# Medicare Secondary Payer – Claims That Have Returned to the Provider

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# Objective

- Review reasons why MSP claims RTP and what providers can do to prevent these RTP claims
  - Preventing errors that cause RTP claims can increase timeliness of your Medicare cash flow and decrease time you spend submitting corrected MSP claims

# Agenda

- MSP Reminders
- RTP Claims
- MSP Claim Preparation
- FISS Reason Codes Related to CAGCs and CARCs
- MSP Resources – Refer to Handout
- Questions and Answers

# MSP Reminders

# Did You Know

- Providers who are familiar with the MSP Provisions, their MSP-related responsibilities, and how to accurately prepare and submit MSP claims are less likely to receive RTP MSP claims from Medicare

# MSP and Providers' Responsibilities

- MSP refers to
  - Situations in which beneficiary has other coverage that is primary to Medicare per federal laws known as MSP provisions
- Providers' responsibilities
  - Identify and bill payers that are primary to Medicare before billing Medicare
  - Bill Medicare as secondary payer when required

# 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) | D |
| 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 | L |

# Medicare Claim Types

- If primary payer does not pay, citing Medicare is primary
  - Submit Medicare primary claim (verify Medicare is primary)
- If primary payer does not pay for a valid reason or does not pay promptly (120 days; accidents only)
  - May submit conditional claim

# Medicare Claim Types

- If primary payer pays in part
  - Submit MSP claim; known as MSP partial-pay claim
- If primary payer pays in full
  - Submit MSP claim, known as MSP full-pay claim
    - Required for all inpatient services
    - Required for outpatient services when beneficiary has not met annual Medicare Part B deductible
    - Requested for all home health and hospice services

# It is Important for MSP Claims to Be Submitted to and Processed by Medicare

- MSP partial-pay and MSP full-pay claims
  - Primary payer's payment is used to satisfy any applied Medicare deductible, coinsurance and/or co-payment
  - Claim will be in history and provider can adjust it within one year of its processed date
- MSP partial-pay claims
  - Balance after primary payer's payment can be considered
- MSP full-pay claims
  - Requirement to submit such a claim is met
  - Track beneficiary's inpatient benefit period
  - Track home health and hospice services and requirements

# RTP Claims

# RTP Claims

- Claims that are RTP
  - Returned to the provider = RTP
  - Are unprocessable
  - Contain claim coding error
  - Conflict between claim and Medicare's records
  - Allow providers to review view errors/conflicts

# Finding RTP Claims

- In FISS DDE status/location = T B9997
  - Log into FISS DDE
  - Select Claims Correction Menu (option 03)
  - Select option from Claim and Attachments Correction Menu based on RTP claim type
    - **IP** = 21, **OP** = 23, **SNF** = 25, **Home Health** = 27, **Hospice** = 29
  - To access specific claim
    - Enter Medicare number and DOS
    - List of RTP claims will be displayed
    - Select claim to be corrected by placing ‘U’ in SEL field
    - Claim opens at page 1

# Tip

- Check your facility's RTP claims in FISS status/location T B9997 routinely

# Claim Correction Tip: FISS DDE Sort

- Providers can use FISS DDE Sort field on Claim Correction screen to sort RTP claims

| Code | Description |
|---|---|
| D | Sorts in ascending receipt date order |
| H | Sorts in ascending Medicare number order |
| M | Sorts in ascending order by medical record number |
| N | Sorts by beneficiary last name in ascending order |
| R | Sorts in ascending reason code order |

# Determining What is Wrong With RTP Claims

- RTP claims have assigned **reason code(s)**
  - One or more for each claim
  - Describe reason(s) claim was RTP and action(s) to resolve
  - Listed in lower left corner of claim page
  - Also available through Inquiries Submenu (01) > Reason Code file (17)

# MSP Claims Are Subject to Same Reason Codes as Other Claims

- RTP MSP claims
  - Are subject to many of **same reason codes** as Medicare primary claims
    - Claim submission error made in either the patient, provider or service specific information, etc.
      - Examples: Error made in use of HCPCs code, revenue code, number of units, etc.

# MSP Claims Are Subject to Additional Reason Codes Than Other Claims

- RTP MSP claims
  - Are subject to **additional reason codes** due to MSP involvement
    - Error in MSP-related claim coding such as MSP CCs, OCs and dates, VCs and amounts, etc.
    - MSP claim information conflicts with information in beneficiary's MSP record in CWF
    - Error in CAGC(s) and/or CARC(s) coding

# Reasons MSP Claims May RTP

- MSP claim may RTP if it
  - Is not coded correctly
    - Submitted without required MSP claim coding
    - Submitted with incorrect MSP claim coding
    - Submitted with conflicting claim coding
    - Submitted without CAGCs and/or CARCs when needed
    - Submitted with incorrect CAGCs and/or CARCs
  - Has information that conflicts with MSP record in CWF
    - Submitted when a matching MSP record for beneficiary is not in CWF
    - Submitted when beneficiary's MSP record in CWF indicates Medicare is primary

# Examples: MSP-Related RTP Reason Codes

- MSP RTP reason codes you may encounter on your MSP claims (not all-inclusive)
  - 31300, 31301 and 31350
  - 3SP25
  - 7MSPE, 7MSPG, 7MSPL and 7MSPR
  - 75003 and 75004
  - Note: There is not a list of FISS reason codes used to RTP MSP claims

# Correcting/Resolving RTP MSP Claims

- Correct/resolve MSP claims in FISS DDE by
  - Adding required MSP claim coding
  - Correcting conflicting claim coding
  - Adding or correcting CAGCs and/or CARCs
  - Storing claim (PF9) after BCRC sets up an MSP record
- Resubmitting new/correct MSP claim
  - No errors, no conflicts

# Tips for Resolving RTP MSP Claims

- Review RTP MSP claim
  - Read all reason code narratives in their entirety
  - Understand all identified errors, conflicts and actions you need to take to resolve before new claim is submitted
  - Contact our PCC if you do not understand why claim RTP
  - Determine what claim type you need to submit
  - Review primary payer's ERA (CAGCs and CARCs)
- Make corrections to claim in FISS DDE
  - Correct **all claim coding errors at one time**
  - **Use available MSP Resources**
  - Hit PF9 key

# Tips for Resolving RTP MSP Claims

- Resolve conflicts between claim and MSP record(s)
  - To resolve conflicts
    - Review MSP record in CWF
      - HETS, NGSConnex or IVR
    - Review completed MSP questionnaire
    - Contact BCRC if necessary; refer to MSP Resources handout
    - Wait for BCRC to complete MSP record addition/correction
- Store claim (PF9) or resubmit new corrected claim
  - All conflicts are resolved
  - Any applicable MSP record additions/corrections are complete

# Preparing MSP Claims – Yes You Can Prepare Accurate MSP Claims

# MSP Fact

- To prevent MSP claims from being RTP by Medicare, providers must prepare such claims accurately the first time and there must not be any conflicts between the claims and the MSP records

# Actions That Can Help You Submit Accurate MSP Claims and Prevent RTPs

- Review response from primary payer
- Verify Medicare is truly secondary
- Ensure there are no conflicts
- Prepare MSP claim
- Report all required claim coding accurately
- Use all available resources
- Check for matching MSP record in CWF
- Contact BCRC if matching MSP record is not present
- Submit MSP claim using an available option
- Maintain documentation

# Instructions for MSP Claims

- Follow all of Medicare's usual requirements
  - Billing, technical, medical, etc.
  - One year timely filing and frequency of billing
- In all MSP situations
  - HHAs submit RAP showing Medicare as primary
    - Not reimbursed on RAP
    - Insurer information reported on final claim
  - Hospice submit NOE showing Medicare as primary
    - Insurer information reported on claim

# Instructions for MSP Claims

- Complete claims in usual manner; report
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered charges as usual
  - Total covered/noncovered days as usual
  - Primary payer as first payer; Medicare as second
  - Appropriate billing codes in appropriate claim fields (FLs) to indicate claim is MSP
    - Correct primary payer code (payer code ID) appears in FISS when claim billed with correct MSP VC

# Avoiding General Coding Errors to Prevent MSP Claim RTPs

- Claim may be RTP if
  - You do not report coding that is usually reported for services being submitted
    - Examples: HCPCS codes, revenue codes, number of units, provider information, patient information, etc.
  - You report Medicare as first payer (payer code ID = Z) and primary payer as second payer (reason code 31300)

# MSP Claims – Claim Fields

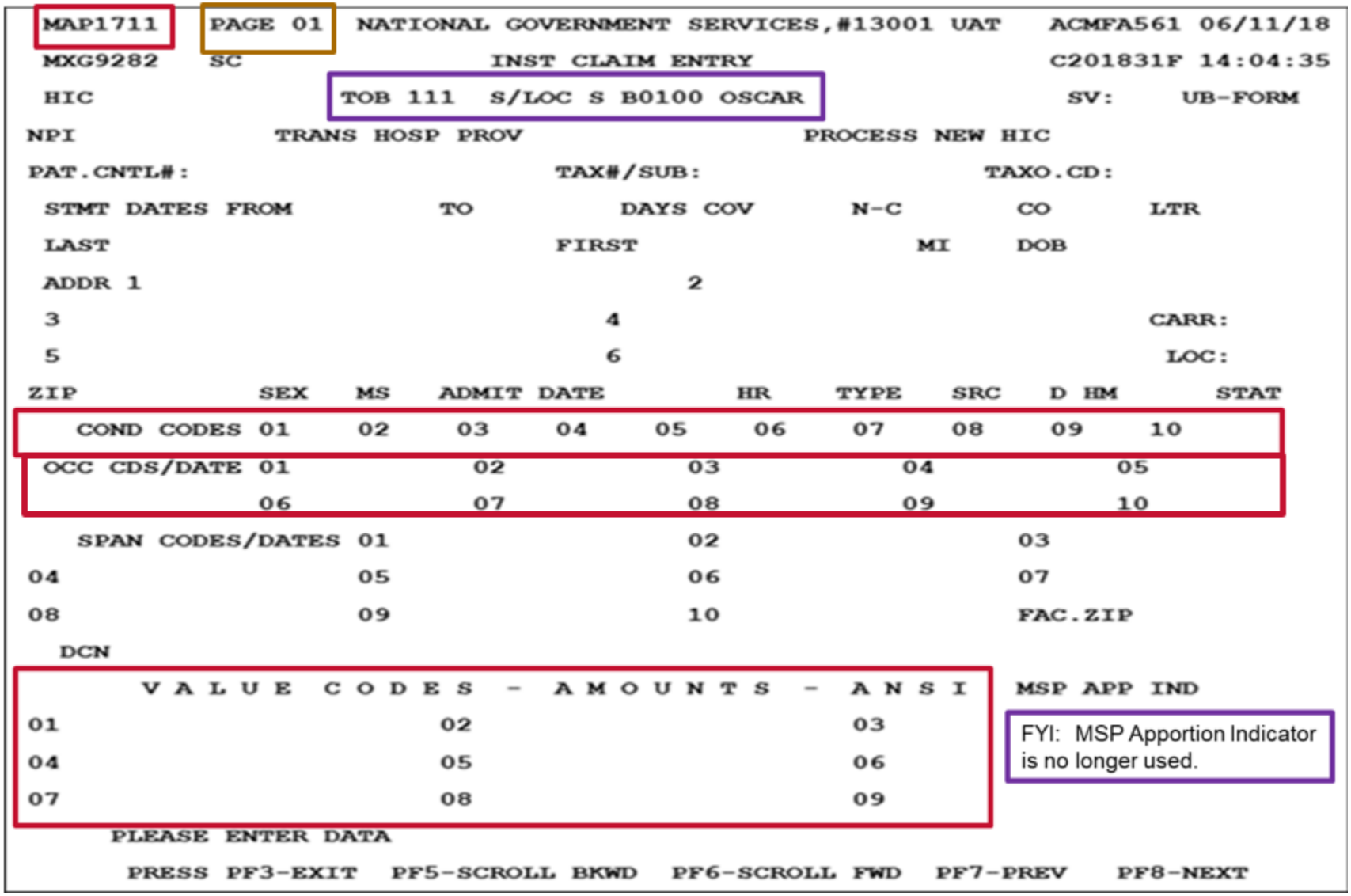
| Code | UB-04 FLs | Electronic Field | FISS DDE |
|---|---|---|---|
| Condition codes | 18–28 | 2300.HI (BG) | Page 01 |
| Occurrence codes and dates | 31–34 | 2300.HI (BH) | Page 01 |
| Value code and payment | 39–41 | 2300.HI (BE) | Page 01 |
| Payer code ID | N/A | N/A | Page 03 |
| Primary insurer name | 50A | 2320.SBR04 | Page 03 |

# MSP Claims – Claim Fields

| Code | UB-04 FLs | Electronic Field | FISS DDE |
|---|---|---|---|
| Insured's name | 58A | 2330A.NM104 | Page 05 |
| Patient's Relationship to Insured | 59A | 2320.SBR02 | Page 05 |
| Insured's unique ID | 60A | 2330A.NM109 | Page 05 |
| Insurance group name | 61A | 2320.SBR04 | Page 05 |
| Insurance group number | 62A | 2320.SBR03 | Page 05 |
| Insurance address | Use Remarks FL 80 | Use Remarks 2300.NTE | Page 06 |

# FISS DDE Claim Entry – Six Pages

| Pages for Claim Entry | MAP | Contains |
|---|---|---|
| Page 01 | MAP1711 | Corresponds to UB-04, FLs 1–41: Patient information, condition codes, occurrence codes, occurrence span codes and value codes |
| Page 02 | MAP1712 | Corresponds to UB-04, FLs 42–49: Revenue and CPT/HCPCS codes, charges and DOS |
| Page 03 | MAP1713 | Corresponds to UB-04, FLs 50–57 and 66–79: Payer, diagnosis code, procédure code and physician information |
| Page 03 | MAP1719 | MSP payment information from primary payer's RA |
| Page 04 | MAP1714 | Corresponds to UB-04, FL 80: Remarks |
| Page 05 | MAP1715 | Corresponds to UB-04, FLs 58–65 |
| Page 06 | MAP1716 | Primary insurer's address information |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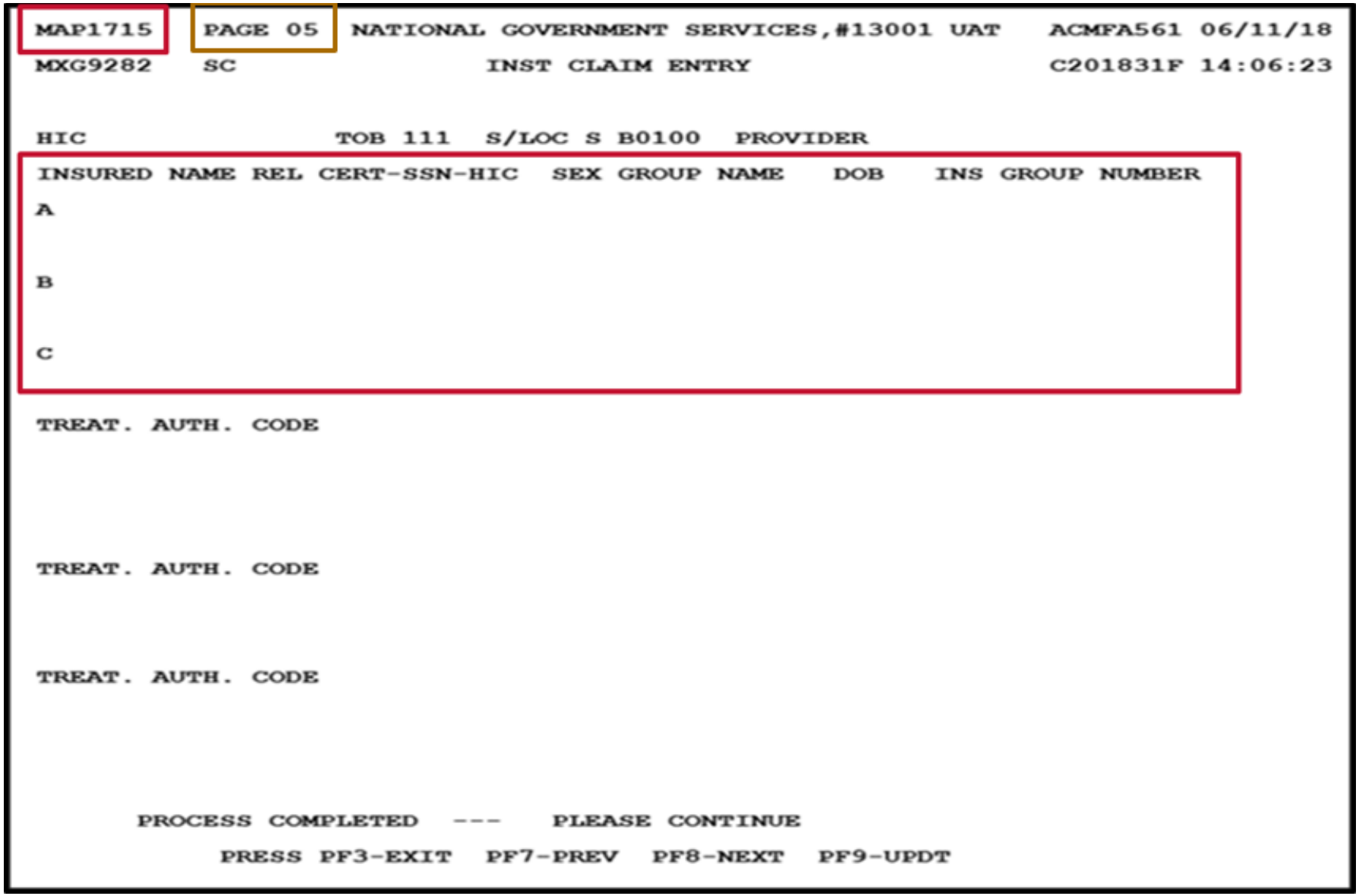
COND CODES 01 02 03 04 05 06 07 08 09 10
OCC CDS/DATE 01 02 03 04 05
06 07 08 09 10
SPAN CODES/DATES 01 02 03
04 05 06 07
08 09 10 FAC.ZIP
DCN
V A L U E C O D E S - A M O U N T S - A N S I
MSP APP IND
01 02 03
04 05 06
07 08 09
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
FYI: MSP Apportion Indicator is no longer used.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A
B
C
TREAT. AUTH. CODE
TREAT. AUTH. CODE
TREAT. AUTH. CODE
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT

# Condition Codes (COND CODES)

- Report MSP-related CCs as applicable
  - **02** = Condition is employment-related
  - **06** = ESRD beneficiary in first 30 months of entitlement covered by EGHP
  - **77** = Full payment received from primary payer

# Condition Code 77

- Report CC 77 when
  - Contractual arrangement (or obligation under law) with primary payer and you received expected amount
- Scenario (contractual arrangement)
  - Medicare covered charges = $5,000
  - Expected from primary payer = $4,000
  - Received from primary payer = $4,000
- Report
  - Medicare-covered charges = $5,000
  - MSP VC ____ with $4,000
  - CC = 77

# Avoiding Condition Code Errors to Prevent MSP Claim RTPs

- Claim may be RTP if you report
  - CC 02 (reason code 31301)
    - Without any other MSP claim coding
    - With incorrect MSP VC (should be MSP VC 15 or 41)
    - With incorrect OC and date (should be OC 04 and date)
  - CC 06
    - Without any other MSP claim coding
    - With incorrect MSP VC (should be MSP VC 13)
    - Without OC 33 and date

# Avoiding Condition Code 77 Errors to Prevent MSP Claim RTPs

- Claim may be RTP if you report
  - CC 77 without any other MSP claim coding (reason code 31350)
- Tip
  - If you were expecting a secondary payment on your MSP claim, but received none, check your claim coding to see if you reported CC 77 in error

# Occurrence Codes and Dates (OCC CDS/DATE)

- Report MSP-related OCs and dates as applicable
  - 01 and DOA if medical-payment plan is primary
  - 02 and DOA if no-fault is primary
  - 03 and DOA if liability is primary
  - 04 and DOA if WC is primary
  - 33 and date ESRD coordination period began

# Avoiding Occurrence Code Errors to Prevent MSP Claim RTPs

- Claim may be RTP if you report
  - OC 01, 02, 03 or 04
    - With incorrect corresponding MSP VC
      - OCs 01 and OC 02 require MSP VC 14
      - OC 03 requires MSP VC 47
      - OC 04 requires MSP VC 15 or 41 (reason code 31301)
    - Without a DOA
    - With a DOA that does not match MSP record's DOA (reason code 7MSPR)
    - With no other MSP claim coding (Medicare listed as primary)
    - And there is no matching MSP record (terminated, deleted, not present)

# Avoiding Occurrence Code Errors to Prevent MSP Claim RTPs

- Claim may be RTP if you report
  - OC 33 and date with incorrect MSP VC
    - OC 33 requires VC 13
  - OC 33 and date but with no other MSP claim coding

# Value Codes and Amounts

- For MSP claims
  - Report applicable MSP VC (for MSP Provision) with amount you received from primary payer for Medicare-covered services
    - VCs = 12, 13, 14, 15, 16, 41, 43 and 47 (see slide 10 or 47)
  - Report VC 44 and OTAF amount when you receive less than you were expecting to receive from primary payer
    - OTAF amount = amount you agreed to accept from primary payer as full payment
  - Do not report VC 44 when you receive equal to or greater than Medicare-covered charges

# Avoiding MSP Value Code Errors to Prevent MSP Claim RTPs

- Claim may be RTP if you report
  - MSP VC but related MSP claim coding is missing
    - MSP VC 13 without CC 06 and OC 33 and date
    - MSP VC 14 without OC 01 or 02 and date
    - MSP VC 47 without OC 03 and date
    - MSP VC 15 without CC 02 and OC 04 and date
  - MSP VC but there is no matching MSP CWF record
  - MSP VC without dollar amount (may appear as conditional claim but there is no other conditional coding)
  - Note: Above fall into reason codes **7MSPL or 7MSPR**

# Avoiding MSP Value Code Errors to Prevent MSP Claim RTPs

- Claim may be RTP if you report
  - Incorrect MSP VC (reason code 7MSPG)
    - MSP VC 12 but beneficiary is under age 65
    - MSP VC 43 but beneficiary is age 65 or over
    - Primary payer code that does not apply (reason code 31300)
  - MSP VC but claim or our records indicate Medicare is primary (reason code 7MSPG)
    - VC 12 or 43 but there is no current employment status
      - Claim may have CC 09, 10, 11, 28 or 29 (indicate Medicare is primary)
      - Claim may have OC 18 and/or 19 and retirement date(s)
    - MSP VC 13 but 30 month coordination period has ended

# VC 44: Example

- Scenario (contractual arrangement)
  - Medicare covered charges = $5,000
  - Expected from primary payer (OTAF) = $3,500
  - Received from primary payer = $3,000
  - Primary payer applied deductible = $500
- Report
  - MSP VC ___ with $3,000 and
  - VC 44 with $3,500

# Avoiding Value Code 44 Errors to Prevent MSP Claim RTPs

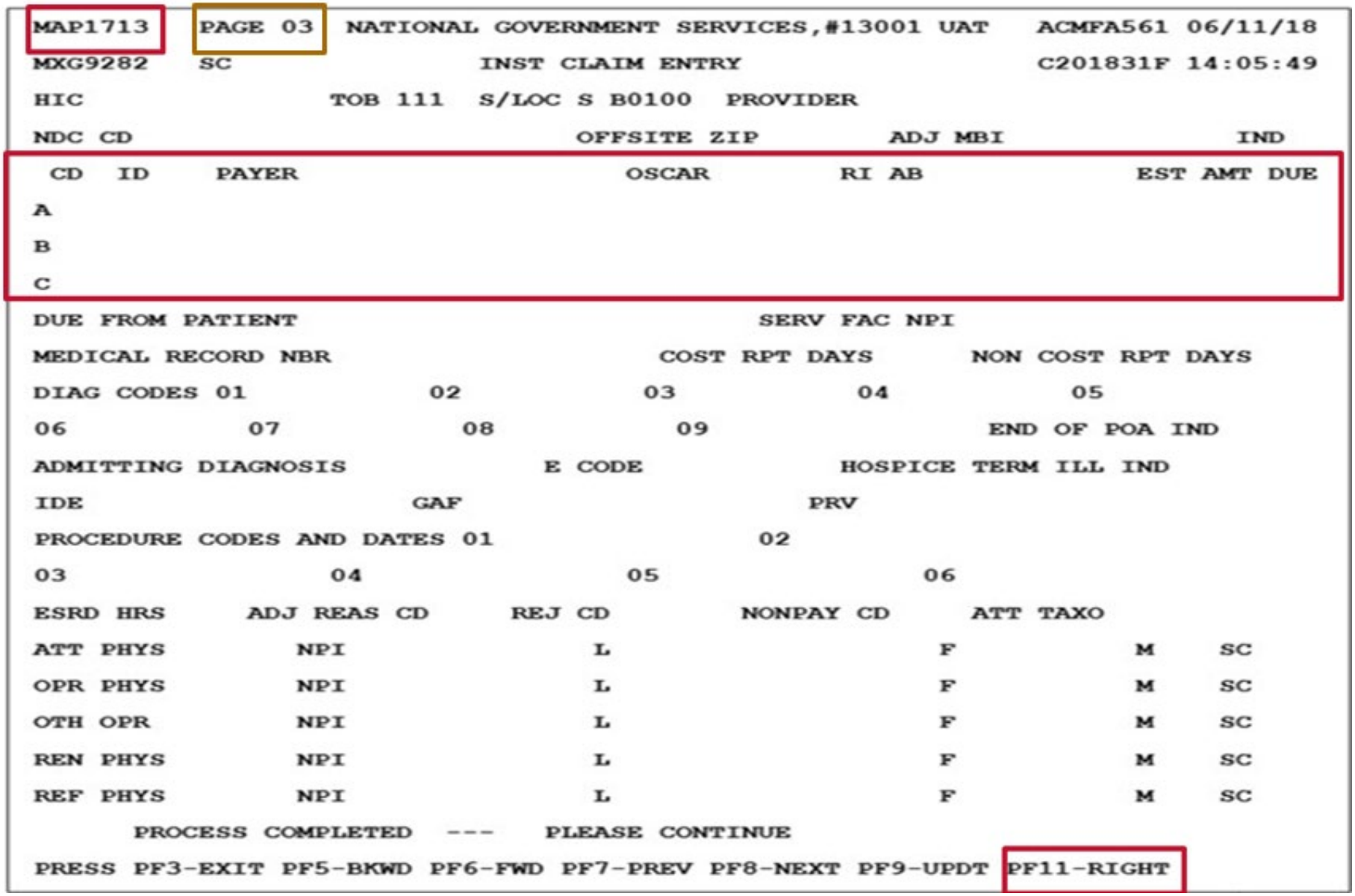
- Claim (adjustments only, TOB XX7) may be RTP
  - If VC 44 amount and MSP calculated OTAF amount (Total charges minus CO group code) are not equal (reason code 33981)
- MSP fact
  - **Original** MSP claims are rejected, rather than RTP, when the above error occurs

# Selecting Appropriate Primary Payer Code When Submitting MSP Claims in FISS DDE

| 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) | D |
| 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 | L |

# Avoiding Primary Payer Code Errors to Prevent MSP Claim RTPs

- Claim submitted with
  - Primary insurer name that does not match MSP VC use
    - Example: Primary insurer name Allstate with MSP VC 12 instead of 14 or 47
  - No primary insurer name (Medicare is listed as second payer)
  - Invalid/vague/unacceptable primary insurer name
    - Hospice, CMS, none, NO or NA, UNK or Unknown, Attorney, Insurer, Supplement or Supplemental, BC, BX, BCBX, BS, Blue Cross or Blue Shied with no characters, entries less than two characters, Commercial (with nothing following), Misc. or Miscellaneous
    - Special characters are not valid within insurer name
      - All of the above fall into reason code 3SP25 criteria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NDC CD OFFSITE ZIP ADJ MBI IND
CD ID PAYER OSCAR RI AB EST AMT DUE
A
B
C
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAG CODES 01 02 03 04 05
06 07 08 09 END OF POA IND
ADMITTING DIAGNOSIS E CODE HOSPICE TERM ILL IND
IDE GAF PRV
PROCEDURE CODES AND DATES 01 02
03 04 05 06
ESRD HRS ADJ REAS CD REJ CD NONPAY CD ATT TAXO
ATT PHYS NPI L F M SC
OPR PHYS NPI L F M SC
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REN PHYS NPI L F M SC
REF PHYS NPI L F M SC
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT

# Patient Relationship (REL) Codes

- Report relationship of patient to identified insured accurately
  - 01 = Spouse
  - 18 = Self
  - 19 = Child
  - 20 = Employee
  - 21 = Unknown
  - 53 = Life partner
  - G8 = Other relationship

# Avoiding Patient Relationship Code Errors to Prevent MSP Claim RTPs

- Claim submitted with
  - Incorrect patient relationship code
  - **Example:** Patient relationship of 18 for self instead of 01 for spouse if insurance is through spouse

# Checking for Matching MSP Record in CWF Before Submitting MSP Claim

- Check for matching MSP record before claim submission
  - If no matching MSP record, contact BCRC and wait for record to appear in CWF
- If you submit MSP claim before matching MSP record is in CWF
  - Claim suspends for manual review and we
  - Send claim information to BCRC
  - RTP claim (reason code 75003) while BCRC investigates/creates MSP record
  - RTP additional claims (reason code 75004) while BCRC update is pending
  - RTP claim (reason code 7A000) if BCRC will not update/create MSP record
- If you receive reason codes 75003 or 75004
  - Contact BCRC with information they need
  - Resubmit claim when correct MSP record is in CWF

# Submitting MSP Claims – Options

- Submit MSP (or Medicare tertiary) claims
  - Electronically via 837I claim,
  - In FISS DDE, or
  - Using hardcopy UB-04/CMS-1450 claim form
    - Include primary payer's RA and EOB statement
    - Send to our Claims Department
    - You must have or obtain approved ASCA waiver
    - Visit our website for
      - ASCA information under Claims & Appeals

# Submitting MSP Claims via FISS DDE

- As of 1/1/2016, per CR8486, providers can
  - Use FISS DDE to
    - Submit and correct MSP, conditional and Medicare tertiary claims
    - Adjust claims for MSP reasons
  - Submit Medicare tertiary claims via 837I claim
    - Hardcopy submission with ASCA waiver no longer required
- FISS process was updated to allow above actions
  - MAP1719 was added so you can enter payments and adjustments from CAS of primary payer's RA (835) – CAGCs, CARCs and amounts
  - MAP103L was added so MACs can key hardcopy claims

# Submitting MSP Claims

- Medicare uses primary payer's adjustment amounts when processing MSP claims for payment
  - Explain why billed amount was not fully paid by primary payer
  - In CAS segment on 835 ERA or paper RA
  - CAGC paired with CARC (communicates primary payer's adjustments)
- Submitting MSP claims via 837I claim ensures
  - Medicare's compliance with HIPAA requirements
  - MSP claims are calculated using payment information from 837I
- FISS process was updated in 2016
  - MAP1719 added to allow providers to enter CACG/CARCs and amounts
    - Note: MAP103L was added to allow MACs to key hardcopy claims

# Did You Know

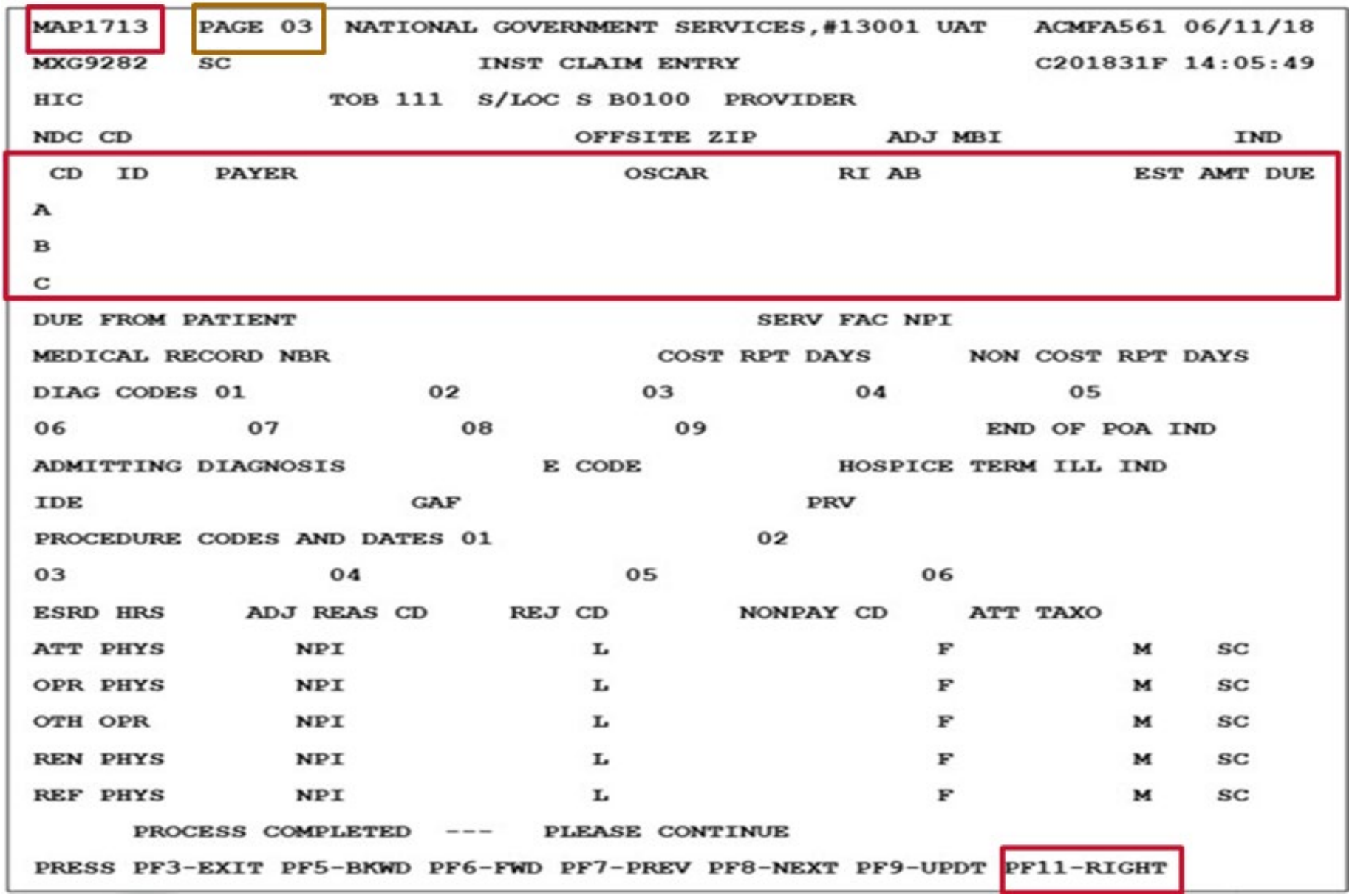
- When you submit MSP or Medicare tertiary claims
  - **In FISS DDE** – Enter MSP CAS information from primary payer's RA directly into MAP1719 (Claim Entry page 03)
  - **Via 837I claim** – Submit MSP CAS information from primary payer's RA; Medicare maps it to MAP1719
    - If claim is RTPd, you can access it in FISS DDE to correct
    - If claim is rejected, you must adjust it (in some cases, you can resubmit)

# Reporting CAGCs and CARCs

- CAGC(s) from primary payer's RA (835)
  - Identifies general category of payment adjustment
  - Required when primary payer adjusts billed charges
  - Options:
    - CO (Contractual Obligations)
    - OA (Other Adjustments)
    - PI (Payer Initiated Reductions)
    - PR (Patient Responsibility)
- CARC(s) from primary payer's RA (835)
  - Communicates an adjustment
  - Explains why primary payer paid differently from amount billed to them
  - External Code Lists/X12

# FISS DDE Claim Entry Page 03 (MAP1719)

- MSP Payment Information page
  - Press F11/PF11, from page 03 (MAP1713), to access
  - Press F6/PF6 to display a second page for payer 2
- Up to 20 entries each for primary payers one and two
  - Field names (enter information from primary payer's RA)
    - Paid date: Enter paid date
    - Paid amount: Enter paid amount (must equal amount entered for MSP VC) and must equal charges less amount with CAGC and CARC
    - GRP: Enter group code(s), also known as CAGC(s)
    - CARC: Enter CARC(s)
    - AMT: Enter dollar amount(s) associated with CAGC and CARC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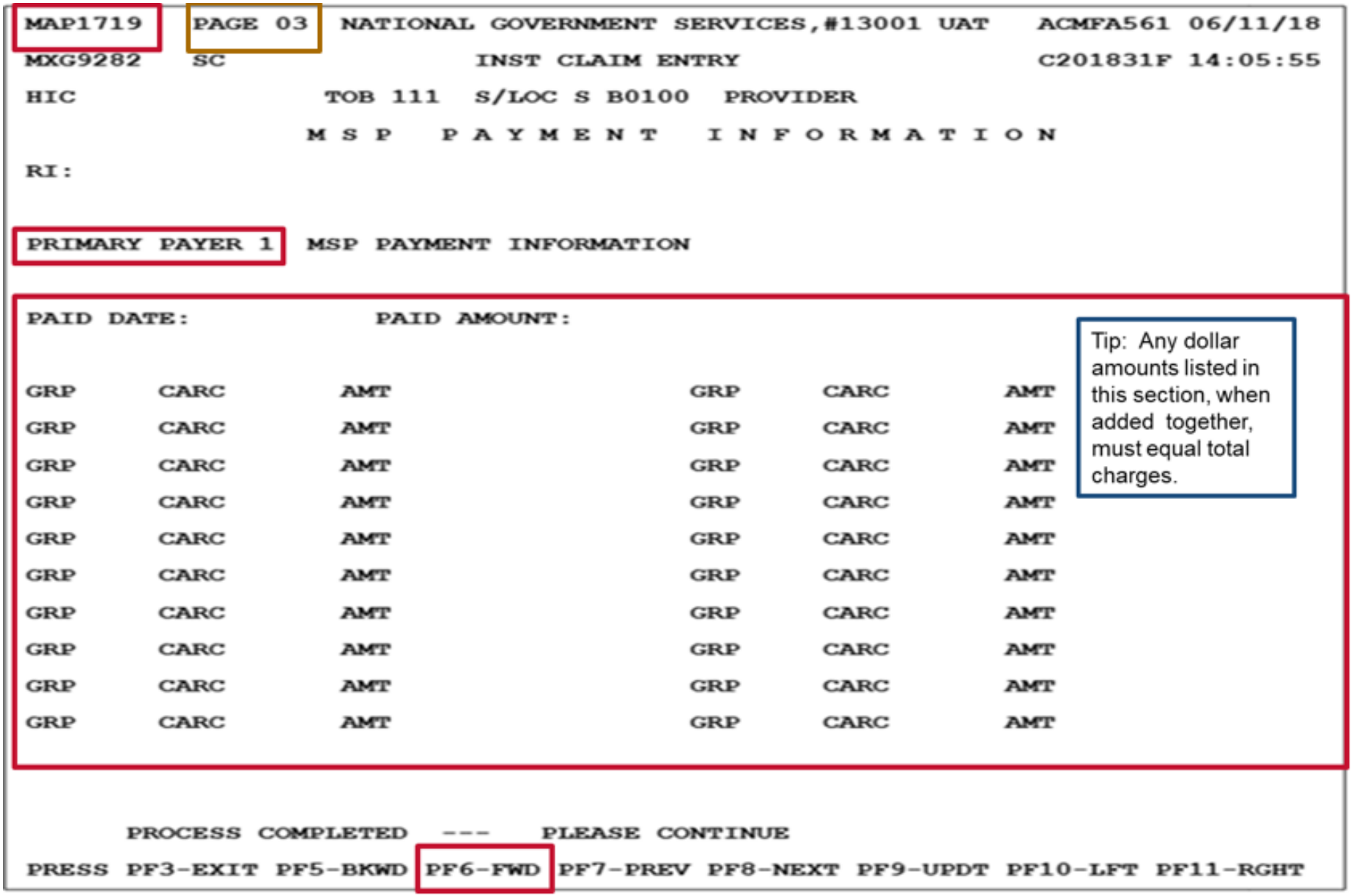
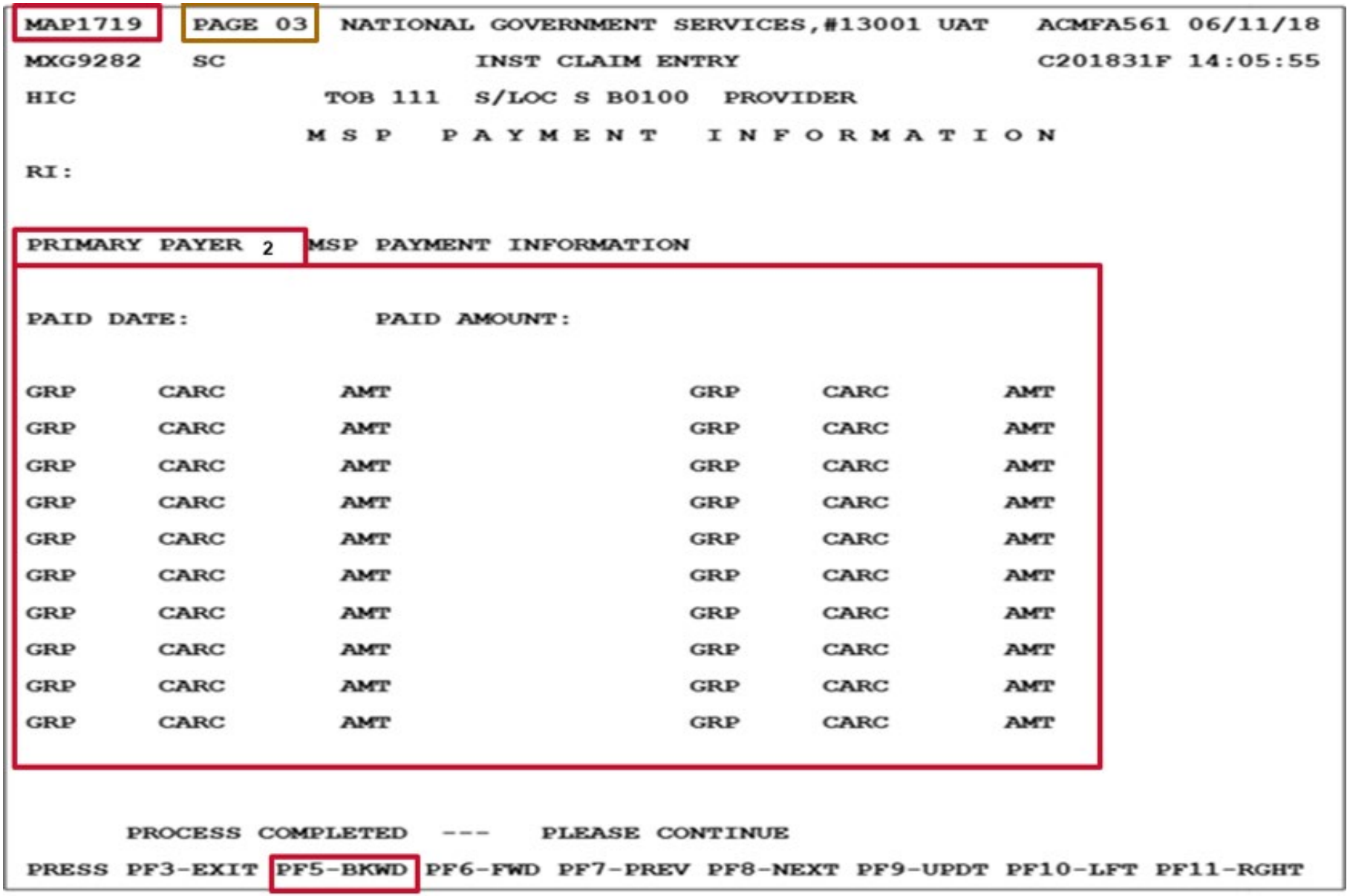
CD ID PAYER OSCAR RI AB EST AMT DUE
A
B
C
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAG CODES 01 02 03 04 05
06 07 08 09 END OF POA IND
ADMITTING DIAGNOSIS E CODE HOSPICE TERM ILL IND
IDE GAF PRV
PROCEDURE CODES AND DATES 01 02
03 04 05 06
ESRD HRS ADJ REAS CD REJ CD NONPAY CD ATT TAXO
ATT PHYS NPI L F M SC
OPR PHYS NPI L F M SC
OTH OPR NPI L F M SC
REN PHYS NPI L F M SC
REF PHYS NPI L F M SC
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT




Tip: Any dollar amounts listed in this section, when added together, must equal total charges.



```
MAP1719   PAGE 03   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
MXG9282    SC                  INST CLAIM ENTRY                C201831F 14:05:55
HIC                TOB 111   S/LOC S B0100   PROVIDER
                 M S P   P A Y M E N T   I N F O R M A T I O N
RI:

PRIMARY PAYER 2   MSP PAYMENT INFORMATION

PAID DATE:              PAID AMOUNT:

GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT

      PROCESS COMPLETED   ---    PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT
```

# Example #1 – Scenario

- Medicare beneficiary
  - Working aged with primary EGHP
  - IP hospital 3/1/21 to 3/25/21
  - Met Part A deductible in same benefit period
- Provider
  - Charges = $10,000
  - Bills EGHP as primary; under contract with EGHP
- EGHP
  - Allowed = $8,000 per contract
  - Applied patient coinsurance = $800
  - Paid = $7,200 on 5/15/21

# Example #1 – CAGC and CARC Claim Coding

- Claim entry – page 01 (MAP1711)
  - MSP VC 12 = $7,200
  - VC 44 = $8,000
- Claim entry – page 03 (MAP1719)
  - Paid date = 051521
  - Paid amount = $7,200
  - CAGCs, CARCs and amounts =
    - CO, 45 = $2,000 and PR, 2 = $800

# FISS Reason Codes Related to CAGCs and CARCs

| Code | Description |
|---|---|
| 31686 | Paid amount on MAP1719 is not equal to charges; no CAGCs/CARCs. |
| 31687 | Primary payer information is not on MAP1719 and Medicare is secondary. |
| 31688 | Validate CARC based on paid date. Compare paid date to CARC effective date. |
| 31689 | Paid amount on MAP1719 does not match MSP VC amount. |

# FISS Reason Codes Related to CAGCs and CARCs

| Code | Description |
|---|---|
| 31690 | Primary payer information is present for primary payer 2 but screen for primary payer 1 is blank or empty. |
| 31691 | 20 or fewer CAGC/CARC combinations on MAP1719 and total charges minus CARC amount(s) does not equal paid amount. |
| 31692 | More than 20 CAGC/CARC combinations on claim. FISS will move ampersands (&) to 20th occurrence and assign this RC. Once field with ampersands (&) is corrected and claim is updated, reason code will not assign. |
| 31693 | Paid date on MAP1719 is incorrect or is not a valid date. Valid format MMDDYY. |

# FISS Reason Codes Related to CAGCs and CARCs – Details For Your Information

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31686

- Problem
  - Amount in PD AMT field (MAP1719) is not equal to charges and there are no entries in Group or CARC fields
- Provider action
  - Compare amount in PD AMT field to total charges
  - If different, claim requires Group/CARC code(s) and amount(s) to explain difference; check primary payer's RA
  - Enter Group/CARC code(s) and/or amount and resubmit

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31687

- Problem
  - Claim submitted as Medicare primary but claim has primary payer information on MAP1719 indicating another party is primary or
  - Claim submitted as Medicare secondary but no information is on MAP1719 for primary payer and secondary payer, if applicable
- Provider action
  - Determine if Medicare is primary or secondary payer
    - If Medicare is primary, remove information on MAP1719 (primary payers 1 and 2)
    - If Medicare is secondary, determine (from primary payer's RA) which group/CARC codes must be entered and verify there is no information for primary payer 2
    - If Medicare is tertiary, primary payers 1 and 2 should have information present, at least one group/CARC combination needs to be entered for primary payer 2
    - Note: 0.00 may be entered in PD AMT field but no entry/blank is unacceptable

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31688

- Problem
  - There is an error with CARC code used
    - CARC not found on CARC file
    - CARC invalid
    - CARC not valid for DOS (prior to effective or after termination date)
- Provider action
  - Go to External Code Lists/X12 to verify validity of CARC or to verify CARC's effective or termination date
  - Resubmit claim with valid CARC

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31689

- Problem
  - Medicare is secondary or tertiary and amount in PD AMT field on MAP1719 is not equal to amount with MSP VC
- Provider action
  - Verify amount on claim page 1 (MAP1711)
  - Verify same amount is on MAP1719
  - Correct and resubmit claim

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31690

- Problem
  - Medicare is not primary payer, information is on MAP1719 for primary payer 2 but not for primary payer 1
- Provider action
  - Determine if Medicare is secondary or tertiary
  - If Medicare is secondary, remove information for primary payer 2
  - If Medicare is tertiary, ensure there is information for primary payers 1 and 2

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31691

- Problem
  - Group/CARC codes are on MAP1719, but total submitted charges minus total CARC amounts is not equal to amount in PD AMT field
- Provider action
  - Amount listed with CARCs should equal difference between total charges and amount paid by primary payer
    - Provider submitted claim with total charges of $3,200.00
    - Due to contractual agreement to accept 70% ($2,240) of total charges, primary indicates with CAGC of CO and CARC 45 a difference of $960
    - Primary also indicates a reduction due to beneficiary deductible by using CAGC of PR and CARC of 1 with $500
    - Amount listed in PD AMT field should be $1,740 (total charges minus contractual agreement amount and deductible)

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31692

- Problem
  - More than 20 CAGC/CARC combinations on claim. FISS will move ampersands (&) to 20th occurrence and assign this RC. Once field with ampersands (&) is corrected and claim is updated, RC will not assign
- Provider action
  - When more than 20 Group/CARC combinations are used on MAP1719, FISS will try to combine like Group/CARCs into one and ampersands will be placed in 20th occurrence field and RTP
  - While Medicare may not need 20 plus Group/CARC combinations, if this is needed for a claim to be crossed over for supplemental billing, provider can put information in Store and Forward Repository and resubmit claim

# FISS Reason Codes Related to CAGCs and CARCs – Reason Code 31693

- Problem
  - Medicare is not primary payer and date entered in PD DT field is either not valid or in wrong format for primary payer 1 or 2
    - Correct format is MMDDYY
- Provider action
  - Check PD DT that was entered on MAP1719 for primary payer 1
  - If tertiary claim, check PD DT for primary payer 2 by using F6
  - Verify date(s) entered are valid and/or formatted correctly
  - Correct as needed and press F9 to store

# What You Should Do Now

- Review MSP Resources handout
- Share information with staff
- Follow instructions for correcting claims in MSP situations
- Develop and implement policies that ensure claims are properly corrected in MSP situations
- Continue to attend educational sessions

# Online Assessment and Questions

- Follow-up email
  - In addition to receiving Medicare University Course Code for this Webinar, attendees will be asked to complete an online assessment
- Questions?
  - Do not enter any beneficiary or claim-related questions in Webinar question box
  - Contact our PCC with such questions

# Thank You!

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