national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Part A Fall 2024 Virtual Conference:

Keeping Compliant with Medicare Starts With You

November 12th, 14th, and 19th

Understanding Your Medicare Secondary Payer (MSP) Responsibilities

11/14/2024

NGSMU
NGS Medicare University

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

0000_0000

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

Recording

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

Objective

Make you aware of your MSP responsibilities so you can be compliant with your Medicare provider agreement and with CMS' MSP policies

Today's Presenters

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

Agenda

MSP and Your Responsibilities

Identifying Payers Primary to Medicare

Benefits Coordination & Recovery Center (BCRC)

Medicare Primary Claims May Reject for MSP

MSP Claims

MSP Resources

Questions and Answers

MSP and Your MSP Responsibilities

What Is MSP?

- Situations in which Medicare does not have primary responsibility for paying beneficiary's health care claims
  - Beneficiary has other coverage that should process claims first
    - Per Federal laws known as MSP provisions
      - Help determine proper order of payers
      - Make certain payers primary to Medicare and Medicare secondary

MSP Provisions – Group Health Plan

- Related to beneficiary's Medicare entitlement reason
  - Age
    - Working aged MSP provision
      - Age 65 or over, EGHP, employed/spouse employed, 20 or more employees
  - Disability
    - Disabled MSP provision
      - Under age 65 and disabled, LGHP, employed/family member employed, 100 or more employees
  - ESRD
    - ESRD MSP provision
      - Any age with ESRD, EGHP through former or current employer of any size, in 30-month MSP coordination period

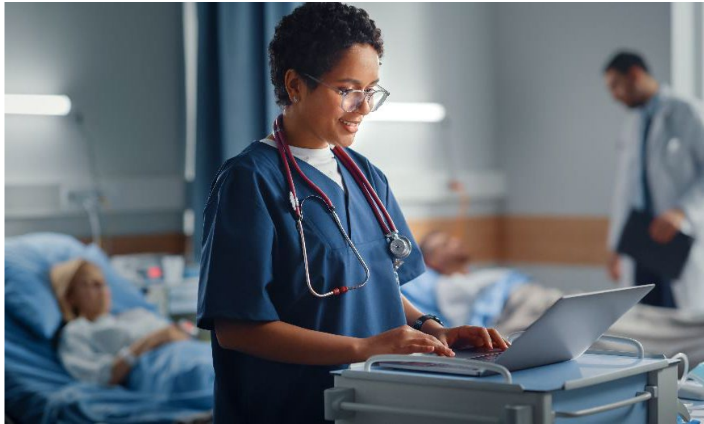
MSP Provisions – Non-Group Health Plan

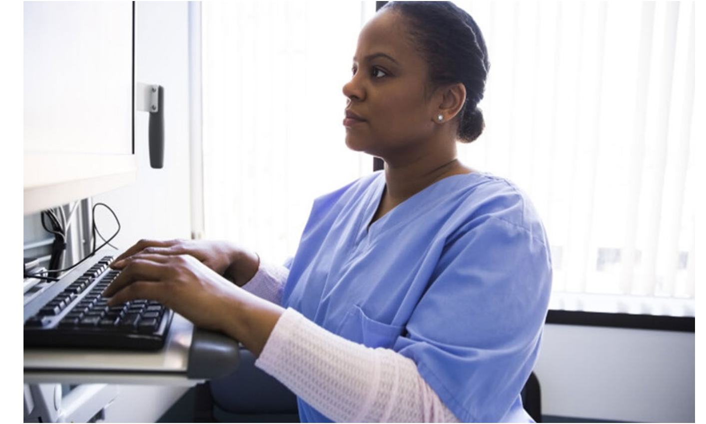
- Not related to beneficiary's Medicare entitlement reason:
  - Federal Black Lung program
  - Government research grant
  - Governmental entities
    - VA, considered "exclusion" to Medicare; MSP payment may not be permitted
  - Workers' compensation (WC)
  - No-fault and medical-payment insurance
    - All types including automobile and premises
  - Liability insurance, including self-insurance

MSP Provision – Conditions/Criteria

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

Providers' MSP Responsibilities per Medicare Provider Agreement





Determine if Medicare Primary Payer for Services

Identify payers primary to Medicare

Submit Claims to Primary Payers Before Medicare

May be more than one primary payer; follow up often

Submit MSP Claims When Required

Follow Claim Preparation and Submission Guidelines

The More You Know…

- Review MSP resources and continue to learn about MSP so you can more easily achieve compliance with your MSP-related provider responsibilities

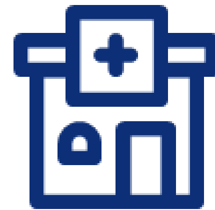
Identifying Payers Primary to Medicare

It's a Requirement!

- Under CMS' Medicare provider agreement, any provider that submits claims to Medicare must determine if Medicare primary payer for those services
  - Therefore, all Medicare providers required to identify payers primary to Medicare
    - Conditions/criteria for one or more MSP provisions met?
    - Document your efforts and responses

Benefits of Identifying Primary Payers

Compliance
Will be compliant with Medicare provider agreement



Prevent MSP hospital review
Compliant hospitals less likely to be selected

Improve cash flow
Primary payers generally pay more than Medicare

Reduce staff time
Correcting claim errors and submitting adjustments

How to Identify Payers Primary to Medicare

- Conduct MSP screening process; two methods
  - Check for MSP information in CWF
    - For every service
  - Collect MSP information from beneficiary or representative by asking questions about other insurance
    - For every IP admission or OP encounter, with some exceptions
      - In some situations, you may not need to collect MSP information
      - In other situations, you may still need to collect MSP information but less often
- Do not depend solely on one or other method

How to Check for MSP Records in CWF

- Part of your Medicare eligibility verification process
  - NGSConnex
    - *NGSConnex User Guide* (Eligibility Lookup > Medicare Secondary Payer)
  - CMS' HETS (X12 270 transmission and 271 response)
    - X12 270 transmission used to
      - Transmit health care eligibility benefit inquiries from health care providers, insurers, clearinghouses and other health care adjudication processors
      - Make inquiries about Medicare eligibility; need beneficiary's entitlement date
    - X12 271 response
      - Appropriate response mechanism for health care eligibility benefit inquiries
    - CMS HETS 270/271 5010 Companion Guide (MSP in Table 44)

When to Check for MSP Records in CWF

- You should ideally check
  - Before beneficiary leaves facility
- You may check
  - During admission or registration process
  - At time of service/during service
  - During billing process
- You must check
  - Before claim submitted to Medicare

MSP Record Information

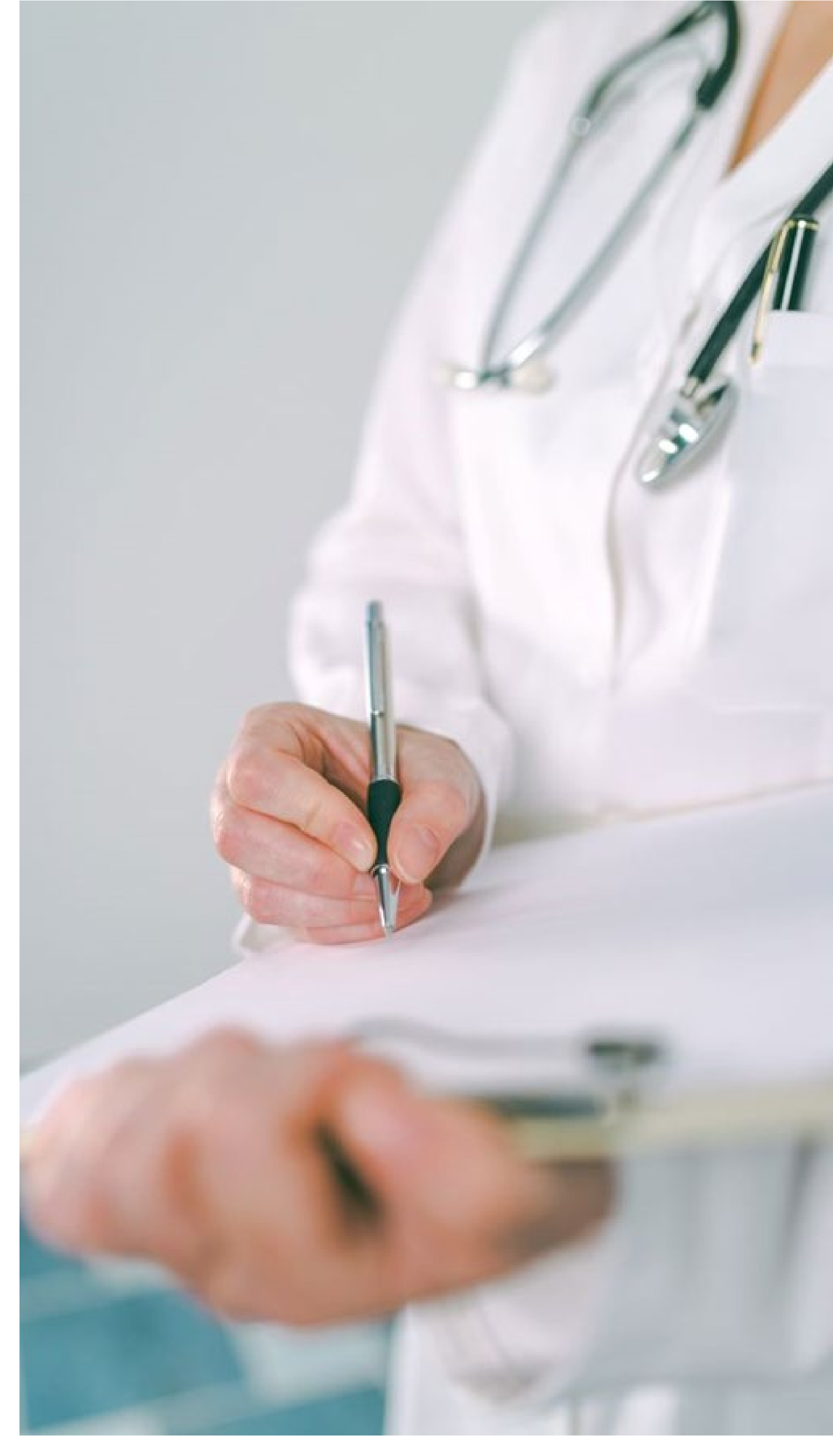
- If MSP record(s) present, information includes:
  - MSP **VC** and **primary payer code** for each MSP provision
    - Use MSP VC to report primary payer's payment on MSP claim
  - MSP effective date
  - MSP termination date, if applicable
  - Patient's relationship to insured
  - Subscriber's name
  - Policy number
  - Insurer information
  - Employer information

MSP Records – Value Codes, Primary Payer Codes and MSP Provisions

- VC **12** (code **A**)
  - Working aged, 65+, with EGHP
- VC **13** (code **B**)
  - ESRD with EGHP in 30-month coordination period
- VC **14** (code **D** or **T**)
  - No-Fault/med-pay or Set-Aside
- VC **15** (code **E** or **W**)
  - WC or Set-Aside
- VC **16** (code **F**)
  - Public Health Services
- VC **41** (code **H**)
  - Federal Black Lung Program
- VC **43** (code **G**)
  - Disabled, under 65, with LGHP
- VC **47** (code **L or S**)
  - Liability insurance or Set-Aside

Did You Know...

- Providers shall not deny medical services or entry to SNF/hospital if you discover
  - MSP record in CWF
  - Claim previously mistakenly rejected by Medicare due to MSP record
- MLN® Fact Sheet: *Medicare Secondary Payer: Don't Deny Services & Bill Correctly*



Must Provider Collect MSP Information?

- Is service an exception?
  - If yes, then MAYBE; depends on which exception applies
  - If no, continue
- Does beneficiary have MSP record in CWF?
  - If yes, continue
  - If no, then YES
- Per beneficiary, any corrections to MSP record(s) needed?
  - If yes, then YES
  - If no, then MAYBE; may still need to ask about coverage not in records

How to Collect MSP Information

- Use hardcopy and/or online
  - CMS' model MSP questionnaire in [CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1]
    - Three parts; each with questions to ask in sequence
      - Part I – Black Lung, WC, No-Fault (automobile and other types) and Liability
      - Part II – Medicare entitlement and employer GHPs
      - Part III – ESRD entitlement/dual entitlement: Age & ESRD or Disability & ESRD
  - Your own compliant form (same content and intent as CMS' model)

Collecting MSP Information – Tips

Use compliant form

Review your facility's form to ensure it is compliant

Ask questions directly

Ask questions on phone or in person rather than giving form to beneficiary

Help beneficiary

Help beneficiary under stand MSP questions

Resources

Have MSP material available should beneficiary need more help with questions

Collect Additional Information for Billing

- CMS removed certain questions from model MSP questionnaire
  - Veterans who want to use VA instead of Medicare
  - Beneficiaries receiving services covered by government research grant
  - Retirement dates of beneficiary and/or spouse
    - If retired, no current employment status for Working Aged or Disabled provision
      - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 1, Section 10 and Chapter 2, Section 10.5
    - If beneficiary/spouse cannot call retirement date, follow CMS' policy for collecting and reporting retirement dates on claims
      - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.1, #4

When to Collect MSP Information

- You **may** collect MSP information (ask questions)
  - Prior to service
  - At time of service
  - During service
  - At conclusion of service
- You **must** collect MSP information (ask questions)
  - Before submitting claim to Medicare, unless service or situation an exception

How Often Must Hospitals Collect MSP Information

- CMS has explicit requirements for hospitals regarding frequency of collecting MSP information (asking questions)
  - **Required** for every IP admission and OP encounter unless
    - MSP record exists, no corrections needed per beneficiary, no primary payer or
    - Exception applies
      - Services rendered to MAO plan enrollees (not required)
      - Hospital reference laboratory services (not required)
      - Hospital recurring OP services (collect initially, then once every 90 days)
      - Hospital-based services such as ambulance (may/may not be required)

Exceptions to Collecting MSP Information for Hospitals

- **Not required** when
  - You render services to MAO plan enrollee
  - Beneficiary receiving reference (non-patient) laboratory services
    - Clinical laboratory diagnostic tests (and/or interpretation of such tests) furnished without face-to-face encounter between beneficiary and hospital
    - TOB 14X
    - Example: Beneficiary seen in physician's office, physician draws specimen and sends to hospital laboratory, hospital submits claim to Medicare

Hospital Recurring Outpatient Services

- **Required** to collect MSP information if beneficiary receiving recurring OP services
  - Identical services and treatments on OP basis more than once within billing cycle
  - Collect **initially** and then **once every 90 days**

Hospital-Based Services

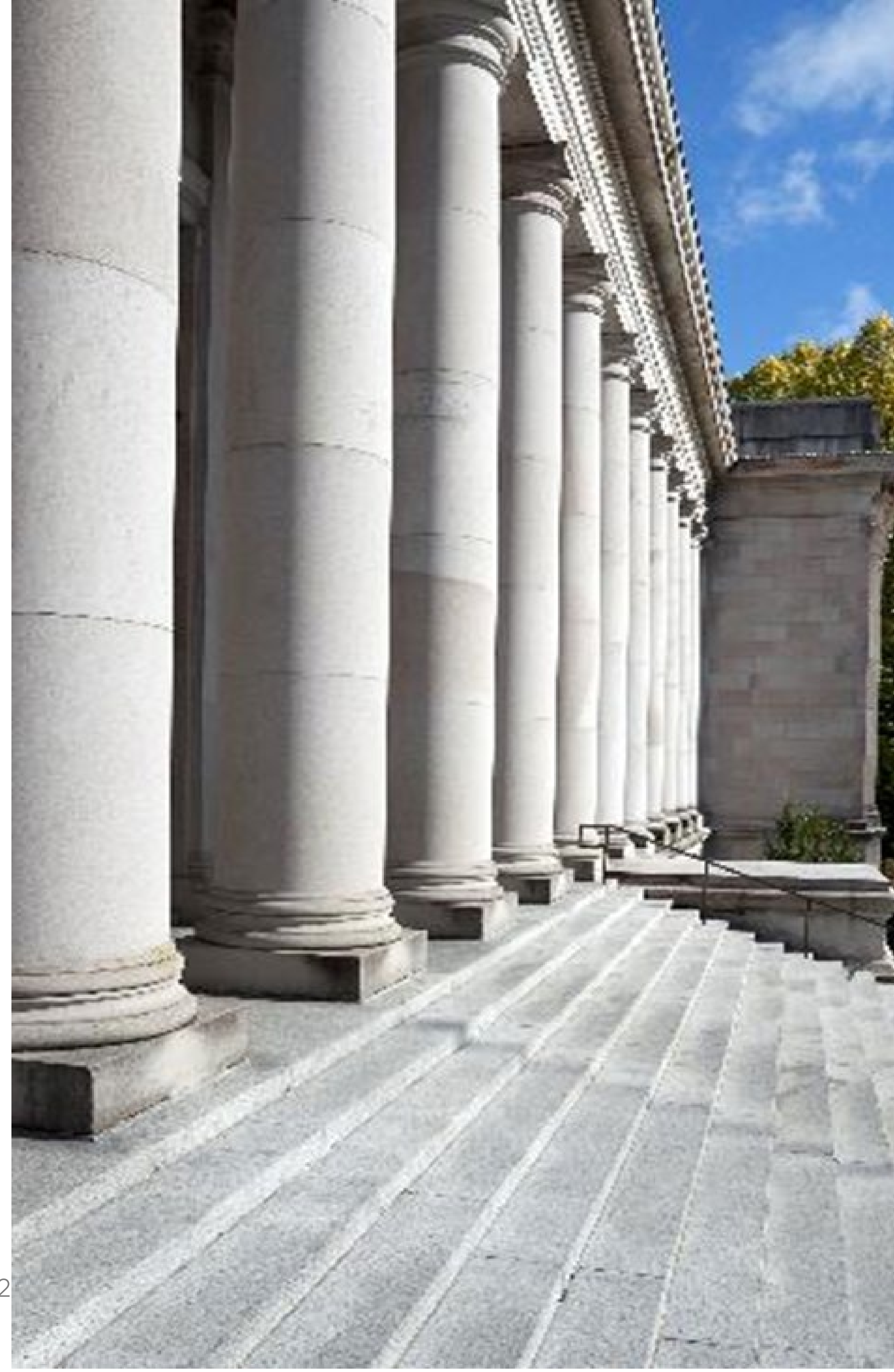
- Hospital-affiliated providers and provider-based services
  - **Required** to collect MSP information if hospital staff did not
  - **Not required** to collect MSP information if hospital staff did
- Independent providers not affiliated with hospital
  - **Required** to collect MSP information

How Often Must Other Provider Types Collect MSP Information?

- CMS does not have explicit MSP collection requirements regarding frequency for other provider types
  - In provider's best interest to collect MSP information as frequently as possible to ensure filing proper claims with Medicare
  - We recommend all providers follow same frequency guidelines CMS established for hospitals

Did You Know...

- If any provider fails to file proper claims with Medicare, we can recover our payments and pursue civil monetary penalties or damages under the False Claims Act in cases where an entity knowingly files claims incorrectly



What Information Should You Record?

- Date on which questions asked
- Beneficiary's responses to questions – positive and negative
  - Do not assume what beneficiary's response would be and fill it in
  - Do not pull forward information from prior DOS without verifying it
- Reason(s) questionnaire/form blank or incomplete
- Actions taken to obtain MSP information when beneficiary unable/refuses to respond to MSP questions
- Retirement dates, even when beneficiary/spouse cannot recall

Documentation Requirements to Support MSP Screening Process

- Retain both:
  - **Completed MSP question responses**; positive and negative
    - Beneficiary **not required** to sign completed questionnaire
    - Hospitals must be able to provide notation explaining why MSP questionnaire not completed if requested during MSP hospital review
  - **CWF print out or copy of 271 response** including all notations
- Maintain MSP information for ten years from DOS
- Paper, optical image, microfilm or microfiche

Determine Proper Order of Payers

- Use collected MSP information and knowledge of MSP provisions to determine which plan primary, secondary, and tertiary (when applicable)
  - In general, Medicare primary when beneficiary
    - Has no other coverage
    - Has coverage but it does not meet MSP provision criteria requirements
    - Had coverage, it met MSP provision criteria requirements but no longer available
  - In general, other payer(s) primary when beneficiary
    - Has coverage that meets MSP provision criteria requirements and available
- Tip: Ensure billing staff has access to MSP question responses

Submit Claims Per Your Determination

If you determine Medicare primary

Submit Medicare primary claim

If you determine another payer primary

Submit claim to primary payer first and Medicare second if required (not at same time)

If you determine more than one payer primary

Submit claims to those payers, in proper order, and to Medicare third (tertiary)

Benefits Coordination & Recovery Center (BCRC)

Did You Know...

- During your MSP screening process with beneficiary, you may learn of information that requires set up of a new MSP record or that could correct existing MSP record in CWF
  - BCRC maintains and handles most corrections to MSP records

How MSP Records Impact Claims

- For Medicare primary claim to process when open MSP record in CWF
  - You must report on claim any explanatory coding to indicate reason Medicare primary or
  - Beneficiary or other party (not provider) must contact BCRC with correction to MSP record
    - Wait for BCRC to make correction before submitting claim, so it does not reject for MSP
- For MSP, Medicare tertiary or conditional claim to process
  - Must be matching MSP record for beneficiary in CWF
    - Matching record = same insurance/coverage as claim

Contacting BCRC

- MACs contact BCRC to request
  - Correction to existing MSP record in CWF using explanatory coding (indicating reason Medicare primary) from incoming claims
  - Set up of new MSP record in CWF using data from incoming MSP, Medicare tertiary and conditional claims
- Beneficiaries and other parties may contact BCRC to report
  - Employment/insurance corrections (to MSP records in CWF)
  - New MSP information (set up new MSP records in CWF)

When Can Providers Contact BCRC?

- To ask general MSP questions only
  - Do not contact BCRC to request set up of new or corrections to existing MSP records
    - MLN Connects® Newsletter 10/26/2023, "Conditional Payment Claims: Continue to Submit to Your Medicare Administrative Contractor"
  - You may refer beneficiaries and other parties to BCRC
    - In addition to or instead of reporting such information on claims, if applicable
- BCRC Contact
  - 855-798-2627
  - TTY/TDD: 1-855-797-2627
  - FAX: 405-869-3307

Medicare Primary Claims May Reject for MSP

Why Do Medicare Primary Claims Reject for MSP?

- When open MSP record in CWF and
  - You did not report explanatory coding on claim to indicate reason Medicare primary
  - Beneficiary or other party
    - Did not contact BCRC to correct MSP record
    - Did contact BCRC but you did not wait until correction complete before submitting claim and did not report explanatory coding on claim to indicate reason Medicare primary

Medicare Primary Claims Rejected for MSP

- Known as cost-avoided claims
- In FISS status location (S/L) RB9997; reason code 34xxx range
- Examples of top claim rejections:
  - 34538 = Claim submitted as primary but open VC 12 MSP record
  - 34540 = Claim submitted as primary but open VC 43 MSP record
- Must be adjusted (TOB XX7) to be resolved
- Do not resubmit or they reject as duplicate claims

Prevent Rejections – Claim Not Related to Open Accident MSP Record in CWF

- Submit primary claim with remarks
  - Claim not related to open accident MSP record (VC 14, 15, 41, 47)
    - You must be able to support such remarks
- Beneficiary does not need to contact BCRC
- We may be able to bypass MSP record and process claim with
  - Do not contact BCRC

Prevent Rejections – Beneficiary's Situation Changed

- Submit primary claim with applicable explanatory claim coding to indicate reason Medicare primary
  - CCs:
    - 09, 10, 11, 28 and 29
  - OCs and dates:
    - 18 and beneficiary's retirement date
    - 19 and spouse's retirement date
    - 25 and date benefits terminated
- We send BCRC requests to correct MSP records in CWF
- Resources:
  - *"Correct a Beneficiary's MSP Record"*
  - *"Prevent an MSP Rejection on a Medicare Primary Claim"*
  - *"Collect and Report Retirement Dates on Medicare Claims"*

MSP Claims

Did Primary Payer Pay in Part or in Full?

- When you receive primary payer's RA (835)
  - Apply payment to beneficiary's account
  - **Determine if primary payer paid in part or in full**
    - Do you have contract with primary payer (or obligated under law) requiring you to accept certain amount as full payment?
      - **No**, you expected primary payer to pay charges
        - If they paid < charges, they paid **in part**
        - If they paid = or > charges, they paid **in full**
      - **Yes**, you expected primary payer to pay certain (expected) amount
        - If they paid < expected amount, they paid **in part** (unless they paid = or > charges, then they paid in full)
        - If they paid = or > expected amount, then they paid **in full**

Must Provider Submit MSP Claims?

- **Required** if
  - Primary payer paid **in part**
    - Payment > zero but < charges or < expected amount and
    - Services = IP or OP
  - Primary payer paid **in full**
    - Payment = charges or = expected amount and
    - Services
      - IP
      - OP (and beneficiary **not met** annual Part B deductible)
      - Home health or hospice (regardless of whether Part B deductible met)
- **Not required** if
  - Primary payer paid **in full**
    - Payment = charges or = expected amount and
    - Services = OP (and beneficiary **met** annual Part B deductible)

Why Medicare Requires MSP Claims

- Consider paying on balance remaining after primary payer's payment, in certain situations
- Credit primary payer's payment toward Medicare deductible and/or coinsurance for IP and OP claims
- Track types of services rendered, such as HH+H services
- Track benefit period for inpatient facilities, such as hospitals and SNFs

How to Submit MSP Claims

- Three options:
  - UB-04/CMS-1450 claim (hardcopy)
    - You must have approved ASCA waiver on file
      - Visit our website > Resources > Forms > ASCA Waiver Request Form
    - Mail to Claims Dept. with primary payer's RA and/or EOB statement
      - Visit our website > Resources > Contact Us > Mailing Addresses > Claims
  - 837I claim
  - FISS DDE claim
- Resources:
  - *"Prepare and Submit an MSP Claim"*
  - FISS DDE Provider Online Guide Chapter V (Claims/Attachments Submenu 02) for Claim Data Entry

How to Prepare MSP Claims – Complete Claim in Usual Manner

- Make primary payer first payer and Medicare second payer
- Report
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered days as usual
    - Do not code days paid by primary payer as noncovered
  - Covered/noncovered charges as usual
    - Do not code charges paid for by primary payer as noncovered
    - Do not bill just for balance after primary payer's payment

How to Prepare MSP Claims – Follow Technical, Medical and Billing Requirements

- Technical
  - One-year timely filing per CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70
- Medical
  - Assessments/other clinical and coverage requirements
- Billing
  - HHA: Submit NOA as primary; report insurer information on claim
  - Hospice: Submit NOE as primary; report insurer information on claim
  - Frequency of billing for your provider type
    - If you submit Medicare claims from admission to discharge, or every 30 or 60 days, this applies when Medicare is secondary; do not split claims

How to Prepare MSP Claims – Report Applicable MSP Billing Codes

- MSP billing codes in **MSP Billing Code Table**
  - Resource: "Prepare and Submit an MSP Claim"
    - **MSP Billing Code Table** provides claim fields and claim codes for
      - UB-04/CMS-1450 claim form
      - 837I claim
      - FISS DDE Claim Entry
- Tip: To ensure MSP claims do not RTP, **code them accurately**

MSP Billing Codes

- CCs
  - **02, 06, 77**
- OCs and dates
  - **01, 02, 03, 04, 33**
- VC and amount received from primary payer toward Medicare covered charges
  - **12, 13, 14, 15, 16, 41, 43 and 47**
- VC 44 and OTAF amount
- Primary payer code
  - **A, B, D, E, F, G, H, L, S or T**

MSP Billing Codes

- Primary insurer's name
- Insured’s name
- Patient’s relationship to insured
  - **01, 18, 19, 20, 21, 53, G8**
- Insured’s unique ID
- Insured group name
- Insurance group number
- Insurance address (in Remarks)

CC 77 – Primary Payer Paid in Full

- You **must** report CC 77 when
  - You have contract (or obligation under law) with primary payer to receive certain amount (expected or OTAF amount) as full payment and you received that amount
    - Example: charges = $5,000; expected = $4,000; received = $4,000
      - Report: charges = $5,000, MSP VC ____ with $4,000 and CC = 77
- You **may** report C 77 when
  - You do not have contract (or obligation under law) with primary payer to receive certain amount as full payment but you received full payment
    - Example: charges = $5,000; expected = $5,000; received = $5,000
      - Report: charges = $5,000, MSP VC ____ with $5,000 and CC = 77

Value Code 44 and Amount – Primary Payer Paid Less Than Expected

- Report VC 44 and OTAF payment amount, when applicable
  - **Required** when primary payer's payment < OTAF payment amount
    - OTAF = amount you agreed to accept from primary payer as full payment
    - You are billing us for (expected amount – received amount); do not bill patient
    - In following example, there is contract between provider and primary payer
      - Medicare covered charges = $5,000
      - Provider expected = $3,500
      - Primary payer paid provider = $3,000 after applying deductible = $500
      - Report MSP VC __ with $3,000 and VC 44 with $3,500
  - Do not report if primary payer paid = or > Medicare covered charges
    - Even if primary payer's payment < OTAF payment amount

Adhere to Your Obligations with Primary Payer

- When Medicare secondary
  - You must adhere to contractual/law obligations with primary payer
- Medicare not supplemental payer
  - If you have contract with or obligated under law to accept certain amount from primary payer as payment in full on claim
    - Report CC 77 or VC 44 (and OTAF payment amount) on MSP claim but never both codes
      - CC 77 = paid in full
      - VC 44 = paid less than full payment

Report Primary Payer Adjustment Reasons and Amounts

- **Required** when primary payer paid differently than charges
  - CAGC/CARC pairs and amounts from primary payer's RA
    - CAGCs – Identify general category of payment adjustment:
      - CO = Contractual Obligations
      - OA = Other Adjustments
      - PI = Payer-initiated Reductions
      - PR = Patient Responsibility
    - CARCs – Explain why primary payer paid differently than billed, examples:
      - 1 = Deductible amount
      - 2 = Coinsurance amount
      - 27 = Expenses incurred after coverage terminated
      - 45 = Charges exceeded fee schedule or maximum allowable amount
      - 96 = Noncovered charges
      - 119 =Benefit maximum reached for this period or occurrence

Report Primary Payer Adjustment Reasons and Amounts

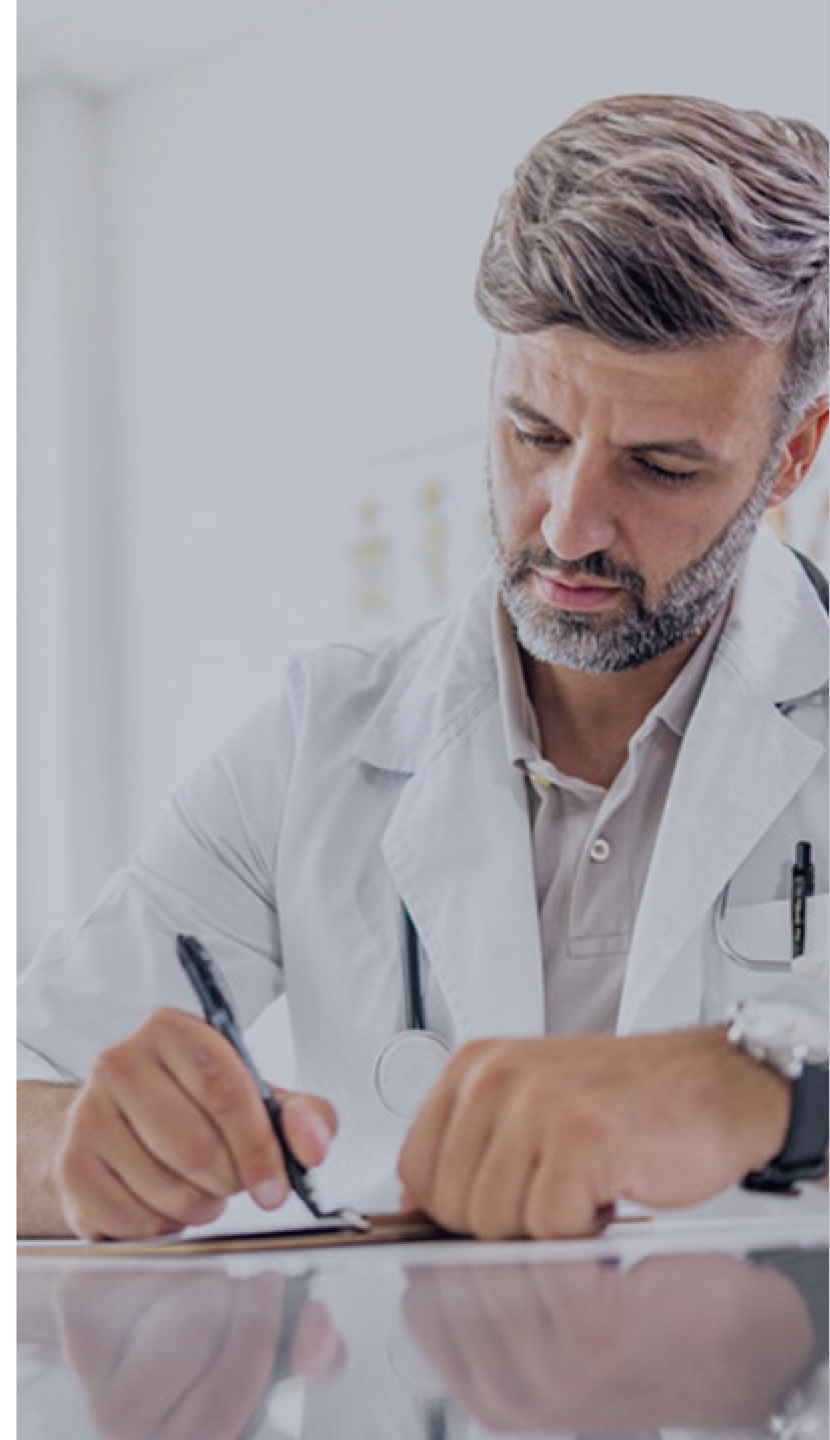
- Also known as MSP CAS information
  - For **hardcopy** UB-04/CMS-1450 claims, **attach RA**
    - Our Claim's Department enters RA coding in FISS DDE
  - For **837I** claims, report in **appropriate loops/segments**
    - Our claims processing system maps such coding to **page MAP1719**
      - If we RTP claim, access such coding in FISS DDE, correct and return
      - If we reject claim, follow reason code narrative and resubmit
  - For **FISS DDE** claims, report in **page MAP1719**
- Resources: X12, CR6426 and CR8486

Matching MSP Record in CWF

- MSP claim must match information in MSP record in CWF
  - Check for matching MSP record in CWF
    - Resource: "Identify Proper Order of Payers for Beneficiary's Services"
  - If claim matches MSP record in CWF
    - Submit MSP claim
  - If claim does not match MSP record in CWF
    - Verify accuracy of claim information
  - If no MSP record in CWF
    - Submit MSP claim and we send claim data to BCRC to request new MSP record
    - Resource: "Set Up Beneficiary's MSP Record"

Correcting RTP MSP Claims – Check Often to Prevent Untimely Filing Rejections

- If your MSP claims RTP
  - Correct such claims in FISS DDE
    - S/L TB9997
    - Resource: *FISS DDE Provider Online Guide*
  - Resubmit new corrected claims
    - Use same three methods as for submitting claims



Adjusting Claims for MSP Reasons – Follow Required Timelines

- To make changes to finalized MSP claims
  - Submit adjustments (TOB XX7)
    - Resource: *"Correct or Adjust a Claim Due to an MSP-Related Issue"*
  - Submit adjustments **within 60 days** of receipt of payments from another payer if you also received primary payment from Medicare
    - Do not cancel claims
    - MSP provisions except Liability: CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 10.4
    - Liability MSP provision: CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2 (E)
  - If primary payer retracts payment indicating Medicare primary, you have **one year** from date we processed your MSP claim to adjust it

Validate Payment of MSP Claims

- MSP payment may be made on MSP claim if
  - Primary payer's payment for Medicare-covered charges less than
    - Your charges for those services
    - Total amount payable by Medicare in absence of primary payer's payment
  - You do not accept or not obligated to accept primary payer's payment as full payment for services
- Amount of secondary benefit = lowest of six calculations when VC 44 and amount present
  - Payment can be zero
- Resource: *"Determine if Medicare Will Make an MSP Payment"*
- Tip: Ensure you reported CC 77 if primary payer paid in full

Do Not Bill Beneficiary Inappropriately for MSP Claims

- For MSP claims, beneficiary
  - **Responsible** for charges/services not covered by Medicare and Medicare deductible and/or coinsurance not satisfied by primary payer's payment
    - Tip: Check Medicare RA for beneficiary responsibility
  - **Not responsible** for amounts primary payers apply toward deductible, coinsurance or copayment
    - Bill us by including these amounts with payment from primary payer in VC 44 amount on MSP claims
- Resource: *"Determine Beneficiary Responsibility on MSP Claim"*

MSP Resources

MSP Resources – NGS

- NGS website > Claims and Appeals > Medicare Secondary Payer
  - *“What is Medicare Secondary Payer?”*
  - *“Identify the Proper Order of Payers for a Beneficiary's Services”*
  - *“Set Up a Beneficiary's MSP 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 an MSP 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”*

MSP Resources – CMS

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16 (General Exclusions)
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapters 1 – 7
  - Chapter 1 - General MSP Overview
  - Chapter 2 - MSP Provisions
  - Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements
  - Chapter 4 - Coordination of Benefits Contractor (COBC) Requirements
  - Chapter 5 - Contractor MSP Claims Prepayment Processing Requirements
  - Chapter 6 - Medicare Secondary Payer (MSP) CWF Process
  - Chapter 7 – MSP Recovery

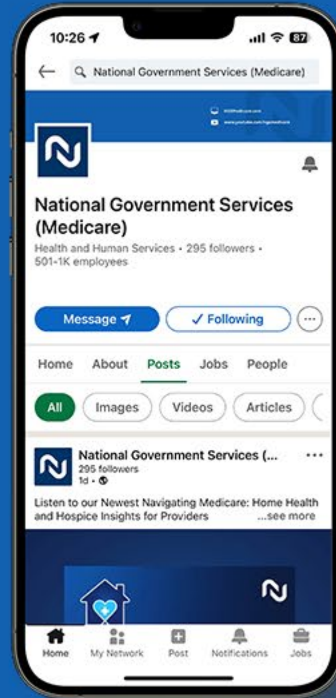
MSP Resources – CMS

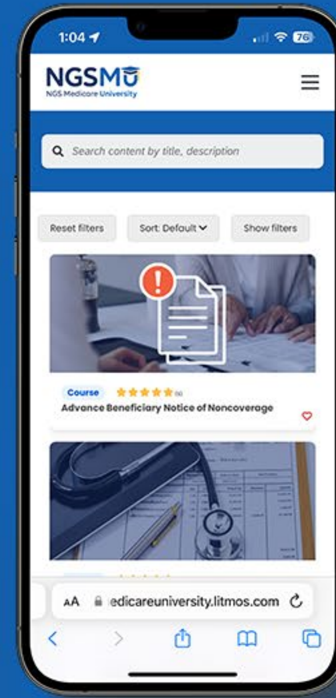
- BCRC Contact
- CMS' HETS (X12 270 transmission and 271 response)
- CMS HETS 270/271 5010 Companion Guide (MSP in Table 44)
- *How Medicare Works With Other Insurance*
- MLN® Booklet: *Medicare Secondary Payer (MSP)*
- MLN® Fact Sheet: *Medicare Secondary Payer: Don't Deny Services & Bill Correctly*
- MSP web pages

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 educational events

Thank you!





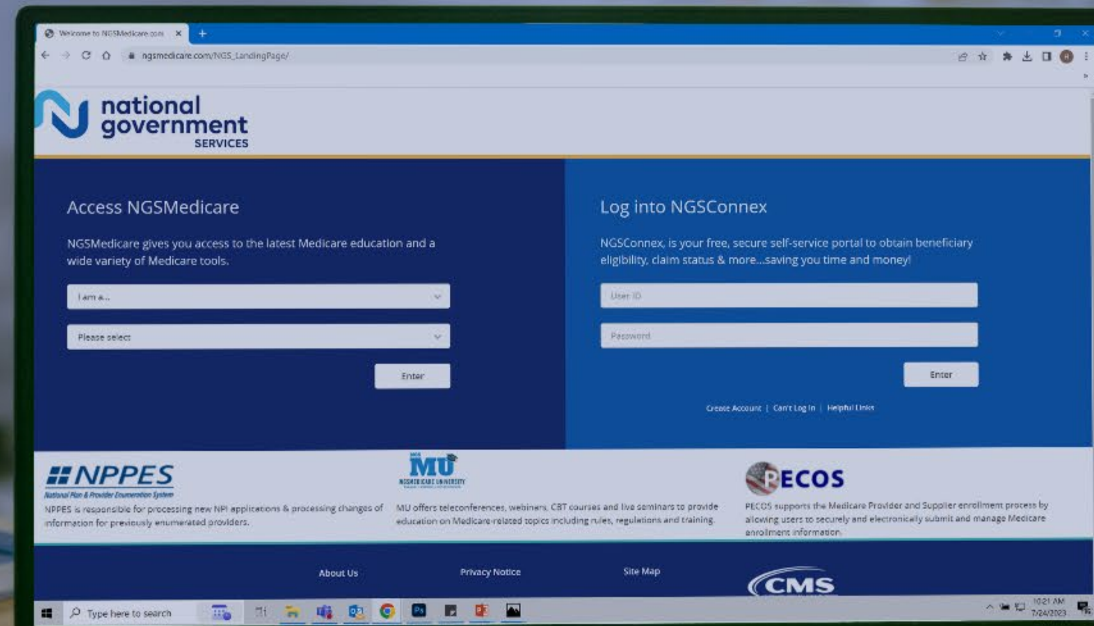
Connect with us on social media

[YouTube Channel](#)
Educational Videos

[Medicare University](#)
Self-paced online learning

[LinkedIn](#)
Educational Content

Find us online



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

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news