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Submitting Medicare Secondary Payer Claims

9/4/2024

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NGSMU
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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

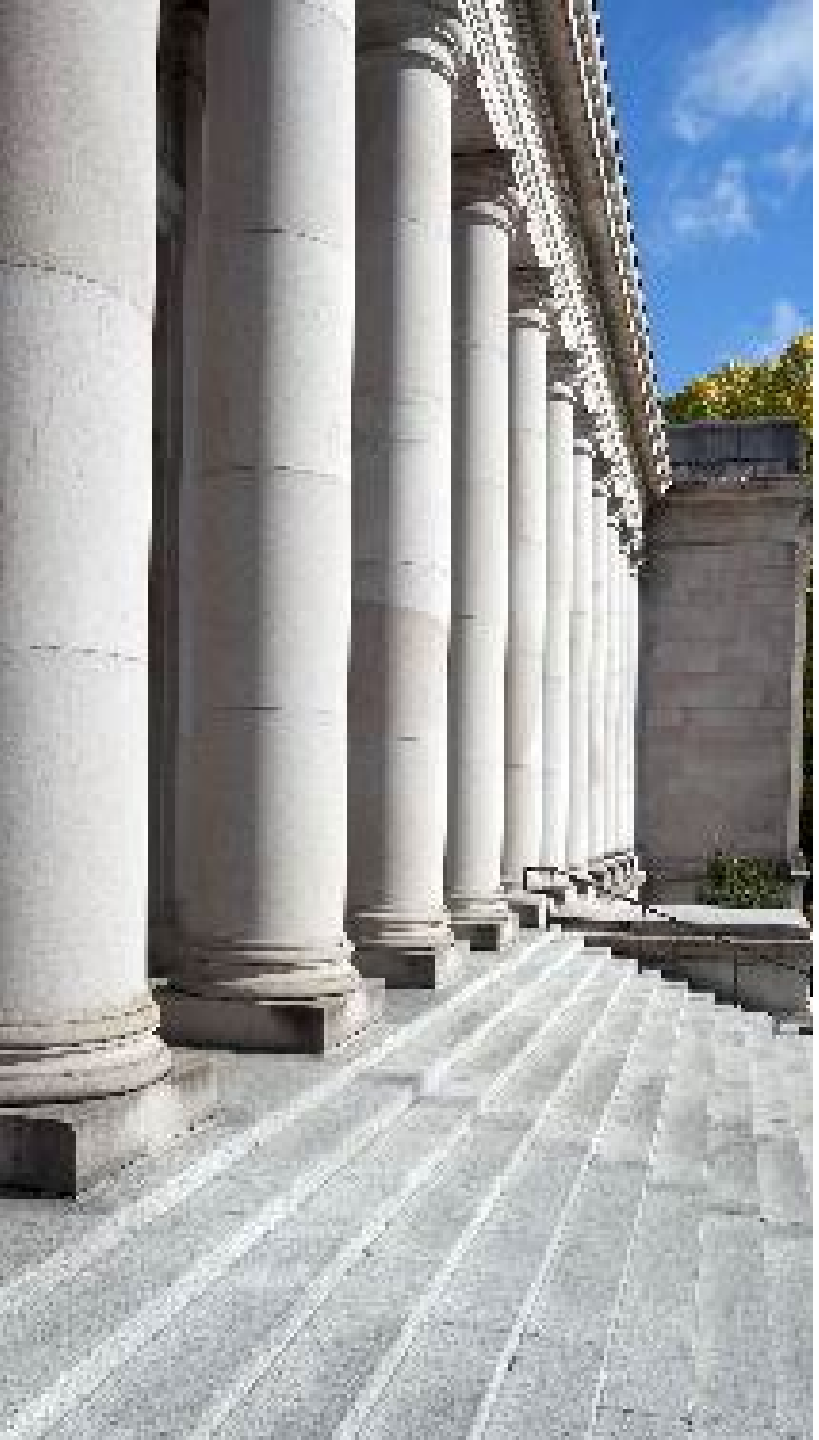
General MSP

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

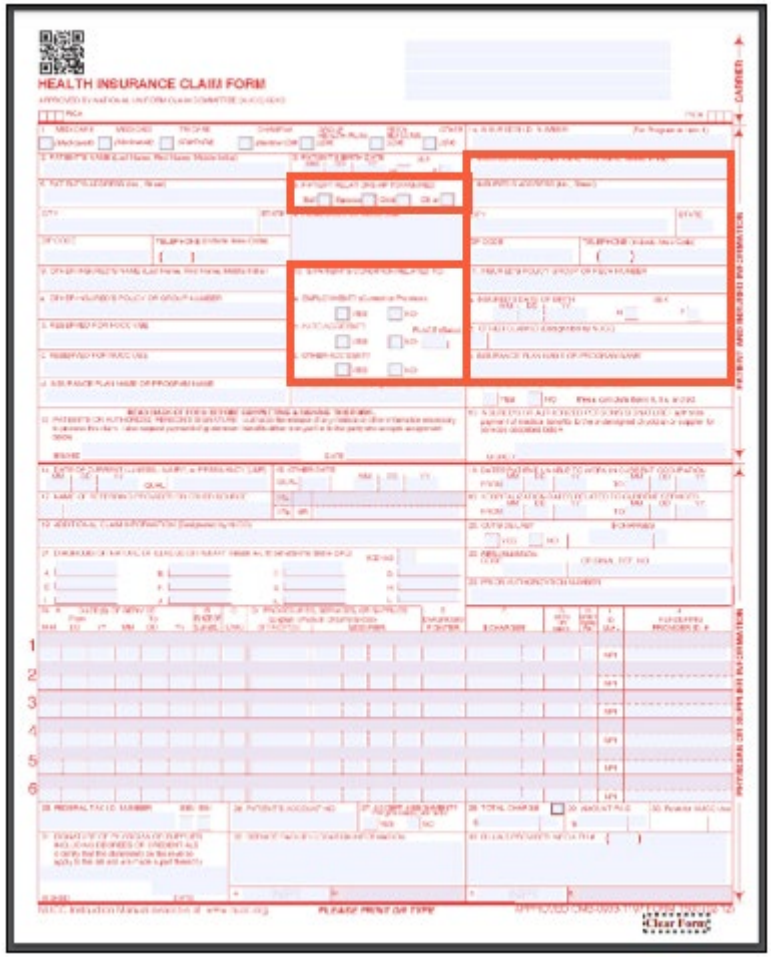
- Limit is one calendar year from date of service
  - Claims not submitted timely are provider-liable
    - Beneficiary cannot be charged
- Exceptions: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70.7
  - Administrative error
  - Retroactive Medicare entitlement, 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)

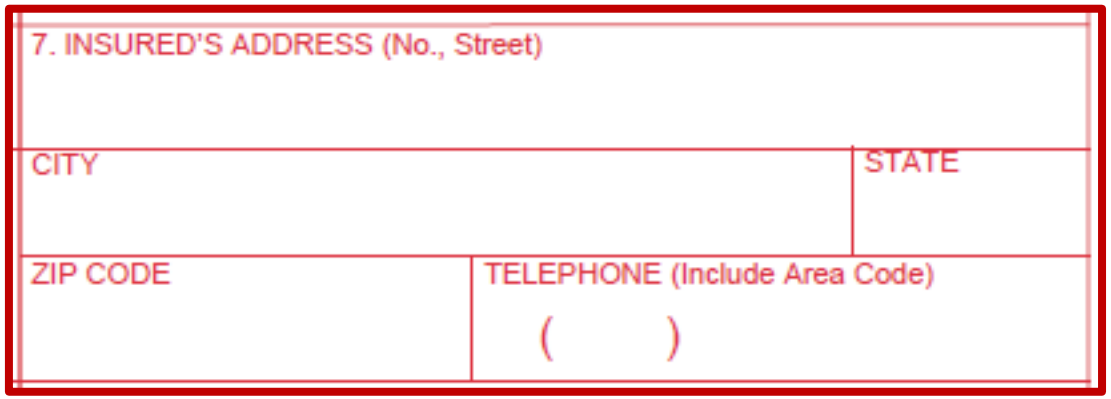
MSP Paper Claim Submissions



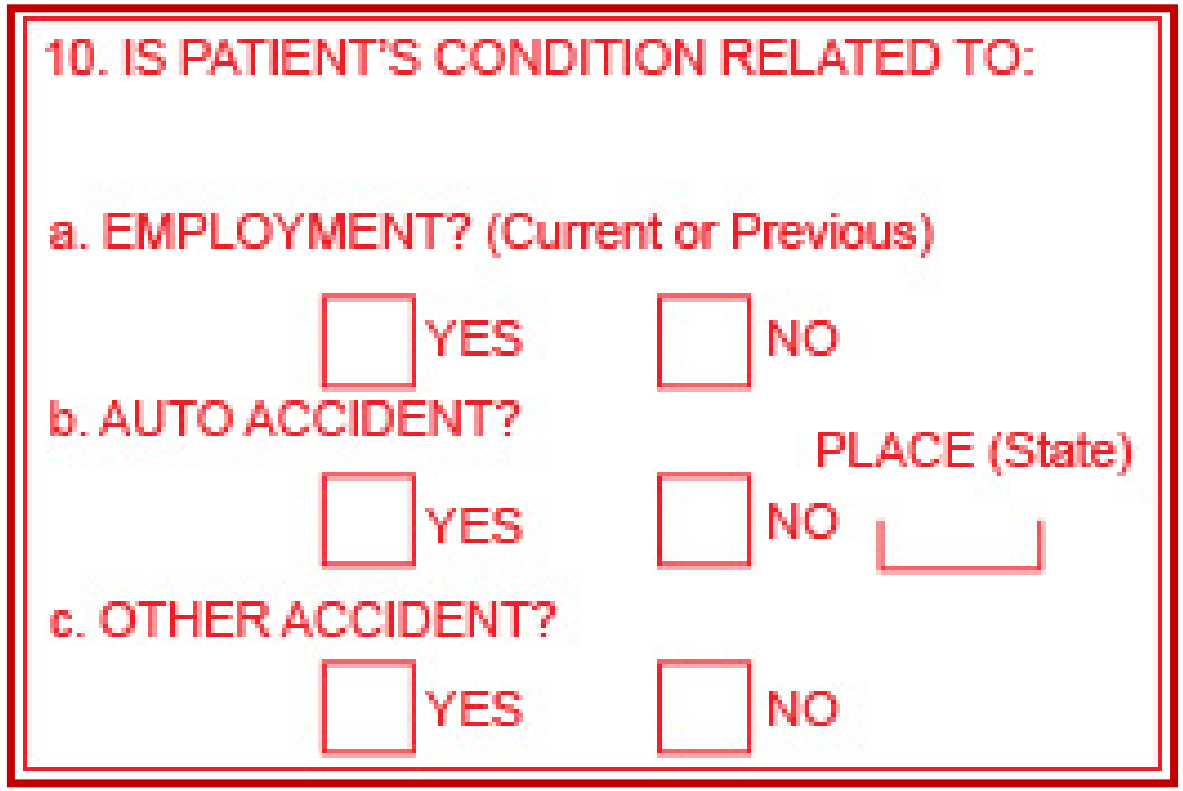
- Paper claims shall be submitted
  - Original red and white
  - CMS-1500 claim form (02/12)
- For MSP claims, specific items must be completed
- NGS website > Claims and Appeals > Medicare Secondary Payer (MSP) > Prepare and Submit an MSP Claim
  - Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

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”



MSP Paper Claim Submissions: Line Item 10


10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

YES NO

b. AUTO ACCIDENT?

PLACE (State)

YES NO

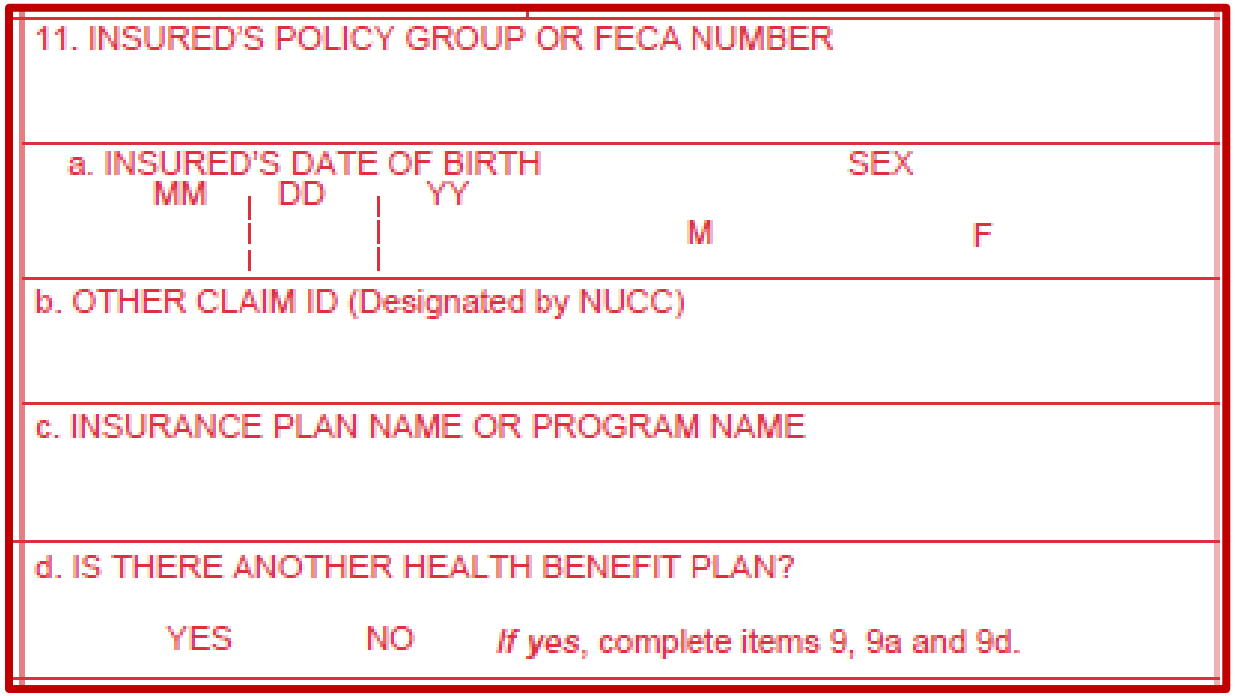
c. OTHER ACCIDENT?

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 MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

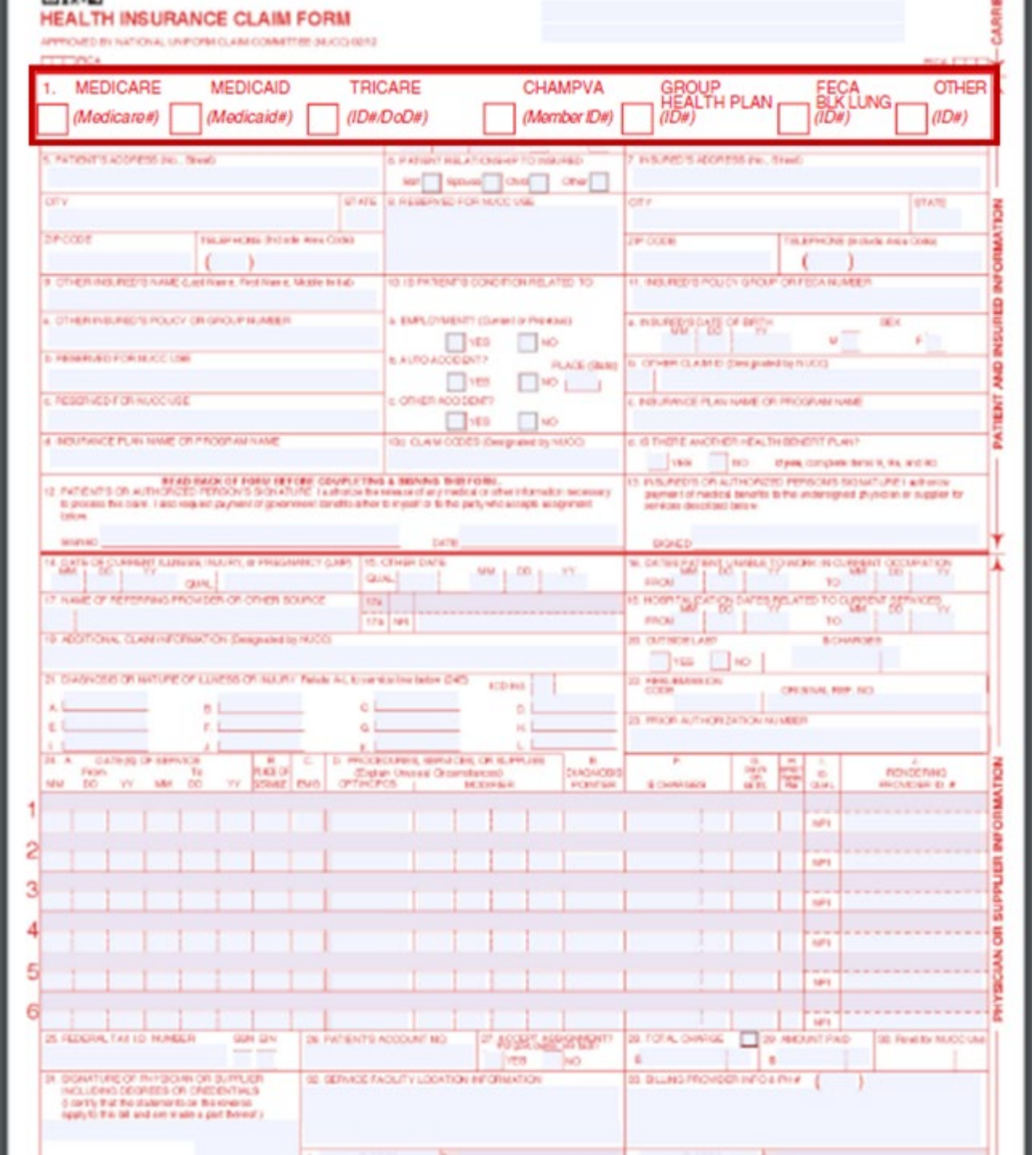
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES NO *If yes*, complete items 9, 9a and 9d.

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



Indication of Medicare as Secondary Payer

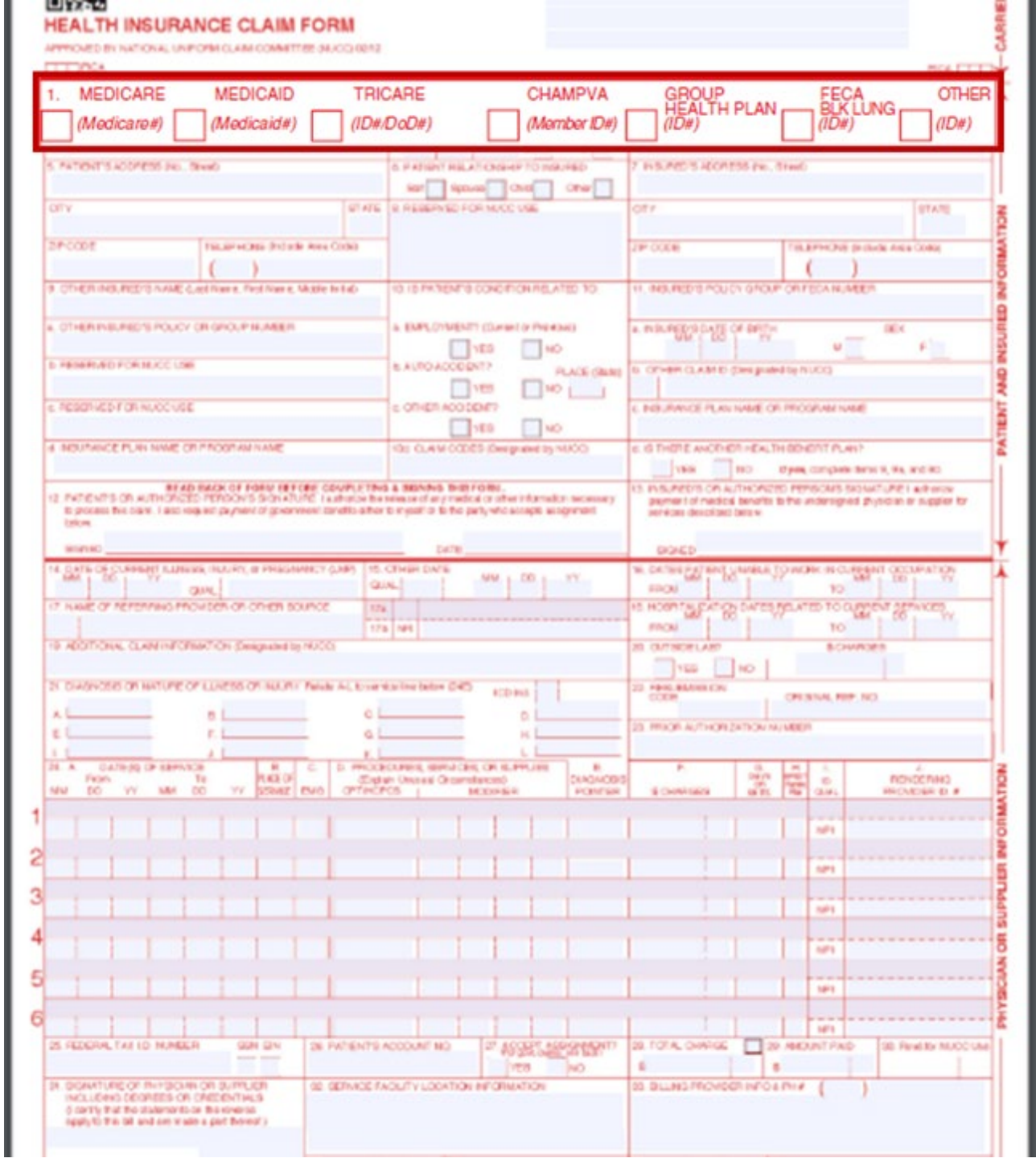
- Payer responsibility sequence number code
- 2000B SBR01 element
  - P = Primary
  - S = Secondary
  - T = Tertiary

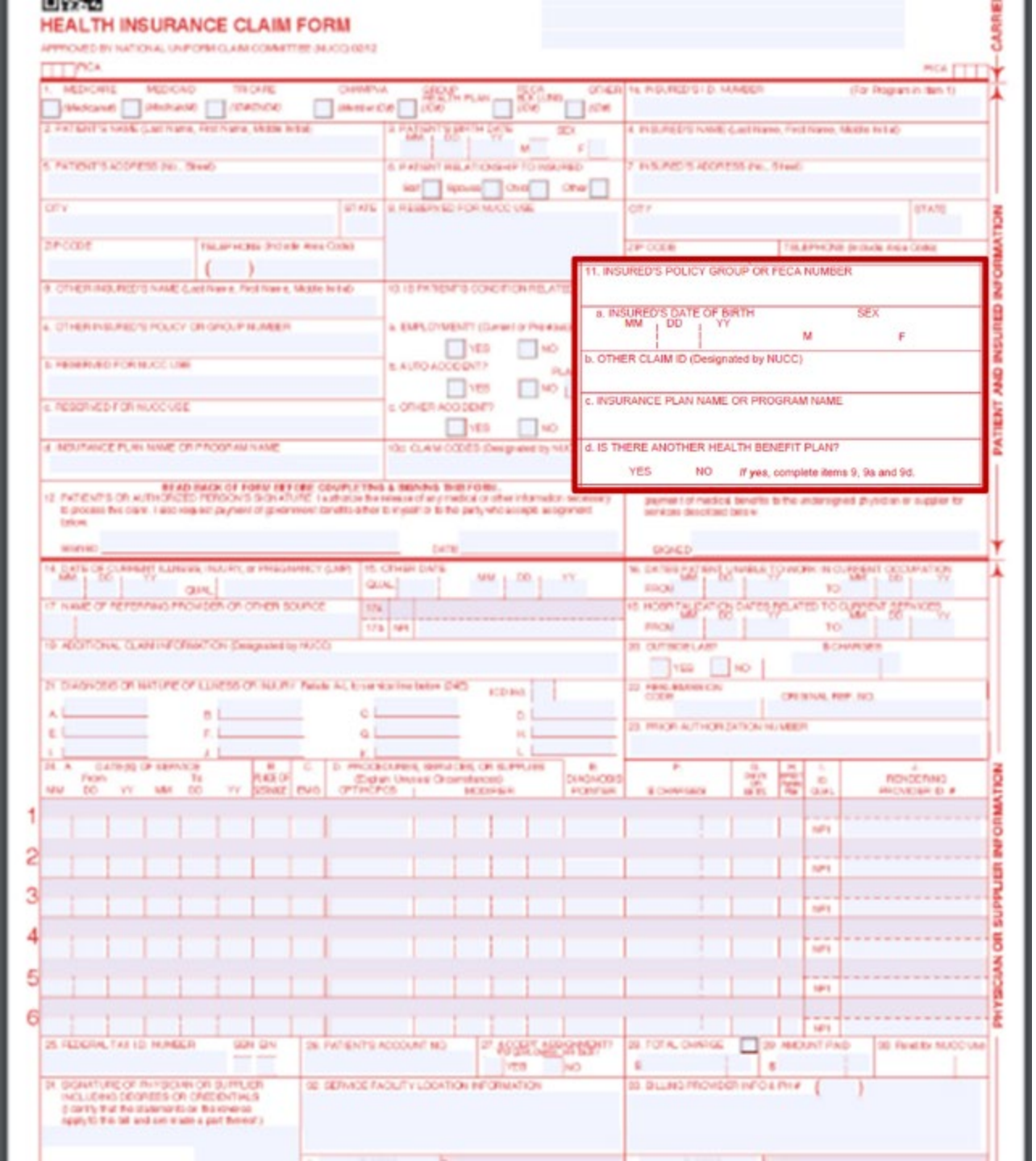
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary
			SBR02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

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)





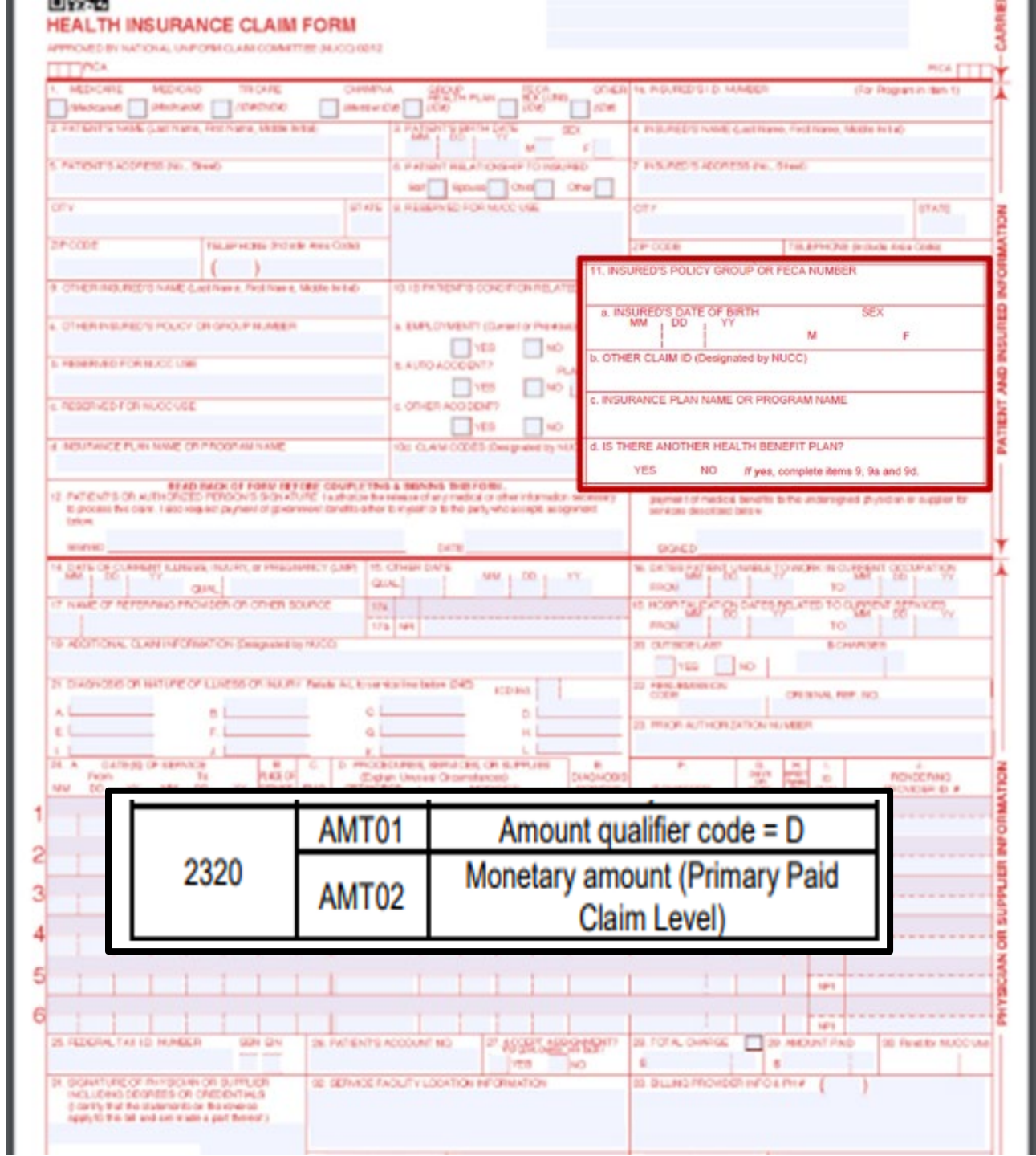
Common MSP Insurance Type Codes

- 2000B or 2320 SBR05 element
- Working aged beneficiary ages 65 or over with employer GHP through self or spouse

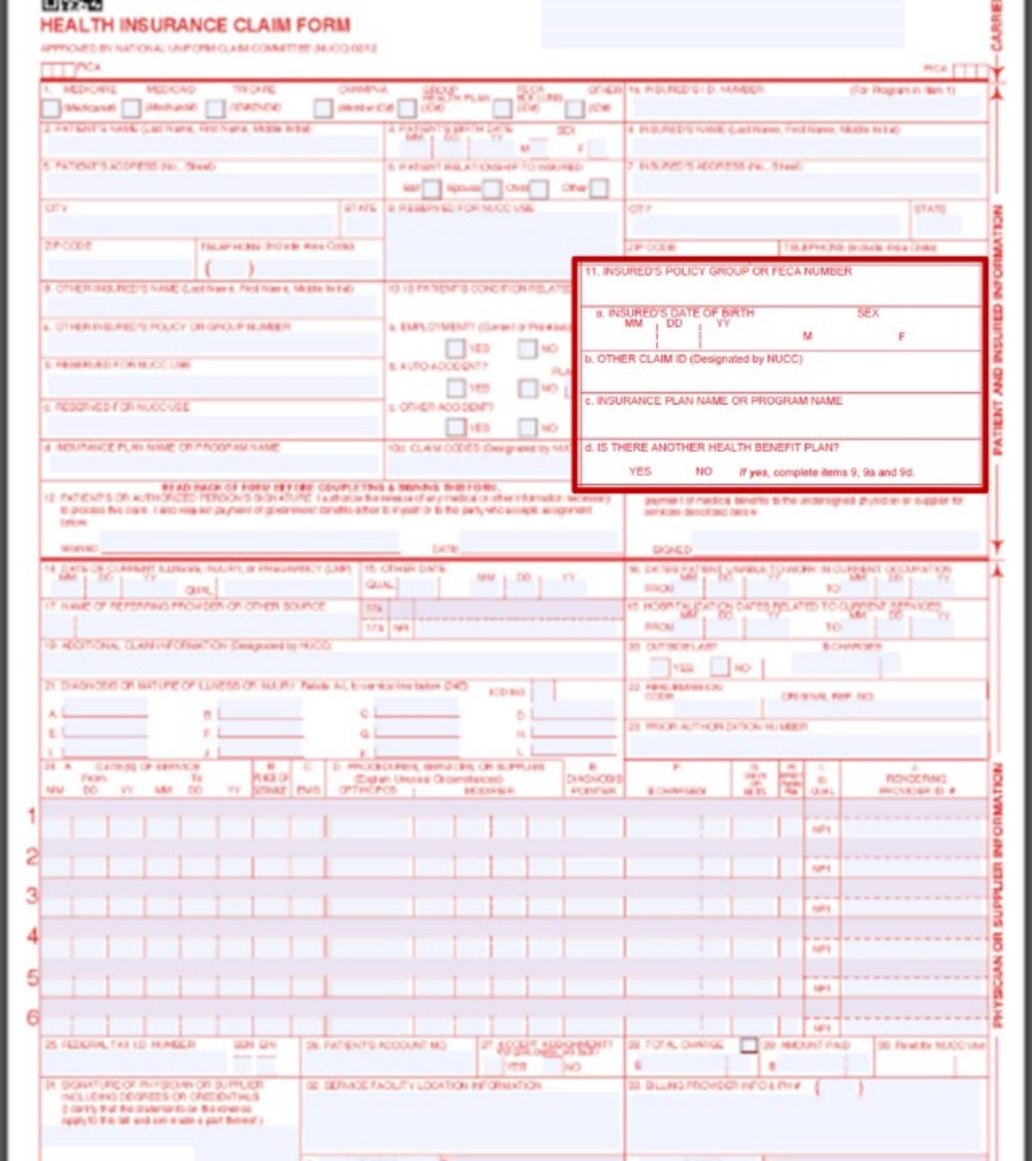
		Insurance Type Code
2000B or 2320	SBR05	Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"

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)



2320	AMT01	Amount qualifier code = D
	AMT02	Monetary amount (Primary Paid Claim Level)



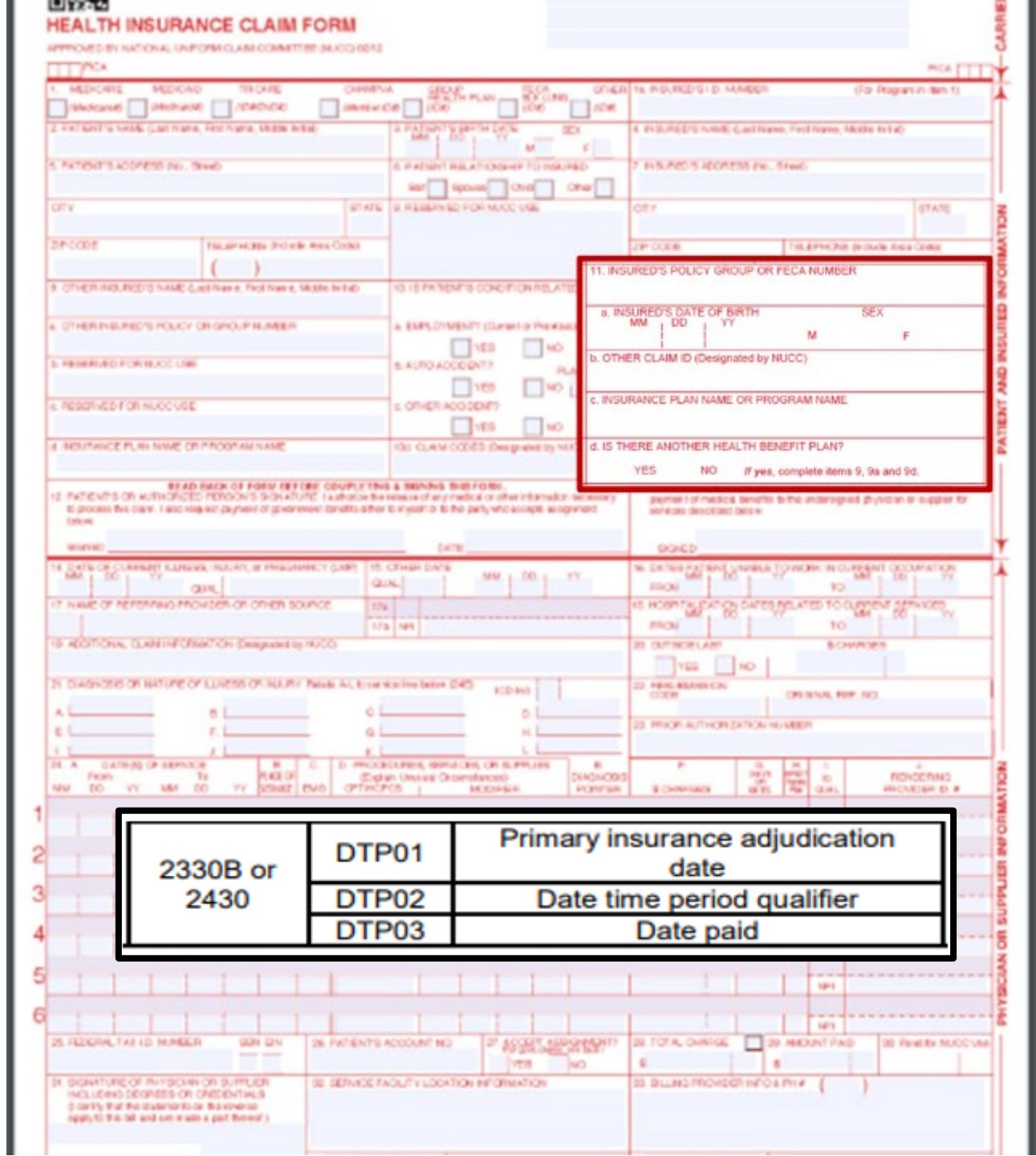
COB Payer Allowed Amount

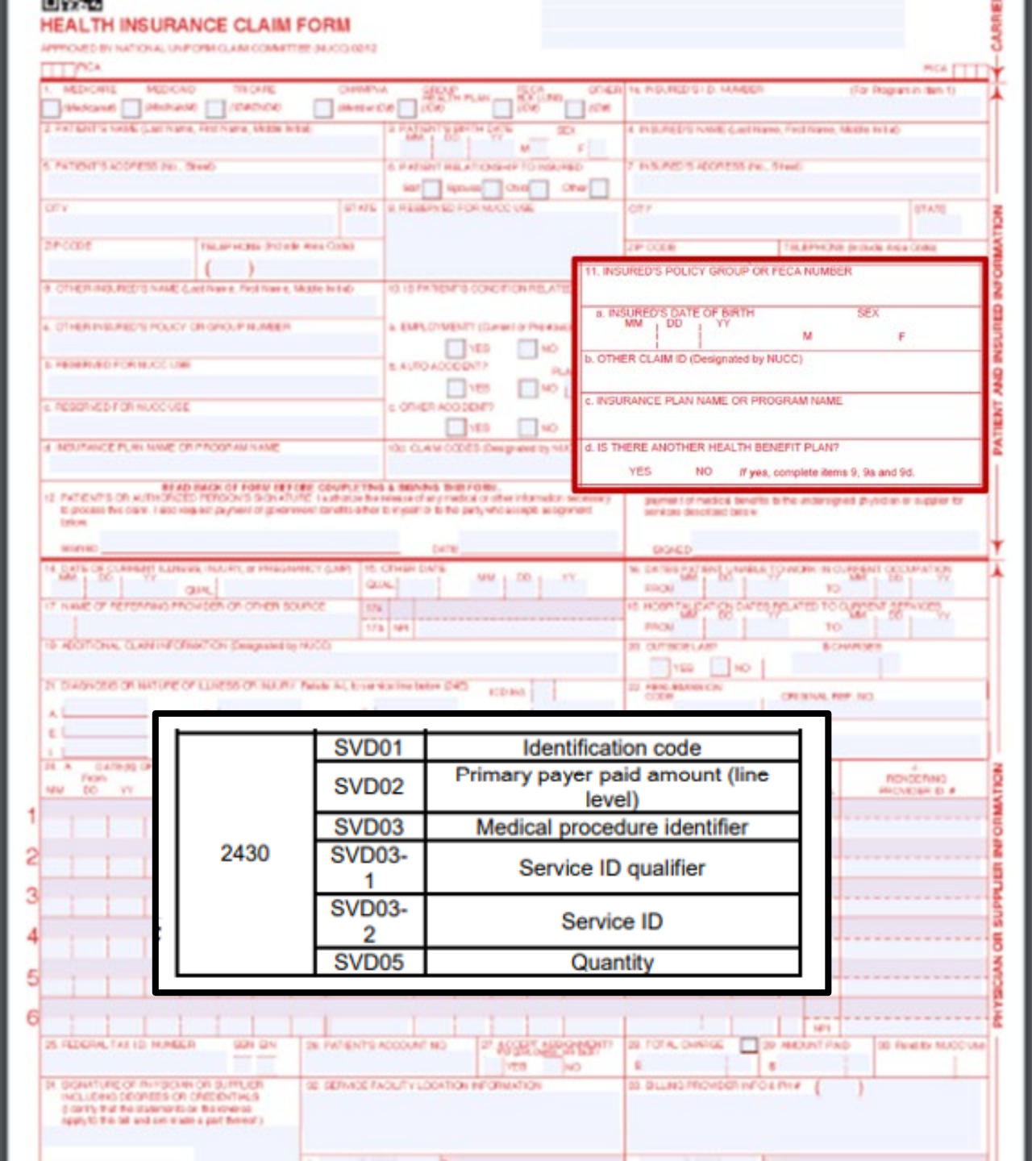
- Claim level
  - Obligated to accept as payment in full (OTAF)
    - Only required when OTAF amount greater than zero
    - Medicare claims processing system determines OTAF amount
      - Subtracts contractual obligation group code amount from submitted charges

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





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

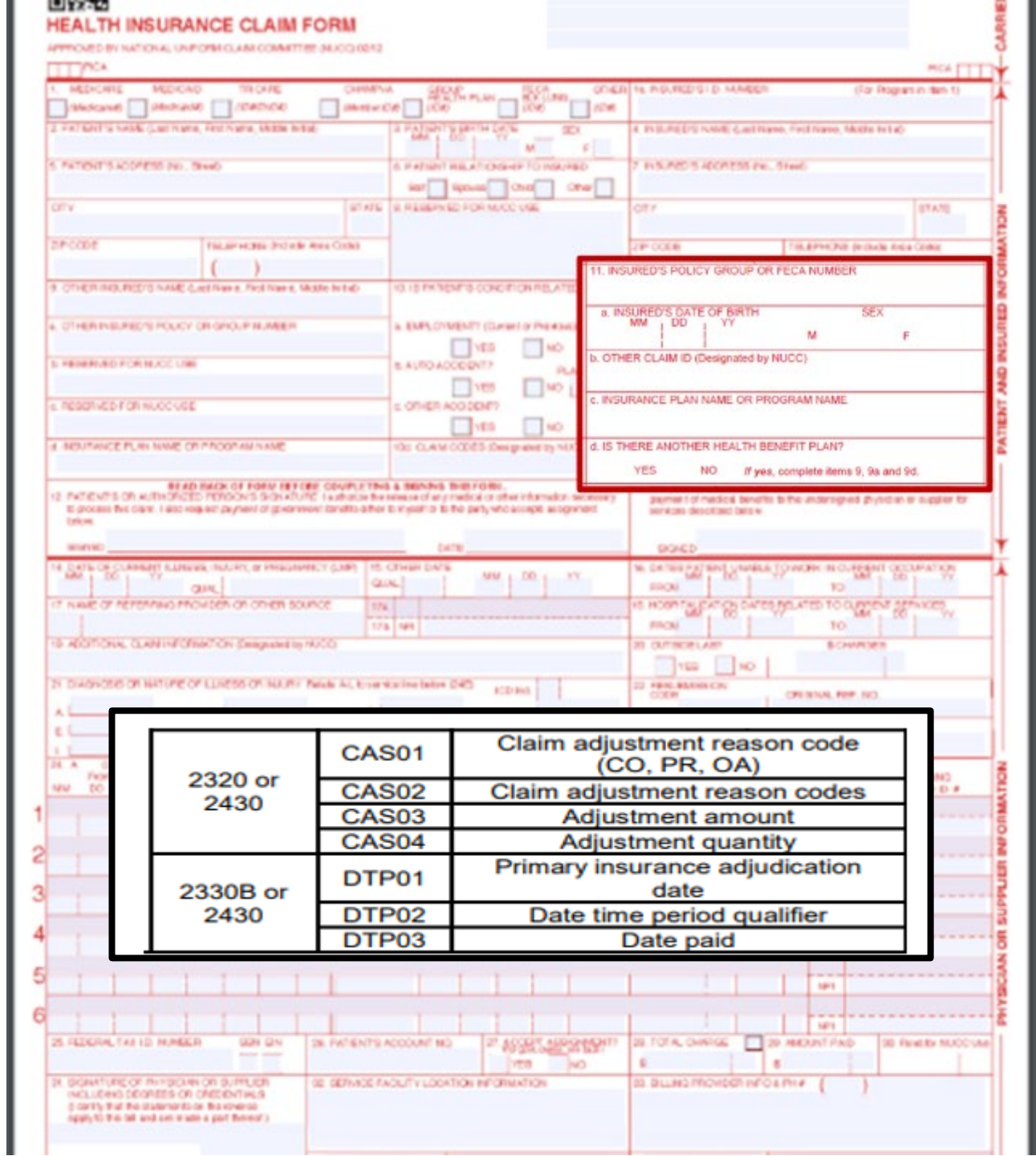
- Line adjudication information
  - Services billed to primary payer
    - Procedure code, units billed, amount paid, etc.
  - Required if claim adjudicated by primary payer and service line adjustments applied
  - SVD segment in 2430 loop
    - Information in SVD01 must match payer ID for primary payer

Reminder: Line Adjudication Information

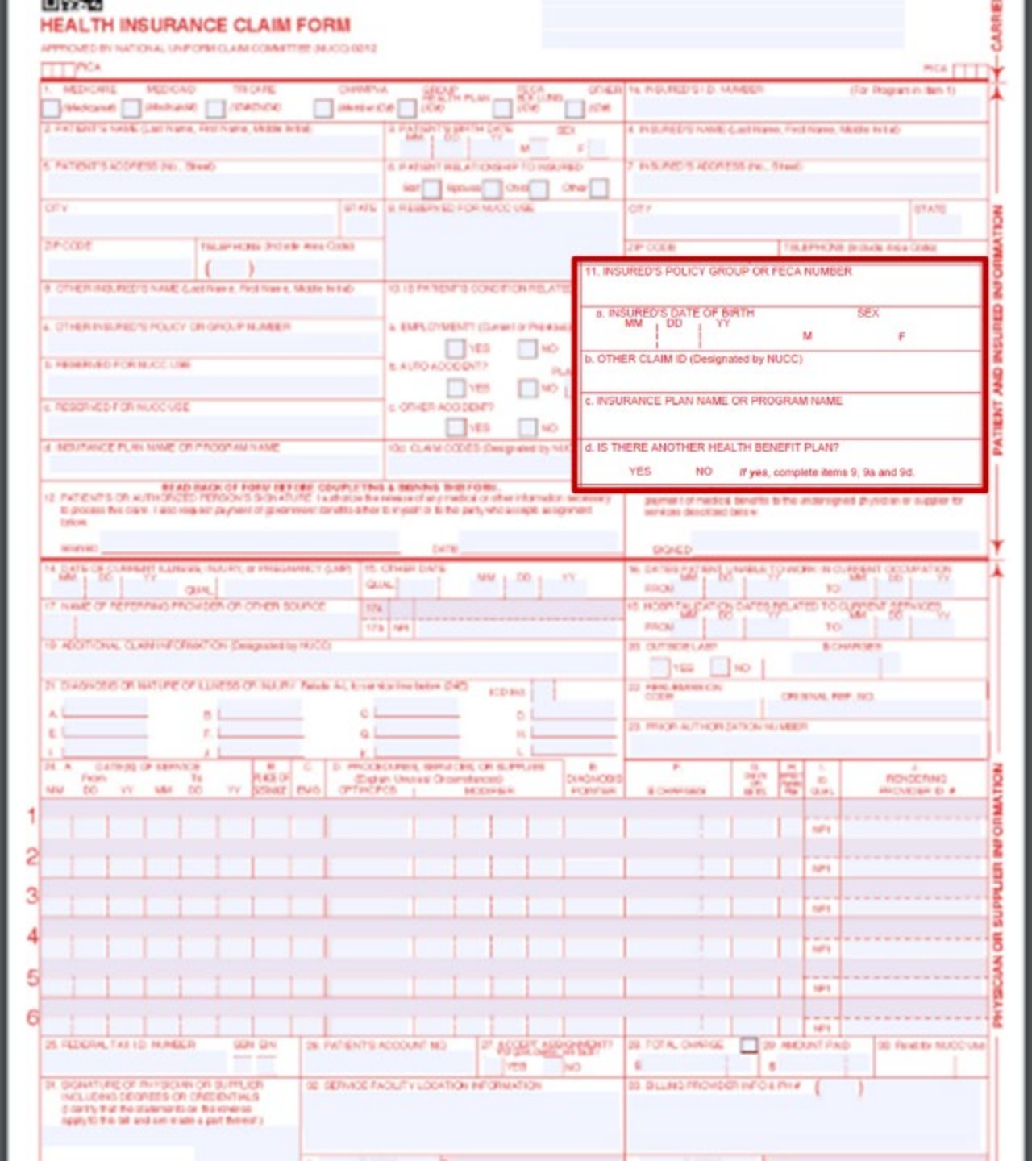
- Payment amount entered in service line adjudication field
- Plus
  - Adjustments listed in line level adjustment fields
- Equals
  - Total amount billed for that service line

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



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



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

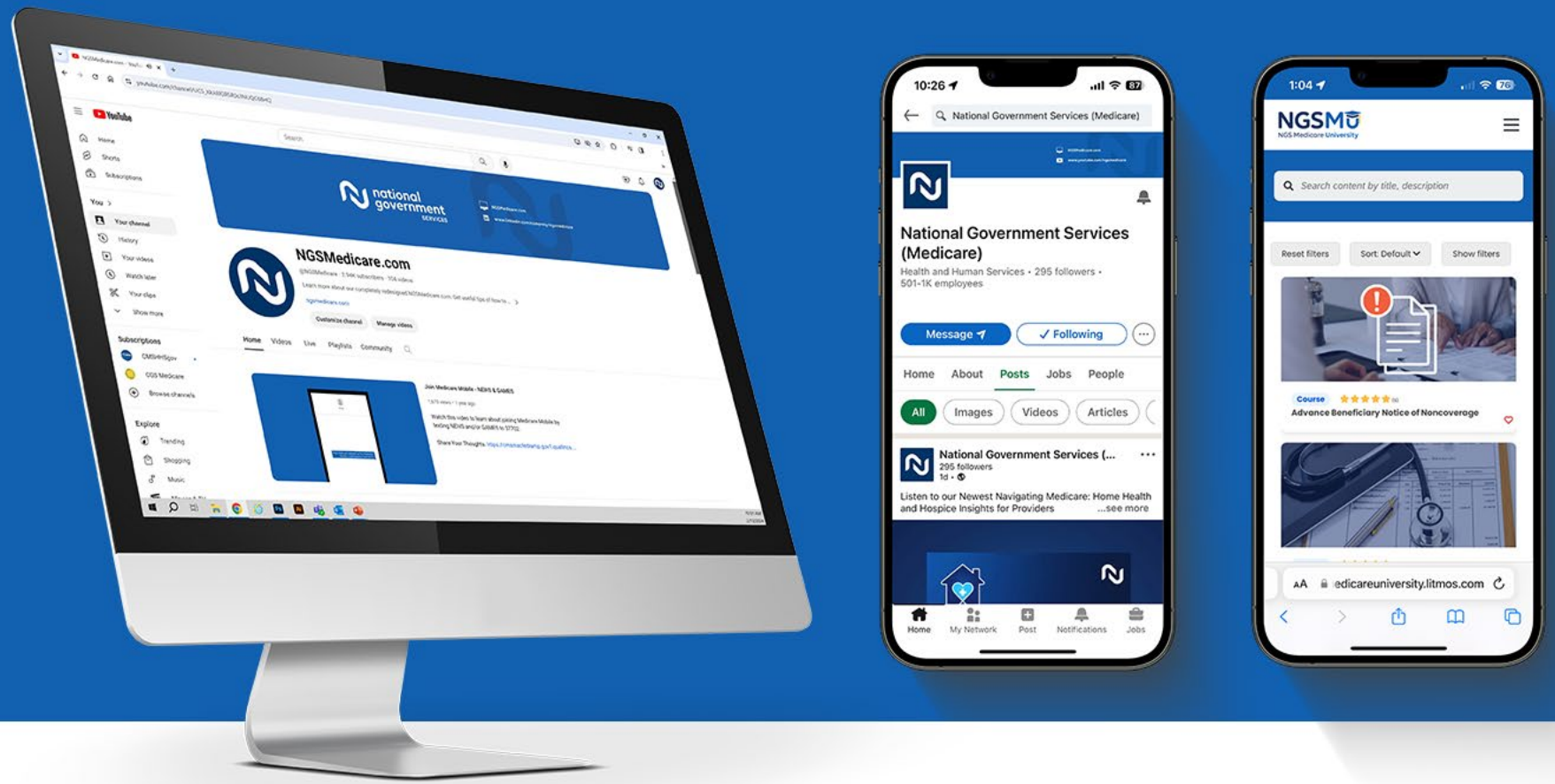
Type of Insurance	CAS	Insurance Type Code 2320 SBR05 From Previous Payer(s)	Claim Filing Indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No Fault/Liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00	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® 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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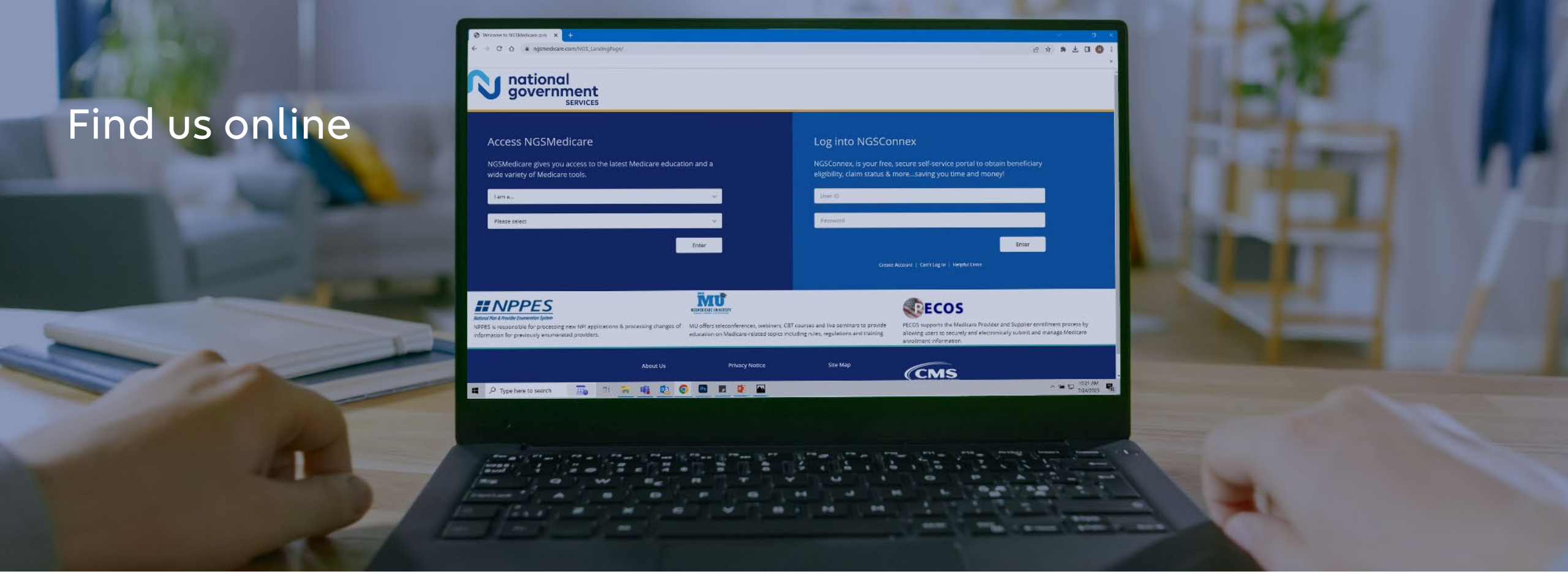

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