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Medicare Secondary Payer: Preparing and Submitting Conditional Claims – Part 1

2/26/2025

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.*

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

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

Today's Presenters

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

Agenda

- MSP and Your MSP Responsibilities
- Conditional Claims
- Preparing and Submitting Conditional Claims
- Submitting Conditional Claims in FISS DDE
- 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
  - 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:
  - CMS' model MSP questionnaire or
    - 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
    - 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 exact 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

Conditional Claims

Conditional Claims – Defined

- Claims submitted to us for payment because
  - You billed primary payer but they did not pay
    - For valid reason
      - You may submit claim
        - Conditionally for MSP provisions (VCs 12, 13, 14, 15, 41, 43 or 47)
        - As Medicare primary for VC 16 and for VA
    - Promptly (within 120 days)
      - You may submit conditionally for accident MSP provisions only – VCs 14, 15, 41 and 47
- If we can pay conditional claim
  - Payment amount and beneficiary responsibility same as when Medicare primary

Promptly – Defined

- No-fault and WC
  - Payment within 120 days after insurer receives claim
- Liability (including self-insurance)
  - Payment within 120 days after earlier of
    - Date general liability claim filed with insurer or lien filed against potential liability settlement (date liability record created in CWF)
    - Date service furnished (or date of discharge for IP)

Conditional Billing When Primary Payer Is GHP (VCs 12, 13 or 43)

- To bill us conditionally, you must have response from GHP with valid reason
  - Applicable in situations in which beneficiary has
    - GHP only or
    - GHP and no-fault, WC or liability coverage (due to an accident)

Conditional Billing When Primary Payer Is Non-GHP Except Liability (VCs 14, 15 or 41)

- To bill us conditionally
  - Within promptly period, you must have response from non-GHP with valid reason
  - After promptly period, you do not need response from non-GHP
- Once promptly period ends
  - Choose to maintain claim with non-GHP or bill us conditionally
    - If you wait for non-GHP, keep our one-year timely filing in mind
    - If beneficiary has primary GHP, bill GHP before us

Conditional Billing When Primary Payer is Liability (VC 47)

- To bill us conditionally
  - Within promptly period, you must have response from liability with valid reason
  - After promptly period, you do not need response from liability
- Once promptly period ends
  - Choose to maintain claim/lien with liability or bill us conditionally
    - If you wait for liability, keep our one-year timely filing in mind
    - If you bill us conditionally, withdraw claim/lien with liability
    - If you are paid by them and us, follow CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2E
    - If beneficiary also has a primary GHP, bill GHP before billing us

When We Can Pay Conditionally

- You have response from primary payer, and they did not pay for valid reason
  - Primary payer is GHP or non-GHP (accidents)
- You do not have response from primary payer, and promptly period ended
  - Primary payer is non-GHP (accidents)
  - Primary payer did not pay promptly or cannot reasonably be expected to pay promptly
  - Note: If beneficiary also has a primary GHP, bill GHP before billing us

When We Cannot Pay Conditionally

- You did not bill primary payer
  - Beneficiary refuses to file or to cooperate with provider in filing claim
- You billed primary payer
  - They did not pay because provider/beneficiary failed to file proper claim with them
    - Only a few situations in which you may submit conditionally
    - You may submit MSP claim per CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5
- You billed primary non-GHP
  - They did not pay because there is also a primary GHP
    - You did not send claim to GHP first or
    - You sent claim to GHP first, and they rejected it stating non-GHP should pay first
      - Submit claim to non-GHP first, GHP next and Medicare third

Preparing and Submitting Conditional Claims

Prepare and Submit Conditional Claims – Steps

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

Background

- Before submitting conditional 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
  - One of the following situations
    - Received response from primary payer indicating not paying your claim for valid reason
    - You have not received response from primary payer (accidents only) after waiting at least 120 days from billing them

Determine if You Can Submit Conditional Claim

- You may submit conditional claim if
  - You billed primary GHP and/or non-GHP and
    - You received response
      - RA (835), EOB statement, letter, other documentation
        - Payment is zero
        - Reason(s) is provided (if not, contact them)
        - Reason is valid (if not, perhaps claim should be Medicare primary)
    - You did not receive response (non-GHPs only)
      - Promptly period of 120 days ended
      - You withdrew claim/lien with liability, if applicable

Prepare Conditional Claim – Similar to MSP Claim

- Conditional claims look like MSP claims since primary payer is reported as first payer and Medicare as second payer
- However, for conditional claims, report:
  - Primary payer's payment amount of zero with appropriate MSP VC
  - Two-digit code in Remarks to indicate reason primary payer did not pay
    - Refer to Conditional Billing Code Table under Remarks
  - OC 24 and date you learned primary payer not going to pay for claim (in all situations except when reporting code DA in Remarks)
  - Any other required coding, when applicable

Prepare Conditional Claim – Complete Claim as Usual

TOB

Report covered TOB; not noncovered

Days/Charges

Report covered days/ charges; not noncovered

Required Claim Coding

Report all Medicare-covered charges

Correct Order of Payers

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

Prepare Conditional Claim – Follow Medicare Requirements

- Technical
  - Example: One-year timely filing
- Medical
  - Example: Clinical requirements and/or assessments
- Billing
  - Example: Frequency of billing for provider type (admit-discharge, every 30 days, every 60 days, etc.)
    - Do not "split bill" claim
      - If primary payer paid for portion of claim but not entire claim (for any reason), submit entire claim as MSP
      - If primary payer did not pay at all on entire claim, even if they were primary for only a portion of claim, submit entire claim as conditional

Prepare Conditional Claim – Follow Medicare Requirements (continued)

- Billing
  - Hospice providers
    - Submit NOE as usual and as Medicare primary
    - Report MSP information on claim(s)
  - Home health providers
    - Submit NOA as usual and as Medicare primary
    - Report MSP information on claim(s)

Prepare Conditional Claim – Use Conditional Billing Code Table

- Prepare and Submit an MSP Conditional Claim
  - Conditional 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

UB-04/CMS-1450 Claim Form

Condition Codes FLs 18-28

Occurrence Codes FLs 31-34

Value Codes FLs 39a-41d

Payer Name FL 50a, b, c

Insured's Name

Remarks FL 80

Conditional 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

Conditional 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 & Remarks Codes	80 (Remarks)	2300.NTE	04 (Remarks) 06 (Address)

CCs (COND Codes)

- Report when applicable:
  - 02 = Employment-related condition
  - 06 = ESRD beneficiary in first 30 months of Medicare entitlement with EGHP
- Do not report CC 77

OCs (OCC CDS/DATE)

- Report when applicable:
  - 01 and DOA if medical-payment coverage primary
  - 02 and DOA if no-fault insurance primary
  - 03 and DOA if liability insurance primary
  - 04 and DOA if WC primary
  - 24 and date of primary payer's notice (RA, EOB, letter) explaining why they did not pay (denied/rejected)
    - Report on all conditional claims except when reporting code DA in Remarks
  - 33 and date ESRD coordination period began

VC for MSP Provision and Amount

- If proper claim filed
  - Report MSP VC 12, 13, 14, 15, 41, 43 or 47 and amount received from primary payer toward Medicare-covered charges
    - For conditional claims, amount = $0
- If proper claim not filed and primary payer reduced payment to zero for this reason
  - Submit MSP claim and report amount you would have received had proper claim been filed
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.5
- Do not report VC 44 and amount

Primary Payer Code (Payer Code ID)

- Report code for first three payers, if applicable
  - Payers labeled A, B and C
- For conditional claims, report
  - **For Payer A = Always enter C (regardless of MSP provision)**
  - For Payer B = 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 conditional claims
  - Report Medicare in FL 50B or equivalent field

Insured's Name

- Report name of person who carries insurance in FL 58A or equivalent field
- For conditional claims
  - Report beneficiary's name in FL 58B 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 conditional claims
  - Report 18 in FL 59B or equivalent field

Insured's Unique ID

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

Insurance Address

- Report primary payer's address
  - In Remarks (on second line) if submitting hardcopy or via 837I claim
  - On page 06 if using FISS DDE to enter claim

Reason Primary Payer Did Not Pay or Did Not Pay Promptly (Remarks)

- Report **two-digit code** indicating why primary payer did not pay or did not pay promptly
  - In Remarks (on first line)
  - Options: NB, PC, CD, FG, BE, PE, DA, DP, LD and PP
    - Ten codes created by NGS
    - Some require more information such as date (MM/DD/YY) placed one space over from code
    - Refer to Conditional Billing Code Table under Remarks

Codes NB, PC and CD

- Primary payer did not pay because
  - Services are not a covered benefit
    - Report code **NB** (for VCs 12, 13, 14, 15, 41 or 43)
  - Preexisting condition
    - Report code **PC** (for VCs 12, 13 or 43)
  - Charges applied to deductible, co-pay or coinsurance
    - Report code **CD** (for VCs 12, 13, 14 or 43)

Code FG

- Primary payer (VCs 12, 13, 15 or 43) did not pay because their guidelines not followed
  - Report code FG (space) then reason (typed out)
    - Claim filed untimely
      - Note: We pay if filed timely with us
    - Provider out of plan's network
      - Note: We pay one time per entire time beneficiary enrolled in that plan
    - Prior authorization not obtained
      - Note: We will not pay claim
  - You may submit MSP claim instead of any of above options and report amount primary payer would have paid if proper claim filed

Code BE (Primary Payer Is GHP)

- Primary GHP (VCs 12, 13 and 43) did not pay because benefits exhausted
  - Report code **BE** with date benefits exhausted (MM/DD/YY)
    - Date may not be same as OC 24 date
    - Example: Benefits may have exhausted on 2/5/2025 but you received notice of this on 2/25/2025 (BE date = 2/5/25 and OC 24 date = 2/25/25)
- Note: Do not submit Medicare primary claim since MSP record remains open until lifetime GHP benefits exhaust or GHP terminates

Code BE (Primary Payer Is Non-GHP Other Than Auto No-Fault)

- Primary non-GHP other than auto no-fault (VC 14 for med-pay, 15 and 41) did not pay because benefits exhausted, and no other primary payer exists
  - Determine date benefits exhausted
    - If DOS less than benefits exhaust date
      - Submit conditional claim and report code **BE** with date benefits exhausted (MM/DD/YY) which may not be same as OC 24 date
    - If DOS greater than benefits exhaust date
      - Submit Medicare primary claim and report **OC 25** with date coverage no longer available (BE date)

Code PE (Primary Payer Is Auto No-Fault)

- Primary auto no-fault (VC 14) did not pay because benefits (PIP) exhausted and no other primary payer exists
  - Auto no-fault states:
    - Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania, Utah, Puerto Rico
  - Determine date benefits exhausted
    - If DOS less than benefits exhaust date
      - Submit conditional claim and report code **PE** with date benefits exhausted (MM/DD/YY) which may not be same as OC 24 date
    - If DOS greater than benefits exhaust date
      - Submit Medicare primary claim and report **OC 25** with date coverage no longer available (BE date)

Code DA

- Primary non-GHP (VCs 14, 15, 41 and 47) did not pay promptly and you choose to submit conditional claim because 120 days has passed (promptly period ended)
  - Report code **DA** with date you billed primary payer (MM/DD/YY)
  - Reminder: Do not also report OC 24 and date on claim

Codes DP, LD and PP

- Primary liability payer (VC 47) did not pay and you are submitting conditional claim because liability insurer's response stated:
  - There will be delay in their payment
    - Report code **DP**
  - They are not responsible for claim
    - Report code **LD**
  - They paid beneficiary (and you had not already been expecting this payment from beneficiary)
    - Report code **PP**

Prepare Conditional Claim – Report Primary Payer Adjustment Reasons and Amounts

- Also known as CAS information
  - Locate on 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

- CAGC options:
  - **CO** = Contractual Obligations
  - **OA** = Other Adjustments
  - **PI** = Payer-initiated Reductions
  - **PR** = Patient Responsibility

CARCs

- 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
  - **192** = Nonstandard adjustment code from paper RA
    - May be only option when billing conditionally because primary non-GHP does not pay within 120-day promptly period

Submitting Conditional 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 and 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

```
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
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FYI: MSP Apportion Indicator is no longer used.

Page 02 – MAP1712

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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

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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; **for conditional claims = $0**
      - Must = MSP VC amount and must = 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

      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
```

Page 04 – MAP1714

```
MAP1714    PAGE 04   NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 06/11/18
MXG9282    SC                  INST CLAIM ENTRY                 C201831F 14:06:14
                                                     REMARK PAGE 01
HIC                   TOB 111   S/LOC S B0100   PROVIDER

REMARKS
```

Tip: There are 10 lines available to enter Remarks. If more are needed, use the F6 key for an additional 10 lines. If even more are needed, use the F6 for an additional 10 lines, making total of 30 lines available.

```
47   PACEMAKER        48   AMBULANCE        40   THERAPY        41   HOME HEALTH
58   HBP CLAIMS (MED B)                     E1   ESRD ATTACH
ANSI CODES - GROUP:        ADJ REASONS:          APPEALS:

      PROCESS COMPLETED   ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV  PF8-NEXT  PF9-UPDT
```

Not used at this time

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
```

national government SERVICES

NGSMU

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 (conditional claim examples) for 2/27/2025

Resources

CMS Resources

- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*
  - Chapter 1 General MSP Overview
  - Chapter 2 MSP Provisions
  - Chapter 3 MSP Provider, Physician and Supplier Billing Requirements
  - Chapter 5 Contractor MSP Claims Prepayment Processing Requirements
  - Chapter 6 Medicare Secondary Payer CWF Process
  - Chapter 7 MSP Recovery

CMS Resources (continued)

- CMS Change Request 6426: Instructions on Utilizing 837 Institutional CAS Segments for MSP Part A Claims
- CMS Change Request 8486: Instructions on Using the CAS for MSP Part A CMS-1450 Paper Claims, DDE, and 837 Institutional Claims Transactions
- Medicare Secondary Payer: Don't Deny Services and Bill Correctly

NGS Resources

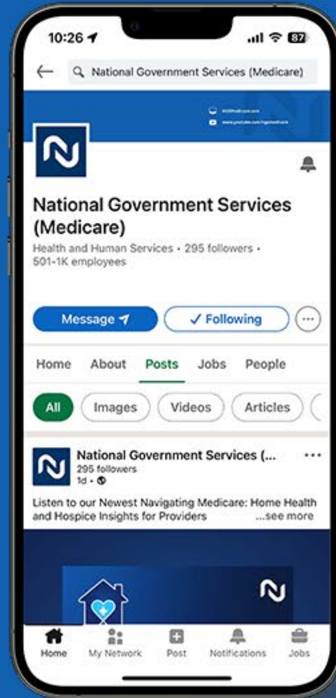
- ASCA Requirements for Paper Claim Submissions
- EDI Enrollment
- *FISS DDE Provider Online Guide*
  - Chapter V (Claims/Attachments Submenu 02) for Claim Data Entry
- Identify the Proper Order of Payers for a Beneficiary's Services
- Prepare and Submit a Medicare Secondary Payer Claim
- Prepare and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

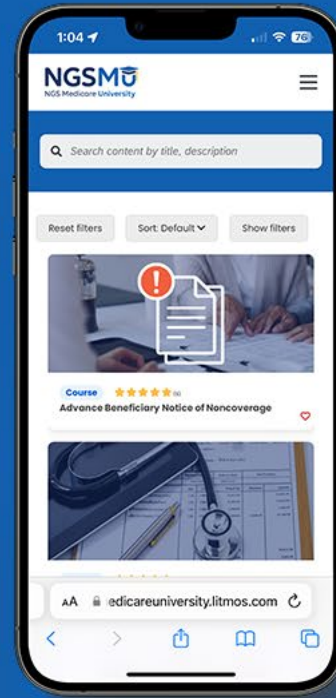
Other Resources

- External code list
- NUBC's UB-04 Data Specifications Manual
- How Medicare Works With Other Insurance

Questions?

Thank you!





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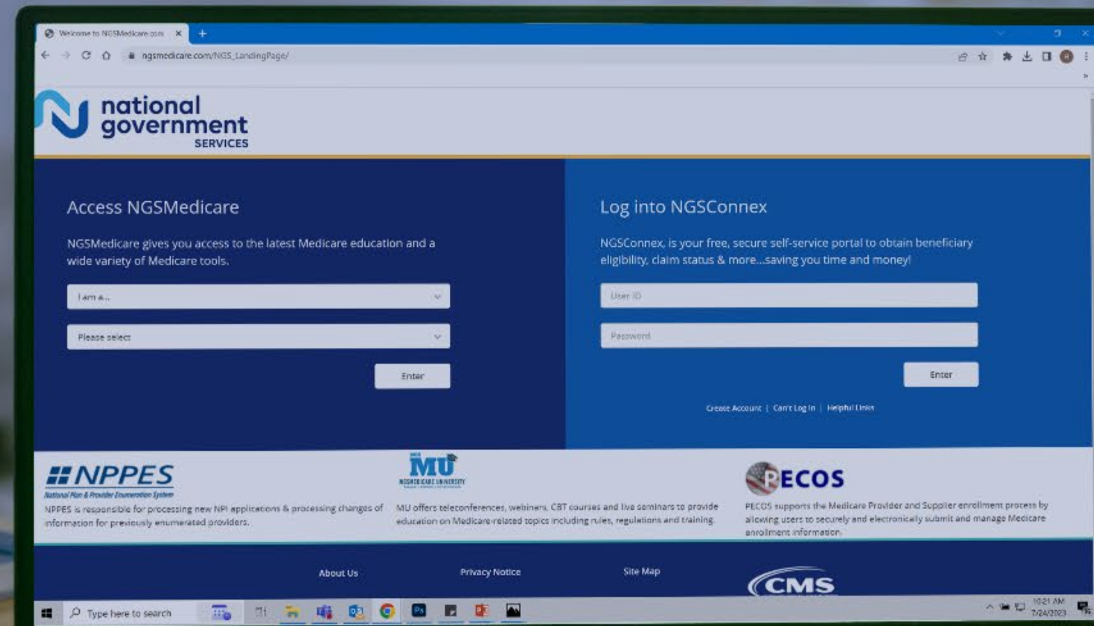

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

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