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Medicare Secondary Payer: Conditional Billing Examples

10/11/2023

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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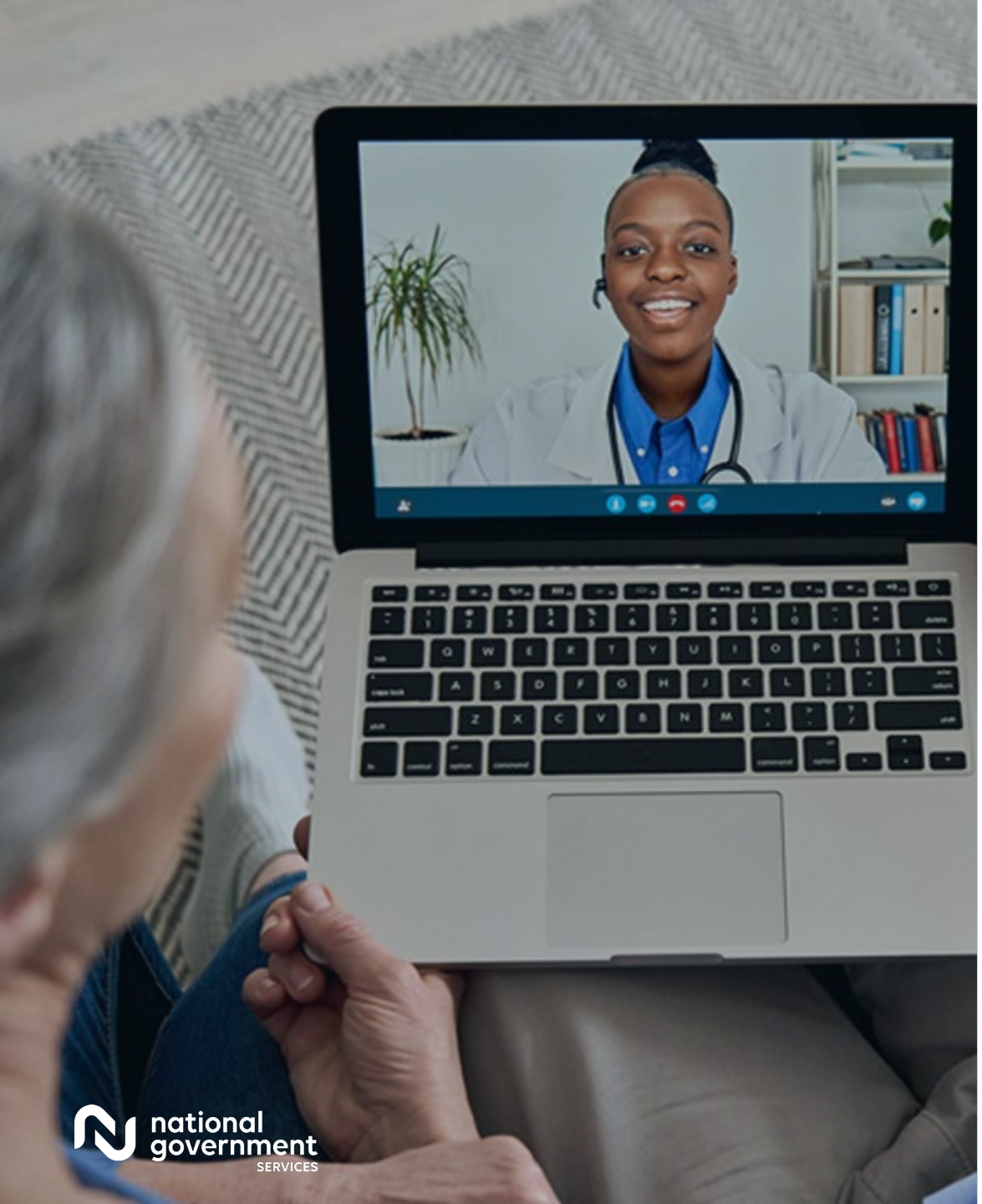

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Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Objective

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

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Agenda

2023 MSP Webinars
Christine Janiszcak

MSP Resources Handout
Christine Janiszcak

Conditional Claim Reminders
Christine Janiszcak

Conditional Claim Preparation and Submission Reminders
Christine Janiszcak and Jan Wood

Conditional Claim Examples – Help Code These Claims
Jan Wood

Questions and Answers

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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!

Conditional Claim Reminders

Conditional Claims and Promptly – Defined

- Claims submitted for conditional payment because you billed primary payer and
  - They did not pay for valid reason (all MSP provisions except VC 16 and VA); examples:
    - ✓ Services not covered, services related to preexisting condition or charges applied to deductible/coinsurance
    - ✓ Guidelines not followed: Claim filed untimely (must be filed timely with us) or out of network (we pay once)
    - ✓ Benefits exhausted (GHP's or non-GHP's benefits)
    - ✓ Liability replied = payment delayed, not responsible or paid patient (you were not expecting patient payment)
  - They did not pay promptly (accident MSP provisions only); promptly means
    - ✓ For no-fault (including med-pay) and WC = Payment within 120 days after insurer receives claim
    - ✓ For liability = Payment within 120 days after earlier of: *date general liability claim filed with insurer/lien filed against potential liability settlement (date liability record created in CWF); or DOS (discharge date for IP)*

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

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)
    - ✓ Note: When beneficiary has GHP and accident coverage, bill accident payer first, GHP next and Medicare third

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 they did not pay
- To bill us conditionally after promptly period
  - You do not need to have response from non-GHP
- Once promptly period ends
  - You can 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
    - ✓ Note: 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 they did not pay
- To bill us conditionally after promptly period
  - You do not need a response from liability
- Once promptly period ends
  - You can 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
    - ✓ 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
    - ✓ MSP claim per CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5 or
    - ✓ Submit conditional claim (no prior authorization, we reject OR provider out of network, we pay only once)
- 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)

Conditional Claim Preparation and Submission Reminders

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 a 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 billed primary non-GHP and you did not receive a response
  - Promptly period ended
  - You withdrew claim/lien with liability, if applicable

How to Bill When There are Two Payers Primary to Medicare

- Submit **Medicare tertiary claim** if both payers paid
  - Report primary payer first, secondary payer next, and Medicare third
- Submit **MSP claim** if one payer paid and other did not (valid reason or promptly)
  - Report paying payer first and Medicare second (omit nonpaying payer)
- Submit **conditional claim** if neither payer paid (valid reason or promptly)
  - Report primary payer first and Medicare second (omit secondary payer)
    - ✓ One MSP VC, zero payment, primary payer code C, insurer information, etc.
    - ✓ If using FISS DDE, complete MAP1719 for Payer 1 only (do not include any data for Payer 2)
    - ✓ Note: FISS can't accept conditional claims (Medicare tertiary) with two primary payers that did not pay

Step Two – Prepare Conditional Claim

- Follow Medicare's usual requirements
  - Technical, medical and billing (including frequency of billing)
    - ✓ HHAs submit NOA as Medicare primary; code insurer information on claim
    - ✓ Hospices submit NOE as Medicare primary; code insurer information on claim
- Complete claim in usual manner
  - Move primary payer to first payer and Medicare to second payer
  - Report covered TOB, required coding, covered/noncovered days and charges
- Report on claim
  - Applicable MSP billing codes from MSP Billing Code Table
    - ✓ Prepare and Submit an MSP Conditional Claim (Table within article)
    - ✓ Provides claim fields and codes for UB-04/CMS-1450 claim form, 837I claim and FISS DDE claim
  - Primary payer adjustment reasons/amounts (MSP CAS information) from primary payer's RA

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

Claim Adjustment Group Codes and Claim Adjustment Reason Codes

- 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 = 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)

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

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)

Condition Codes, Occurrence Codes/Dates and Value Codes/Amount

- Report applicable
  - MSP CCs (COND)
    - ✓ 02 (zero two) = Condition is employment-related
    - ✓ 06 (zero six) = ESRD beneficiary in first 30 months of entitlement with EGHP
  - MSP OCs (OCC CDS/DATE)
    - ✓ 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 of why they did not pay (except when DA in Remarks)
- MSP VC (12, 13, 14, 15, 16, 41, 43, 47) and VC amount = $0

Patient's Relationship to Insured

- Report code for relationship of patient to insured in FL 59A,B,C or equivalent field
  - 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 and Insurance Address

- Report in Remarks
  - Two-digit code explaining reason primary payer did not pay or did not pay promptly (first line); known as explanation code
    - ✓ NGS-created codes: 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
  - Primary payer's address (second line) for hardcopy and 837I claims
    - ✓ Note: Use claim page 06 for FISS DDE claim entry

Remarks: Codes NB, PC, CD and FG

- Report code
  - **NB** = Primary payer did not pay because services are not a covered benefit
    - ✓ VCs 12, 13, 14, 15, 41 or 43
  - **PC** = Primary payer did not pay because services are related to a pre-existing condition
    - ✓ VCs 12, 13 or 43
  - **CD** = Primary payer did not pay because charges applied to deductible, co-pay or coinsurance
    - ✓ VCs 12, 13, 14 or 43
  - **FG** (space) then reason (typed out) = Primary payer did not pay because their guidelines not followed (VCs 12, 13, 15 or 43)
    - ✓ Claim was filed untimely (We pay if filed timely with us)
    - ✓ Provider is out of plan's network (We pay one time per entire time beneficiary is enrolled in that plan)
    - ✓ Prior authorization was not obtained (We do not pay)

Remarks: Codes BE and PE

- Report code, with date benefits exhausted (MM/DD/YY)
  - **BE** = Primary **GHP** (VCs 12, 13 and 43) did not pay because benefits exhausted
    - ✓ Do not submit primary claim unless beneficiary's lifetime benefits under GHP exhausted for all services
  - **PE** = 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
    - ✓ Notify BCRC of benefits exhaust date so they can post it to MSP record
    - ✓ If DOS < benefits exhaust date, claim coded as conditional
    - ✓ If DOS > benefits exhaust date, claim coded as primary
  - **PE** = Primary **auto no-fault** (VC 14) did not pay because PIP exhausted and no other primary payer
    - ✓ No-fault states: Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania, Utah and Puerto Rico
    - ✓ Notify BCRC of benefits exhaust date so they can post it to MSP record
    - ✓ If DOS < benefits exhaust date, claim coded as conditional
    - ✓ If DOS > benefits exhaust date, claim coded as primary
- Benefits exhaust date in Remarks may not be same as OC 24 date

Remarks: Codes DA, DP, LD and PP

- Report code
  - DA with date you billed primary payer (MM/DD/YY) when primary non-GHP (VCs 14, 15, 41 and 47), did not pay promptly and 120 days has passed (promptly period ended)
    - ✓ Do not also report OC 24 and date on claim
    - ✓ If primary payer is liability (VC 47), you must withdraw liability claim/lien
- Report code
  - **DP** = Liability payer (VC 47) did not pay stating there will be a delay in their payment
  - **LD** = Liability payer (VC 47) did not pay stating they are not responsible for claim
  - **PP** = Liability payer (VC 47) did not pay stating they paid beneficiary and you were not already expecting this payment from beneficiary

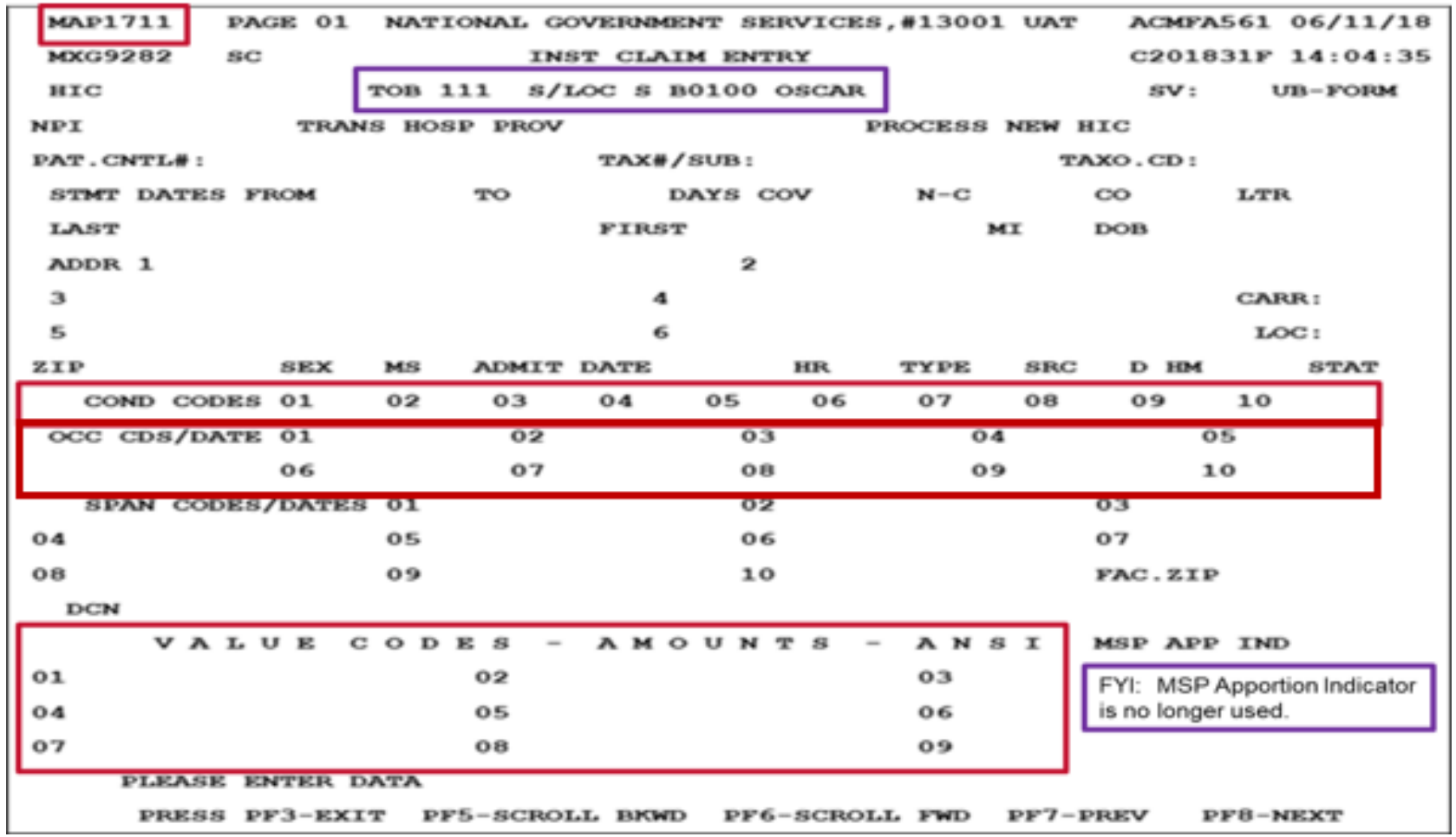
FISS DDE Claim Entry – Reminders

- 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 menu selection: 02
  - On MAP1703, enter menu selection: 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 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

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                                                        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

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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
```
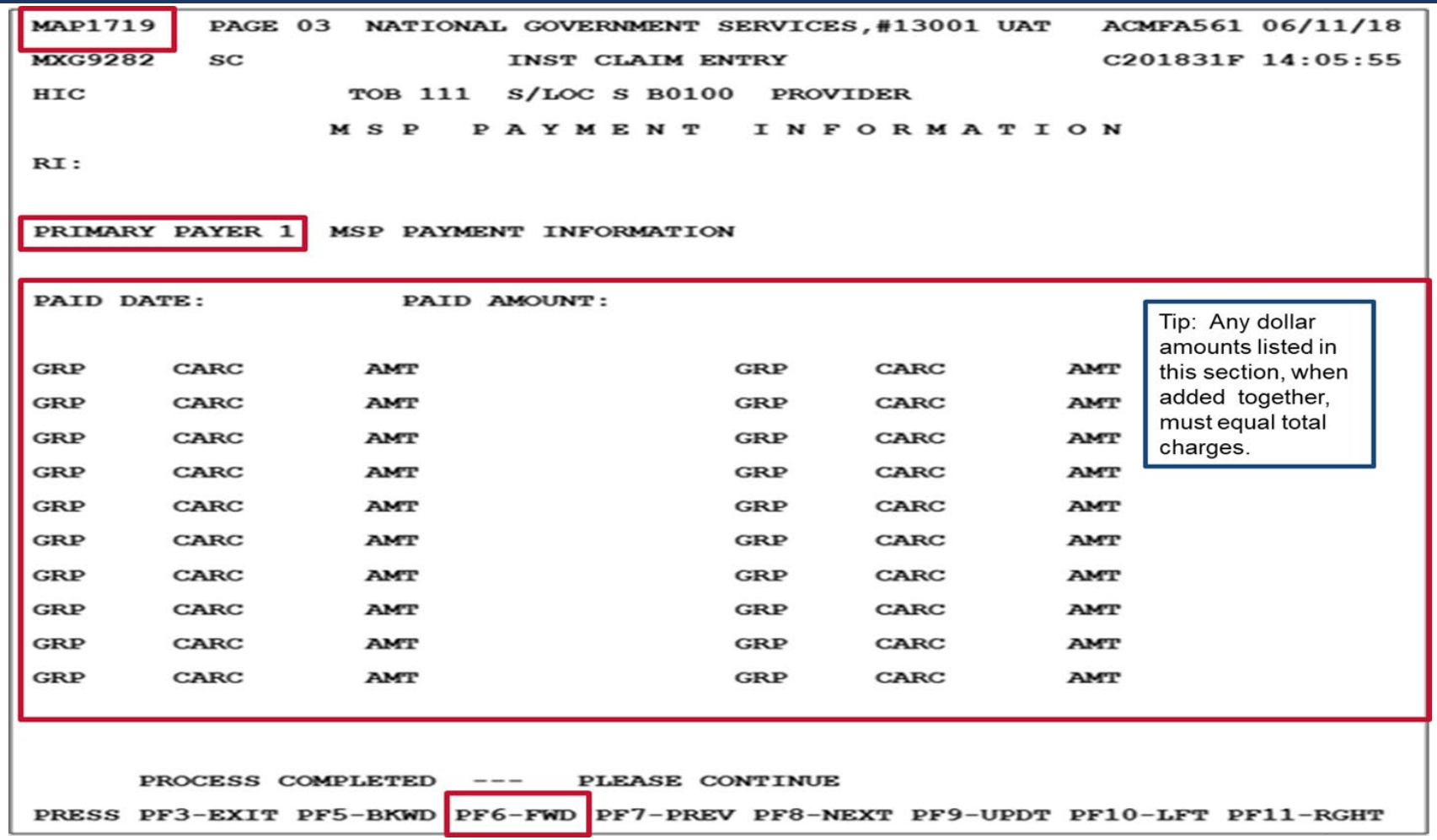

Page 03 (Additional) – MAP1719

- 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 always be 0 for conditional claims)
      - **GRP:** CAGC(s)
      - **CARC:** CARC(s)
      - **AMT:** Dollar amount with each CAGC/CARC pair

Page 03 (Additional) – MAP1719



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                  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
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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.

Page 03 (Additional) – MAP1719

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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
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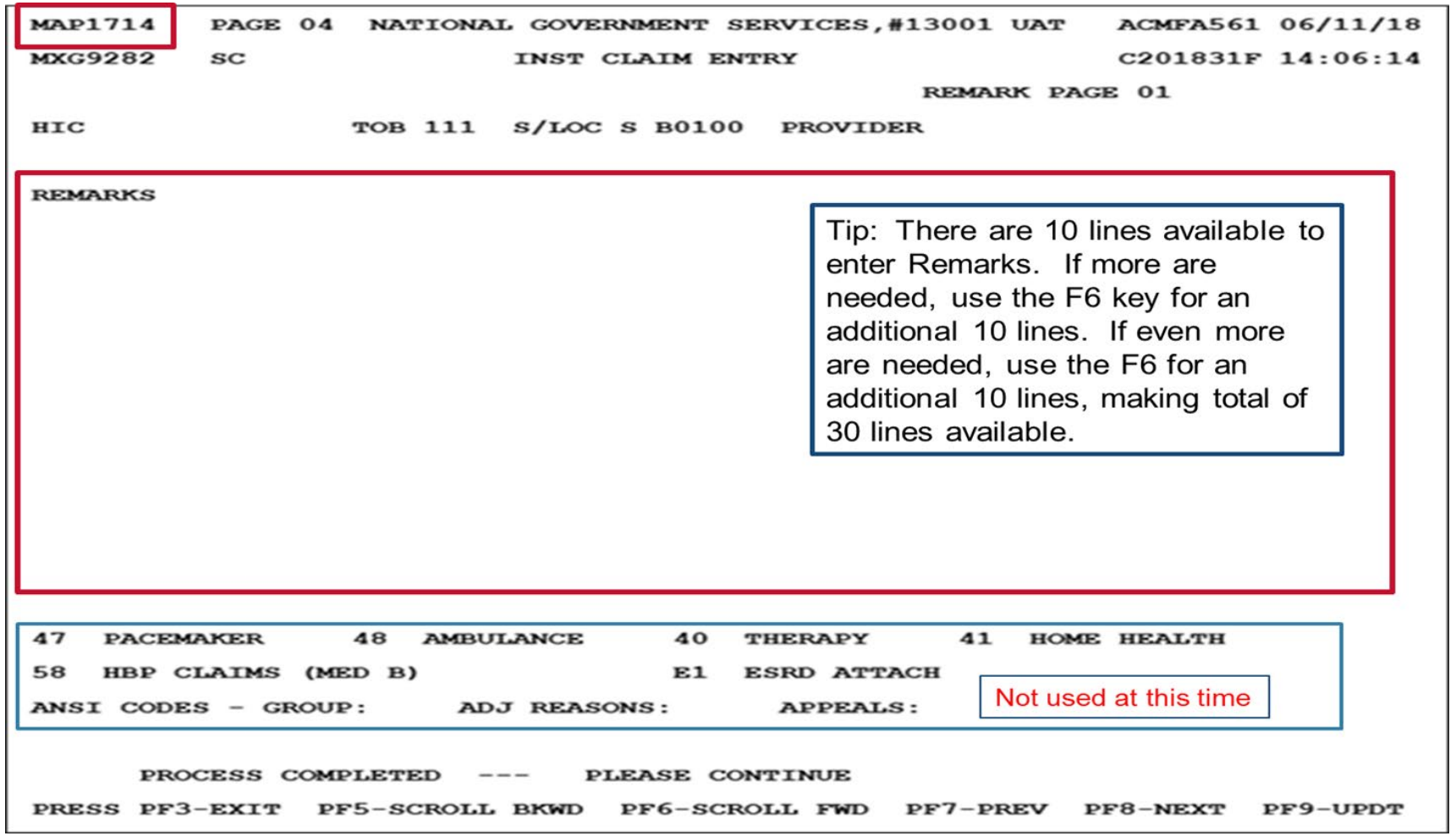
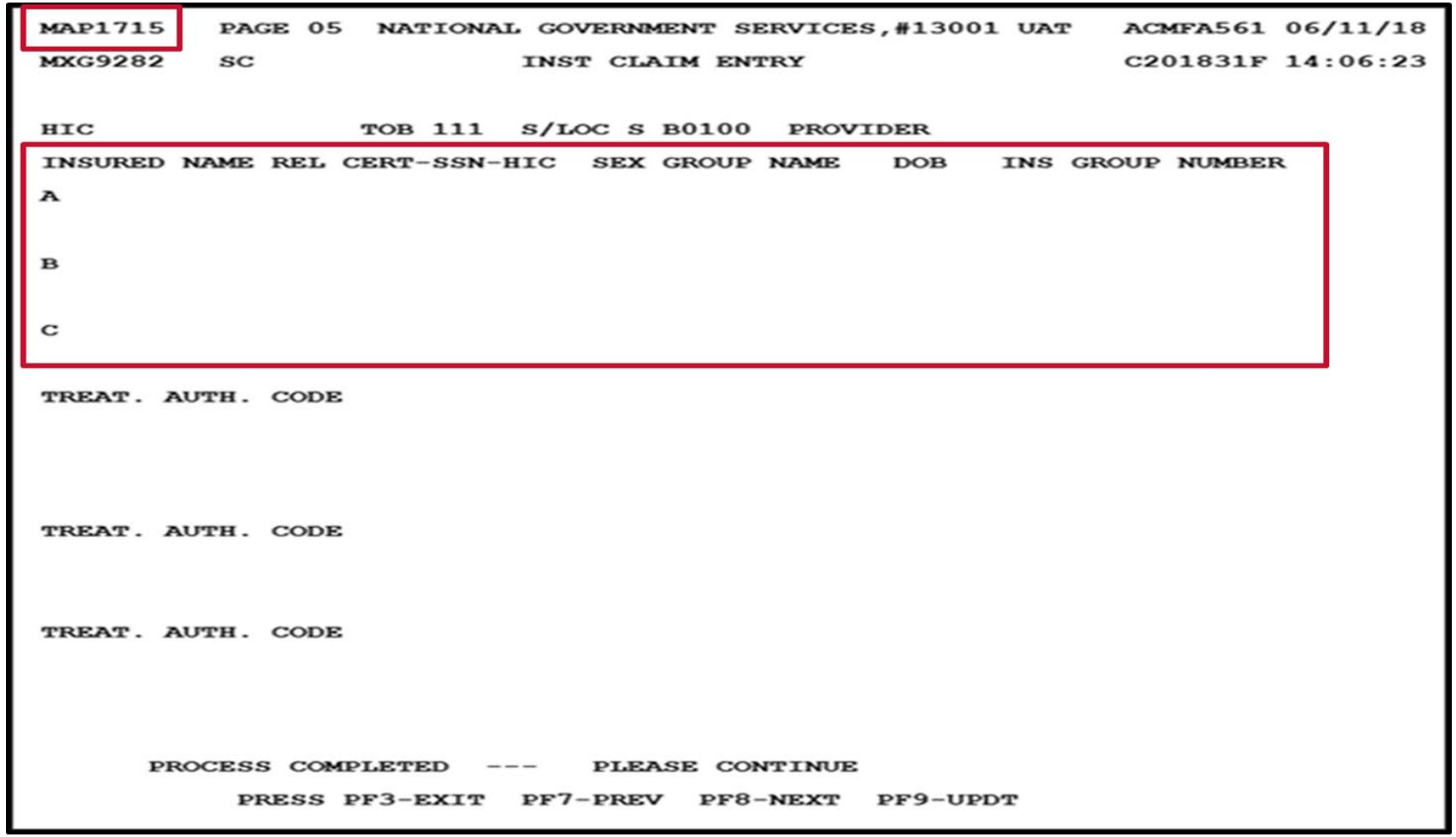
Page 04 – MAP1714



Page 05 – MAP1715



Page 06 – MAP1716

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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
```

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 CCs, OCs and VCs**

Example One

Item	Information
Beneficiary	Beneficiary 1, Age 69
Employed	Employer with 28 employees
Insurance	EGHP through above employer
Service	OP FQHC
DOS	12/10/2022
Medicare covered charges	$600
Expected to receive	$450
Primary payer paid	$0 (Per EOB dated 3/26/2023, $450 applied to deductible; FQHC submits conditional claim)

Example One – Claim Coding

Code(s)	Information
CC(s)?	None
OC 24 needed?	**Yes**
If so, with what date?	**Help code date**
Any other OCs and dates?	No
Which MSP VC?	12
Explanation code in Remarks?	**Help select code**
Explanation code date required?	No
If so, with what date?	N/A

Polling Question One

- For this example, what date is required with OC 24 and which explanation code is required in Remarks?
  - 12/10/2022 and NB
  - 12/10/2022 and CD
  - 3/26/2023 and NB
  - 3/26/2023 and CD

Example Two

Item	Information
Beneficiary	Beneficiary 2, Age 69 (retired)
DOA	2/9/2023 (fall in grocery store)
Insurance	Liability (no medical-payment)
Service	IP Hospital
DOS	2/10/2023–2/13/2023
Medicare covered charges	$29,000
Filed claim with primary payer	2/16/2023
Primary payer paid	$0 (no response within 120 days); Hospital withdrew claim with Liability and submits conditional claim

Example Two – Claim Coding

Code(s)	Information
CC(s)?	None
OC 24 needed?	**No**
If so, with what date?	N/A
Any other OCs and dates?	03 and 2/9/2023
Which MSP VC?	**Help select code**
Explanation code in Remarks?	DA
Explanation code date required?	Yes
If so, with what date?	**Help code date**

Polling Question Two

- For this example, which MSP VC is required and which explanation code DA date is required in Remarks?
  - 14 and DA = 2/16/2023
  - 14 and DA = 2/10/2023
  - 47 and DA = 2/16/2023
  - 47 and DA = 2/10/2023

Example Three

Item	Information
Beneficiary	Beneficiary 3, Age 35 with ESRD, coordination period began 1/1/2022
Employed	Parent works
Insurance	EGHP through above employer
Service	HH
DOS	12/15/2022–1/10/2023
Medicare covered charges	$4,000
Expected to receive	$3,500
Primary payer paid	$0 (Per EOB dated 2/20/2023, provider out of network; HH submits conditional claim)

Example Three – Claim Coding

Code(s)	Information
CC(s)?	06
OC 24 needed?	**Yes**
If so, with what date?	**Help code date**
Any other OCs and dates?	33 and 1/1/2022
Which MSP VC?	13
Explanation code in Remarks?	**Help select code**
Explanation code date required?	No
If so, with what date?	N/A

Polling Question Three

- For this example, what date is required with OC 24 and which explanation code is required in Remarks?
  - 1/10/2022 and FG “out of network”
  - 2/20/2023 and FG “out of network”
  - 1/10/2022 and NB
  - 2/20/2023 and NB

Example Four

Item	Information
Beneficiary	Beneficiary 4, Age 66
Employed	Spouse works for employer with 68 employees
Insurance	EGHP through above employer
Service	Hospice
DOS	11/2/2022–11/29/2022
Medicare covered charges	$5,500
Expected to receive	$5,000
Primary payer paid	$0 (Per EOB dated 12/24/2022, hospice services not covered benefit; Hospice submits conditional claim)

Example Four – Claim Coding

Code(s)	Information
CC(s)?	None
OC 24 needed?	**Yes**
If so, with what date?	12/24/2022
Any other OCs and dates?	None
Which MSP VC?	**Help select code**
Explanation code in Remarks?	**Help select code**
Explanation code date required?	No
If so, with what date?	N/A

Polling Question Four

- For this example, 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

Example Five

Item	Information
Beneficiary	Beneficiary 5, Age 53
Employed	Employer with 113 employees
Insurance	LGHP through above employer
Service	IP SNF
DOS	11/1/2022–12/13/2022
Medicare covered charges	$155,000
Expected to receive	$150,000
Primary payer paid	$100,000 through 11/25/2022 per EOB dated 1/1/2023. SNF received no more payment. LGHP's SNF benefits exhausted on 11/25/2022; SNF submits conditional claim)

Did You Know

- For Example Five, SNF must submit two claims
  - MSP claim 11/1/2022–11/30/2022 and
  - Conditional claim 12/1/2022–12/13/2022

Example Five – Claim Coding

Code(s)	Information
CC(s)?	None
OC 24 needed?	**Yes**
If so, with what date?	1/1/2023
Any other OCs and dates?	None
Which MSP VC?	43
Explanation code in Remarks?	**Help select code**
Explanation code date required?	Yes
If so, with what date?	**Help code date**

Polling Question Five

- For this example, which explanation code and date is required in Remarks?
  - BE = 11/25/2022
  - BE = 1/1/2023
  - PE = 11/25/2022
  - PE = 1/1/2023

Example Six

Item	Information
Beneficiary	Beneficiary 6, Age 81 (retired)
DOA (automobile)	12/9/2022 (not auto no-fault state)
Insurance	Auto med-pay (no liability)
Service	OP facility
DOS	12/30/2022
Medicare covered charges	$250.00
Filed claim with primary payer	1/15/2023
Primary payer paid	$0 (per EOB dated 2/10/2023, benefits exhausted on 1/30/2023, which is after this DOS. OP facility submits conditional claim.)

Example Six – Claim Coding

Code(s)	Information
CC(s)?	None
OC 24 needed?	**Yes**
If so, with what date?	2/10/2023
Any other OCs and dates?	**Help select code(s) and date(s)**
Which MSP VC?	14
Explanation code in Remarks?	**Help select code**
Explanation code date required?	Yes
If so, with what date?	Help code date

Polling Question Six

- For this example, which OC/date is required **and** which explanation code/date is required in Remarks?
  - 01 = 12/30/2022 and BE = 02/10/2023
  - 01 = 12/09/2022 and BE = 01/30/2023
  - 02 = 12/30/2022 and BE = 02/10/2023
  - 02 = 12/09/2022 and PE = 01/30/2023

Example Seven

Item	Information
Beneficiary	Beneficiary 7, Age 75 (retired)
DOA (automobile)	12/9/2022 (auto no-fault state)
Insurance	Auto no-fault (no liability)
Service	OP facility
DOS	2/3/2023
Medicare covered charges	$550.00
Filed claim with primary payer	2/15/2023
Primary payer paid	$0 (per EOB dated 2/20/2023, benefits exhausted on 2/10/2023 which is after this DOS. OP facility submits conditional claim.)

Example Seven – Claim Coding

Code(s)	Information
CC(s)?	None
OC 24 needed?	**Yes**
If so, with what date?	2/20/2023
Any other OCs and dates?	**Help select code(s) and date(s)**
Which MSP VC?	14
Explanation code in Remarks?	**Help select code**
Explanation code date required?	Yes
If so, with what date?	**Help code date**

Polling Question Seven

- For this example, which OC/date is required **and** which explanation code/date is required in Remarks?
  - 01 = 12/9/2022 and PE = 2/10/2023
  - 01 = 12/9/2022 and BE = 2/10/2023
  - 02 = 12/9/2022 and PE = 2/10/2023
  - 02 = 2/3/2023 and PE = 2/10/2023

Example Eight

Item	Information
Beneficiary	Beneficiary 8, Age 63
Employed	Employer with 161 employees
Insurance	LGHP through above employer
Service	IP Hospital
DOS	11/1/2022–12/13/2022
Medicare covered charges	$160,000
Expected to receive	$150,000
Primary payer paid	$75,000 through 11/10/2022 per EOB dated 1/11/2023 because care from 11/11/2022 to 12/13/2022 is not a covered benefit. Care is covered by Medicare.

Polling Question Eight

- For this example, hospital must submit
  a) Two claims; one MSP claim from 11/1/2022 to 11/10/2022 and one conditional claim from 12/1/2022 to 12/13/2022
  b) One MSP claim from 11/1/2022 to 12/13/2022
  c) One conditional claim from 11/1/2022 to 12/13/2022

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)

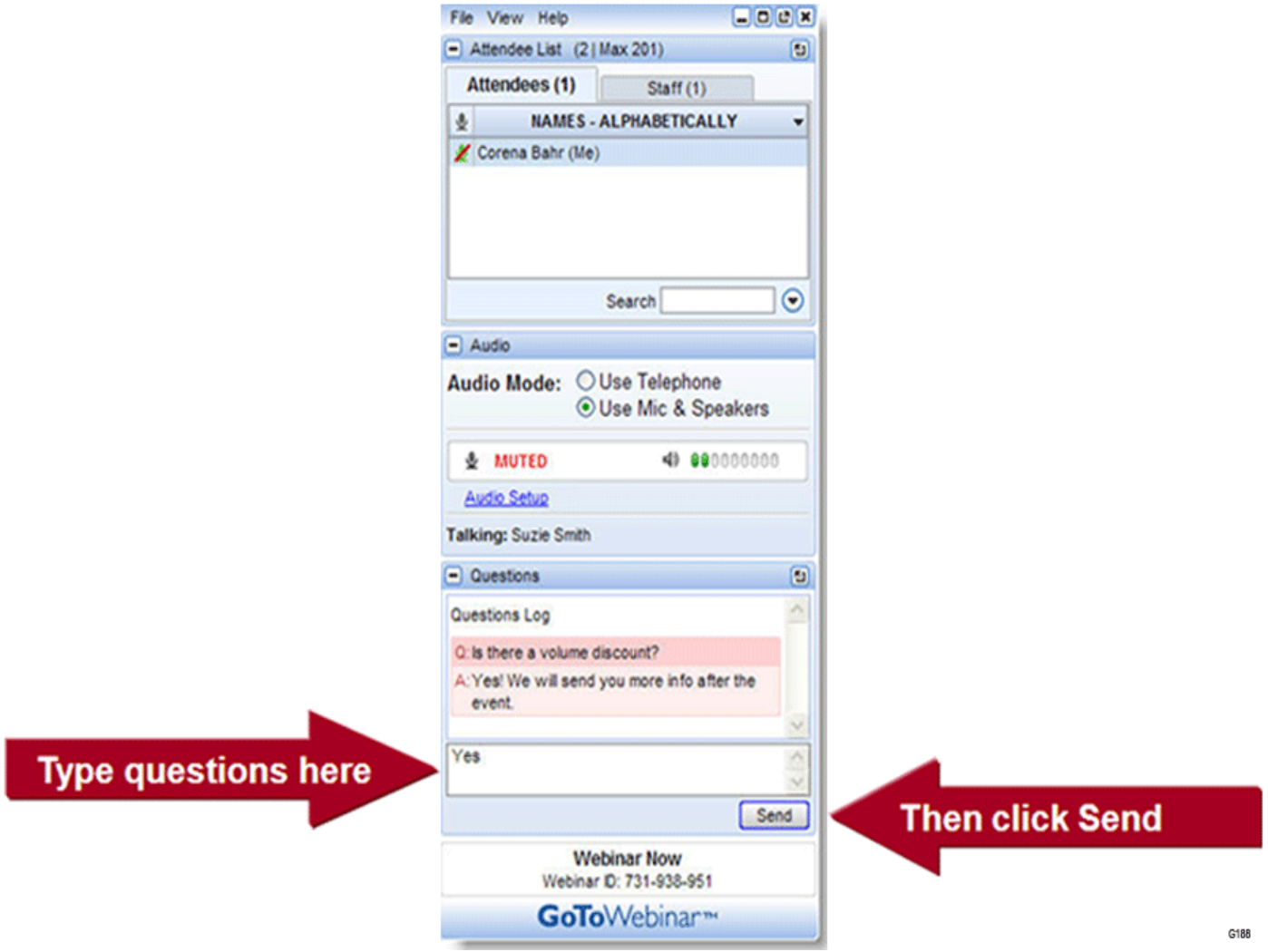
What You Should Do Now

- 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.

To Ask a Question Using the Question Box



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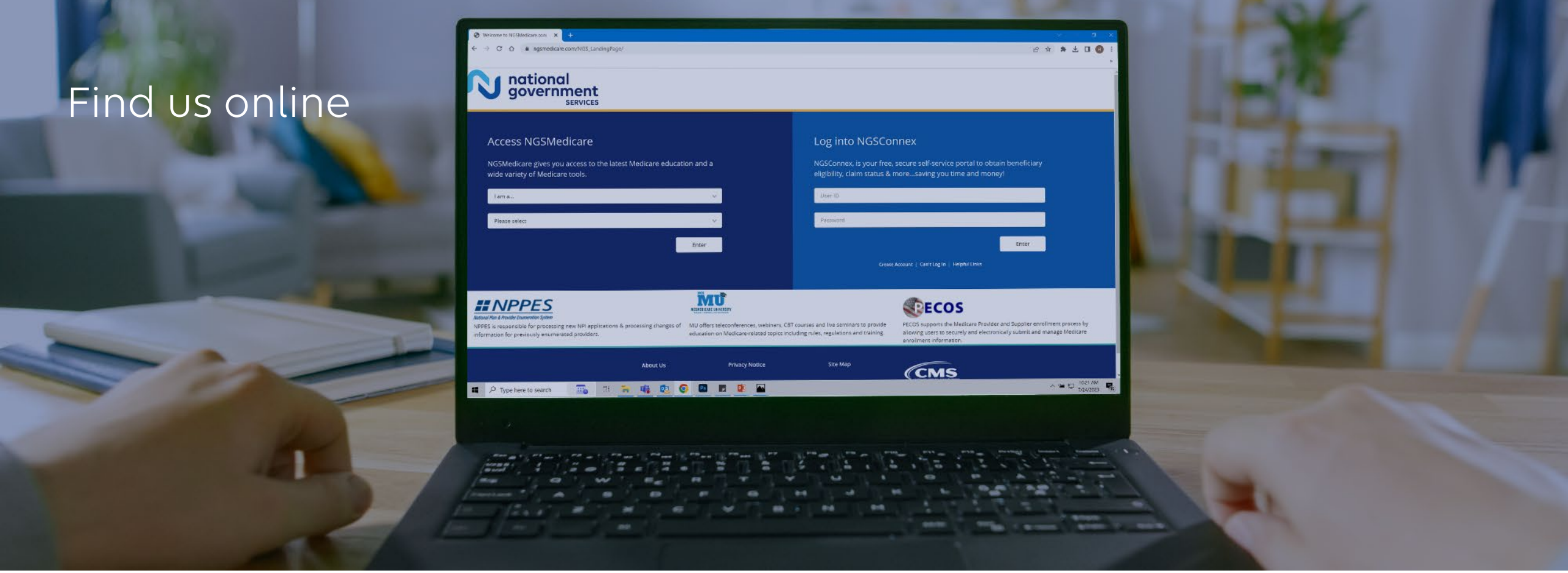

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