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NGS PROVIDER EXPERIENCE
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Prepare and Submit Compliant Medicare Secondary Payer Claims

6/6/2024

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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

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Objective

Increase understanding of how to prepare and submit compliant MSP claims after receiving payment from primary payer(s)

Agenda

MSP and Your MSP-Related Responsibilities
Christine Janiszcak

Prepare and Submit MSP Claims
Christine Janiszcak

Claim Fields and MSP Claim Codes
Christine Janiszcak

Enter and Submit MSP Claims in FISS DDE
Christine Janiszcak

MSP References
Christine Janiszcak

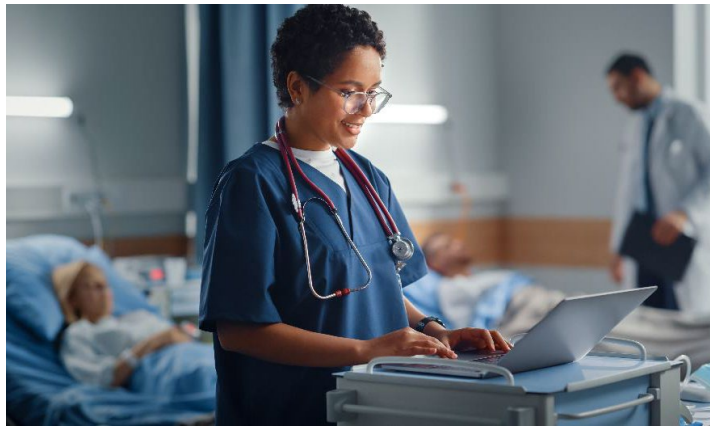
Questions and Answers
Christine Janiszcak and all

MSP and Your MSP-Related Responsibilities

What Is MSP?

- Medicare beneficiary has insurance/coverage primary to Medicare
  - Based on federal laws known as MSP provisions
    - Help determine proper order of payers
    - Make certain payers primary to Medicare
    - Have criteria/conditions that must be met
      - If not met, services not subject to that provision; Medicare primary
      - If met, services subject to that provision; other payer primary, Medicare secondary

Providers' MSP-Related Responsibilities Per Medicare Provider Agreement

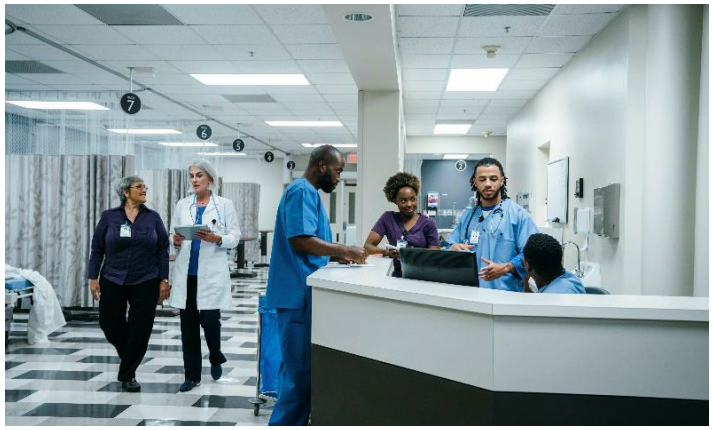


Identify payer(s) primary to Medicare

Determine if Medicare primary payer for beneficiary's services

Submit claims to primary payer(s) before Medicare

There may be more than one payer primary to Medicare



Submit MSP claims to Medicare when required

Follow MSP claim submission guidelines

Identify Payers Primary to Medicare

Check for beneficiary's MSP records in CWF for each service

MSP VC or **Primary Payer code** for each MSP provision as well as insurance details

Collect MSP information from beneficiary (MSP screening process) for every IP admission or OP encounter, with some exceptions

Use CMS' model questionnaire at CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1 or own compliant form

Collect additional information for billing purposes

For more information on identifying primary payers, refer to Identify the Proper Order of Payers for a Beneficiary's Services

MSP VCs and Primary Payer Codes

VC	Payer Code	MSP Provision/Medicare Exclusion
12	A	Working aged, age 65 and over, EGHP, 20 or more employees
13	B	ESRD with EGHP in 30-month coordination period
14	D or T	No-Fault (auto/other types including medical-payment) or Set-Aside
15	E or W	Workers' Compensation or Set-Aside
16	F	Public Health Services
41	H	Federal Black Lung Program
43	G	Disabled, under age 65, LGHP, 100 or more employees
47	L or S	Liability Insurance or Set-Aside

Determine Proper Order of Payers

- Determine which plan is primary, secondary or tertiary payer
  - Use collected MSP information and your knowledge of MSP provisions
    - In general, Medicare primary when beneficiary
      - Has no other insurance or coverage
      - Has insurance or coverage that does not meet MSP provision criteria
      - Had insurance or coverage, met MSP provision criteria, but no longer available
    - In general, other payer(s) primary when beneficiary
      - Has insurance or coverage that meets MSP provision criteria and available

Submit Claims According to Your Decision

- Medicare primary
  - Submit claim to Medicare first
- Another payer primary
  - Submit claim to that payer first and Medicare second if required
    - May submit conditional claim to Medicare if primary payer doesn't pay for valid reason or doesn't pay promptly (within 120 days; accidents only)
- More than one other payer primary
  - Submit claims to those payers first, in appropriate order, and Medicare third (tertiary)

Prepare and Submit MSP Claims

Prepare and Submit MSP Claims – Six Steps

1. Determine if you must submit MSP claim
2. Prepare MSP claim (MSP Billing Code Table)
3. Check for matching MSP record in CWF
4. Submit MSP claim
5. Check if MSP claim processed
6. Return or resubmit corrected claim, as applicable

Step One – Determine if You Must Submit MSP Claim

- Upon receipt of primary payer's RA (835)
  - Apply payment to beneficiary's account
  - Determine if primary payer paid in part or in full
    - If they paid in part, submit MSP claim so we can consider balance
    - If they paid in full, submit MSP claim if required

Did Primary Payer Pay in Part or in Full?

- Do you have contract with primary payer or obligation under law requiring you to accept certain amount from them as full payment for claim?
  - Certain amount = expected amount or obligated to accept as payment in full (OTAF) amount
    - If no, you expected primary payer to pay Medicare covered charges
      - If they paid less than Medicare covered charges, they paid in part
      - If they paid equal to or greater than Medicare covered charges, they paid in full
    - If yes, you expected primary payer to pay OTAF amount
      - If they paid less than OTAF amount, they paid in part
      - If they paid equal to or greater than OTAF amount, they paid in full
      - If they paid equal to or greater than Medicare covered charges, they paid in full

When to Submit an MSP Claim

- You **are required** to submit MSP claim if
  - Primary payer paid in part
    - Payment greater than zero but less than Medicare covered charges or OTAF amount **and**
    - Services are IP or OP
  - Primary payer paid in full
    - Payment = Medicare covered charges or OTAF amount **and**
    - Services are IP **or**
    - Services are OP and beneficiary has not met annual Medicare Part B deductible
- You **are not required** to submit MSP claim if
  - Primary payer paid in full
    - Payment = Medicare covered charges or OTAF amount **and**
    - Services are OP and beneficiary has met annual Medicare Part B deductible

Why Medicare Needs MSP Claims

Claim Balances

We consider balance remaining after primary payer's payment

Satisfy Medicare Deductible and/or Coinsurance

We apply primary payer's payment toward beneficiary's Medicare responsibility

Claim Tracking

We track types of services rendered

Benefit Periods

We track benefit periods for inpatient facility services (hospitals and SNFs)

Step Two – Prepare MSP Claim

- Complete claim in usual manner
  - Move primary payer to first payer and Medicare to second payer (or to third if we are tertiary)
- Follow Medicare's usual requirements
  - Technical, medical and billing
- Report on claim
  - Applicable MSP billing codes from MSP Billing Code Table
  - Primary payer's adjustment reasons and amounts (MSP CAS information) from primary payer's RA (CAGS/CARCs)

Complete Claim in Usual Manner

Covered TOB

Report covered TOB; do not code as noncovered (xx0)

All Claim Coding Usually Required

Report all coding as you usually would if Medicare primary

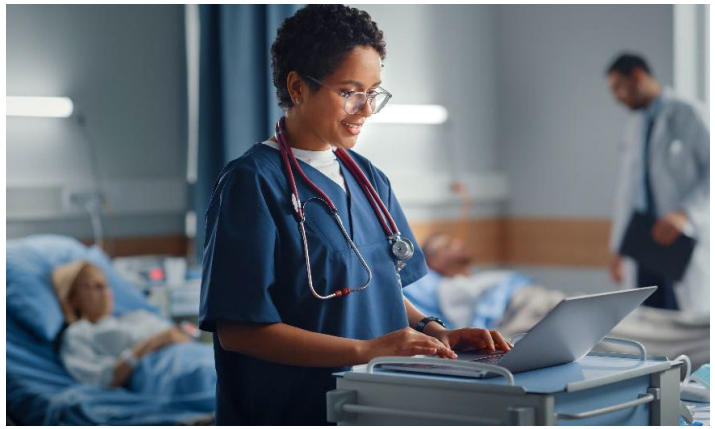
Total Covered and Noncovered Days as Usual

Report covered and noncovered days as you usually would if Medicare primary; do not report days paid by primary payer as noncovered

Total Covered and Noncovered Charges as Usual

Report covered and noncovered charges as you usually would if Medicare primary; do not report charges paid by primary payer as noncovered and do not just balance bill

Follow Medicare's Usual Requirements

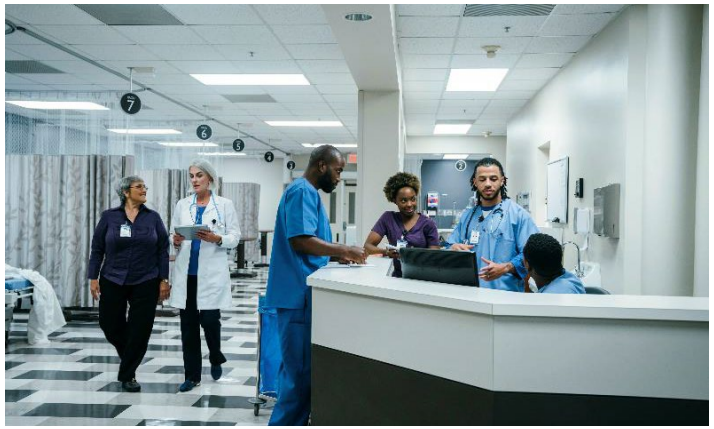


Technical

Example: One-year timely filing

Medical

Examples: Assessments/other clinical requirements



Billing

Example: 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 secondary

Report on Claim Primary Payer Adjustment Reasons and Amounts

- Report CAGC/CARC pairs and amounts from primary payer's RA
  - X12.org External Code lists
    - 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 on Claim Primary Payer Adjustment Reasons and Amounts – continued

- To report MSP CAS information
  - For 837I claims, report in appropriate loops/segments
    - Our claims processing system maps CAS coding to MAP1719
      - If we RTP claim, review claim coding in FISS DDE, correct and return
      - If we reject claim, follow reason code narrative (adjust or resubmit)
  - For FISS DDE claims, report in MAP1719
  - For hardcopy UB-04/CMS-1450 claims, attach RA
    - Our claims department enters RA coding into FISS DDE

Step Three – Check for Matching MSP Record in CWF

- Check for matching MSP record in CWF
  - Use provider self-service tools in Step 1 of *"Identify the Proper Order of Payers for Beneficiary's Services"*
    - Matching = MSP record information and MSP claim information matches

Step Four – Submit MSP Claim

- Submit MSP claim even if no matching MSP record in CWF and maintain documentation; do not contact BCRC
  - To submit, use available options
    - 837I claim
    - FISS DDE claim entry
    - 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 department with primary payer's RA and EOB statement
      - Visit our website > Resources > Contact Us > Mailing Addresses > Claims

Processing of MSP Claims

- If **matching MSP record** in CWF
  - We process claim unless reason why we cannot
- If **no matching MSP record** in CWF
  - We send MSP information on claim to BCRC by
    - Adding MSP record (“I” validity) or
    - Submitting Electronic Correspondence Referral System (ECRS) transaction
  - We also
    - Process claim if possible
    - May suspend claim up to 45 days while we wait to hear from BCRC
    - RTP claim depending on BCRC’s response
    - Reject claim for reasons related or not related to MSP record/BCRC

Step Five – Check if MSP Claim Processed

- Once you submit MSP claim, check FISS to determine if claim processed
  - If yes, apply any MSP payment and Medicare adjustments to beneficiary's account
  - If no, move to Step Six

Step Six – Return or Resubmit Corrected Claim as Applicable

- If MSP claim suspended
  - Wait for us to process claim; we may be waiting on BCRC's response
- If MSP claim RTP or rejected
  - Correct and return claim in FISS DDE or resubmit new correct claim
    - Follow reason codes provided

Claim Fields and MSP Claim Codes

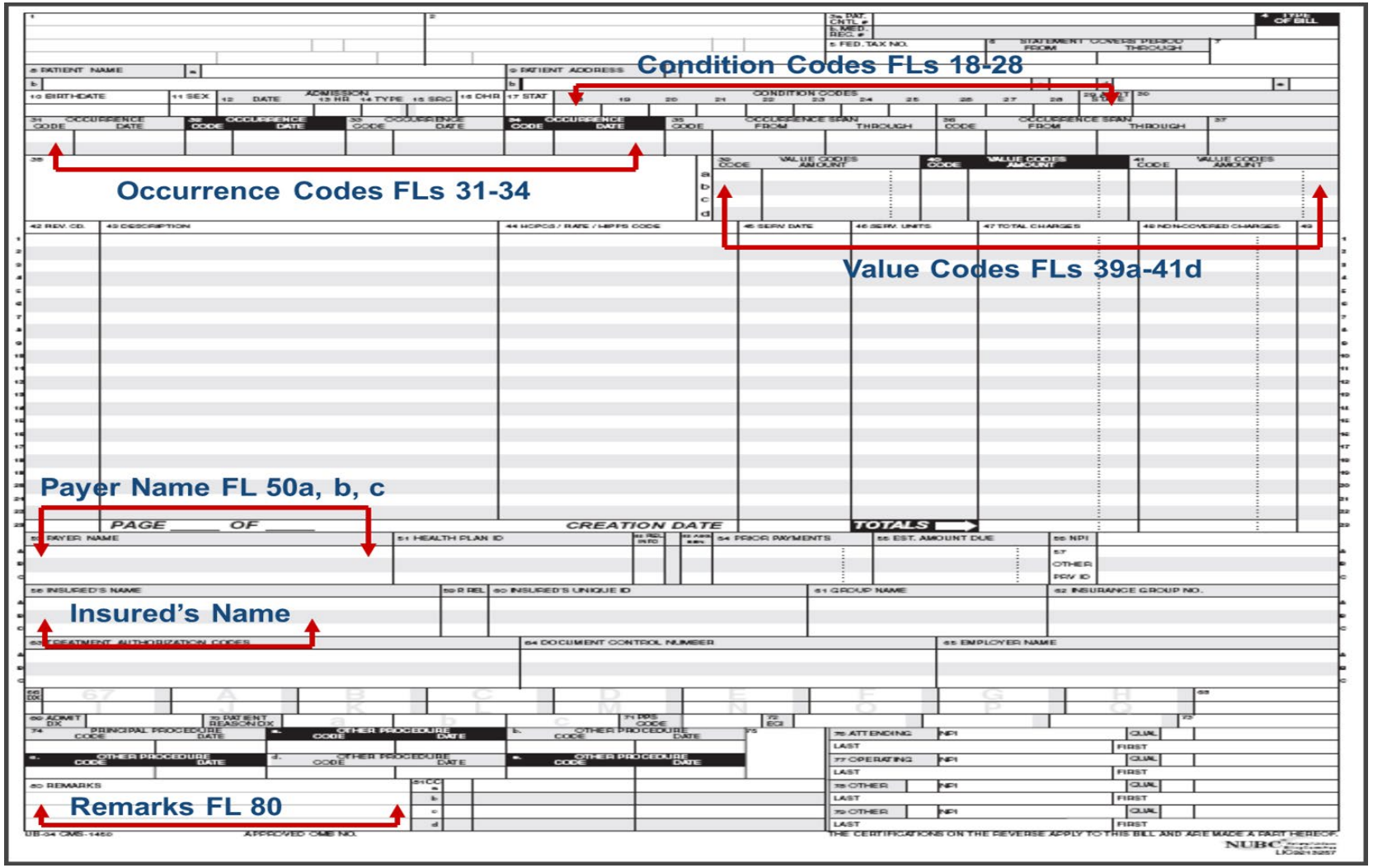
MSP Billing Code Table (Claim Fields)

Claim Codes	UB-04/CMS-1450 FLs	837I Fields	FISS DDE Page
CCs (or COND CDS)	18-28	2300.HI (BG)	01
OCs and dates (or OCC CDS/DATES)	31-34	2300.HI (BH)	01
VCs and amounts	39-41	2300.HI (BE)	01
Primary payer code (Payer code ID)	N/A	N/A	03
Primary insurer name	50A	2320.SBR04	03

MSP Billing Code Table (Claim Fields) – continued

Claim Codes	UB-04/CMS-1450 FLs	837I Fields	FISS DDE Page
Insured's Name	58A	2330A.NM104	05
Patient's Relationship to Insured	59A	2320.SBR02	05
Insured's Unique ID	60A	2330A.NM109	05
Insurance Group Name	61A	2320.SBR04	05
Insurance Group Number	62A	2320.SBR03	05
Insurance Address	80	2300.NTE	06

UB-04/CMS-1450 Claim Form



CCs or COND CDS

- Report on claim applicable MSP CCs
  - 02 (zero two) = Condition is employment-related
  - 06 (zero six) = ESRD beneficiary in first 30 months of entitlement with EGHP
  - 77 = Full payment received from primary payer

Contract or Obligation Under Law

- CC 77 or VC 44
  - Report CC 77 on claim when you
    - Have contract with primary payer to accept certain amount as full payment **or**
    - Are obligated under law to accept certain amount as full payment **and**
    - Received that amount (certain amount = OTAF amount)
  - Example:
    - Medicare covered charges = $5,000
    - You have contract with primary payer to receive $4,000 as full payment
    - You received $4,000
  - Do not report CC 77 on claim when you
    - Receive less than OTAF amount
      - Report VC 44 and OTAF amount instead

Condition Code 77

- You may report CC 77 when
  - You do not have contract with primary payer to receive a certain amount as full payment or are not obligated to accept a certain amount as full payment
  - You received amount equal to or greater than Medicare covered charges
- Example
  - Medicare covered charges = $5,000
  - You do not have contract with primary payer
  - You received $5,000 or more

OCs and Dates (OCs or OCC CDS/DATE)

- Report on claim any applicable MSP OCs
  - 01 and DOA if med-pay 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

VCs and Amounts

- Report on claim
  - MSP VC and amount received from primary payer toward Medicare covered charges
    - MSP VCs = 12, 13, 14, 15, 16, 41, 43 or 47
    - If primary payer reduced payment because of failure to file proper claim but paid greater than zero, you may submit MSP claim with MSP VC amount = amount you would have received from them if proper claim was filed
      - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5
  - VC 44 and OTAF amount, when applicable

VC 44 and Amount

- Report on claim VC 44 and OTAF amount when
  - Primary payer's payment less than OTAF amount
    - You are billing us for OTAF amount – received amount; do not bill beneficiary for this amount
- Do not report on claim VC 44 and OTAF amount when
  - Primary payer's payment equal to or greater than Medicare covered charges
    - Even if primary payer's payment less than OTAF amount

VC 44 and Amount – Scenarios

- In below scenarios, there is a contract
  - Scenario 1
    - Medicare covered charges = $5,000; OTAF amount = $3,500
    - Primary payer paid = $3,000 after applying deductible = $500
    - Report on claim **MSP VC with $3,000 and VC 44 with $3,500**
  - Scenario 2
    - Medicare covered charges = $100; OTAF amount = $75
    - Primary payer paid = $50 after applying copayment = $25
    - Report on claim **MSP VC with $50 and VC 44 with $75**
  - Scenario 3
    - Medicare covered charges = $2,000; OTAF amount = $1,000
    - Primary payer paid = $500 due to maximum benefit reached
    - Report on claim **MSP VC with $500 and VC 44 with $1,000**

Primary Payer Code (Payer Code ID)

- Report primary payer code for first three payers
- First three payers labeled A, B and C
  - MSP claims, report
    - For Payer A = A, B, D, E, F, G, H, L, S, T or W
    - For Payer B = Z
  - Medicare tertiary claims, report
    - For Payer A = A, B, D, E, F, G, H, L, S, T or W
    - For Payer B = A, B, D, E, F, G, H, L, S, T or W
    - For Payer C = Z

Primary Insurer Name

- Report complete/full name of primary insurer
  - Name must match MSP record
  - Name must not be vague such as no-fault
    - For MSP claims, report Medicare in FL 50B or equivalent field
    - For Medicare tertiary claims, report Medicare in FL 50C or equivalent field

Insured's Name

- Report name of person who carries insurance
  - MSP claims
    - Report beneficiary's name in FL 58B or equivalent field
  - Medicare tertiary claims
    - Report beneficiary's name in FL 58C or equivalent field

Patient's Relationship to Insured

- Report code for relationship of patient to insured
  - 01 = Spouse
  - 18 = Self
  - 19 = Child
  - 20 = Employee
  - 21 = Unknown,
  - 53 = Life partner
  - G8 = Other relationship
- MSP claims: Report 18 in FL 59B or equivalent field
- Medicare tertiary claims: Report 18 in FL 59C or equivalent field

Insured's Unique ID

- Report beneficiary's ID with primary insurer
  - MSP claims
    - Report beneficiary's MBI in FL 60B or equivalent field
  - Medicare tertiary claims
    - Report beneficiary's MBI in FL 60C or equivalent field

Enter and Submit MSP Claims in FISS DDE

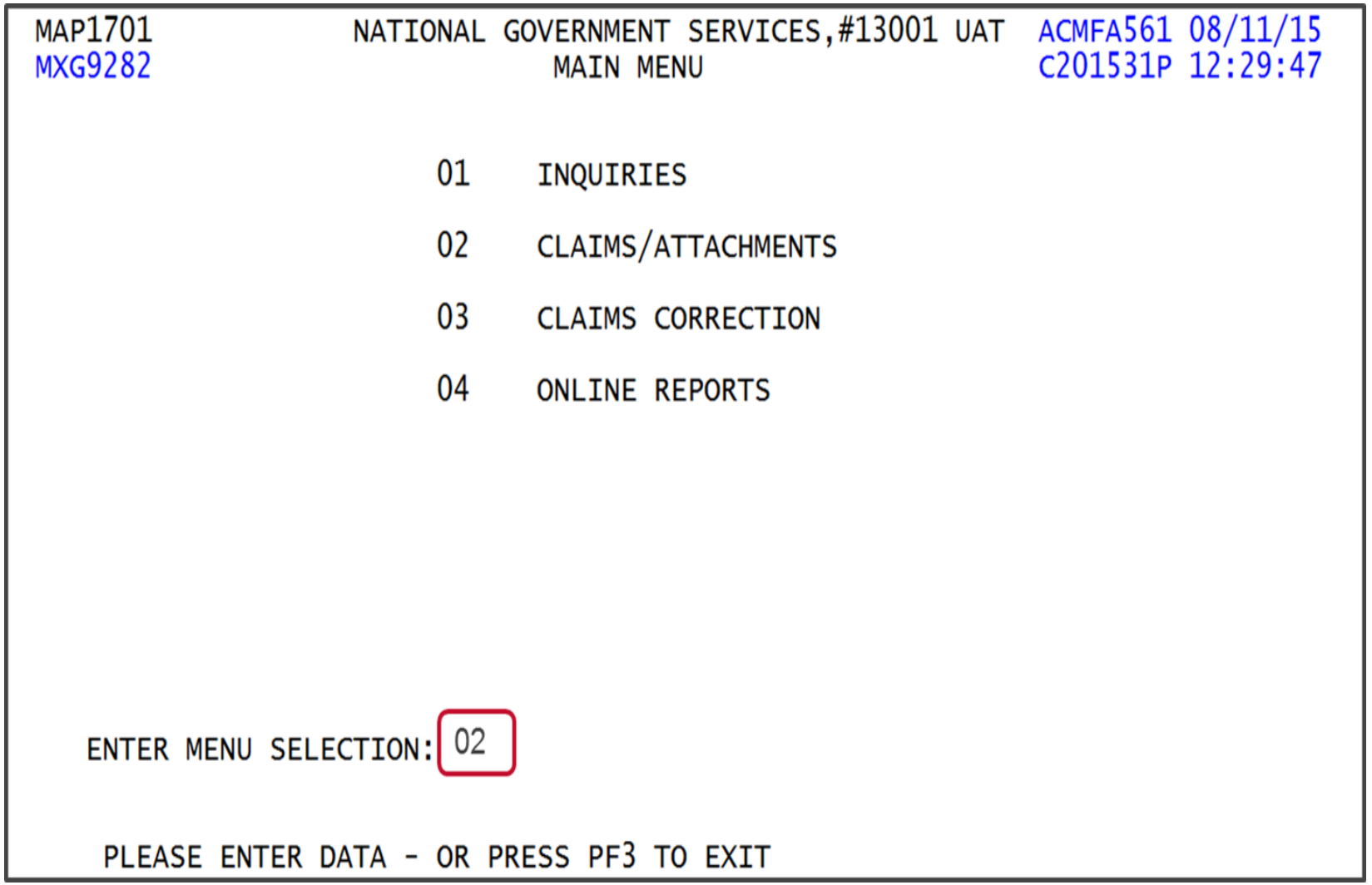
FISS DDE

- MACs use to process claims and maintain records
- Allows remote user connectivity to Medicare mainframe
- Providers access through online computer system
- Requires logon ID and password (do not share)
  - EDI enrollment information
- Providers can use to
  - Research claim coding
  - Submit, track, correct, adjust and cancel claims
  - View reports
- *FISS DDE Provider Online Guide*
  - Chapter V (Claims/Attachments Submenu 02) for Claim Data Entry

FISS DDE – Entering Claims

- From main menu, select Claims/Attachments
  - On MAP1701, enter menu selection: 02
  - From MAP1703, enter menu selection from choices below
    - IP = 20
    - OP = 22
    - SNF = 24
    - Home Health = 26
    - Hospice = 28

FISS DDE Main Menu – Claims/Attachments (Submenu 02)



FISS DDE Claims and Attachments Entry Menu – Claims

```
MAP1703          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 06/12/18
MXG9282           CLAIM AND ATTACHMENTS ENTRY MENU         C201831F 14:56:54

                          CLAIMS ENTRY

                    INPATIENT                20
                    OUTPATIENT               22
                    SNF                      24
                    HOME HEALTH              26
                    HOSPICE                  28
                    NOE/NOA                  49
                    ROSTER BILL ENTRY        87

                        ATTACHMENT ENTRY

                    HOME HEALTH              41
                    DME HISTORY              54
                    ESRD  CMS-382 FORM       57

  ENTER MENU SELECTION:
```

FISS DDE Navigation

Program Function Key	Screen Movement	Program Function Key	Screen Movement
F3/PF3	Return to menu/submenu or originating screen when using SC field	F10/PF10	Return to left viewing screen
F4/PF4	Exit entire online system by terminating session	F11/PF11	Move to right viewing screen
F5/PF5	Scroll backward within page of screen data	<Control>	Move down one line at a time
F6/PF6	Scroll forward within page of screen data	<Home>	Move to SC field
F7/PF7	Move backward one page at a time	<Tab>	Move to next field on screen
F8/PF8	Move forward one page at a time	SC Field	Navigate to specific inquiry file, F3/PF3 to return to original page
F9/PF9	Save, update, submit	Page Field	Move to specific page within claim

FISS DDE Claim Entry – Key Points

- Six pages to claim
  - Set up like UB-04/CMS-1450
- Enter all required data
  - Not just MSP data
  - Cursor skips fields not required
- TOB defaults
  - 111 for IP, 131 for OP, 211 for SNF
    - Type over default for different TOB

FISS DDE Pages for Claim Entry and UB-04/CMS-1450 Claim FLs – Six Pages

Page	MAP	UB-04/CMS-1450 Claim FLs
01	MAP1711	FLs 1-41: Patient information, CCs, OCs, OSCs, VCs
02	MAP1712	FLs 42-49: Revenue and CPT/HCPCS codes, charges and DOS
03	MAP1713	FLs 50-57 & 66-79: Payer, diagnosis code, procedure code and physician information
03	MAP1719	Payment information from primary payer's RA
04	MAP1714	FL 80: Remarks
05	MAP1715	FL 58-62: Insured and insurance information
06	MAP1716	Primary insurer's address

Page 01 – MAP1711

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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.

Page 02 – MAP1712

```
MAP1712    PAGE 02   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 03/21/19
MXG9282    SC                  INST CLAIM ENTRY                  A20192BF 12:44:48
                                                        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
```

Page 03 – MAP1713

```
MAP1713   PAGE 03   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
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
```

Page 03 (Additional) – MAP1719

- To access MAP1719 from MAP1713, press F11/PF11
- Enter MSP CAS information from primary payer's RA
  - Two pages (for up to two payers); up to 20 entries on each page
    - On first page (primary payer "1"), enter data and press F6/PF6
    - On second page (primary payer "2"), enter data
      - Paid date: Paid date of RA
      - Paid amount: Amount you received from primary payer
        - Must = MSP VC amount AND Medicare covered charges – CAGC/CARC amount(s)
      - GRP: CAGC(s)
      - CARC: CARC(s)
      - AMT: Dollar amount with each CAGC/CARC pair

Page 03 (Additional) – MAP1719

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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 1   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
```

Tip: Any dollar amounts listed in this section, when added together, must equal total charges.

Page 03 (Additional) – MAP1719

```
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
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
```

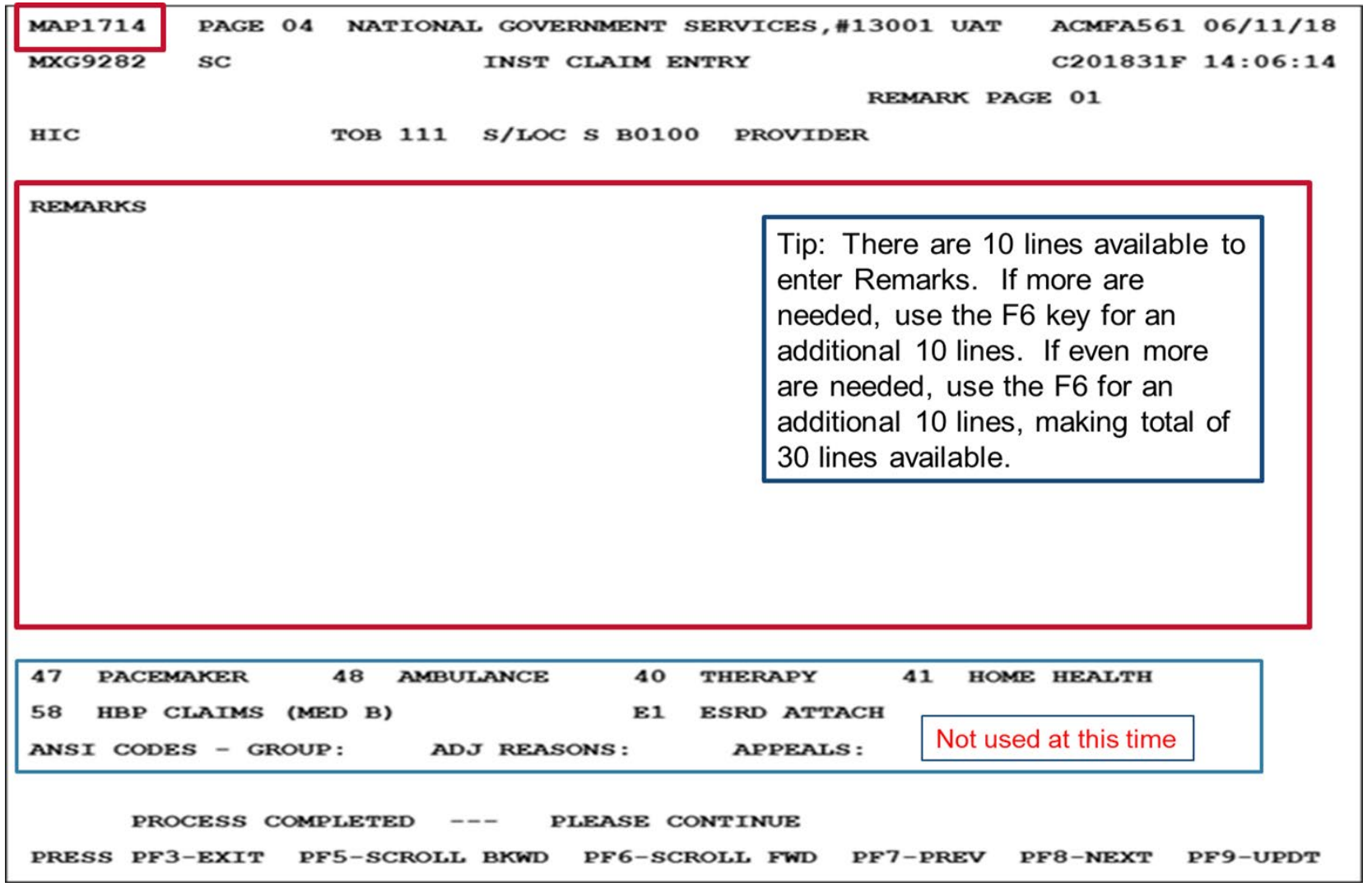
Example One With Claim Coding

- Beneficiary
  - Working aged with EGHP, IP SNF 3/1/2024–3/25/2024 (requirements met)
- Provider
  - Medicare covered charges = $10,000, billed EGHP as primary (contract)
- EGHP
  - Allowed = $8,000, coinsurance = $800, paid = $7,200 on 5/15/2024
- CAGC/CARC claim coding
  - Page 01 (MAP1711)
    - **MSP VC 12 = $7,200 and VC 44 = $8,000**
  - Page 03 (MAP1719)
    - **Paid date: 051524**
    - **Paid amount: $7,200**
    - **CAGCs/CARCs and amounts: CO45 = $2,000 and PR2 = $800**

Example Two With Claim Coding

- Beneficiary
  - Disabled with LGHP (termed 3/1/2023), IP hospital 1/15/2024–4/7/2024
- Provider
  - Medicare covered charges = $80,000 ($50,000 for 1/14–2/29 and $30,000 for 3/1–4/7), billed LGHP as primary (contract)
- LGHP
  - Allowed $40,000 for 1/14–2/29 ($1,000 deductible, paid $39,000 on 5/10/204), no payment for 3/1–4/7
- CARC/CARC claim coding
  - Page 01 (MAP1711)
    - **MSP VC 43 = $39,000 and VC 44 = $70,000**
  - Page 03 (MAP1719)
    - **Paid date: 051024**
    - **Paid amount: $39,000**
    - **CAGCs/CARCs and amounts: CO45 = $10,000, PR1 = $1,000 and PR 27 = $30,000**

Page 04 – MAP1714



Page 05 – MAP1715

```
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
```

Page 06 – MAP1716

```
MAP1716   PAGE 06  NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 06/30/20
MXG9282   SC                INST CLAIM ENTRY                 A20203BF 09:08:22

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
```

What You Should Do Now

- Be familiar with MSP references
- 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 webinars and other MSP-related educational events

MSP References

MSP References – CMS

- 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 References – CMS

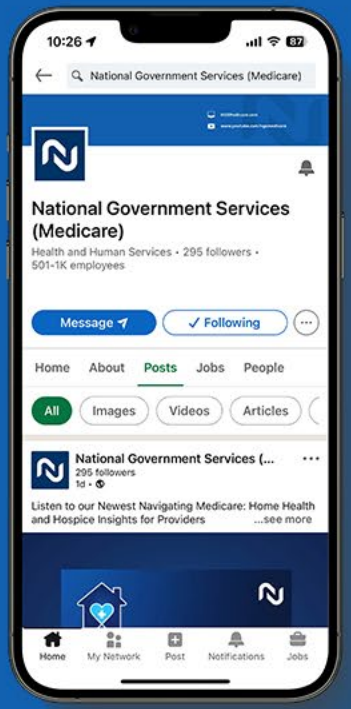
- *Medicare and Other Health Benefits: Your Guide to Who Pays First*
- MLN® Fact Sheet: *Medicare Secondary Payer: Don't Deny Services & Bill Correctly*
- MLN® Booklet: *Medicare Secondary Payer (MSP)*
- MSP web pages
- Coordination of Benefits & Recovery Overview web pages
- CR6426: *Instructions on Utilizing 837 Institutional CAS Segments for Medicare Secondary Payer (MSP) Part A Claims*
- CR8486: *Instructions on Using the Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A CMS-1450 Paper Claims, Direct Data Entry (DDE), and 837 Institutional Claims Transactions*

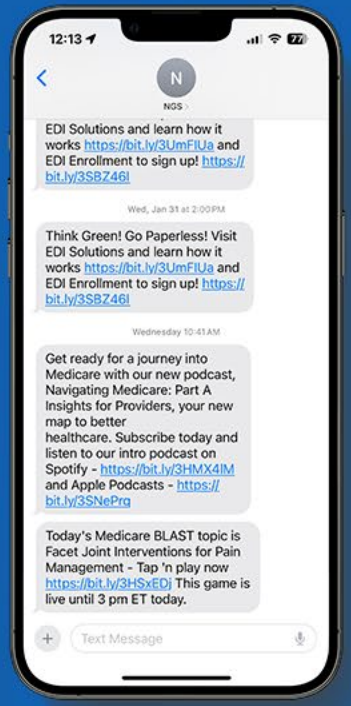
MSP References – NGS

- Articles on our website
  - *"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"*
- *FISS DDE Provider Online Guide*

Questions?

Thank you!





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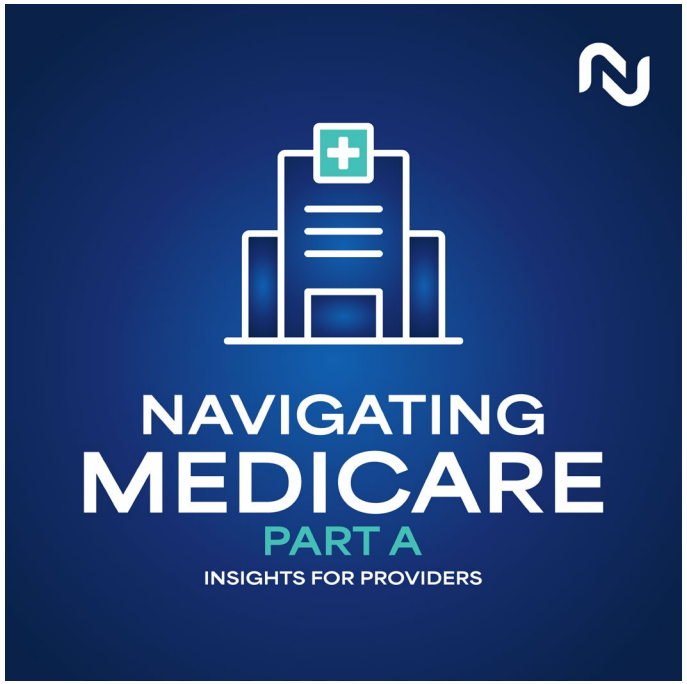

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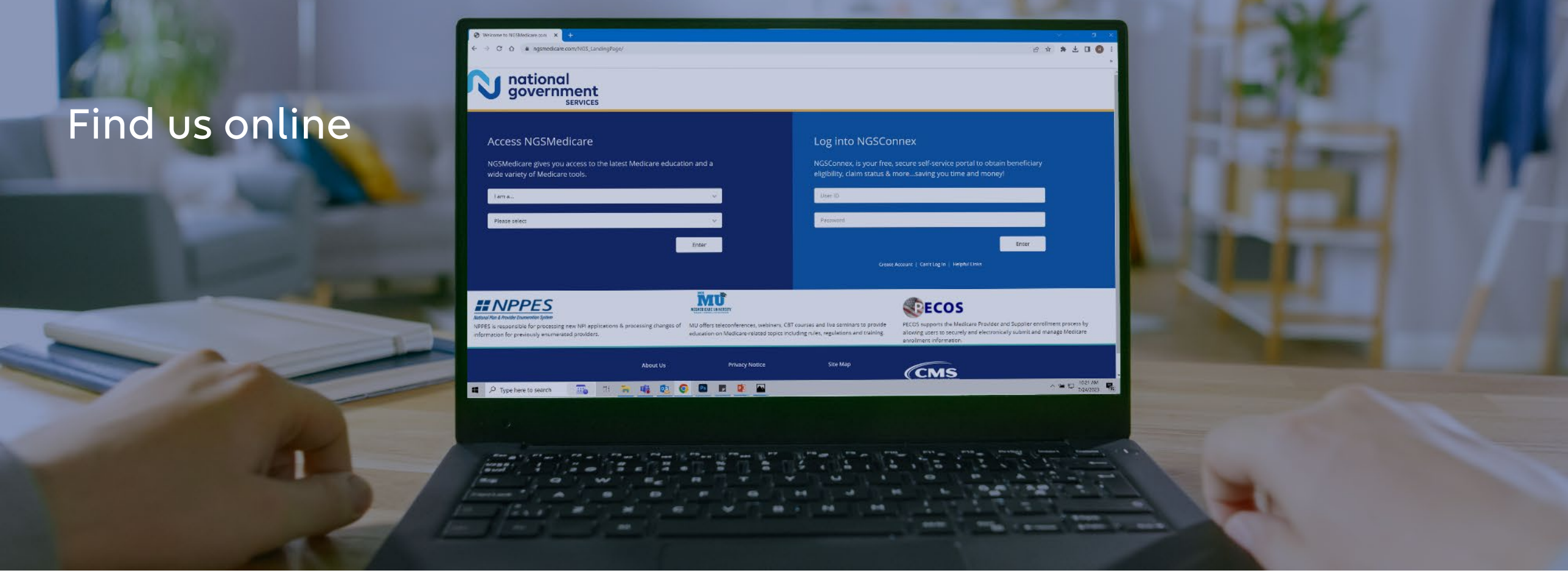

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