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Medicare Secondary Payer: Preparing and Submitting Claims – Part 1

1/29/2025

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

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

Today's Presenters

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

Agenda

MSP and Your MSP Responsibilities

Preparing and Submitting MSP Claims

Submitting MSP Claims in FISS DDE

Test Your Knowledge

Resources

Questions

MSP and Your MSP Responsibilities

What Is MSP?

- Beneficiary has coverage primary to Medicare
- Based on federal laws known as **MSP provisions**
  - Help determine proper order of payers
  - Make certain payers primary to Medicare
- Each has criteria/conditions that must be met
  - If all met, services subject to that provision making other insurer primary and Medicare secondary
  - If one or more not met, services not subject to that provision; Medicare primary unless criteria/conditions of another MSP provision met

Your MSP Responsibilities Per Medicare Provider Agreement

Determine if Medicare Primary Payer

Identify payers primary to Medicare

Submit Claims to Primary Payers Before Medicare

May be more than one primary payer to Medicare

Submit MSP Claims to Us When Required

Follow claim submission guidelines

How to Identify Payers Primary to Medicare

- Conduct MSP screening process
  - Check for MSP information in Medicare's records
    - Providers must check for MSP records for beneficiary in CWF
      - For each service rendered
  - Collect MSP information from beneficiary/representative
    - Providers may need to ask questions about other insurance
      - For every IP admission or OP encounter, with some exceptions

MSP Screening Process – Check for MSP Records in CWF

- Use provider self-service tools
  - Identify the Proper Order of Payers for a Beneficiary's Services
- If MSP record(s) present, information includes:
  - **MSP VC** and primary **payer code** for each MSP provision
    - See next slide – Use MSP VC to report primary payer's payment on MSP claim
  - MSP effective date
  - MSP termination date, if applicable
  - Subscriber's name
  - Policy number
  - Patient's relationship to insured
  - Insurer's information

MSP Provisions, Value Codes and Primary Payer Codes

MSP Provision	Value Code	Payer Code
Working aged, 65 and over, working/spouse working with EGHP, 20 or more employees	12	A
ESRD with EGHP, current/former employer, in 30-month coordination period	13	B
No-Fault (automobile/other types including medical-payment) or No-Fault Set Aside	14	D or T
WC or WC Set Aside	15	E or W
Public Health Services	16	F
Federal Black Lung Program	41	H
Disabled, under 65, working/family member working with LGHP, 100 or more employees	43	G
Liability Insurance or Liability Set Aside	47	L or S

MSP Screening Process – Collect MSP Information from Beneficiary/Representative

- Ask questions about other insurance using one of following:
  - **CMS' model MSP questionnaire**
    - Three parts with questions to be asked 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 Medicare entitlement, if applicable (including dual entitlement)
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
  - Your own compliant form – Same content and intent as CMS' model

Collect Additional Information for Billing

- Collect additional information if applicable
  - Veterans who want to use VA coverage instead of Medicare
  - Beneficiaries receiving services covered by Government Research Grant
  - Retirement dates of beneficiary and/or spouse/family member
    - Report such dates on your claims using OC 18 for beneficiary's and OC 19 for spouse's retirement date; we send such dates to BCRC and process claim(s)
    - Policy when beneficiary/spouse cannot recall retirement date:
      - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.1, #4

Determine Proper Order of Payers

- Determine primary, secondary, tertiary, etc. 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 – does not meet MSP provision criteria requirements
      - Had insurance or coverage – meets MSP provision criteria requirements, but no longer available
    - In general, other payer(s) primary when beneficiary
      - Has insurance or coverage – meets MSP provision criteria requirements and available

Submitting Claims

If Medicare primary

Submit Medicare primary claim; indicate on claim reason Medicare primary

If another payer primary

Submit claim to that payer first and Medicare second, if required

May submit conditional claim to Medicare, if appropriate

If more than one payer primary

Submit claims to those payers in proper order and to Medicare tertiary

Preparing and Submitting MSP Claims

Prepare and Submit MSP Claims – Steps

- Prepare and Submit a Medicare Secondary Payer Claim
  - Background
  - Step 1: Determine if you must submit an MSP claim
  - Step 2: Prepare MSP claim (includes MSP Billing Code Table)
  - Step 3: Check for matching MSP record for beneficiary in CWF
  - Step 4: Submit MSP claim
  - Step 5: Keep checking for MSP claim to process
  - Step 6: Return or resubmit a corrected claim

Background

- Before submitting MSP claim, you must have
  - Conducted MSP screening process
  - Collected additional information for billing purposes
  - Determined primary payer(s) based on MSP provisions
  - Submitted claim(s) to that payer(s)
  - Conducted any necessary follow up with them
  - Received payment (more than zero)

Determine if You Must Submit an MSP Claim

- You must submit MSP claim if primary payer paid claim
  - In part (more than zero but less than full payment)
    - Primary payer paid less than Medicare-covered charges or less than amount you agreed to accept, per contract or obligation under law, as full payment of such charges
  - In full and claim for
    - Home health or hospice services
    - IP services
    - OP services and beneficiary not met annual Medicare Part B deductible
      - Primary payer paid Medicare-covered charges or amount you agreed to accept, per contract or obligation under law, as full payment of such charges

Why MSP Claims Required

Beneficiary's Medicare Responsibility

We credit primary payer's payment toward Medicare deductible and/or coinsurance

Claim Balance Remaining

We consider payment of claim balance to provider after primary payer's payment

Claim/Service Tracking

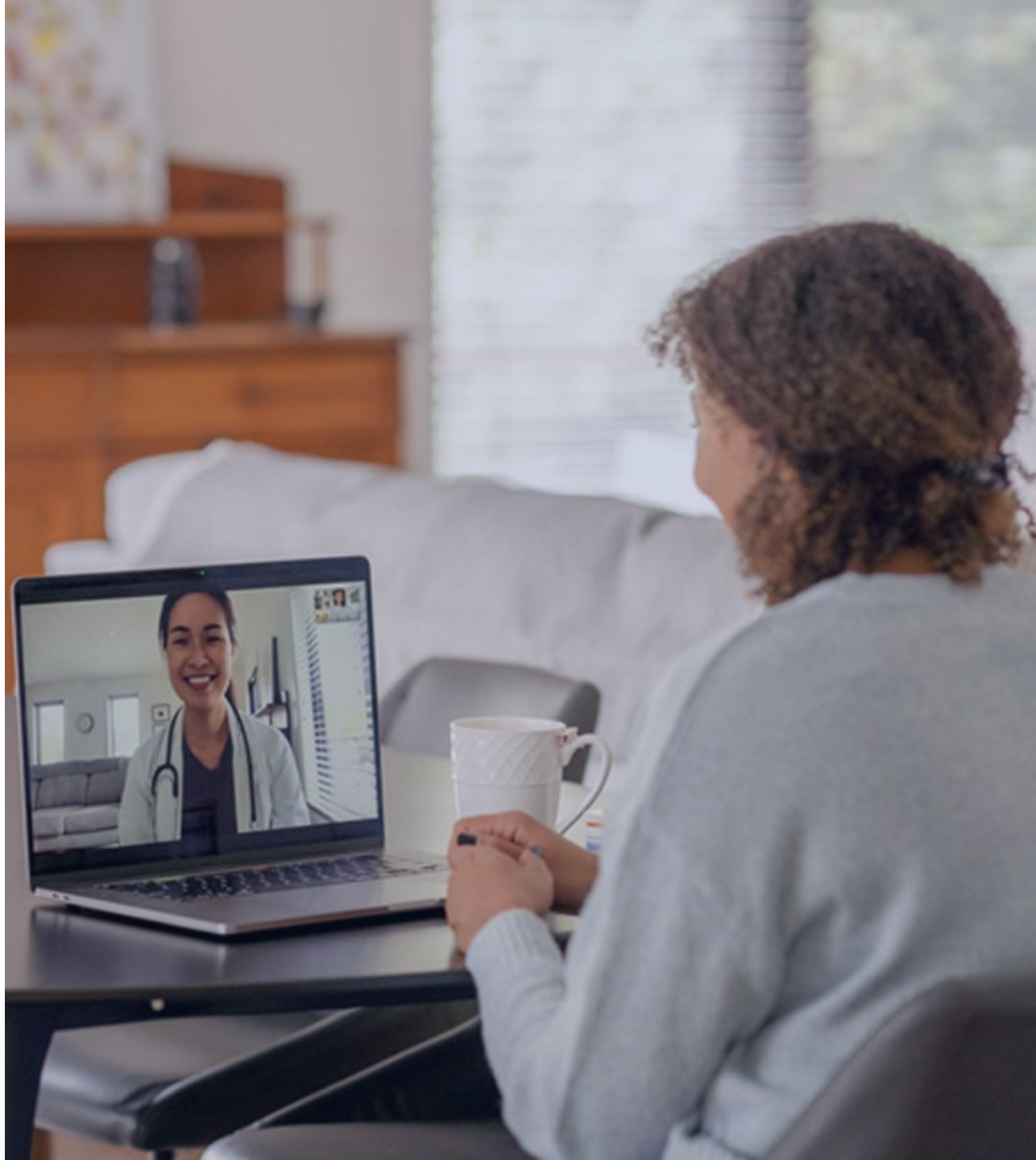
We track types of services rendered such as HHH services

Benefit Period Tracking

We track benefit period for IP services at hospitals and SNFs

Did You Know...

- You are not required to submit MSP claim if
  - Primary payer paid in full, and
  - Claim is for OP services (other than HHH), and
  - Beneficiary met annual Medicare Part B deductible



MSP Claim vs. Medicare Tertiary Claim

- If beneficiary has two primary payers, claim type you submit depends on whether they both paid
  - If both paid
    - Submit **Medicare tertiary claim** reporting both payers and payment information
  - If one paid but other did not for valid reason or within 120-day promptly period (accidents)
    - Submit **MSP claim** reporting payer that paid and their payment information
      - Do not report payer or payment information for payer that did not pay

Prepare MSP Claim – Complete Claim as Usual

TOB

Report covered TOB; not noncovered

Days/Charges

Report covered days/charges; not noncovered because another payer paid

Required Claim Coding

Report all Medicare-covered charges; not just balance remaining

Correct Order of Payers

Report primary payer first; Medicare second or third, as applicable

Prepare MSP Claim – Follow Medicare Requirements

- Technical
  - Example: One-year timely filing
- Medical
  - Example: Clinical and/or assessments
- Billing
  - Example: Frequency of billing for your provider type (admission-discharge, every 30 days, every 60 days, etc.)
    - **Hospice**: Submit NOE as Medicare primary.; report MSP information on claim(s)
    - **HH**: Submit NOA as Medicare as primary; report MSP information on claim(s)
  - Note: Do not “split bill” if Medicare secondary for portion of claim

Prepare MSP Claim – Use MSP Billing Code Table

- Prepare and Submit a Medicare Secondary Payer Claim
  - MSP Billing Code Table
    - Lists information for claim and three additional columns for claim submission options:
      - UB-04/CMS-1450 claim form FL (need ASCA waiver)
      - 837I claim fields (loops/segments)
      - FISS DDE Claim Entry page number
  - When billing, use current NUBC codes:
    - NUBC members access billing codes from NUBC's UB-04 Data Specifications Manual

MSP Billing Code Table

- Report applicable MSP billing codes:

Information	UB-04/CMS-1450 FLs	837I Fields	FISS DDE Page
CCs	18-28	2300.HI (BG)	01
OCs and Dates	31-34	2300.HI (BH)	01
VCs and Amount	39-41	2300.HI (BE)	01
Primary Payer Code ID	N/A	N/A	03
Primary Insurer Name	50 A, B, C	2320.SBR04	03

MSP Billing Code Table (continued)

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

CCs (COND Codes)

- Report when applicable:
  - **02** (zero two) = Employment-related condition
  - **06** (zero six) = ESRD beneficiary in first 30 months of Medicare entitlement with EGHP
  - **77** = Received full payment from primary payer

Contract or Obligation Under Law

- Report CC 77 **or** VC 44 and "obligated to accept as full" (OTAF) payment amount when
  - Required/obligated to accept certain amount as full payment from primary payer
    - Per contract as participating provider
    - Per obligation under law

CC 77

- Report when you
  - Have contract with primary payer/obligation under law to receive certain amount (OTAF or expected amount) as full payment and
  - Received that amount from primary payer
- Example:
  - Medicare-covered charges = $5,000
  - OTAF/expected = $4,000
  - Received = $4,000
- Report:
  - Medicare-covered charges = $5,000
  - MSP VC = $4,000
  - CC = 77

OCs (OCC CDS/DATE)

- Report when applicable:
  - **01** (zero 1) and DOA if medical-payment coverage primary
  - **02** (zero 2) and DOA if no-fault insurance primary
  - **03** (zero 3) and DOA if liability insurance primary
  - **04** (zero 4) and DOA if WC primary
  - **33** and date ESRD coordination period began

VC for MSP Provision and Amount

- Report MSP VC 12, 13, 14, 15, 16, 41, 43 or 47 and
  - Amount received from primary payer toward Medicare-covered charges if proper claim filed
  - Amount you would have received from primary payer toward Medicare-covered charges had proper claim been filed
    - When primary payer reduced payment because of failure to file proper claim but paid more than zero
      - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5

VC 44 and Amount

- Report when you
  - Have contract with primary payer/obligation under law to receive certain amount (OTAF or expected amount) as full payment **and**
  - Received less than that amount from primary payer
    - Note: You are billing us for (expected amount – received amount); do not bill beneficiary for this amount
- Do not report when
  - Primary payer's payment equal to or more than Medicare-covered charges
    - Even if primary payer's payment less than OTAF/expected amount

Scenarios – VC 44 and Amount

- In scenarios = Contract between provider and primary payer
  - Scenario 1
    - Medicare-covered charges = $5,000
    - Primary payer paid provider = $3,000 after applying deductible = $500
    - Provider expected (OTAF) = $3,500; reports MSP VC with $3,000 and VC 44 with $3,500
  - Scenario 2
    - Medicare-covered charges = $100
    - Primary payer paid provider = $50 after applying copayment = $25
    - Provider expected (OTAF) = $75; reports MSP VC with $50 and VC 44 with $75
  - Scenario 3
    - Medicare-covered charges = $2,000
    - Primary payer paid provider = $500 due to maximum benefit reached
    - Provider expected (OTAF) = $1,000; reports MSP VC with $500 and VC 44 with $1,000

Primary Payer Code (Payer Code ID)

- Report **code** for first three payers, if applicable
  - Payers labeled A, B and C
- For MSP claims, report
  - For Payer A = A, B, D, E, F, G, H, L, S or T
  - For Payer B = Z (Medicare)
- For Medicare tertiary claims, report
  - For Payer A = A, B, D, E, F, G, H, L, S or T
  - For Payer B = A, B, D, E, F, G, H, L, S or T
  - For Payer C = Z (Medicare)

Primary Insurer Name

- Report complete/full name in FL 50A or equivalent field
  - Must match name in MSP CWF record
  - 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 in FL 58A or equivalent field
- For MSP claims
  - Report beneficiary's name in FL 58B or equivalent field
- For Medicare tertiary claims
  - Report beneficiary's name in FL 58C or equivalent field

Patient's Relationship to Insured

- Report applicable **code** in FL 59A or equivalent field
  - **01** = Spouse
  - **18** = Self
  - **19** = Child
  - **20** = Employee
  - **21** = Unknown
  - **53** = Life partner
  - **G8** = Other relationship
- For MSP claims
  - Report 18 in FL 59B or equivalent field
- For Medicare tertiary claims
  - Report 18 in FL 59C or equivalent field

Insured's Unique ID

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

Prepare MSP Claim – Report Primary Payer Adjustment Reasons and Amounts

- Also known as CAS information; from primary payer's RA
- Required when primary payer adjusts billed charges
  - CAGC(s): Identifies general category of those payment adjustments
  - CARC(s): Explains why primary payer paid differently than billed
  - References: External code list, CR6426 and CR8486
- To report on claims:
  - For hardcopy UB-04/CMS-1450 claims, attach RA
  - For 837I claims, report in appropriate loops/segments
  - For FISS DDE claims, report in MAP1719

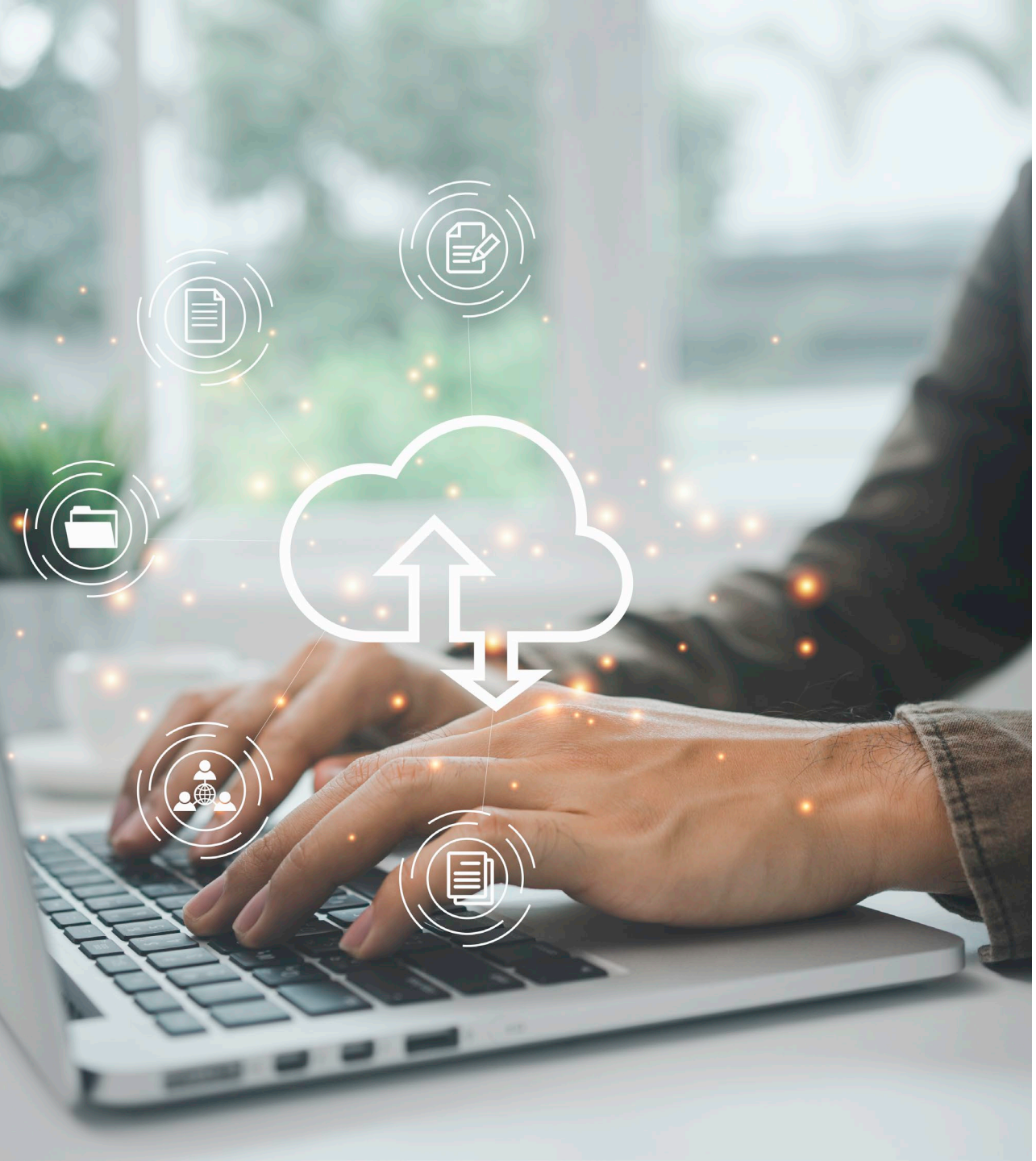
CAGCs and CARCs

- CAGC options:
  - CO = Contractual Obligations
  - OA = Other Adjustments
  - PI = Payer-initiated Reductions
  - PR = Patient Responsibility
- CARC options include but are not limited to:
  - 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 period or occurrence

Submitting MSP Claims in FISS DDE

FISS DDE

- We 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)

```
MAP1701          NATIONAL GOVERNMENT SERVICES,#13001 UAT   ACMFA561 08/11/15
MXG9282                      MAIN MENU                     C201531P 12:29:47

                        01    INQUIRIES

                        02    CLAIMS/ATTACHMENTS

                        03    CLAIMS CORRECTION

                        04    ONLINE REPORTS




    ENTER MENU SELECTION: 02

     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

FISS DDE Claims and Attachments Entry Menu – Claims Entry

```
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:


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

FISS DDE Navigation Keys

Program Function Key	Screen Movement
F3/PF3	Return to menu/submenu or originating screen when using SC field. Do not press while entering claims.
F4/PF4	Exit entire online system by terminating session
F5/PF5	Scroll backward within page of screen data
F6/PF6	Scroll forward within page of screen data
F7/PF7	Move backward one page at a time
F8/PF8	Move forward one page at a time
F9/PF9	Save, update, submit

FISS DDE Navigation Keys (continued)

Program Function Key	Screen Movement
F10/PF10	Return to left viewing screen
F11/PF11	Move to right viewing screen
<Control>	Move down one line at a time
<Home>	Move to SC field
<Tab>	Move to net field on screen
SC Field	Navigate to specific inquiry file, F3/PF3 to return to original page
Page Field	Move to specific page within claim

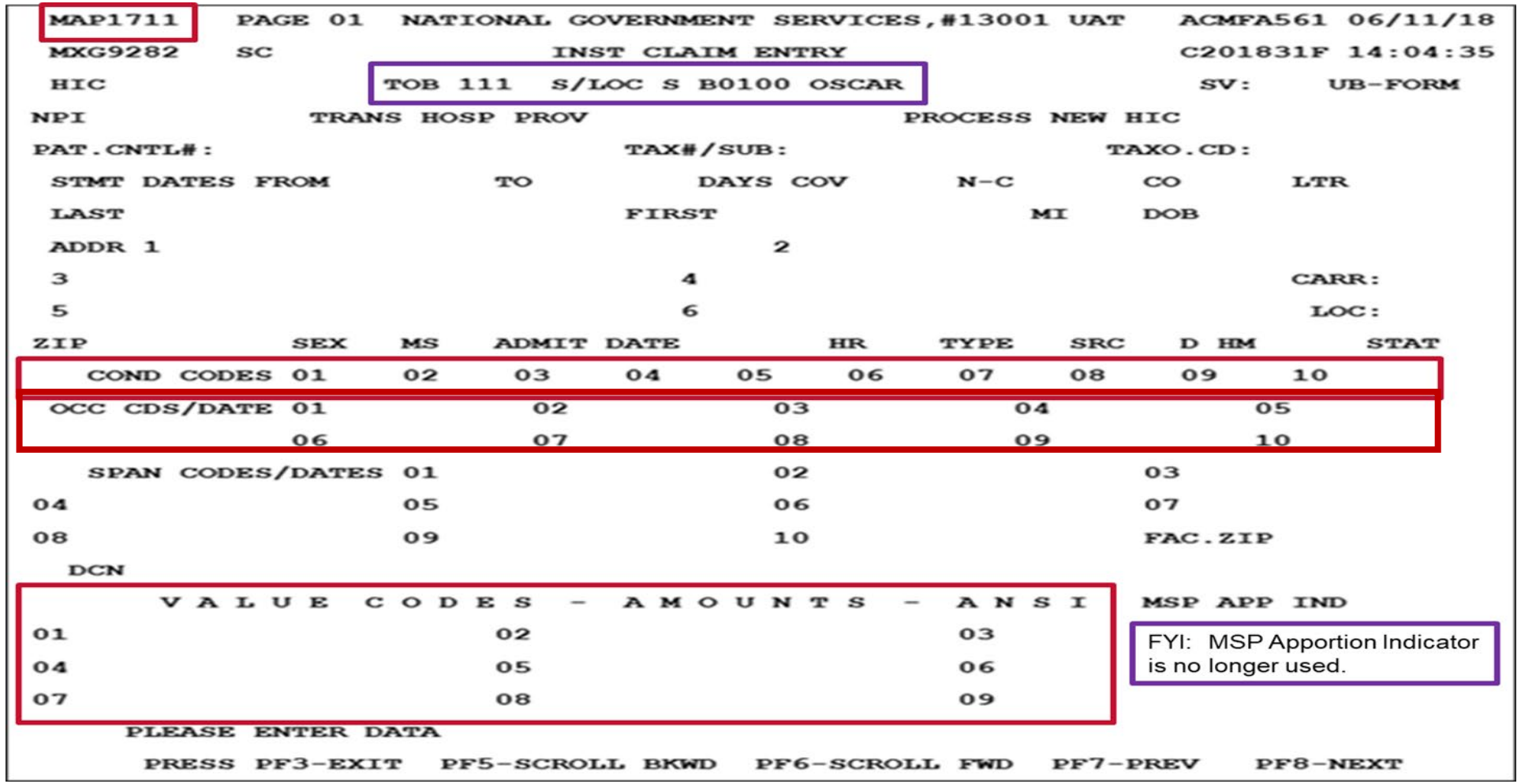
FISS DDE Claim Entry – Key Points

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

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

Page	MAP	UB-04/CMS-1450 FLs
01	MAP1711	FLs 1-41: Patient information, CCs, OCs, OSCs and VCs
02	MAP1712	FLs 42-49: Revenue and CPT/HCPCS codes, charges and DOS
03	MAP1713	FLs 50-57 & 66-79: Payer, diagnosis and procedure codes, 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



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 from MAP1713, press F11/PF11
- Enter MSP CAS information from primary payer's RA
- Two pages (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
    - **Paid amount:** Amount received from primary payer (Must = MSP VC amount and = charges – CAGC/CARC amounts)
    - **GRP:** CAGC(s)
    - **CARC:** CARC(s)
    - **AMT:** Dollar amount with each CAGC/CARC pair

Page 03 (Additional) – MAP1719 (continued)

```
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 (continued two)

```
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

       PROCESS COMPLETED   ---    PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF10-LFT PF11-RGHT
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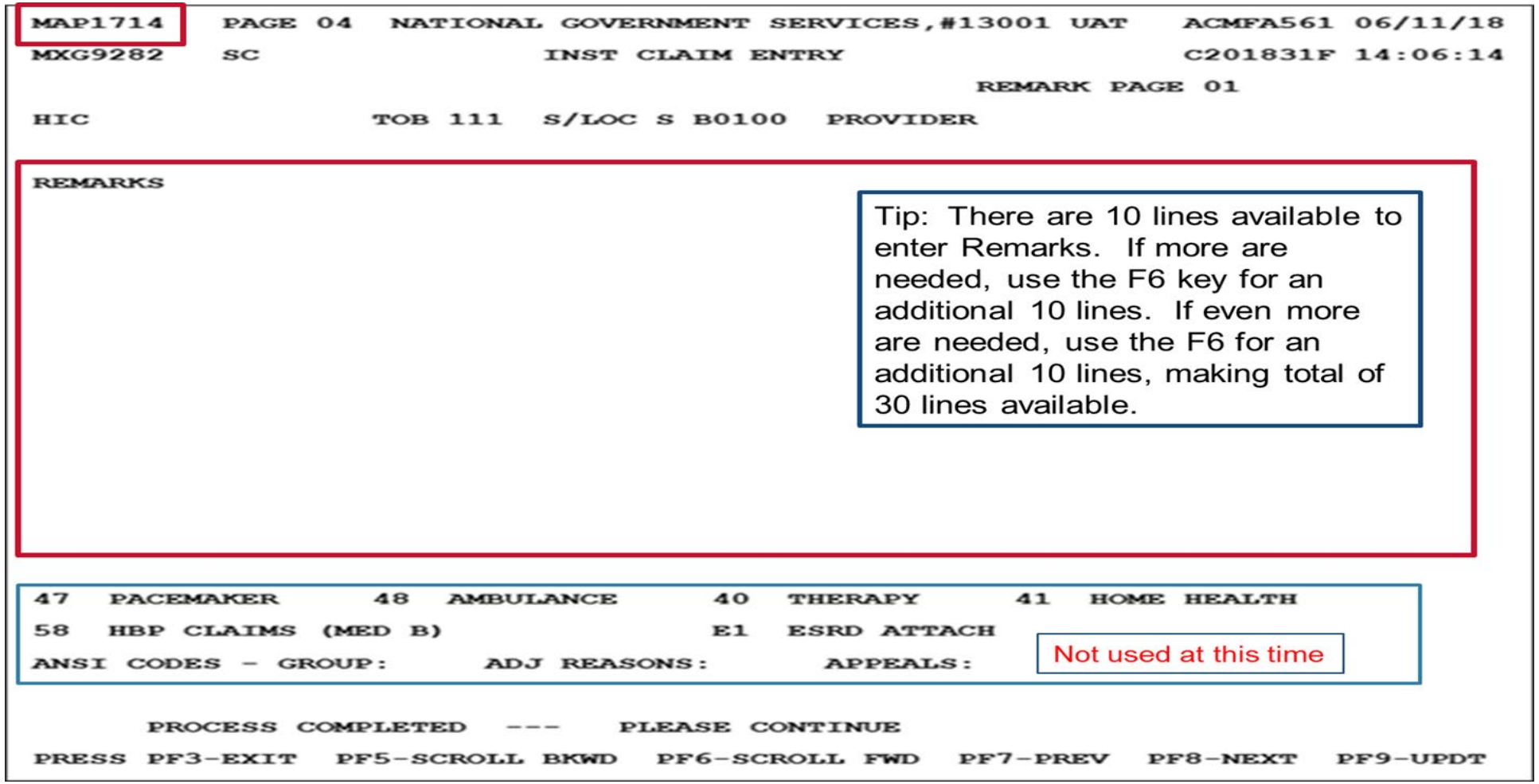
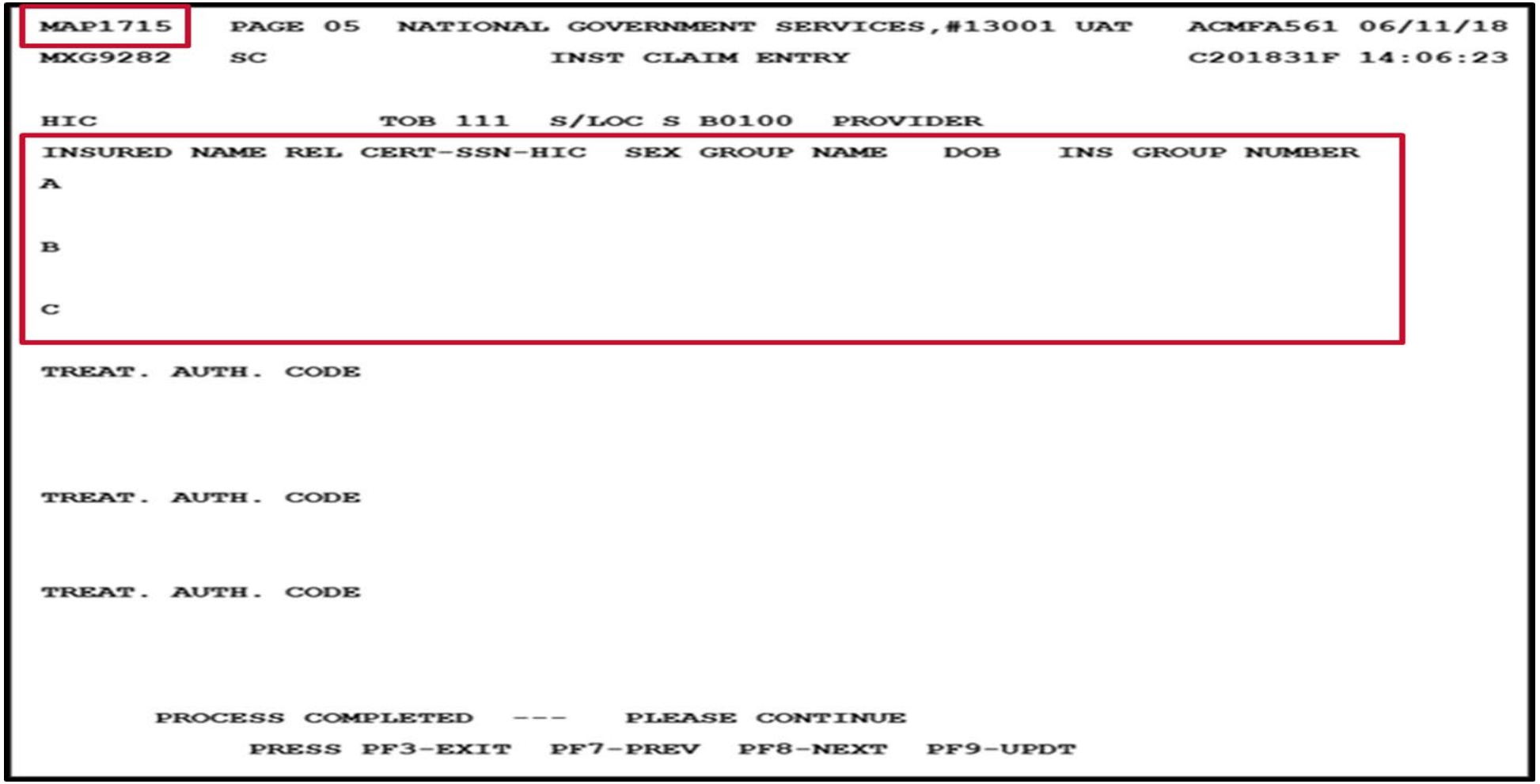
Page 04 – MAP1714



Page 05 – MAP1715



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
```

Test Your Knowledge

Question #1

- Before submitting MSP claim, you must have
  A. Conducted an MSP screening process
  B. Determined who is primary payer and submitted a claim to them
  C. Received payment more than zero from primary payer
  D. All of the above

Question #2

- You are not required to submit an MSP claim if the primary payer paid in full for Medicare-covered charges
  A. True
  B. False

Question #3

- Reporting CC 77 on an MSP claim lets us know you were paid in full by the primary payer for Medicare-covered services
  A. True
  B. False

Question #4

- You must report OC 04 and DOA when No-Fault insurance is the primary payer for claim
  A. True
  B. False

Question #5

- You must report the appropriate MSP VC and an amount greater than zero on all MSP claims
  A. True
  B. False

Question #6

- Reporting VC 44 and the OTAF/expected amount on an MSP claim lets us know you were paid in full by the primary payer for Medicare-covered services
  A. True
  B. False

Question #7

- On MSP claims, you must report a code to represent the patient's relationship to insured
  A. True
  B. False

Question #8

- You must submit all MSP claims in FISS DDE
  A. True
  B. False

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 webinars
  - Register for Part 2 of this webinar (MSP claim examples) for 1/30/2025
- Review articles
  - Determine if Medicare Will Make MSP Payment
  - Determine Beneficiary Responsibility on MSP Claim

Resources

CMS Resources

- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, all sections
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5
- CMS Change Request 6426: Instructions on Utilizing 837 Institutional CAS Segments for Medicare Secondary Payer (MSP) Part A Claims
- CMS Change Request 8486: 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

NGS Resources

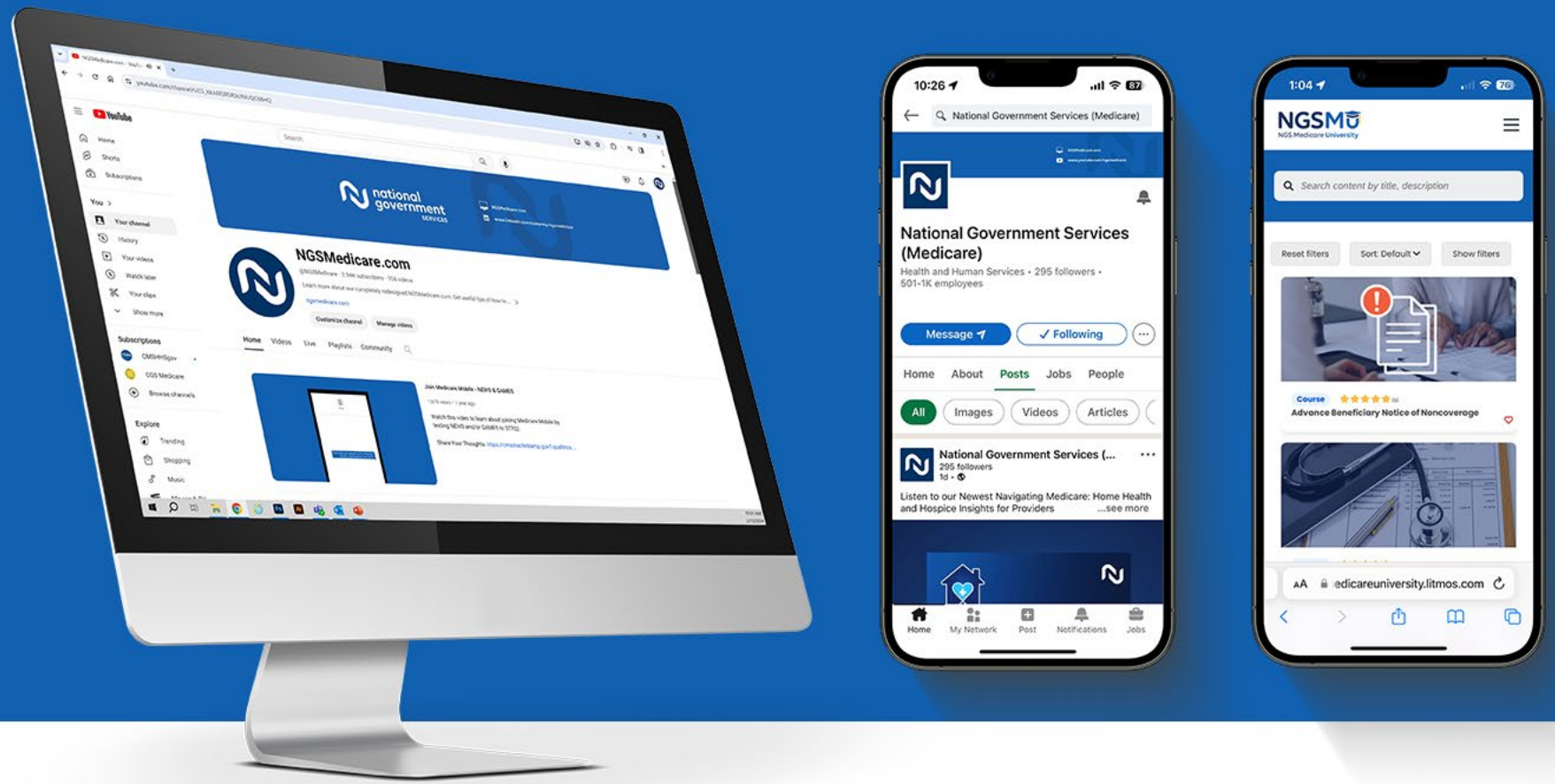
- ASCA Requirements for Paper Claim Submissions
- Determine if Medicare Will Make MSP Payment
- Determine Beneficiary Responsibility on MSP Claim
- EDI Enrollment
- *FISS DDE Provider Online Guide*
  - Chapter V (Claims/Attachments Submenu 02) for Claim Data Entry
- Identify the Proper Order of Payers for a Beneficiary's Services
- Prepare and Submit a Medicare Secondary Payer Claim

External Resources

- External code list
- NUBC's UB-04 Data Specifications Manual

Questions?

Thank you!



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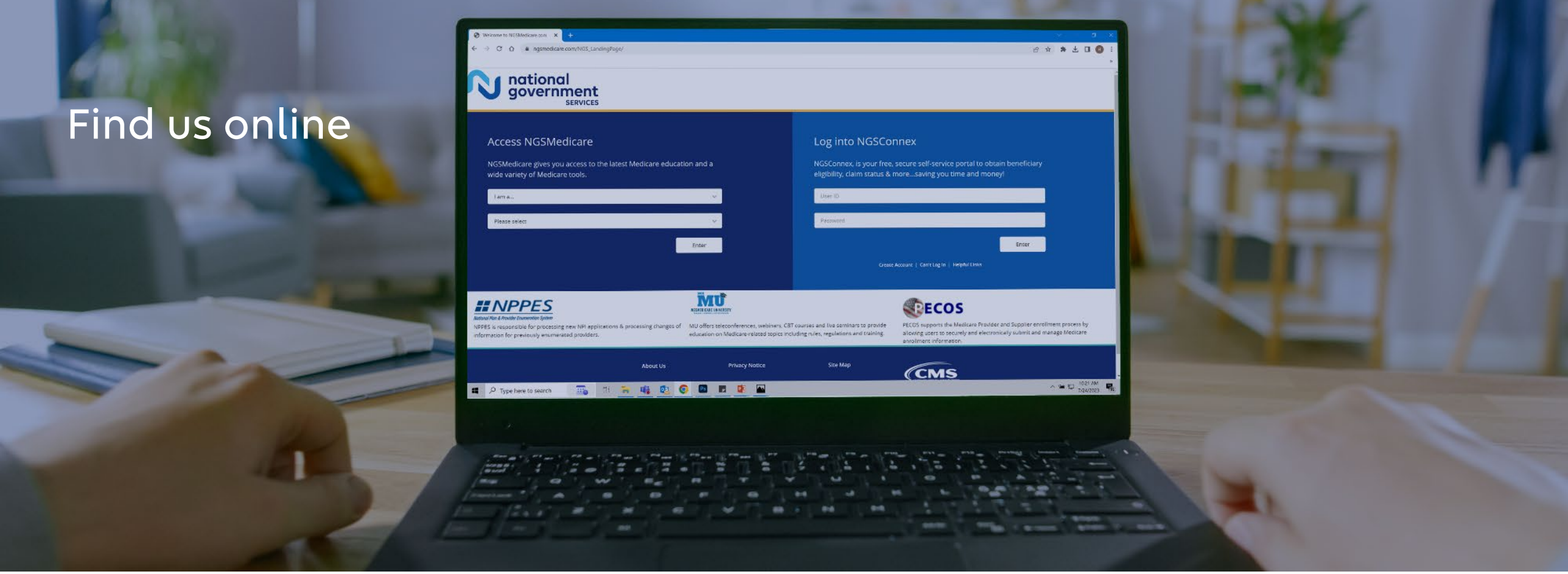

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[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

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