Home Health Medicare Secondary Payer (MSP) Billing

Agenda

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The purpose of the Medicare Secondary Payer Program is to determine if there is another party which should be the primary payer for services provided to a Medicare beneficiary.

Before billing Medicare, it is the provider’s responsibility to determine whether or not Medicare is the primary payer. It is required by Medicare regulations, and is part of the agreement to be a Medicare participating provider.
Where do I begin?!?!?!

Verifying MSP Information
Verifying MSP Information

- Determine whether Medicare is Primary or Secondary
  - HIQH/HIQA
  - Online Provider Services (OPS)
  - MSP Questionnaire
    - Required on admission
    - Beneficiary signature not necessary
  - Check Retirement Dates

- Suggest providers review and update regularly as entitlement or payer status may change after you admit the beneficiary

(MSP) General Claims Filing Requirements
Medicare Claims Filing Requirement

- **OASIS**
  - Complete OASIS Assessment

- Providers are required to submit claims to Medicare regardless of whether or not Medicare is the primary payer

***RAPs and MSP***

- Submit the RAP as you normally do
  - This establishes the home health episode on the Common Working File (CWF)

- Do NOT put MSP codes on the RAP

- Put MSP codes ONLY on the final claim

- Placing MSP codes on RAPs will delay processing and payment
**RAPs and MSP**

- When Medicare is the secondary payer and a valid MSP segment exists on the Common Working File (CWF):
  - The RAP will process and the episode will be created, but zero payment will be made on the RAP
  - Adjustment is made on the Final Claim

**Medicare Claims Filing Requirement**

- Effective October 1, 2009, MSP claims (original and adjustment claims) can no longer be submitted through the Direct Data Entry (DDE) system.
Medicare Claims Filing Requirement

Providers have the following options to submit MSP claims to Palmetto GBA:

- Submit claims electronically using the PC-ACE Pro32 Software, which is a free software that can be downloaded from the Palmetto GBA Web site
- Submit claims via a vendor software program that supports the Claim Adjustment Segments (CAS)
- Submit hard copy claims if currently authorized to submit hard copy claims

References:
Change Request 6426, Transmittal 70
www.cms.gov/transmittals/downloads/R70MSP.pdf

Palmetto GBA Article
www.PalmettoGBA.com
Under the Resources section, select Medicare Secondary Payer

Final Claims and MSP

For beneficiaries who have other insurance that is primary to Medicare, Home Health agencies must submit the claims to the primary payer before submitting to Medicare

Primary EOB/RA received
- What did the Insurance Company pay?
  - Less than what Medicare would have paid for the episode?
    - Submit the bill to Medicare for secondary payment consideration
  - More than what Medicare would have paid for the episode?
    - Submit the claim with the appropriate codes
    - Medicare may not pay any additional money
MSP Terminology

When submitting claims involving a Medicare Secondary Payer (MSP) situation, certain data are required to be reported on the claim. Providers should also be familiar with the most commonly used terminology under the MSP program, which are as follows:

**Charge Amount** - the amount the provider billed for services rendered. This amount should match the amount billed to both the primary insurer and Medicare.

**Medicare Allowable** - the amount Medicare approved for reimbursement. The total amount of Medicare reimbursement varies among different types of bills.

**Primary Insurance Allowable/Primary Allowed** - the amount the primary insurer approved for services.

**Primary Obligated to Accept Payment in Full (OTAF)** - this is the discount payment amount as a network member, or the contract amount received through an agreement with primary insurer.

**Primary Paid** - the amount the primary insurer agreed to pay the provider for services rendered.
New Billing Requirements

Changes Implemented with Change Request 6426

- In accordance with Change Request (CR) 6426, issued on June 26, 2009, effective October 1, 2009, providers are also required to enter the Claim Adjustment Segments (CAS) either at the line level or claim level.

- CAS information includes codes which delineate what was paid by the primary insurer as well as any amounts not paid by the primary insurer.
Changes Implemented with Change Request 6426

- Amounts not paid by the primary insurer are identified by Group Codes and Claim Adjustment Reason Codes (CARCs). A list of CARCs can be accessed at [www.wpc-edi.com](http://www.wpc-edi.com). Group Codes are defined as follows:

  - **CO** - Contractual Obligation
  - **CR** - Correction and Reversals
  - **OA** - Other Adjustments
  - **PI** - Payer Initiated Reductions
  - **PR** - Patient Responsibility

- It is the provider’s responsibility to understand the information provided on the primary insurer’s Remittance Advice (RA) or Explanation of Benefits (EOB) and the various codes or messages printed on the RA/EOB.

- Providers should ensure that the information reported on the claim and the CAS is accurate and correct.

- The system is set to automatically calculate the amount of secondary payment (if any) based on the information provided in the CAS.
Changes Implemented with Change Request 6426

- Other factors used to evaluate MSP payments include:
  - Primary allowed amount
  - Medicare's allowable
  - Contractual agreements or network limits (OTAF)
  - Primary insurer’s payment
  - Date of claim submission
  - Medicare deductibles
  - Reasons for primary payment denials
    - Identified by Claim Adjustment Reason Codes (CARCs)
    - Entered as part of the Claim Adjustment Segments (CAS)

Changes Implemented with Change Request 6426

- There are two distinct levels of reporting the CAS information, which is also known as the MSP Coordination of Benefits (COB):
  - Claim-Level COB Reporting
  - Line-Level COB Reporting

- The decision to report the CAS information at the claim-level versus the line-level is made based upon the information communicated to the provider via the primary insurer’s RA or EOB

- The primary insurer’s RA/EOB may be in electronic (ANSI-835) or paper format

- The primary payer’s RA/EOB serves as the source for CAS data to be entered into the claim form's appropriate fields
Changes Implemented with Change Request 6426

- Claim-Level COB reporting is done when the primary insurer’s RA/EOB contains data that is not specific to a particular service line.
- The location of the screens in which the reporting of the CAS information takes place may vary between electronic billing software programs.

Changes Implemented with Change Request 6426

- Line-Level COB reporting is done when the primary insurer’s RA/EOB contains data that is specific to a particular service line(s).
- The location of the screens in which the line-level reporting of the CAS information takes place will vary with each type of electronic billing software.
- The Line-Level COB reporting information will include the following:
  - Service Line Adjudication (SVD) Information
  - Line-Level Adjustment (CAS) & Miscellaneous Adjudication Info
  - Procedure Code Description
  - Adj/Payment Date
  - Remaining Amt Owed
Changes Implemented with Change Request 6426

- Entering of the CAS information, regardless of whether or not it is reported at the claim or line level, is vital to the calculation of payment (if any) to be made on a secondary basis.

- Providers are encouraged to ensure that they know and understand the primary insurer’s RA/EOB and how to enter the information in their Medicare billing software.

Changes Implemented with Change Request 6426

- The business requirements in CR 6426 also stipulate how the system must be set to process claims with certain CARCs appear in the CAS on the claim.

- The Table attached to the handout provides a summary of certain CARCs and the actions taken by the Medicare claims processing system.
MSP Billing Reminders

MSP Situations

- Medicare is considered secondary to:
  - Working Aged
  - End Stage Renal Disease
  - Disability
  - No-Fault
  - Worker’s Compensation
  - Black Lung
  - Veteran’s Administration (VA)
  - Liability
MSP Situations

- Submit all MSP claims to Palmetto GBA
  - Even if the insurance company has paid in full
    - Why?
      - Posts a record to CWF
      - Establishes a home health episode

Non-MSP Situations

- Medicare is always primary to
  - Medicaid
    - Medicare is always primary as long as the patient qualifies for the Medicare services needed
  - TRICARE/TRICARE for Life/CHAMPUS
  - Private Supplemental Insurance
  - Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - except in cases of ESRD eligibility
    - Provided for:
      - Individuals who leave employment but want to keep their health coverage
      - Individuals who lose coverage based on eligibility (e.g., dependent child who exceeds the age limit on the parent's policy)
Non-MSP Situations

- Medicare Advantage (MA) plans also known as Medicare HMO plans are not an MSP situation
  - MA plan is the beneficiary’s Medicare coverage
  - Providers, except hospice, bill the MA plan for all services provided
  - Medicare traditional fee-for-service cannot be billed as secondary

MSP Situations

- With open MSP segment on CWF
  - Primary insurer denies, stating Medicare is primary
    - Example: Beneficiary is retired
  - The provider should contact the Coordination of Benefits Contractor (COBC) to request that the record be updated
    - Copy of documentation
    - Denial letter
    - Employer letter with retirement date
    - MSP questionnaire
  - Once the COBC updates the record, the claim may be submitted to Medicare for primary payment consideration
When submitting the final claim to Medicare

- Fill in all fields on the UB04 as you normally do

- In addition to what is normally put on the final claim, add the necessary MSP codes (i.e., value, occurrence, condition codes, etc.) as appropriate
Home Health Final Claims

- The RAP will cancel as it normally does when any final claim posts

- **Note:** Providers often mistakenly resubmit RAPs because they get a reason code that no RAP exists
  - The RAP **does** exist, so **do not** resubmit another RAP

MSP Determinations on Final Claims

- MSP is calculated on a per episode basis
  - **1 episode of care = 1 MSP calculation and payment for that episode**

- Providers are encouraged to track payments from other payers on the same per episode basis
Home Health Final Claim and MSP

- Submit final claim as an MSP claim with all applicable MSP codes
  - MSP Value Codes and Amounts
  - MSP Condition Codes
  - MSP Occurrence Codes and Dates
  - MSP Payer Identification Codes
  - MSP Relationship Codes

- Submit MSP final claim with Remarks (if applicable)

Working Aged – Payment Made

- If the Employer Group Health Plan (EGHP) makes a primary payment, submit the claim with the following information:
  - **Value Code 12 (FL 39 – 41)** and the amount paid by the EGHP
  - On line A of **FL 50 use Payer ID Code A** and list the name of the GHP as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS
Working Aged – Payment Not Made

- If payment is not made by the EGHP, the claim will either be submitted for primary payment consideration or, if the criteria are met, submit a **Conditional Payment** claim with the following information:
  - **Occurrence Code (OC) 24 (FL 31 - 34)** and date of denial
    - Omit OC 24 and date when CARCs 1, 2, 3, and 66 are entered on the claim
  - **Value Code 12 (FL 39 - 41)** with zero amount paid by the GHP
  - On line A of FL 50 **use Payer ID Code C** and list the name of the GHP as the primary payer, list Medicare as secondary on line B
    - When CARCs listed above are entered on the claim, enter **Payer ID Code A**
  - Annotate reason for why payment was not made in Remarks (FL 80)
  - Enter appropriate information in the CAS

Disability – Payment is Made

- If the Large Group Health Plan (LGHP) makes a primary payment, submit the claim with the following information:
  - Show **Value Code 43 (FL 39 - 41)** and the amount paid by the LGHP
  - On line A of **FL 50 use Payer ID Code G** and list the name of the LGHP as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS
Disability – Payment Not Made

- If payment is not made by the LGHP, the claim will either be submitted for primary payment consideration or, if the criteria are met, submit a **Conditional Payment** claim with the following information:
  - **Occurrence Code (OC) 24 (FL 31 – 34)** and date of denial
    - Omit OC 24 and date when CARCs 1, 2, 3, and 66 are entered on the claim
  - **Show Value Code 43 (FL 39 – 41)** with zero amount paid by the GHP
  - On line A of **FL 50 use Payer ID Code C** and list the name of the GHP as the primary payer, list Medicare as secondary on line B
    - When CARCs listed above are entered on the claim, enter Payer ID Code C
  - Annotate reason for why payment was not made in Remarks (FL 80)
  - Enter appropriate information in the CAS

End Stage Renal Disease (ESRD) Payment Made

- If the GHP makes a primary payment, submit the claim with the following information:
  - **Condition Code 06 (FL 18 – 28)**
  - **Occurrence Code 33 (FL 31 – 34)** with the first month of the Medicare coordination period for ESRD
  - **Show Value Code 13 (FL 39 – 41)** and the amount paid by the GHP
  - On line A of **FL 50 use Payer ID Code B** and list the name of the GHP as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS
ESRD – Payment Not Made

- If payment is not made or denied by the GHP, the claim will either be submitted for primary payment consideration or, if the criteria are met, submit a Conditional Payment claim with the following information:
  - **Condition Code 06 (FL 18 – 28)**
  - **Occurrence Code (OC) 24 (FL 31 – 34) and date of denial**
    - Omit OC 24 and date when CARCs 1, 2, 3, and 66 are entered on the claim
  - **Occurrence Code 33 (FL 31 – 34) with the first month of the Medicare coordination period for ESRD**
  - **Show Value Code 13 (FL 39 – 41) with zero amount paid by the GHP**
  - On line A of **FL 50 use Payer ID Code C** and list the name of the GHP as the primary payer, list Medicare as secondary on line B
    - When CARCs listed above are entered on the claim, enter **Payer ID Code B**
  - Annotate reason for why payment was not made in Remarks (FL 80)
  - Enter appropriate information in the CAS

Working Aged/Disability/ESRD
Payment Not Made - Proper Claim Not Filed

- **Example:**
  - Failure to obtain prior authorization

- **What to do:**
  - Submit the claim for secondary payment consideration
  - Enter the appropriate value code (12, 13, or 43)
  - Enter any other codes required (e.g., ESRD also requires condition code 06 and occurrence code 33)
  - Enter amount primary insurer would have paid if payment had been made in remarks
  - If provider would have been under contractual agreement, enter value code 44 and the contractual agreement amount
  - If provider would have been obligated to accept payment in full (OTAF), enter condition code 77
  - Enter appropriate Payer ID code (A, B, or C)
  - Enter appropriate information in the CAS

Special Note: There may be instances where the primary insurer denies payment due to the provider’s failure to submit a proper claim (e.g., timely filing) where Medicare may not make secondary payment. Be sure to refer to the regulations in the CMS’ Internet Only Manual (IOM), Publication 100-05, Medicare Secondary Payer Manual. CR 6426 also contains information which CARCs are set up in the system to deny and not make Medicare payment.
No-Fault – Payment Made

- If the no-fault insurance makes primary payment, submit the claim with the following information:
  - **Occurrence Code 02 (FL 31 – 34)** with the date of the accident/injury
  - **Show Value Code 14 (FL 39 – 41)** and the amount paid by the no-fault insurance
  - On line A of **FL 50 use Payer ID Code D** and list the name of the no-fault insurance as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS

No-Fault – Payment Not Made

- If payment is not made by the No-Fault insurance and the criteria are met, submit a Conditional Payment claim with the following information:
  - **Occurrence Code 02 (FL 31 – 34)** with the date of the accident/injury
  - **Occurrence Code 24 (FL 31 – 34)** and date of denial, or
  - **Show Value Code 14 (FL 39 – 41)** with zero amount paid by the no-fault insurance
  - On line A of **FL 50 use Payer ID Code C** and list the name of the no-fault insurance as the primary payer, list Medicare as secondary on line B
  - Annotate reason for denial in Remarks (FL 80)
  - Enter appropriate information in the CAS
Liability Insurance – Payment Made

- If the liability insurance makes primary payment, submit the claim with the following information:
  - Occurrence Code (FL 31 – 34) 01 or 03 (please see explanation for each code) with the date of the accident/injury
  - Show Value Code 47 (FL 39 – 41) and the amount paid by the liability insurance
  - On line A of FL 50 use Payer ID Code L and list the name of the liability insurance as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS

Liability Insurance – Payment Not Made

- If payment is not made by the liability insurance and the criteria are met, submit a Conditional Payment claim with the following information:
  - Occurrence Code 01 or 03 (please see explanation for each code) with the date of the accident/injury
  - Occurrence Code 24 (FL 31 – 34) and date of denial
  - Show Value Code 47 (FL 39 – 41) with zero amount paid by the liability insurance
  - On line A of FL 50 use Payer ID Code C and list the name of the liability insurance as the primary payer, list Medicare as secondary on line B
  - Annotate remarks, if aware that an attorney has been retained include the attorney's name and address (FL 80)
  - Enter appropriate information in the CAS
Workers’ Compensation – Payment Made

- If the Workers’ Compensation (WC) insurer makes primary payment, submit the claim with the following information:
  - **Occurrence Code 04 (FL 31 – 34)** with the date of the accident/injury
  - Show **Value Code 15 (FL 39 – 41)** and amount paid by the WC carrier
  - On line A of **FL 50 use Payer ID Code E** and list the name of the WC carrier as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS

Workers’ Compensation – Payment Not Made

- If payment is denied by the WC insurance and the criteria are met, submit a **Conditional Payment** claim with the following information:
  - **Occurrence Code 04 (FL 31 – 34)** with the date of the WC accident/injury
  - **Occurrence Code 24 (FL 31 – 34)** and date of denial
  - Show **Value Code 15 (FL 39 – 41)** with zero amount paid by the WC insurance
  - On line A of **FL 50 use Payer ID Code C** and list the name of the WC carrier as the primary payer, list Medicare as secondary on line B
  - Annotate reason for denial in Remarks (FL 80)
  - Enter appropriate information in the CAS
No Payment Made by No-Fault, Liability, or Workers’ Compensation when Benefits are Exhausted

- When a valid MSP segment exists on the CWF for No-Fault, Liability, or Workers’ Compensation and payment was denied stating that benefits are exhausted, the provider should:
  - Contact the COBC for direction on how to get the record updated
  - the claim should be submitted to Medicare for primary payment
  - Enter **Occurrence Code 25 (FL 31 – 34)** and date benefits were exhausted

Services Unrelated to No-Fault, Liability, or Workers’ Compensation - Occurrence Code 05

- If a trauma diagnosis exists on the claim but it is not related to open MSP No-fault, Liability, or Workers’ Compensation segment on the CWF
  - Provider has investigates to ensure that injury or illness is not related to the open MSP segment
  - Claim is billed as Medicare primary
  - Enter Occurrence Code 05 (FL 31 – 34) only if ICD-9 code(s) may indicate treatment is trauma related (i.e., broken leg) AND this is not related to No-Fault, Liability or Workers’ Compensation
  - Show remarks (FL 80) indicating services are not related to the open segment on the CWF
Services are Not Related to the Open No-Fault, Liability, or Workers’ Compensation when Segment

- When a valid MSP segment exists on the CWF for No-Fault, Liability, or Workers’ Compensation and the service rendered are not related to the illness or injury and no other trauma diagnosis exists on the claim:
  - Submit the claim to Medicare for primary payment
  - Annotate in remarks (FL 80) “services not related to illness or injury on open ________ segment.” (Fill in the blank with No-Fault, Liability or Workers’ Compensation)

Black Lung

- Black Lung is diagnosis driven.
- If diagnosis is not related to the black lung disease, submit claim to Medicare as usual.
- If the Department of Labor (DOL) does not pay for the services in full, bill Medicare as secondary. The denial notice should give the specific reason for non-payment.
- If a claim is denied because of your failure to furnish documentation needed by DOL, payment may not be made under Medicare.
Black Lung – Payment Made

- If the Black Lung program makes primary payment, submit a claim with the following information:
  - Show Value Code 41 (FL 39 – 41) and amount paid by the Black Lung program
  - On line A of FL 50 use Payer ID Code H and list the Black Lung Program as the primary payer, list Medicare as secondary on line B
  - Enter appropriate information in the CAS

Black Lung – Payment Denied

- If the claim is related to the Black Lung diagnosis and denied by the Black Lung Program, submit the claim to Medicare as Primary
  - Annotate reason for denial in Remarks (FL 80)
Veterans Affairs (VA)

- Although certain MSP procedures may be applied to VA, it is not an MSP provision. Generally, an authorization issued by the VA binds them to pay in full for the items and services provided.

- If a claim is not sent to VA, submit to Medicare as a regular Medicare primary claim.

Veterans Affairs (VA) - Payment Made

- If the VA makes primary payment but does not make full payment, and the provider is not obligated to accept the amount paid as payment in full, submit the claim with the following information:
  - Show Value Code 42 (FL 39 – 41) and amount paid by the VA
  - On line A of FL 50 use Payer ID Code I and list VA as the primary payer, list Medicare as secondary on line B
  - Enter the appropriate information in the CAS
  - Please refer to CMS' Web site under Internet Only Manuals (IOM), Pub 100-02, Medicare Benefit Policy, Manual Chapter 16, Section 50 for further information regarding VA
Coding & Other Guidelines which Apply to All MSP Situations

No Open Segment on CWF

- If a claim is submitted to Medicare for secondary payment and there is no MSP record on CWF at the time the claim is received for processing, the system will attempt to generate a record automatically.
- If there is not sufficient information provided on the claim for this to happen or if there are contradictory files on CWF, the claim will suspend with a CWF “U” code.
- The Claims Department will RTP claim to provider advising them to contact COBC to set up a valid record.
- If provider sends the information to us, then we will attempt to set up a record.
Submitting Total Charges

- When billing secondary claims to Medicare, providers should not change the amount billed to the primary insurer to show the Medicare rate.

- Submit the claim exactly as it was submitted to the primary insurer(s) so that the claim will match the Explanation of Benefits (EOB).

Completing Remarks

- Submit MSP claim with remarks, when applicable.
  - **Very** important when submitting MSP claims.
  - Enter as much information as possible.
  - After submitting a claim, check page 4 in DDE often for return correspondence from the Palmetto GBA claims department.
Correct Use of Condition Code 08

- Providers should submit claims with condition code 08 when the beneficiary refused to give insurance information
- FISS will automatically reject these claims, however it will trigger the COBC to initiate investigation
- Also, it allows the provider to bill the patient for the services
  - Provide Remarks on the claim

Coding Claims-Value Code 44

- Value Code 44 is used when a provider has a contract with an insurance company to accept a specific amount for services provided and the amount the insurer reimbursed is less than the contracted amount
  - When filing the secondary claim to Medicare, the provider would show the 44 value code and the total contracted amount from your Explanation of Benefits (EOB). This amount should be greater than the actual paid amount.
  - Provider would also show the MSP value code (12, 13 or 43) with the amount of the actual reimbursement received from the insurance company.
  - Medicare uses the contracted amount in its payment calculation to determine if a secondary payment is due from Medicare.
Coding Claims- Condition Code 77

- Condition Code 77 is used when a provider has a contract with an insurer to accept a specific amount for services provided and the amount the insurer reimbursed is to be considered payment in full.
  - When filing the secondary claim to Medicare, the provider would show the Condition Code 77 along with the appropriate MSP value code (12, 13, 42 or 43) with the amount of the actual reimbursement received.
  - Since the provider received the total contracted amount, they should not expect payment from Medicare.
  - Never enter both condition code 77 and value code 44.

Treatment Authorization Code

- The treatment authorization code (Oasis matching key):
  - UB-04 Field Locator (FL) 63
  - Needs to be shown on line ‘B’ when Medicare is the secondary payer.

**Note:** FLs with ‘A’, ‘B’, ‘C’ capabilities must match up with the appropriate payer and payer code.
Other MSP Billing Tips

- Claims appearing on remits or in DDE in S/LOC “R B7516” are not finalized
  - Claims go to S/LOC “R B7516” and remain in this location for 75 days to become final.
  - Adjusting claims before final (R B9997 or P B9997) receive the 30928 reason code in most cases.
  - “An adjustment is being submitted against a record in a post pay location. The MSP record on CWF needs to be in a finalized status before making an adjustment. Please wait until the record on CWF has been finalized and resubmit your adjustment.”
MSP Billing Tips

- Do not attempt adjusting claims until final or until CWF is updated
- Request processing if CWF is updated prior to your 75-day hold
- If the record on CWF is not related to the claim (i.e., worker’s compensation or liability), then the providers must indicate in remarks on the adjustment “not related to the open record”

Important!!

- Providers should understand the EOB issued by the primary insurance company
  - Ask questions
  - Understand the agreements in the contract with the insurance company
  - Understand what is contractual
  - Understand what is considered payment in full
Conditional Payment Claims

Submitting Claims for Conditional Payment

- A conditional payment *may* be made on the claim when:
  - There is an expectation that payment will be recovered from the primary payer once payer status or liability settlements are resolved.
  - The claim was filed to the primary payer and payment was denied by the primary payer.

- Submit the claim with all appropriate codes and annotate in the remarks field why payment was not made. The remarks should reflect the reason stated on the primary Explanation of Benefits (EOB).
Submitting a Claim for Conditional Payment

- Submit a claim for conditional payment when:
  - Payment denied by primary insurer
    - Acceptable denial
    - Unacceptable denial
  - Submit entire claim to primary insurer
  - Do not send conditional payment request claim if payment is expected from the primary insurer
- Remarks
  - The Claim Adjustment Segments (CAS) are also utilized in the Medicare claims processing system to determine if the denial made by the primary insurance is acceptable for a conditional payment

Conditional Payment in No-Fault, Liability, or Workers’ Compensation Situations

- The provider should obtain liability information and attempt to collect for 120 days from the date of the accident
- After the 120 day period the provider may submit a claim to request a conditional payment, if desired
- The occurrence code related to the accident along with the date of the accident should be shown on the claim
- The system will require occurrence code 24 and a date
- The applicable MSP value code with six zeroes in the amount field should be shown
- The primary payer’s name first with a payer code of “C” and Medicare as the secondary or tertiary payer with a payer code of “Z” should be shown
Conditional Payment in No-Fault, Liability, or Workers’ Compensation Situations

- A conditional payment cannot be made without an open MSP record on CWF for the same MSP situation and covering the dates of service on the claim being submitted.

- In the Remarks section, any information related to the liability insurer, attorney or insurance company should be provided. Also, the employer’s name and address should be included.

- Report Information to the COBC

Adjusting MSP Claims
Adjusting MSP Claims

- If a claim has been rejected and has posted to the CWF, providers must submit an adjustment request once they have received payment from the primary insurer, a denial or have information documenting Medicare is primary.

- MSP rejected claims are often posted to CWF therefore, if the provider resubmits their claim electronically, it will be denied as a duplicate.

- When a RAP is rejected (receives a Z no pay code) because of an open MSP record, the provider should not send a request for the RAP to be cancelled or adjusted. The provider should just submit the final claim with the correct information and/or codes.

  Reminder: Adjustments cannot be submitted through DDE

Adjusting MSP Claims

- How to know when a claim can be adjusted
  - Most finalized claims that are processed, paid, or rejected (status location code – P B9997 or R B9997) are “posted” to Medicare history in CWF
  - If a historical record of a claim does exist, an adjustment transaction must be processed to update the historical record
  - If no historical record of the claim exists in CWF, the provider is still free to “create” one, and therefore a new original claim can be submitted
Adjusting MSP Claims

How to Know when a Claim can be Adjusted

- Access the finalized claim in FISS DDE using the Claims Inquiry function - #12 on the INQUIRY Menu
- Confirm that the status location code equals P B9997 or R B9997
- NOTE: Claims in status location P B9996 CANNOT be adjusted
  - Providers must wait until these claims progress to status locations P B9997 and R B9997
- Claims in R B7516 can be adjusted if the claim will be processed for primary or secondary payment
  - CWF records were updated to reflect Medicare as the primary payer,
  - or
  - Provider has primary insurer EOB to enter appropriate codes and amounts

Go to Page 2 of the claim which displays the revenue line items and charges billed on the claim
- The first function key selection available at the bottom of Page 2 should be PF2/F2
- Press PF2/F2 on your keyboard
Adjusting MSP Claims

How to Know when a Claim can be Adjusted Continued...

- Reviewing the page now displayed (line item detail); on the left toward the top is the TPE-TO-TPE (tape to tape) field. If this field contains an “X”, the finalized claim was **NOT** “posted” to CWF.

- Providers may still resubmit a new, revised original claim.

- If the TPE-TO-TPE field is blank or contains any value other than “X”, the claim is “posted” in CWF.

- You must adjust the claim.
For MSP adjustments, one of the following condition codes should be used on the claim:

- **D7** – Used when Medicare originally processed a claim as primary and the provider is submitting a primary payment made by another insurer.

- **D8** – Used where Medicare originally processed a claim as secondary or rejected the claim for MSP, and the provider is submitting information that shows Medicare should be the primary payer.

- **D9** – Used when submitting an adjustment claim for conditional payment.

- **D6** – This code (cancellation) should never be used when Medicare originally processed a claim as primary and the provider has now received a payment from another insurer as primary. Instead, a D7 should be used showing the primary payer information and amount the primary payer paid.
Adjusting MSP Claims

- Ensure that the correct cross-reference Document Control Number (DCN) is captured from DDE and entered in FL 60 of the Claim Form.
Timely Filing of MSP Claims

- The initial claim must be submitted within the timely filing period.
- The normal Medicare timely filing and reopening rules apply.
- An initial determination on a previously adjudicated claim may be reopened for any reason for 1 (one) year from the date of that determination.
- After 1 (one) year and prior to 4 (four) years from the date of determination, “good cause” is required for Medicare to reopen the claim.
Timely Filing

- In general, Medicare does not consider a situation “good cause” where:
  - Medicare processed a claim in accordance with the information on the claim form and consistent with the information in the Medicare’s systems of records and
  - A third party mistakenly paid primary when it alleges that Medicare should have been primary

MSP Claims Filing Requirements Summary
Home Health Claims and MSP Summary

- **OASIS**
  - Complete OASIS Assessment
- **Bill primary insurer for a payment determination (full or partial payment, or denial)**
- **RAP**
  - Submit as you normally do, without MSP Codes
  - If a primary record exists in the CWF, the RAP will process as a No Pay RAP = “Z”
- **Final Claim**
  - Fill in all the usual field locators
  - Add MSP Codes
  - Add Remarks (if applicable)
  - Enter appropriate information in the Claim Adjustment Segments as applicable

Resources
Resources

- CMS Manual System
  - Pub. 100-05 - Medicare Secondary Payer
    - www.cms.gov/manuals

- COB Contractor-Address general written inquiries to:
  - MEDICARE - Coordination of Benefits
  - MSP Claims Investigation Project
    - P.O. Box 33847
    - Detroit, MI 48232
    - Phone Number: 1-800-999-1118

- RHHI MSP Job Aid
  - www.PalmettoGBA/rhhi
  - Select RHHI Job Aids in the Top Links box on the left side of the page

Questions
Thank You for Attending!!!

The information provided in this handout was current as of July 31, 2010. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates after July 31, 2010 posted at www.PalmettoGBA.com/rhhi.
The Table below describes the actions taken by the Medicare claims processing system when certain Claim Adjustment Reason Codes (CARCs) appear in the Claim Adjustment Segments (CAS) of the claim.

<table>
<thead>
<tr>
<th>CARCs</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, 3, or 66</td>
<td>When the primary payer payment is equal to zero on all lines of service, Medicare will make a primary payment. Occurrence Code 24 and date are not required on the claim.</td>
</tr>
<tr>
<td>1 and 66</td>
<td>When the primary payer makes a payment greater than zero, Medicare secondary payment calculation will occur and payment (if any) will be made accordingly. Occurrence Code 24 and date are not required on the claim.</td>
</tr>
<tr>
<td>15, 17, 29, 58, 61, 95, 112, 117, 125, 130, 150, 163, 164, 179, 181, 182, 197, 210, 223, B4, B5, B7, B8, B10, B16.</td>
<td>The dollar amounts reported will be added to the primary payer payment amount reported on the claim. The amount of secondary payment, if any, will then be calculated and made accordingly.</td>
</tr>
<tr>
<td>4, 10, 11, 13, 14, 16, 19, 20, 21, 34, 39, 54, 101, 110, 111, 114, 115, 128, 129, 133, 136, 140, 146, 155, 158, 165, 174, 175, 176, 177, 180, 188, 189, 201, 206, 207, 208, A1, B15, B18, B23</td>
<td>No Medicare payment will be made</td>
</tr>
<tr>
<td>26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 204, B1 (if a Medicare covered visit), B14, W1</td>
<td>If the service is covered by Medicare and the primary payer did not make a payment, Medicare will make primary payment. Note: for W1 Medicare shall pay conditionally when the “E” Workers’ Comp record is open on CWF and payment will not be made within the promptly period.</td>
</tr>
<tr>
<td>5, 6, 7, 8, 9, 12, 18, 23, 24, 33, 38, 40, 97, 107, 109, 116, 138, 148, 171, 172, 178, 183, 185, 191, 193, 224, A7, B11, B12, B13.</td>
<td>The claim may be suspended for manual review claims to determine whether or not Medicare can payment. The claim will be processed in accordance with all applicable MSP and claims processing rules and procedures.</td>
</tr>
<tr>
<td>44, 45, 59, 90, 91, 94, 100, 102, 103, 106, 118, 131, 147, 151, 152, 153, 154, 160, 156, 157, 159, 173, 190, 192, 194, 198, 202, 203, B9, B20, B22</td>
<td>When the service is covered and payable by Medicare, the system will: 1) make a secondary payment for a given service, or group of services, and 2) utilize the primary payer’s payment amount to determine what, if any, payment can be made.</td>
</tr>
<tr>
<td>225</td>
<td>No payment will be made. The claim will be denied and return to the provider.</td>
</tr>
</tbody>
</table>