Medicare Secondary Payer: Preparing and Submitting Conditional Claims (Examples) – Part 2 Handout

Conditional Billing Code Table

Code	Instruction – Report code(s) as applicable
Condition codes (CCs)	**CC 02** = Condition is employment related **CC 06** = ESRD patient in 1st 30 months of eligibility or entitlement covered by EGHP
Occurrence codes (OCs) and dates	**OC 01** and DOA or injury = primary payer is medical-payment coverage **OC 02** and DOA or injury = primary payer is no-fault/no-fault set aside **OC 03** and DOA or injury = primary payer is liability insurance/liability set aside **OC 04** and DOA or injury = primary payer is WC/WC set aside **OC 24** and date you learned/were notified primary payer would not make payment for valid reason (date of RA, notice, letter, EOB statement, etc.) – For all conditional claims except when reporting code DA in Remarks. **OC 33** and 1st day of coordination period for ESRD patient covered by EGHP
MSP value codes (VCs) and amount	**Represents MSP provision and amount primary payer paid toward Medicare-covered charges. For conditional claims, this amount is always $0** **VC 12** = Working aged beneficiary (65 or older, has Part A) or spouse with EGHP, employer size 20 or more employees **VC 13** = ESRD patient (any age) with EGHP in 30-month coordination period **VC 14** = no-fault/no-fault set aside (auto and other types such as PIP, med-pay) **VC 15** = WC/WC set aside **VC 41** = Federal Black Lung program **VC 43** = Disabled beneficiary (under 65, has Part A) or family member employed with LGHP, employer size 100 or more employees **VC 47** = Liability insurance/liability set aside

Two-digit code for Remarks and, if applicable, a date in MM/DD/YY format or other required information (one space over from code) to explain valid reason primary payer did not pay.	**BE** = Benefits exhausted. Report date benefits exhausted (one space over from BE) in MM/DD/YY format. This may not be same as date you learned benefits exhausted (OC 24 date). Auto no-fault states do not use BE (see PE). Accepted with VCs 12, 13, 14 (for med-pay), 15, 41 or 43. Note: If primary payer is med-pay (VC 14), benefits exhausted, claim's DOS is after benefits exhaust date, and claim is also not responsibility of another payer such as liability, submit Medicare primary claim instead with OC 25 and date coverage no longer available for accident. This is date on which coverage (WC or med-pay) is no longer available to beneficiary. **CD** = Charges applied to co-payment, coinsurance, and/or deductible. Accepted with VCs 12, 13, 14, or 43. **DA** = 120 days passed since primary payer was billed. Report date primary payer was billed (one space over from DA) in MM/DD/YY. Do not also report OC 24 with date. Accepted with VCs 14, 15, 41, or 47 but for VC 47, you must have withdrawn claim with liability. **DP** = Delay in payment from liability insurer (you were notified). Accepted with VC 47. **FG** = Beneficiary did not follow guidelines of primary plan. Use only in in situations below. Indicate (one space over from FG) which reason. Accepted with VCs 12, 13, 15, or 43. • Out of network (we pay once) • Untimely filing with primary payer (we pay if timely with us) • No prior authorization (we cannot pay) **LD** = Response from liability insurer states they feel they are not responsible for claim. Accepted with VC 47. **NB** = Not a covered benefit. Accepted with VCs 12, 13, 14, 15, 41, or 43. **PC** = Pre-existing condition. Accepted with VCs 12, 13, or 43. **PE** = No-fault (also known as PIP) benefits exhausted toward medical expenses. Report date benefits exhausted (one space over from PE) in MM/DD/YY format. This may not be same as date you learned benefits exhausted (OC 24 date). Accepted with VC 14. You must have a copy of the PIP. Note: If the primary payer is no-fault, benefits exhausted, claim's DOS is after the date benefits exhausted, and claim is also not the responsibility of another payer such as liability, submit Medicare primary claim instead with OC 25 and date coverage no longer available for accident. This is date on which coverage (no-fault) is no longer available to beneficiary. **PP** = Beneficiary was paid by liability insurer. Used for conditional claims involving liability insurance payments to beneficiary where you are not expecting any payment from them. Do not use this for med-pay payments to beneficiary (VC 14) as you are required to pursue those dollars. Accepted with VC 47.