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National Government Services

Submitting Medicare Secondary Payer Claims

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- After this session, you will understand how to properly bill Medicare as the secondary payer and billing MSP on a paper claim versus an electronic claim. You will also know how to submit claims conditionally.
- More importantly, you will know how to utilize NGS self-service tools on our website and where to find MSP contact information.

Agenda

- Claim Submissions
  - CMS-1500 Claim Form (02/12)
  - Electronic
  - Conditional

MSP

- Medicare Secondary Payer term used when Medicare does not have primary payment responsibility
- Protects Medicare Trust Funds by ensuring Medicare does not pay for services when other health insurance coverage is primarily responsible

MSP Types

- Group Health Plans
  - Working aged (12)
  - Disabled (43)
  - ESRD (13)
- Non-Group Health Plans
  - Workers' Compensation (15)
  - Automobile or other no-fault insurance (14)
  - Liability (47)
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapters 1–8

Government Programs

- Federal Black Lung Program
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3
- Veterans Administration
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5

Provider Responsibilities

- Determine if Medicare is primary payer for services rendered
  - Maintain office procedures to identify primary payer other than Medicare at each visit
  - Bill other payers before billing Medicare
  - Submit MSP claims when required even if primary payer made payment in full
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Sections 20.1 and 20.2

Claim Submission Timeliness

- Limit is one calendar year from date of service
  - Claims not submitted timely are provider-liable
    - Beneficiary cannot be charged
- Exceptions: MLN Matters® *MM7270 Revised: Changes to the Time Limits for Filing Medicare Fee-For-Service Claims*
  - Administrative error
  - Retroactive Medicare entitlement, including when State Medicaid agencies involved
  - Retroactive disenrollment from Medicare Advantage Plan or Program of All-Inclusive Care of the Elderly Provider Organization

ASCA

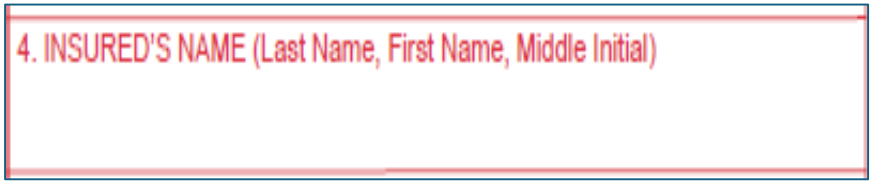
- Most providers required to submit MSP claims electronically due to ASCA regulations
  - If submit all other claims electronically, must also submit MSP claims electronically
- Ten ASCA exceptions include
  - Medicare tertiary (third) payer claims
  - Providers submitting < ten claims per month
  - Physician/practitioner/supplier with < ten FTE employees
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 24, Section 90-90.6

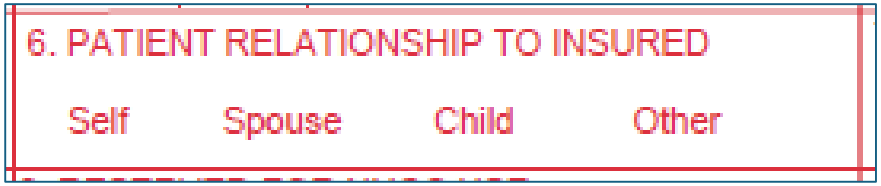
MSP Paper Claim Submissions

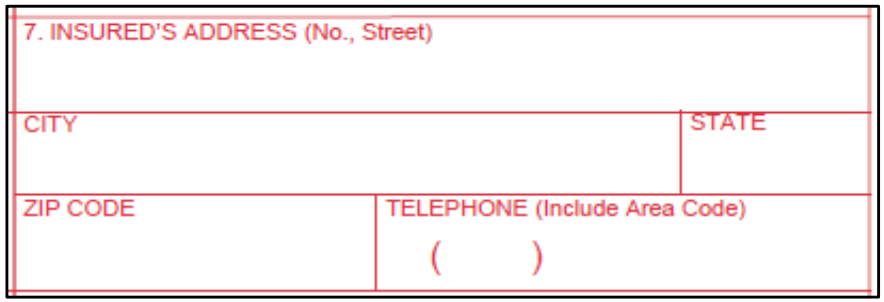
- Paper claims shall be submitted
  - Original red and white
  - CMS-1500 claim form (02/12)
- For MSP claims, specific items must be completed
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 26

MSP Paper Claim Submissions

- Item 4
  - If insurance primary to Medicare, list name of insured
  - When insured and patient are same, enter “SAME”
- Item 6
  - Check appropriate box for patient’s relationship to insured
- Item 7
  - Enter insured’s address and telephone number
  - When address is same as patient’s, enter “SAME”

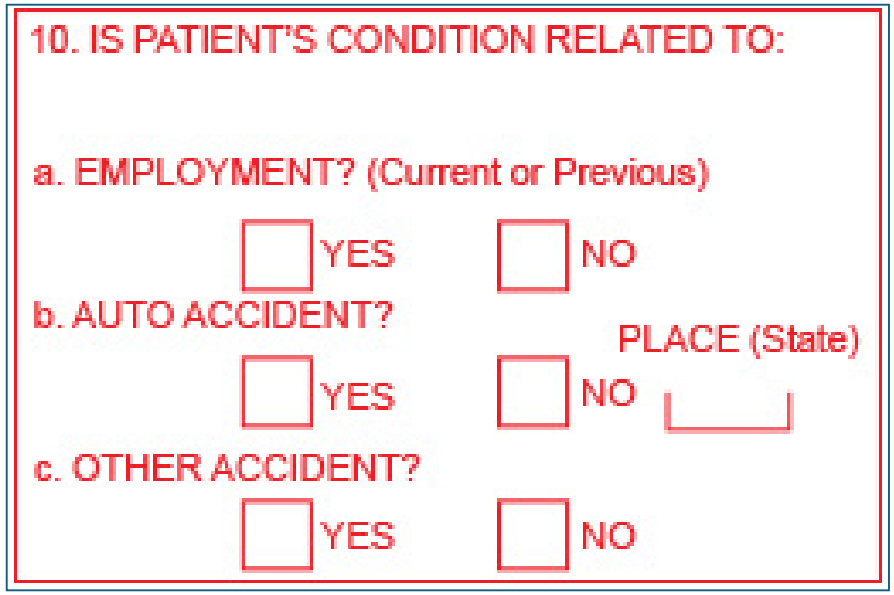






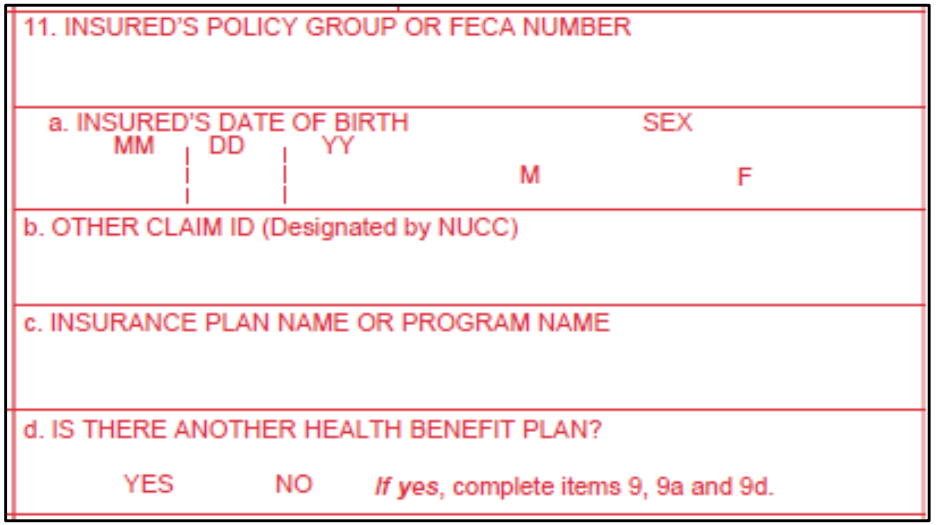
MSP Paper Claim Submissions

- Item 10a
  - Is patient's condition related to employment? Yes/No
- Item 10b
  - Is patient's condition related to auto accident? Yes/No
  - If answer = yes, include two digit state code under Place
- Item 10c
  - Is patient's condition related to other accident? Yes/No



MSP Paper Claim Submissions

- Item 11
  - Enter insured's policy or group number
- Item 11a
  - Enter insured's eight-digit birth date and sex if different from Item 3
- Item 11b
  - Enter employer's name, if applicable
- Item 11c
  - Enter nine digit payer ID for primary insurer or complete primary payer's program/plan name


11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES NO *If yes*, complete items 9, 9a and 9d.

MSP Electronic Claim Completion

- Electronic claim submission methods
  - Directly to Medicare (PC-ACE)
  - Through clearinghouse or vendor via HIPAA-compliant software
- Must use 837P
- Information needed similar to paper claims
  - Required items on paper claim have electronic equivalents

MSP Electronic Claim Submission

- Required MSP data for electronic claim
  - Indication of Medicare as the secondary payer
  - Insurance type code
  - COB payer paid amount claim level
  - Claim contract information (OTAF) – claim level
    - OTAF = obligated to accept as payment in full
  - Claim adjudication date – claim level
  - Service line information
    - Line adjudication information
    - Line adjustments
    - Line adjudication date

Indication of Medicare as Secondary Payer

- Payer responsibility sequence number code
- 2000B SBR01 element
  - P = Primary
  - S = Secondary
  - T = Tertiary

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)

Indication of Medicare as Secondary Payer

- Claim filing indicator code
- 2000B SBR09 element
  - MB = Medicare (for most cases)
  - AM = Automobile medical
  - CI = Commercial insurance company
  - LI = Liability, LM = Liability medical
  - WC = Workers' compensation health claim

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Common MSP Type Codes

- 2000B or 2320 SBR05 element

Code	Description
12	Working aged beneficiary age 65 or over with employer GHP through self or spouse
13	End-stage renal disease beneficiary in 30 month coordination period with an employer GHP
14	No fault insurance including automobile and other types
15	Worker's Compensation
41	Federal Black Lung Program
42	Veteran's Administration
43	Disabled beneficiary under age 65 with LGHP
47	Liability insurance

2000B or 2320	SBR05	Insurance Type Code
		Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"

COB Payer Paid Amounts

- Claim level
  - Required when claim has service line approved/allowed amount and service line paid amount
  - AMT segment – loop 2320 (Other subscriber information)
    - COB payer paid amount – claim level
      - With D qualifier
      - Total amount primary payer paid on claim (zero allowed)

2320	AMT01	Amount qualifier code = D
	AMT02	Monetary amount (Primary Paid Claim Level)

COB Payer Paid Amounts

- Claim level
  - Obligated to accept as payment in full
  - Only required when OTAF amount greater than zero
    - Medicare claims processing system determines OTAF amount
      - Subtracts contractual obligation group code amount from submitted charges

2300 or 2400	CN102	OTAF amount

Claim Adjudication Date

- Claim level
  - Required on all electronic MSP claims
  - Report the date the claim paid/processed by primary payer by using a DTP segment in loop 2330B
    - DTP01 element = 573 (indicates date listed is date claim paid)
    - DTP02 element = D8 (indicates format of date)
    - DTP03 element = enter date claim paid/adjudicated by primary payer

2330B or 2430	DTP01	Primary insurance adjudication date
	DTP02	Date time period qualifier
	DTP03	Date paid

Service Line Information

- Line adjudication information
  - Services billed to primary payer
    - Procedure code, units billed, amount paid, etc.
  - Required if claim adjudicated by primary payer and service line adjustments applied
  - SVD segment in 2430 loop
    - Information in SVD01 must match payer ID for primary payer

2430	SVD01	Identification code
	SVD02	Primary payer paid amount (line level)
	SVD03	Medical procedure identifier
	SVD03-1	Service ID qualifier
	SVD03-2	Service ID
	SVD05	Quantity

Service Line Information

- Line adjustments
  - Required if primary payer made line level adjustments
  - CAS segment of 2430 loop, include
    - Monetary adjustment amounts
    - CARC from primary remittance advice
    - Claim adjustment group code, such as
      - CO,OA, PI, PR

2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)
	CAS02	Claim adjustment reason codes
	CAS03	Adjustment amount
	CAS04	Adjustment quantity

Service Line Information

- Line adjudication date
  - Required on all electronic MSP claims
  - DTP segment of 2430 loop
    - Date/time qualifier of 573
    - Date/time period format qualifier of D8

2330B or 2430	DTP01	Primary insurance adjudication date
	DTP02	Date time period qualifier
	DTP03	Date paid

Remember

- Payment amount entered in service line adjudication field
- Plus
  - Adjustments listed in line level adjustment fields
- Equals
  - Total amount billed for that service line

MSP Electronic Claim Submission

- MSP electronic billing guidance on our website
  - Education > Job Aids & Manuals
    - Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P
    - Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

Billing MSP Claims via PC-ACE

- Parallels items on paper CMS-1500 claim form
- Creates compliant ANSI X12 file to submit to NGS electronically
- PC-ACE Medicare Secondary Payer Reference Guide available on our website
  - Claims > EDI Solutions> EDI Software: PC-ACE> PC-ACE Software Instructions, Resources and Guides

Conditional Claims/Payments

- Medicare pays the provider because payment has not been made or is not expected to be made by primary insurer
- Payments are made “on condition” that Medicare will be reimbursed if it is demonstrated that the insurance is or was responsible for making primary payment for services rendered

Conditional Claims/Payments

- Four circumstances when a conditional payment can be made
  - Beneficiary appeal/protest GHP denial of claim
  - GHP denied claim because timely filing limit expired
  - Provider failed to file proper claim due to mental/physical incapacity of beneficiary
  - Claim sent to specific primary insurers and payment not made within promptly period

Conditional Payment Data Requirements

837 5010 Professional Claims - MLN Matters® *MM7355: Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims*

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/Liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02-Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Medicare Part B CMS-1500 Crosswalk for 5010

Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

The information contained in this crosswalk is for reference purposes only.

* = If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.

** = Use if different than information given at the claim level. 7/6/2012 - KJT 1

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)
2	Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card
			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr. Sr.)	
3	Patient's Birth Date and gender	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8
			DMG03	Gender	
4*	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the **insured's** name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	
5	Patient's address and telephone number	2010BA	N301	Subscriber address line 1	Enter the patient's mailing address
			N302	Subscriber address line 2	
			N401	Subscriber city name	
			N402	Subscriber state	
			N403	Subscriber ZIP code	

Thank You!

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

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