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MSP: Preparing and Submitting Conditional Claims When the Primary Payer Does Not Make Payment

7/6/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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

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

Objective

- Increase providers' understanding of how to prepare and submit compliant conditional claims after receiving no payment from primary payer

Agenda

- 2022 MSP webinar series and other events
- MSP and your MSP responsibilities
- Prepare and submit conditional claims
- Claim fields and MSP claim codes
- Enter and submit conditional claims in FISS DDE
- 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 HHHs 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 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; 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, other coverage is primary when beneficiary
    - Has coverage that meets MSP Provision criteria and it is available
  - 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

Submit Claims According to Your Determination

- If Medicare is primary, submit claim to
  - Medicare as primary
- If another payer is primary, submit claim to
  - Primary payer first; follow up often
  - Medicare as secondary, if required
- If more than one payer is primary, submit claim to
  - Primary payer first, secondary payer next, etc.; follow up often
  - Medicare as tertiary, if required

Code Medicare Claims Accurately

- If Medicare is primary
  - Report explanatory billing codes on primary claims
  - Contact BCRC before submitting claims, if necessary
    - No GHP, GHP terminated, or employer size not met
    - Services related to prior accident; benefits exhausted before DOS
    - Services related to prior accident, case settled, no future medicals
- If another payer is primary and Medicare is secondary
  - Report MSP billing codes on MSP or conditional claims

Medicare Claim Types

- If primary payer
  - Does not pay citing Medicare is primary, submit primary claim (verify Medicare is primary)
  - Pays in part, submit MSP claim
  - Pays in full, submit MSP claim if required
  - Does not pay for valid reason or does not pay promptly (120 days; accidents only), submit conditional claim

Conditional Claims

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 but VC 16 and to VA
        - » If such payers do not pay, submit primary claims
    - Did not pay promptly (generally means within 120 days)
      - Applies to accident MSP Provisions only (VCs 14, 15, 41 and 47)
- If we can make conditional payment
  - Payment and beneficiary responsibility are same as if we are primary

Promptly – Defined

- Promptly means
  - For no-fault and WC
    - Payment within 120 days after insurer receives claim
  - For liability (including self-insurance)
    - Payment within 120 days after earlier of
      - Date a 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 (or date of discharge for IP)

Conditional Billing When Primary Payer is a GHP (VCs 12, 13 or 43)

- To bill us conditionally
  - You must have response from GHP (valid reason)
    - Applicable in situations where beneficiary has
      - GHP only or
      - GHP and no-fault, WC or Liability coverage (due to an accident)

Conditional Billing When Primary Payer is a Non-GHP Except Liability (VCs 14, 15 or 41)

- To bill us conditionally within promptly period
  - You must have response from non-GHP (valid reason)
- To bill us conditionally after promptly period
  - You do not need to have response from non-GHP
    - Once promptly period expires, you have choice to
      - Maintain claim with non-GHP or
      - Bill us conditionally
        - » If beneficiary also has primary GHP, you must bill them before us

Conditional Billing When Primary Payer is Liability (VC 47)

- To bill us conditionally within promptly period
  - You must have response from liability (valid reason)
- To bill us conditionally after promptly period
  - You do not need to have response from liability
    - Once promptly period expires, you have choice to
      - Maintain claim/lien with liability or
      - Bill us conditionally
        - » If beneficiary also has primary GHP, you must bill them before us
        - » You must withdraw liability claim/lien except those for services not covered by Medicare and for Medicare deductible and coinsurance

Conditional Billing When Primary Payer is Liability (VC 47)

- If you
  - Do not **withdraw** liability claim/lien and
  - Receive payments from them and from us
    - Follow instructions in CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2E

Situations in Which We Can Make Conditional Payment

- Primary payer is non-GHP or GHP
  - You have response from them
  - They did not pay for valid reason
- Primary payer is non-GHP (accidents)
  - You do not have response from them
  - They did not pay promptly/cannot reasonably be expected to pay promptly
  - Promptly period expired
    - If beneficiary has primary GHP, submit to them before us

Situations in Which We Cannot Make Conditional Payment

- You did not bill primary payer because
  - Beneficiary refuses to file a claim with insurer, or to cooperate with provider in filing claim
- You billed primary payer but they did not pay because
  - Provider/beneficiary failed to file proper claim with insurer resulting in no payment
    - You may submit MSP claim per CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5

Situations in Which We Cannot Make Conditional Payment

- You billed primary non-GHP but they did not pay because
  - There is also primary GHP
    - You did not send claim to GHP first or
    - You sent claim to GHP first and they rejected it stating non-GHP should pay first
      - Submit claim to non-GHP first, GHP next and Medicare third

Prepare and Submit 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

Step One – Determine if You Can Submit Conditional Claim

- You billed primary GHP and/or non-GHP and
  - You received response
    - RA (835), EOB statement, letter, other documentation
      - Payment is zero
      - Reason(s) is provided (if not, contact them)
      - Reason is valid (if not, perhaps claim should be primary)
  - You did not receive response (non-GHPs only)
    - Promptly period expired
    - You withdrew claim/lien with liability, if applicable

Step Two – Prepare Conditional Claim

- Complete claim in usual manner
  - Move primary payer to first payer and Medicare to second payer
- Follow Medicare's usual requirements
  - Technical, medical and billing
- Report on claim
  - Applicable MSP billing codes from MSP Billing Code Table
  - Primary payer adjustment reasons and amounts (MSP CAS information) from primary payer's RA

Complete Claim in Usual Manner

- Report
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered days as usual
  - Covered/noncovered charges as usual

Follow Medicare's Usual Requirements

- Technical
  - One-year timely filing
- Medical
  - Assessments/other clinical requirements
- Billing
  - Frequency of billing for your provider type
    - If you submit Medicare claims from admission to discharge, or every 30 or 60 days, this applies when Medicare is secondary

Home Health and Hospice Providers

- In MSP situations
  - HHAs
    - Submit NOA showing Medicare as primary
    - Report insurer information on final claim
  - Hospices
    - Submit NOE showing Medicare as primary
    - Report insurer information on claim(s)

Report on Claim Applicable MSP Billing Codes

- Report any applicable MSP billing codes from MSP Billing Code Table
  - Prepare and Submit an MSP Conditional Claim
    - Look for above Table within article
      - Provides claim fields and claim codes
        - » UB-04/CMS-1450 claim form
        - » 837I claim
        - » FISS DDE Claim Entry

Report on Claim Any Primary Payer Adjustment Reasons and Amounts

- Also known as MSP CAS information; report
  - CAGC/CARC pairs and amounts from primary payer's RA
    - CAGCs – Identify general category of payment adjustment
      - CO = Contractual Obligations
      - OA = Other Adjustments
      - PI = Payer-initiated Reductions
      - PR = Patient Responsibility
    - CARCs – Explain why primary payer paid differently than billed
- References: X12, CR6426 and CR8486

CARCs

- Examples include but are not limited to
  - 1 = Deductible amount
  - 2 = Coinsurance amount
  - 27 = Expenses incurred after coverage terminated
  - 45 = Charges exceeded fee schedule or maximum allowable amount
  - 96 = Noncovered charges
  - 119 =Benefit maximum reached for this period or occurrence
  - 192 = Non standard adjustment code from paper remittance (may be only option when billing conditionally because primary non-GHP does not pay within 120-day promptly period)

Report on Claim Primary Payer Adjustment Reasons and Amounts

- To report MSP CAS information
  - For hardcopy UB-04/CMS-1450 claims, attach RA
    - Our Claim's Department will enter RA coding into FISS DDE
  - For 837I claims, report in appropriate loops/segments
    - Our claims processing system maps such coding to MAP1719
      - If we RTP claim, access such coding in FISS DDE, correct and return
      - If we reject claim, follow reason code narrative (adjust or resubmit)
  - For FISS DDE claims, report in MAP1719
    - Claim page 3, first right view (F11)

Step Three – 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

Step Four – Wait for BCRC to Set Up Open 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
- If MSP record does not appear in CWF
  - Follow up with BCRC

Step Five – 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

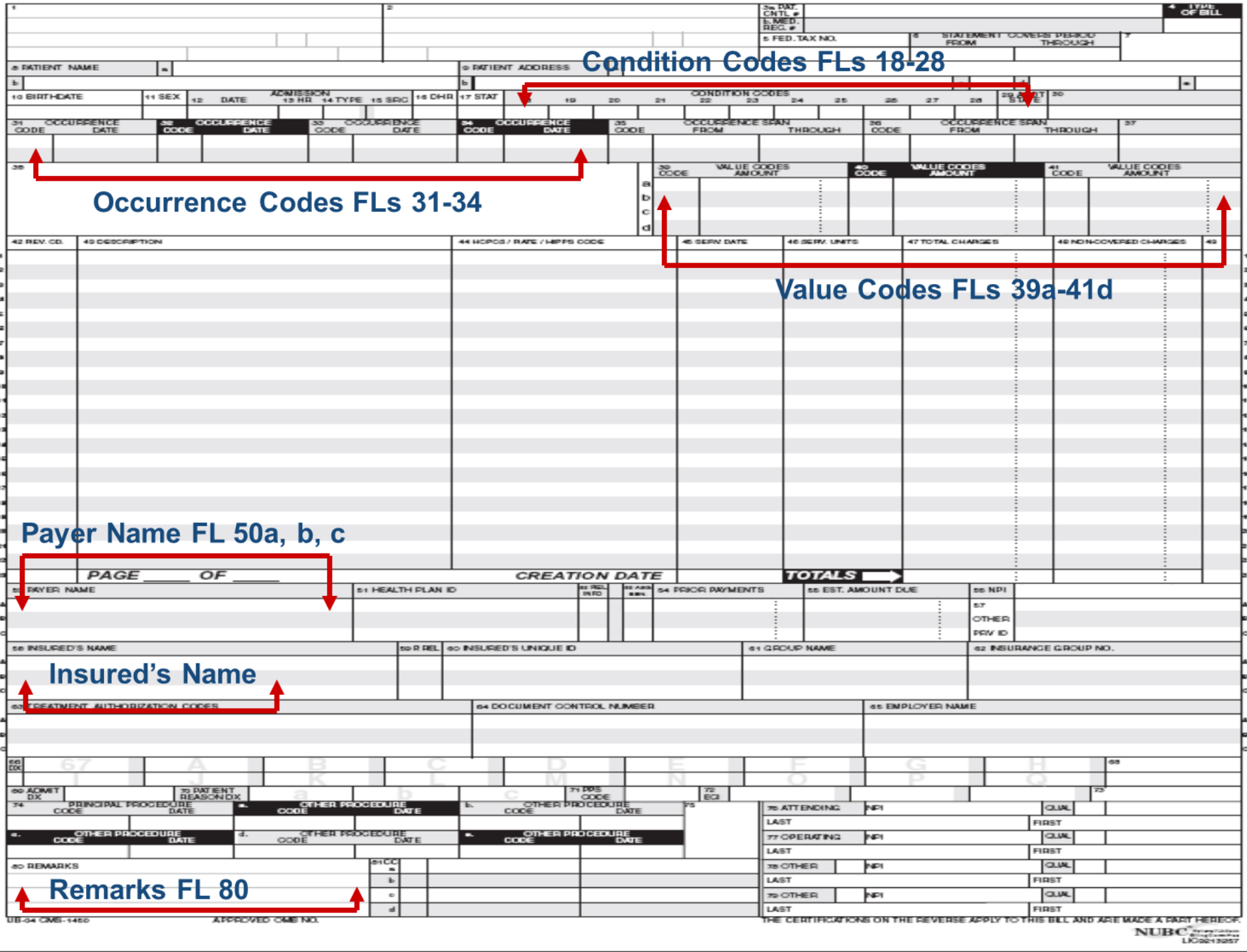
Claim Fields and MSP Claim Codes

MSP Billing Code Table (Claim Fields for Claim Codes)

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) = C	N/A	N/A	Page 03
Primary Insurer Name	50A	2320.SBR04	Page 03

MSP Billing Code Table (Claim Fields for Claim Codes)

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)


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

Condition Codes (CCs or COND Codes)

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

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

- Report applicable MSP OCs
  - 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 of primary payer's notice (RA, EOB, letter) explaining why they did not pay (denied/rejected)
    - Report on conditional claims except when billing DA in Remarks

Value Codes (VCs) and Amounts

- Report
  - MSP VC (12, 13, 14, 15, 16, 41, 43, 47) and amount received from primary payer toward Medicare covered charges
    - For conditional claims, report MSP VC amount = $0
- Do not report
  - VC 44 and OTAF amount

Primary Payer Code (Payer Code ID)

- Report for up to three payers
  - Payers labeled A, B and C
    - For conditional claims, report
      - For Payer A = C
      - For Payer B = Z

Primary Insurer Name

- Report complete/full name
  - Name must match MSP record
  - Name must not be vague such as “no-fault”
    - For conditional claims, report
      - Medicare in FL 50B or equivalent field

Insured's Name

- Report name of person who carries insurance
  - For conditional claims, report
    - Beneficiary's name in FL 58B or equivalent field

Patient's Relationship to Insured

- Report code for relationship of patient to insured
  - 01 = Spouse
  - 18 = Self
  - 19 = Child
  - 20 = Employee
  - 21 = Unknown,
  - 53 = Life partner
  - G8 = Other relationship
- For conditional claims, report
  - 18 in FL 59B or equivalent field

Insured's Unique ID

- Report beneficiary's ID with primary insurer
  - For conditional claims, report
    - Beneficiary's MBI in FL 60B or equivalent field

Insurance Address (Remarks)

- Report primary payer's address
  - In Remarks (on second line) if submitting hardcopy or via 837I claim
  - On page 06 if using FISS DDE to enter claim

Reason Primary Payer Did Not Pay or Did Not Pay Promptly (Remarks)

- Report two digit code indicating why primary payer did not pay or did not pay promptly
  - In Remarks (on first line)
  - Code options
    - Ten codes created by NGS
      - NB, PC, CD, FG, BE, PE, DA, DP, LD and PP
        - » Some require more information such as date (MM/DD/YY) placed one space over from code

Remarks: Codes NB, PC and CD

- Primary payer did not pay because
  - Services are not a covered benefit
    - Report code **NB**
      - VCs 12, 13, 14, 15, 41 or 43
  - Preexisting condition
    - Report code **PC**
      - VCs 12, 13 or 43
  - Charges applied to deductible, co-pay or coinsurance
    - Report code **CD**
      - VCs 12, 13, 14 or 43

Remarks: Code FG

- Primary payer (VCs 12, 13, 15 or 43) did not pay because
  - Their guidelines were not followed
    - Report code **FG** (space) then the reason (typed out)
      - 1 = **claim was filed untimely**
        - » We pay if filed timely with us
      - 2 = **provider is out of plan's network**
        - » We pay one time only per entire time beneficiary is enrolled in that plan
      - 3 = **prior authorization was not obtained**
        - » We do not pay

Remarks: Code BE (Primary Payer is GHP)

- Primary GHP (VCs 12, 13 and 43) did not pay because
  - Benefits exhausted
    - Report code **BE** with date benefits exhausted (MM/DD/YY)
      - May not be same as OC 24 date; may need to contact primary payer
- Note: Do not submit primary claim since MSP record stays open until lifetime benefits exhaust or GHP terminates

Remarks: Code BE (Primary Payer is Non-GHP Other Than Auto No-Fault)

- Primary non-GHP other than auto no-fault (VC 14 for med-pay, 15 and 41) did not pay because
  - Benefits exhausted and no other primary payer exists
    - Determine date benefits exhausted; notify BCRC
      - If DOS < benefits exhaust date, submit conditional claim and report code **BE** with date benefits exhausted (MM/DD/YY)
        - » May not be same as OC 24 date; may need to contact primary payer
      - If DOS > benefits exhaust date, submit primary claim

Remarks: Code PE (Primary Payer is Auto No-Fault)

- Primary auto no-fault (VC 14) did not pay because
  - Benefits (PIP) exhausted and no other primary payer exists
    - Auto no-fault: Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania, Utah, Puerto Rico
    - Determine date benefits exhausted; notify BCRC
      - If DOS < benefits exhaust date, submit conditional claim and report code **PE** with date benefits exhausted (MM/DD/YY)
        - » May not be same as OC 24 date; may need to contact primary payer
      - If DOS > benefits exhaust date, submit primary claim

Remarks: Code DA

- Primary non-GHP (VCs 14, 15, 41 and 47), did not pay promptly and you choose to submit conditional claim because
  - 120 days has passed (promptly period expired)
    - Report code **DA** with date you billed primary payer (MM/DD/YY)
    - Reminder: Do not also report OC 24 and date on claim

Remarks: Codes DP, LD and PP

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

Enter and Submit Conditional Claims in FISS DDE

FISS DDE

- We use to process claims and maintain records
- Allows remote user connectivity to Medicare mainframe
- Providers access through online computer system
- Requires logon ID and password (do not share)
- EDI enrollment information

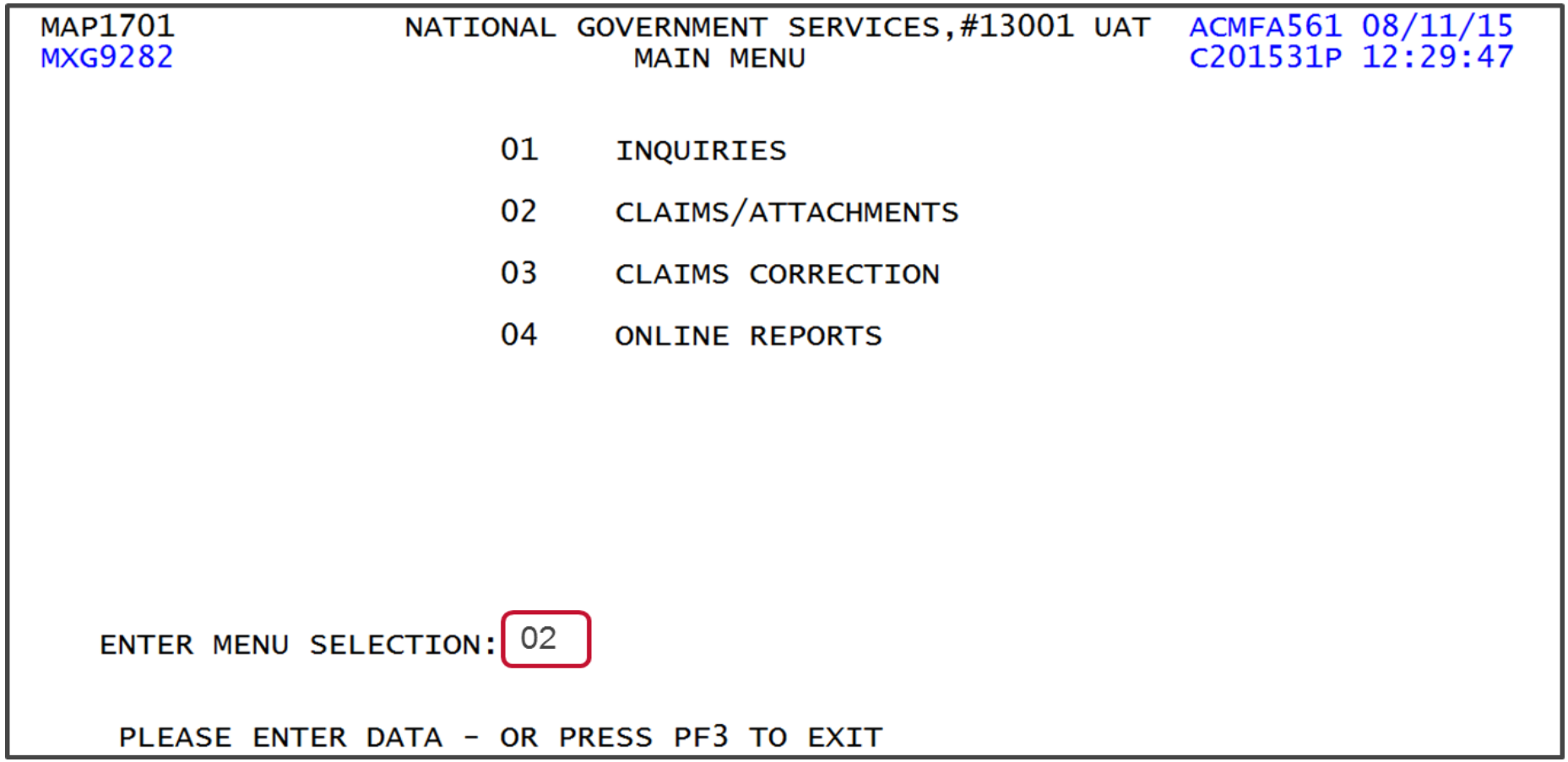
FISS DDE

- Providers can use to
  - Research coding
  - **Submit claims**
  - Track submitted claims
  - Correct, adjust, and cancel claims
  - View reports
    - Above includes MSP, Medicare tertiary and conditional claims
- FISS DDE Provider Online Guide
  - Chapter V (Claims/Attachments Submenu 02) for Claim Data Entry

FISS DDE – Entering Claims

- From main menu, select Claims/Attachments
  - On MAP1701, enter menu selection: 02
  - From MAP1703, enter menu selection from choices below
    - IP = 20
    - OP = 22
    - SNF = 24
    - Home Health = 26
    - Hospice = 28

FISS DDE Main Menu – Claims/Attachments (Submenu 02)



FISS DDE Claims and Attachments Entry Menu – Claims Entry

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MAP1703          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 03/07/16
MXG9282           CLAIM AND ATTACHMENTS ENTRY MENU         C2016200 15:33:23

                          CLAIMS ENTRY

                    INPATIENT                20
                    OUTPATIENT               22
                    SNF                      24
                    HOME HEALTH              26
                    HOSPICE                  28
                    NOE/NOA                  49
                    ROSTER BILL ENTRY        87

                          ATTACHMENT ENTRY

                    HOME HEALTH              41
                    DME HISTORY              54
                    ESRD  CMS-382 FORM       57

   ENTER MENU SELECTION: _


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

FISS DDE Navigation Keys

Program Function Key	Screen Movement
F3/PF3	Return to menu/submenu or originating screen when using SC field. Do not press while entering claim before you save it or entered data is lost.
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

FISS DDE Navigation Keys

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, F3/PF3 return to original page
Page field	Move to specific page within claim

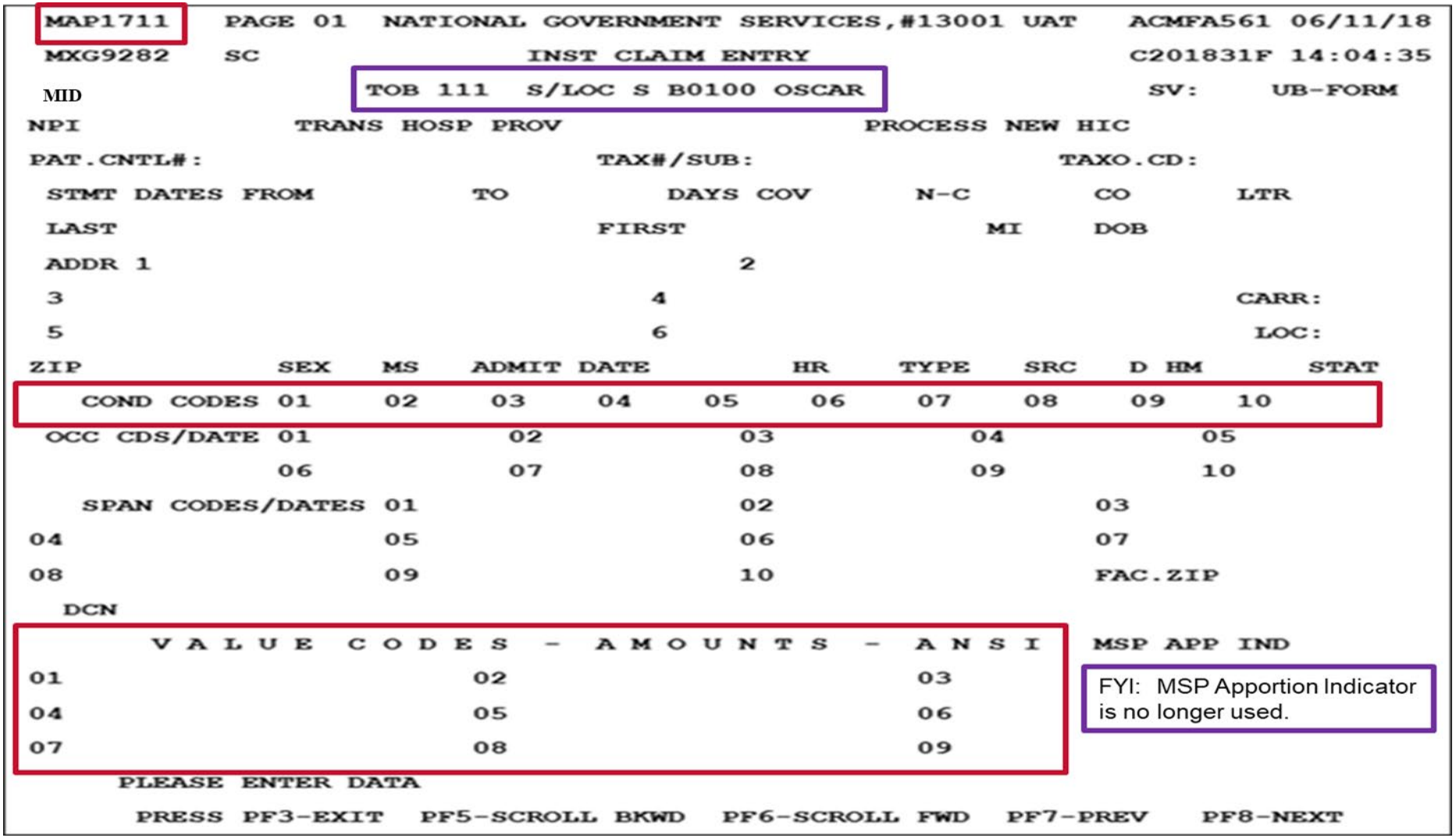
FISS DDE Claim Entry – Key Points

- Six pages to a claim
  - Set up similar to UB-04/CMS-1450 claim form
- Enter all required data, not just MSP coding
  - Cursor may skip fields not required
- TOB defaults depending on TOB
  - 111 for IP, 131 for OP and 211 for SNF
    - If entering different TOB, type over default

FISS DDE Claim Entry – Six Pages

Pages for Claim Entry	MAP	UB-04/CMS-1450 Claim Form FLs
Page 01	1711	FLs 1–41: Patient information, condition, occurrence, occurrence span and value codes
Page 02	1712	FLs 42–49: Revenue and CPT/HCPCS codes, charges, and DOS
Page 03	1713	FLs 50–57 & 66–79: Payer, diagnosis code, procédure code and physician information
Page 03	1719	MSP payment information from primary payer's RA
Page 04	1714	FL 80: Remarks
Page 05	1715	FLs 58–62: Insured and insurance information
Page 06	1716	Primary insurer's address information

MAP1711 (Page 01)



FYI: MSP Apportion Indicator is no longer used.

MAP1712 (Page 02)

```
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 (Original Page 03)

```
MAP1713   PAGE 03   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
MXG9282   SC                  INST CLAIM ENTRY                  C201831F 14:05:49
 MID                  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
```

MAP1719 (Additional Page 03)

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

```
MAP1719   PAGE 03   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
MXG9282   SC                  INST CLAIM ENTRY                 C201831F 14:05:55
 MID                  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
```

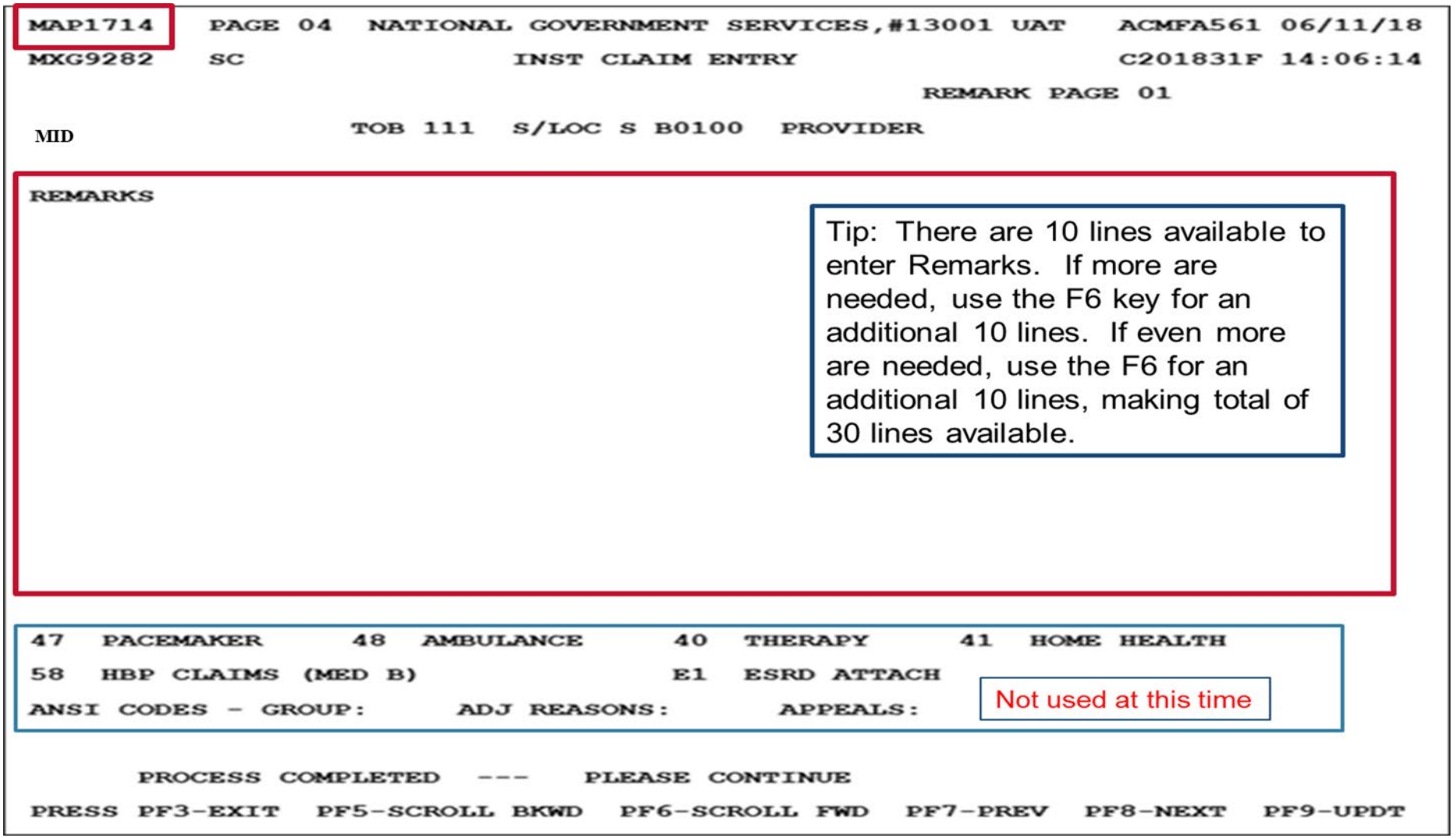
Example – Scenario

- Beneficiary
  - Disabled with LGHP (Medicare primary 2/1/2022; LGHP terminated)
  - IP hospital 1/29/2022-3/2/2022 (Part A deductible met)
- Provider
  - Charges = $35,000 ($3,000 for up to 1/31, $0 for 2/1-3/2)
  - Bills LGHP as primary (Contract)
- LGHP
  - Allowed = $1,500 (up to 1/31)
  - Applied patient deductible = $1,500 (up to 1/31)
  - Paid = $0 on 4/10/2022

Example – CAGC/CARC Claim Coding

- Claim entries on page 01 (MAP1711)
  - MSP VC 43 = $0
- Claim entries on page 03 (MAP1719)
  - Paid date = 041022
  - Paid amount = $0
  - CAGCs/CARCs and amounts
    - CO45 = $1,500, PR1 = $1,500 and PR 27 = $32,000

MAP1714 – Page 04



MAP1715 – Page 05

```
MAP1715    PAGE 05   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
MXG9282    SC                    INST CLAIM ENTRY                C201831F 14:06:23

 MID                          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

```
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
- Develop and implement policies that ensure your MSP responsibilities are met
- Review articles
  - Determine if Medicare Will Make MSP Payment
  - Determine Beneficiary Responsibility on MSP Claim

Thank You!

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

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