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Medicare Secondary Payer Conditional Billing Examples

07/20/2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objective

- Review claim examples that represent compliant conditional claims prepared after your facility receives no payment from primary payer

Agenda

- 2022 MSP Webinar Series and Other Events
- Reminders – 7/6/2022 Webinar on Preparing and Submitting Conditional Claims
- Claim Examples for Various Conditional Situations
- Polling Questions to Help Code Claim Examples – Refer to Handout
- 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 and 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

Conditional Claims – Reminders

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 (see next slide)** except VC 16 and VA
        - » If PHS or VA do not pay, submit Medicare primary, not conditional, claim
    - Did not pay **promptly (within 120 days)**
      - Applies to accident MSP Provisions (VCs 14, 15, 41, 47)
- When we pay claim conditionally
  - Payment and beneficiary responsibility are same as if we are primary payer for claim

MSP Provisions with MSP Value Codes

MSP VC	MSP Provision
12	Working aged, age 65 and over, EGHP through self or spouse, 20 or more employees
13	ESRD with EGHP through self or family member in coordination period
14	No-Fault (automobile & other types including medical-payment) or Set-Aside
15	Workers' Compensation (WC) or Set-Aside
16	PHS; research grants
41	Federal Black Lung Program
43	Disabled, under age 65, LGHP through self or family member, 100 or more employees
47	Liability Insurance or Set-Aside

Promptly – Defined

- Promptly means
  - For no-fault (VC 14) and WC (VC 15)
    - Payment within 120 days after insurer receives claim
  - For liability, including self-insurance (VC 47)
    - Payment within 120 days after earlier of
      - Date 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 (date of discharge for IP)

Valid Reasons

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

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

- To bill us conditionally
  - You must have GHP's response; reason they did not pay is valid
- Applicable when beneficiary has
  - GHP only or
  - GHP and no-fault, WC or liability coverage (service is related to accident)
    - When beneficiary has GHP and accident coverage, bill accident payer first, GHP next and Medicare third

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

- To bill us conditionally within promptly period
  - You must have non-GHP's response; reason they did not pay is valid
- To bill us conditionally after promptly period
  - You do not need non-GHP's response
  - 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 liability's response; reason they did not pay is valid
- To bill us conditionally after promptly period
  - You do not need to have liability's response
  - You can maintain liability claim/lien **or** bill conditionally
    - If beneficiary also has primary GHP, you must bill them before us **and** you must withdraw liability claim/lien
      - If you receive liability and Medicare payments, review CMS IOM Publication 100-05, *MSP Manual*, Chapter 2, Section 40.2E

Medicare Can Pay Conditionally When

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

Medicare Cannot Pay Conditionally When…

- You did not bill primary payer because
  - Beneficiary refused to file or cooperate with you to file
- You billed primary payer but they did not pay
  - Claim was not proper claim
    - No prior authorization (we reject conditional claim)
    - Out of network provider (we pay conditional claim only once)
      - You may submit MSP claim with MSP VC amount = amount you would have received from primary payer had proper claim been filed
        - » CMS IOM Publication 100-05, *MSP Manual*, Chapter 5, Section 40.7.5

Medicare Cannot Pay Conditionally When…

- Beneficiary involved in accident and has primary non-GHP as well as primary GHP
  - You billed primary non-GHP but did not bill primary GHP
  - You billed primary GHP but did not bill primary non-GHP
    - Bill non-GHP first, then GHP, then Medicare

Claim Preparation and Submission Reminders

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

Step Two – Prepare Conditional Claim

- Complete claim in usual manner
  - Move primary payer to first payer and Medicare to second (or third)
  - Covered TOB, required coding, covered/noncovered days/charges
- Follow Medicare's usual requirements
  - Technical, medical and billing
    - HHAs submit NOA as Medicare primary; code insurer information on claim
    - Hospices submit NOE as Medicare primary; code insurer information on claim
- Report on claim
  - Applicable MSP billing codes from MSP Billing Code Table
    - Prepare and Submit an MSP Conditional Claim

Step Two – Prepare Conditional Claim

- Primary payer adjustment reasons (CAGCs/CARCs) and amounts from RA
  - In loops/segments (837I), on page 3/MAP1719 (FISS DDE) and submit primary payer's RA for hardcopy claim submissions
  - 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
    - 1 = deductible, 2 = coinsurance, 45 = charges exceed fee schedule or maximum allowed, 96 = noncovered charges, 119 = benefit maximum reached, **192 = non standard adjustment code from paper RA**
- References: X12, CR6426 and CR8486

Two Payers Are Primary to Medicare

- Bill both payers in proper order
  - Primary, wait for response or promptly period end, then
  - Secondary, wait for response or promptly period end
- If **both paid**, submit **Medicare tertiary claim**
  - Primary first, secondary next, Medicare third
- If **one paid and other did not** (valid reason or promptly), submit **MSP claim**
  - Paying payer first, Medicare second (omit nonpaying payer)

Two Payers are Primary to Medicare

- If **neither paid** (valid reason or promptly), submit **conditional claim**
  - Primary payer first, Medicare second (omit secondary payer)
    - One MSP VC, zero payment, insurer information, etc.
    - If using FISS DDE, complete MAP1719 for Payer 1 only
      - Do not include any data on MAP1719 for Payer 2
  - FISS cannot accept conditional claims (Medicare as tertiary) with two primary payers that made no payment

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

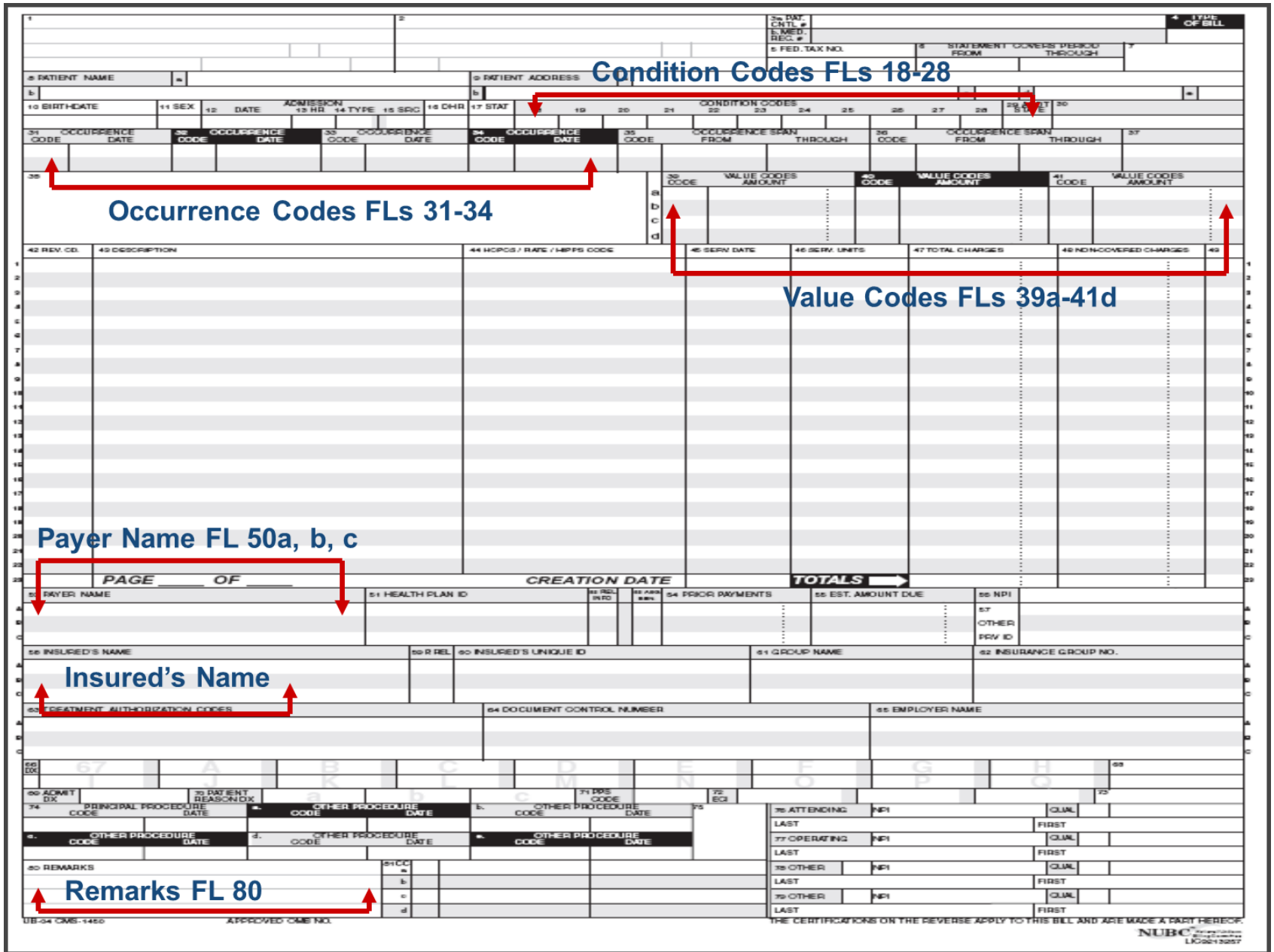
MSP Billing Code Table (Claim Fields for Claim Codes)

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) **is always = 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)

Claim Form Example



Condition Codes (CCs or COND Codes)

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

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

- Report applicable MSP OCs
  - **01** and DOA = No-fault(not auto)/med-pay is primary
  - **02** and DOA = No-fault (auto) is primary
  - **03** and DOA = Liability is primary
  - **04** and DOA = WC is primary
  - **33** and date = 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 coding 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

Patient's Relationship to Insured

- Report **code** for relationship of patient to insured in FLs 59A, B, C or equivalent fields
  - **01** = Spouse, **18** = Self, **19** = Child, **20** = Employee,
  - **21** = Unknown, **53** = Life partner, **G8** = Other relationship
- For conditional claims, report
  - When **one payer** is primary and did not pay
    - One of above codes in 59A (for primary payer) and 18 in 59B
  - When **two payers** are primary and did not pay
    - One of above codes in 59A (for primary payer) and 18 in 59B

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

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

Remarks: Codes NB, PC, CD and FG

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

Remarks: Code BE

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

Remarks: Code PE

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

Remarks: Codes DP, LD and PP

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

Remarks: Code DA

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

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

FISS DDE Claim Entry – Reminders

- Providers can use to enter/submit claims
  - FISS DDE Provider Online Guide, Claim Entry: Chapter V
- From main menu, select Claims/Attachments
  - On MAP1701, enter: 02
  - On MAP1703, enter: 20=IP, 22=OP, 24=SNF, 26=HH, 28=Hospice
- Six pages to claim; similar to UB-04/CMS-1450
- Enter all required data, not just MSP
- Cursor may skip fields not required
- TOB defaults: 111=IP, 131=OP, 211=SNF (type over)

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 and 66–79: Payer, diagnosis code, procedure 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

MAP1719 (Additional Page 03)

```
MAP1719    PAGE 03   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
MXG9282    SC                  INST CLAIM ENTRY                  C201831F 14:05:55
HIC                  TOB 111   S/LOC S B0100   PROVIDER
MID                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
HIC                 TOB 111   S/LOC S B0100   PROVIDER
MID
                  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
```

Conditional Claim Examples – Help Code These Claims

Assumptions for MSP Claim Examples

- Beneficiaries
  - Have Medicare Parts A and B
  - Have not met annual Medicare Part B deductible
- Providers
  - Ensured there is matching MSP record for each claim
  - Followed Medicare's usual claim filing guidelines
  - Reported all usual codes, MSP codes and CAGCs/CARCs
    - **Except for certain condition, occurrence and value codes**

Example #1	
Beneficiary	Beneficiary 1, Age 69
Employed	For employer with 25 employees
Insurance	EGHP through above employee
Service	OP FQHC
DOS	12/10/2021
Charges	$600
Expected to receive	$450
Primary paid	$0 (Per EOB dated 1/10/2022, $450 applied to deductible, OP facility submits conditional claim)

Example #1 – Claim Coding	
CCs?	None
OC 24 needed?	Yes
If so, with what date?	***Help code date***
Any other OCs and dates?	None
Which MSP VC?	12
Explanation code in Remarks?	***Help select code***
Explanation code date required?	No

Polling Question #1

- For example #1, what date is required with OC 24 and which explanation code is required in Remarks?
  - 12/10/2021 and NB
  - 12/20/2021 and CD
  - 1/10/2022 and NB
  - 1/10/2022 and CD

Example #2	
Beneficiary	Beneficiary 2, Age 74 (Retired)
DOA	2/9/2022 (fall in grocery store)
Insurance	Liability Insurer (no med-pay)
Service	IP Hospital
DOS	2/10/2022–2/13/2022
Charges	$29,000
Filed Claim with Primary Payer	2/16/2022
Primary paid	$0 (no response within 120 days); Hospital withdrew claim with Liability and submits conditional claim

Example #2 – Claim Coding

CCs?	None
OC 24 needed?	No
Any other OCs and dates?	03 = 2/9/2022
Which MSP VC?	***Help select code***
Explanation code in Remarks?	***Help select code***
Explanation code date required?	Yes
If so, what date?	***Help code date***

Polling Question #2

- For example #2, which MSP VC is required and which explanation code and date is required in Remarks?
  - 14 and DA = 2/16/2022
  - 14 and DA = 2/10/2022
  - 47 and DA = 2/16/2022
  - 47 and DA = 2/10/2022

Example #3	
Beneficiary	Beneficiary 3, Age 35 with ESRD (30-month coordination period began 1/1/2022
Employed	Parent works for employer
Insurance	EGHP through parent's employer
Service	Home Health
DOS	12/15/2021–1/10/2022
Charges	$4,000
Primary paid	$0 (per EOB dated 2/20/2022, provider not in EGHP's network); HHA submits conditional claim

Example #3 – Claim Coding

CCs?	03 (zero 3)
OC 24 needed?	Yes
If so, with what date?	***Help code date***
Other OCs and dates?	33 = 1/1/2022
Which MSP VC?	13
Explanation code in Remarks?	***Help select code***
Explanation code date required?	No

Polling Question #3

- For example #3, what date is required with OC 24 and which explanation code is required in Remarks?
  - 1/10/2022 and FG “out of network”
  - 2/20/2022 and FG “out of network”
  - 1/10/2022 and NB
  - 2/20/2022 and NB

Example #4	
Beneficiary	Beneficiary 4, Age 66
Employed	Spouse works for employer with 38 employees
Insurance	EGHP through spouse's employer
Service	Hospice
DOS	11/2/2021–11/29/2021
Charges	$5,500
Primary paid	$0 (per EOB dated 12/24/2021, hospice provider received no payment, hospice services not covered benefit); hospice provider submits conditional claim

Example #4 – Claim Coding

CCs?	None
OC 24 needed?	Yes
If so, with what date?	12/24/2021
Other OCs and dates?	None
Which MSP VC?	***Help select code***
Explanation code in Remarks?	***Help select code***
Explanation code date required?	No

Polling Question #4

- For example #4, which MSP VC is required and which explanation code is required in Remarks?
  - 12 and NB
  - 43 and NB
  - 12 and CD
  - 43 and CD
  - 12 and BE

Example #5	
Beneficiary	Beneficiary 5, Age 53
Employed	For employer with 112 employees
Insurance	LGHP through above employer
Service	IP SNF (submits monthly claims)
DOS	11/1/2021–12/13/2021
Charges	$180,000
Primary paid	$90,000 through 11/25/2020 (per EOB dated 1/1/2022, SNF received no more payment, LGHP's SNF benefits exhausted on 11/25/2021); SNF submits conditional claim

Did You Know

- For example #5, SNF must submit two claims
  - MSP claim 11/1/2021–11/30/2021 and
  - **Conditional claim 12/1/2021–12/13/2021**

Example #5 – Claim Coding

CCs?	None
OC 24 needed?	Yes
If so, with what date?	***Help code date***
Other OCs and dates?	None
Which MSP VC?	43
Explanation code in Remarks?	***Help select code***
Explanation code date required?	Yes
If so, what date?	***Help code date***

Polling Question #5

- For example #5, what date is required with OC 24 and which explanation code and date is required in Remarks?
  - 1/1/2022 and BE = 11/25/2021
  - 11/25/2021 and BE = 11/25/2021
  - 1/1/2022 and PE = 11/25/2021
  - 11/25/2021 and PE = 11/25/2021

Example #6	
Beneficiary	Beneficiary 6, Age 81 (retired)
DOA (auto)	12/9/2021 (not a No-Fault state)
Insurance	Auto med-pay (no liability)
Service	OP facility
DOS	12/30/2021
Charges	$250
Filed claim with primary payer	1/15/2022
Primary paid	$0 (per EOB from med-pay dated 2/10/2022, benefits exhausted on 1/30/2022 which is after this DOS). OP facility submits conditional claim.

Example #6 – Claim Coding

CCs?	None
OC 24 needed?	Yes
If so, with what date?	2/10/2022
Other OCs and dates?	***Help select code and date***
Which MSP VC?	14
Explanation code in Remarks?	***Help select code***
Explanation code date required?	Yes
If so, what date?	***Help code date***

Polling Question #6

- For example #6, which OC and date is required **and** which explanation code and date is required in Remarks?

a) 01 = 12/30/2021 and BE = 02/10/2022

b) 01 = 12/09/2021 and BE = 01/30/2022

c) 02 = 12/30/2021 and BE = 02/10/2022

d) 02 = 12/09/2021 and PE = 01/30/2022

Example #7	
Beneficiary	Beneficiary 7, Age 75 (retired)
DOA (auto)	12/9/2021 (in auto No-Fault state)
Insurance	Auto No-Fault (no liability)
Service	OP facility
DOS	2/3/2022
Charges	$550
Filed claim with primary payer	2/15/2022
Primary paid	$0 (per EOB from No-Fault dated 2/20/2022, benefits exhausted on 2/10/2022 which is after this DOS). OP facility submits conditional claim.

Example #7 – Claim Coding	
CCs?	None
OC 24 needed?	Yes
If so, with what date?	2/20/2021
Other OCs and dates?	***Help select code and date***
Which MSP VC?	14
Explanation code in Remarks?	***Help select code***
Explanation code date required?	Yes
If so, what date?	***Help code date***

Polling Question #7

- For example #7, which OC and date is required **and** which explanation code and date is required in Remarks?
  - 01 = 12/9/2021 and PE = 2/10/2022
  - 01 = 12/9/2021 and BE = 2/10/2022
  - 02 = 12/9/2021 and PE = 2/10/2022
  - 02 = 2/3/2022 and PE = 2/10/2022

Example #8	
Beneficiary	Beneficiary 8, Age 63
Employed	For employer with 161 employees
Insurance	LGHP through above employer
Service	IP Hospital (bills admit to discharge)
DOS	11/1/2021–12/13/2021
Charges	$150,000
Primary paid	$75,000 through 11/10/2021; then $0 per EOB dated 1/11/2022 because care through 12/13/2021 is not covered benefit. Care is covered by Medicare.

Polling Question #8

- For example #8, hospital must submit
  a) Two claims; one MSP claim from 11/1/2021 to 11/10/2021 and one conditional claim from 12/1/2021 to 12/13/2021
  b) One MSP claim from 11/1/2021 to 12/13/2021
  c) One conditional claim from 11/1/2021 to 12/13/2021

Example #9	
Beneficiary	Beneficiary 9, Age 63
DOA (auto)	8/13/2021, two-car accident, traditional auto insurance state, liability also involved
Insurance	Med-pay (Acme) for beneficiary, at-fault party has liability coverage (Axel)
Service	IP Hospital (bill admit to discharge)
DOS	8/13/2021–9/1/2021
Charges	$80,000
Primary paid	Billed med-pay on 9/15/2022, no response. After 120 days, billed liability on 1/20/2022, no response. After 120 days, withdraws liability claim/lien to bill conditionally.

When You Have Two Primary Payers and No Payment

- Billed two insurers, neither has paid
- Even though there are two payers primary to Medicare, report only one insurer on claim (payer that is primary)
- Enter applicable OC, VC, primary payer code = C, insurer name, etc., for that primary payer
- Report information on MAP1719 for only insurer under Primary Payer 1

Conditional Claim Wrap-Up

- Conditional claims
  - Are claims submitted to Medicare when primary payer has not paid promptly (accident situation) or for a valid reason
  - Require OC 24 and date of primary payer's notice (RA, EOB statement, letter, etc.) explaining why they did not pay claim
    - Exception: when primary payer for accident did not pay promptly
  - Require MSP VC and primary payer's payment amount of $0
  - Require two-digit explanation code in Remarks that explains why primary payer did not pay (some also require a date in MM/DD/YY format)

What You Should Do Now

- Review MSP Resources handout
- Review R87MSP.pdf (cms.gov)
- Share information with staff
- Continue to learn about MSP; attend education sessions
- Develop and implement policies that ensure your MSP responsibilities are met
- Submit conditional claims when appropriate and code accurately

Thank You!

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

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