MSP: Preparing/Submitting MSP Claims When Primary Payer Makes Payment

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Today's Presenters

- Christine Janiszcak
  - Provider Outreach and Education Consultant
- Jan Wood
  - Provider Outreach and Education Consultant

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Objective

- Increase providers' understanding of how to prepare and submit compliant MSP claims after receiving payment from primary payer
  - You are less likely to receive returned claims if you know how to prepare and submit compliant MSP claims

Agenda

- MSP and your MSP responsibilities
- Preparing MSP claims
- Submitting MSP claims
- Submitting MSP claims using FISS DDE
- MSP resources – refer to handout
- Questions and answers

MSP and Your MSP Responsibilities

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 and Medicare is primary unless criteria/conditions of another MSP provision are met

Providers' MSP Responsibilities

- Determine proper order of payers for beneficiary
  - Identify payers by conducting MSP screening process
    - Must check for MSP record(s) in CWF using CMS' HETS (X12 270 transmission and 271 response), NGSConnex or our IVR system for every service
    - May need to collect MSP information by asking MSP questions, using CMS' model MSP questionnaire or compliant form, for every IP admission or OP encounter unless exception applies
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Sections 20.1 and 20.2.1
- Submit claims to primary payer(s) before Medicare
- Submit MSP claims or conditional claims as appropriate

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

Proper Order of Payers

- Providers must determine which plan is primary, secondary, tertiary, etc., payer
  - Compare any MSP information in CWF to collected MSP information and use your knowledge of MSP Provisions
    - Document your decision
      - In general, Medicare is primary when
        - » Beneficiary has no other coverage
        - » Beneficiary has other coverage but it doesn't meet MSP provision criteria
        - » Beneficiary has other coverage, it meets MSP provision criteria but it is not available
      - In general, other payer(s) is primary when
        - » Beneficiary has other coverage that meets MSP provision criteria and it is available

Submit Claims According to Determination You Make and Code Them Accurately

- If you determine Medicare is primary
  - Submit Medicare primary claim with explanatory billing codes
- If you determine another payer is primary
  - Submit claim to
    - Primary payer first; follow up as Medicare's one year timely filing rule applies
    - Medicare second with correct billing codes
  - Do not bill a primary payer and Medicare simultaneously
- If you determine more than one payer is primary
  - Submit claim to
    - Primary payer first, secondary payer next, etc.; follow up
    - Medicare as tertiary, etc. with correct billing codes
  - Do not bill primary payer(s) and Medicare simultaneously

Preparing MSP Claims

Prepare and Submit MSP Claims – Steps

- Follow all steps:
  - Identify/bill appropriate primary payer for beneficiary's services
  - Upon receipt of primary payer's payment, apply it to account
  - Prepare MSP claim if necessary (partial or full payment)
  - Use correct MSP claim coding including CARC(s), RARC(s) and primary payer's adjustment amount(s) from their RA (835)
  - Ensure MSP claim information matches MSP record in CWF
    - Contact BCRC to set up or make changes to MSP record if necessary
      - Refer to MSP Resources handout for BCRC information and SE1416
    - Wait for updates to show in CWF before moving on to next step

Matching MSP Record in CWF

- A matching record means MSP record in CWF contains same information you will report on your claim
- If you submit an MSP claim for which there is no matching MSP record in CWF
  - Your claim will suspend for up to 100 days in Medicare's claim processing system while we contact BCRC to set up MSP record

Prepare and Submit MSP Claims – Steps

- Follow all steps (continued)
  - Review MSP claim to ensure required coding is present
  - Submit MSP claim using available options
  - Upon receipt of Medicare's payment, apply it to account
  - Apply any adjustments from Medicare's RA to account
  - Bill beneficiary only when appropriate
    - May bill beneficiary for services not covered by Medicare, Medicare deductible, coinsurance and/or co-pay not satisfied by primary payer's payment
  - Maintain documentation

MSP Claim Types – Partial-Pay Claim

- MSP partial-payment claim; primary payer paid in part
  - Primary payer applied deductible, coinsurance, co-payment, etc.
  - Submit for all types of services
    - Submit all Medicare covered charges; not just balance
  - Medicare considers this balance

MSP Claim Types – Full-Pay Claim

- MSP full-pay claim; primary payer paid in full
  - Submit if required but you may submit even if not required
    - Submit all Medicare covered charges
  - Required for
    - All IP stays
    - OP services if beneficiary has not met Medicare Part B deductible
    - All HH and Hospice services even if beneficiary has met Part B deductible
  - Medicare tracks benefit periods/services and credits Medicare deductibles

General Instructions for Medicare Claims

- For MSP claims, follow Medicare's requirements
  - Our requirements apply to all Medicare claims even MSP
    - Billing requirements including providers' frequency of billing
      - If Medicare is secondary, can we submit separate claims when primary payer starts or stops paying during claim's billing period? If Medicare were primary, we would submit one claim.
      - Answer: No, since we require one claim, submit one claim as MSP claim
    - Technical requirements including timely filing, etc.
    - Medical requirements

Home Health and Hospice Providers

- In 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(s)

Coding Your MSP Claims

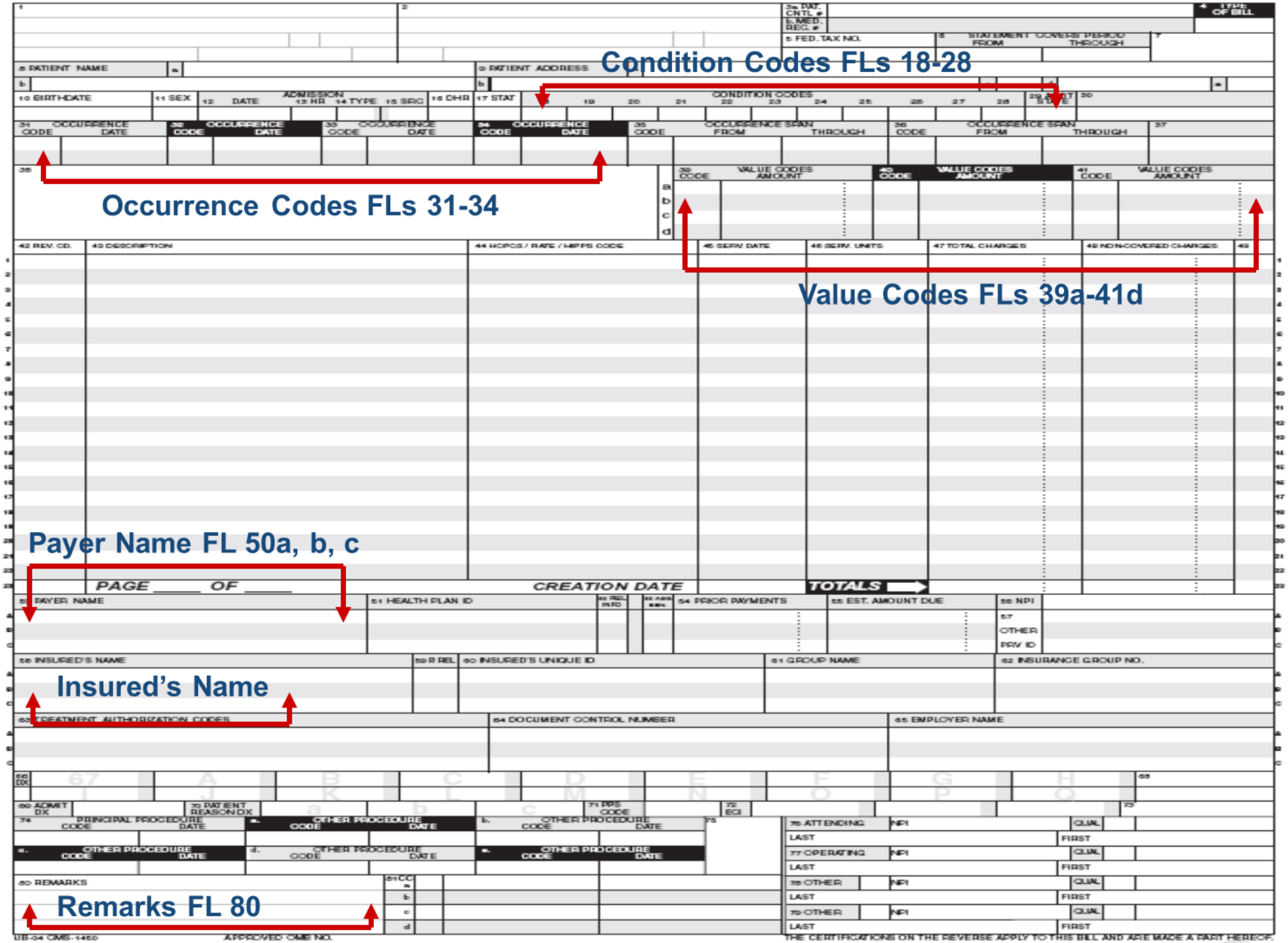
- Complete claims in usual manner; report
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered days as usual
  - Covered/noncovered charges as usual
  - Primary payer as first payer
  - Medicare as second payer
  - Appropriate billing codes in applicable claim fields (FLs) to indicate claim is MSP

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


Condition Codes FLs 18-28
Occurrence Codes FLs 31-34
Value Codes FLs 39a-41d
Payer Name FL 50a, b, c
Insured's Name
Remarks FL 80
PAGE _____ OF _____
CREATION DATE
TOTALS
UB-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC

MSP Claim Coding Options: Condition Codes (CCs or COND CODES)

- Two-digit code
  - Describes condition or event applicable to claim
- Report
  - Any applicable CC
  - MSP-related CCs as applicable
    - 02 (zero two) = Condition is employment-related
    - 06 (zero six) = ESRD beneficiary in first 30 months of entitlement covered by EGHP
    - 77 = Full payment received from primary payer

Contractual Arrangement or Obligation Under Law

- Report one of following codes when you are obligated/required to accept a certain amount as payment in full from a primary payer, per a contractual arrangement or obligation under law
  - CC 77 or
  - VC 44 and the expected amount

Condition Code 77

- Must report CC 77 when
  - Contractual arrangement (or obligation under law) with primary payer and
  - You received expected amount
- May report (not required to) CC 77 when
  - No contractual arrangement (or obligation under law) with primary payer but
  - You received full payment

Condition Code 77 Example

- 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

MSP Claim Coding Options: Occurrence Codes and Dates (OCs or OCC CDS/DATE)

- Two-digit code with date
  - Describes event applicable to claim
- Report:
  - Any applicable OC and date
  - MSP-related OCs and dates as applicable:
    - 01 (zero one) and DOA if medical-payment plan is primary
    - 02 (zero two) and DOA if no-fault is primary
    - 03 (zero three) and DOA if liability is primary
    - 04 (zero four) and DOA if WC is primary
    - 33 and date ESRD coordination period began

MSP Claim Coding Options: Value Codes and Amounts (VCs)

- Two-digit code with dollar amount
- Report
  - Any applicable VC and dollar amount
  - MSP VC for MSP provision and amount
    - MSP VC options: 12, 13, 14, 15, 16, 41, 43 and 47
    - Amount = amount you received from primary payer toward Medicare-covered services on claim
  - VC 44 and OTAF amount when applicable

Primary Payer's Payment Reduced Due to Failure to File a Proper Claim

- If primary payer reduced their payment on a claim because of failure to file a proper claim
  - You may submit an MSP claim but
    - Primary payer's payment amount must reflect amount you would have received had claim been properly filed with primary payer
      - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5

Value Code 44 and Amount

- Report VC 44 and OTAF amount
  - When primary payer's payment is less than amount you were expecting
    - OTAF amount = amount you agreed to accept from primary payer as full payment
- Do not report VC 44 and OTAF amount
  - When primary payer's payment is equal to or greater than Medicare-covered charges
    - Even if it is less than amount you were expecting

VC 44 Example #1

- 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

VC 44 Example #2

- Scenario (contractual arrangement)
  - Medicare covered charges = $100
  - Expected from primary payer (OTAF) = $75
  - Received from primary payer = $50
  - Primary payer applied co-payment = $25
- Report
  - MSP VC ___ with $50 and
  - VC 44 with $75

VC 44 Example #3

- Scenario (contractual arrangement)
  - Medicare covered charges = $2,000
  - Expected from primary payer (OTAF) = $1,000
  - Received from primary payer = $500
  - Primary payer's maximum reached
- Report
  - MSP VC ___ with $500 and
  - VC 44 with $1,000

Did You Know

- By reporting a VC 44 and OTAF amount when appropriate, you are asking Medicare to consider the difference between the amount you received from the primary payer and the amount you were expecting to receive from them
  - Do not bill the beneficiary for this amount, regardless of whether or not Medicare makes a secondary payment

MSP Claim Coding Options: 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

Submitting MSP Claims

MSP Claim Submission 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

MSP Claim Submission via 837I Claim

- Submitting MSP claims via 837I claim ensures
  - Medicare's compliance with HIPAA requirements
  - MSP claims are calculated using payment information from 837I
- 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 on 835 ERA or paper remittance
  - CAGC paired with CARC (explains primary payer's adjustments)

MSP Claim Submission 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

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)

Submitting MSP Claims in FISS DDE

What is FISS DDE?

- Processing system we use to process claims and maintain records
- Process that allows remote user connectivity to Medicare mainframe
  - Providers access through FISS DDE online computer system
- Providers use FISS DDE to
  - Research coding
  - Submit claims and track submitted claims
  - Correct, adjust, and cancel claims
  - View reports

Accessing FISS DDE

- FISS logon ID and password required
- Visit our website for EDI enrollment information (under Claims and Appeals)
  - Left side listing articles should be on EDI Enrollment article
  - Click on Start Enrollment Process under Step 1
  - Read and then click on “Accept” for the Attestation
  - Check box for “I need to complete a Part A Logon Request Form,” submit when completed
- User logon ID and password are for individual use only
  - Do not share with coworkers or other staff

Navigating FISS DDE

Program function key	Screen movement
F3/PF3	Return to menu/submenu or originating screen when using SC field
F4/PF4	Exit entire online system by terminating session
F5/PF5	Scroll backward within page of screen data
F6/PF6	Scroll forward within page of screen data
F7/PF7	Move backward one page at a time
F8/PF8	Move forward one page at a time
F9/PF9	Save, update, submit

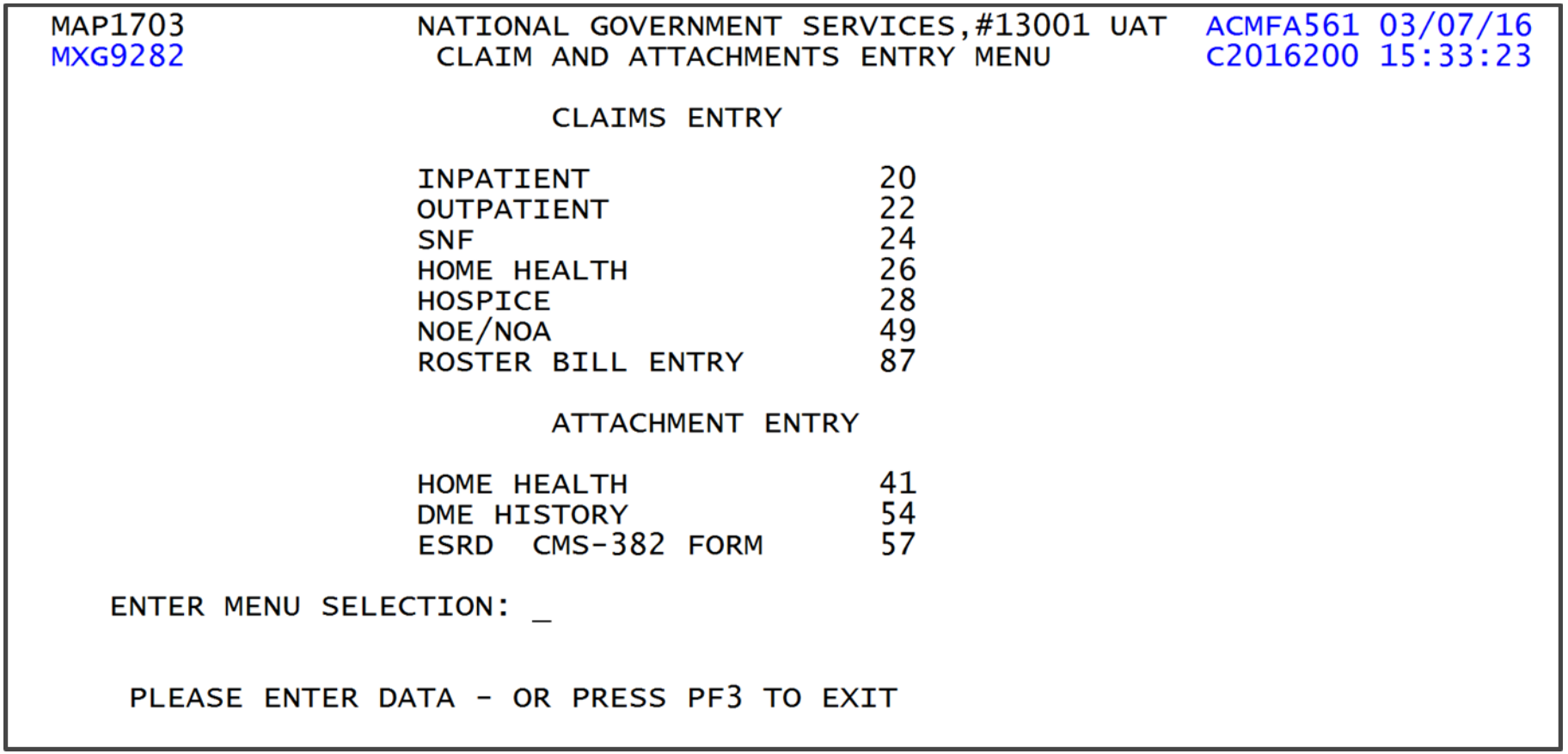
Navigating FISS DDE

Program function key	Screen movement
F10/PF10	Return to left viewing screen
F11/PF11	Move to right viewing screen
<Ctrl>	Move down one line at a time
<Home>	Move to SC field
<Tab>	Move to next field on screen
SC field	Navigate to specific inquiry file, use F3/PF3 to return to original page
Page field	Move to specific page within claim

Main Menu – Claims/Attachments

```
MAP1701                NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 08/11/15
MXG9282                          MAIN MENU                       C201531P 12:29:47

                          01    INQUIRIES

                          02    CLAIMS/ATTACHMENTS

                          03    CLAIMS CORRECTION

                          04    ONLINE REPORTS




    ENTER MENU SELECTION: 02

     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Claim Entry Menu

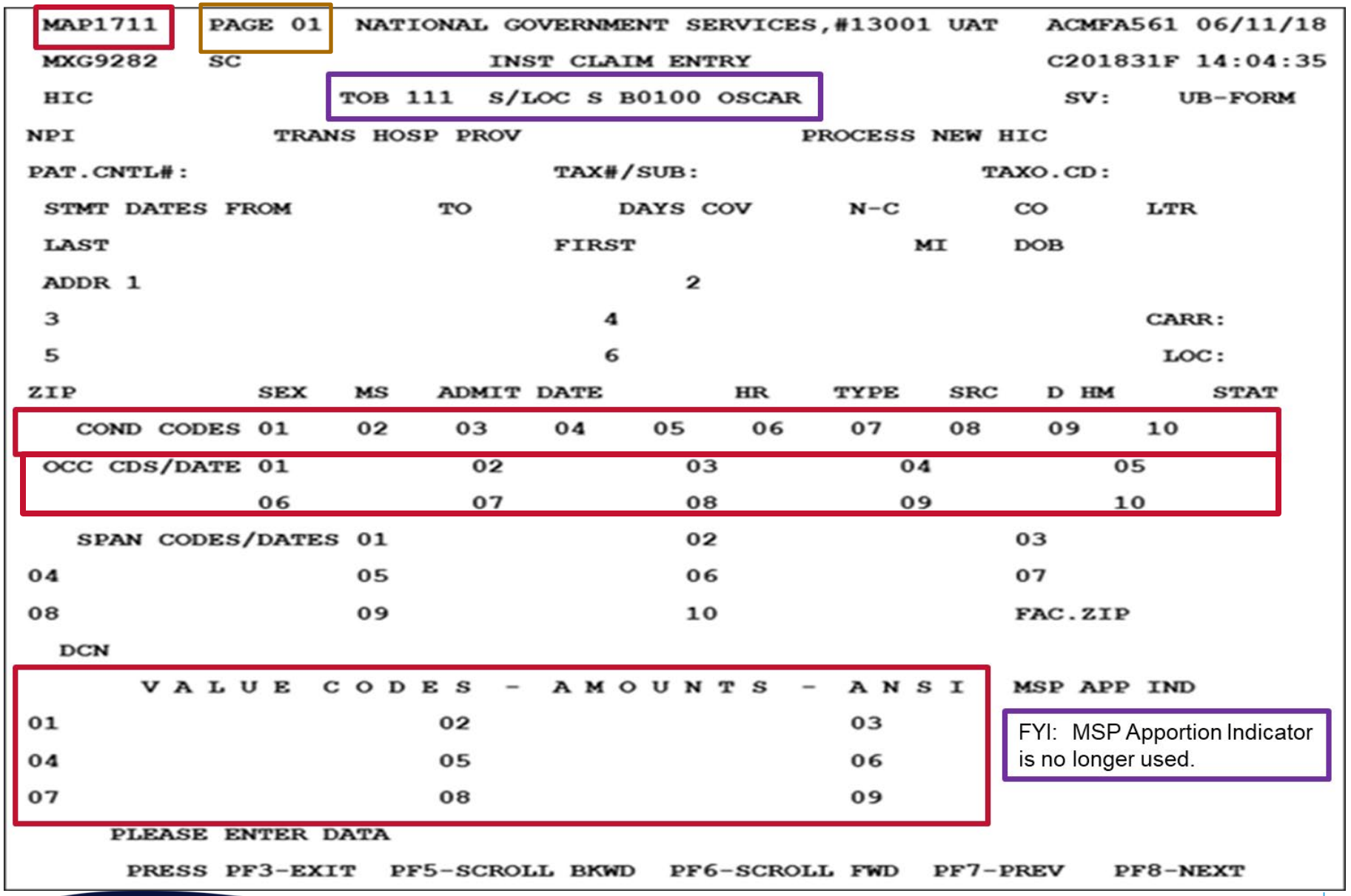


Claim Entry – Key Points

- Data entry screens set up similar to UB-04 claim form
- Six pages to a claim
- Depending on TOB
  - Cursor may skip fields not required
- TOB defaults to 111 for IP, 131 for OP and 211 for SNF
  - If entering a different TOB, type over default
- Do not press F3/PF3 key
  - If pressed while entering claim before it is stored (F9/PF9), all keyed information will be lost

Claim Entry – Six Pages

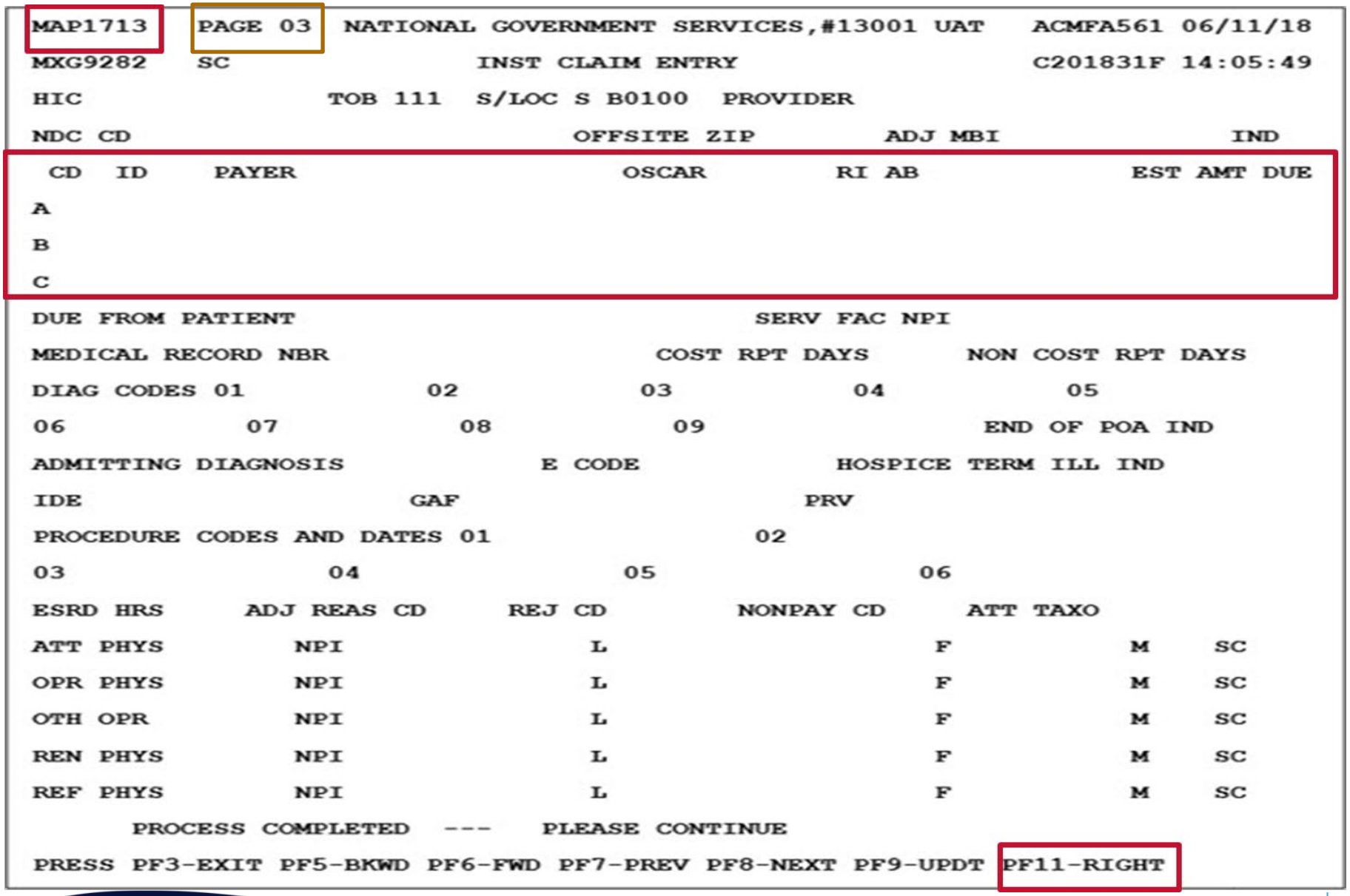
Pages for Claim Entry	MAP	Contains
Page 01	MAP1711	Corresponds to UB-04, FLs 1–41: Patient information, condition codes, occurrence codes, occurrence span codes and value codes
Page 02	MAP1712	Corresponds to UB-04, FLs 42–49: Revenue and CPT/HCPCS codes, charges and DOS
Page 03	MAP1713	Corresponds to 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



FYI: MSP Apportion Indicator is no longer used.

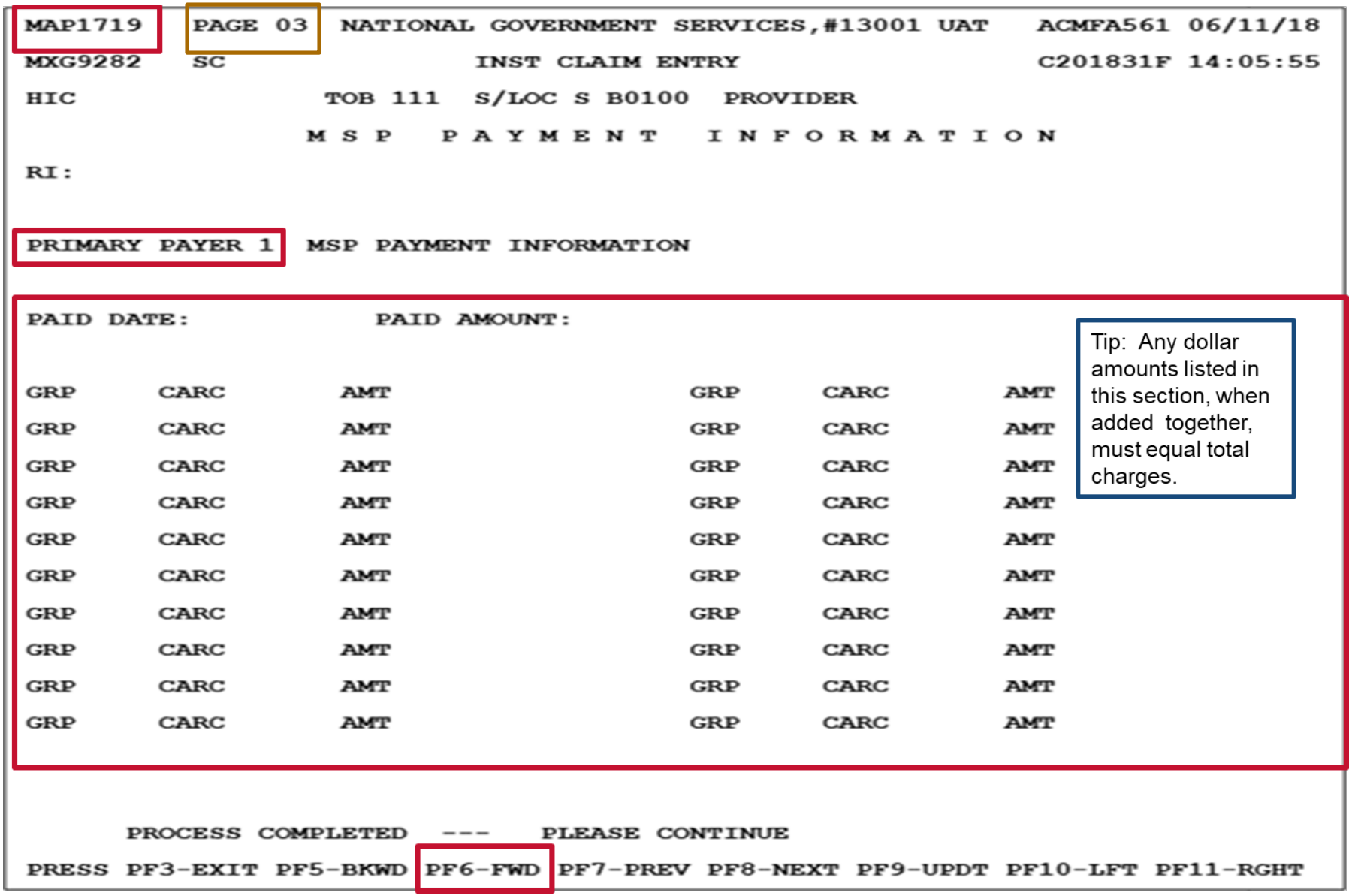
```
MAP1712    PAGE 02  NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 03/21/19
MXG9282    SC                  INST CLAIM ENTRY                A20192BF 12:44:48
                                                        REV CD PAGE 01
MID                  TOB 111   S/LOC S B0100   PROVIDER
UTN                     PROG         REP PAYEE     RRB EXCL IND     PROV VAL TYPE
                                     TOT     COV                                SERV    RED
CL   REV   HCPC MODIFS      RATE UNIT    UNIT   TOT CHARGE NCOV CHARGE   DATE    IND
```

```
       PROCESS COMPLETED   ---    PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

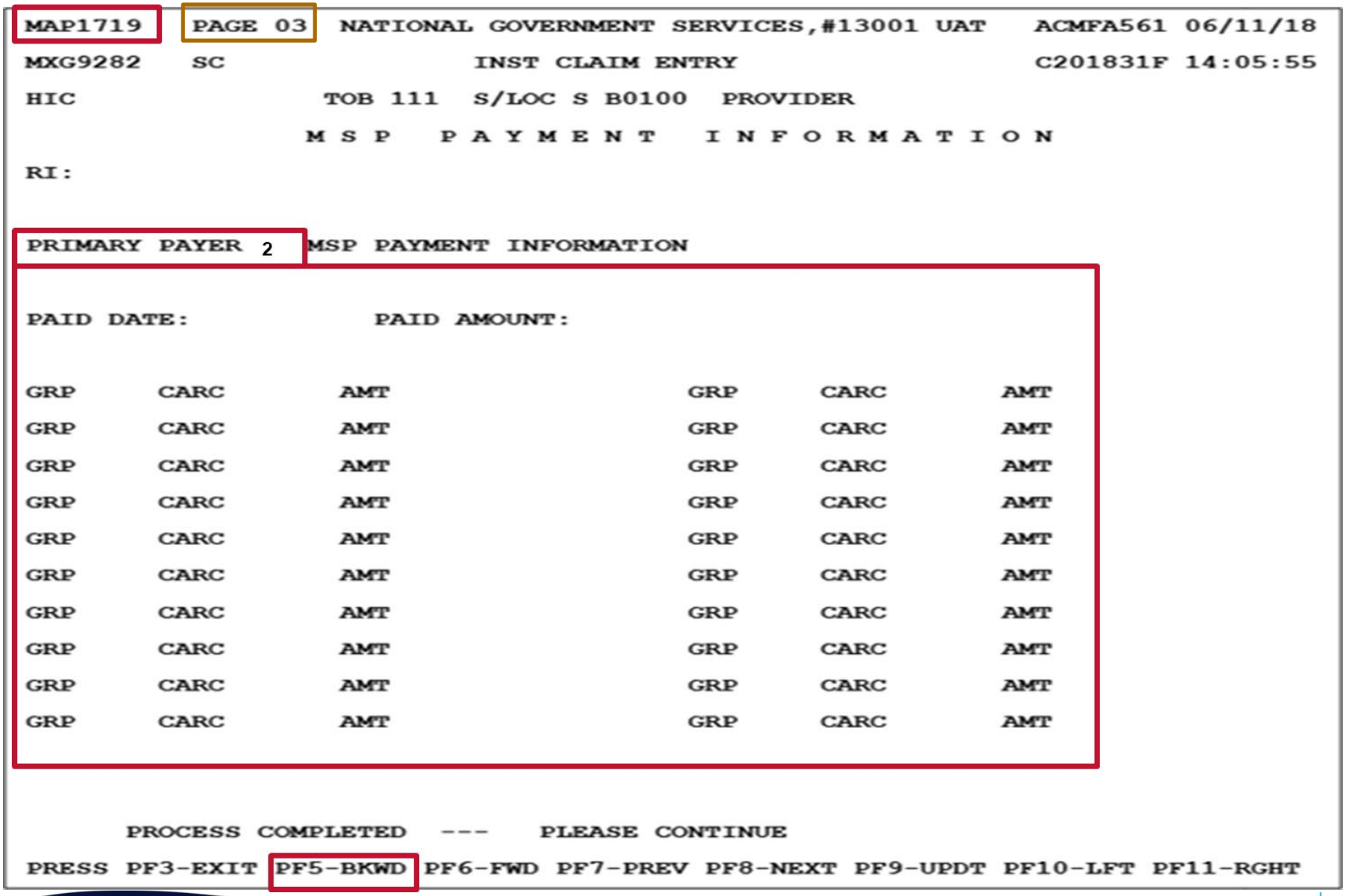

MAP1713 PAGE 03 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:05:49
HIC TOB 111 S/LOC S B0100 PROVIDER
NDC CD OFFSITE ZIP ADJ MBI IND
CD ID PAYER OSCAR RI AB EST AMT DUE
A
B
C
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT 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
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

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 1 and 2
  - 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 amounts with CAGCs and CARCs
    - GRP: Enter group code(s), also known as CAGC(s)
    - CARC: Enter CARC(s)
    - AMT: Enter dollar amount(s) associated with CAGC and CARC



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

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

Example #1 – Scenario

- Medicare beneficiary
  - Working aged with primary EGHP
  - IP hospital 03/1/21 to 03/25/21
  - 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 05/15/21

Example #1 – CAGC and CARC Claim Coding

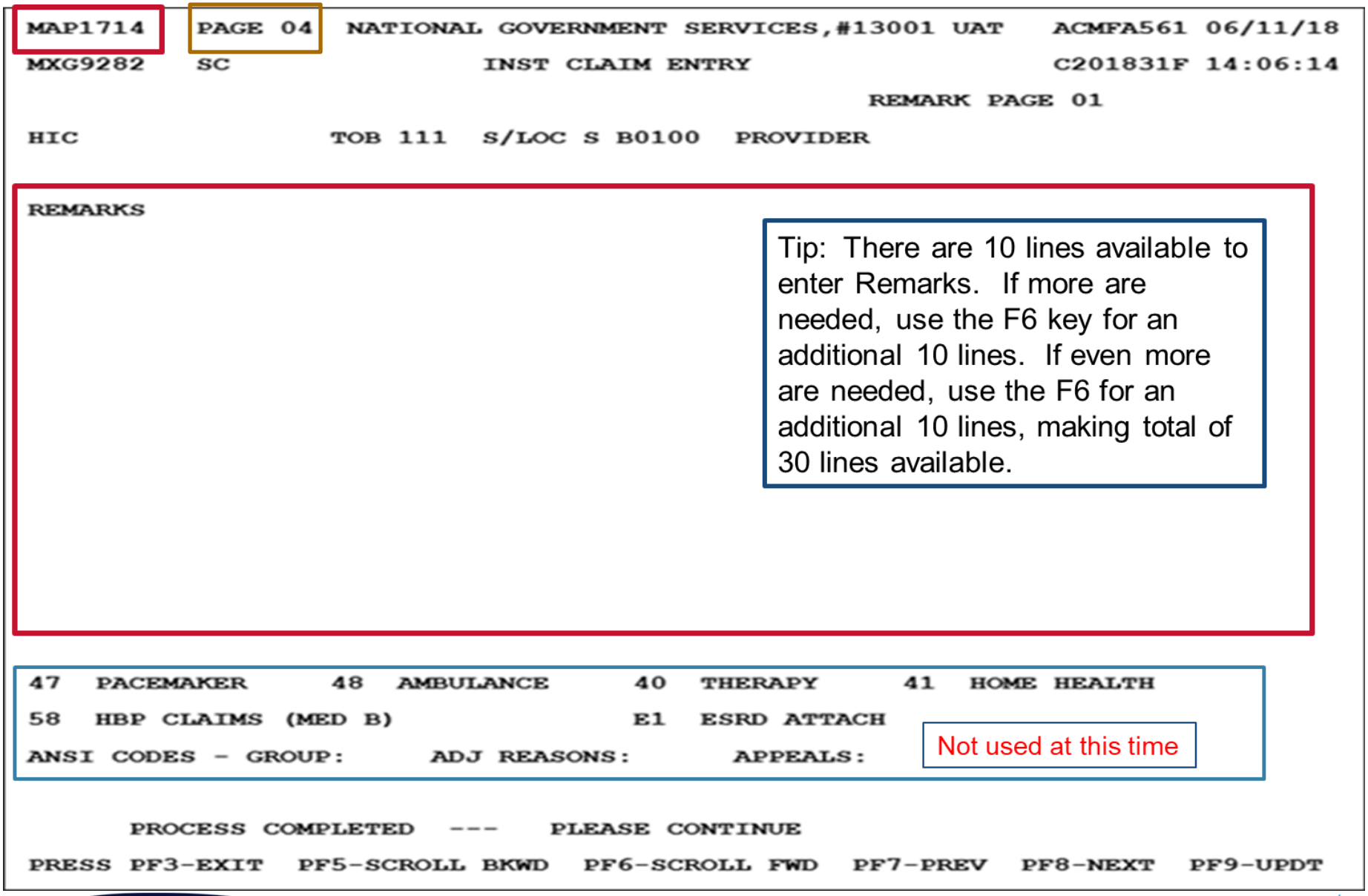
- Claim entry – page 01 (MAP1711)
  - MSP VC 12 = $7,200
  - VC 44 = $8,000
- Claim entry – page 03 (MAP1719)
  - Paid date = 051521
  - Paid amount = $7,200
  - CAGCs, CARCs and amounts =
    - CO, 45 = $2,000 and PR, 2 = $800

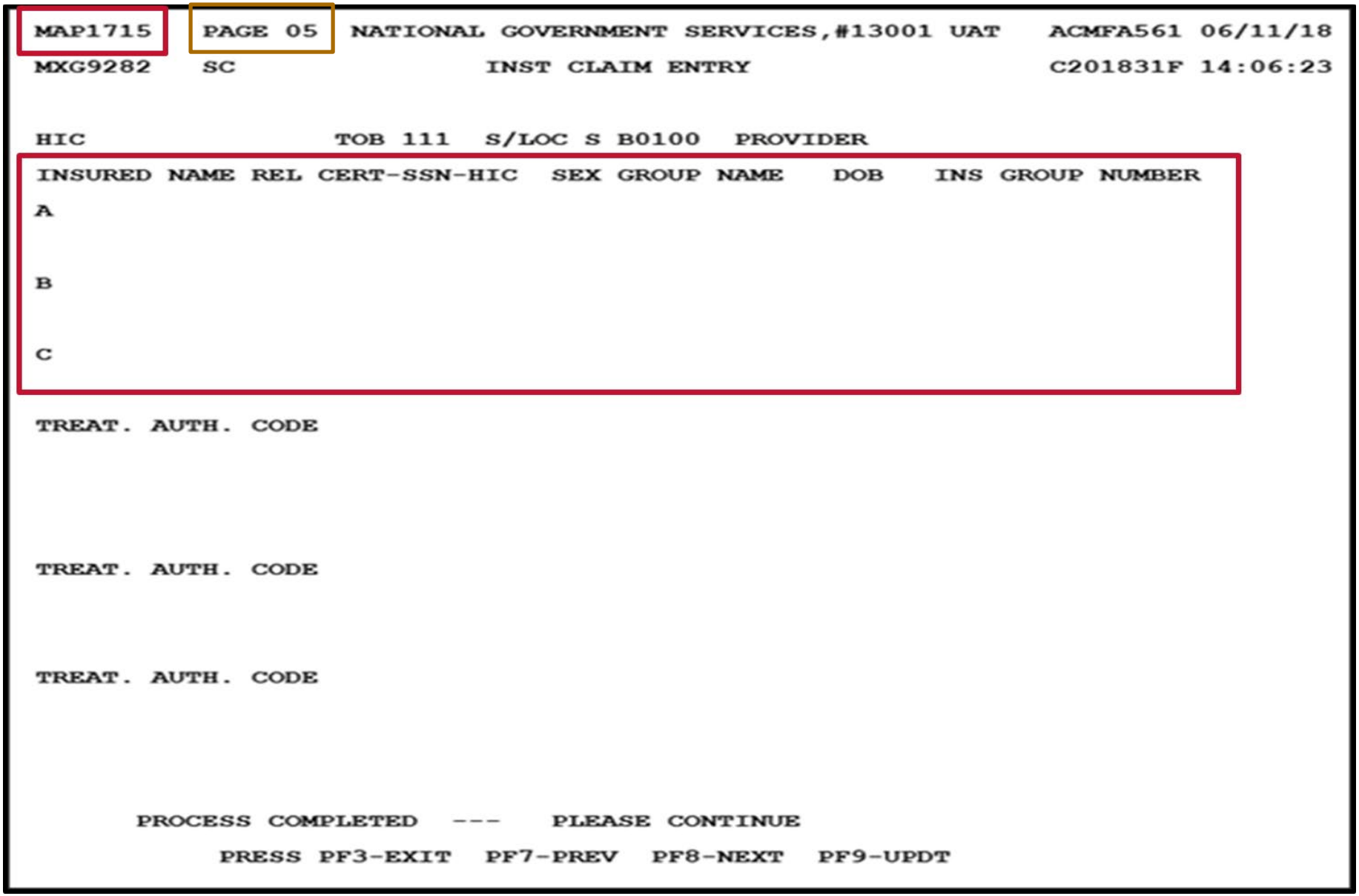
Example #2 – Scenario

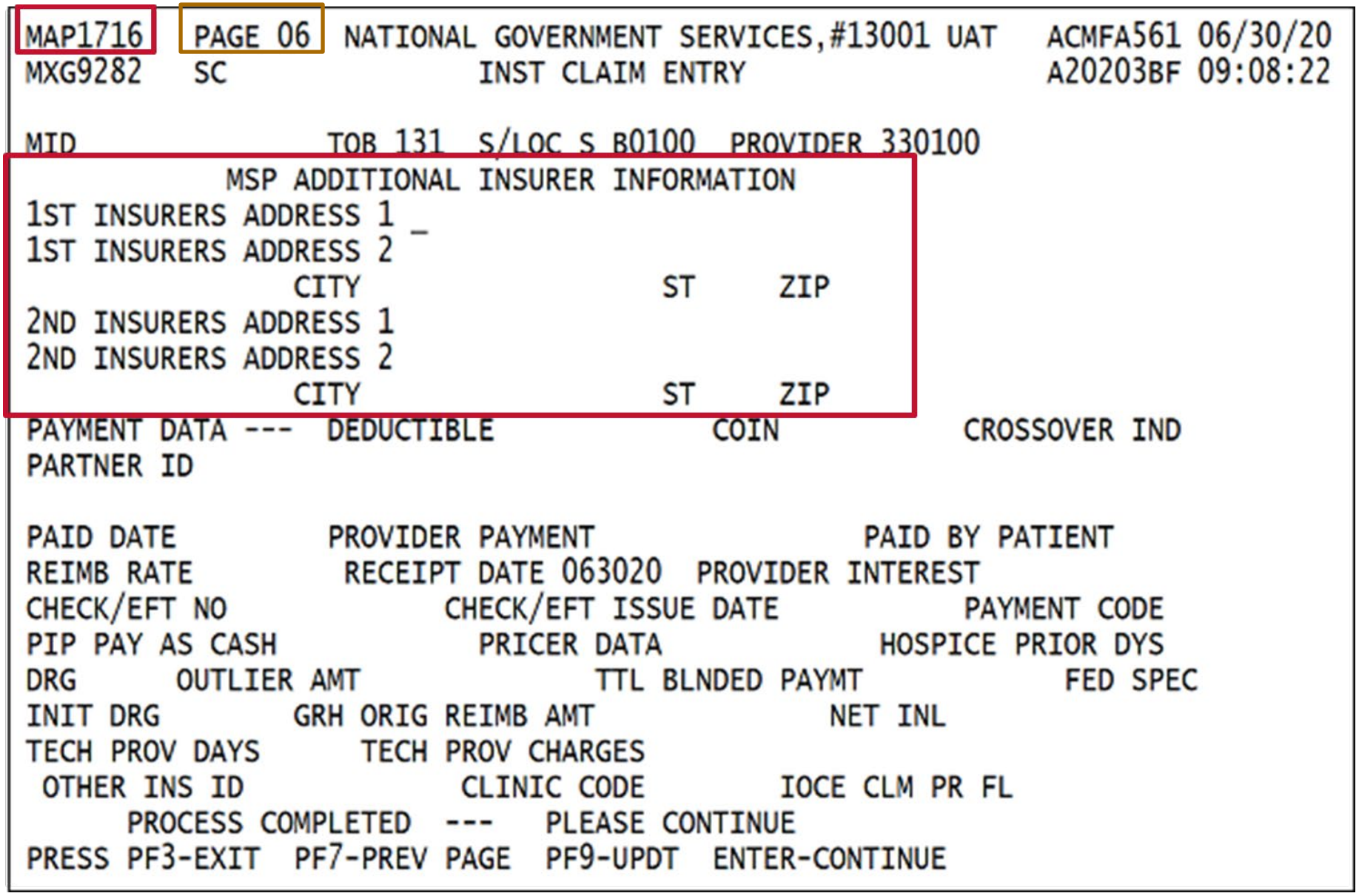
- Medicare beneficiary
  - Disabled with primary LGHP (Medicare primary 03/1/21; LGHP terminated)
  - IP hospital 01/15/21 to 04/07/21
  - Met Part A deductible in same benefit period
- Provider
  - Charges = $80,000 ($50,000 to 02/28/21 and $30,000 from 03/1/21 to 04/07/21)
  - Bills LGHP as primary; under contract with LGHP
- LGHP
  - Allowed = $40,000 per contract (to 02/28/21)
  - Applied patient deductible = $1,000 (to 02/28/21)
  - Paid = $39,000 on 05/10/21 (to 02/28/21); no payment for 03/01/21 to 04/07/21

Example #2 – CAGC and CARC Claim Coding

- Claim entry – page 01 (MAP1711)
  - MSP VC 43 = $39,000
  - VC 44 = $70,000
- Claim entry – page 03 (MAP1719)
  - Paid date = 051021
  - Paid amount = $39,000
  - CAGCs, CARCs and amounts =
    - CO, 45 = $10,000, PR, 1 = $1,000 and PR, 27 = $30,000


MAP1714 PAGE 04 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:06:14
REMARK PAGE 01
HIC TOB 111 S/LOC S B0100 PROVIDER
REMARKS
Tip: There are 10 lines available to enter Remarks. If more are needed, use the F6 key for an additional 10 lines. If even more are needed, use the F6 for an additional 10 lines, making total of 30 lines available.
47 PACEMAKER 48 AMBULANCE 40 THERAPY 41 HOME HEALTH
58 HBP CLAIMS (MED B) E1 ESRD ATTACH
ANSI CODES - GROUP: ADJ REASONS: APPEALS:
Not used at this time
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-UPDT


MAP1715 PAGE 05 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:06:23
HIC TOB 111 S/LOC S B0100 PROVIDER
INSURED NAME REL CERT-SSN-HIC SEX GROUP NAME DOB INS GROUP NUMBER
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


MAP1716 PAGE 06 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/30/20
MXG9282 SC INST CLAIM ENTRY A20203BF 09:08:22
MID TOB 131 S/LOC S B0100 PROVIDER 330100
MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
CITY ST ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
CITY ST ZIP
PAYMENT DATA --- DEDUCTIBLE COIN CROSSOVER IND
PARTNER ID
PAID DATE PROVIDER PAYMENT PAID BY PATIENT
REIMB RATE RECEIPT DATE 063020 PROVIDER INTEREST
CHECK/EFT NO CHECK/EFT ISSUE DATE PAYMENT CODE
PIP PAY AS CASH PRICER DATA HOSPICE PRIOR DYS
DRG OUTLIER AMT TTL BLNDED PAYMT FED SPEC
INIT DRG GRH ORIG REIMB AMT NET INL
TECH PROV DAYS TECH PROV CHARGES
OTHER INS ID CLINIC CODE IOCE CLM PR FL
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE

What You Should Do Now

- Review MSP Resources handout
- Share information with staff
- Continue to learn more about MSP
- Continue to attend educational sessions
- Develop and implement policies that ensure providers MSP responsibilities are met
- Submit MSP claims when required and code accurately

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

MSP Resources

See MSP Resources Handout in Control Panel

Thank You!

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

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