Virtual Conference – Medicare Essentials: Who Pays My Claim?

10/18/2022

national government SERVICES

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presenters

- Provider Outreach and Education Consultants
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  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objective

- Provide overview of
  - Basic Medicare provider enrollment information and providers responsibilities so we can pay your claims
  - What MAO plans are and when to/when not to bill us for services you render to MAO plan enrollees
  - Which payers are primary to Medicare under MSP provisions, how to identify them and when to bill Medicare as secondary
- Acronyms defined: NGS Acronym Search Tool

Agenda

- Medicare FFS
- MAO plans
- MSP
- Resources
- Questions and answers

Medicare Fee-For-Service

Provider Authorization and Accreditation

- Providers must meet all federal and state requirements
- Contact State Survey Agency (SA) for assistance with certification materials for provider/supplier type
- Each state has unique requirements and processes for licensing and registration that may vary, ensure all applicable requirements met for your provider type

NPI

- Unique ten-digit numeric identification number for covered health care providers
  - HIPAA standard transactions
- Created to help send health information electronically more quickly and effectively
- Must be submitted on Medicare provider enrollment forms

NPI

- National Plan and Provider Enumeration System (NPPES)
  - Assigns NPIs
  - Keeps and updates information about health care providers with NPIs
  - Issues NPI Registry and NPPES Downloadable File
- For help logging into NPPES, contact NPI Enumerator at 800-465-3203
  - TTY 800-692-2326

NPI

- Organization health care providers obtain NPI Entity Type 2
- Parts/subparts
  - Work somewhat independently from their parent organization but aren't legal entities by themselves
  - May offer different types of health care or offer health care in separate physical locations
  - If subpart conducts any HIPAA standard transactions separately from parent organization, get separate NPI

Medicare Provider Enrollment

- No provider shall receive payment for services furnished to Medicare beneficiary unless provider enrolled in Medicare program
- Each provider must enroll with appropriate Medicare FFS contractor
  - Medicare Provider Enrollment Educational Tool
- Ensure provider meets any unique Medicare statutory and regulatory requirements

Enrolling in Medicare Fee-For-Service

- Part A providers use form CMS-855A
  - Complete electronically via Provider Enrollment Chain & Ownership System (PECOS) or on paper
- Submit proper documentation with application
  - Paper - list of supporting documents in section 17
  - Via PECOS – list of supporting documentation needed displayed
- Sign and date application

Application Fee

- Required for institutional providers
  - Initially enrolling
  - Revalidating their enrollment
  - Adding new Medicare practice location
- Application Fee Requirements for Institutional Providers
- How to Pay the Application Fee
- How to Submit a Hardship Request

Requests for Additional Information

- Respond to FFS contractor requests promptly and fully
- Submit ASAP but no later than 30 days from initial development letter date or application will be rejected
- Contact person identified on application will either receive email, fax or USPS mail
  - Includes instructions for needed actions, corrections and required documents

Application Process Timeline

- Provider Enrollment Application Process Timeline
- All MACs have goals set by CMS to finalize applications if all required information available
  - Internet-based PECOS application within 15 days
  - CMS-855 paper application within 30 days

Provider Enrollment Common Errors

- Section 2
  - Not listing legal business name as registered with IRS
  - License and/or certification information missing or has expired
- Sections 4, 5, 6, 7, 8, 15, and/or 16
  - Change/Add/Delete not checked off
  - Effective date missing

Provider Enrollment Common Errors

- Section 6
  - Authorized official listed not in appropriate role
  - Not adding new authorized/delegated official
- Provider prints certification statement(s) for PECOS submission however forget to upload (PDF or TIFF) signed and dated document
- Supporting documentation not uploaded to PECOS or mailed to MAC

Electronic Funds Transfer

- Claim payments electronically transferred to bank instead of mailed hard copy check
- Submit Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588)
  - Include copy of voided check or signed bank confirmation letter on bank letterhead listing IRS legal business name as account name/routing number/ account number
  - Signed by authorized or delegated official

Provider Enrollment Revalidation

- All providers five years after initial enrollment or last revalidation
  - Only when notified and before due date
  - Notices are mailed two–three months prior to due date
  - Unsolicited revalidation applications returned if received more than seven months prior due date
  - Verify entire Medicare enrollment record
- Avoid payment hold/deactivation of Medicare billing privileges by responding promptly

Provider Enrollment Revalidation

- Check PECOS
- Check CMS website:
  - Medicare Provider-Supplier Enrollment – Revalidations
  - Medicare Revalidation List Tool
    - Due date will display or "TBD" if not currently due

Participating Providers

- Providers who receive Medicare reimbursement must comply with rules, including
  - Not charging individuals for covered items and/or services
  - Returning any money incorrectly collected
  - No discrimination when providing services
    - Medicare beneficiaries versus non-Medicare patients

Deactivation of Billing Privileges/ Suspension of Payment

- Inactivity - failure to bill Medicare for 12 consecutive months
- Failure to complete revalidation within required time frame
- Unreported changes to provider address or bank information within required time frame (DNF initiative)

Termination of Provider Participation

- Voluntary (provider-requested) termination
  - File written notice to CMS stating intention to terminate and official date termination takes effect
- Involuntary termination
  - CMS may terminate provider Medicare agreement
    - Not compliant with Medicare guidelines and/or regulations
    - No longer meets appropriate requirements for participation
    - Failed to supply cost report information
    - Refuses to participate in audits of financial and/or medical records

Termination Payment Exceptions

- Payment can continue for up to 30 days
  - Services furnished on/after termination date for beneficiaries admitted prior to termination date
  - Services under plan of treatment following effective termination date of HHA or hospice if plan was established before termination date

Collecting Overpayments from Terminated Providers

- Contractor discovers overpayment due from terminated provider
  - Provider contacted with request for lump sum payment
  - Additional collections activities follow, as appropriate
- Provider no longer with Medicare but still participating in Medicaid Program
  - Action to withhold federal share of Medicaid payments initiated, as appropriate

MAO Plans

What is an MAO Plan?

- Medicare plan other than FFS Medicare in which beneficiary can enroll
  - Covers healthcare needs
- If beneficiary enrolls in such a plan, he/she does not also have traditional Medicare
- Refer to
  - Health plans general information
  - Medicare Advantage Plans

Who Offers MAO Plans?

- Private companies approved by Medicare, these can be set up in different ways
  - Health Maintenance Organization (HMO) Plans
  - Preferred Provider Organization (PPO) Plans
  - Private Fee-for-Service (PFFS) Plans
  - Special Needs Plans (SNPs)
  - Medical Savings Account (MSA) Plan
  - HMO Point Of Service (HMOPOS) Plans

Facts About MAO Plans

- MAO plans
  - Must offer services FFS Medicare offers except hospice care
    - FFS Medicare covers hospice care even if hospice beneficiary elected MAO plan (exceptions in some states)
  - May offer additional coverage
    - Most include Medicare prescription drug coverage (Part D)
  - May not have same billing rules as FFS Medicare

Eligibility for MAO Plan Enrollment

- In general, a beneficiary is eligible to elect/enroll in a MAO plan if criteria met
  - Who can join a Medicare Advantage Plan?
- Beneficiary must
  - Be entitled to Medicare Part A and enrolled in Part B
  - Permanently reside in MAO plan service area
  - Complete enrollment request
  - How to join a Medicare Advantage Plan

When Does Enrollment or Disenrollment Become Effective?

- Enrollment in MAO plan
  - Generally, effective first of month after beneficiary applies
    - There are exceptions
- Disenrollment from MAO plan
  - Generally, effective first of month after beneficiary disenrolls
    - There are exceptions

Identifying Beneficiaries Enrolled in MAO Plans

- Ask each beneficiary to whom you render services if he/she is enrolled in MAO plan
- Verify MAO plan enrollment before billing
  - HETS, IVR, NGSConnex
  - Check plan's **Option type**
  - Check coverage start and end dates
  - Obtain MAO plan ID number and MBI
    - MAO Plan Directory (zip file)

Risk-Based vs. Cost-Based Medicare HMOs

- **Option type code** indicates who to bill
  - Option code **1** (cost-based); rare
    - Send IP and OP claims to FFS Medicare
  - Option code **C** (risk-based); common
    - Beneficiaries must follow plan guidelines
    - Send IP and OP claims to Medicare HMO
      - May also need to send IP claims to FFS Medicare
      - Do not send OP claims to FFS Medicare
        - » **Claims reject with reason code U5233**

Beneficiary Enrolled in Option Code C Medicare HMO – Inpatient Stays

- If enrolled for **entire** IP stay
  - Bill Option code C Medicare HMO for stay and then also submit claim to us if required (informational)
- If enrolled for **portion** of IP stay
  - Billing depends on provider type per
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 90
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 190.10.6 (IPFs)

Enrolled in Option Code C Medicare HMO for Portion of IP Billing Period

- For **PPS hospitals** (ACHs, IPFs, IRFs, and LTCHs), beneficiary's status at admission determines liability for IP claim
  - If enrolled in Option code C Medicare HMO at admission
    - Bill HMO for entire stay even if disenrollment from that plan becomes effective during stay
  - If enrolled in FFS Medicare at admission
    - Bill us for entire stay even if enrollment in Option code C Medicare HMO becomes effective during stay

Enrolled in Option Code C Medicare HMO for Portion of IP Billing Period

- **For non-PPS hospitals** (cancer hospitals, children's hospitals, CAHs) and **SNFs,** split IP claim
  - If enrolled in Option code C Medicare HMO at admission but disenrollment from such plan becomes effective during stay
    - Split IP claim
      - Bill HMO for first part of IP stay and FFS Medicare for remainder
  - If enrolled in FFS Medicare at admission but enrollment in Option code C Medicare HMO becomes effective during stay
    - Split IP claim
      - Bill us for first part of IP stay and HMO for remainder

Submit IP Claims to Traditional Medicare After Option Code C Medicare HMO

- Some providers must send IP claims to us, in addition to Option code C Medicare HMO
  - Hospitals
    - Teaching per Program Memorandum A-98-21 and CR2476
    - Nonteaching (except IPFs) per CR5647 Revised (IRFs: CR7674)
    - CAHs per CR7145 and CR7172
  - SNFs per CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 90
- Medicare's one-year timely filing applies

MSP

What is MSP?

- MSP refers to situations in which Medicare does not have primary responsibility for paying a beneficiary's health care claims
  - Beneficiary has other coverage that
    - Is primary to Medicare per Federal law and
    - Should process such claims before Medicare
      - Refer to What is Medicare Secondary Payer?

Your MSP Responsibilities Per Medicare Provider Agreement

- Determine if Medicare is primary payer for beneficiary's services
  - Identify payers primary to Medicare
    - Determine if conditions/criteria of an MSP provision been met?
- Submit claims to other payer before Medicare
- Submit MSP claims when required

MSP History and Provisions

- In 1980, Congress began to enact series of provisions that made Medicare secondary payer to certain other payers
  - Known as MSP provisions which
    - Resulted in more situations in which Medicare is not primary
    - Shifted costs from Medicare to private sources
    - Help determine proper order of payers
    - Are categorized into GHP vs. non-GHP provisions
      - Each has its own set of criteria

GHP MSP Provisions

- Related to Medicare entitlement reason
  - Entitlement reasons and related MSP provisions:
    - Age for beneficiaries age 65 or older
      - **Working Aged with EGHP MSP provision**
    - Disability for beneficiaries under age 65
      - **Disabled with LGHP MSP provision**
    - ESRD for beneficiaries any age
      - **ESRD with EGHP MSP provision**

Non-GHP MSP Provisions

- Not related to Medicare entitlement reason
  - Federal Black Lung program
  - Government research grant
  - Governmental entities (certain coverage, such as VA, is considered "exclusion" to Medicare)
  - WC
  - No-fault and medical-payment insurance (all types including automobile and premises)
  - Liability insurance

MSP Provisions – Criteria

- Each provision has its own set of criteria
  - If all criteria within a provision are met
    - Beneficiary's services are subject to that provision
      - Medicare is prohibited from paying for such services if payment was made or can reasonably be expected to be made promptly by primary payer; Medicare is secondary
  - If one or more criteria within a provision are not met
    - Beneficiary's services are not subject to that provision
      - Medicare is primary unless criteria of another MSP provision are met

Retired

- If a person is retired, he/she is not considered to have current employment status for purposes of Working Aged with EGHP and Disabled with LGHP MSP provisions
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 1, Section 50

Working Aged with EGHP

- EGHP is primary if five criteria met
  - Beneficiary is age 65 or over
  - Beneficiary is enrolled in Medicare Part A
  - Beneficiary/spouse (of any age) is currently employed
  - Beneficiary is enrolled in GHP through that employer
  - Employer has 20 or more full- and/or part-time employees
    - Single employer has 20 or more employees
    - Multi-/multiple-employer; at least one has 20 or more employees

Disabled with LGHP

- LGHP is primary if five criteria met
  - Beneficiary is under age 65
  - Beneficiary is enrolled in Medicare Part A
  - Beneficiary/any age family member currently employed
  - Beneficiary is enrolled in LGHP through that employer
  - Employer has 100 or more full- and/or part-time employees
    - Single employer has 100 or more employees
    - Multi-/multiple-employer; at least one has 100 or more employees

ESRD with EGHP

- EGHP is primary if three criteria met
  - Beneficiary is eligible for or enrolled in Medicare based solely on ESRD
  - Beneficiary is enrolled in GHP through current/former employer (any size) or through that of a family member
  - Beneficiary is in 30-month coordination period
- A beneficiary may be eligible for enrolled in Medicare based on ESRD and age or disability
  - Apply dual entitlement rule to determine primary payer

Federal Black Lung Program

- Provides medical benefits to coal miners disabled as result of lung disease or other illnesses attributable to coal mining
- Initiated by Federal Coal Mine Health and Safety Act of 1969
- Administered through Department of Labor
- Primary to Medicare for related conditions

Government Research Grant

- Government financing earmarked for particular services to patients (e.g., in form of a research grant)
- Primary to Medicare
- Medicare cannot pay for same services

Veteran's Administration

- Veterans with Medicare choose plan to use
  - If chooses Medicare, bill us as primary
  - To receive services under VA, beneficiary must
    - Go to VA facility, or
    - Have VA authorize/agree to pay for services in non-VA facility
  - If chooses VA and they authorize, bill VA for payment
    - Do not submit MSP claims; review Billing Medicare Part A When VA-Eligible Medicare Beneficiaries Receive Services in Non VA Facilities

Workers' Compensation

- Provides compensation to employees for injury or disease suffered in connection with employment
- Coverage could be through current or former employer
- Claims typically billed to WC Carrier
- Primary to Medicare for related conditions

No-Fault/Medical-Payment Insurance: Automobile and Other Types

- Pays for expenses for injuries sustained on property or premises of insured, or in use, occupancy or operation of automobile
  - **Regardless of who may be responsible**
- Includes, but not limited to
  - Automobile, homeowners and premises insurance
- Referred to as med-pay, medical expense or medical payments, or PIP
- Primary to Medicare for related conditions

Liability Insurance

- Provides payment for injury, illness or damage to property
  - Based upon legally established responsibility
- Includes, but not limited to
  - Automobile liability, uninsured and under-insured motorist, homeowner's liability, malpractice, product liability, general casualty insurance
- Primary to Medicare for related conditions

How Providers Can Identify Payers Primary to Medicare

- Refer to Identify the Proper Order of Payers for a Beneficiary's Services
  - Before billing Medicare, you
    - Must check for MSP information in Medicare's records (CWF)
      - For each service rendered to beneficiary (no exceptions)
    - May need to collect MSP information from beneficiary or representative by asking questions about insurance
      - For every IP admission or OP encounter with beneficiary (exceptions)

Check for MSP Information in Medicare's CWF Records

- Part of Medicare eligibility verification process
- Various ways: HETS, IVR, NGSConnex
- MSP record(s) include
  - **MSP VC** or **primary payer code** for MSP provision
  - MSP effective date and termination date (if any)
  - Subscriber's name, policy number, patient relationship to insured
  - Insurer's information

MSP Records in CWF – Value Codes and Primary Payer Codes for MSP Provisions

MSP VC	MSP Provision	Primary Payer Code
12	Working aged, age 65 and over, EGHP, 20 or more employees	A
13	ESRD with EGHP in coordination period	B
14	No-Fault (automobile and other types including medical-payment) or Set-Aside	D or T
15	Workers' Compensation or Set-Aside	E or W
16	Public Health Services; research grants	F
41	Federal Black Lung Program	H
43	Disabled, under age 65, LGHP, 100 or more employees	G
47	Liability Insurance or Set-Aside	L or S

How to Ask Questions About Other Insurance

- Use either
  - CMS' model MSP questionnaire
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
    - Has three parts, each with questions to help identify MSP situations
  - Provider's own compliant MSP form
- Questionnaire/form can be in electronic and/or hardcopy format
- May need to collect additional information for billing purposes such as retirement date(s)
- Ask questions before billing Medicare

Determine Proper Order of Payers

- Determine which plan is primary, secondary, tertiary, etc. payer
  - Use collected MSP data and your knowledge of MSP
    - In general, Medicare is primary when beneficiary
      - Has no other coverage
      - Has coverage but it does not meet MSP provision criteria
      - Had coverage, it met MSP provision criteria but it is no longer available
    - In general, other payer(s) is primary when beneficiary
      - Has coverage, meets MSP provision criteria, and it is available

Submit Claims Per Your Determination

- If Medicare is primary, submit primary claim
- If another payer is primary
  - Submit claim to other payer first
    - Follow up often as one year timely filing appeals
  - Submit claim to Medicare second if required
    - May submit conditional claim to us in certain circumstances
- If more than one payer is primary
  - Submit claims to those payers, in proper order, and to Medicare third (tertiary), etc.

MSP Claim Types

- If primary payer paid claim
  - Submit **MSP claim** if they paid in part
  - Submit **MSP claim** if they paid in full and services are
    - IP or OP (and Part B deductible is not met)
- If primary payer did not pay claim
  - For valid/acceptable reason, submit **conditional claim**
  - Promptly (within 120 days; accident cases only), you may continue to wait or submit **conditional claim**

Preparing and Submitting MSP, Conditional and Medicare Tertiary Claims

- To prepare, refer to
  - Prepare and Submit an MSP Claim
  - Prepare and Submit an MSP Conditional Claim
  - Prepare and Submit a Medicare Tertiary Claim
- Submission options
  - Electronically via 837I
  - In FISS DDE
  - Hardcopy (CMS-1450/UB-04 claim form) to Claims Department (Approved ASCA waiver is required)

Correcting MSP, Conditional and Medicare Tertiary Claims

- To correct
  - Use FISS DDE (FISS S/L TB9997) or
  - Resubmit new corrected claims
    - Electronically via 837I
    - In FISS DDE
    - Hardcopy (CMS-1450/UB-04 claim form) to our Claims Department (approved ASCA waiver is required)

Adjusting Claims Due to MSP-Related Issues

- Refer to Correct or Adjust a Claim Due to an MSP-Related Issue
- Submission options
  - Electronically via 837I
  - In FISS DDE
  - Hardcopy (CMS-1450/UB-04 claim form) to Claims Department
    - Approved ASCA waiver is not required

Who is the BCRC?

- BCRC
  - Contracted by CMS effective 2/1/2014
  - Consolidates activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries
  - Takes actions to identify health benefits available to a Medicare beneficiary and coordinates payment process to prevent Medicare mistaken payments
  - Maintains and updates MSP records in CWF
    - BCRC does not process claims or handle claim-specific inquiries

Contact BCRC to…

- Ask general MSP question or a question about secondary claim development questionnaires
- Report new accident, employment, insurance OR changes to employment or insurance
- Tips:
  - Have documentation on employer/insurer letterhead if requesting a MSP record be updated
  - Wait for BCRC to set up or update MSP record before you submit claims

Contact BCRC to…

- Set up new MSP record to match claim
  - Must be in CWF for MSP or conditional claims to process
  - Refer to Set Up a Beneficiary's MSP Record
- Update existing MSP record
  - Make changes to MSP information (record remains MSP)
  - Make Medicare primary for reasons other than retirement or claim is not related to accident record
  - Refer to Correct a Beneficiary's MSP Record
    - Coding Prevent an MSP Rejection on a Medicare Primary Claim

Rejections of Medicare Primary Claims Due to MSP Records in CWF

- Claim rejects for MSP if MSP record and
  - You did not report coding as to why we are primary
  - You did not contact BCRC to update MSP record
  - You contacted BCRC to update MSP record but did not wait until update was complete before submitting claim
- Claims rejected for MSP
  - Known as cost-avoided claims
  - In FISS S/L R B9997; reason code 34XXX range
  - Must adjust; do not resubmit or rejects as duplicate

What You Should Do Now

- Share information with other staff members
- Maintain provider enrollment responsibilities
- Develop and implement policies that ensure you submit claims to us correctly
  - For beneficiaries with MAO plans and primary insurance
- Be familiar with resources
- Check our Events calendar
- Sign up for our Email Updates

Resources

NGS Toll-Free Phone Numbers and Additional Information

- Check our website for telephone number
  - Log in – select your provider type and state
    - Provider type options
      - Part A; Part B; FQHC-RHC; HH+H; Persons with Medicare; Congressional Offices
  - Once logged in select "Contact Us" (listed at top of page)
    - IVR or PCC

NGS Resources

- NGSMedicare.com
  - Electronic mailing list (Email Update)
  - CBT modules in Medicare University
  - Top Claim Errors
  - Medicare Monthly Review
- NGS YouTube Videos
- NGS Twitter: @NGSMedicare

NGS Resources – Provider Enrollment

- Enrollment page
- Check Provider Enrollment Application Status
- Helpful Tips
- Time Requirements to Notify Medicare of Changes

NGS Resources – MSP

- ASCA Requirements for Paper Claim Submission
- Our website articles under Claims and Appeals > Medicare Secondary Payer
  - What is Medicare Secondary Payer?
  - Identify the Proper Order of Payers for a Beneficiary's Services
  - Set Up a Beneficiary's MSP Record
  - Correct a Beneficiary's MSP Record

NGS Resources – MSP

- Prevent an MSP Rejection on a Medicare Primary Claim
- Collect and Report Retirement Dates on Medicare Claims
- Prepare and Submit an MSP Claim
- Prepare and Submit an MSP Conditional Claim
- Prepare and Submit a Medicare Tertiary Claim
- Determine if Medicare will Make an MSP Payment
- Determine Beneficiary Responsibility on an MSP Claim
- Correct or Adjust a Claim Due to an MSP-Related Issue

CMS Resources

- CMS website
- MLN Matters articles
- CMS Transmittals
- CMS Internet-Only Manuals (IOMs)
- Open Door Forums (ODF)
- MLN Connects® Provider eNews
  - **Note:** Providers who are subscribed to their MAC's Email Updates already receive CMS eNews

CMS Resources

- MLN Publications & Multimedia
- MLN® Booklet: Medicare Billing: Form CMS-1450 and the 837 Institutional
- MLN Web-Based Training
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75, Billing Code Fields
- CMS YouTube Videos
- CMS Twitter: @CMSGov

CMS Resources – Provider Enrollment

- NPI: What You Need to Know booklet
- Provider Enrollment
  - Medicare Provider Enrollment Educational Tool
  - CMS-855A - Medicare Enrollment Application form for Institutional Providers
  - CMS-588 - Electronic Funds Transfer (EFT) Authorization Agreement form
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 10 Sections 10.2.1 and 10.2.7

CMS Resources – Provider Enrollment

- Revalidation articles
  - MLN Matters Special Edition Article SE21003 *"New Provider Enrollment Administrative Action Authorities"*
  - MLN Matters Special Edition Article SE1617 " *Timely Reporting of Provider Enrollment Information Changes*
  - MLN Matters Special Edition Article SE1605 Revised *"Provider Enrollment Revalidation – Cycle 2"*

CMS Resources – MAO Plans

- CMS IOM Publications
  - 100-04, *Medicare Claims Processing Manual*, Chapter 3, Sections 20.3, 20.8, 140.2.5.3 and 200.2
  - 100-16, *Medicare Managed Care Manual*
- Medicare Advantage Plan Directory
- Medicare.gov
- MLN® Booklet: *Original Medicare vs. Medicare Advantage*

CMS Resources – MSP

- CMS IOM Publications
  - *100-02, Medicare Benefit Policy Manual, Chapter 16*
  - *100-05, Medicare Secondary Payer Manual, All Chapters*
- MLN® Booklet: *Medicare Secondary Payer*

CMS Resources – MSP

- BCRC Contact page
- Telephone inquiries: 855-798-2627
  - Hearing/speech impaired: TTY/TDD: 855-797-2627
  - Monday–Friday, 8:00 a.m.–8:00 p.m. ET
- Fax 405-869-3307 (Medicare Data Collections)
- Mailing address
  - Medicare – Data Collections
  - P.O. Box 138897, Oklahoma City, OK 73113-8897

Other Resources – Provider Enrollment

- National Plan and Provider Enumeration System (NPPES)
- Log Into PECOS

Official UB-04 Data Specifications Manual (NUBC Manual)

- Available from the NUBC website
  - NUBC: a voluntary, multidisciplinary committee that develops data elements for claims and claim-related transactions, and is composed of all major national provider and payer organizations (including Medicare)
    - Maintains codes needed to complete the Form CMS-1450 (UB-04 claim) and compliant X12N 837 institutional claim
    - Responsible for the design and printing of the UB-04 form
    - Data elements referenced in manual are also used in the electronic claim standards
    - NUBC Manual contains a Mapping crosswalk between the UB-04 and the HIPPA 5010 (837) electronic transaction

Thank You!

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

FOLLOW US