rejects the claim). If liability insurance will not pay during the promptly period, a provider, physician, or other supplier may either:

- Bill Medicare for payment and withdraw all claims/liens against the liability insurance/beneficiary's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance); or

- Maintain all claims/liens against the liability insurance/beneficiary's liability insurance settlement.

C – Special Rule for Oregon [See 42 CFR § 411.54(d)(2)]

As a result of a court order, providers, physicians, and other suppliers in Oregon:

- May either (i.e., double billing is not permitted) bill Medicare or bill liability insurance (the filing of a lien against a beneficiary's liability insurance settlement is considered billing the liability insurance) if the liability insurer pays within 120 days after the earlier of the following

dates:

- The date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement; or

- The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

- Must withdraw claims/liens against the liability insurance/beneficiary's liability insurance settlement following expiration of the 120-day period and bill Medicare.

However, CMS will not terminate the provider agreement of a provider that does not comply with the court order if that provider is following the procedures outlined in B above.

D – Charges to Beneficiaries

Provider Charges to Beneficiaries for Services Covered By Medicare

The following applies to providers that participate in Medicare, emergency hospitals that do not participate in Medicare, and foreign hospitals with an election to bill Medicare:

- If the provider bills Medicare, the provider must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the provider pursues liability insurance, the provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

Physician and Other Supplier Charges to Beneficiaries for Services Covered By Medicare

The following applies to physicians and other suppliers who participate in Medicare:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

The following applies to physicians and other suppliers who do not participate in Medicare and who submit or would be required to submit an assigned claim:

- If the physician or other supplier bills Medicare, the physician or other supplier must accept the Medicare approved amount as payment in full and may charge beneficiaries only deductibles and coinsurance.

- If the physician or other supplier pursues liability insurance, the physician or other supplier may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs, but may not collect payment from the beneficiary until after the proceeds of the liability insurance are available to the beneficiary.

- Physicians and other suppliers (with the exception of DMEPOS suppliers) who do not participate in Medicare and who submit an unassigned claim may charge beneficiaries no more than the limiting charge and may collect payment without regard to whether the liability insurance is available to the beneficiary.

Physicians and other suppliers who do not participate in Medicare, do not submit an unassigned claim, and are not required to submit an assigned claim if they submitted a claim to Medicare, may pursue liability insurance but the amount may not exceed the limiting charge.

Charges to Beneficiaries for Services Not Covered by Medicare

- For services for which there is no Medicare coverage available regardless of who furnishes them, providers, physicians, and other suppliers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

- For services of foreign hospitals that have no election to bill Medicare, providers may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

- For services of foreign physicians and other suppliers, the physician or other supplier may charge and collect actual charges from beneficiaries without regard to whether the proceeds of the liability insurance are available to the beneficiary.

E – Provider, Physician, or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary's Liability Insurance Settlement

As cited above in B, providers, physicians, and other suppliers must withdraw all claims/liens against liability insurance/beneficiary's liability insurance settlement (except for claims related to services not covered by Medicare and for Medicare deductibles and coinsurance) when they bill Medicare. A/B MACs and DME MACs may learn of a situation where the provider, physician, or other supplier billed Medicare but did not withdraw the claim/lien. In such situations, A/B MACs and DME MACs must:

- Advise the provider, physician, or other supplier and beneficiary that the act of billing Medicare limits the payment that the provider, physician, or other supplier may receive for the services billed to the Medicare approved amount. This applies even if Medicare did not pay the claim or the provider, physician, or other supplier refunded the Medicare payment to Medicare.

- If the provider, physician, or other supplier collected on a claim/lien after billing Medicare, advise the provider, physician, or other supplier and beneficiary that:
    - The provider, physician, or other supplier must refund the Medicare payment in instances where the amount collected on the claim/lien is for the full charges of the claim/lien and the Medicare payment is greater than or equal to the full charges of the claim/lien and greater than or equal to the amount collected on the claim/lien (see example one below for an illustration of this policy); or

    - The provider, physician, or other supplier must refund the lesser of the amount collected on the claim/lien or the Medicare payment in instances where the amount collected on the claim/lien is less than the full charges of the claim/lien due to policy limits (see example two below for an illustration of this policy); and

    - The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment if the provider, physician, or other supplier received payment for services not covered by Medicare and for Medicare deductibles and coinsurance (see example three below for an

illustration of this policy); or

- The provider, physician, or other supplier must refund to the beneficiary the difference between the amount collected on the claim/lien and the Medicare payment less any amounts due from the beneficiary for services not covered by Medicare and for Medicare deductibles and coinsurance (see example four below for an illustration of this policy).

- *Nothing within this manual, or the respective regulations cited herein, prevents a provider, physician, or other supplier, from maintaining a claim or lien against the liability insurance or beneficiary's liability insurance settlement once the Medicare timely filing period has lapsed.*

EXAMPLES

EXAMPLE 1: Charges from the facility are $5,000. Medicare is billed. The facility receives $8,000 from Medicare. The facility receives $5,000 from the liability insurance. The facility must repay Medicare $8,000.

EXAMPLE 2: Charges from the facility are $150,000. Medicare is billed. The facility receives $110,000 from Medicare. The facility receives $100,000 (due to policy limits) from the liability insurance. The facility must repay Medicare $100,000.

EXAMPLE 3: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deductible has been satisfied. The Medicare coinsurance of $160.00 has been paid. There are no charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives $1,000 from the liability insurance. The facility must repay Medicare $640.00 and send $360.00 to the Medicare beneficiary.

EXAMPLE 4: Charges from the facility are $1,000. Medicare is billed. The Medicare allowable is $800.00. The Medicare deducible has been satisfied. The Medicare coinsurance of $160.00 has not been paid. There are $50.00 in charges for non-covered Medicare services. The facility receives $640.00 from Medicare. The facility receives
$1,000 from the liability insurance. The facility must repay Medicare
$640.00. The facility may retain $210.00 for the unpaid Medicare coinsurance and charges for the non-covered Medicare services. The facility must send to the Medicare beneficiary the remainder of the liability insurance payment ($150.00).

F – Permissible Liens

The MSP provisions do not create lien rights when those rights do not exist under State law. Where permitted by State law, a provider, physician, or other supplier may file a lien for full charges against a beneficiary's liability settlement. (A lien against a beneficiary will be considered a lien against a liability settlement if there is a binding agreement that the lien will only be enforced if there is a settlement and will be withdrawn otherwise.)

- The provider, physician, or other supplier may enforce a permissible lien up to the lesser of the amount of the settlement and charges for the services incorporated in the lien. The provider, physician, or other supplier may not charge interest, lien filing, and administrative fees to the beneficiary or against the lien.