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Medicare Secondary Payer: Adjustment Claims

8/14/2025

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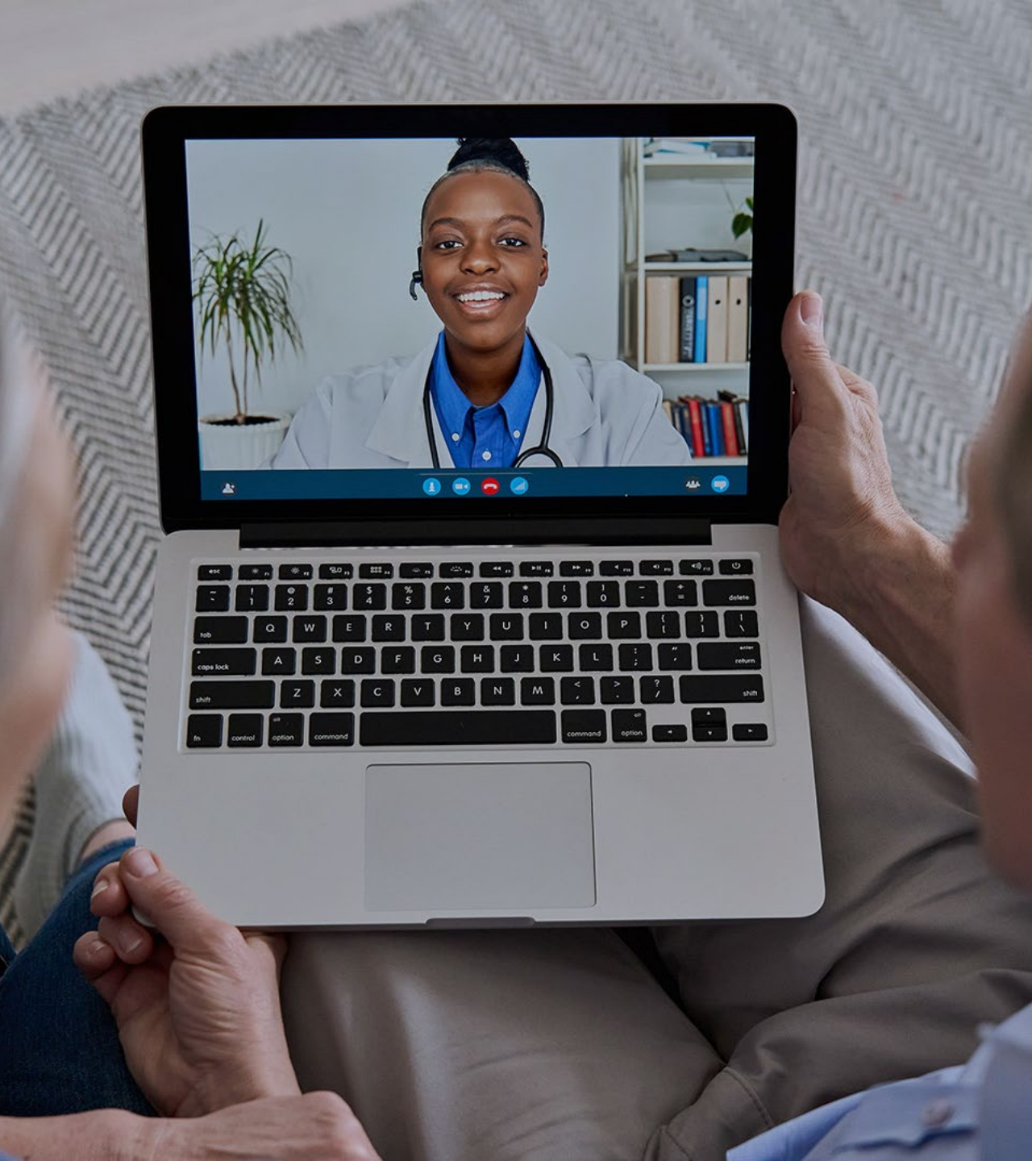

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Objective

Assist providers in understanding when and how to adjust finalized claims to make MSP-related changes

Today's Presenters

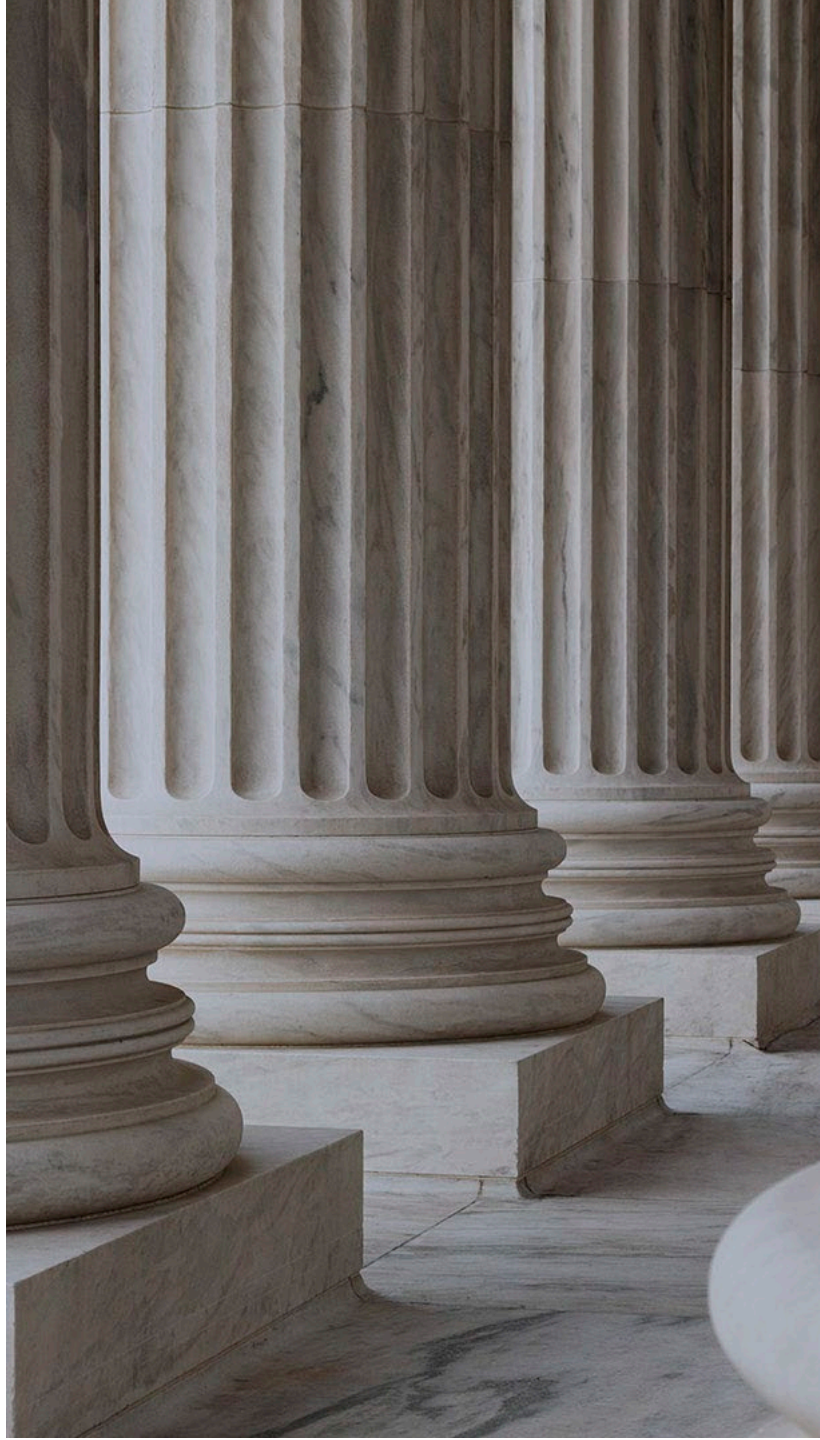
- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Christine Janiszcak
  - Kathy Mersch

Agenda

MSP and Your Responsibilities

What Is MSP?

- Beneficiary has insurance/coverage primary to Medicare
  - Based on federal laws known as MSP provisions
    - Help determine proper order of payers
    - Make certain payers primary to Medicare
- What is Medicare Secondary Payer?



MSP Provision Conditions/Criteria

- Each provision has own set of conditions/criteria
  - If all within specific provision met
    - Beneficiary's services subject to that provision
    - Medicare prohibited from paying for these services if "payment was made or can reasonably be expected to be made promptly" by primary payer
    - Medicare secondary payer
  - If one or more within specific provision not met
    - Beneficiary's services not subject to that provision
    - Medicare primary payer unless criteria of another MSP provision met

Providers' MSP-Related Responsibilities per Medicare Provider Agreement

Determine if Medicare primary payer for beneficiary's services

Identify insurance/coverage primary to Medicare

Submit claims to primary payers before Medicare

May be more than one payer primary to Medicare

Submit proper MSP claims to us when required

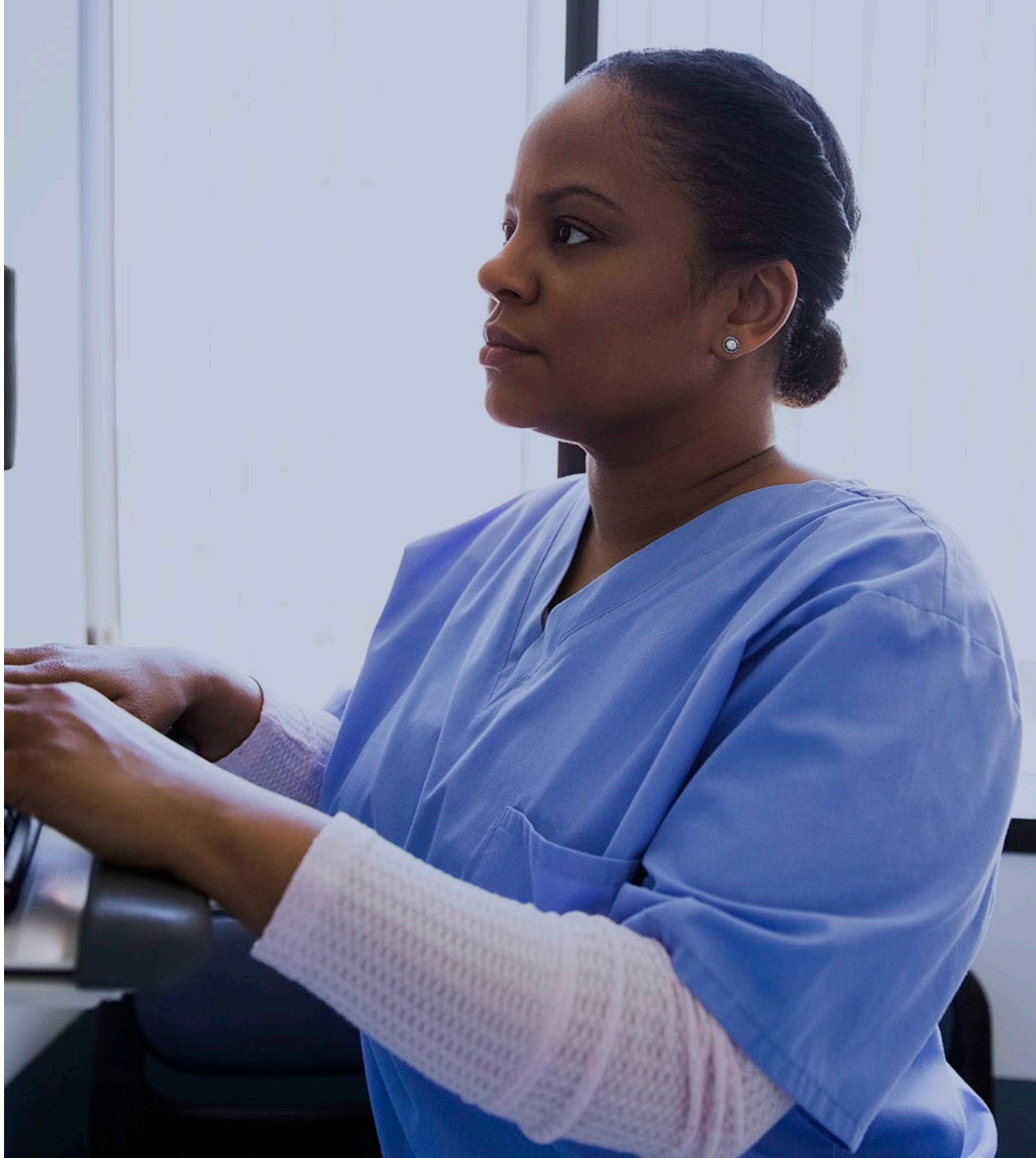
Follow MSP claim submission guidelines

Conduct MSP Screening Process to Identify Payers Primary to Medicare

- **Check** for MSP information in Medicare's records
  - Check for MSP records for beneficiary in CWF
    - For each service rendered; no exceptions
- **Collect** MSP information from beneficiary/representative
  - Ask questions about any other insurance/coverage
    - For every IP admission or OP encounter; some exceptions

Check for MSP Records in CWF

- Use provider self-service tools
  - Identify the Proper Order of Payers for a Beneficiary's Services



MSP Provisions, VCs and Primary Payer Codes

MSP Provision	Value Code	Payer Code
Working aged, 65 and over, working/spouse working with EGHP, 20 or more employees	12	A
ESRD with EGHP, current/former employer, in 30-month coordination period	13	B
No-Fault (automobile/other types including medical-payment) or No-Fault Set Aside	14	D or T
WC or WC Set Aside	15	E or W
Public Health Services	16	F
Federal Black Lung Program	41	H
Disabled, under 65, working/family member working with LGHP, 100 or more employees	43	G
Liability Insurance or Liability Set Aside	47	L or S

Collect MSP Information From Beneficiary or Representative

- Ask questions about any other insurance/coverage using:
  - CMS' model MSP questionnaire
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
      - Part I – Black Lung, WC, No-Fault and Liability
      - Part II – Medicare entitlement and employer GHPs
      - Part III – ESRD Medicare entitlement (including dual entitlement)
  - Your own compliant form
    - Same content and intent as model
- Document all responses

Collect Additional Information for Billing

- Does veteran want to use VA coverage instead of Medicare?
- Are services covered by government research grant?
- When did retirement occur?
  - On claims, report OC 18 and beneficiary's retirement date and/or OC 19 and spouse's retirement date
    - Collect and Report Retirement Dates on Medicare Claims
  - Policy when beneficiary/spouse cannot recall retirement date
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.1, #4

Determine Proper Order of Payers

- Use collected information and your MSP knowledge
  - Medicare primary when beneficiary
    - Has no other insurance/coverage
    - Has other insurance/coverage that does not meet MSP provision criteria
    - Had other insurance/coverage that met MSP provision criteria but no longer available
  - Other payer(s) primary when beneficiary
    - Has other insurance/coverage that meets MSP provision criteria and still available

Submitting Claims

- If **Medicare** primary
  - Submit Medicare primary claim
    - Indicate reason Medicare primary
- If **another payer** primary
  - Submit claim to that payer first
  - Submit MSP or conditional claim as appropriate
- If **more than one payer** primary
  - Submit claims to those payers in proper order
  - Submit Medicare tertiary claim

Medicare Claim Types

- Medicare primary
  - Claims submitted to/processed by Medicare as primary
- Cost-avoided
  - Claims submitted to Medicare as primary but rejected due to open MSP record in CWF (FISS rejection reason code commonly in 34XXX range)
- MSP
  - Claims submitted to/processed by Medicare as secondary payer after primary payer paid in part or in full
- Conditional
  - Claims submitted to/processed by Medicare conditionally because primary payer did not pay for valid reason or did not pay promptly (within 120 days; accidents only)

Code Medicare Claims Accurately

- For Medicare primary claims, report explanatory billing codes to indicate why Medicare primary
  - Prevent an MSP Rejection on a Medicare Primary Claim
  - Collect and Report Retirement Dates on Medicare Claims
- For MSP claims, report MSP claim coding
  - Prepare and Submit an MSP Claim
- For conditional claims, report conditional claim coding
  - Prepare and Submit an MSP Conditional Claim

Adjust Claim for MSP-Related Reason

Claim Adjustments

- Submit adjustment to change claim for MSP-related reason
  - Claim must be in finalized FISS S/LOC PB9997 or RB9997
    - Claims in S/LOC PB9997 (processed) include:
      - MSP and conditional claims that met Medicare requirements
      - Medicare primary claims that met Medicare requirements and did not reject (cost avoid) due to open MSP records in CWF
    - Claims in S/LOC RB9997 (rejected) include:
      - Medicare primary claims rejected (cost-avoided) due to MSP records in CWF
- Do not adjust MSP and conditional claim with errors related to CAGCs, CARCs or amounts
  - Submit new claim with errors corrected

MSP-Related Reasons to Adjust Claims

- Providers may need to adjust claims to change:
  - Medicare primary claim to MSP or conditional claim
  - Cost-avoided claim to MSP or conditional claim
  - Cost-avoided claim to Medicare primary claim (as submitted)
  - MSP or conditional claim to correct claim coding such as MSP VC
  - MSP or conditional claim to Medicare primary claim
  - MSP claim to conditional claim
  - Conditional claim to MSP claim
- Do not cancel claims to make these changes

Timely Filing – Adjustments Related to MSP

- Medicare's one-year timely filing applies to all claims and adjustments
- When MSP involved, exceptions apply to certain adjustments; if you submitted:
  - MSP claim, but primary payer later retracted payment
    - Adjust claim within one year of our RA date
  - Medicare primary claim, but primary payer later paid
    - Adjust claim within 60 days of date you received primary payer's payment
  - Conditional claim, but primary payer later paid
    - Adjust claim within 60 days of date you received primary payer's payment
      - Special policy for liability insurance payments received after billing conditionally

Options for Submitting Adjustments

- 837I claim
- FISS DDE claim entry
- Hardcopy claim (UB-04/CMS-1450 claim form)
  - Submit hardcopy claims and adjustments to our Claims Department
  - Include primary payer's RA
  - Hardcopy claim adjustments do not require approved ASCA waiver

Adjustment Coding

- TOB XX7
- DCN of original claim (claim being adjusted)
- CC (also known as claim change reason code) = D7, D8 or D9
- Coding for any claim changes needed
  - Include payer claim adjustment segment (CAS) coding from primary payer's RA for MSP and conditional claims
    - CAGC(s): Identifies general category of those payment adjustments
    - CARC(s): Explains why primary payer paid differently than billed
    - References: External code list, CR6426 and CR8486
- FISS claim adjustment reason code if using FISS DDE
  - List in FISS DDE Inquiry Menu (01): Adjustment Reason Code File (16)

CCs D7, D8 and D9

- **D7** = Make Medicare secondary payer
  - Adjusting Medicare primary, conditional or cost-avoided claim to make Medicare secondary
- **D8** = Make Medicare primary payer
  - Adjusting MSP claim to make Medicare primary
- **D9** = Make any other change (use Remarks field)
  - Adjusting MSP or conditional claim
  - Adjusting cost-avoided claim to make Medicare primary

Preparing MSP-Related Claim Adjustments

Charts for Preparing MSP-Related Adjustments

- Correct or Adjust a Claim Due to an MSP-Related Issue
  - **Preparing MSP-Related Claim Adjustments** chart
    - Claim's current type
    - Claim type you need to change to or change you need to make
    - Example scenario
    - CC for adjustment (D7, D8 or D9)
    - Comment codes by number (1–11); provide instructions
  - **Comment Code Definitions** chart
    - Defines comment codes in Preparing MSP-Related Adjustments chart
    - Note: Do not report actual comment codes on adjustments

Comment Codes 1-3

- Comment code 1
  - Report MSP claim coding; see Prepare and Submit an MSP Claim
- Comment code 2
  - Report conditional claim coding; see Prepare and Submit an MSP Conditional Claim
- Comment code 3
  - Report MSP or conditional claim coding; see Prepare and Submit an MSP Claim or Prepare and Submit an MSP Conditional Claim
  - Explain adjustment reason in Remarks

Comment Codes 4 and 5

- Comment code 4
  - Medicare primary and GHP MSP record (VC 12, 13, or 43) requires correction; see Correct a Beneficiary's MSP Record
  - Report claim coding on adjustment indicating why Medicare primary; see Prevent an MSP Rejection on a Medicare Primary Claim
- Comment code 5
  - If claim rejected due to open accident MSP record (VCs 14, 15 or 47), you determined claim not for accident (i.e., no trauma diagnosis codes) and not related to MSP record, report this in Remarks
    - Example: Report “services not related to VC __ (fill in) MSP record”
    - Do not report OC 05

Comment Codes 6 and 7

- Comment code 6
  - If claim rejected due to open accident MSP record (VCs 14, 15 or 47), you determined claim for accident (i.e., trauma diagnosis codes) but no primary payer and not related to MSP record, report this in Remarks
    - Example: Report “services not related to VC ___ (fill in) MSP record”
    - Report OC 05 and date of current accident
- Comment code 7
  - If comment code 5 or 6 applies, see Correct a Beneficiary's MSP Record and Prevent an MSP Rejection on a Medicare Primary Claim

Comment Codes 8 and 9

- Comment code 8
  - If primary payer liability (MSP VC 47), see CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2 (E)
  - You accepted our conditional payment and should have withdrawn your claim/lien against liability/beneficiary's liability insurance settlement
- Comment code 9
  - When you submit MSP claim, but primary payer later retracts payment, you may adjust MSP claim within one year of our RA date

Comment Codes 10 and 11

- Comment code 10
  - You must repay us within 60 days from date you received payment from payer primary to Medicare
  - For all MSP provisions, except liability, refer to CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 10.4
- Comment code 11
  - If submitting adjustment in FISS DDE, change noncovered days and charges back to covered (as originally billed)
  - Delete noncovered charge lines and rekey each as covered (Place “D” on claim line, hit <HOME> key, then hit <ENTER> key)

Change Medicare Primary Claim to MSP Claim

- Example
  - After billing us as primary, you billed primary payer and received payment
- Report on adjustment
  - CC = D7
- Follow comment code
  - 2

Change Medicare Primary Claim to Conditional Claim

- Example
  - After billing us as primary, you billed primary payer, but they did not pay for valid reason or did not pay promptly (within 120 days; accidents)
- Report on adjustment
  - CC = D9
- Follow comment code
  - 2

Change MSP Claim Coding

- Example
  - After billing as MSP, you identified a needed change in claim coding (i.e., MSP VC amount)
- Report on adjustment
  - CC = D9
- Follow comment codes
  - 3
  - 10

Change MSP Claim to Conditional Claim

- Example
  - After billing as MSP, you received retraction from primary payer (they cited valid reason other than Medicare primary)
- Report on adjustment
  - CC = D9
- Follow comment codes
  - 2
  - 9

Change MSP Claim to Medicare Primary Claim

- Example
  - After billing as MSP, you received retraction from primary payer (they cited reason as Medicare primary)
- Report on adjustment
  - CC = D8
- Follow comment codes
  - 4
  - 9

Change Cost-Avoided Claim to MSP Claim

- Example
  - After billing us as primary (claim rejected for MSP), you billed primary payer and received payment
- Report on adjustment
  - CC = D7
- Follow comment codes
  - 1
  - 11

Change Cost-Avoided Claim to Conditional Claim

- Example
  - After billing us as primary (claim rejected for MSP), you billed primary payer, but they did not pay for valid reason or did not pay promptly (within 120 days; accidents)
- Report on adjustment
  - CC = D9
- Follow comment codes
  - 2
  - 11

Change Cost-Avoided Claim to Medicare Primary Claim

- Example
  - After billing us as primary (claim rejected for MSP), you verified Medicare primary
- Report on adjustment
  - CC = D9
- Follow comment codes
  - 4
  - 5
  - 6
  - 7
  - 11

Change Conditional Claim Coding

- Example
  - After billing us conditionally, you identified needed change in claim coding (i.e., MSP VC)
- Report on adjustment
  - CC = D9
- Follow comment code
  - 3

Change Conditional Claim to MSP Claim

- Example
  - After billing us conditionally, you received payment from primary payer
- Report on adjustment
  - CC = D7
- Follow comment codes
  - 1
  - 8 (if primary payer = VC 47)
  - 10

Change Conditional Claim to Medicare Primary Claim

- Example
  - After billing us conditionally, you determined Medicare primary
- Report on adjustment
  - CC = D9
- Follow comment code
  - 4

Processing Your MSP or Conditional Adjustments

- Upon receipt of **incoming MSP or conditional claim adjustment**, we check for **matching MSP record in CWF**
  - If present, we process claim
  - If not present, we set up record, ask BCRC to validate it, then we process claim adjustment
    - Note: If record set up unsuccessful, we ask BCRC to set up and validate record, then we process claim once record present in CWF
- BCRC
  - Reviews/investigates MSP information
  - Validates MSP record we set up or sets up/validates MSP record
- Set Up a Beneficiary's Medicare Secondary Payer Record

Processing Your Medicare Primary Adjustments

- When incoming claim adjustment contains explanatory coding, we can
  - Send information on claim to BCRC, when applicable
  - Process claim or, in some cases, wait for BCRC to correct MSP record and then process adjustment
- BCRC
  - Reviews/investigates information
  - Corrects MSP record if they receive responses to their investigation
- Correct a Beneficiary's MSP Record

No Explanatory Claim Coding to Indicate Why Medicare Primary on Adjustment

- Provider
  - May not contact BCRC in this circumstance
  - May refer beneficiary or other party to BCRC
  - Must wait until MSP record in CWF corrected before submitting Medicare primary claim adjustment
- BCRC
  - Toll-free lines
    - 855-798-2627
    - TTY/TDD: 855-797-2627 for hearing and speech impaired
  - Available
    - Monday–Friday, 8:00 a.m.–8:00 p.m., ET, except holidays

Using FISS DDE for Adjustments

FISS DDE

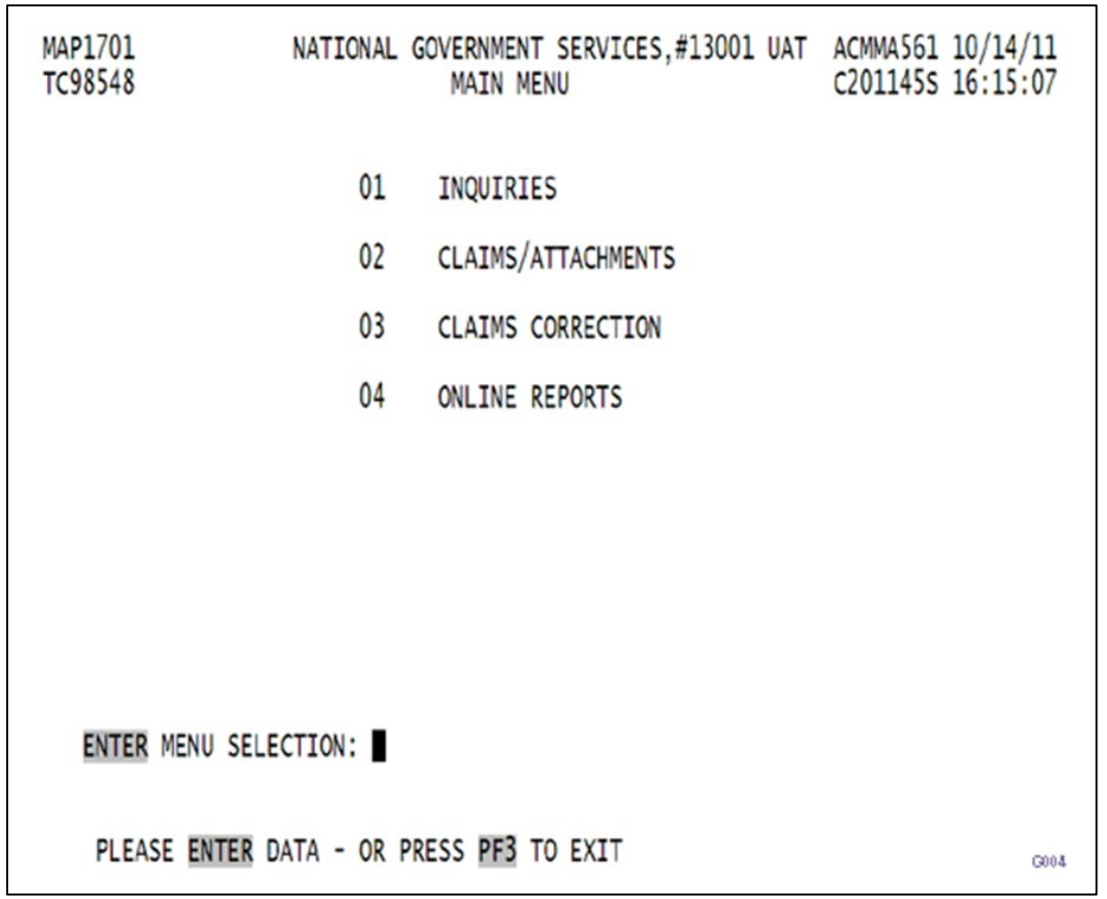
- System we use to process claims and maintain records
- Allows remote user connectivity to Medicare mainframe
- Providers access through online computer system
- Requires logon ID and password (**do not share**)
  - EDI enrollment information
- Providers can use to
  - Research claim coding
  - Submit, track, correct, adjust and cancel claims
- *FISS DDE Provider Online Guide*

How to Adjust a Claim in FISS DDE

- Gather required information
  - DCN of claim being adjusted
  - CC = D7, D8 or D9
  - FISS DDE adjustment reason code
    - FISS DDE Inquiry Menu (01): Adjustment Reason Code File (16)
      - Example = OT
  - Primary payer's RA, EOB statement or letter, as applicable
- Access processed/rejected claim
- Report required adjustment coding and make claim changes
- Submit and verify claim adjustment

Access Claim

- Log into FISS DDE
- From Main Menu (MAP1701)
  - Enter 03 at Enter Menu Selection to select Claims Correction Menu (MAP1704)



FISS DDE Claims Correction Menu (MAP1704)

- From Claims Correction Menu (MAP1704)
- Enter number from below at Enter Menu Selection to select type of claim to be adjusted
  - Inpatient – 30
  - Outpatient – 31
  - SNF – 32
  - Home Health – 33
  - Hospice – 35

```
MAP1704          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 12/18/19
MXG9282          CLAIM AND ATTACHMENTS CORRECTION MENU     A20201AF 11:58:07

                          CLAIMS CORRECTION
                    INPATIENT                21
                    OUTPATIENT               23
                    SNF                      25
                    HOME HEALTH              27
                    HOSPICE                  29
                          CLAIM ADJUSTMENTS     CANCELS
                    INPATIENT                30       50
                    OUTPATIENT               31       51
                    SNF                      32       52
                    HOME HEALTH              33       53
                    HOSPICE                  35       55
                          ATTACHMENTS
                    PACEMAKER                42
                    AMBULANCE                43
                    HOME HEALTH              45

  ENTER MENU SELECTION:


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

Access Claim (continued)

- On Claim Summary Inquiry Menu (MAP1741), key
  - Beneficiary's MBI (MID field)
  - DOS of claim to be adjusted (optional)
  - Facility's NPI (if needed)
- List of processed claims displays (defaults to P S/LOC)
  - For list of rejected claims, overwrite P in S/LOC field with R
- Key U in SEL field next to claim to be adjusted and press enter
  - Claim opens at claim page 01
  - TOB automatically changes to XX7
  - FISS pulls in DCN of claim to be adjusted

List of Beneficiary's Claims on MAP1741

```
MAP1741            NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 12/12/18
MXG9282   SC              CLAIM SUMMARY INQUIRY              C2019100 14:16:27
                              NPI
      MID                PROVIDER                S/LOC          TOB
 OPERATOR ID MXG9282     FROM DATE          TO DATE           DDE SORT
 MEDICAL REVIEW SELECT            DCN
      MID             PROV/MRN    S/LOC      TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS









    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

FISS DDE Pages and Corresponding UB-04/CMS-1450 Claim Form Locators

Page	MAP	UB-04/CMS-1450 FLs
01	MAP1711	FLs 1-41: Patient information, CCs, OCs, OSCs and VCs
02	MAP1712	FLs 42-49: Revenue and CPT/HCPCS codes, charges and DOS
03	MAP1713	FLs 50-57 and 66-79: Payer, diagnosis and procedure codes, 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

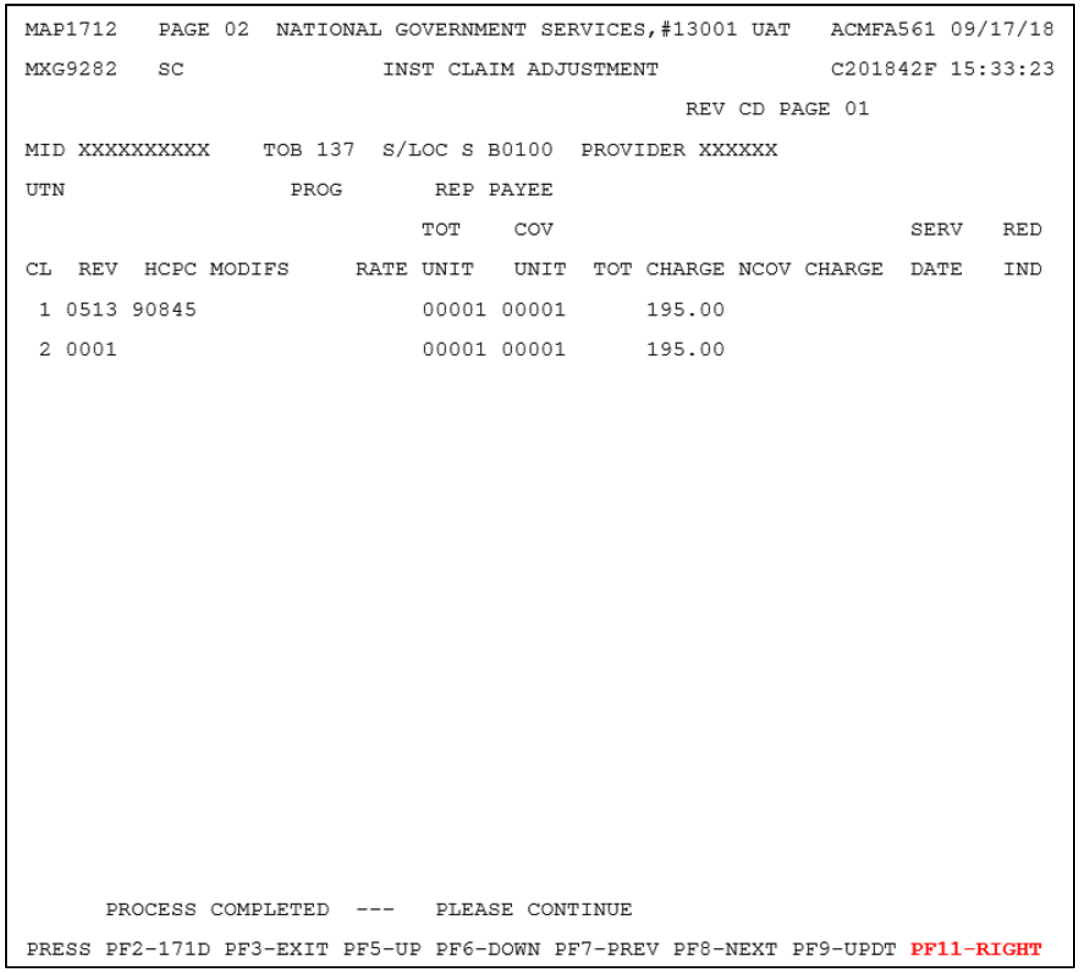
Make Changes on Claim Pages 01 (MAP1711)

- Key claim change reason code (CC) in COND CODE field
- Make changes to any applicable fields
  - If adjustment MSP-related, change CCs, OCs, VCs as needed

```
 MAP1711    PAGE 01  NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 09/17/18
 MXG9282    SC                INST CLAIM ADJUSTMENT              C201842F 14:08:16
 MID XXXXXXXXXX     TOB 137  S/LOC S B0100 OSCAR XXXXXX          SV:     UB-FORM
NPI 0000000000 TRANS HOSP PROV                    PROCESS NEW MID
PAT.CNTL#: XXXXXXXXXXXX          TAX#/SUB:                  TAXO.CD:
 STMT DATES FROM 121417  TO 121417  DAYS COV      N-C        CO       LTR
 LAST XXXXX                        FIRST XXXXXXX          MI     DOB XXXXXXXX
 ADDR 1 123 ANYSTREET DR                    2
 3 BRONX NY                              4                                CARR:
 5                                       6                                 LOC:
ZIP 104725040 SEX F MS   ADMIT DATE         HR    TYPE    SRC 1 D HM       STAT 30
   COND CODES 01 D7 02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01           02          03          04          05
              06           07          08          09          10
   SPAN CODES/DATES 01                  02                  03
04                  05                  06                  07
08                  09                  10                  FAC.ZIP
  DCN XXXXXXXXXXXXXX
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 A1      100.00         02 A2       19.00         03 76       80.00
04                        05                       06
07                        08                       09
       PROCESS COMPLETED  ---   PLEASE CONTINUE
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

Page 02 (MAP1712)

- Make changes to any applicable fields
- If adjustment reason involves making changes to claim lines
  - Change units, codes, and rates as applicable
  - Recalculate total charges if necessary



```
MAP1712   PAGE 02  NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 09/17/18
MXG9282   SC              INST CLAIM ADJUSTMENT             C201842F 15:33:23
                                                  REV CD PAGE 01
MID XXXXXXXXXX    TOB 137  S/LOC S B0100  PROVIDER XXXXXX
UTN                  PROG       REP PAYEE
                                 TOT    COV                              SERV   RED
CL  REV  HCPC MODIFS     RATE UNIT   UNIT  TOT CHARGE NCOV CHARGE  DATE   IND
 1 0513 90845                 00001 00001      195.00
 2 0001                       00001 00001      195.00

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

Adjusting Claims That Rejected for MSP

- When claims reject due to MSP record (cost-avoid)
  - FISS moves charges to noncovered (NCOV CHARGES field) on claim page 02
- When adjusting cost-avoided claims
  - Claim lines must be deleted and added as new covered charge lines
    - Reminder on Deleting Revenue Code Line(s) in the Fiscal Intermediary Standard System Direct Data Entry System
  - Ensure Total Charge line (0001) rekeyed and calculated appropriately

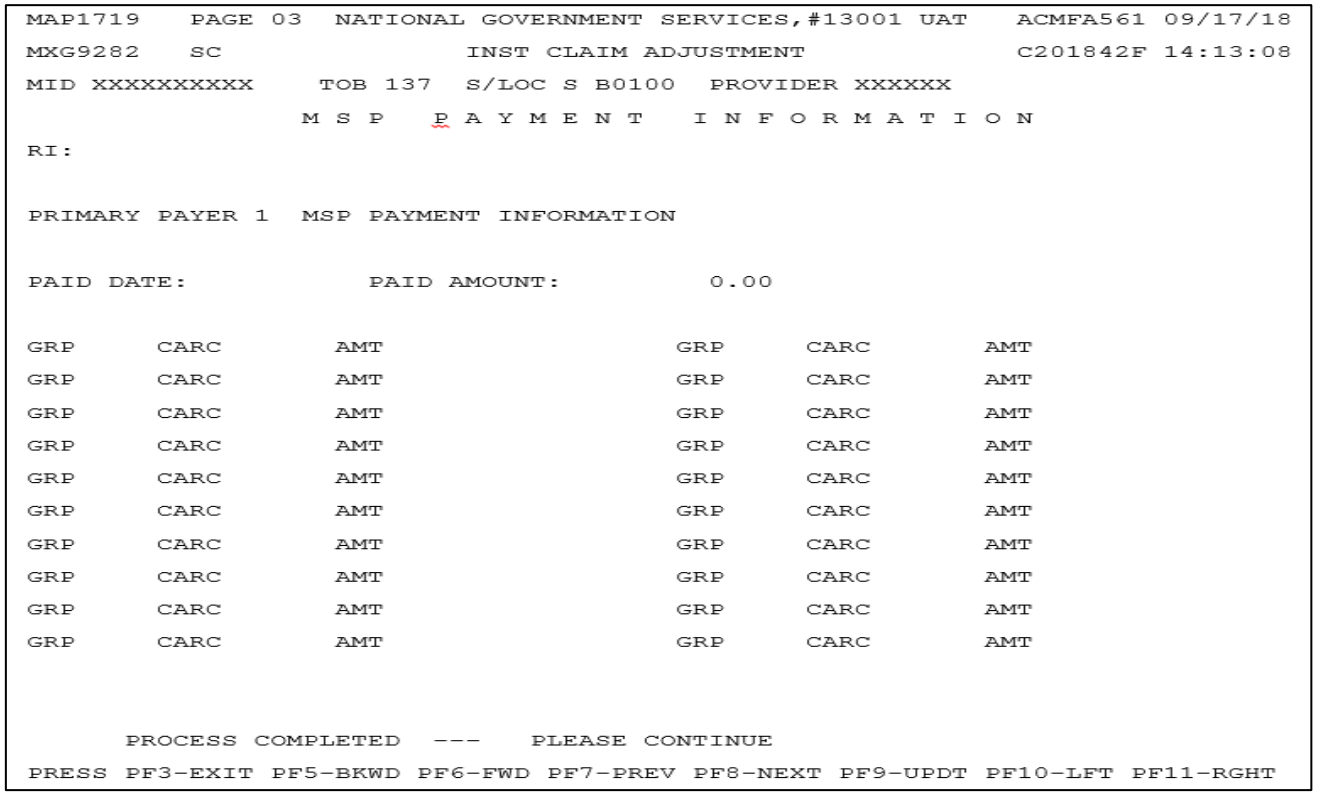
Make Changes to Claim Page 03 (MAP1713)

- Key adjustment reason code in ADJUSTMENT REASON CODE field
- Make changes to any applicable fields
- Press F11/PF11 key to get to Additional Claim Page 03 (MAP1719)

```
MAP1713    PAGE 03   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 09/17/18
MXG9282    SC                 INST CLAIM ADJUSTMENT             C201842F 14:11:44
MID XXXXXXXXXX     TOB 137   S/LOC S B0100   PROVIDER XXXXXX
NDC CD                                 OFFSITE ZIP         ADJ MBI              IND H
 CD  ID     PAYER                        OSCAR         RI AB              EST AMT DUE
A Z         MEDICARE                     XXXXXX                                 0.00
B                                                                              0.00
C                                                                              0.00
DUE FROM PATIENT          0.00          0.00     SERV FAC NPI   0000000000
MEDICAL RECORD NBR                        COST RPT DAYS       NON COST RPT DAYS
DIAG CODES 01 29630       02              03             04             05
06             07             08              09                    END OF POA IND
ADMITTING DIAGNOSIS                E CODE              HOSPICE TERM ILL IND
IDE                        GAF            0.0000      PRV
PROCEDURE CODES AND DATES 01 9412     121492 02
03                  04                  05                  06
ESRD HRS 00  ADJ REAS CD OT   REJ CD          NONPAY CD      ATT TAXO
ATT PHYS          NPI 0000000000     L XXXXXXX              F XXXX       M     SC
OPR PHYS          NPI 0000000000     L                      F            M     SC
OTH OPR           NPI 0000000000     L                      F            M     SC
REN PHYS          NPI 0000000000     L                      F            M     SC
REF PHYS          NPI 0000000000     L                      F            M     SC
      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
```

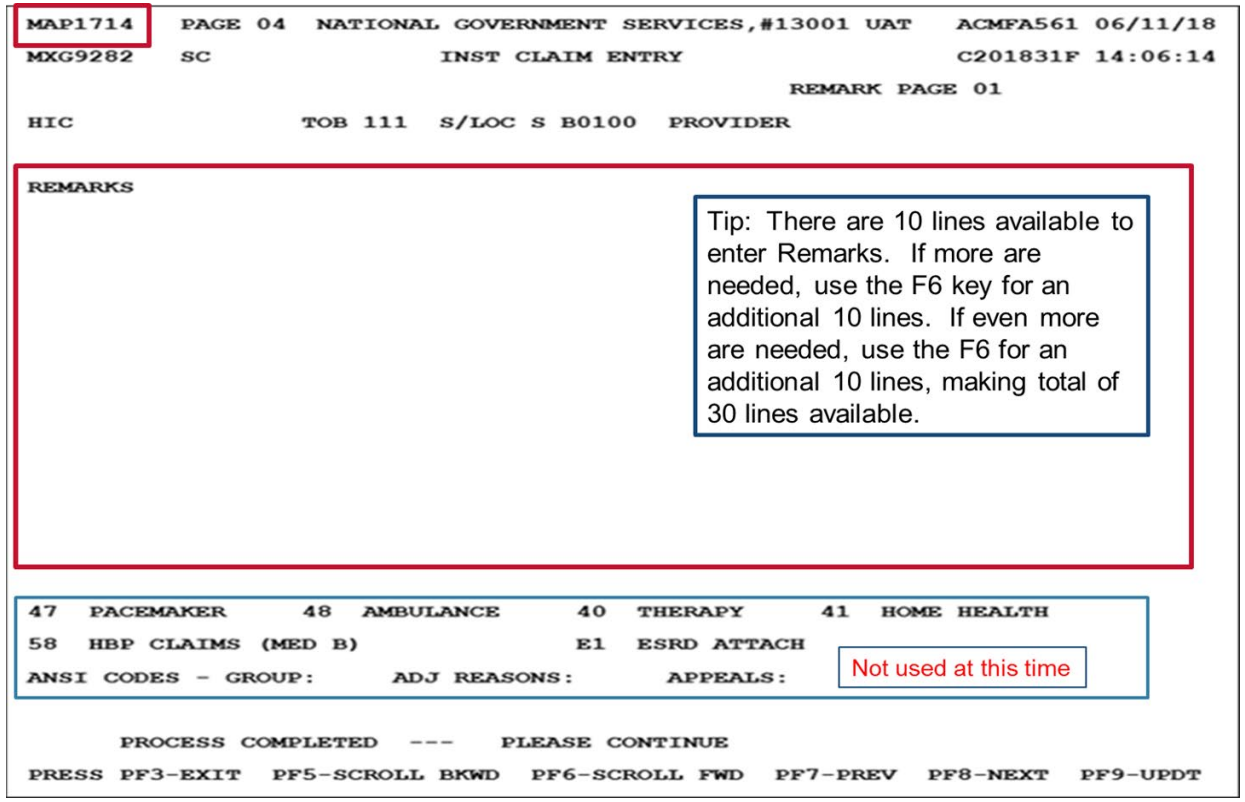
Make Changes to Additional Claim Page 03 (MAP1719)

- Enter MSP CAS information from primary payer's RA
  - Paid date
  - Paid amount
  - GRP (CAGCs)
  - CARC (CARCs)
  - AMT (dollar amount for CAGC/CARC pairs must equal claim's total charges)
- If multiple primary payers, enter data for primary payer one on first page
  - Press F6/PF6 to enter information for primary payer two on second page



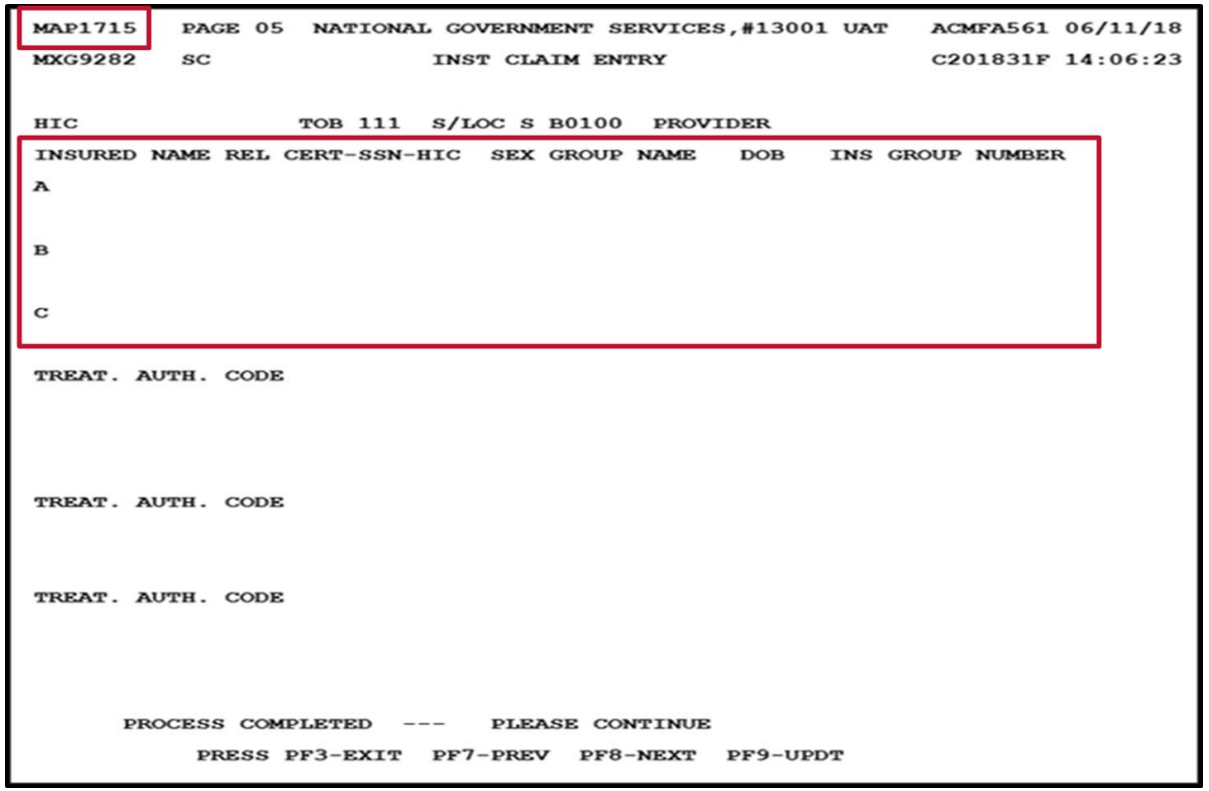
Make Changes to Claim Page 04 (MAP1714)

- Add/make changes to remarks as needed
- Required when you report CC D9 and when adjustment is a conditional claim
  - Refer to Remarks section of Conditional Billing Code Table in Prepare and Submit an MSP Conditional Claim



Make Changes to Claim Page 05 (MAP1715)

- Add/make changes to insured and insurance information
  - Lines A, B and C (when applicable)



Make Changes to Claim Page 06 (MAP1716)

- Add or make changes to primary insurer address (when applicable)

```
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
            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
```

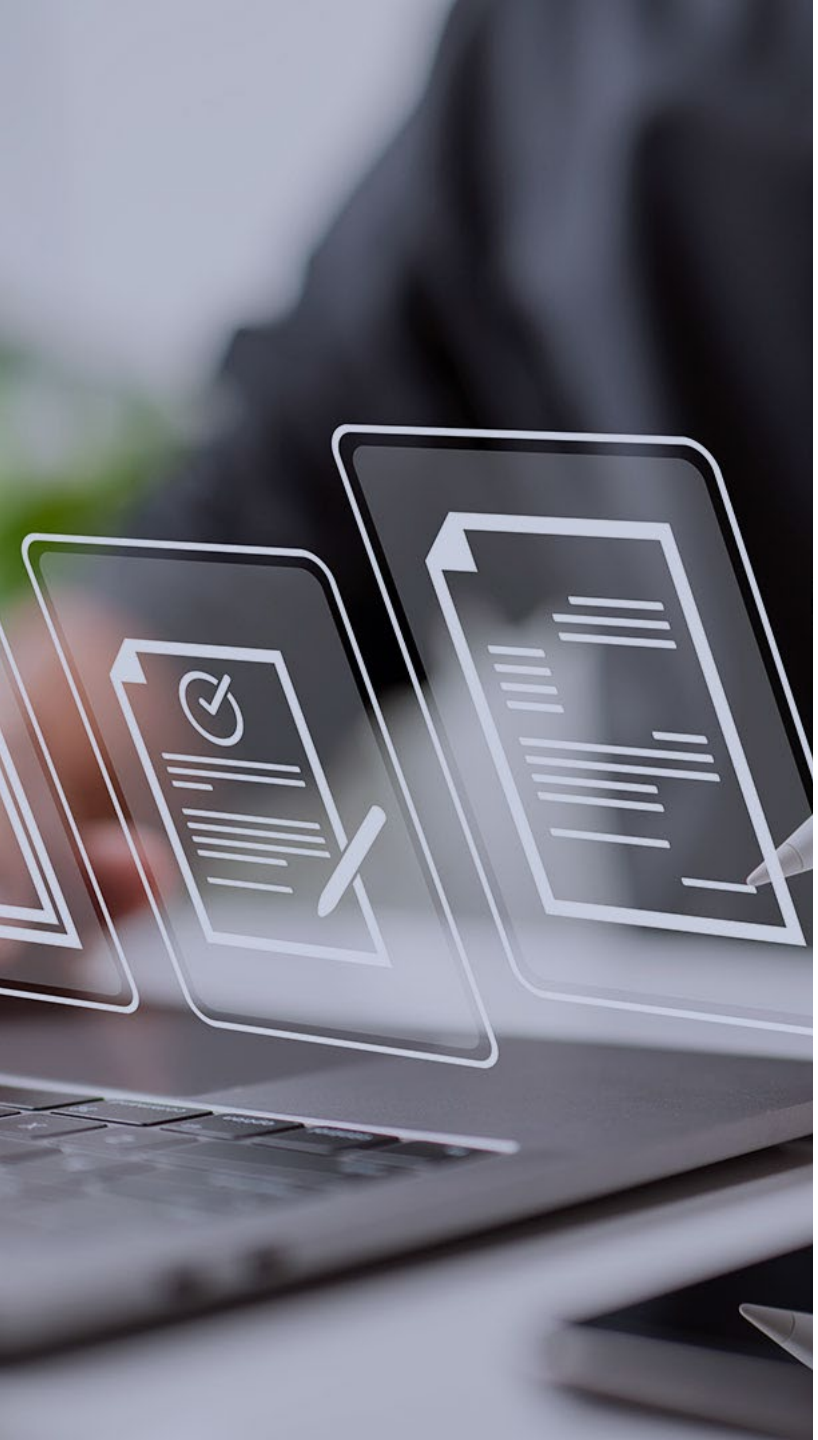
Submit and Verify Claim Adjustment

- Review claim changes to ensure accuracy
- Hit <F9/PF9> on keyboard to submit adjustment
- Verify claim submitted correctly
  - Go into Inquiries submenu (Option 01; MAP1702)
  - Choose Claims Summary inquiry (Option 12; MAP1741)
    - Available next day after submitting adjustment
    - Key MBI and DOS of adjustment
    - Successfully submitted adjustments appear in S/LOC SB2500

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

References and Resources



NGS References and Resources

- ASCA Requirements for Paper Claim Submissions
- Acronym Search
- Contact Us
- EDI Enrollment
- Events
- *FISS DDE Provider Online Guide*
- Reminder on Deleting Revenue Code Line(s) in the Fiscal Intermediary Standard System Direct Data Entry System

NGS MSP Articles

- What is Medicare Secondary Payer?
- Identify the Proper Order of Payers for a Beneficiary's Services
- Set Up a Beneficiary's Medicare Secondary Payer Record
- Correct a Beneficiary's MSP Record
- Prevent an MSP Rejection on a Medicare Primary Claim
- Collect and Report Retirement Dates on Medicare Claims
- Prepare and Submit a Medicare Secondary Payer Claim
- Prepare and Submit an MSP Conditional Claim
- Correct or Adjust a Claim Due to an MSP-Related Issue
- Determine if Medicare will Make an MSP Payment
- Determine Beneficiary Responsibility on an MSP Claim

CMS' MSP References and Resources

- BCRC Contact
- How Medicare Works with Other Insurance (for beneficiaries)
- MLN® Booklet: *Medicare Secondary Payer*
- MLN® Fact Sheet: *Medicare Secondary Payer: Don't Deny Services & Bill Correctly*

CMS' MSP References and Resources – CRs

- CMS Change Request 6426: *Instructions on Utilizing 837 Institutional CAS Segments for Medicare Secondary Payer (MSP) Part A Claims*
- CMS Change Request 8486: *Instructions on Using the Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A CMS-1450 Paper Claims, Direct Data Entry (DDE), and 837 Institutional Claims Transactions*

CMS' MSP References and Resources – IOMs

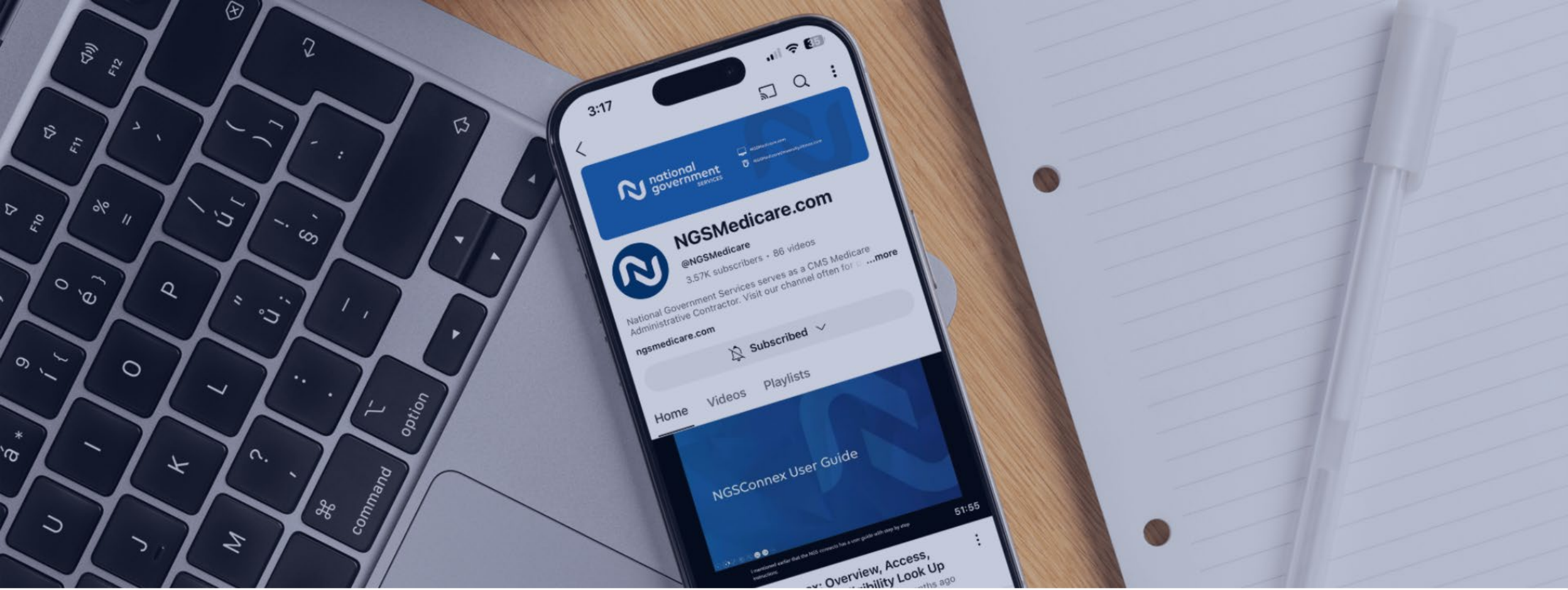
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*
  - Chapter 2, Section
    - 40.2 (letter E), Provider, Physician, or Other Supplier Bills Medicare and Maintains Claim/Lien Against the Liability Insurance/Beneficiary's Liability Insurance Settlement
  - Chapter 3, Sections
    - 10.3, Provider, Physician, and Other Supplier Responsibility When a Request is Received from an Insurance Company or Attorney
    - 10.4, Provider, Physician, and Other Supplier Responsibility When Duplicate Payments Are Received
    - 20, Obtain Information from Patient or Representative at Admission or Start of Care
    - 20.1, General Policy
    - 20.2, Verification of Medicare Secondary Payer (MSP) Online Data and Use of Admission Questions
    - 20.2.1, Model Admission Questions to Ask Medicare Beneficiaries

CMS' Coordination of Benefits & Recovery

- Overview
  - What's New
  - Medicare Secondary Payer
  - End-Stage Renal Disease (ESRD)
  - Coordination of Benefits
  - Group Health Plan Recovery
  - Non-Group Health Plan Recovery
  - Contacts
- Attorney Services
  - Reporting a Case
- Beneficiary services
  - Reporting Other Health Insurance
- Employer Services
- Insurer Services
- Provider Services
  - Your Billing Responsibilities

Questions?

Thank you!



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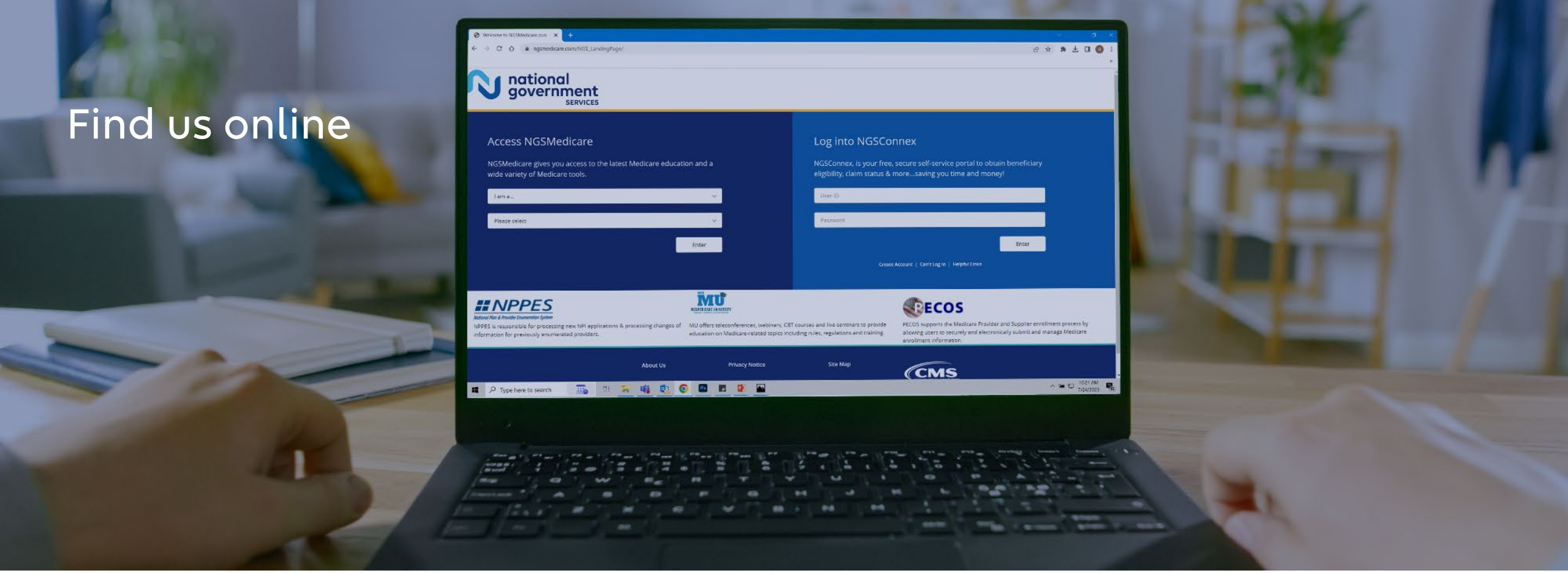

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

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