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

8/3/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education Consultants
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Objective

- Review reasons conditional claims return to the provider (RTP) and what providers can do to prevent this

Agenda

- 2022 MSP Education
- MSP Reminders
- RTP Claims
- Conditional Claim Preparation
- MSP Resources – Refer to Handout
- Questions and Answers

2022 MSP Webinar Series

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MSP Webinar Series

- 17 different MSP webinars
- Wednesdays except 5/5/2022 (Thursday)
  - March 2022
    - **3/9** = Fundamentals
    - **3/23** = Resources
  - April 2022
    - **4/6** = Identifying Primary Payers
    - **4/20** = Setting Up & Correcting CWF Records
    - **4/27** = MSP Rejections on Primary Claims

MSP Webinar Series

- May 2022
  - **5/4** = Working Aged with EGHP Provision
  - **5/5** = Disabled with LGHP Provision (Thursday)
  - **5/18** = ESRD with EGHP Provision
- June 2022
  - **6/1** = No-fault, Medical-payment and Liability Provisions
  - **6/15** = Submitting Claims When Primary Payer Makes Payment (MSP Billing)
  - **6/22** = MSP Billing Examples

MSP Webinar Series

- July 2022
  - **7/6** = Submitting Claims When Primary Payer Does Not Make Payment (Conditional Billing)
  - **7/20** = Conditional Billing Examples
  - **7/27** = MSP Claims That RTP
- August 2022
  - **8/3** = Conditional Claims That RTP
  - **8/10** = Adjustments Involving MSP
  - **8/17** = MSP Payment and Beneficiary Responsibility

Additional 2022 MSP Events

- Virtual conferences include MSP as topic
  - Typically held twice a year
- Let's Chat About MSP Part A webinars
  - For all Part A providers including HH+Hs and FQHCs/RHCs
  - Ask MSP-related questions (no PHI)
  - Event posted to our website but no presentation
  - Monthly, Thursdays except 11/29/2022 (Tuesday)
    - 1/27, 2/24, 3/31, 4/28, 5/26, 6/30, 7/28, 8/25, 9/29, 10/27, 11/29, 12/15

MSP Reminders

What is MSP?

- Beneficiary has coverage primary to Medicare
  - Based on federal laws known as MSP provisions
    - Help determine proper order of payers
    - Make certain payers primary to Medicare
    - Each has criteria/conditions that must be met
      - If all are met, services are subject to that provision making other insurer primary and Medicare secondary
      - If one or more are not met, services are not subject to that provision; Medicare is primary unless criteria/conditions of another are met

Providers' MSP-Related Responsibilities

- Per your Medicare provider agreement
  - Determine if we are primary for beneficiary's services
    - Identify payers primary to Medicare
      - Conduct MSP screening process = Check for MSP records in CWF and ask beneficiary/representative MSP questions
        - » Identify Proper Order of Payers for Beneficiary's Services
        - » CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapter 3, Section 20.2.1
  - Submit claims to primary payer(s) before Medicare
  - Submit MSP claims if required or conditional claims

MSP Records in CWF – Available Information

- If MSP record(s) present, information includes
  - **MSP VC** and **primary payer code** for MSP provision
  - MSP effective date
  - MSP termination date, if applicable
  - Subscriber's name
  - Policy number
  - Patient's 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

Determine Proper Order of Payers

- Compare MSP record information to MSP information you collected
- Use your knowledge of MSP provisions
  - In general, Medicare is primary when beneficiary
    - Has no other coverage
    - Has other coverage but it doesn't meet MSP provision criteria or it meets MSP provision criteria but it is no longer available
  - In general, other coverage is primary when beneficiary
    - Has coverage that meets MSP provision criteria and it is available

Submit Claims According to Your Determination and Code Accurately

- If Medicare is primary, submit claim to
  - Us as primary with explanatory billing codes
- If another payer is primary, submit claim to
  - Primary payer first; follow up often
  - Medicare secondary, if required, with MSP billing codes
- If multiple payers are primary, submit claim to
  - Primary payer first, secondary next, etc.; follow up often
  - Medicare tertiary, if required, with MSP billing codes

Medicare Claim Types

- If primary payer
  - Paid in part, submit MSP (partial-pay) claim
  - Paid in full, submit MSP (full-pay) claim if required
  - Does not pay indicating Medicare is primary, verify Medicare is primary and if so, submit primary claim
  - Does not pay for valid reason, submit conditional claim
  - Does not pay promptly for accident (within 120 days; non-GHP), you may submit conditional claim

Conditional Claims – Defined

- Claims submitted to us for payment because
  - You billed primary payer but they
    - Did not pay for valid reason
      - Applies to all MSP provisions except PHS and VA
        - » If PHS or VA do not pay, submit Medicare primary, not conditional, claim
    - Did not pay promptly (within 120 days)
      - Applies to accident MSP provisions (VCs 14, 15, 41, 47)
- When we pay claim conditionally
  - Payment and beneficiary responsibility are same as if we are primary payer for claim

Valid Reasons

- Primary payer did not pay or did not pay promptly (accidents only) because
  - Services are not covered benefit or preexisting condition
  - Charges are applied to deductible, coinsurance, co-pay
  - Claim was filed untimely (must be filed timely with us)
  - Provider is out of network (we can pay only once)
  - GHP's or non-GHP's benefits are exhausted
  - Liability replied = payment delayed, not responsible or paid patient (you were not expecting patient payment)

Promptly – Defined

- Promptly means
  - For no-fault (VC 14) and WC (VC 15)
    - Payment within 120 days after insurer receives claim
  - For liability, including self-insurance (VC 47)
    - Payment within 120 days after earlier of
      - Date general liability claim was filed with insurer or lien was filed against potential liability settlement (we consider this date to be date liability record was created in CWF); or
      - Date service was furnished (date of discharge for IP)

Medicare Can Pay Conditionally When…

- You billed primary payer
  - They responded (you have response)
  - They did not pay for valid reason
- You billed primary non-GHP for accident
  - They did not respond (you do not have response)
  - 120-day promptly period has passed
  - There is not also GHP that should have paid before us

RTP Claims

RTP Claims

- Claims that are RTP
  - Cannot be processed by Medicare as is
  - Contain claim coding error(s)
  - Contain information that conflicts with information in our records
  - Can be viewed, reviewed, corrected and returned to us if you have FISS DDE
    - Tip: Check your RTP claims routinely

Locate Your RTP Claims

- In FISS DDE status/location = T B9997
  - Log into FISS DDE
  - Select Claims Correction Menu (option 03)
  - Select claim type option
    - IP = 21, OP = 23, SNF = 25, Home Health = 27, Hospice = 29
  - To access specific claim
    - Enter MBI and DOS and list of RTP claims is displayed
    - Select claim to correct by placing 'U' in SEL field
    - Claim opens at page 1

Claim Correction Tip: FISS DDE Sort

- Use FISS DDE Sort field on Claims 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

Determine What is Wrong With RTP Claims

- RTP claims have assigned reason code(s)
  - One or more for each claim
  - With narratives that describe claim's problem(s) and action(s) you need to take to resolve them
  - Listed in lower left corner of claim page
- Reason code narrative
  - Also available through Inquiries Submenu (01) > Reason Code file (17)

Conditional Claims With Errors Can RTP

- RTP conditional claims are subject to
  - Same reason codes as primary claims
    - Error in reported patient, provider or service information, etc.
    - Error in use of CPT/HCPCs code(s), revenue code(s), units, etc.
  - Additional reason codes due to MSP involvement
    - Error in use of MSP coding (MSP CCs, OCs, VCs, etc.)
    - Conflict between claim information and MSP record information
    - Error in use of CAGC(s) and/or CARC(s) coding

Reasons Conditional Claims RTP

- Conditional claim may RTP if it
  - Is not coded correctly
    - Does not have conditional coding and/or CAGCs/CARCs/amounts
    - Has incorrect conditional coding and/or CAGCs/CARCs/amounts
    - Has conflicting coding
  - Has information that conflicts with MSP record in CWF
    - Submitted when there is no matching MSP record in CWF
    - Submitted when MSP record in CWF indicates Medicare is primary

Examples: RTP Reason Codes for Conditional Claims

- RTP reason codes you may encounter on your conditional claims (not all-inclusive)
  - 31102
  - 31300, 31301, 31350, 31361 and 31409
  - 3SP25
  - 7MSPE, 7MSPG, 7MSPL and 7MSPR
  - 75003 and 75004
  - **Fact:** There is not a list of FISS reason codes used to RTP conditional claims

Correct/Resolve RTP Conditional Claims

- To correct/resolve RTP conditional claims
  - Using FISS DDE
    - Add/correct MSP coding
    - Add/correct CAGCs/CARCs/amounts
    - Correct conflicting coding
    - **Resolve any conflicts between claim and MSP record in CWF**
    - Store/return claim (PF9)
  - Using appropriate claim submission option
    - Resubmit new/correct conditional claim with no errors and/or conflicts

Resolve Conflicts Between MSP Claim and MSP Record

- Prior to returning or resubmitting claim
  - Review claim you submitted
  - Review MSP record in CWF (HETS, NGSConnex or IVR)
  - Review completed MSP questionnaire
  - Determine if you identified/billed correct primary payer (is Medicare truly secondary per MSP provisions?)
  - Determine type of claim you need to submit
  - Contact BCRC if necessary; refer to MSP Resources handout
  - Wait for BCRC to complete MSP record addition/correction

Tips to Correct/Resolve RTP Conditional Claims in FISS DDE

- Correct all errors at one time if possible
- Review all reason codes in their entirety
- Ensure you understand errors, conflicts and actions
  - Contact PCC and/or use available resources if necessary
  - Review primary payer's RA (CAGCs/CARCs/amounts)
- Remember to hit PF9 key

Prepare Conditional Claims – Yes You Can Prepare Accurate Conditional Claims

Prepare and Submit Conditional Claims – Five Steps

- Determine if you can submit conditional claim
- Prepare conditional claim
- Check for MSP record in CWF
- Wait for BCRC to set up MSP record in CWF
- Once MSP record is set up, submit conditional claim

Determine if You Can Submit Conditional Claim

- You billed primary GHP and/or non-GHP and
  - Received response
    - RA (835), EOB statement, letter, other documentation
      - Payment is zero
      - Reason(s) provided (if not, contact them)
      - Reason(s) valid (if not, conduct research; perhaps you billed incorrect payer or claim should be billed as Medicare primary)
  - Did not receive response (non-GHPs only)
    - Promptly period expired
    - You withdrew liability claim/lien, if applicable

Prepare Conditional Claim

- Follow Medicare's usual requirements
  - Technical, medical and billing
    - HHAs submit NOAs and hospices submit NOEs with Medicare as primary; report MSP information on claim(s)
- Complete claim in usual manner; report
  - Covered TOB, covered/noncovered days/charges as usual and usual claim coding
  - Primary payer as first payer and Medicare as second or third payer

Prepare Conditional Claim

- Report
  - MSP billing codes (Table) for conditional claims
    - Prepare and Submit an MSP Conditional Claim
  - CAS information (CAGCs/CARCs) and amounts
    - From primary payer's RA (835) in appropriate
      - Loops/segments (837I claims)
      - Fields on page 3/MAP1719 (FISS DDE claims)
      - Note: For hardcopy claims, attach primary payer's EOB statement

Two Payers Are Primary to Medicare

- Bill both payers in proper order
  - Once you receive response and/or wait promptly period (accidents only) from both payers, submit claim as
    - **Medicare tertiary** if both paid with primary first, secondary next, Medicare third
    - **MSP** if one paid and other did not (valid reason or promptly) with paying payer first, Medicare second (omit non-paying payer)
    - **Conditional** if neither paid (valid reason or promptly) with primary payer first, Medicare second (omit secondary payer)
      - One MSP VC with zero payment and payer 1 information (MAP1719)
        - » Do not submit conditional claims with two non-paying primary payers

General Claim Coding Errors

- Claim may RTP if you
  - Do not report coding that is usually required for submitted services
    - Various reason codes apply
      - Examples: CPT/HCPCS codes, revenue codes, number of units, provider information, patient information, etc.
  - Report Medicare as first payer (payer code ID = Z) and primary payer's (insurer's) name as second payer
    - Reason code 31300

MSP Billing Code Table (Conditional Claims)

Claim Codes	UB-04/CMS-1450 FLs	837I Fields	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 ($0)	39–41	2300.HI (BE)	Page 01
Primary Payer Code (Payer Code ID) **is always = C**	N/A	N/A	Page 03
Primary Insurer Name	50A	2320.SBR04	Page 03

MSP Billing Code Table (Conditional Claims)

Claim Codes	UB-04/CMS-1450 Claim FLs	837I Fields	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 & Explanation Code	FL 80 (Remarks)	2300.NTE (Remarks)	Page 06 (Address), Page 04 (Code)

Report Applicable MSP Condition Codes (CCs or COND Codes)

- Report CC
  - 02 if condition is employment-related
  - 06 if ESRD beneficiary is in first 30 months of entitlement with EGHP
- Do not report CC
  - 77 = Full payment received from primary payer

Condition Code Errors

- Claim may RTP if you report CC
  - 02 with
    - No other conditional claim coding
    - Incorrect MSP VC (should be MSP VC 15 or 41)
    - Incorrect OC and date (should be OC 04 and DOA)
  - 06 with
    - No other conditional claim coding
    - Incorrect MSP VC (should be MSP VC 13)
    - No OC 33 and date

Report Applicable MSP Occurrence Codes and Dates (OCs or OCC CDS/DATE)

- Report
  - 01 and DOA if med-pay 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
  - 24 and date you learned primary payer would not pay (date of their EOB statement, RA, etc.)
    - Always report OC 24 unless you reporting Remarks **DA**

Occurrence Code Errors

- Claim may RTP if you report OC
  - 01, 02, 03 or 04 with
    - No other conditional coding
    - Incorrect MSP VC
      - OCs 01 and 02 require MSP VC 14
      - OC 03 requires MSP VC 47
      - OC 04 requires MSP VC 15 or 41
    - No DOA or a DOA that does not match MSP record in CWF
    - No matching MSP record in CWF

Occurrence Code Errors

- 33 and date with
  - No other conditional coding
  - Incorrect MSP VC
    - OC 33 requires MSP VC 13
- OC 24 and date with
  - No other conditional coding
  - No MSP VC or MSP VC without $0 amount
- No OC 24 and date
  - But claim coded otherwise as conditional

Report Applicable MSP Value Code and Amount of Zero

- MSP VC options include
  - 12, 13, 14, 15, 16, 41, 43 and 47
- Report with amount you received from primary payer for Medicare-covered services on claim
  - For conditional claims, amount is always = $0

MSP Value Code Errors

- Claim may RTP if you report
  - MSP VC with zero payment but no other conditional coding
    - MSP VC 13 without CC 06 and OC 33 and date
    - MSP VC 14 without OC 01 or 02 and DOA
    - MSP VC 47 without OC 03 and DOA
    - MSP VC 15 without CC 02 and OC 04 and DOA
  - MSP VC with no amount or incorrect amount
  - MSP VC with zero payment but claim/record indicates Medicare is primary

MSP Value Code Errors

- Incorrect MSP VC
  - MSP VC 12 but beneficiary is under age 65
  - MSP VC 43 but beneficiary is age 65 or over
  - Accident MSP VC when GHP is primary payer or vice versa
- MSP VC 12 or 43 but no current employment status
  - Claim may have CC 09, 10, 11, 28 or 29
  - Claim may have OC 18 and/or 19 and retirement date(s)
- MSP VC 13 but MSP ESRD coordination period ended
- VC 44 (should not be present)

Report Applicable Primary Payer Codes (Payer Code ID) in FISS DDE Only

- Report code for up to first three payers (in FISS DDE)
  - Payers labeled A, B and C
    - For conditional claims, report
      - For Payer A = C regardless of MSP Provision/MSP VC
      - For Payer B = Z

Primary Payer Code Errors

- Claim may RTP if you report
  - Incorrect primary payer code (should always be a C)
  - Invalid primary payer code
  - Primary payer code C on Payer B line instead of Payer A line
  - Primary payer code Z (Medicare) on Payer A line instead of on Payer B line

Report Primary Insurer Name

- Report complete/full name of primary insurer
  - Name must match MSP record
    - For conditional claims, report
      - Medicare in 50B or equivalent field

Primary Insurer Name Errors

- Claim may RTP if you report insurer name that
  - Does not match MSP VC reported
    - Example: Allstate with MSP VC 12 (not 14 or 47)
  - Is "blank" but Medicare is reported as secondary payer
  - Is invalid, vague or unacceptable
    - 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
    - Contains special characters
- Does not match insurer name on MSP record

Report 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

Patient Relationship Code Errors

- Claim may RTP if you report
  - Patient relationship code that
    - Is invalid
      - Not reportable option
    - Is incorrect
      - Example: Patient relationship of 18 for self instead of 01 for spouse if insurance is through spouse
    - Does not match beneficiary's relationship to insured on MSP record in CWF

Remarks: Reason Primary Payer Did Not Pay or Did Not Pay Promptly & Insurance Address

- Report two-digit code explaining reason primary payer did not pay or did not pay promptly
  - In Remarks (on first line)
    - Code options limited to ten
      - Codes were created by NGS: **NB, PC, CD, FG, BE, PE, DA, DP, LD and PP**
        - » Some require more information (e.g., a date in MM/DD/YY format) which is placed one space over from code
- Report primary payer's address(s)
  - In Remarks (on second line) for hardcopy and 837I claims
  - In claim page 06 for FISS DDE claim entry

Remarks: Codes NB, PC, CD and FG

- Primary payer did not pay because
  - Services are not covered benefit (VC 12, 13, 14, 15, 41 or 43) = NB
  - Preexisting condition (VC 12, 13 or 43) = PC
  - Deductible, co-pay or coinsurance (VC 12, 13, 14 or 43) = CD
  - Their guidelines were not followed (VCs 12, 13, 15 or 43) = FG
    - Add one of following reasons
      - **Claim was filed untimely** (Note: we pay if filed timely with us)
      - **Provider is out of plan's network** (Note: we pay once only)
      - **Prior authorization was not obtained** (Note: we do not pay)

Remarks: Code BE

- Primary payer did not pay because
  - Benefits exhausted = **BE**
    - If GHP (VC 12, 13 or 43)
      - Determine exact date benefits exhausted
      - Add exhaust date (MM/DD/YY)
    - If non-GHP (not auto no-fault) (VC 14, 15, 41)
      - Ensure no other primary payer exists
      - Determine exact date benefits exhausted; notify BCRC
        - » Add exhaust date (MM/DD/YY) if DOS < exhaust date
        - » Note: Submit primary claim if DOS > exhaust date

Remarks: Code PE

- Primary auto no-fault did not pay because
  - PIP benefits (VC 14) exhausted = **PE**
    - Auto no-fault: Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania, Utah, Puerto Rico
  - Ensure no other primary payer exists
  - Determine exact date benefits exhausted; notify BCRC
  - Add exhaust date (MM/DD/YY) if DOS < exhaust date
    - Note: Submit primary claim if DOS > exhaust date

Remarks: Codes DP, LD and PP

- Primary liability plan (VC 47) did not pay and you chose to submit conditional claim
  - Liability insurer's response stated
    - There will be delay in their payment = DP
    - They are not responsible for claim = LD
    - They paid beneficiary and you had not already been expecting this payment from beneficiary = PP

Remarks: Code DA

- Primary non-GHP (VCs 14, 15, 41 and 47) did not pay promptly and you chose to submit conditional claim because
  - 120 days has passed (promptly period expired) = <u>DA</u>
    - Add date you billed primary payer (MM/DD/YY)
      - Reminders
        - » Do not also report OC 24 and date on claim
        - » If primary payer is liability (VC 47), you must withdraw liability claim/lien

Remarks Errors

- Claim may RTP if you report
  - No two-digit explanation code at all
  - Code FG but did not report reason
  - Incorrect code (does not exist or has other characters)
  - Correct code but no date or incorrect date format; should be MM/DD/YY
  - Correct code but one that may not be used with MSP VC
  - Code DA and date but did not wait promptly period

Report Primary Payer Adjustment Reasons and Amounts (CAS Information)

- Report CAGC/CARC pairs and amounts from primary payer's RA
  - CAGCs = General category of payment adjustment
    - CO = Contractual Obligations, OA = Other Adjustments
    - PI = Payer-initiated Reductions, PR = Patient Responsibility
  - CARCs = Why primary payer paid differently than billed
    - Suggest CARC 192 when reporting DA and date primary payer was billed in Remarks (non standard adjustment code from RA)
- References: X12, CR6426 and CR8486

MAP1719 (Additional Page 03)

- To access from MAP1713, press F11/PF11
- Enter MSP CAS information (primary payer's RA)
  - Two pages for up to two payers
    - Enter data for primary payer 1, press F6/PF6, enter data for primary payer 2 if applicable (up to 20 entries on each page)
      - **Paid date:** Paid date
      - **Paid amount:** Dollar amount received from primary payer ($0)
        - » Must = MSP VC amount and := "charges – CAGC/CARC amounts"
      - **GRP:** CAGC(s) and **CARC:** CARC(s)
      - **AMT:** Dollar amount with each CAGC/CARC pair

MAP1719 (Additional Page 03)

```
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 1   MSP PAYMENT INFORMATION

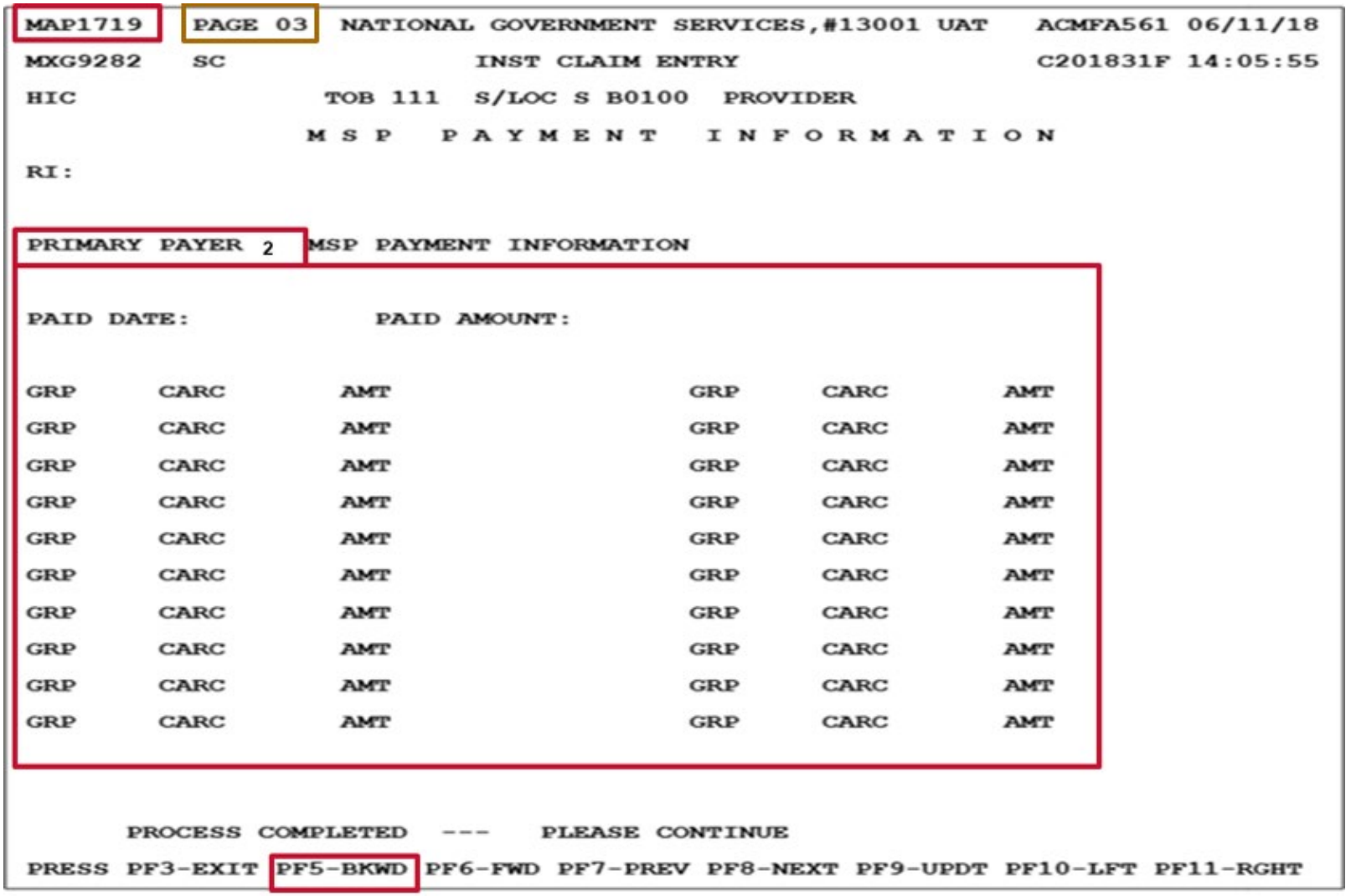
PAID DATE:              PAID AMOUNT:

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

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

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

MAP1719 (Additional Page 03)



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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

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

Check for MSP Record in CWF

- MSP record in CWF and claim must match
  - Check for matching MSP record in CWF
    - Use provider self-service tools listed under Step 2 in
      - – Identify Proper Order of Payers for Beneficiary's Services
  - If there is matching MSP record in CWF, go to Step Five
  - If there is not, contact BCRC and request they set one up
    - Follow instructions in Set Up Beneficiary's MSP Record
      - – If you submit claim for which there is no MSP record, we suspend it for up to 100 days while we contact BCRC to request they set one up

RTP Reason Codes Related to MSP Record in CWF

- If you submit claim before matching MSP record is in CWF
  - We suspend claim for review, send information to BCRC and
    - RTP incoming claim (reason code 75003); BCRC investigates
    - RTP additional claims (reason code 75004); BCRC action pending
    - RTP claims (reason code 7A000) if BCRC will not add/update record
- If you receive reason code 75003 or 75004
  - Contact BCRC with information they need
  - Resubmit claim (PF9 in FISS DDE) when MSP record is in CWF

Wait for BCRC to Set Up MSP Record

- After you contact BCRC
  - Continue to check for MSP record to appear in CWF
    - Use provider self-service tools listed under Step 2 in
      - Identify Proper Order of Payers for Beneficiary's Services
- If MSP record appears in CWF
  - Go to Step Five (Submit conditional claim)
- If MSP record does not appear in CWF
  - Follow up with BCRC

Once MSP Record is Set Up, Submit Conditional Claim

- Submit claim using available options
  - UB-04/CMS-1450 claim (hardcopy)
    - You must have approved ASCA waiver on file
      - Visit our website > Resources > Forms > ASCA Waiver Request Form
    - Mail to Claims Dept. with primary payer's RA, EOB statement
      - Visit our website > Resources > Contact Us > Addresses > Claims
  - 837I claim
  - FISS DDE claim entry
- Maintain documentation

What You Should Do Now

- Review MSP Resources Handout and CR7355
  - CR7355 "Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer Claims"
- Share information with staff
- Continue to learn more about MSP
- Develop and implement policies that ensure you meet your MSP responsibilities and correct RTP claims

Thank You!

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

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