



General Provider Information

I. MSP CATEGORIES: Explanation of MSP laws and regulations.

1. Employee Group Health Plan (EGHP)

Medicare benefits are secondary to benefits payable under EGHP for employees age 65 or over and their spouses.

Medicare is the secondary payer when:

The employer has 20 or more employees and pays a portion or all of the group health insurance for its employees.

Medicare is primary when:

The employer has less than 20 employees; or the plan denies a claim because the benefits are exhausted or services are not covered under the employer plan; or the patient and/or spouse are retired.

When you have been notified of a Medicare beneficiary's change in work status, please notify the Coordination of Benefits Contractor (COBC), either by letter or phone.

2. Large Group Health Plan (LGHP)

OBRA '93 (Omnibus Budget Reconciliation Act)

Effective August 1993, Medicare determines that MSP status for a disabled beneficiary by the existence of a large group health plan (LGHP) coverage based on the individual's current employment status. The employee must be currently working during the dates of service.

Medicare is secondary payer when:

The plan covers employees of at least one employer with 100 or more employees. If the plan is a multi-employer plan (such as a union plan which covers employees of some small employers and also employees of at least one employer that covers 100 or more employees under the plan), Medicare is secondary.

Medicare is primary when:

The group plan covers less than 100 employees; or the plan denies the claim because benefits are exhausted or services are not covered under the plan; or the patient, spouse, and/or family member are retired.

3. End Stage Renal Disease (ESRD)

Due to the Balanced Budget Act of 1997, effective August 1, 1997, the coordination period for ESRD beneficiaries is 30 months for coordination periods that began March 1, 1996, or later.

Medicare is secondary when:

During the coordination period, Medicare is the secondary payer to benefits payable under an employer group plan.



1. If the beneficiary receives a kidney transplant, the coordination period begins with the date of the first treatment.
2. If the beneficiary does home/self training dialysis, the 3-month waiting period does not apply and the coordination period will start at the beginning of the month in which the first dialysis treatment was given.
3. If the beneficiary is receiving hemodialysis, the coordination period starts at the beginning of the fourth month of renal dialysis treatment.
4. **COBRA**
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) states an employer must offer continuation of group insurance coverage for a specified time to an employee upon job termination. If a beneficiary has COBRA coverage and is entitled to Medicare, then Medicare would be primary, except in ESRD cases. If a beneficiary is entitled due to ESRD, then the COBRA coverage is primary for the coordination period.
5. **Vow of poverty provision**
OBRA '93 makes the exemption from MSP provisions for individuals who have taken a vow of poverty retroactive to 1981. Employers must certify that an individual has taken a vow of poverty with respect to work activity that is the basis for qualifying for the group health plan.
6. **TRICARE**
Medicare is primary over TRICARE. This is a federal program that is supplemental to Medicare.
7. **Automobile/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.
 - The provider or beneficiary has filed a claim under an automobile or nofault insurance policy or plan (including a self-insured plan) and the provider determines the insurer will not pay promptly within 120 days of receipt due to case litigation or resolution of settlement. **THE PROVIDER CANNOT BILL BOTH MEDICARE AND THE INSURER AND/OR PLACE A LIEN WITH THE ATTORNEY.**
 - The denial from the primary insurer is based on any reason except that the primary insurer offers only secondary coverage of services covered by Medicare.
 - The time limit for filing the claim with the primary insurer has expired.
8. **Workers' Compensation**
If a patient is involved in a work related accident, the Workers' Compensation carrier should be billed prior to Medicare.

**9. 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.

10. Black Lung

If you are aware that a Medicare beneficiary may be entitled to have the services reimbursed by the Department of Labor (DOL) under the Federal Black Lung Program, bill DOL for only Black Lung-related claims and submit a no-payment bill (*Medicare Secondary Payer Manual*, Publication 100-5, Chapter 5, Section 30.4) to your MAC Contractor.

The address for sending bills to DOL is:
Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook MD 20703-0828

11. Veterans Affairs

If it is known that a patient is covered by VA, bill Veterans Affairs prior to submitting the bill to Medicare. If the patient is VA eligible and chooses to receive services in a Medicare certified provider, put a 26 in Form Locators 18-28 on your UB04.

II. Billing Procedures**Preparation of MSP bills/Completing the UB04 Form**

When billing Medicare as the secondary payer, all claims should be submitted electronically through direct data entry by indicating "requesting conditional payments" in the remarks section. The claim should be completed as a Medicare primary claim with the exception of:

1. Form Locator 39A-41D

Enter the MSP value code and amount paid by the primary insurance in these form locators.

The value codes to be used are:

- 12 Working Aged (EGHP)
- 13 End Stage Renal Disease (ESRD)
- 14 No-Fault
- 15 Worker's Compensation (WC)
- 16 Other Federal Agencies
- 41 Black Lung
- 42 Veterans Administration (VA)
- 43 Disabled (43)
- 44 Used when the hospital has a contract with the insurer to accept a specific amount as payment in full.
- 47 Liability

**Value Code 44**

A 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. A 44 code should only be used for claims where there is a contractual agreement with an insurance company. The value code 44 is used with the amount the provider was obligated to accept. Use the appropriate value code (12, 13, or 43) with the amount actually received from the insurance company. A condition code 77 is used when the insurance pays the entire contractual. Use the correct value code (12, 13, or 43) with the amount actually received from the insurance company.

2. Form Locator 50A

Enter the name of the primary payer.

3. Form Locator 58

Enter the insured person's name (last name first).

4. Form Locator 59

Enter the patient's relationship to insured. Use the codes below to identify the relationship to the patient.

- 01 Spouse
- 04 Grandparent
- 05 Grandchild
- 07 Niece/Nephew
- 10 Foster Child
- 15 Ward of the Court
- 17 Step Child
- 18 Patient is Insured
- 19 Natural Child, Insured has financial responsibility
- 20 Employee
- 21 Unknown
- 22 Handicapped Dependent
- 23 Sponsored Dependent
- 24 Dependent of Minor Dependent
- 32, 33 Parent
- 39 Organ donor
- 40 Cadaver donor
- 41 Injured Plaintiff
- 43 Natural Child, insured does not have financial responsibility
- 53 Life Partner

5. Form Locator 60

Enter the insured's unique identification number.

6. Form Locator 61

Enter the name of group or plan through which the insurance is provided to the insured.

7. Form Locator 62

Enter the insurance group number.



8. **Form Locator 64**
Document Control Number to identify claim to be adjusted.
9. **Form Locator 65**
Enter the employer name.
10. **Form Locators 31-34- Occurrence Codes**
Use the following occurrence codes when applicable:
 - 01 Auto Accident
 - 02 Accident- No Fault
 - 03 Accident- Liability
 - 04 Accident- Employment related
 - 05 Other Accident
 - 06 Crime Victim
 - 18 Beneficiary's Date of Retirement
 - 19 Spouse's Date of Retirement
 - 24 Date Insurance Denied
 - 33 First Day of Coordination period for ESRD
11. **Form Locators 18-28- Conditions Codes**
The following condition codes should be used when applicable:
 - 02 Condition is employment related
 - 04 HMO Employee
 - 05 Lien has been filed
 - 06 ESRD patient is in first 30 months of entitlement and covered by a group health plan (GHP)
 - 07 Treatment for hospice patient
 - 08 Beneficiary would not provide information concerning insurance coverage
 - 09 Neither patient nor spouse is employed
 - 10 Patient and/or spouse is employed but no EGHP exists
 - 11 Disabled beneficiary but no LGHP
 - 28 Patient and/or spouse EGHP is secondary to Medicare
 - 77 Provider accepts or is obligated to accept payment by a primary payer as payment in full due to contractual agreement or law
12. **Form Locator 80- Remarks**
Many times remarks can be written on the claim to provide the MAC Contractor with information to process the claim more effectively. Below are some examples of remarks for specific situations.
 - **Group (GHP, LGHP, and ESRD)**
Group payment applied to deductible Group insurance denied claim.
 - **Workers' Compensation**
Workers' Compensation denied claim. Settlement benefits denied.
 - **Black Lung**
Black Lung denied. Claim not entitled to Black Lung.
 - **Veterans Administration**
VA denied claim. No VA coverage.
 - **Auto/Liability**
Auto benefits denied. Fell at home no liability.
13. **Form Locator 29- Accident State**