

# Submitting Medicare Secondary Payer Claims

3/4/2025

**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.*

# Today's Presenters

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Provider Outreach and  
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Provider Outreach and  
Education





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# Objective

To understand how to properly bill Medicare as the secondary payer to avoid unnecessary appeals, including how to submit claims conditionally.

Learn how to utilize NGS self-service tools on our website and where to find MSP information.



# Agenda

- [General MSP](#)
  - Why MSP
  - MSP Insurance Type Codes
  - Government Programs
  - Provider Responsibilities
  - Claim Submission Timeliness
  - Administrative Simplification Compliance Act (ASCA)
- [Paper CMS-1500 Claim Form \(02/12\)](#)
- [MSP Electronic Submissions](#)
- [MSP Conditional Payment](#)

# General MSP



# Why MSP

- Medicare Secondary Payer term used when Medicare does not have primary payment responsibility
- Protects Medicare Trust Fund by ensuring Medicare does not pay for services when other health insurance coverage is primarily responsible

# MSP Categories and Type Codes

- Group Health Plans
  - Working aged (12)
  - Disabled (43)
  - ESRD (13)
- Nongroup Health Plans
  - Workers' Compensation (15)
  - Automobile or other no-fault insurance (14)
  - Liability (47)
- [CMS IOM Publication 100-05, Medicare Secondary Payer Manual, Chapters 1–8](#)







# Government Programs

- Federal Black Lung Program
- Veterans Administration
  - [CMS IOM Publication 100-05, Medicare Secondary Payer Manual, Chapter 3](#)
  - [CMS IOM Publication 100-05, Medicare Secondary Payer Manual, Chapter 5](#)
  - [CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 16](#)

# Government Programs Protocol

- If you were paid by both NGS Medicare and another government program, such as, Federal Black Lung Program, Veterans Administration or US Family Health Plan
- In NGSConnex, [Initiate Clerical Error Reopening](#)
- When NGSConnex asks, *“Is this overpayment because Medicare paid as the primary payer, but another insurer is primary?”*
- Select NO, because government programs are not MSP claims
- You will be directed to Reopening Details screen to proceed with your reopening request
- At claim line Click the drop-down arrow in “Claim Line Action” field and select “Initiate Overpayment”
- If claim line was billed in error, this will result in claim line being denied and recoupment of payment



# Provider Responsibilities

- Determine if Medicare is primary payer for services rendered
  - Maintain office procedures to identify primary payer other than Medicare at each visit
  - Bill other payers before billing Medicare
  - Submit MSP claims when required even if primary payer made payment in full
- [CMS IOM Publication 100-05, Medicare Secondary Payer Manual, Chapter 3, Sections 20.2.1](#)

# Claim Submission Timeliness

- Limit is one calendar year from date of service
  - Claims not submitted timely are provider-liable
    - Beneficiary cannot be charged
- Exceptions: [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 70.7](#)
  - Administrative error
  - Retroactive Medicare entitlement, including when state Medicaid agencies involved
  - Retroactive disenrollment from Medicare Advantage Plan or Program of All-Inclusive Care of the Elderly (PACE) Provider Organization





# Administrative Simplification Compliance Act (ASCA)

- Most providers required to submit MSP claims electronically due to ASCA regulations
  - If submit all other claims electronically, must also submit MSP claims electronically
- Ten ASCA exceptions include
  - Medicare tertiary (third) payer claims
  - Providers submitting < ten claims per month
  - Physician/practitioner/supplier with < ten FTE employees
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 24, Section 90-90.6](#)

# Paper CMS-1500 Claim Form (02/12)



# MSP Paper Claim Submissions: Line Items 4, 6, and 7

- Item 4
  - If insurance primary to Medicare, list name of insured
  - When insured and patient are same, enter “SAME”
- Item 6
  - Check appropriate box for patient’s relationship to insured
- Item 7
  - Enter insured’s address and telephone number
  - When address is same as patient’s, enter “SAME”

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
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6. PATIENT RELATIONSHIP TO INSURED			
Self	Spouse	Child	Other

7. INSURED'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)
	(    )



# MSP Paper Claim Submissions: Line Item 10

**10. IS PATIENT'S CONDITION RELATED TO:**

**a. EMPLOYMENT? (Current or Previous)**

YES       NO

**b. AUTO ACCIDENT?**

YES       NO      PLACE (State)

**c. OTHER ACCIDENT?**

YES       NO

- Item 10a
  - Is patient's condition related to employment? Yes/No
- Item 10b
  - Is patient's condition related to auto accident? Yes/No
  - If answer = yes, include two-digit state code under Place
- Item 10c
  - Is patient's condition related to other accident? Yes/No

# MSP Paper Claim Submissions: Line Item 11-11c

- Item 11
  - Enter insured's policy or group number
- Item 11a
  - Enter insured's eight-digit birth date and sex if different from Item 3
- Item 11b
  - Enter employer's name, if applicable
- Item 11c
  - Enter nine-digit payer ID for primary insurer or complete primary payer's program/plan name

11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. INSURED'S DATE OF BIRTH			SEX	
MM	DD	YY	M	F
b. OTHER CLAIM ID (Designated by NUCC)				
c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
YES		NO		<i>If yes, complete items 9, 9a and 9d.</i>

# MSP Electronic Submissions

# MSP Electronic Claims Submission Requirements

- Required MSP data for electronic claims
  - Indication of Medicare as the secondary payer
  - Insurance type code
  - COB payer paid amount claim level
  - Claim contract information (OTAF) – claim level
    - OTAF = obligated to accept as payment in full
  - Claim adjudication date – claim level
  - Service line information
    - Line adjudication information
    - Line adjustments
    - Line adjudication date
- [Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P](#)



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/00/0012

1. MEDICARE  (Medicare#)    MEDICAID  (Medicaid#)    TRICARE  (ID#/DoD#)    CHAMPVA  (Member ID#)    GROUP HEALTH PLAN  (ID#)    FECA BLK LUNG  (ID#)    OTHER  (ID#)

5. PATIENT'S ADDRESS (No. Street)    6. PATIENT RELATIONSHIP TO INSURED:  Self  Spouse  Child  Other

7. INSURED'S ADDRESS (No. Street)    8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)    10. IS PATIENT'S CONDITION RELATED TO:  YES  NO

11. INSURED'S POLICY GROUP OR FECA NUMBER    12. PATIENT'S EMPLOYMENT (Current or Former):  YES  NO

13. PATIENT'S DATE OF BIRTH: MM DD YY    14. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES  NO

15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE    16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE    18. HOSPITALIZATION DATES RELATED TO CURRENT AFFILIATION: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes)

21. PRIOR AUTHORIZATION NUMBER

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
SBR01			Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary)	
SBR02			Individual Relationship Code	Individual relationship code (18 = Self)	

# Indication of Medicare as Secondary Payer

- Payer responsibility sequence number code
- 2000B SBR01 element
  - P = Primary
  - S = Secondary
  - T = Tertiary

# Claim Filing Indicator Codes

- 2000B SBR09 element
  - MB = Medicare (for most cases)
  - AM = Automobile medical
  - CI = Commercial insurance company
  - LM = Liability medical
  - WC = Workers' Compensation health claim

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary)
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE  (Medicare#)    MEDICAID  (Medicaid#)    TRICARE  (ID#/DoD#)    CHAMPVA  (Member ID#)    GROUP HEALTH PLAN  (ID#)    FECA BLK LUNG  (ID#)    OTHER  (ID#)

5. PATIENT'S ADDRESS (No. Street)    6. IF PATIENT RELATED TO INSURED:    7. INSURED'S ADDRESS (No. Street)  
 CITY    STATE    ZIP CODE    CITY    STATE    ZIP CODE    TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)    9. OTHER INSURED'S POLICY OR GROUP NUMBER    10. IS PATIENT'S CONDITION RELATED TO:    11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE    13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM    15. OTHER DATE    16. DATE (MM/DD) WHEN LAST WORKED IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE    18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY    20. PRIORITY AUTHORIZATION NUMBER

21. A. DATE(S) OF SERVICE    B. PLACE OF SERVICE    C. PROVIDER'S, SUPPLIER'S, OR SUPPLIER'S IDENTIFICATION NUMBER    D. DIAGNOSIS HICSDIC    E. CHARGE    F. ICD-9-CM    G. ICD-9-CM    H. ICD-9-CM    I. ICD-9-CM    J. PROVIDING PHYSICIAN ID #

22. FEDERAL TAX ID NUMBER    23. PATIENT'S ACCOUNT NO.    24. TOTAL CHARGE    25. AMOUNT PAID    26. SERVICE FACILITY LOCATION INFORMATION    27. BILLING PROVIDER INFO & PAYER

1. MEDICARE MEDICAID TRICARE CHAMPVA SEVERE DISABILITY PLAN DEER/NOV LUMP OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO PREVIOUS ONE? YES NO 10. IS PRESENT CONDITION RELATED TO OTHER ONE? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts assigned claim.

13. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED DATE 14. OTHER DATE QUAL. 15. OTHER DATE QUAL. 16. ORDER NO. AND NUMBER WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SSN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL events within last 90 days) 22. HEMORRHOID CODE ORIGINAL REF NO.

23. A. CARRIER OF SERVICE From To 24. A. CARRIER OF SERVICE From To

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CARE DETAILS (If bills for the claim are to be entered apply to the SE and not to this part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAYER ( )

Insurance Type Code	
2000B or 2320	SBR05
Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"	

# Common MSP Insurance Type Codes

- 2000B or 2320 SBR05 element
  - 12 - Working aged beneficiary ages 65 or over with employer GHP through self or spouse
  - 13 - ESRD beneficiary in 30-month coordination period with an employer GHP
  - 14 - No fault insurance including automobile and other types
  - 15 - Worker's Compensation
  - 41 - Federal Black Lung Program
  - 42 - Veteran's Administration
  - 43 - Disabled beneficiary under age 65 with LGHP
  - 47 - Liability insurance

# COB Payer Paid Amount

- Claim level
- Required when claim has service line approved/allowed amount and service line paid amount
- AMT segment – loop 2320 (Other subscriber information)
  - COB payer paid amount – claim level
    - With D qualifier
    - Total amount primary payer paid on claim (zero allowed)

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHIRBA SEVERE ILLNESS PLAN SEVERE ILLNESS OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (No. Area Code) CITY STATE ZIP CODE TELEPHONE (No. Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. IS PATIENT'S CONDITION RELATED TO OTHER INSURED'S POLICY OR GROUP NUMBER?

11. INSURED'S POLICY GROUP OR PECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of all information concerning this claim. I also request payment or grievance benefits other than this to be paid to the party who accepts assigned claim.)

13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 14. OTHER DATE 15. OTHER DATE

16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT AFFILIATION

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABORATORY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From ICD-9-CM, ICD-10-CM, or ICD-10-PCS) 22. HEMATOLOGIC CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM TO B. PLACE OF SERVICE C. PROCEDURE, SUPPLY, OR SUPPLIER D. CHARGE E. CARRIER F. NONCOVERED CHARGE #

1	AMT01	Amount qualifier code = D
2	AMT02	Monetary amount (Primary Paid Claim Level)

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degree or credentials (Only if the claimant is a business entity, apply to the SE and SE-MK on back of this form)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO ( )



1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN SELF OR NON-EMPLOYED OTHER % INSURED'S ID NUMBER (For Programs in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO PREVIOUS ONE? YES NO 10. IS PRESENT CONDITION RELATED TO OTHER ONE? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. INSURED'S DATE OF BIRTH MM DD YY SEX 13. OTHER CLAIM ID (Designated by NUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits other to myself or to the party who accepts assigned claim.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes) 22. PRIOR AUTHORIZATION NUMBER

23. A. CARRIER OF SERVICE FROM TO B. PLACE OF SERVICE C. PROVIDER, SUPPLIER, OR SUPPLIER IDENTIFICATION NUMBER D. DIAGNOSIS HICSDRUG E. CHARGES F. PAY RATE G. PAY PERIOD H. ID. QUAL. I. PROVIDING PROVIDER ID #

24. FEDERAL TAX ID NUMBER 25. PATIENT'S ACCOUNT NO. 26. ACCOUNT ASSIGNMENT? YES NO 27. TOTAL CHARGE 28. AMOUNT PAID 29. NUMBER NUCC USE

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (Only if the claim is to be processed by the 95 and not a self-pay claim) 31. SERVICE FACILITY LOCATION INFORMATION 32. BILLING PROVIDER INFO & PAY ( )

# COB Payer Allowed Amount

- Claim level
  - Obligated to accept as payment in full (OTAF)
    - Only required when OTAF amount greater than zero
    - Medicare claims processing system determines OTAF amount
      - Subtracts contractual obligation group code amount from submitted charges

Loop	Field	Data Element Description
2300 or 2400	CN102	OTAF amount

# Claim Adjudication Date

- Claim level
  - Required on all electronic MSP claims
  - Report the date the claim paid/processed by primary payer by using a DTP segment in loop 2330B
    - DTP01 element = 573 (indicates date listed is date claim paid)
    - DTP02 element = D8 (indicates format of date)
    - DTP03 element = enter date claim paid/adjudicated by primary payer

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

1. MEDICARE MEDICAID TRICARE CHIRBA SELECT HEALTH PLAN SELECT (LIFE) OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE 8. RESERVED FOR NUCC USE CITY STATE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO THIS CLAIM?

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of all medical or other information necessary to process this claim. I also request payment of government benefits other than this to the party who accepts assigned claim.)

13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 14. OTHER DATE 15. DATE OF BIRTH (MM DD YY) 16. WORK IN CURRENT OCCUPATION (MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT AFFILIATION (MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABORATORY 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (From AL, ICD-9-CM, ICD-10-CM, ICD-10-PCS) 22. PRELABORATION CODE 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE FROM TO B. PROCEDURE, SERVICE, OR SUPPLY C. CHARGE D. CHARGE CODE E. CHARGE F. CHARGE G. CHARGE H. CHARGE I. CHARGE J. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. RESERVE NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degree or credentials (Only if the claimant or business applies to this SE and on main a part below)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ( )

2330B or 2430	DTP01	Primary insurance adjudication date
	DTP02	Date time period qualifier
	DTP03	Date paid

1. MEDICARE MEDICAID TRICARE CHIP/VA SEVERE DISABILITY PLAN SELF OR NON-EMPLOYED OTHER % INSURED'S ID NUMBER (For Programs in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO PREVIOUS ONE? 10. IS THIS CLAIM FOR A SERVICE COVERED BY THIS POLICY? 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. IS THIS CLAIM FOR A SERVICE COVERED BY THIS POLICY? 13. IS THIS CLAIM FOR A SERVICE COVERED BY THIS POLICY?

14. STATE OF CURRENT RESIDENCE (MM DD YY) 15. OTHER DATE (MM DD YY) 16. DATE OF BIRTH (MM DD YY) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABORATORY 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Include ALL ICD-9-CM codes) 22. PHYSICIAN OR SUPPLIER IDENTIFICATION NUMBER 23. A. DATE OF SERVICE (MM DD YY) 24. B. FROM (MM DD YY) 25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. NUMBER NUCC USE 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of office unless it differs from the address on the reverse apply to the SE and use it with a part benefit) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ( )

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH SEX  
MM DD YY M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  
YES NO If yes, complete items 9, 9a and 9d.

2430	SVD01	Identification code
	SVD02	Primary payer paid amount (line level)
	SVD03	Medical procedure identifier
	SVD03-1	Service ID qualifier
	SVD03-2	Service ID
	SVD05	Quantity

# Service Line Information

- Line adjudication information
  - Services billed to primary payer
    - Procedure code, units billed, amount paid, etc.
- Required if claim adjudicated by primary payer and service line adjustments applied
- SVD segment in 2430 loop
  - Information in SVD01 must match payer ID for primary payer

# Reminder: Line Adjudication Information

- Payment amount entered in service line adjudication field
- Plus
  - Adjustments listed in line level adjustment fields
- Equals
  - Total amount billed for that service line

# Service Line Adjustment Information

- Line adjustments
  - Required if primary payer made line level adjustments
  - CAS segment of 2430 loop, include
    - Monetary adjustment amounts
    - CARC from primary remittance advice
    - Claim adjustment group code CO,OA, PI, PR

**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHIRBA SELECT HEALTH PLAN SELF-EMPLOYED OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Provide Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. IS PATIENT'S CONDITION RELATED TO OTHER INSURED'S POLICY OR GROUP NUMBER?

11. INSURED'S POLICY GROUP OR PECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of all medical or other information necessary to process this claim. I also request payment of government benefits other than Social Security to the party who accepts assigned claim.)

13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY CLAIM 14. OTHER DATE 15. DATE OF LAST WORK IN CURRENT OCCUPATION

16. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17. HOSPITALIZATION DATES RELATED TO CURRENT AFFILIATION

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 19. OUTSIDE LABORATORY 20. PHYSICIAN OR SUPPLIER INFORMATION

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ICD-9-CM code when both ICD-9-CM and ICD-10-CM are used) 22. ORIGINAL REF. NO.

23. FEDERAL TAX ID NUMBER 24. PATIENT'S ACCOUNT NO. 25. ACCRUE ASSIGNMENT? 26. TOTAL CHARGE 27. AMOUNT PAID 28. NUMBER NUCC USE

29. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degree or credentials (certify that the information furnished applies to this bill and can make a part thereof)) 30. SERVICE FACILITY LOCATION INFORMATION 31. BILLING PROVIDER INFO & Print ( )

2320 or 2430	CAS01	Claim adjustment reason code (CO, PR, OA)
	CAS02	Claim adjustment reason codes
	CAS03	Adjustment amount
	CAS04	Adjustment quantity
2330B or 2430	DTP01	Primary insurance adjudication date
	DTP02	Date time period qualifier
	DTP03	Date paid

1. MEDICARE MEDICAID TRICARE CHIP/VA GROUP HEALTH PLAN SELF OR NEW LEAVE OTHER % INSURED'S ID NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street)

CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. IS PRESENT CONDITION RELATED TO PREVIOUS ONE? YES NO 10. IS PRESENT CONDITION RELATED TO OTHER ACCIDENT? YES NO 11. IS PRESENT CONDITION RELATED TO OTHER ACCIDENT? YES NO 12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment or government credits either to myself or to the party who accepts assigned claim.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREVIOUSLY CLAIMED 15. OTHER DATE QUAL 16. DATE OF LAST WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LABOR CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide ALL ICD-9-CM codes) 22. PHYSICIAN CODE ORIGINAL REF NO 23. PRIOR AUTHORIZATION NUMBER

24. A. CARRIER OF SERVICE From To B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLIER D. PHYSICIAN IDENTIFICATION E. CHARGES F. DATE OF SERVICE G. RATE PER UNIT H. ID. QUAL I. PROVIDING PROVIDER ID #

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO 27. ACCOUNT ASSIGNMENT? YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. NUMBER NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDIT CARDS (If bills to the insurer or to a vendor apply to the 31 and are in a self biller.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PAY ( )

# Service Line Adjudication Date

- Line adjudication date
  - Required on all electronic MSP claims
  - DTP segment of 2430 loop
    - Date/time qualifier of 573
    - Date/time-period format qualifier of D8

2330B or 2430	DTP01	Primary insurance adjudication date
	DTP02	Date time period qualifier
	DTP03	Date paid

# MSP Electronic Claim Submissions

- MSP electronic billing guidance
  - [NGS Website](#) > Resources > Claims and Appeals > CMS 1500 Claim Form
    - [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)
  - [NGS Website](#) > Resources > Claims and Appeals > Medicare Secondary Payer (MSP) > Prepare and Submit an MSP Claim
    - [Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P](#)
- Billing MSP Claims via PC-ACE
  - Parallels items on paper CMS-1500 claim form
  - Creates compliant ANSI X12 file to submit to NGS electronically
  - PC-ACE Medicare Secondary Payer Reference Guide available on our website
    - Resources > EDI Solutions
      - [EDI Software About PC-ACE](#)

# MSP Conditional Payment





# Conditional Payment

- Medicare pays the provider because payment has not been made or is not expected to be made by primary insurer
- Payments are made “on condition” that Medicare will be reimbursed if it is demonstrated that the insurance is or was responsible for making primary payment for services rendered

# Conditional Claim Payments

- Four circumstances when a conditional payment can be made
  - Beneficiary appeal/protest GHP denial of claim
  - GHP denied claim because timely filing limit expired
  - Provider failed to file proper claim due to mental/ physical incapacity of beneficiary
  - Claim sent to specific primary insurers and payment not made within promptly period



# Conditional Payment Data Requirements

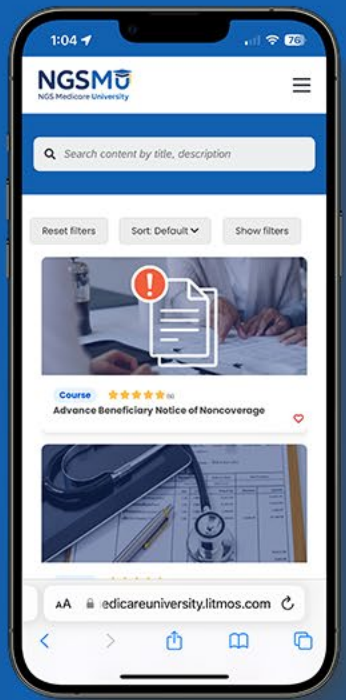
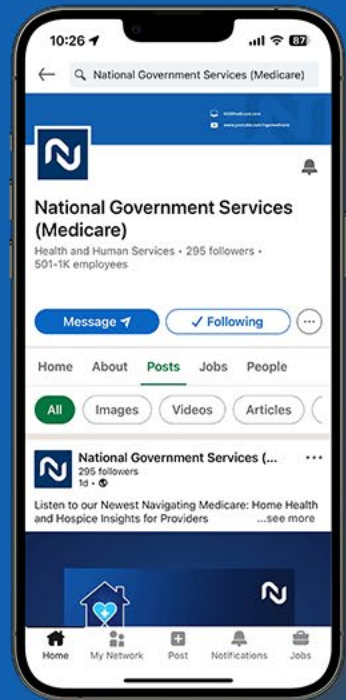
Type of Insurance	CAS	Insurance Type Code 2320 SBR05 From Previous Payer(s)	Claim Filing Indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No Fault/Liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	\$0.00	N/A	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	\$0.00	02 Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

# References and Resources


- [Prepare and Submit MSP Claim](#)
- [Conditional Payment Information](#)
- [Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims](#)
- [Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P](#)
- [MLN<sup>®</sup> Fact Sheet: Medicare Secondary Payer: Don't Deny Services & Bill Correctly](#)
- [Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-05, Medicare Secondary Payer \(MSP\) Manual, Chapter 2, MSP Provisions, Section 40.2: Billing in MSP Liability Insurance Situations](#)

# Questions?

Thank you!



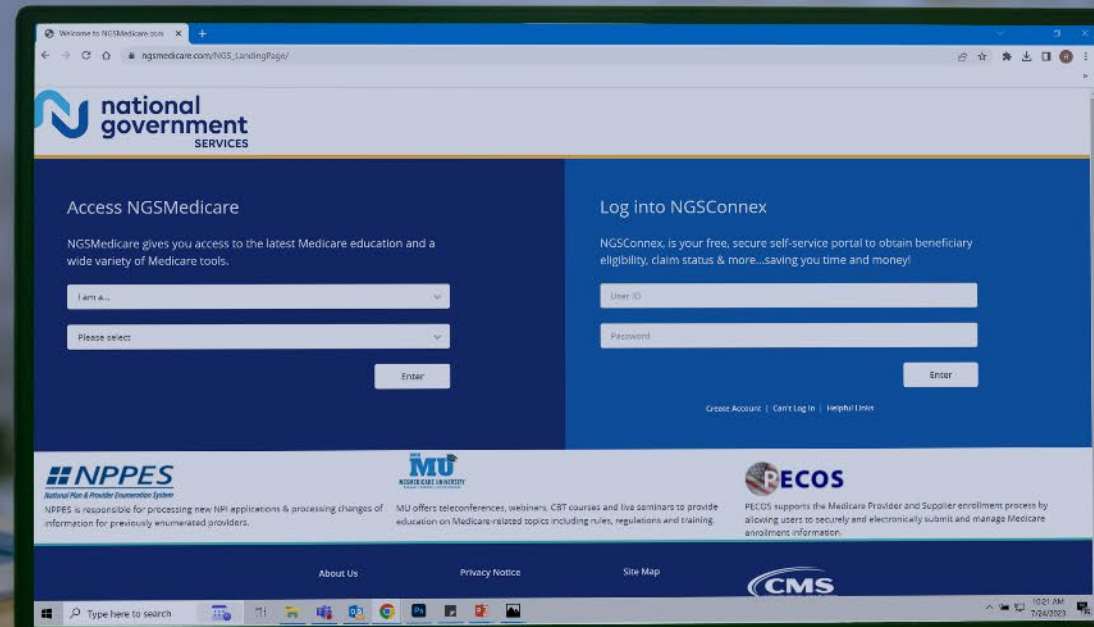
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