Medicare Secondary Payer – Conditional Billing

7/7/2021

Today's Presenters

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Objective

- Increase providers' understanding of how to prepare and submit compliant conditional claims after receiving no payment from primary payer
  - You are less likely to receive returned claims if you know how to prepare and submit compliant conditional claims

Agenda

- MSP and your MSP responsibilities
- Conditional claims
- Preparing conditional claims
- Submitting conditional claims
- MSP resources – Also refer to handout
- Questions and answers

MSP and Your MSP Responsibilities

What is MSP?

- Beneficiary has coverage primary to Medicare
  - Based on federal laws known as **MSP provisions**
    - Help determine proper order of payers
    - Make certain payers primary to Medicare
    - Each has criteria/conditions that must be met
      - **If all are met**; services are subject to that provision making other insurer primary and Medicare secondary
      - **If one or more are not met**; services are not subject to that provision and Medicare is primary unless criteria/conditions of another MSP provision are met

MSP Provisions

- GHP MSP Provisions
  - Working Aged MSP Provision
  - Disabled MSP Provision
  - ESRD MSP Provision
- Non-GHP MSP Provisions
  - Federal Black Lung Program
  - PHS including research grants
  - Workers' Compensation
  - Automobile no-fault (medical-payment coverage or PIP)
  - Other types of no-fault coverage (premises med-pay)
  - Liability coverage

Providers' MSP Responsibilities

- Determine proper order of payers for beneficiary
  - Identify payers by conducting MSP screening process
    - Must check for MSP record(s) in CWF using CMS' HETS (X12 270 transmission and 271 response), NGSConnex or our IVR system for every service
    - Collect MSP information by asking MSP questions, using CMS' model MSP questionnaire or compliant form, for every IP admission or OP encounter unless exception applies
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Sections 20.1 and 20.2.1
- Submit claims to primary payer(s) before Medicare
- Submit MSP claims or conditional claims as appropriate

MSP Records in CWF – Value Codes and Primary Payer Codes for MSP Provisions

MSP VC	MSP Provision	Primary Payer Code
12	Working aged, age 65 and over, EGHP, 20 or more employees	A
13	ESRD with EGHP in coordination period	B
14	No-Fault (automobile and other types)	D
15	Workers' Compensation or Set-Aside	E or W
16	Public Health Services; research grants	F
41	Federal Black Lung Program	H
43	Disabled, under age 65, LGHP, 100 or more employees	G
47	Liability Insurance	L

Proper Order of Payers

- Providers must determine which plan is primary, secondary, tertiary, etc., payer
  - Compare any MSP information in CWF to collected MSP information and use your knowledge of MSP Provisions
    - Document your decision
      - In general, Medicare is primary when
        - » Beneficiary has no other coverage
        - » Beneficiary has other coverage but it doesn't meet MSP provision criteria
        - » Beneficiary has other coverage, it meets MSP provision criteria but it is not available
      - In general, other payer(s) is primary when
        - » Beneficiary has other coverage that meets MSP provision criteria and it is available

Submit Claims According to Determination You Make

- Submit claims to Medicare accordingly
  - If you determined Medicare is primary
    - Submit Medicare primary claim
  - If you determined another payer is primary
    - Submit claim to other payer first and Medicare second
  - If you determined more than one payer is primary
    - Submit claims to those payers first, in proper order, and Medicare third
      - Follow-up with primary payers often
      - Medicare's one year timely filing regulations apply
      - Do not bill the primary payer and Medicare at same time

Code Medicare Claims Accurately

- Submit claims with billing codes that represent MSP status
  - If another payer is primary and Medicare is secondary
    - Report applicable MSP billing codes on MSP **or conditional** claim(s)
  - If Medicare is primary
    - Report applicable explanatory billing codes on Medicare primary claim(s)
      - Beneficiary/spouse retired
      - Claim is not related to prior accident
      - Claim is related to a current accident but there is no insurance
    - Contact BCRC if necessary before submitting Medicare primary claim(s)
      - No GHP, GHP terminated, employer size not met
      - Claim related to prior accident, insurance benefits exhausted before your DOS
      - Claim related to prior accident, case settled before your DOS and no future medical dollars

Medicare Claim Types

- If primary payer
  - Pays in part
    - Submit MSP claim; known as MSP partial-pay claim
  - Pays in full
    - Submit MSP claim, known as MSP full-pay or no-pay claim
  - Does not pay for a valid reason or does not pay promptly (120 days; accidents only)
    - Submit **conditional claim**
  - Does not pay citing Medicare is primary
    - Submit Medicare primary claim (verify Medicare truly is primary)

Conditional Claims

Conditional Claims – Defined

- Claims submitted to Medicare requesting conditional payment because
  - You billed primary payer but they
    - **Did not pay for valid reason**
      - Applies to all MSP VCs except VCs 16 and 42
        - » For VCs 16 and 42, if primary payer does not pay, submit primary claims
    - **Did not pay promptly**
      - Applies to MSP VCs 14, 15, 41 and 47 (accidents only)
    - Generally, promptly means within 120 days
- If Medicare can make conditional payment
  - Payment and beneficiary responsibility are same as if we're primary

Promptly – Defined

- For no-fault insurance and WC
  - Promptly means payment within 120 days after receipt of claim by no-fault insurer or WC carrier
- For liability insurance (including self-insurance)
  - Promptly means payment within 120 days after earlier of
    - Date a general liability claim filed with insurer or lien filed against potential liability settlement (Medicare considers this date to be date liability record was created on CWF); **or**
    - Date service furnished or date of discharge (for inpatient)

Conditional Billing When Primary Payer is a GHP

- If beneficiary has a primary GHP (VCs 12, 13 and 43)
  - To bill conditionally, you must have a response from GHP
    - This is applicable in situations where beneficiary has
      - GHP only
      - GHP and was involved in an accident with available no-fault, WC or liability coverage

Conditional Billing When Primary Payer is a Non-GHP

- If beneficiary has a primary non-GHP (VCs 14, 15, 41 and 47)
  - To bill conditionally **within promptly period**
    - You must have a response from non-GHP (with a valid reason)
  - To bill conditionally **after promptly period expires**
    - You do not need to have a response from non-GHP
      - Once promptly period expires, you have a choice to
        - » Maintain claim with non-GHP **or**
        - » Bill conditionally (if beneficiary also has a primary GHP, bill them before Medicare)

Conditional Billing When Primary Payer is Liability

- If, after promptly period has expired, you choose to bill conditionally, and primary payer is **liability (VC 47)**, you must **withdraw** liability claim/lien
  - If you receive payments from Medicare and from liability claim/lien, see CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2E for instructions

Situations in Which Conditional Payment Can be Made

- When primary payer (any VC except 16 and 42) did not pay for valid reason
  - You may submit conditional claim with explanation code in Remarks
- For accidents (VCs 14, 15, 41 or 47), when primary payer did not pay promptly/cannot reasonably be expected to pay promptly and promptly period is expired
  - You may submit conditional claim with explanation code in Remarks of DA and date on which primary non-GHP was billed
    - DA = You billed primary payer, waited promptly period, did not receive response
  - If beneficiary also has primary GHP, submit to GHP before Medicare

Situations in Which Conditional Payment Cannot Be Made

- Primary payer was not billed or did not pay because
  - Beneficiary refuses to file a claim with insurer, or cooperate with provider in filing claim
  - Provider/beneficiary failed to file proper claim with insurer resulting in no payment (you may submit MSP claim per CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5)
- Primary payer for accident (no-fault, WC or liability) did not pay because
  - There is primary GHP coverage and you did not send claim to them first or they rejected claim stating no-fault, WC or liability should pay first

Preparing Conditional Claims

Prepare and Submit Conditional Claims – Steps

- Follow all steps
  - Identify/bill appropriate primary payer for beneficiary's services
  - Prepare conditional claim
    - If primary payer is a GHP, you must have response from them
    - If primary payer is a non-GHP
      - You must have response from them or
      - 120-day promptly period must have expired (MSP VCs 14, 15, 41 or 47 only)
  - Use correct MSP claim coding including CARC(s), RARC(s) and primary payer's adjustment amount(s) from their RA (835)
  - Ensure MSP claim information matches MSP record in CWF
  - Contact BCRC to set up/change MSP record if necessary
    - Refer to MSP Resources handout for BCRC information and SE1416

Matching MSP Record in CWF

- A matching record means MSP record in CWF contains same information you will report on your claim
- If you submit a conditional claim for which there is no matching MSP record in CWF
  - Your claim will suspend for up to 100 days in Medicare's claim processing system while we contact BCRC to set up MSP record

Prepare and Submit Conditional Claims – Steps

- Follow all steps (continued)
  - Wait for any updates to show in CWF before moving to next step
  - Review conditional claim to ensure required coding is present
  - Submit conditional claim using available options
  - Upon receipt of Medicare's payment, apply it to account
  - Apply any adjustments from Medicare's RA to account
  - Bill beneficiary only when appropriate
    - May bill beneficiary only for services not covered by Medicare, Medicare deductible, coinsurance and/or co-pay
  - Maintain documentation

General Instructions for Medicare Claims

- For conditional claims, follow **Medicare's requirements**
  - Such requirements apply to all Medicare claims including conditional claims
    - **Billing** requirements including providers' frequency of billing
      - If Medicare is secondary, can we submit separate claims when primary payer starts or stops paying during claim's billing period? If Medicare were primary, we would submit one claim.
      - **Answer:** No, since we require one claim, submit one claim as MSP claim
    - **Technical** requirements including timely filing, etc.
    - **Medical** requirements

Home Health and Hospice Providers

- In MSP situations
  - HHAs
    - Submit RAP showing Medicare as primary
    - Not reimbursed on RAP
    - Insurer information reported on final claim
  - Hospice
    - Submit NOE showing Medicare as primary
    - Insurer information reported on claim(s)

Coding Your Conditional Claims

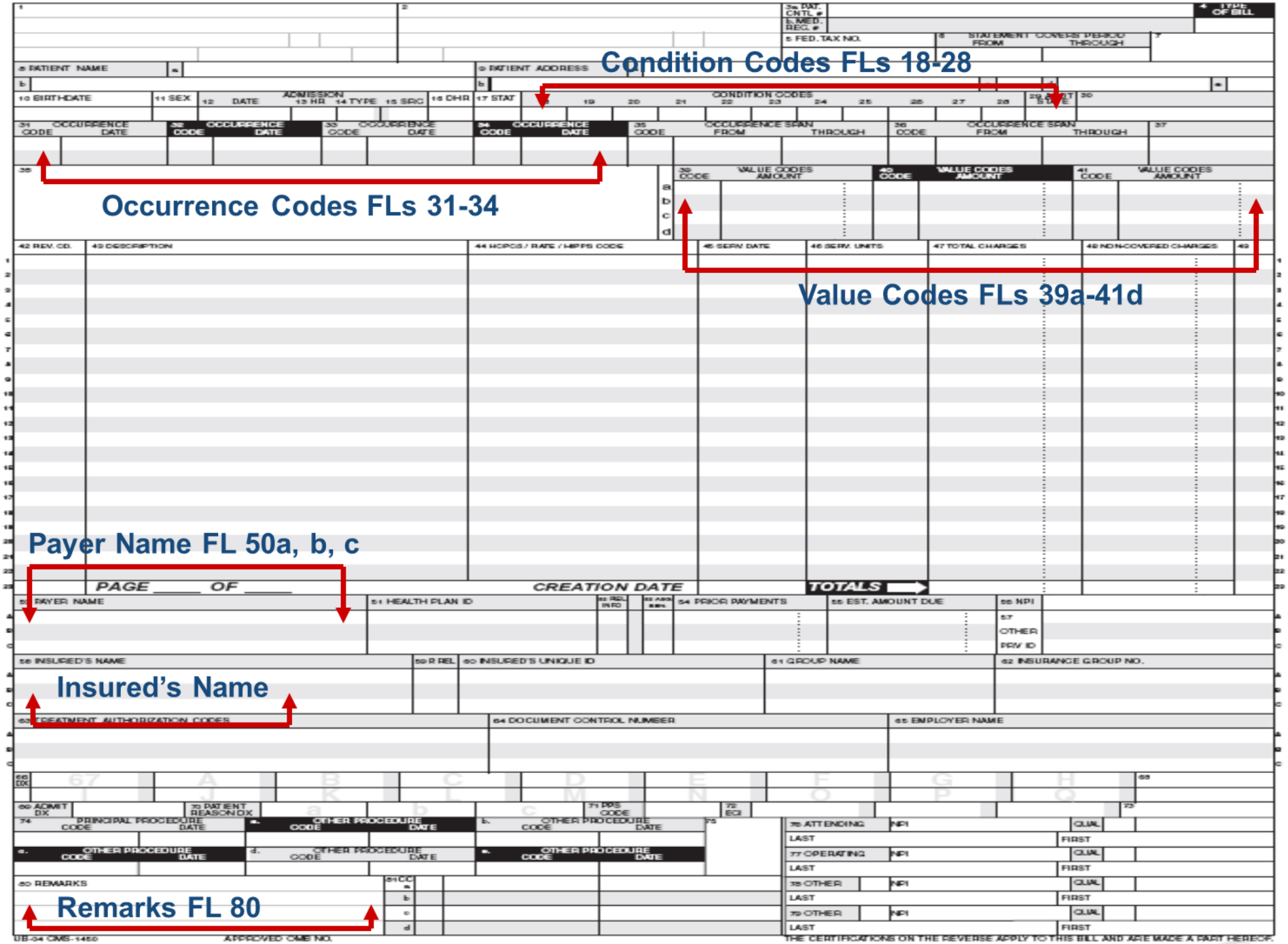
- Complete claims in usual manner; report:
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered days as usual
  - Covered/noncovered charges as usual
  - Primary payer as first payer
  - Medicare as second payer
  - Appropriate billing codes in applicable claim fields (FLs) to indicate claim is conditional

Conditional Claims – Claim Fields

Code	UB-04 FLs	Electronic Field	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	39–41	2300.HI (BE)	Page 01
Primary payer code (C)	N/A	N/A	Page 03
Primary insurer name	50A	2320.SBR04	Page 03

Conditional Claims – Claim Fields

Code	UB-04 FLs	Electronic Field	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
Reason primary didn't pay ***and*** Insurance address (unless using FISS DDE)	Use Remarks for both FL 80	Use Remarks for both 2300.NTE	Remarks for reason (Page 04), Page 06 (address)


Condition Codes FLs 18-28
Occurrence Codes FLs 31-34
Value Codes FLs 39a-41d
Payer Name FL 50a, b, c
Insured's Name
Remarks FL 80

Conditional Claims versus MSP Claims

- Conditional claims look **similar** to MSP claims
  - On conditional claims, do not report
    - CC 77 or VC 44
  - On conditional claims, report
    - MSP VC and amount of zero
    - OC 24 and date (except in one situation)
    - **Primary payer code = C in FISS regardless of MSP VC**
    - Remarks code to let us know reason primary payer did not pay

Conditional Claim Coding Options: Condition Codes (CCs or COND CODES)

- Two-digit code; describes condition or event applicable to claim
- Report any applicable CC and applicable MSP CCs:
  - 02 (zero two) = Condition is employment-related
  - 06 (zero six) = ESRD beneficiary in first 30 months of entitlement covered by EGHP

Conditional Claim Coding Options: Occurrence Codes and Dates (OCs or OCC CDS/DATE)

- Two-digit code and date; describes event applicable to claim
- Report any applicable OCs and dates and applicable MSP OCs and dates:
  - 01 (zero one) and DOA if medical-payment plan is primary
  - 02 (zero two) and DOA if no-fault is primary
  - 03 (zero three) and DOA if liability is primary
  - 04 (zero four) and DOA if WC is primary
  - 33 and date ESRD coordination period began
  - 24 and date of primary payer's notification (RA, EOB, letter) explaining why they did not pay (denied/rejected/did not pay for a valid reason) unless you are reporting code DA in Remarks

Conditional Claim Coding Options: Value Codes and Amounts (VCs)

- Two-digit code with dollar amount
- Report any applicable VC and dollar amount
- For conditional claims, report
  - Applicable MSP VC with amount you received from primary payer for Medicare-covered services
    - **VCs** = 12, 13, 14, 15, 41, 43 and 47
    - **Amount is always = zero**
  - Do not report a VC 44 with amount

Conditional Claim Coding Options: Patient Relationship (REL) Codes

- Report relationship of patient to identified insured accurately
  - 01 = Spouse
  - 18 = Self
  - 19 = Child
  - 20 = Employee
  - 21 = Unknown
  - 53 = Life partner
  - G8 = Other relationship

Conditional MSP Claim Coding Options: Remarks

- Conditional claims require **reason** why primary payer did not pay or did not pay promptly
  - Report a **two-digit explanation code** in first line of Remarks
    - Ten code options, created by NGS
      - **NB, PC, CD, FG, BE, PE, DA, DP, LD and PP**
      - Some codes require additional information such as a date (MM/DD/YY)
        - » If so, place information at least one space over from code
- Also in Remarks:
  - Report primary payer's address in second line
    - If using FISS DDE, report this on page 6 instead

Remarks: Codes NB, PC and CD

- If you receive no payment from primary payer for one of following reasons, submit conditional claim and report applicable code
- Primary payer rejected claim because:
  - **NB =** Not a covered benefit (VCs = 12, 13, 14, 15, 41 and 43)
  - **PC** = Preexisting condition (VCs = 12, 13 and 43)
  - **CD** = Charges applied to deductible, co-pay or coinsurance (VCs = 12, 13, 14 and 43)

Remarks: Code FG

- If you receive no payment from primary payer (VCs = 12, 13, 15 and 43) for one of following reasons, submit conditional claim and report code FG (follow guidelines) with number 1, 2 or 3:
- Number definitions; plan rejected claim because:
  - **1** = Claim was filed untimely (we pay if filed timely with us)
  - **2** = Provider is out of network (we pay one time only per entire time beneficiary enrolled in that plan)
  - **3** = Prior authorization not obtained (we do not pay)

Remarks: Code BE (and Primary Payer is GHP)

- If you receive no payment from GHP (VCs = 12, 13 and 43) because benefits exhausted
  - Submit **conditional claim**
    - Do not submit Medicare primary claim because MSP record stays open until lifetime benefits exhaust or EGHP terminates
- Report following code on such claim:
  - **BE** = Benefits exhausted
    - Requires exact date benefits exhausted (MM/DD/YY)
      - This may not be same date you reported with OC 24
      - Contact insurer if necessary

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

- If you receive no payment from a non-GHP other than auto no-fault (VCs = 14 for med-pay, 15 and 41) because benefits exhausted
  - Submit **conditional claim** when claim's DOS is before benefit exhaust date and no other primary payer exists
  - Submit **primary claim** when claim's DOS is after benefit exhaust date and no other primary payer exists
- Report following code on such conditional claims:
  - **BE** = Benefits exhausted
    - Requires exact date benefits exhausted (MM/DD/YY)
    - This may not be same date you reported with OC 24
    - Contact insurer if necessary; BCRC needs date to terminate MSP record

Did You Know

- Automobile no-fault states include Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania and Utah. Puerto Rico, a U.S. commonwealth, is also no-fault.

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

- If you receive no payment from auto no-fault (VC = 14) because benefits exhausted and no other primary payer exists
  - Submit **conditional claim** when DOS is before benefit exhaust date
  - Submit **primary claim** when DOS is after benefit exhaust date
- Report following code on such conditional claims in auto no-fault states only:
  - **PE** = PIP benefits exhausted
    - Requires exact date benefits exhausted (MM/DD/YY)
    - This may not be same date you reported with OC 24
    - Contact insurer if necessary; BCRC needs date to terminate MSP record

Remarks: Code DA

- If you receive no payment from primary payer promptly for accident claims (VCs = 14, 15, 41 and 47), you may submit conditional claim and report following code:
  - **DA** = 120 days passed (promptly period ended)
    - Requires date primary insurer was billed (MM/DD/YY)
  - Reminder: Do not also report OC 24 and date on claim

Remarks: Codes DP, LD and PP

- If you receive no payment from primary payer (VC = 47 only) for one of following reasons, you may submit conditional claim and report applicable code
  - **DP** = Delay in payment
    - Liability insurer's response stated there will be delay in their payment
  - **LD** = Liability denied
    - Liability insurer's response stated they are not responsible for claim
  - **PP** = Patient was paid
    - Liability insurer paid patient

Submitting Conditional Claims

Claim Submission Options

- Submit MSP, tertiary and conditional claims:
  - Electronically via 837I claim,
  - In FISS DDE, or
  - Using hardcopy UB-04/CMS-1450 claim form
    - Send to our Claims Department
      - Include primary payer's RA, EOB and any other relevant information
    - You must have or obtain approved ASCA waiver
    - Visit our website for
      - ASCA information under Claims & Appeals
      - Claims address under Contact Us > P.O. Box Mailing Addresses > Claims

Submit Conditional Claims in FISS DDE

- As of 1/1/2016, per CR8486, providers can
  - Use FISS DDE to
    - Submit and correct MSP, conditional and Medicare tertiary claims
    - Adjust claims for MSP reasons
  - Submit Medicare tertiary claims via 837I claim
    - Hardcopy submission with ASCA waiver no longer required
- FISS process was updated to allow above actions
  - MAP1719 was added so you can enter payments and adjustments from CAS of primary payer's RA (835) – CAGCs, CARCs and amounts
  - MAP103L was added so MACs can key hardcopy claims

Did You Know

- When you submit conditional claims
  - **In FISS DDE** – Enter MSP CAS information from primary payer's RA directly into MAP1719 (Claim Entry page 03)
  - **Via 837I claim** – Submit MSP CAS information from primary payer's RA; Medicare maps it to MAP1719
    - If claim is RTP, you can access it in FISS DDE to correct
    - If claim is rejected, you must adjust it (in some cases, you can resubmit)

Submitting Conditional Claims in FISS DDE

What is FISS DDE?

- Processing system we use to process claims and maintain records
- Process that allows remote user connectivity to Medicare mainframe
  - Providers access through FISS DDE online computer system
- Providers use FISS DDE to
  - Research coding
  - Submit claims and track submitted claims
  - Correct, adjust, and cancel claims
  - View reports

Accessing FISS DDE

- FISS logon ID and password required
- Visit our website for EDI enrollment information (under Claims and Appeals)
  - Left side listing articles should be on EDI Enrollment article
  - Click on Start Enrollment Process under Step 1
  - Read and then click on “Accept” for the Attestation
  - Check box for “I need to complete a Part A Logon Request Form,” submit when completed
- User logon ID and password are for individual use only
  - Do not share with coworkers or other staff

Navigating FISS DDE

Program function key	Screen movement
F3/PF3	Return to menu/submenu or originating screen when using SC field
F4/PF4	Exit entire online system by terminating session
F5/PF5	Scroll backward within page of screen data
F6/PF6	Scroll forward within page of screen data
F7/PF7	Move backward one page at a time
F8/PF8	Move forward one page at a time
F9/PF9	Save, update, submit

Navigating FISS DDE

Program function key	Screen movement
F10/PF10	Return to left viewing screen
F11/PF11	Move to right viewing screen
<Ctrl>	Move down one line at a time
<Home>	Move to SC field
<Tab>	Move to next field on screen
SC field	Navigate to specific inquiry file, use F3/PF3 to return to original page
Page field	Move to specific page within claim

Main Menu – Claims/Attachments

```
MAP1701          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 08/11/15
MXG9282                       MAIN MENU                    C201531P 12:29:47

                        01    INQUIRIES

                        02    CLAIMS/ATTACHMENTS

                        03    CLAIMS CORRECTION

                        04    ONLINE REPORTS

    ENTER MENU SELECTION: 02

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

Claim Entry Menu

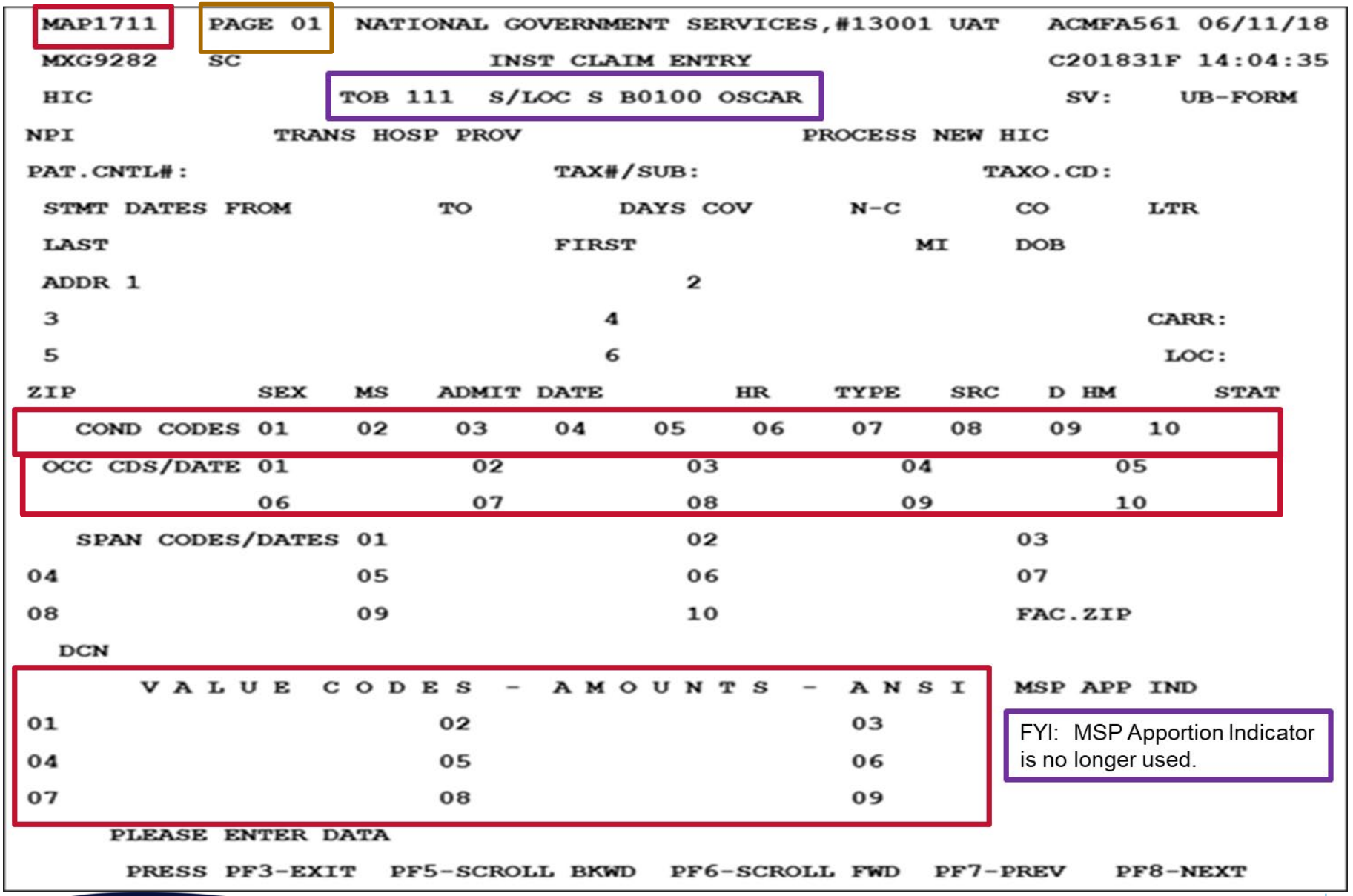
```
MAP1703              NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 03/07/16
MXG9282               CLAIM AND ATTACHMENTS ENTRY MENU         C2016200 15:33:23

                              CLAIMS ENTRY

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

                             ATTACHMENT ENTRY

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

    ENTER MENU SELECTION: _


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

Claim Entry – Key Points

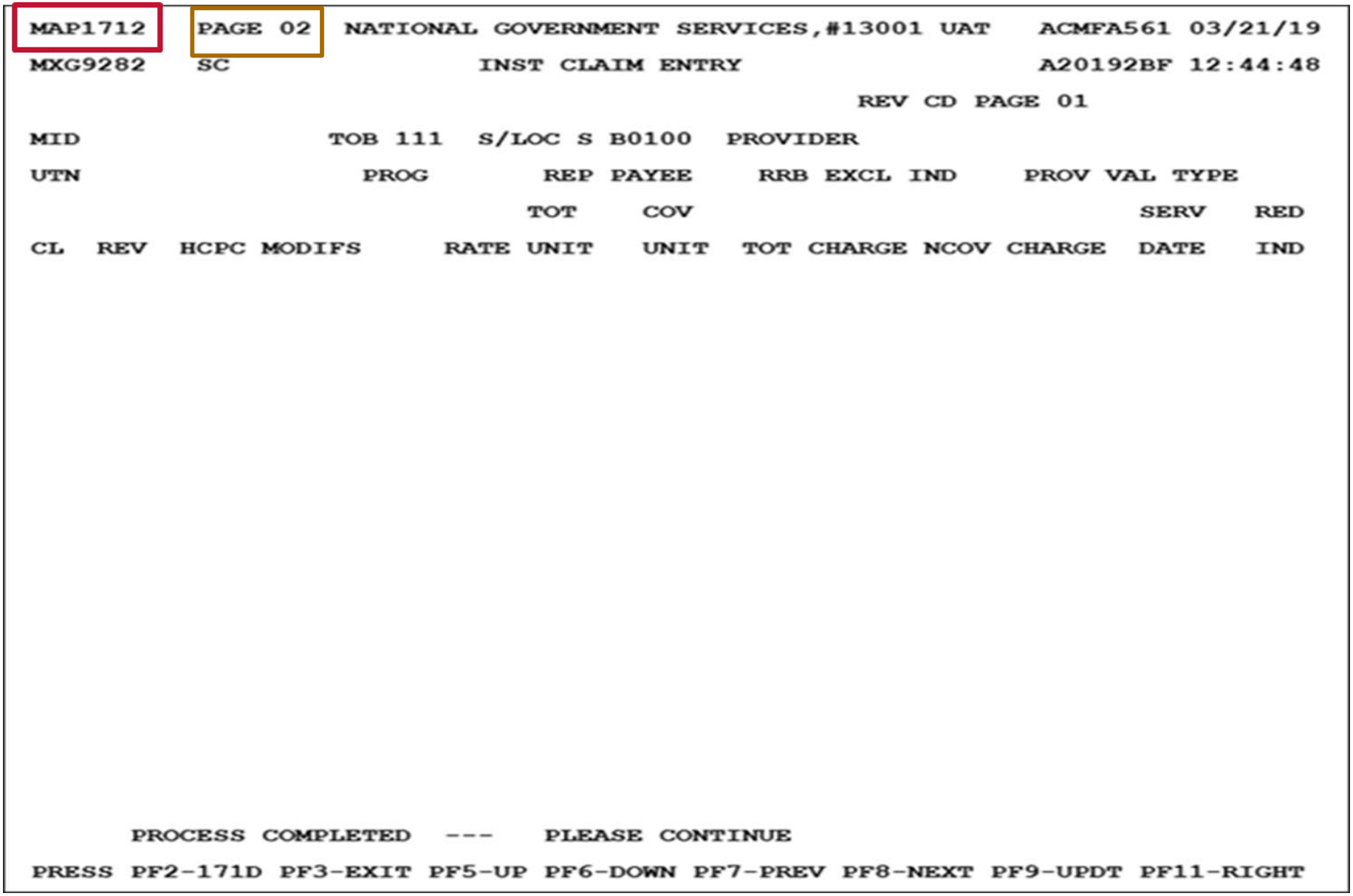
- Data entry screens set up similar to UB-04 claim form
- Six pages to a claim
- Depending on TOB
  - Cursor may skip fields not required
- TOB defaults to 111 for IP, 131 for OP and 211 for SNF
  - If entering a different TOB, type over default
- Do not press F3/PF3 key
  - If pressed while entering claim before it is stored (F9/PF9), all keyed information will be lost

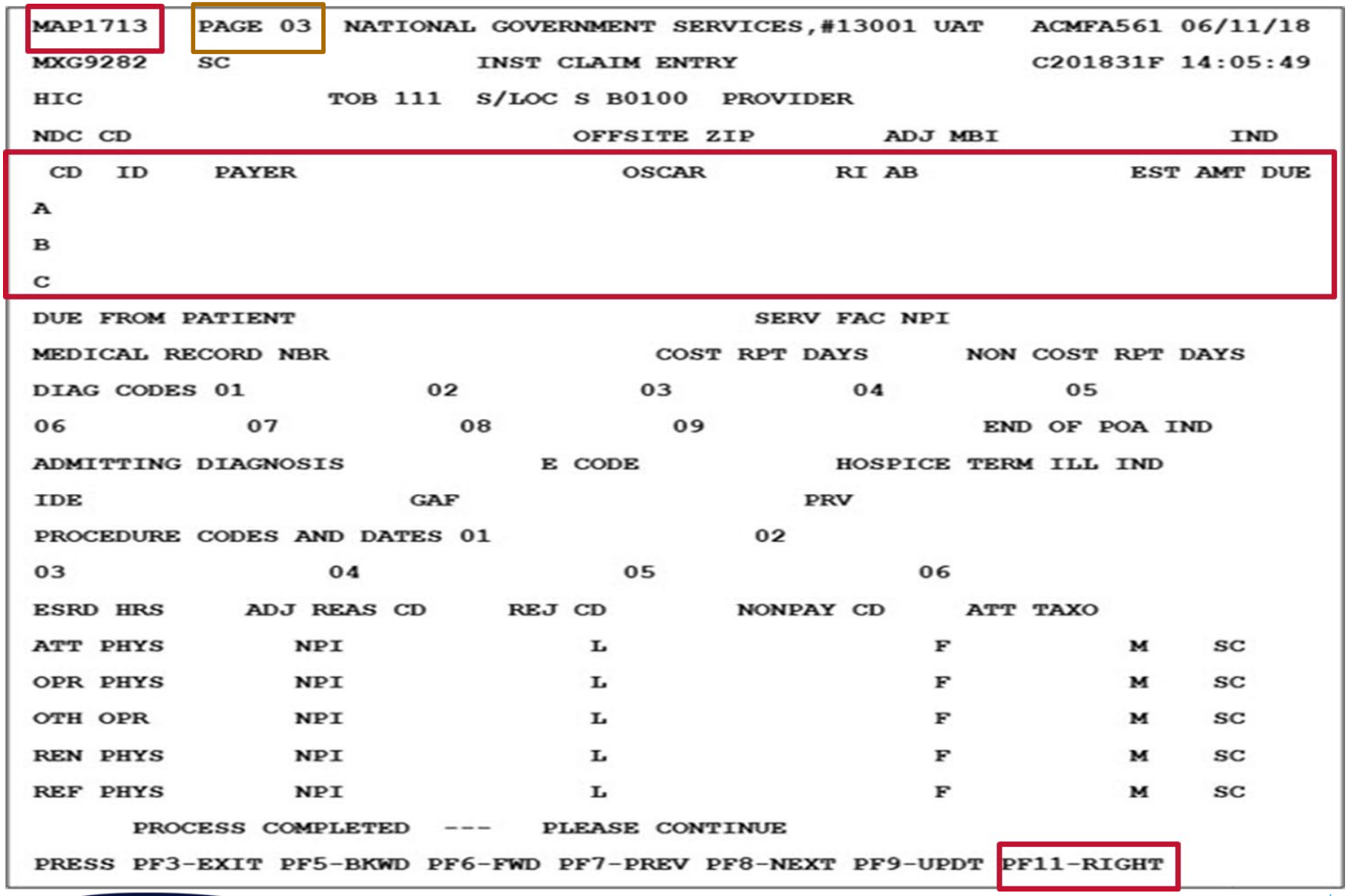
Claim Entry – Six Pages

Pages for Claim Entry	MAP	Contains
Page 01	MAP1711	Corresponds to UB-04, FLs 1–41: Patient information, condition codes, occurrence codes, occurrence span codes and value codes
Page 02	MAP1712	Corresponds to UB-04, FLs 42–49: Revenue and CPT/HCPCS codes, charges and DOS
Page 03	MAP1713	Corresponds to UB-04, FLs 50–57 and 66–79: Payer, diagnosis code, procédure code and physician information
Page 03	MAP1719	MSP payment information from primary payer's RA
Page 04	MAP1714	Corresponds to UB-04, FL 80: Remarks
Page 05	MAP1715	Corresponds to UB-04, FLs 58–65
Page 06	MAP1716	Primary insurer's address information



FYI: MSP Apportion Indicator is no longer used.


MAP1712 PAGE 02 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 03/21/19
MXG9282 SC INST CLAIM ENTRY A20192BF 12:44:48
REV CD PAGE 01
MID TOB 111 S/LOC S B0100 PROVIDER
UTN PROG REP PAYEE RRB EXCL IND PROV VAL TYPE
TOT COV SERV RED
CL REV HCPC MODIFS RATE UNIT UNIT TOT CHARGE NCOV CHARGE DATE IND
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT

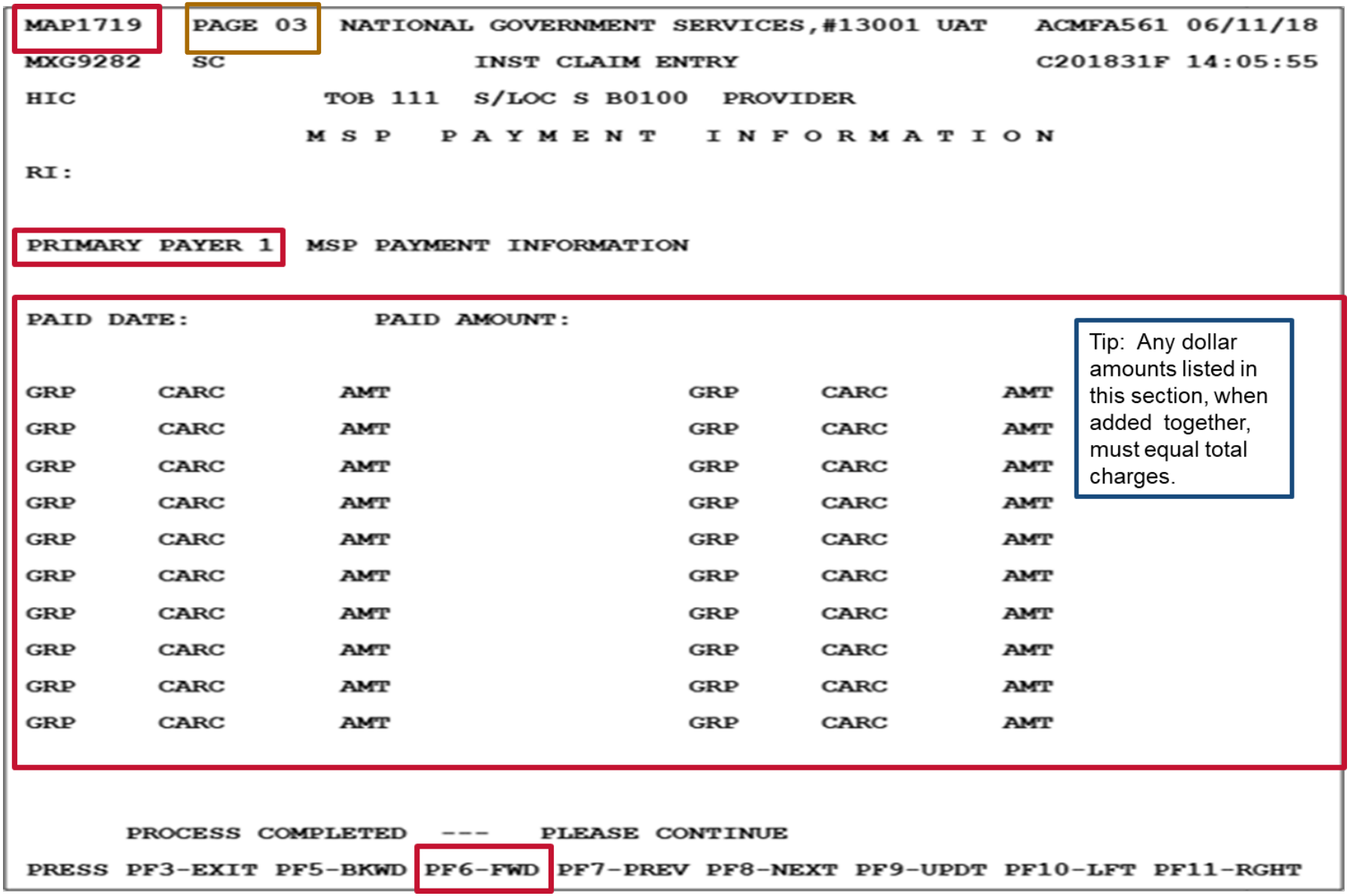

MAP1713 PAGE 03 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:05:49
HIC TOB 111 S/LOC S B0100 PROVIDER
NDC CD OFFSITE ZIP ADJ MBI IND
CD ID PAYER OSCAR RI AB EST AMT DUE
A
B
C
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAG CODES 01 02 03 04 05
06 07 08 09 END OF POA IND
ADMITTING DIAGNOSIS E CODE HOSPICE TERM ILL IND
IDE GAF PRV
PROCEDURE CODES AND DATES 01 02
03 04 05 06
ESRD HRS ADJ REAS CD REJ CD NONPAY CD ATT TAXO
ATT PHYS NPI L F M SC
OPR PHYS NPI L F M SC
OTH OPR NPI L F M SC
REN PHYS NPI L F M SC
REF PHYS NPI L F M SC
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT

Claim Entry Page 03 (MAP1719)

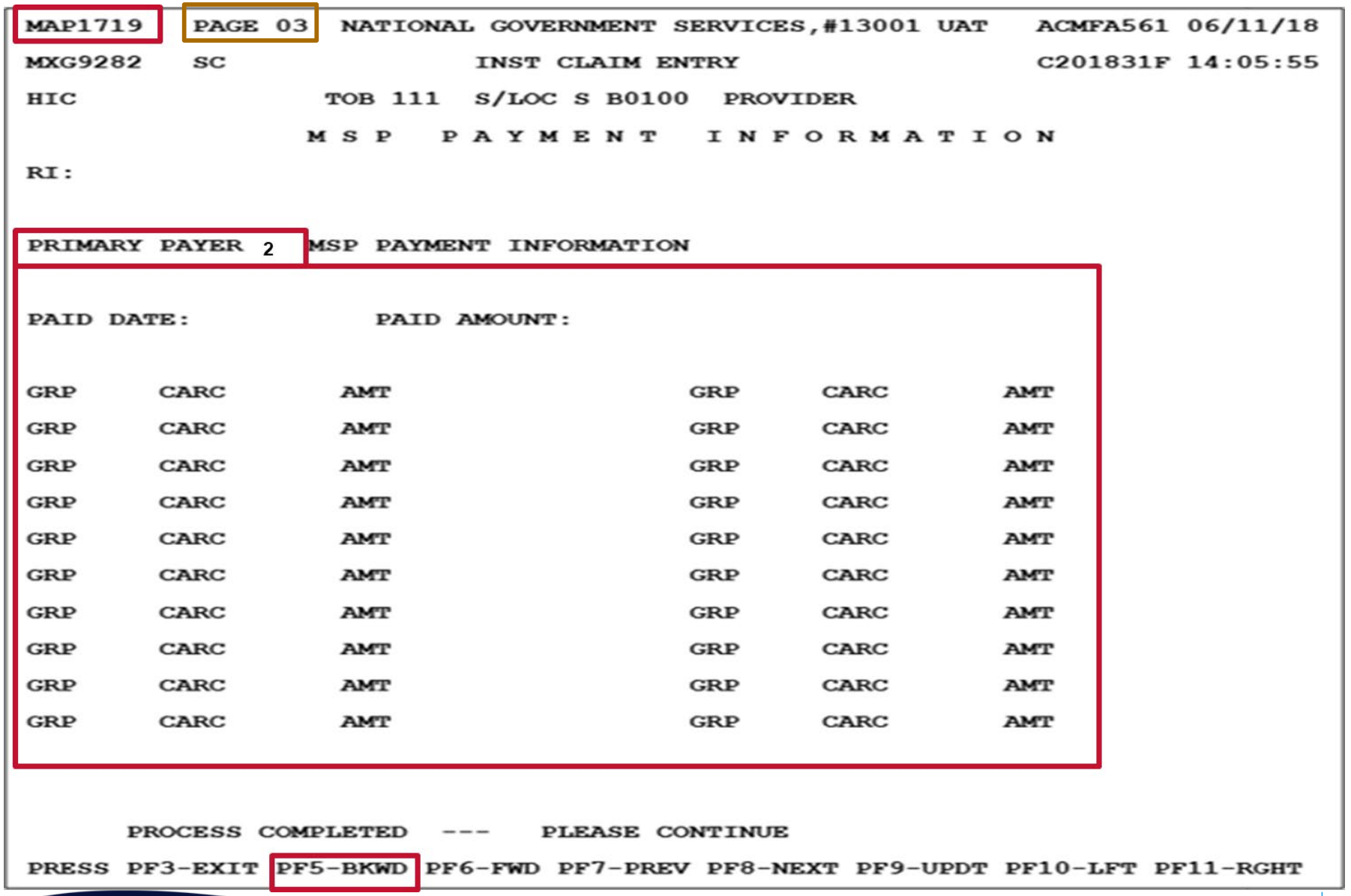
- MSP Payment Information page
  - Press F11/PF11, from page 03 (MAP1713), to access
  - Press F6/PF6 to display a second page for payer 2
- Up to 20 entries each for primary payers 1 and 2
  - Field names (enter information from primary payer's RA)
    - Paid date: Enter paid date Paid amount: Enter paid amount (must equal amount entered for MSP VC) and must equal charges less amounts with CAGCs and CARCs
    - GRP: Enter group code(s), also known as CAGC(s)
    - CARC: Enter CARC(s)
    - AMT: Enter dollar amount(s) associated with CAGC and CARC

Reporting CAGCs and CARCs

- CAGC(s) from primary payer's RA (835)
  - Identifies general category of payment adjustment
  - Required when primary payer adjusts billed charges
  - Options:
    - CO (Contractual Obligations)
    - OA (Other Adjustments)
    - PI (Payer Initiated Reductions)
    - PR (Patient Responsibility)
- CARC(s) from primary payer's RA (835)
  - Communicates an adjustment
  - Explains why primary payer paid differently from amount billed to them
  - External Code Lists/X12



Tip: Any dollar amounts listed in this section, when added together, must equal total charges.

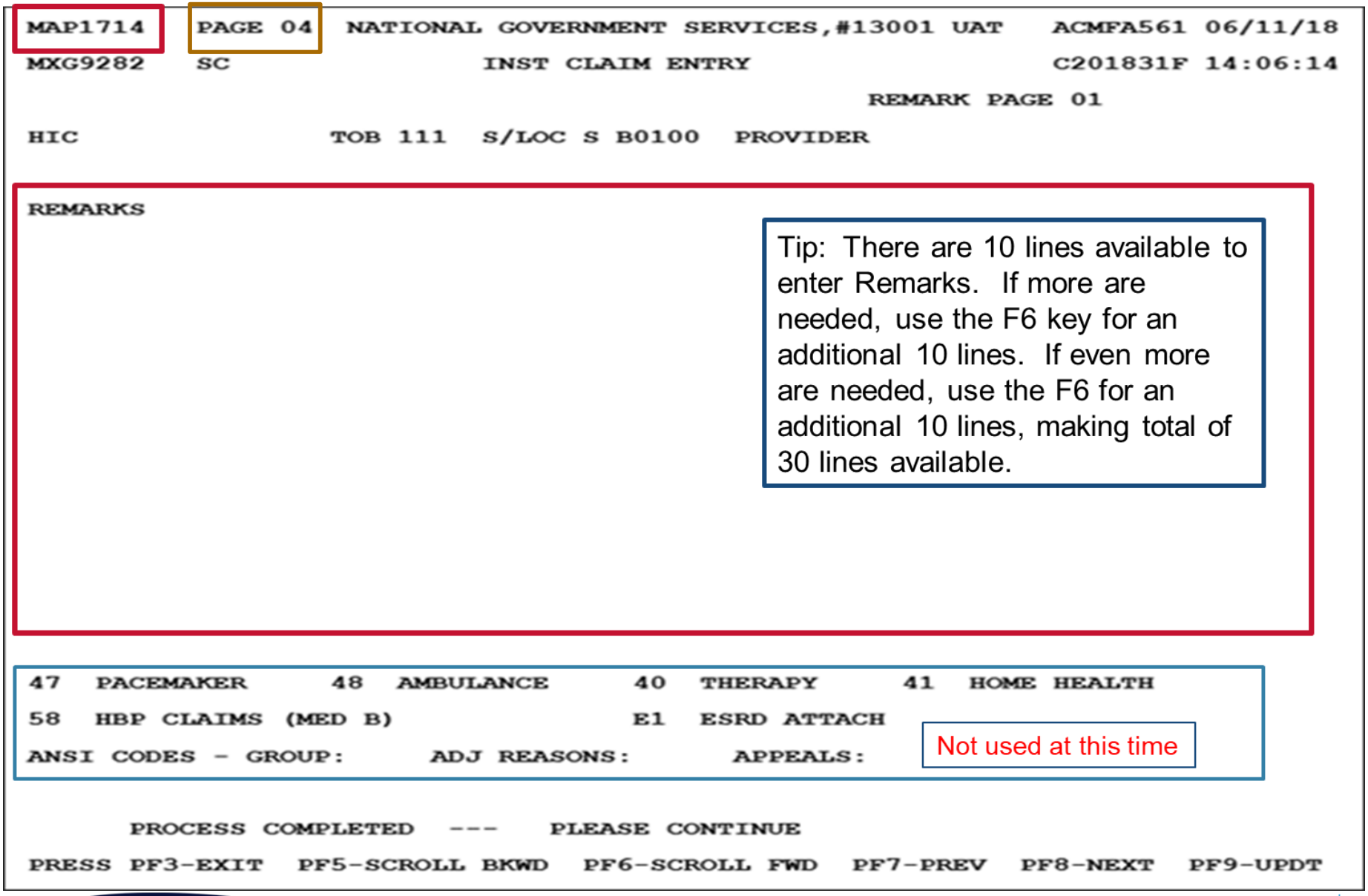

MAP1719 PAGE 03 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:05:55
HIC TOB 111 S/LOC S B0100 PROVIDER
M S P P A Y M E N T I N F O R M A T I O N
RI:
PRIMARY PAYER 2 MSP PAYMENT INFORMATION
PAID DATE: PAID AMOUNT:
GRP CARC AMT GRP CARC AMT
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT

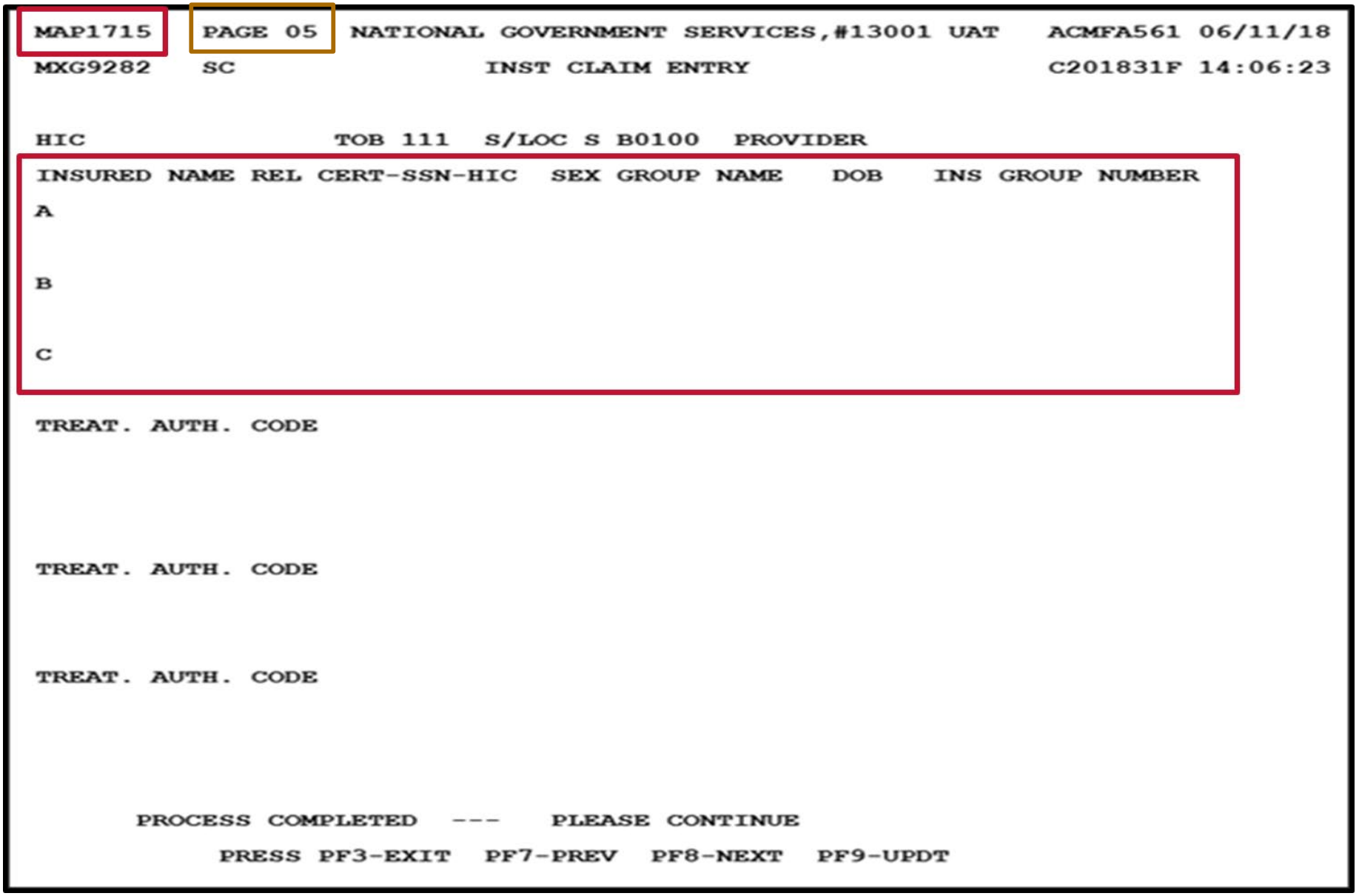
Reporting CAGCs and CARCs – Example

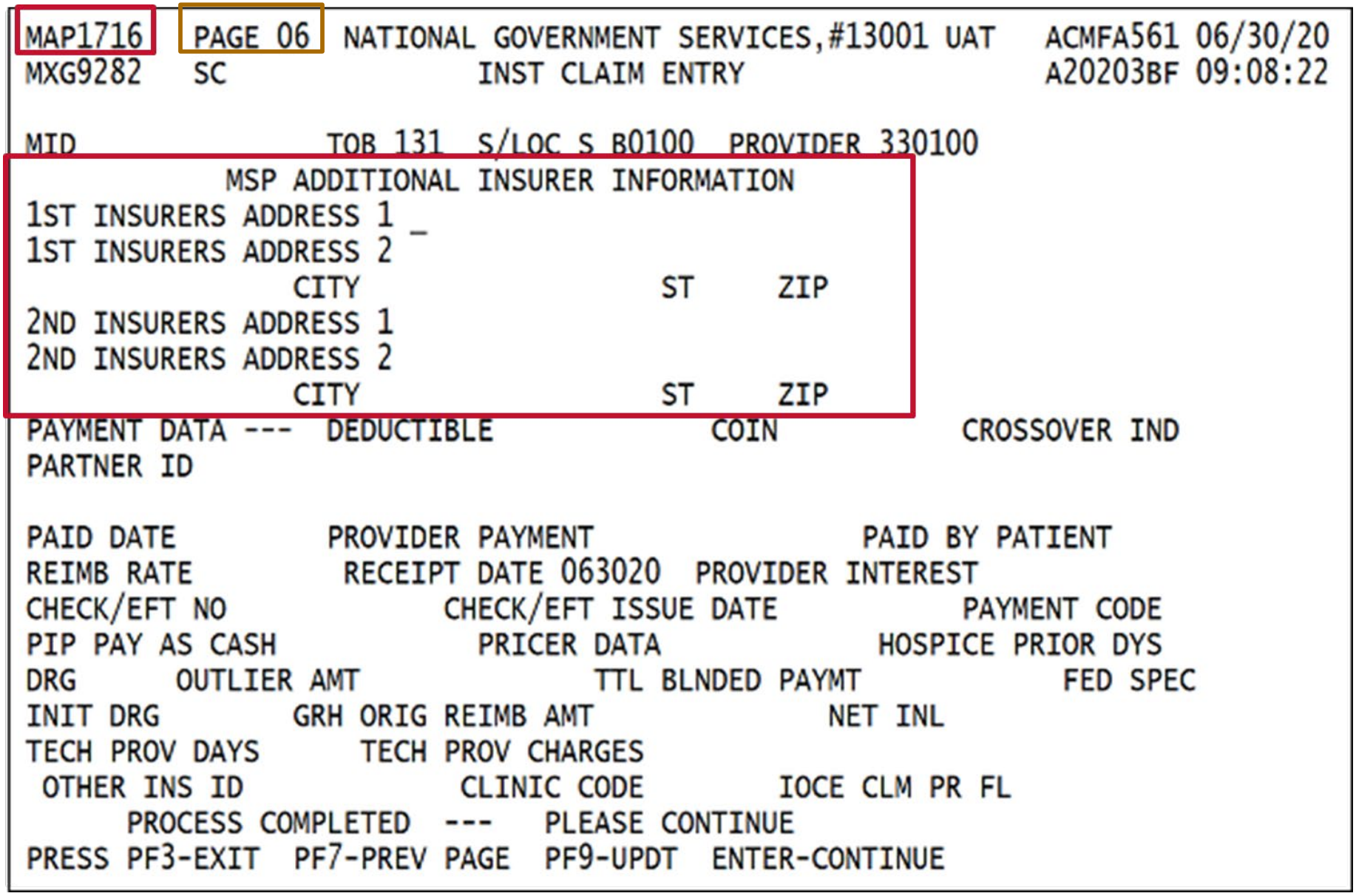
- Medicare beneficiary
  - Working aged with EGHP primary to Medicare
  - Receives OP services: 3/1/2021 for $500
- Provider
  - Bills EGHP as primary; under contract with EGHP
- EGHP
  - Allowed = $400 per contract
  - Applied patient deductible = $400
  - Paid = $0 on 5/15/2021
- FISS DDE claims entry – page 03 (MAP1719)
  - Paid amount = $0 on 5/15/2021
  - CAGCs/CARCs and amounts = CO 45 with $100 and PR 1 with $400

Reporting CAGCs and CARCs – Example

- Medicare beneficiary
  - In single car accident on 5/2/2021
  - Taken to ER, receives OP services on 5/2/2021 for $650
- Provider
  - Bills beneficiary's auto med-pay insurer as primary
- Auto med-pay insurer
  - Received claim for total charges of $650
  - Had already paid $1,000
  - Paid $0 on 5/15/2021; per letter, benefits exhausted when insurer paid another provider on 5/10/2021
- FISS DDE claims entry – page 03 (MAP1719)
  - Paid amount = $0 on 5/15/2021
  - CAGCs/CARCs and amounts = CO 119 with $650


MAP1714 PAGE 04 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:06:14
REMARK PAGE 01
HIC TOB 111 S/LOC S B0100 PROVIDER
REMARKS
Tip: There are 10 lines available to enter Remarks. If more are needed, use the F6 key for an additional 10 lines. If even more are needed, use the F6 for an additional 10 lines, making total of 30 lines available.
47 PACEMAKER 48 AMBULANCE 40 THERAPY 41 HOME HEALTH
58 HBP CLAIMS (MED B) E1 ESRD ATTACH
ANSI CODES - GROUP: ADJ REASONS: APPEALS:
Not used at this time
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT PF9-UPDT


MAP1715 PAGE 05 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/11/18
MXG9282 SC INST CLAIM ENTRY C201831F 14:06:23
HIC TOB 111 S/LOC S B0100 PROVIDER
INSURED NAME REL CERT-SSN-HIC SEX GROUP NAME DOB INS GROUP NUMBER
A
B
C
TREAT. AUTH. CODE
TREAT. AUTH. CODE
TREAT. AUTH. CODE
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT


MAP1716 PAGE 06 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 06/30/20
MXG9282 SC INST CLAIM ENTRY A20203BF 09:08:22
MID TOB 131 S/LOC S B0100 PROVIDER 330100
MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
CITY ST ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
CITY ST ZIP
PAYMENT DATA --- DEDUCTIBLE COIN CROSSOVER IND
PARTNER ID
PAID DATE PROVIDER PAYMENT PAID BY PATIENT
REIMB RATE RECEIPT DATE 063020 PROVIDER INTEREST
CHECK/EFT NO CHECK/EFT ISSUE DATE PAYMENT CODE
PIP PAY AS CASH PRICER DATA HOSPICE PRIOR DYS
DRG OUTLIER AMT TTL BLNDED PAYMT FED SPEC
INIT DRG GRH ORIG REIMB AMT NET INL
TECH PROV DAYS TECH PROV CHARGES
OTHER INS ID CLINIC CODE IOCE CLM PR FL
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF7-PREV PAGE PF9-UPDT ENTER-CONTINUE

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 and 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
  - MSP VC and primary payer's payment amount of zero
  - A two-digit explanation code in Remarks that explains why primary payer did not pay

What You Should Do Now

- Review MSP Resources handout
- Share information with staff
- Continue to learn more about MSP
- Continue to attend educational sessions
- Develop and implement policies that ensure providers MSP responsibilities are met
- Submit MSP claims when required and code accurately

Online Assessment and Questions

- Follow-up email
  - In addition to receiving Medicare University Course Code for this Webinar, attendees will be asked to complete an online assessment
- Questions?
  - Do not enter any beneficiary or claim-related questions in Webinar question box
  - Contact our PCC with such questions

MSP Resources – Also Refer to Handout

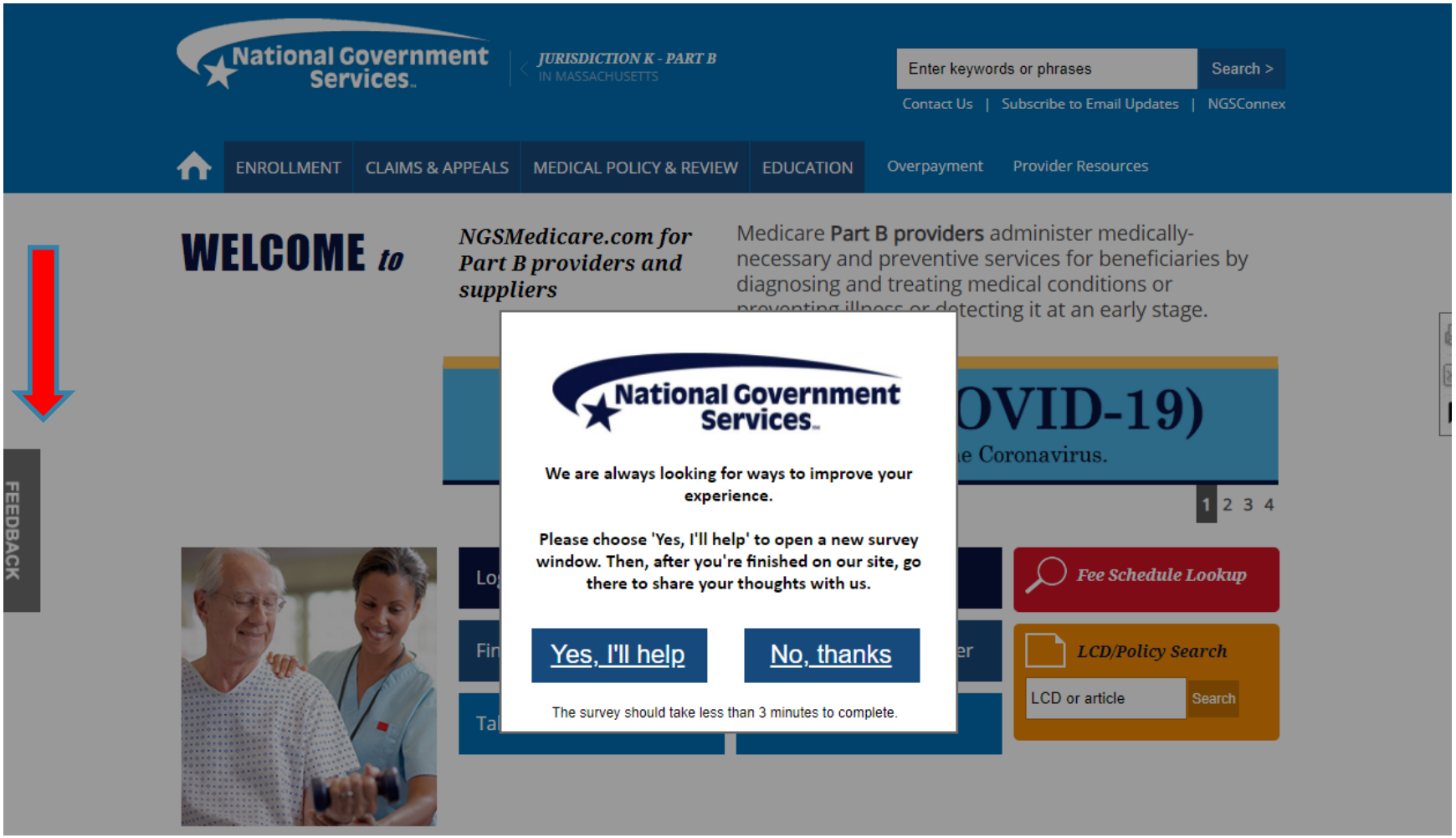
Education Tab on our Website

- For a complete listing of our educational activities, visit the Education mega tab on our website
- Our Education includes links to
  - Webinars, Teleconferences & Events Calendar
  - Medicare University
  - New Provider Center
  - POE Advisory Group
  - And much more
- Easiest, fastest way to be aware of POE information

CMS' MSP Resources

- MLN Matters® *MM7355 (Revised): Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims*

Your Feedback Matters!
NGSMedicare



Your Feedback Matters!
NGSConnex

Thank You!

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

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