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

10/4/2023

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

Provider Outreach and Education Consultants

- Christine Janiszcak
- Jan Wood
- Kathy Mersch

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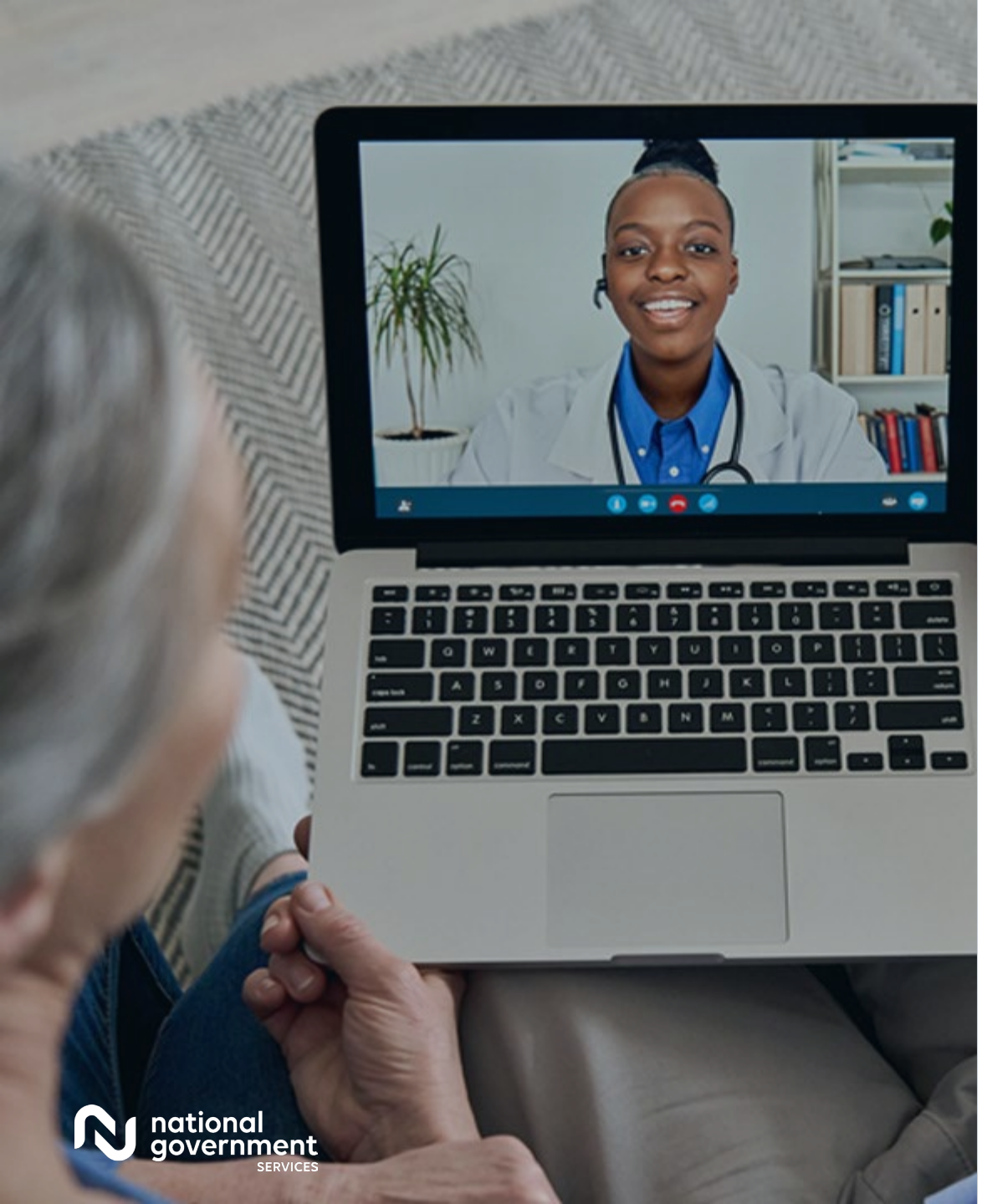

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Objective

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

Agenda

2023 MSP webinars
Christine Janiszcak

MSP Resources handout
Christine Janiszcak

MSP and your MSP responsibilities
Christine Janiszcak

Conditional claims
Christine Janiszcak

Prepare and submit conditional claims
Christine Janiszcak

Claim fields and MSP claim codes
Jan Wood

Enter and submit conditional claims using FISS DDE
Jan Wood

Questions and answers
All

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2023 MSP Webinar Series

- May 2023
  - 5/4: MSP Fundamentals
- June 2023
  - 6/28: MSP Resources
- July 2023
  - 7/13: Identifying Primary Payers
  - 7/18: Setting Up & Correcting CWF Records
  - 7/20: MSP Rejections on Primary Claims
- August 2023
  - 8/8: Working Aged with EGHP MSP Provision
  - 8/10: Disabled with LGHP MSP Provision
  - 8/15: ESRD with EGHP MSP Provision
- September 2023
  - 9/6: No-Fault & Liability MSP Provisions
  - 9/20: Preparing & Submitting MSP Claims
  - 9/28: MSP Billing Examples
- October 2023
  - 10/4: Preparing & Submitting Conditional Claims
  - 10/11: Conditional Billing Examples
  - 10/18: MSP Claims That RTP
  - 10/25: Conditional Claims That RTP
- November 2023
  - 11/21: Adjustments Involving MSP
  - 11/28: Payment & Beneficiary Responsibility

2023 Additional MSP Webinars

- Virtual conferences (include MSP as topic)
  - Twice a year
- Let's Chat About MSP Part A
  - Once a month
  - For all Part A providers including HHHs and FQHCs/RHCs
  - Ask MSP-related questions (no PHI)
  - Event posted to our website but no presentation

MSP Resources Handout

Fact: The more you know about MSP, the more easily you can achieve compliance with your MSP-related provider responsibilities

Tips: Review MSP resources available to you and continue to learn about MSP!

MSP and Your MSP-Related 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 that other insurer primary and Medicare secondary
      - If one or more are not met, services not subject to that provision; Medicare is primary unless criteria/conditions of another are met

Providers' MSP-Related Responsibilities Per Medicare Provider Agreement

Determine if Medicare is primary payer for beneficiary's services

Identify payers primary to Medicare

Submit claims to primary payer(s) before Medicare

May be more than one payer primary to Medicare

Submit MSP claims to Medicare when required

Follow claim submission guidelines

Identify Payers Primary to Medicare

- MSP screening process
  - Check for MSP information in Medicare's records
    - ✓ Providers must check for MSP records for beneficiary in CWF for each service rendered
  - Collect MSP information from beneficiary or representative
    - ✓ Providers may need to ask questions about other insurance for every IP admission or OP encounter, with some exceptions

MSP Records in CWF – Information

- If MSP record(s) present, information includes:
  - MSP VC and primary payer code for each MSP provision
    - ✓ See next slide – Use MSP VC to report primary payer's payment on MSP claim
  - MSP effective date
  - MSP termination date, if applicable
  - Subscriber's name
  - Policy number
  - Patient's relationship to insured
  - Insurer's information

MSP Value Codes and Primary Payer Codes

MSP VC	MSP Provision/Medicare Exclusion	Payer Code
12	Working aged, age 65 and over, EGHP, 20 or more employees	A
13	ESRD with EGHP in 30-month 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	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

Collect MSP Information

- Ask questions about MSP status using CMS' model questionnaire or your own compliant form
  - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
  - Three parts with questions to be asked in sequence
    - ✓ Part I – Black Lung, WC, No-Fault (automobile and other types) and Liability
    - ✓ Part II – Medicare entitlement and employer GHPs
    - ✓ Part III – ESRD Medicare entitlement, if applicable (including dual entitlement)

Collect Additional Billing Information

- Collect additional information if applicable
  - Veterans who want to use VA coverage instead of Medicare
  - Beneficiaries receiving services covered by a Government Research Grant
  - Retirement dates of beneficiary and/or spouse/family member
    - ✓ Report on your claims with OC 18 for beneficiary's and OC 19 for spouse's retirement date; we send to BCRC and process claim(s)
    - ✓ Policy for when beneficiary/spouse cannot recall: CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.1, #4

Determine Proper Order of Payers

- Determine which plan is primary, secondary, tertiary, etc. payer
  - Use collected MSP information and your knowledge of MSP provisions
    - ✓ In general, Medicare is primary when beneficiary
      - Has no other insurance or coverage
      - Has insurance or coverage but it does not meet MSP provision criteria requirements
      - Had insurance or coverage, it met MSP provision criteria requirements, but it is no longer available
    - ✓ In general, other payer(s) is primary when beneficiary
      - Has insurance or coverage that meets MSP provision criteria requirements and it is available

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If Medicare is primary

Submit Medicare primary claim

If another payer is primary

Submit claim to that payer first and Medicare second if required

May need to submit conditional claim to Medicare if primary payer does not pay for a valid reason or promptly (within 120 days; accidents only)

If more than one payer is primary

Submit claims to those payers and to Medicare third (tertiary), etc.

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 of MSP provision 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

Submit Correct Medicare Claim Type

- Submit Medicare primary claim if
  - Primary payer does not pay citing Medicare is primary (verify Medicare is primary)
- Submit MSP claim if
  - Primary payer pays in part
  - Primary payer pays in full if required
- Submit conditional claim if
  - Primary payer does not pay for a valid reason or does not pay promptly (120 days; accidents only)

Do Not Deny Medical Services

- Physicians, providers and suppliers shall not deny medical services or entry to a SNF or hospital after you discover that there is:
  - Open or closed GHP or NGHP MSP record found in HETS or on CWF; or a claim that was previously mistakenly rejected by Medicare due to MSP occurrence
  - Medicare Secondary Payer: Do Not Deny Services & Bill Correctly

Conditional Claims

Conditional Claims – Defined

- Claims submitted to us for payment because
  - You billed primary payer but they
    - ✓ Did not pay for valid reason (for all MSP provisions except VC 16 and VA in which case you may bill Medicare as primary)
    - ✓ Did not pay promptly (within 120 days; applicable for accident MSP provisions only – VCs 14, 15, 41 and 47)
- If we can make conditional payment
  - Payment amount and beneficiary responsibility is same as if we are primary

Promptly – Defined

- Promptly, for no-fault and WC
  - Payment within 120 days after insurer receives claim

- Promptly, for liability (including self-insurance)
  - 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 (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 with valid reason
  - Applicable in situations in which 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 with valid reason
- To bill us conditionally after promptly period
  - You do not need response from non-GHP
- Once promptly period ends
  - Choose to maintain claim with non-GHP or bill us conditionally
    - ✓ If you wait for non-GHP, keep our one-year timely filing in mind
    - ✓ If beneficiary has primary GHP, bill GHP before us

Conditional Billing When Primary Payer is Liability (VC 47)

- To bill us conditionally within promptly period
  - You must have response from liability with valid reason

- To bill us conditionally after promptly period
  - You do not need response from liability
- Once promptly period ends
  - Choose to maintain claim/lien with liability or bill us conditionally
    - ✓ If you wait for liability, keep our one-year timely filing in mind
    - ✓ If you bill us conditionally, withdraw claim/lien with liability (except for services not covered by Medicare and Medicare deductible/coinsurance)
    - ✓ If you are paid by them and us, follow CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2E
    - ✓ If beneficiary has primary GHP, bill GHP before us

When We Can Pay Conditionally

- You have response from primary payer, and they did not pay for valid reason
  - Primary payer is GHP or non-GHP (accidents)
- You do not have response from primary payer and promptly period ended
  - Primary payer is non-GHP (accidents)
  - Primary payer did not pay promptly/cannot reasonably be expected to pay promptly
  - Note: If beneficiary also has a primary GHP, bill GHP before us

When We Cannot Pay Conditionally

- You did not bill primary payer
  - Beneficiary refuses to file a claim with insurer, or to cooperate with provider in filing claim
- You billed primary payer
  - They did not pay because provider/beneficiary failed to file proper claim with them
    - ✓ You may submit MSP claim per CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5
- You billed primary non-GHP
  - 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

1. Determine if you can submit conditional claim
2. Prepare conditional claim
3. Check for MSP record in CWF
4. Wait for BCRC to set up MSP record in CWF
5. 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 ended
    - ✓ 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 (Table is within article)
    - ✓ Provides claim fields and claim codes for UB-04/CMS-1450 claim form, 837I claim and FISS DDE Claim Entry

Report on Claim Primary Payer Adjustment Reasons and Amounts

- Primary payer adjustment reasons
  - Also known as MSP CAS information
  - Found on primary payer's RA
  - CAGS/CARCs
  - References: X12, CR6426 and CR8486
- 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
  - For FISS DDE claims, report in MAP1719

Report on Claim Primary Payer Adjustment Reasons and Amounts

- CAGCs – Identify general category of payment adjustment; include:
  - CO = Contractual Obligations
  - OA = Other Adjustments
  - PI = Payer-initiated Reductions
  - PR = Patient Responsibility
- CARCs – Explain why primary payer paid different than billed; include but 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 = Nonstandard adjustment code from paper remittance (may be only option when billing conditionally because primary non-GHP does not pay within 120-day promptly period)

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 matching MSP record in CWF, 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 in CWF

- 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 in CWF, Submit MSP 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 > Mailing Addresses > Claims
  - 837I claim
  - FISS DDE claim entry
- Maintain documentation

Claim Fields and MSP Claim Codes

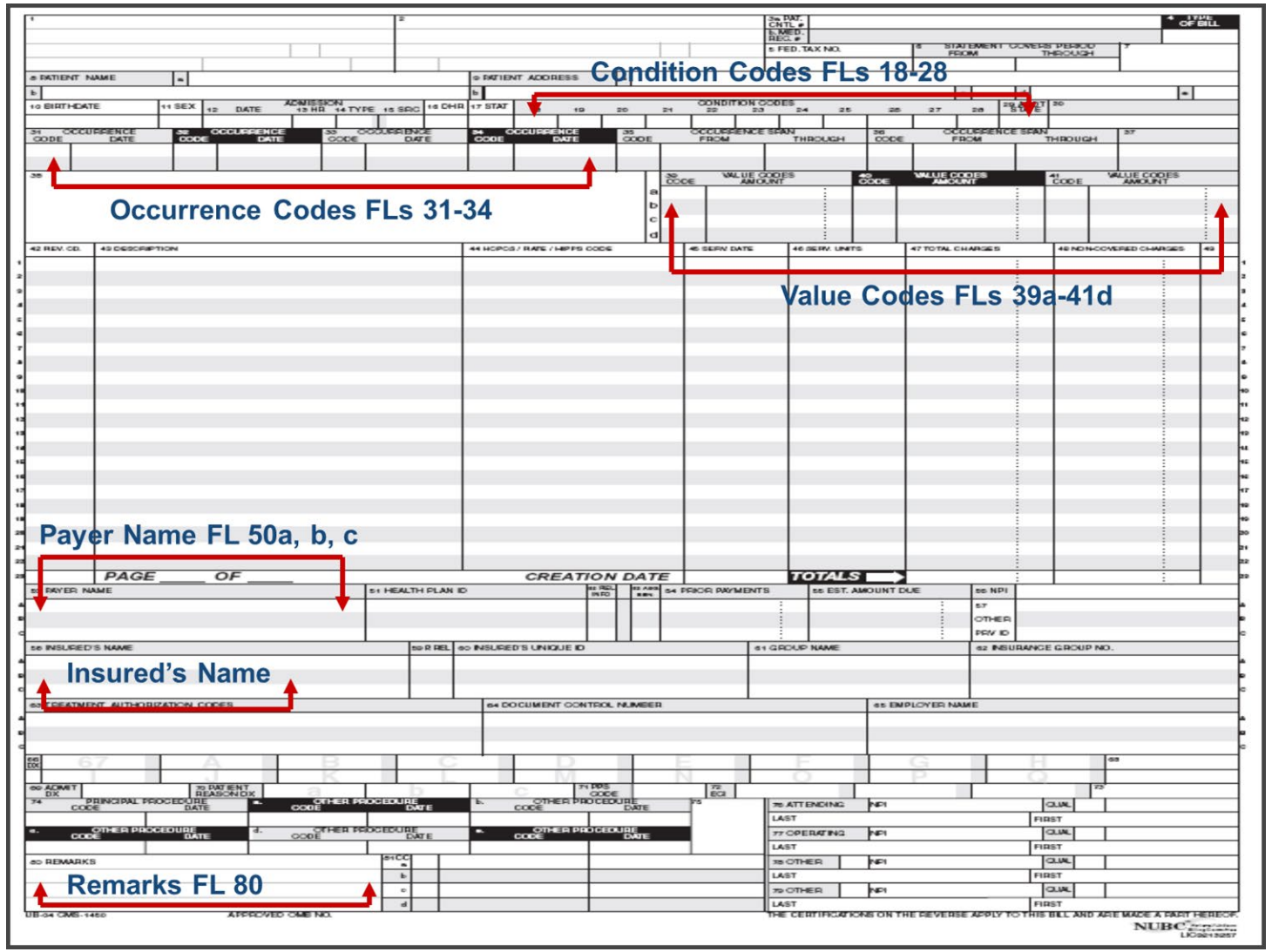
MSP Billing Code Table (Claim Fields)

Claim Codes	UB-04/CMS-1450 Claim FLs	837I Claim Fields	FISS DDE Page
Condition Codes	18-28	2300.HI (BG)	01
Occurrence Codes and Dates	31-34	2300.HI (BH)	01
Value Codes and Amounts	39-41	2300.HI (BE)	01
Primary Payer Code (Payer Code ID) = C	N/A	N/A	03
Primary Insurer Name	50A	2320.SBR04	03

MSP Billing Code Table (Claim Fields)

Claim Codes	UB-04/CMS-1450 Claim FLs	837I Claim Fields	FISS DDE Page
Insured's Name	58A	2330A.NM104	05
Patient's Relationship to Insured	59A	2320.SBR02	05
Insured's Unique ID	60A	2330A.NM109	05
Insurance Group Name	61A	2320.SBR04	05
Insurance Group Number	62A	2320.SBR03	05
Insurance Address & Explanation Codes	80 (Remarks)	2300.NTE	06 (Address), 04 (Code)

UB-04/CMS-1450 Claim Form



Condition Codes (CCs or COND Codes)

- Report applicable MSP CCs
  - 02 (zero two) = Condition is employment-related
  - 06 (zero six) = 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 (zero 1) and DOA if med-pay is primary
  - 02 (zero 2) and DOA if no-fault is primary
  - 03 (zero 3) and DOA if liability is primary
  - 04 (zero 5) and DOA if WC (or Federal BL Program) 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 code 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 this code for up to three payers
  - Payers labeled A, B and C
    - ✓ For conditional claims, report C for payer A and report Z for payer B

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: NB, PC, CD, FG, BE, PE, DA, DP, LD and PP
    - ✓ Ten codes created by NGS; 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** (for VCs 12, 13, 14, 15, 41 or 43)
  - Preexisting condition
    - ✓ Report code **PC** (for VCs 12, 13 or 43)
  - Charges applied to deductible, co-pay or coinsurance
    - ✓ Report code **CD** (for 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 **reason** (typed out)
    - ✓ **Claim was filed untimely** (Note: We pay if filed timely with us)
    - ✓ **Provider is out of plan's network** (Note: We pay one time per entire time beneficiary is enrolled in that plan)
    - ✓ **Prior authorization was not obtained** (Note: 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; you may need to contact primary payer for date
- 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) which may not be same as OC 24 date (You may need to contact primary payer for date)
    - ✓ 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) which may not be same as OC 24 date (You may need to contact primary payer for date)
    - ✓ 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 ended)
  - 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 are submitting 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

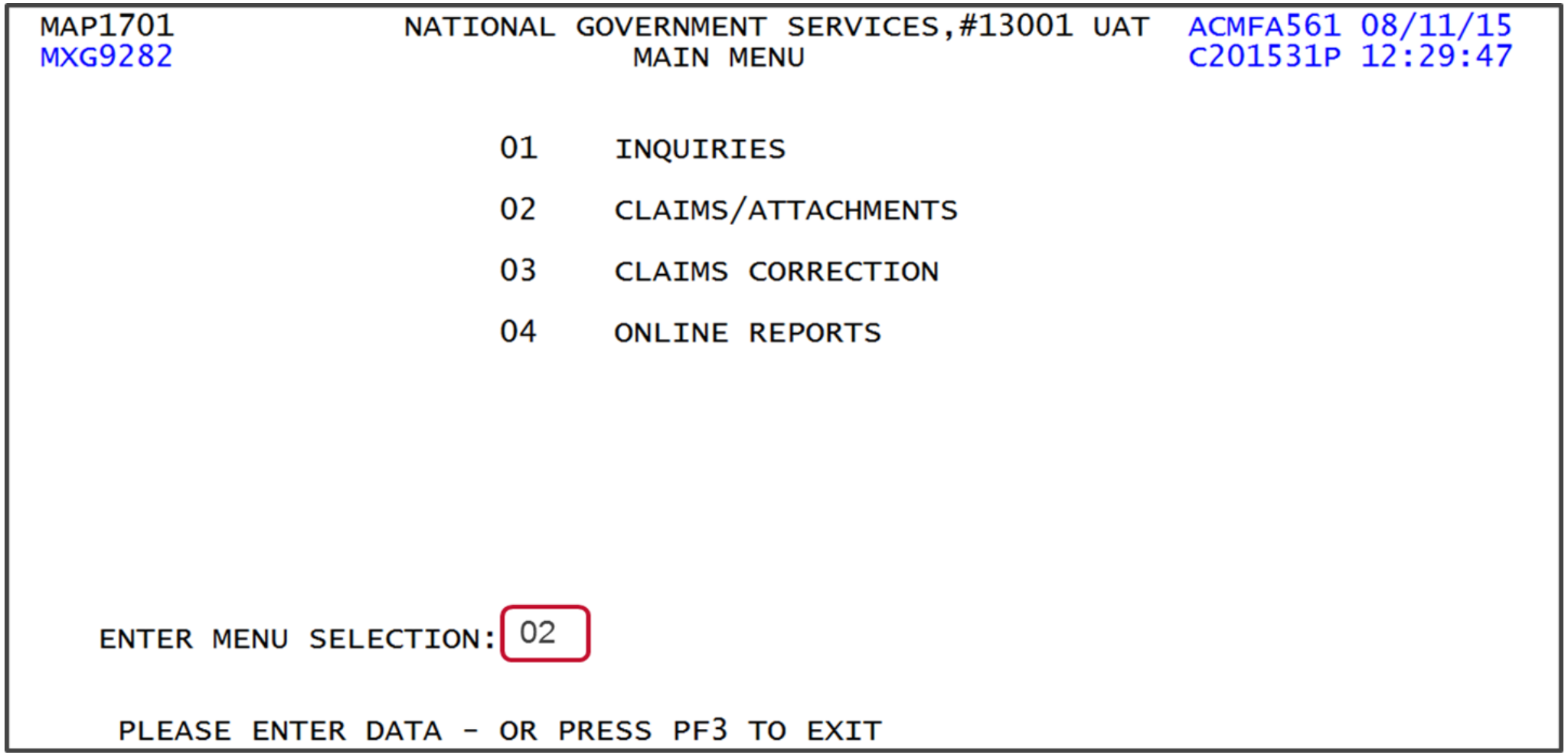
FISS DDE

- 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
- Providers can use to
  - Research claim coding
  - Submit, track, correct, adjust and cancel claims including MSP, Medicare tertiary and conditional
  - View reports
- 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

```
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
F114/PF11	Move to right viewing screen
<Control>	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 to return to original page
Page Field	Move to specific page within claim

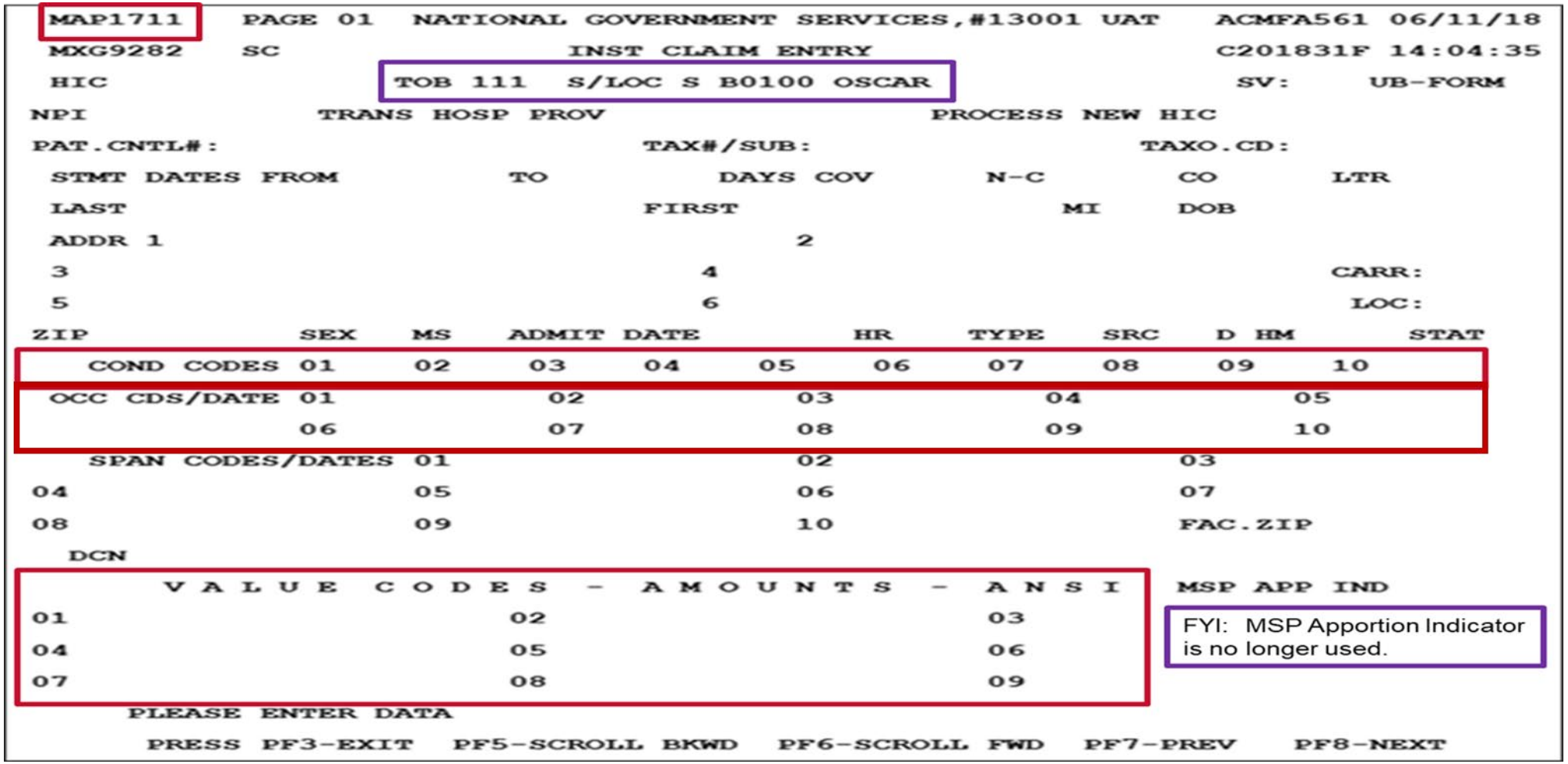
FISS DDE Claim Entry – Key Points

- 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 Pages for Claim Entry and UB-04/CMS-1450 Claim Form Locators – Six Pages

Page	MAP	UB-04/CMS-1450 Claim FLs
01	MAP1711	FLs 1-41: Patient information, condition, occurrence, occurrence span and value codes
02	MAP1712	FLs 42-49: Revenue and CPT/HCPCS codes, charges and DOS
03	MAP1713	FLs 50-57 & 66-79: Payer, diagnosis code, procedure code and physician information
03	MAP1719	Payment information from primary payer's RA
04	MAP1714	FL 80: Remarks
05	MAP1715	FL 58-62: Insured and insurance information
06	MAP1716	Primary insurer's address

Page 01 – MAP1711



Page 02 – MAP1712

```
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
```

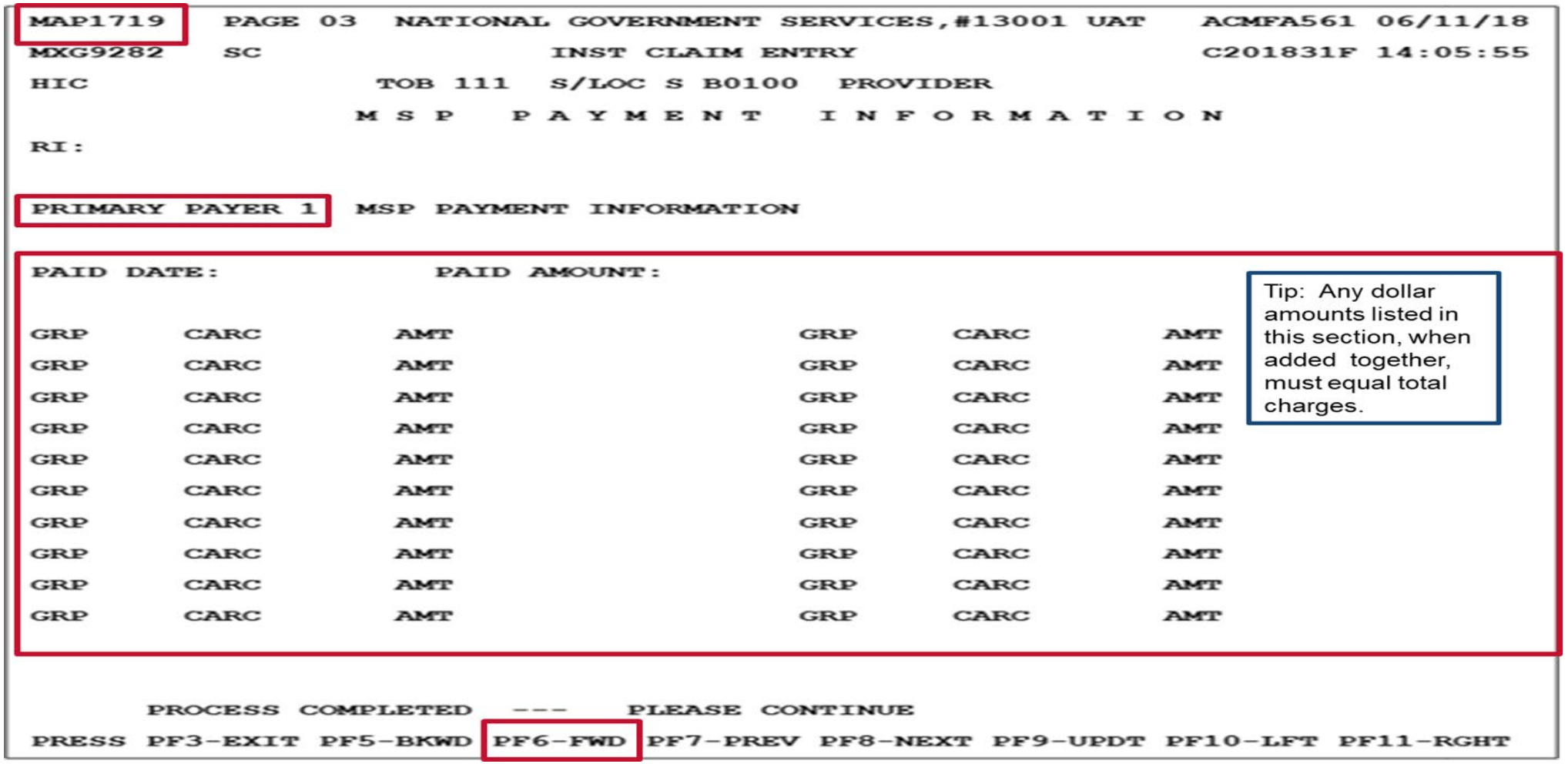
Page 03 – MAP1713

```
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
```

Page 03 (Additional) – MAP1719

- 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:** Amount received from primary payer (Must = MSP VC amount and = charges – CAGC/CARC amounts)
      - **GRP:** CAGC(s)
      - **CARC:** CARC(s)
      - **AMT:** Dollar amount with each CAGC/CARC pair

Page 03 (Additional) – MAP1719



Page 03 (Additional) – MAP1719

```
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
```

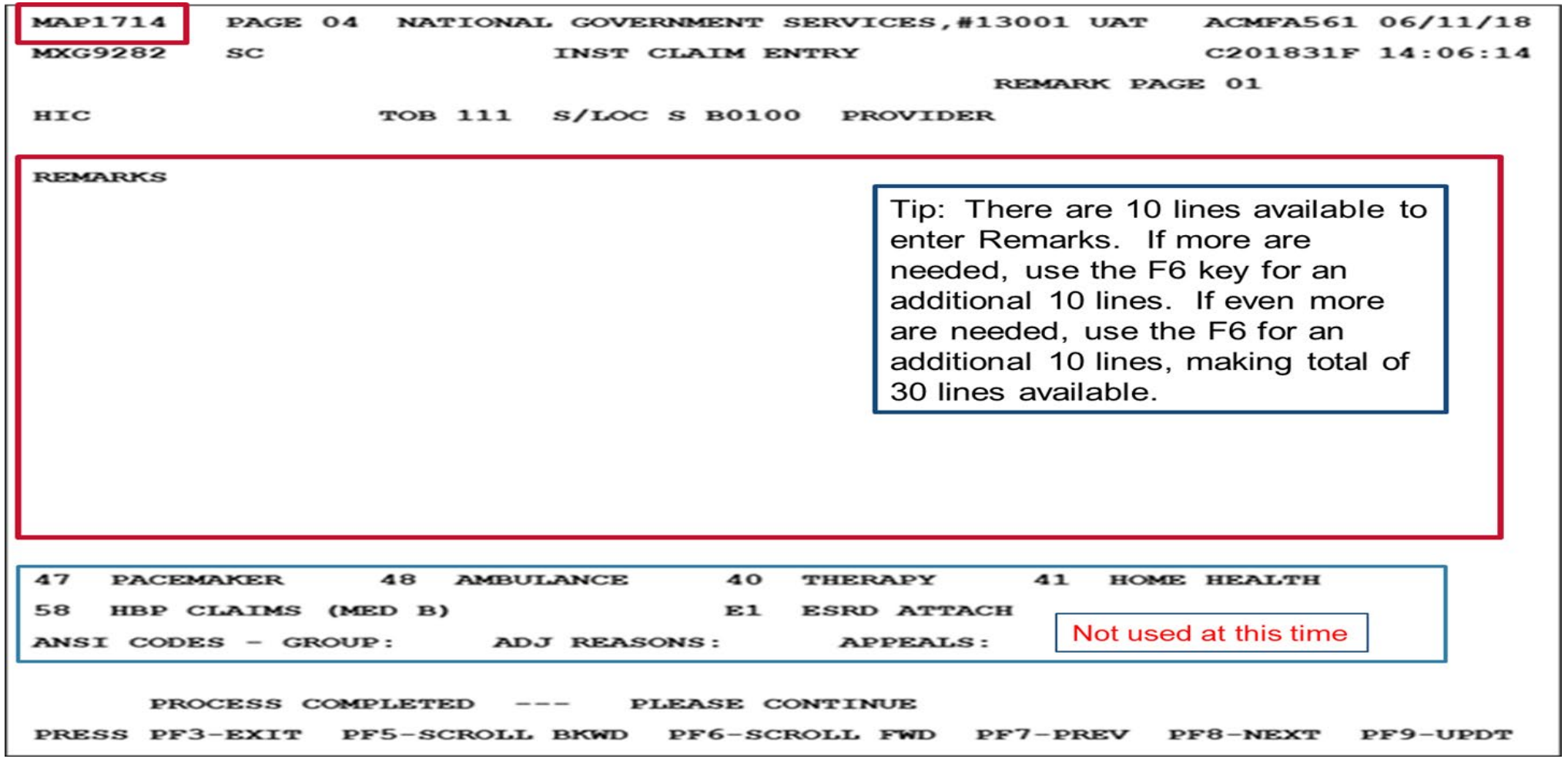
Example One – Scenario and CAGC/CARC Claim Coding

- Scenario:
  - Beneficiary
    - ✓ Disabled with LGHP (Medicare primary 2/1/2023; LGHP terminated)
    - ✓ Received services at IP hospital 1/29/2023-3/2/2023 (Part A deductible met)
  - Provider
    - ✓ Charges = $35,000 ($3,000 for up to 1/31, $32,000 for 2/1-3/2) and bills LGHP as primary
  - LGHP (contract)
    - ✓ Allowed = $1,500 (of $3,000 for up to 1/31 but applied to patient deductible)
    - ✓ Paid 0 on 4/10/2022
- Claim entries:
  - Page 01 (MAP1711): MSP VC 43 = $0
  - Page 03 (MAP1719):
    - ✓ Paid date = 041023 and Paid amount = $0
    - ✓ CAGS/CARCs/Amounts: CO45 = $1,500, PR1 = $1,500 and PR27 = $32,000

Example Two – Scenario and CAGC/CARC Claim Coding

- Scenario:
  - Beneficiary
    - ✓ In auto accident on 3/1/2023 in traditional auto state (no No-Fault) and no auto med-pay is available, however, beneficiary holds driver of other auto responsible and that driver has liability insurance
    - ✓ Receives OP services on 3/2/2023 related to accident
  - Provider
    - ✓ Charges = $800, bills Liability insurance on 3/10/2023; no response within 120 days, chooses to submit conditional claim, withdraws claim with liability insurance and submits conditional claim
  - Liability Insurance (no contract)
    - ✓ Received claim on 3/12/2023 but has not paid provider
- Claim entries:
  - Page 01 (MAP1711): MSP VC 47 = $0
  - Page 03 (MAP1719):
    - ✓ Paid date = 031023 (date billed liability insurer) and Paid amount = $0
    - ✓ CAGS/CARCs/Amounts: PR192 = $800

Page 04 – MAP1714



Page 05 – MAP1715

```
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
```

Page 06 – MAP1716

```
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

- Be familiar with MSP resources
- Develop and implement policies that ensure your facility meets its MSP responsibilities
- Ensure your admissions/registration department works closely with your billing department
- Share this presentation with coworkers
- Continue to attend our MSP webinars

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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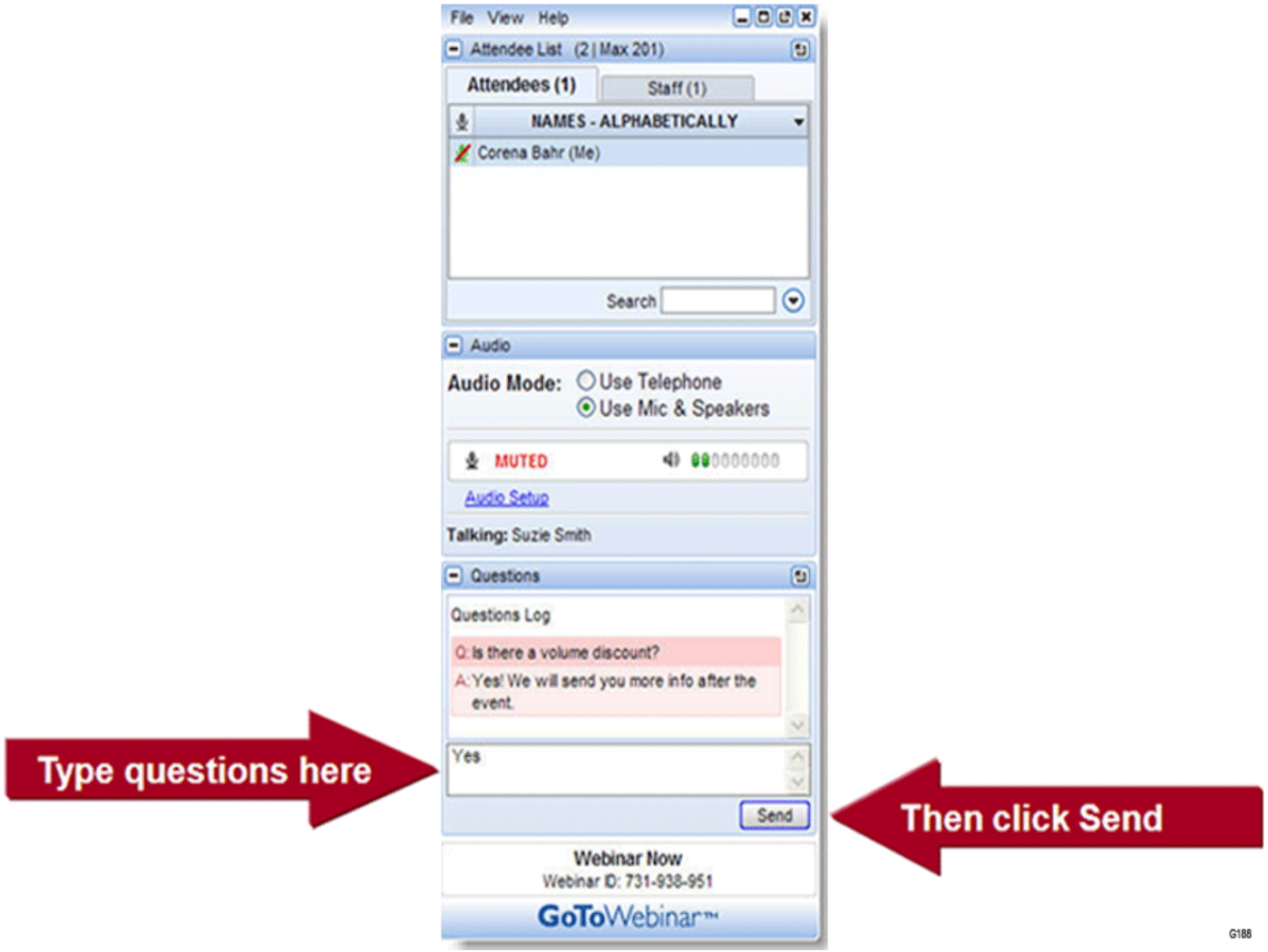

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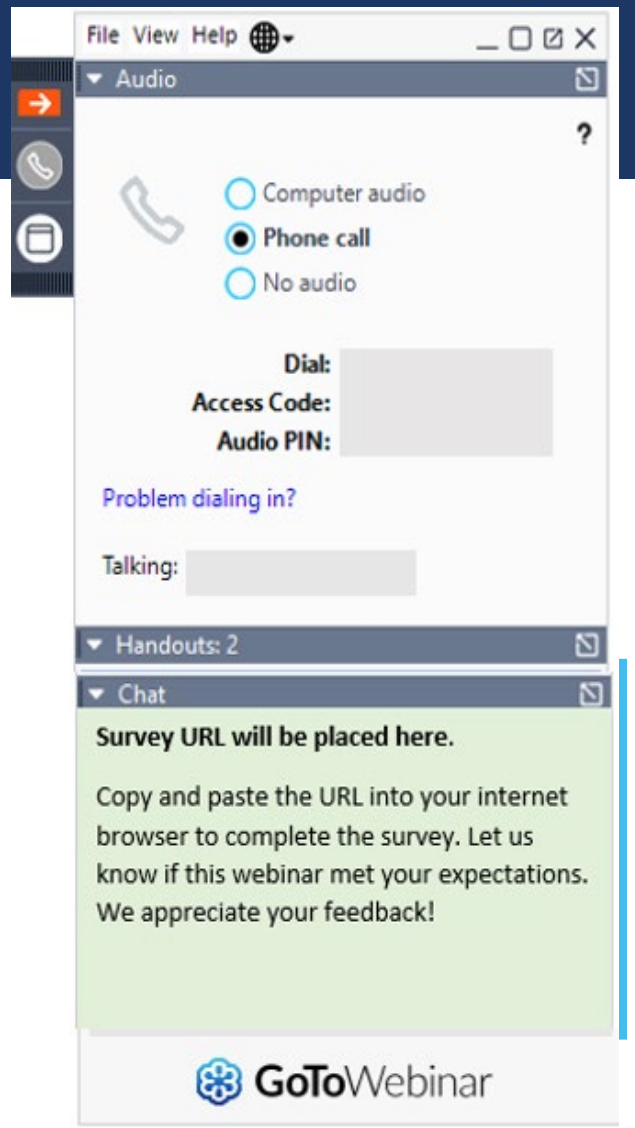
Copy/Paste URL to your Internet Browser	Open/Complete Survey	Share your feedback with us!

Thank you for your feedback!



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