Medicare Secondary Payer – Conditional Claims That Have Returned to the Provider

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Today's Presenters

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Objectives

- Review reasons why conditional claims RTP and what providers can do to prevent these RTP claims
  - Preventing RTP claims can increase timeliness of your Medicare cash flow and decrease time you spend correcting and/or submitting new conditional claims

Agenda

- MSP Reminders
- RTP Claims
- Preparing Conditional Claims
- What You Should Do Now
- MSP Resources – Refer to Handout
- Questions and Answers

MSP Reminders

Did You Know

- Providers who are familiar with the MSP Provisions, their MSP related responsibilities, and how to accurately prepare and submit MSP claims are less likely to receive RTP claims from Medicare

MSP and Providers' Responsibilities

- MSP refers to
  - Situations in which beneficiary has other coverage that is primary to Medicare per federal laws known as MSP provisions
- Provider responsibilities
  - Identify and bill payers that are primary to Medicare before billing Medicare
  - Bill Medicare as secondary payer when required

MSP Provisions With MSP VCs and Payer Codes

MSP VC	MSP Provision	Primary Payer Code (C if conditional)
12	Working aged, 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 and W
16	Public Health Services; research grants	F
41	Federal Black Lung Program	H
43	Disabled, under 65, LGHP, 100 or more employees	G
47	Liability Insurance	L

Claim Types

- If primary payer pays in part
  - Submit MSP claim; known as MSP partial-pay claim
- If primary payer pays in full
  - Submit MSP claim, known as MSP full-pay claim, when required
- If primary payer does not pay, citing Medicare is primary
  - Submit Medicare primary claim (first verify Medicare is primary)
- If primary payer does not pay for a valid reason or does not pay promptly (120 days; accidents only)
  - Submit conditional claim

Conditional Claims – Defined

- Claims submitted to Medicare requesting conditional payment because
  - Primary payer 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, may submit Medicare primary claim
  - Primary payer 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 is same as if Medicare were primary

Situations in Which Conditional Payment Can be Made

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

RTP Claims

RTP Claims

- Claims that are RTP
  - Returned to the provider = RTP
  - Are unprocessable
  - Contain claim coding error
  - Conflict between claim and Medicare's records
  - Allow providers to review view errors/conflicts

Finding RTP Claims

- In FISS DDE status/location = T B9997
  - Log into FISS DDE
  - Select Claims Correction Menu (option 03)
  - Select option from Claim and Attachments Correction Menu based on RTP claim type
    - **IP** = 21, **OP** = 23, **SNF** = 25, **Home Health** = 27, **Hospice** = 29
  - To access specific claim
    - Enter Medicare number and DOS
    - List of RTP claims will be displayed
    - Select claim to be corrected by placing ‘U’ in SEL field
    - Claim opens at page 1

Tip

- Check your facility's RTP claims in FISS status/location T B9997 routinely

Claim Correction Tip: FISS DDE Sort

- Providers can use FISS DDE Sort field on Claim Correction screen to sort RTP claims

Code	Description
D	Sorts in ascending receipt date order
H	Sorts in ascending Medicare number order
M	Sorts in ascending order by medical record number
N	Sorts by beneficiary last name in ascending order
R	Sorts in ascending reason code order

Determining What is Wrong With Your RTP Claims

- RTP claims have assigned reason code(s)
  - One or more for each claim
  - Describe reason(s) claim was RTP and action(s) to resolve
  - Listed in lower left corner of claim page
  - Also available through Inquiries Submenu (01) > Reason Code file (17)

Conditional Claims Are Subject to Same Reason Codes as Other Claims

- RTP conditional claims
  - Subject to many of same reason codes as Medicare primary claims
    - Claim submission error made in patient-, provider- or service-specific information, etc.
      - **Examples**: Error made in use of HCPCs code, revenue code, number of units, etc.

Conditional Claims Are Subject to Additional Reason Codes Than Other Claims

- RTP conditional claims
  - Subject to additional reason codes due to MSP involvement
    - Claim submission error
    - Error in conditional claim coding such as MSP CCs, OCs and dates, VCs, explanation code in remarks, etc.
    - Conditional claim information conflicts with information in beneficiary's MSP record in CWF

Reasons Conditional Claims May RTP

- Conditional claim may RTP if
  - Not coded correctly
    - Submitted without required conditional claim coding
    - Submitted with incorrect conditional claim coding
    - Submitted with conflicting claim coding
    - Submitted without CAGCs and/or CARCs when needed
    - Submitted with incorrect CAGCs and/or CARCs
  - Contains information that conflicts with MSP record in CWF
    - Submitted when a matching MSP record for beneficiary is not in CWF
    - Submitted when beneficiary's MSP record in CWF indicates Medicare is primary

Examples: MSP-Related RTP Reason Codes

- MSP-related RTP reason codes you may encounter on your conditional claims (not all-inclusive)
  - 31102
  - 31300, 31301, 31350, 31361 and 31409
  - 3SP25
  - 7MSPE, 7MSPG, 7MSPL and 7MSPR
  - 75003 and 75004
  - **Fact:** There is not a list of FISS reason codes used to RTP conditional claims

Correcting/Resolving RTP Conditional Claims

- Correct/resolve conditional claims in FISS DDE
  - Add required conditional claim coding
  - Correct conflicting claim coding
  - Add or correct CAGCs and/or CARCs
  - Store claim (<F9/PF9>) after BCRC sets up an MSP record
  - Resubmit corrected or new conditional claim
    - No errors, no conflicts

Tips for Resolving RTP Conditional Claims

- Review RTP conditional claim
  - Read all reason code narratives in their entirety
  - Understand all identified errors, conflicts and actions you need to take to resolve before new claim is submitted
  - Contact our PCC if you do not understand why claim RTP
  - Determine what claim type you need to submit
  - Review primary payer's ERA (CAGCs and CARCs)
- Make corrections to claim in FISS DDE
  - Correct all claim coding errors at one time
  - Use available MSP Resources; refer to Resources slides
  - Hit <PF9> key

Tips for Resolving RTP Conditional Claims

- Resolve conflicts between claim and MSP record(s)
  - Review MSP record in CWF
    - Use HIQA, HIQH, HETS, NGSConnex or IVR
  - Review completed MSP questionnaire
  - Contact BCRC if necessary; refer to Resources
  - Wait for BCRC to complete MSP record correction
- Store claim (PF9) or resubmit corrected claim when
  - All claim corrections are made
  - All conflicts are resolved
  - Any applicable MSP record corrections/additions are complete

Preparing Conditional Claims – Yes You Can Prepare Accurate Conditional Claims

MSP Fact

- To prevent conditional claims from being RTP by Medicare, providers must prepare such claims accurately the first time and there must not be any conflicts between the claims and the MSP records

Actions That Can Help Providers Submit Accurate Conditional Claims and Prevent RTPs

- Submit proper claim to proper primary payer
- Review response from primary payer (if have one)
  - If GHP is primary (VC 12, 13 or 43), to bill conditionally
    - Must have GHP's response; reason for nonpayment of claim must be valid
  - If NGHP is primary (VC 14, 15, 41 or 47), determine if 120 day promptly period has been met
    - To bill conditionally within 120-day promptly period
      - Must have NGHP's response; reason for nonpayment of claim must be valid
    - To bill conditionally after 120-day promptly period
      - Do not need NGHP's response

Actions That Can Help Providers Submit Accurate Conditional Claims and Prevent RTPs

- Prepare conditional claim per our instructions
- Report required claim coding
- Use available conditional billing resources
- Check for matching MSP record in CWF
- If no matching MSP record, contact BCRC
- Submit conditional claim once MSP record in CWF
- Use appropriate method to submit conditional claim
- Maintain documentation to support conditional claim

Did You Know

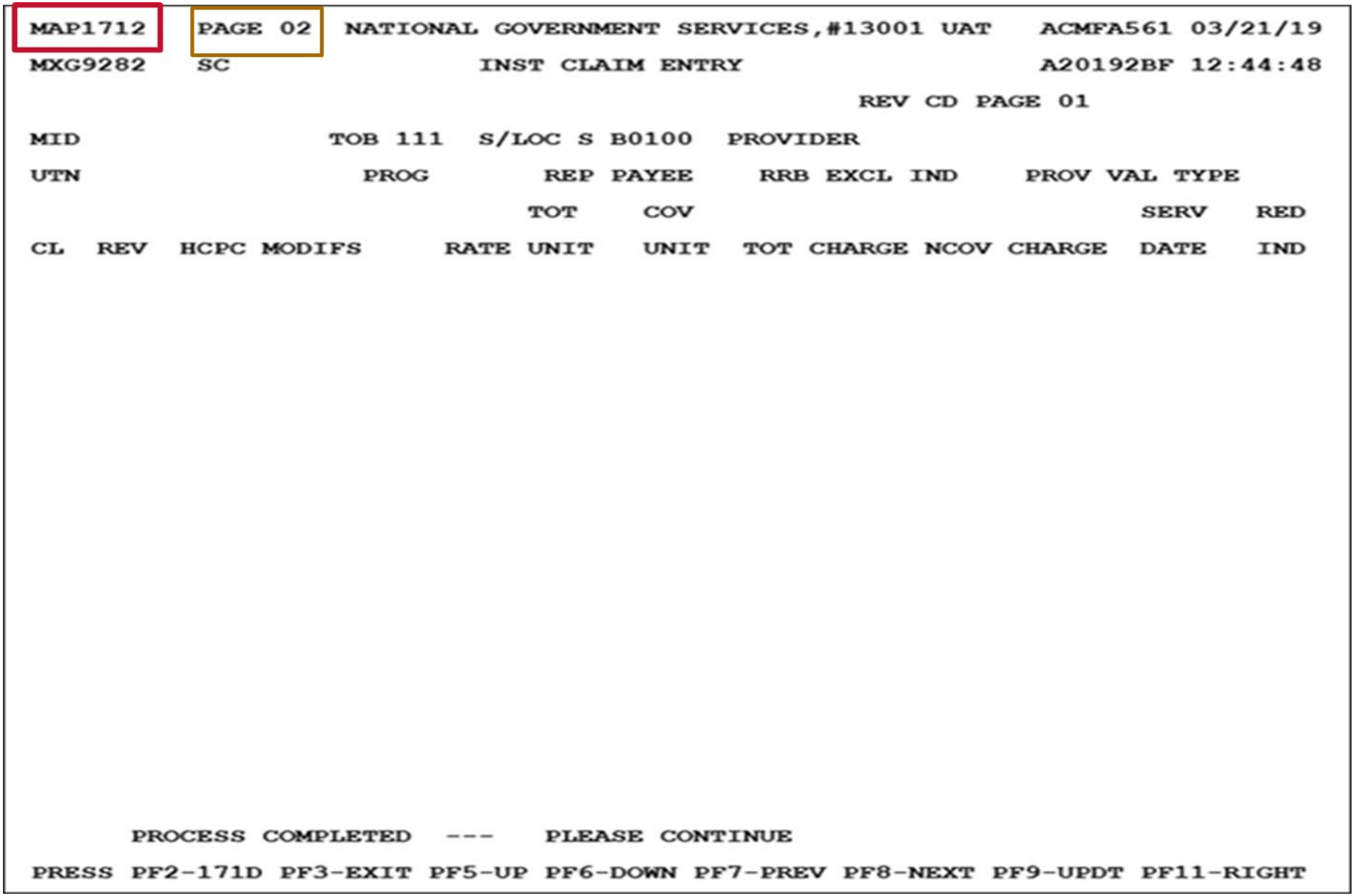
- If you submit a conditional claim for an accident because you did not receive a prompt response from the primary payer, your claim may be RTP if the promptly period has not expired

General Instructions for Preparing Conditional Claims

- Follow all of Medicare's usual requirements
  - Billing, technical, medical, etc.
  - Including one year timely filing and frequency of billing
- In all MSP situations including conditional
  - 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

General Instructions for Preparing Conditional Claims

- Complete claims in usual manner; report
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered charges as usual
  - Total covered/noncovered days as usual
  - Primary payer as first payer; Medicare as second
  - Appropriate billing codes in appropriate claim fields (FLs) to indicate claim is a conditional claim
    - Correct primary payer code of “C” appears in FISS when claim billed with correct MSP VC and zero payment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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

Avoiding General Coding Errors to Prevent Conditional Claim RTPs

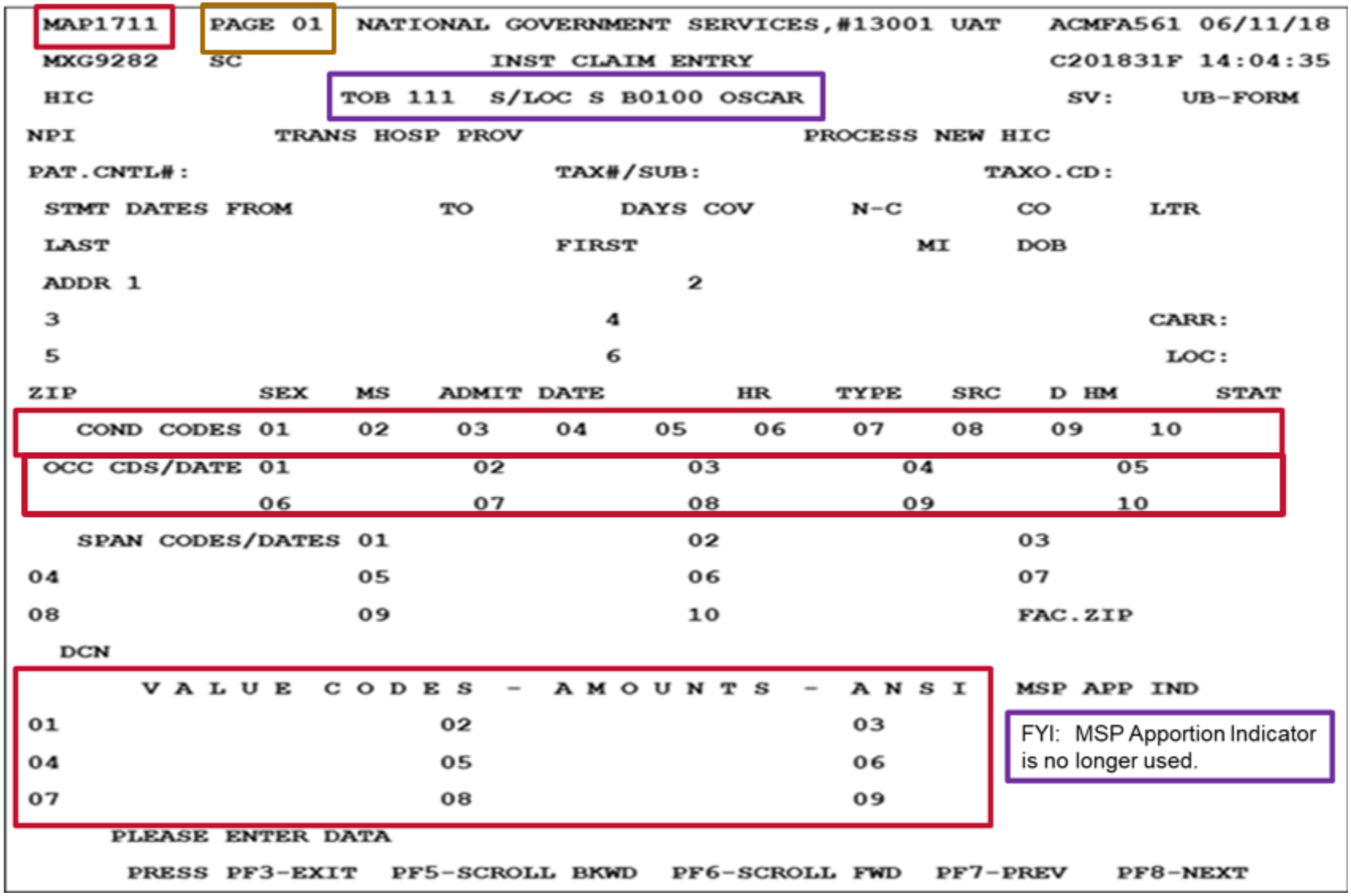
- Claim may be RTP if
  - You do not report coding that is usually reported for services being submitted
    - Examples: HCPCS codes, revenue codes, number of units, provider information, patient information, etc.
  - You report Medicare as first payer (payer code Z) and primary payer as second payer (reason code 31300)

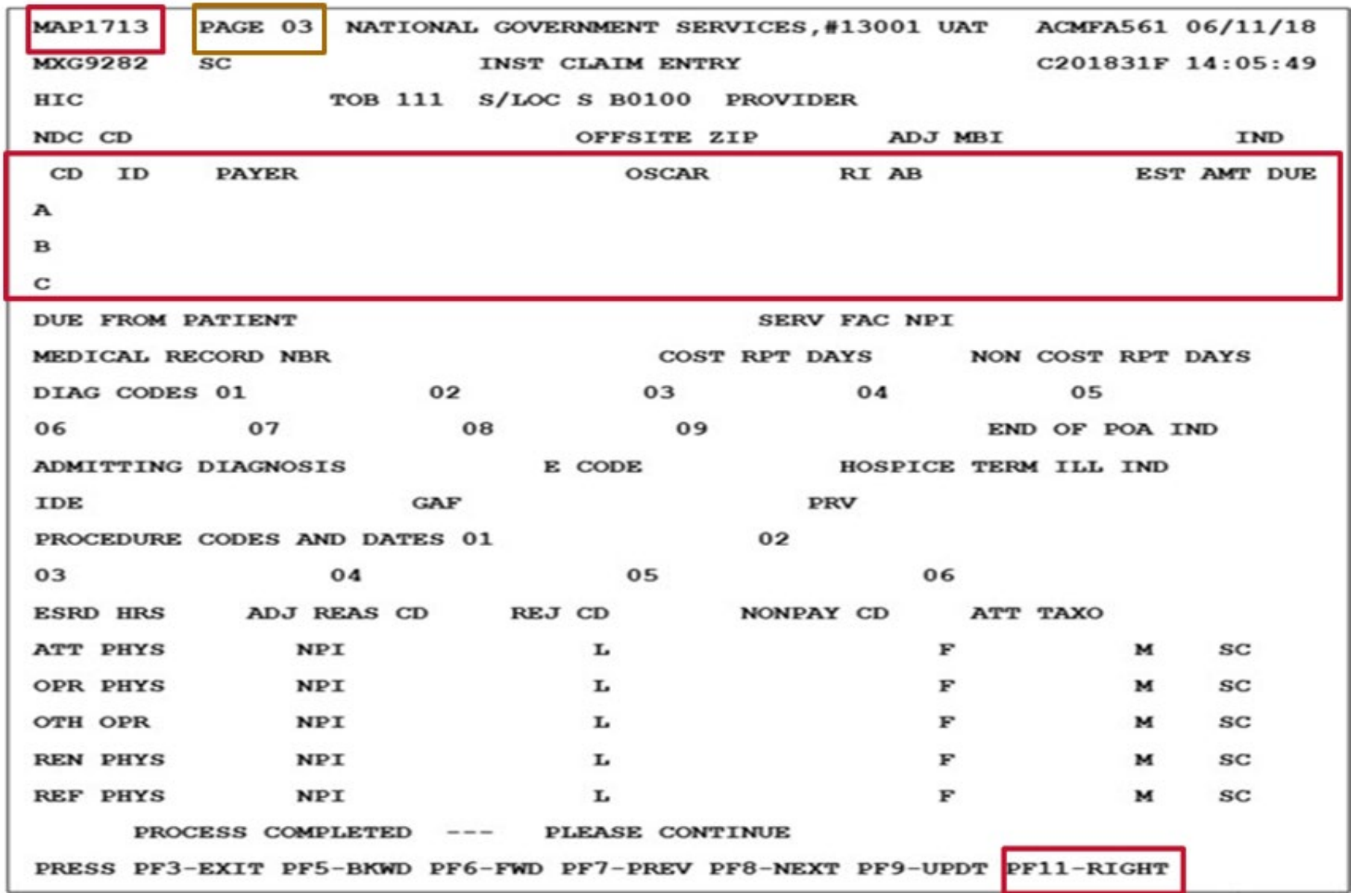
Conditional Claims – Claim Fields

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 $0	39–41	2300.HI (BE)	Page 01
Payer code ID (Conditional = 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)	Remarks for both FL 80	Remarks for both 2300.NTE	Remarks for reason (Page 04), Address (Page 06)


MAP1711
PAGE 01
NATIONAL GOVERNMENT SERVICES,#13001 UAT
ACMFA561 06/11/18
MXG9282 SC
INST CLAIM ENTRY
C201831F 14:04:35
HIC
TOB 111 S/LOC S B0100 OSCAR
SV: UB-FORM
NPI
TRANS HOSP PROV
PROCESS NEW HIC
PAT.CNTL#:
TAX#/SUB:
TAXO.CD:
STMT DATES FROM
TO
DAYS COV
N-C
CO
LTR
LAST
FIRST
MI
DOB
ADDR 1
2
3
4
CARR:
5
6
LOC:
ZIP
SEX
MS
ADMIT DATE
HR
TYPE
SRC
D HM
STAT
COND CODES 01 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
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 02 03
04 05 06
07 08 09
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
FYI: MSP Apportion Indicator is no longer used.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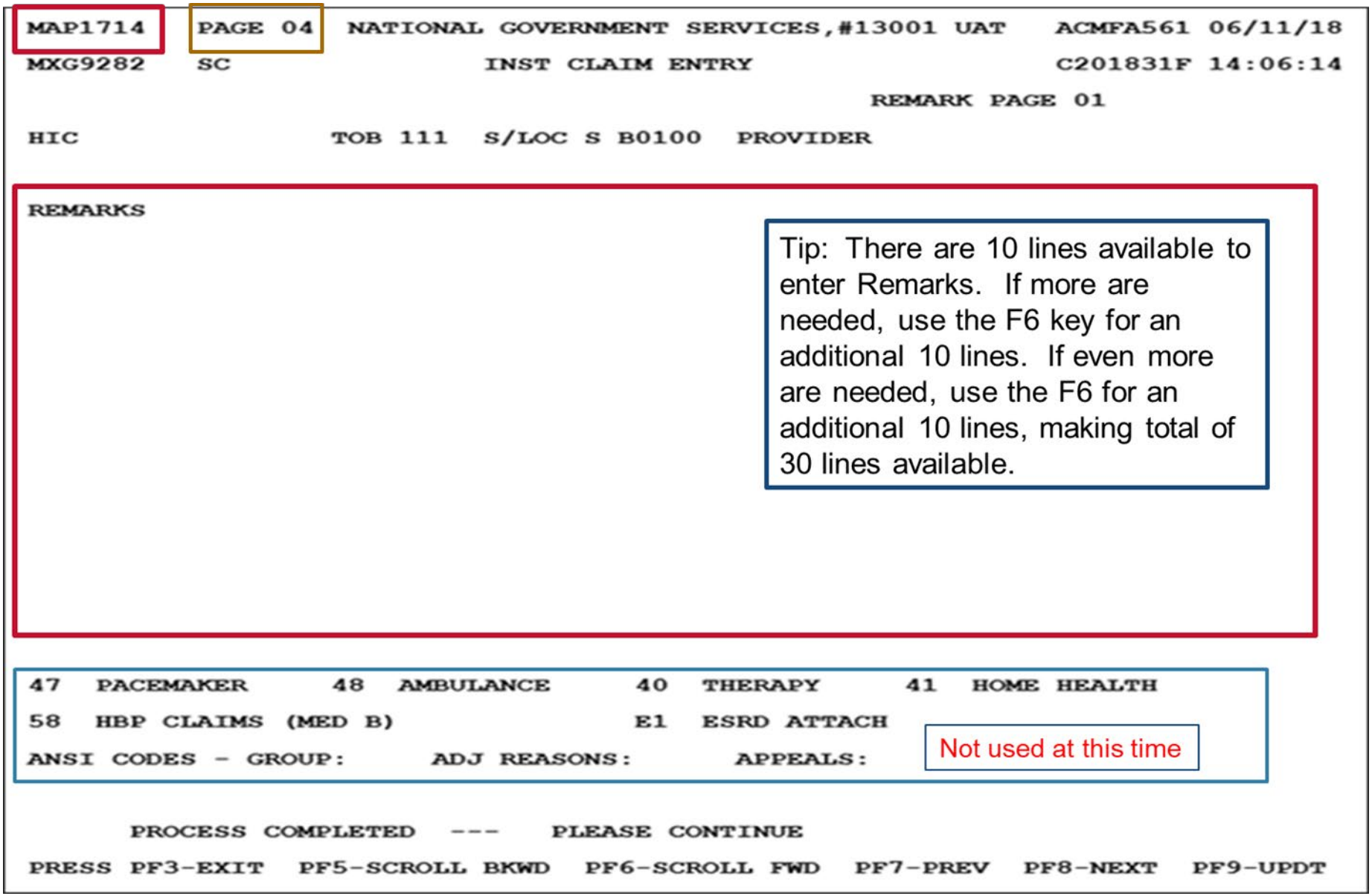
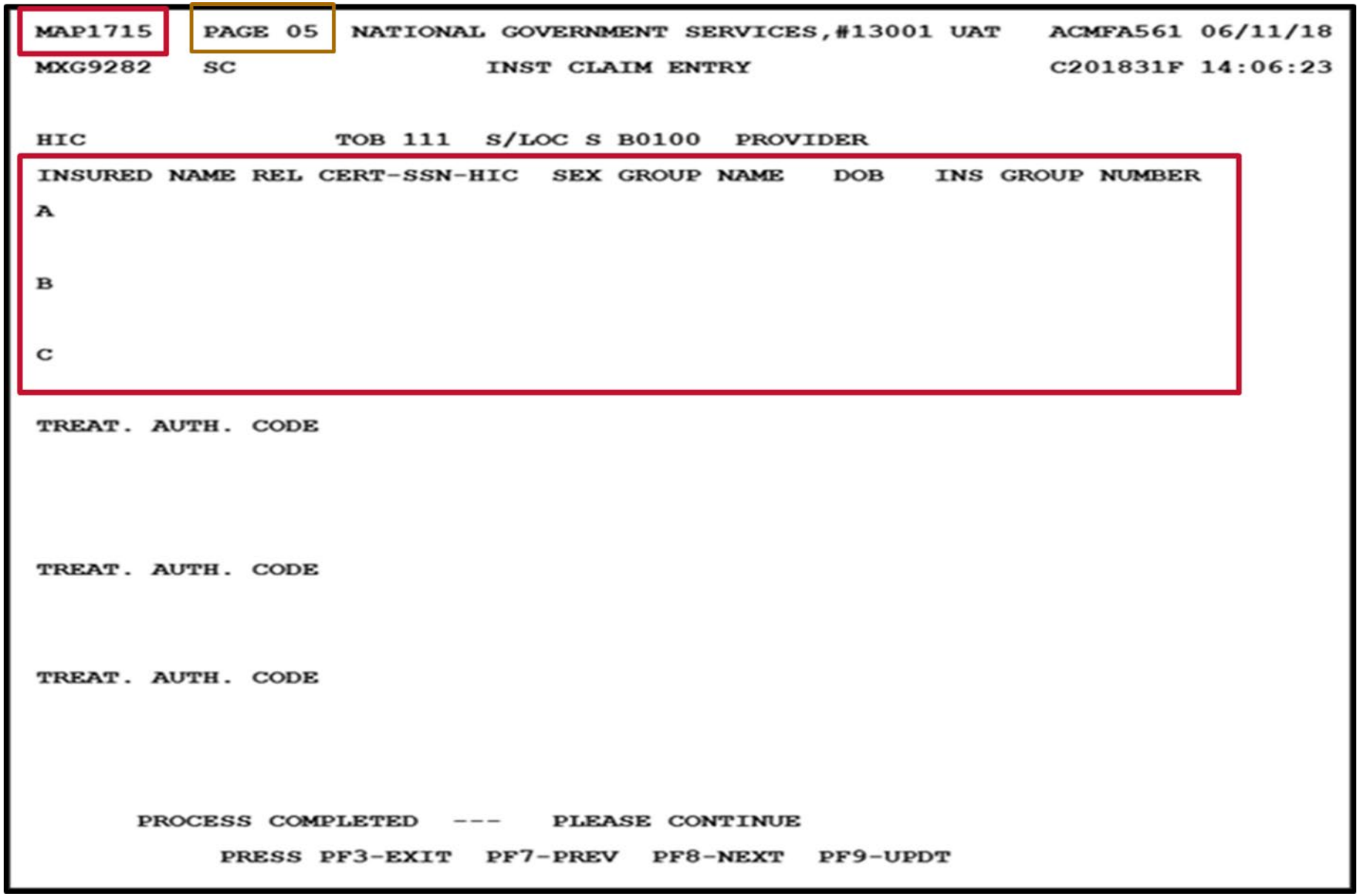
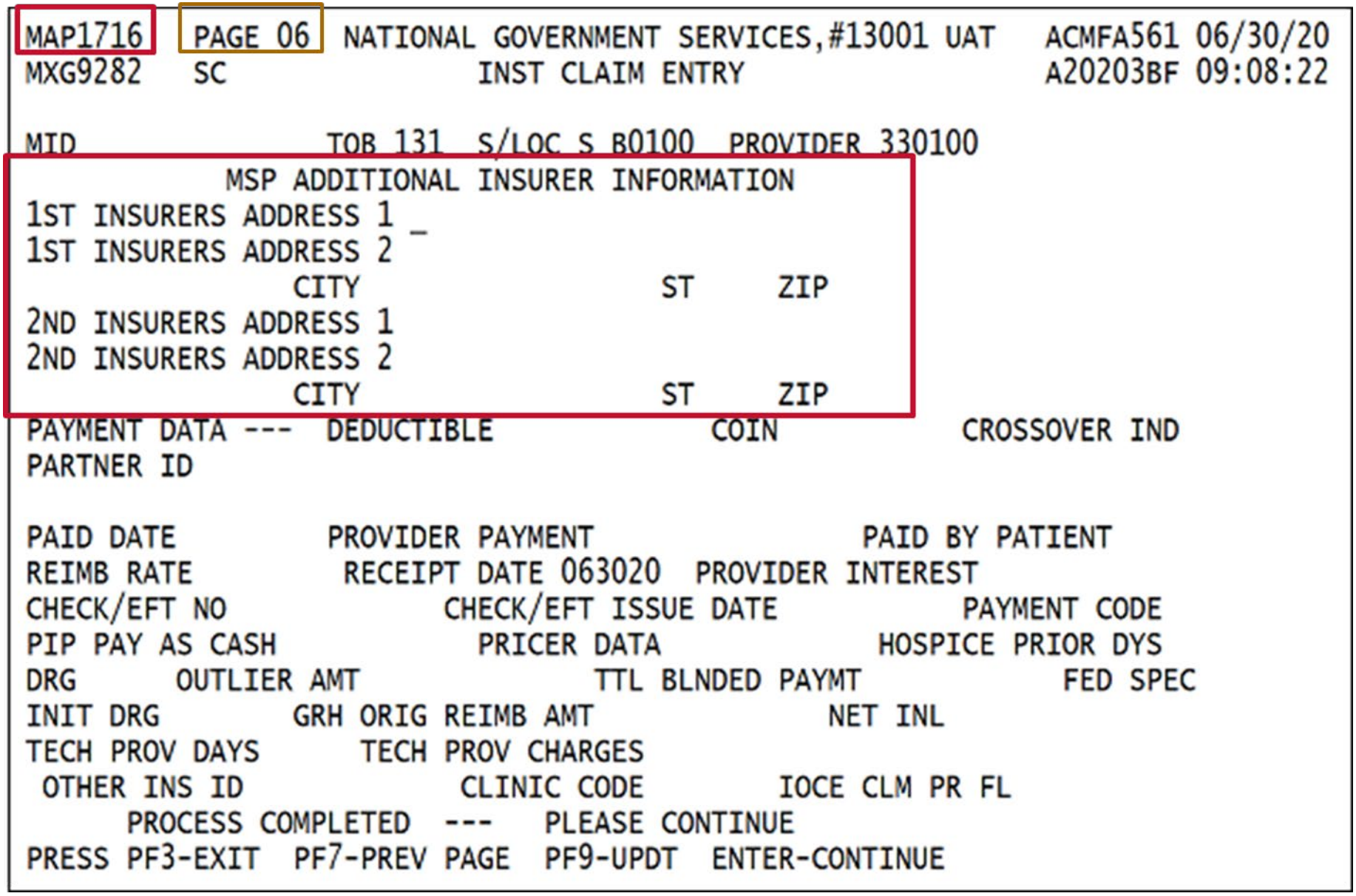
MXG9282 SC INST CLAIM ENTRY C201831F 14:05:49
HIC TOB 111 S/LOC S B0100 PROVIDER
NDC CD OFFSITE ZIP ADJ MBI IND
CD ID PAYER OSCAR RI AB EST AMT DUE
A
B
C
DUE FROM PATIENT SERV FAC NPI
MEDICAL RECORD NBR COST RPT DAYS NON COST RPT DAYS
DIAG CODES 01 02 03 04 05
06 07 08 09 END OF POA IND
ADMITTING DIAGNOSIS 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


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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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

Condition Codes (COND)

- Report applicable MSP-related CCs
  - 02 = Condition is employment-related
  - 06 = ESRD beneficiary in first 30 months of entitlement covered by EGHP

Avoiding Condition Code Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if
  - You report CC 02 (reason code 31301)
    - Without any other MSP or conditional claim coding
    - With incorrect MSP VC (should be MSP VC 15 or 41)
    - With incorrect OC and date (should be OC 04 and date)
  - You report CC 06
    - Without any other MSP or conditional claim coding
    - With incorrect MSP VC (should be MSP VC 13)
    - Without OC 33 and date

Occurrence Codes and Dates (OCC CDS/DATE)

- Report MSP-related OCs as applicable
  - 01 and DOA if medical-payment plan is primary
  - 02 and DOA if no-fault is primary
  - 03 and DOA if liability is primary
  - 04 and DOA if WC is primary
  - 33 and date ESRD coordination period began
  - 24 with date you learned primary payer would not pay (date of primary payer's EOB statement, letter, RA, etc.)
    - Always report OC 24 unless you are reporting code DA in Remarks

Avoiding Occurrence Code Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if
  - You report OC 01, 02, 03 or 04 (accident)
    - With an incorrect corresponding MSP VC
      - OC 01 and OC 02 require MSP VC 14
      - OC 03 requires MSP VC 47
      - OC 04 requires MSP VC 15 or 41 (reason code 31301)
    - Without a DOA
    - With a DOA that does not match MSP record's DOA (reason code 7MSPR)
    - Without other MSP or conditional claim coding (Medicare reported as primary)
    - And there is no matching MSP record (terminated, deleted, not present)

Avoiding Occurrence Code Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if
  - You report OC 33 and date with incorrect MSP VC
    - OC 33 requires VC 13
  - You report OC 33 and date but with no other MSP or conditional claim coding
  - You report MSP VC and zero payment but no other required conditional claim coding such as an OC (reason code 31102)
  - You do not report OC 24 and date (reason code 31303)

Avoiding Occurrence Code Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if
  - You report OC 24 and date but no MSP VC (reason code 31409)
  - You report OC 24 and date, MSP VC but no VC amount (reason code 31361)
  - You report an incorrect MSP VC amount (should be zero)
  - You report VC 44 and amount (should not be present for conditional claim)

MSP Value Codes and Amounts

- Report MSP VC for MSP provision with zero payment (you received no payment from primary payer)
  - MSP VCs
    - 12, 13, 14, 15, 41, 43 or 47 (refer to handout)

Avoiding Value Code Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if you report
  - MSP VC but related MSP claim coding is missing
    - VC 13 without CC 06 AND OC 33 and date
    - VC 14 without OC 01 or 02 and date
    - VC 47 without OC 03 and date
    - VC 15 without CC 02 and OC 04 and date
  - MSP VC without dollar amount (may appear as conditional claim but there is no other conditional coding)
  - MSP VC but there is no matching MSP record in CWF
  - Above fall into reason codes 7MSPL or 7MSPR

Avoiding Value Code Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if you report
  - Incorrect MSP VC (reason code 7MSPG)
    - MSP VC 12 but beneficiary is under age 65
    - MSP VC 43 but beneficiary is over age 65
  - Primary payer code that does not apply (reason code 31300)
  - MSP VC but claim or our records indicate Medicare is primary (reason code 7MSPG)
    - VC 12 or 43 but there is no current employment status
      - Claim may have CC 09, 10, 11, 28 or 29 (indicate Medicare is primary)
      - Claim may have OC 18 and/or 19 and retirement date(s)
    - VC 13 but 30-month coordination period has ended

Avoiding Primary Payer Code Error to Prevent Conditional Claim RTPs; Always Report a C

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

Avoiding Primary Payer Errors to Prevent Conditional Claim RTPs

- Claim submitted with
  - Primary insurer name that does not match MSP VC use
    - Primary insurer name Allstate with MSP VC 12 instead of 14 or 47
  - No primary insurer name (Medicare is listed as second payer)
  - Invalid/vague/unacceptable primary insurer name
    - Hospice, CMS, none, NO or NA, UNK or unknown, attorney, insurer, supplement or supplemental, BC, BX, BCBX, BS, Blue Cross or Blue Shied with no characters, entries less than two characters, commercial (with nothing following), misc. or miscellaneous
    - Special characters are not valid within insurer name
      - All of the above fall into reason code 3SP25 criteria

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

Avoiding Patient Relationship Errors to Prevent Conditional Claim RTPs

- Claim submitted with
  - Incorrect patient relationship code
  - Example: Patient relationship of 18 for self instead of 01 for spouse if insurance is through spouse

Remarks for Explanation Coding

- All conditional claims require reason in Remarks as to why primary payer did not pay or did not pay promptly
  - Reason is placed in Remarks on first line if possible
  - Report reason as a two-digit explanation code (ten options to choose from, all created by National Government Services)
    - NB, PC, CD, FG, BE, PE, DA, DP, LD and PP
  - Some explanation codes require additional information such as a date
    - If so, place additional information at least one space over from explanation code
  - Reminder: Report primary payer's address in Remarks on second line unless entering conditional claim in FISS DDE, then use page 06

Avoiding Remarks Errors to Prevent Conditional Claim RTPs

- Claim may be RTP if
  - You made an error in Remarks field
    - You reported code FG but did not report a reason (reason code 70102)
    - You did not report a two-digit explanation code at all
    - You reported a code that is not correct, either a code that is not one of the ten options or has other characters not needed
    - You reported a correct code but did not report date in MM/DD/YY format when required
    - You reported a code that is one of the ten options but it is unacceptable with the associated MSP VC that was reported
    - All of the above fall into RTP reason code 70104

Checking for Matching MSP Record in CWF Before Submitting Conditional Claim

- If you submit claim before matching MSP record is in CWF
  - Claim suspends for manual review
- We send claim information to BCRC and RTP
  - Claim with reason code 75003 while BCRC investigates/creates MSP record
  - Additional claims with reason code 75004 while BCRC update is pending
  - Claim(s) with reason code 7A000 if BCRC will not update/create MSP record
- If you receive reason codes 75003 or 75004
  - Contact BCRC with information they need
  - Resubmit claim when correct MSP record is in CWF

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

Submitting Conditional Claims

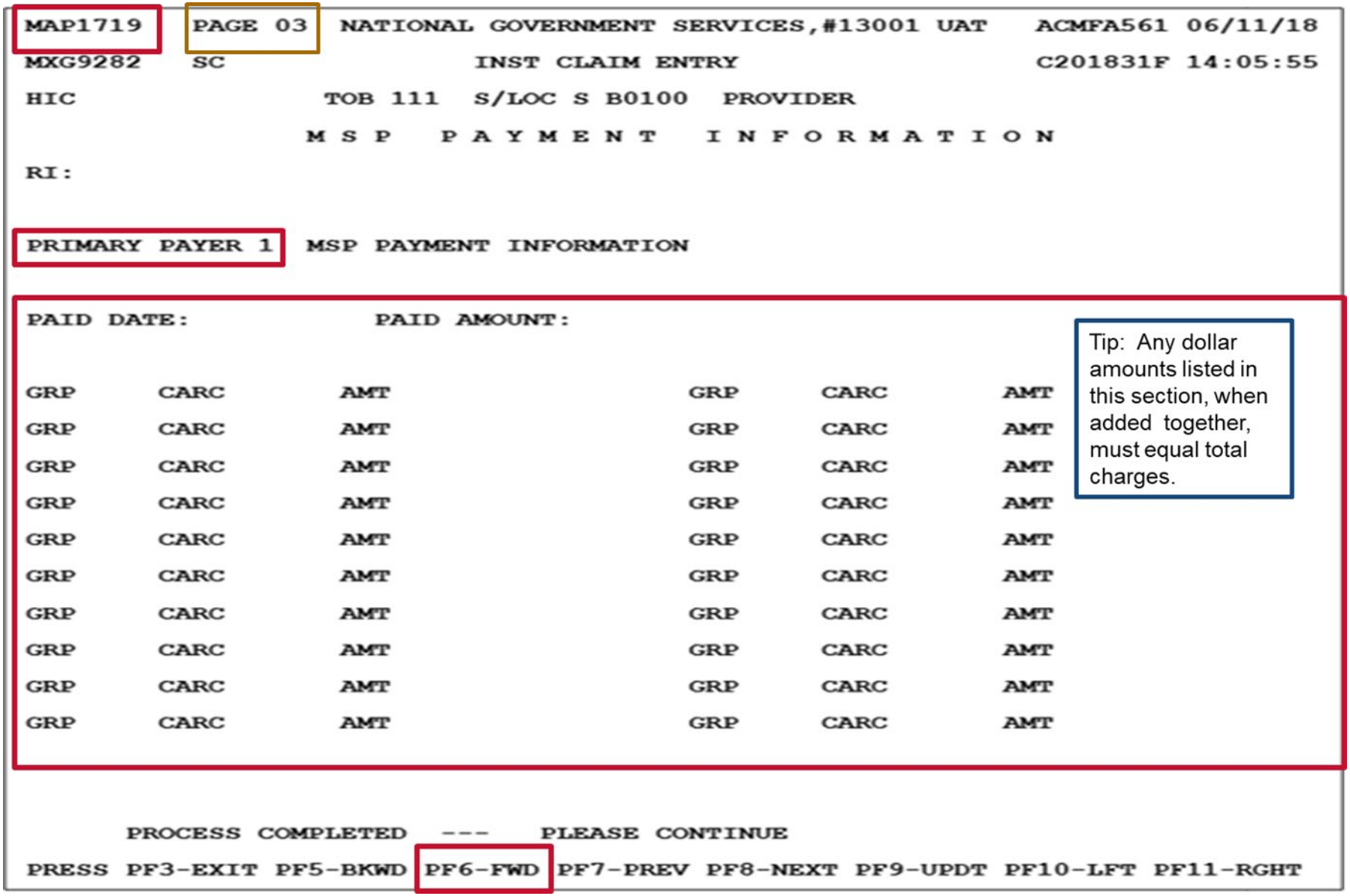
- Submitting conditional claims via 837I claim ensures
  - Medicare's compliance with HIPAA requirements
- Medicare uses primary payer's adjustment amounts when processing conditional claims for payment
  - Explain why billed amount was not fully paid by primary payer
  - In CAS segment on 835 ERA or paper remittance
  - CAGC paired with CARC (communicates primary payer's adjustments)
- FISS process was updated in 2016
  - MAP1719 added to allow providers to enter CACG/CARCs and amounts

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) and 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
  - Suggest CARC 192 when reporting DA and date primary payer was billed in Remarks

FISS DDE 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 of zero (must equal amount entered for MSP VC, zero) and must equal charges less amount(s) with CAGC(s) and CARC(s)
    - GRP: Enter group code(s), also known as CAGC(s)
    - CARC: Enter CARC(s)
    - AMT: Enter dollar amount(s) associated with CAGC and CARC



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
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT
GRP      CARC       AMT                  GRP      CARC       AMT

       PROCESS COMPLETED   ---    PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT
```

Example With CAGC and CARC Coding

- Medicare beneficiary
  - Working aged with EGHP primary to Medicare
  - DOS: 3/25/2021 OP; already met Medicare Part B deductible
- Provider
  - Bills EGHP as primary for charges of $500; under contract
- EGHP
  - Allowed $400; applied $400 to deductible and paid $0 (RA 5/15/2021)
- Claim entry
  - Page 01 (MAP1711), enter MSP VC 12 = $0
  - Page 03 (MAP1719), enter:
    - Paid date = 051521 and amount = $0
    - CAGCs, CARCs and amounts = CO 45 with $100 and PR 1 with $400

FISS Reason Codes Related to CAGCs and CARCs

Code	Description
31686	Paid amount on MAP1719 is not equal to charges; no CAGCs/CARCs
31687	Primary payer information is not on MAP1719 and Medicare is secondary
31688	Validate CARC based on paid date. Compare paid date to CARC effective date.
31689	Paid amount on MAP1719 does not match MSP VC amount

FISS Reason Codes Related to CAGCs and CARCs

Code	Description
31690	Primary payer information is present for primary payer 2 but screen for primary payer 1 is blank or empty
31691	20 or fewer CAGC/CARC combinations on MAP1719 and total charges minus CARC amount(s) does not equal paid amount
31692	More than 20 CAGC/CARC combinations on claim. FISS will move ampersands (&) to 20th occurrence and assign this RC. Once field with ampersands (&) is corrected and claim is updated, reason code will not assign
31693	Paid date on MAP1719 is incorrect or is not a valid date. Valid format MMDDYY

What You Should Do Now

- Review MSP Resources Handout
- Review MLN Matters® article MM7355
- 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 conditional claims when appropriate 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 – Refer to Handout

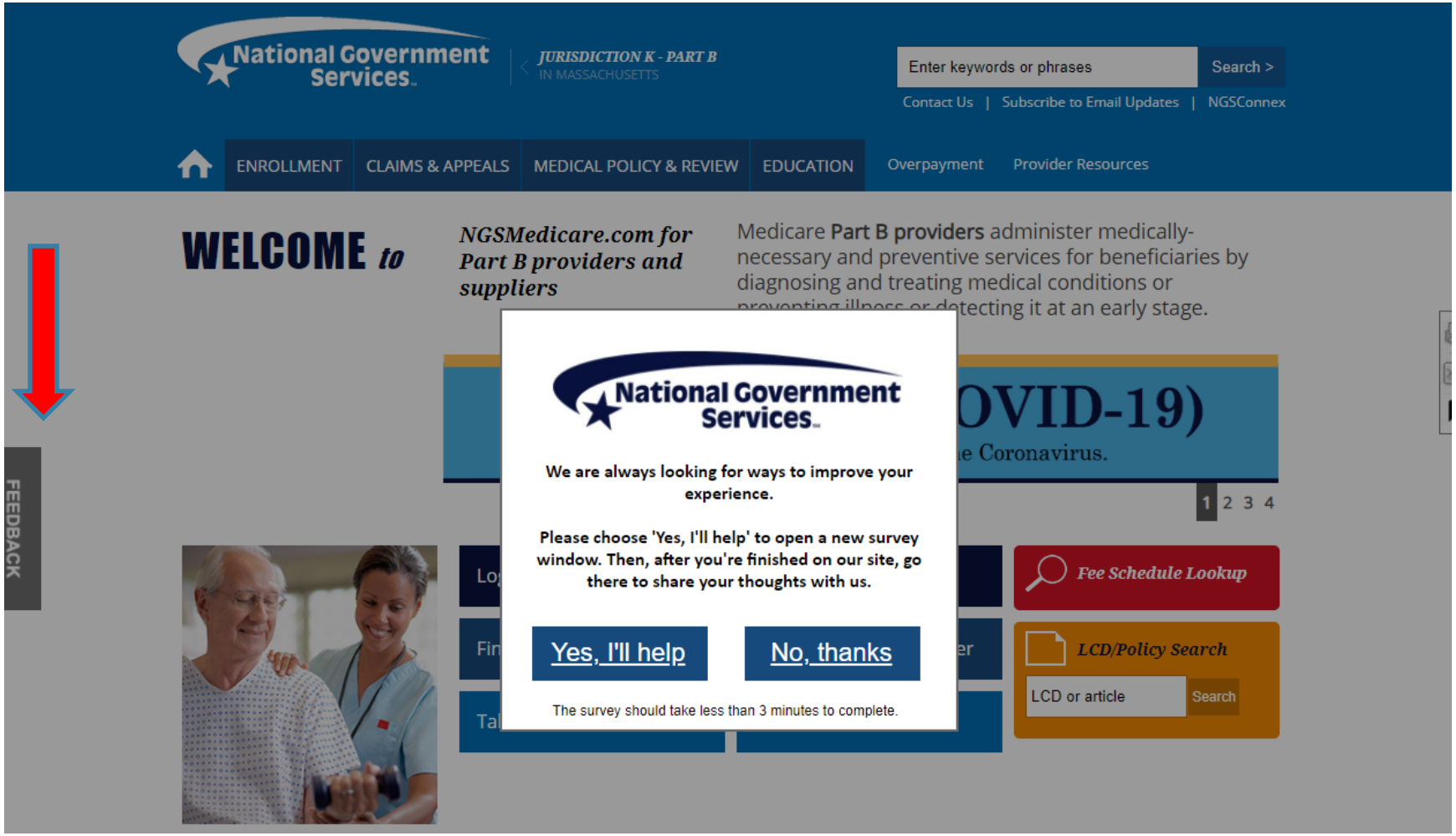
CMS' MSP Resources

- 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*

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

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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