



Medicare Secondary Payer (MSP) – Useful Tips for Claim Submission

Medicare Secondary Payer (MSP) refers to situations in which Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. The role of Medicare as the secondary payer is conceptually similar to the coordination of benefits clause in private health insurance policies. By federal law, Medicare is secondary payer to a variety of government and private insurance benefit plans. For a list of those plans, refer to http://www.wpsmedicare.com/mac/business/b_msp_determine.pdf.

The provider is responsible for determining if insurance is primary or supplementary to Medicare, and what type of insurance the beneficiary has. For beneficiaries who have more than one insurer, the provider should obtain all pertinent information from the patient or responsible party concerning all relevant insurers. After doing so, the provider should determine which insurer is primary, secondary, tertiary, etc. and file claims accordingly, in the order of liability.

Health Insurance Claim Form CMS 1500 instructions, included in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM), Publication 100-04, Chapter 26, Section 10.2, provides instruction for completion of Items 1-11 on the CMS 1500 Claim Form.

Providers should complete Items 10a through 10c to indicate if employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Any item checked "YES" indicates there may be other insurance primary to Medicare. Item 10d is not used for Medicare purposes.

Completion of Item 11 is required. By completing this item, the provider acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer. If there is insurance primary to Medicare, the provider must enter the insured's policy or group number and proceed to items 11a - 11c. For MSP situations, items 4, 6, and 7 must also be completed.

In situations where there is no insurance primary to Medicare, the provider must enter the word "NONE" in item 11. Failure to do so will result in the claim being deemed as unprocessable.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in item 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly. Item 11d should always be left blank.

The Administrative Simplification Compliance ACT (ASCA) requires that all claims be submitted to Medicare electronically, with few exceptions. MSP claims are not an exception, unless there is more than one primary payer to Medicare.

Information on MSP, including how to file electronic Part B claims when Medicare is the Secondary Payer is available on the Jurisdiction 5 (J5) Medicare Administrative Contractor (MAC) MSP homepage at the following WPS Medicare Website address:

http://www.wpsmedicare.com/mac/business/b_msp_claims.pdf