Medicare Secondary Payer (MSP) and Conditional Claims Billing Code Chart

Primary Reference: The Center for Medicare & Medicare Services (CMS) Internet Only Manual (IOM), Publication 100-04, *Medicare Claims Processing Manual,* Chapter 25, Section 75

Condition Codes (CCs) (UB-04 FLs 18-28)

Code	Description
02	Condition is employment related
06	End-Stage Renal Disease (ESRD) beneficiary in first 30 months of eligibility/entitlement covered by an Employer Group Health Plan (EGHP)
08	Beneficiary refused to provide information concerning other insurance coverage
09	Neither the beneficiary nor spouse is employed
10	Beneficiary and/or spouse is employed but no EGHP
11	Disabled beneficiary and/or family member is employed but no Large Group Health Plan (LGHP)
28	Beneficiary's and/or spouse's EGHP is secondary to Medicare. Beneficiary and/or spouse are employed and there is an EGHP that covers beneficiary but either: 1. EGHP is a single employer plan and employer has fewer than 20 full- and/or part-time employees; or 2. EGHP is a multi- or multiple-employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled beneficiary and/or family member's LGHP is secondary to Medicare. Beneficiary and/or family member(s) are employed and there is a LGHP that covers beneficiary but either: 1. LGHP is a single employer plan and employer has fewer than 100 full- and/or part-time employees; or 2. LGHP is a multi-or multiple employer plan and all employers participating in plan have fewer than 100 full- and/or part-time employees.
63	Services rendered to beneficiary in State or local custody (prisoner) meets requirements of 42 CFR 411.4(b) for payment
77	Provider accepts or is obligated/required, due to a contractual arrangement/law, to accept payment by primary payer as payment in full (and that amount has been received and no Medicare payment is due). MSP claim is being filed because claim is an inpatient claim or claim is an outpatient claim and the beneficiary has not yet met his/her annual Medicare Part B deductible.
D7	Change to make Medicare the secondary payer (report on adjustment when original claim was processed as a Medicare primary claim, conditional claim or was rejected for MSP.)
D8	Change to make Medicare the primary payer (report on adjustment when original claim was processed as an MSP claim or as a conditional claim).
D9	Any other change (report on adjustment claim when original claim was rejected for MSP but Medicare is primary or when original claim was processed as an MSP or conditional claim and a change needs to be made to the claim such as a change in the MSP VC amount).

Occurrence Codes (OCs) and Dates (UB-04 FLs 31 – 34)

Code	Description
01	Accident/Medical Payment Coverage – Date of accident/injury for which there is medical payment coverage. Reported with VC 14.
02	No-Fault Insurance (including automobile and other accidents) – Date of accident/injury for which the State has applicable No-Fault laws. Reported with VC 14.
03	Accident/Tort Liability - Date of an accident/injury resulting from a third party's action that may involve a civil court action in an attempt to require payment by third party, other than No-Fault. Reported with VC 47.
04	Accident/Employment-Related - Date of an accident/injury related to beneficiary's employment. Reported with VC 15 or VC 41.
05	Accident/No Medical Payment, No-Fault or Liability Coverage – Date of accident/injury for which there is no Medical Payment or other third-party liability coverage.
06	Crime victim - Date on which a medical condition resulted from alleged criminal action committed by one or more parties
18	Date of retirement (beneficiary)
19	Date of retirement (spouse)
24	Date Insurance denied - Date of receipt of a denial of coverage by a higher priority payer. This could be date of primary payer's Explanation of Benefit (EOB) statement, letter or other documentation. Date is required on all conditional claims unless reporting two-digit explanation code of "DA" in Remarks.
25	Date Coverage No Longer Available – Date on which coverage, including Workers' Compensation benefits or No-Fault coverage, is no longer available to beneficiary.
33	First day of MSP ESRD coordination period for ESRD beneficiaries covered by an EGHP

Value Codes (VCs) and Amounts (UB-04 FLs 39-41)

When entering amounts for VCs (except for VC 44) the following applies:

- Enter amount provider received from primary payer toward Medicare covered charges on claim.
- If requesting conditional payment, enter six zeros (0000.00).
- If no payment or reduced payment received because of failure to file a proper claim with primary payer, enter amount provider would have received had it filed a proper claim with primary payer.

Code	Description. Also provided is the associated Primary Payer Code as seen on MSP file in CWF
12	Working Aged beneficiary/spouse with an EGHP (beneficiary over 65). Beneficiary must have Medicare Part A entitlement (enrolled in Part A) for this Provision to apply. *Primary Payer Code = A.*
13	ESRD beneficiary with EGHP in MSP/ESRD 30-month coordination period. Primary Payer Code = B.
14	No-Fault including automobile/other. Examples: Personal Injury Protection (PIP) and Medical Payment Coverage. Requires OC 01 or 02 with date of accident/injury. *Primary Payer Code = D.*
15	Workers Compensation (WC). Requires CC 02 and OC 04 with date of accident/injury. *Primary Payer Code = E.*
16	Public Health Services (PHS) or other federal agency. Conditional billing does not apply. *Primary Payer Code = F.*
41	Federal Black Lung (BL) Program. *Primary Payer Code = H.*
42	Veterans Administration (VA). Conditional billing does not apply. *Primary Payer Code = I.*
43	Disabled beneficiary under age 65 with an LGHP. Beneficiary must have Medicare Part A entitlement (enrolled in Part A) for this Provision to apply. *Primary Payer Code = G.*
44	Amount provider was obligated/required to accept from a primary payer as payment in full due to contract/law when that amount is less than charges but higher than amount actually received. An MSP payment may be due. Note: When applicable, this VC is reported in addition to MSP VC.
47	Any Liability Insurance. Requires OC 03 with date of accident/injury. *Primary Payer Code = L.*

Patient Relationship Codes (UB-04 FL 59A, B, C)

Code	Description	Code	Description	Code	Description
01	Spouse	20	Employee	40	Cadaver Donor
18	Self	21	Unknown	53	Life partner
19	Child	39	Organ Donor	G8	Other relationship

Remarks *(Two-digit explanation code used for conditional claims) (UB-04 FL 80)
*** MSP and conditional claims also require the primary payer's address to be present in Remarks**

Code	Description	Acceptable with VC(s)
BE	Benefits are exhausted. Always requires date benefits were exhausted in MM/DD/YY format. *Report OC 24 with date insurance denied (see OC 24 above).* Note: Automobile No-Fault states should NOT use this code on automobile accident claims- See code PE below.	12, 13, 14, 15, 41, 43
CD	Charges applied to co-payment, coinsurance or deductible. *Report OC 24 with date insurance denied (see OC 24 above).*	12, 13, 43
DA	120 days have passed since the primary payer was billed. Always requires date primary payer was billed in MM/DD/YY format. *Do NOT report OC 24 with date insurance denied.*	14, 15, 41, 47* ** For VC 47, provider must have withdrawn claim with Liability.*
DP	Delay in payment from Liability Insurer. *Report OC 24 with date insurance denied (see OC 24 above).*	47
FG	Beneficiary did not follow guidelines of their primary health plan. Only used for out of network, untimely filing or no prior authorization. Always requires statement as to which of these guidelines was not followed. *Report OC 24 with date insurance denied (see OC 24 above).*	12, 13, 15, 43
LD	Response is received from Liability Insurer stating they feel they are not responsible for the claim. *Report OC 24 with date insurance denied (see OC 24 above).*	47
NB	Not a covered benefit. *Report OC 24 with date insurance denied (see OC 24 above).*	12, 13, 14, 15, 41, 43
PC	Pre-existing condition. *Report OC 24 with date insurance denied (see OC 24 above).*	12, 13, 43
PE	No-Fault (also known as PIP) has been exhausted toward medical expenses. Always requires date benefits were exhausted in MM/DD/YY format. Provider must have copy of PIP on file. *Report OC 24 with date insurance denied (see OC 24 above).*	14
PP	Beneficiary paid by Liability Insurer. Used only for conditional claims involving Liability Insurance payments to the beneficiary where the provider is not expecting any payment from the beneficiary. *Report OC 24 with date insurance denied (see OC 24 above).* Note: May NOT be used for medical payment insurance payments to the beneficiary (VC 14). Providers are required to pursue those dollars.	47