DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Medicare is denying an increasing number of claims, because providers are not identifying the correct primary payer prior to claims submission. Medicare would like to remind providers, physicians, and suppliers that they have the responsibility to bill correctly and to ensure claims are submitted to the appropriate primary payer. Please refer to the "Medicare Secondary Payer (MSP) Manual", Chapter 3**,** for current MSP billing requirements.

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Guidance for Correct Claims Submission When Secondary Payers Are Involved

Note: This article was updated on April 17, 2014, to show that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC). The article also was updated to provide the BCRC phone numbers. All other information remains unchanged. This article was updated on April 30, 2014 to include links to the most current articles that reflect the changes in Medicare policy that have occurred since SE1217 was published in 2012.

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended for providers, physicians, and suppliers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and carriers (hereafter referred to as Medicare contractors)) for services provided to Medicare beneficiaries.

Note: At the time this article was first published in 2012, the information reflected Medicare policy correctly at that time. Since then more current information is available and new articles are posted. See the Additional Information section for the updated publications detailing what providers need to know in order to remain current.

Provider Action Needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

Remember: A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Background

Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare Secondary Payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the "MSP Manual" in Chapter 3, Section 20.2.1 at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf** on the CMS website. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

Identify and bill the correct primary payer

Medicare 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 before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

Accident Related Claims

If the beneficiary has an open MSP Liability (L), No-Fault (NF), or Workers' Compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. DO NOT deny treatment.

To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. **If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.**
2. If the beneficiary has both a Group Health Plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If you believe a claim was inappropriately denied:

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the Medicare Benefits Coordination and Recovery Center (BCRC), formerly known as the Coordination of Benefits Contractor (COBC) at 1-855-798-2627 (8 AM to 8 PM Eastern Time) **if a beneficiary's MSP record needs to be updated.**

- The BCRC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.

Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the BCRC at 1-405-869-3307 (address the fax to Medicare- MSP General Correspondence) or the beneficiary may need to be on the line to validate the change.

Please do not call the BCRC to adjust claims or about mistaken payments. They will not be able to assist you.

Key Points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.
- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the BCRC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information.
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Additional Information

- If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the BCRC's toll-free lines. For more information on contacting the BCRC or the Medicare

Coordination of Benefits process, visit the Medicare Coordination of Benefits Web page at **http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html** on the CMS website.

- The Medicare Learning Network (MLN) has a Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff (ICN 006903) at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf** on the CMS website. This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the BCRC.
- MLN Matters® Special Edition Article SE 1227, entitled, "Important Reminder About Medicare Secondary Payer Laws," may be viewed at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1227.pdf** on the CMS website. SE1227 is a reminder that it is against Medicare Secondary Payer laws to accept payment from a beneficiary upon admission or when services are rendered when another insurance is primary to Medicare.