Completing the UB-04 & Medicare Secondary Payer

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HBS
Healthcare Business Specialists

Meet Your Presenter

Doug Swords, CHBME

Co-founder and VP, Revenue Cycle Management

Doug is a Co-Founder of Azalea Health and serves as Vice President of Revenue Cycle Management (RCM). Azalea is a cloud-based Health IT and RCM service company based in Valdosta and Atlanta GA. Swords has experience in Healthcare Administration and RCM dating back to 2003. He specializes in optimizing RCM operations for medical providers and facilities of all sizes and specialties.. He believes in analyzing data and performance measures to drive revenue growth for both Azalea and it's clients.

Doug holds a Bachelor's degree in Business Administration in Finance from Valdosta State University where he received the GOLD Alumni Award in 2008. Doug is a Certified Healthcare Business Management Executive (CHBME) through the Healthcare Business management Association (HBMA). He is currently the Board President for the Valdosta Lowndes County Habitat for Humanity Affiliate. He also serves on Advisory Boards for the Valdosta State University Langdale College of Business and the South Georgia chapter of the Medical Group Management Association (MGMA)

Helen Williams, CPC, CPM

Strategic Healthcare Consultant
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Helen Williams has more than 25 years of experience in healthcare financial management, billing and coding in practices, clinics, RHC and hospitals, including a variety of specialties. Working collaboratively with practices and hospitals, Williams helps healthcare organizations navigate the changing regulatory environment of healthcare, streamline operations, improve workflow and maximize revenue. Her extensive background includes RHC certification and policies, physician billing services, financial management consulting and workflow analysis, Medicare and Medicaid, verification, cash management and more. Williams is a certified ICD-10 coding professional.

Azalea and RHCs

- **Locations: Valdosta, Atlanta GA**
- **Multispecialty RCM**
  - Experience with 30+ specialties
- **Specialized in RHC billing & reimbursement**
  - Provider Based & Independent
  - 200+ RHC clients with ~40 RHC accounts under RCM mgmt
- **Certified Rural Health Coding & Billing (RH-CBS) Specialists on Staff**
- **Focused on Performance**
  - Clean Claim Rate
  - Days in AR
  - Denial %

Azalea's RHC Services and Offerings

Professional Services

- Assist with the setup and development of RHC's
- Provide consulting services to enhance clinic operations

SaaS

- EHR solution with RHC clinical and billing capabilities. Works with independent & provider based.

RCM

- End to End Revenue Cycle Management Services
- Assist with reporting and pulling cost report data

Completing the UB04

Completing the UB-04

Resources:

- **Medicare**
  - Medicare Claims Processing Manual - Chapter 9 - Rural Health Clinics
    - 50 - General Requirements for RHC and FQHC Claims (page 7)
  - Noridian RHC Billing Guide
  - Novitas UB04 Claim Sample
- **Medicaid**
  - UB-04 claim rules may vary by state for Medicaid programs
  - Pull RHC Billing manual from each state's MCAID website
  - Ex Georgia: Policies and Procedures Manual for FQHCs and RHCs
    - APPENDIX G - BILLING INSTRUCTIONS AND CLAIM FORMS (page 48)

Completing the UB-04 Bill Type

Field 4: RHC Bill Types

- **0711 - Admit to discharge**
- 0717 - Adjustment
- 0718 - Cancel
- 0710 - No payment

Tip: Don't forget the leading zero (0)!!

Code Structure

1st Digit – Leading Zero
CMS ignores the first digit

2nd Digit - Type of Facility
7 - Special facility (Clinic)

3rdDigit - Classification (Special Facility Only)
1 – Rural Health Clinic
7 – Federally Qualified Health Centers

4th Digit – Frequency	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
1 - Admit Through Discharge Claim	This code is used for a billing for a confined treatment.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct a previously submitted bill. This is the code used on the corrected or "new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

Completing the UB-04

Form Field	Required?	Description	Notes
5	Y	Federal Tax ID	Must match 855A and EDI enrollments
6	Y	Statement Covers Period (From-Through)	Use DOS for both from and to dates
8	Y	Patient Name	Must match medicare ID card
9	Y	Patient Address	
10	Y	Patient Birthday	
11	Y	Patient Sex	

Completing the UB-04

Form Field	Required?	Description	Notes
14	Y	Priority (Type) of Admission or Visit	This is new – RHCs will most like use the following: 2 - urgent **3 - elective (most common)** 9 - information not available
15	Y	Point of Origin for Admission or Visit (source)	Typical responses for RHCs **1 - nonhealthcare point of origin (home-most common)** 5 - from ICF, SNF or ALF 9 - information not available

Completing the UB-04

Form Field	Required?	Description	Notes
17	Y	Status: discharged to	Typical Responses for RHCs* **01-discharge to home or self care** 03-discharge to SNF 04-discharge to custodial care fac
18-28	N	Condition Codes	Rarely used with RHCs except for secondary payer, denials, and Hospice.
29	N	Accident state	Not used
30	N	Leave Blank	

*take note of leading "0"

Completing the UB-04: Condition Codes

PALMETTO GBA
A CELERIAN GROUP COMPANY

Jurisdiction J Part A

Did You Know Putting Condition Code D9 on Your Claim Will Cause it to Suspend?

When you make an adjustment or cancel a previously processed claim, you are required to include a condition code on your claim that explains the reason for the change. Only one claim change condition code may be reported on the claim. Providers should assure they select the one that best describes the claim change even if more than one change was made to the claim. Providers are also reminded not to select D9 unless no other code applies as it will cause the claim to suspend for manual review.

*A note in UB04 FL 80 is required when D9 condition code is used

Claim Change Reasons:

- D0 - Changes to service dates
- D1 - Changes in charges
- D2 - Changes in revenue code/HCPC
- D3 - Second or subsequent interim PPS bill
- D4 - Change in Grouper input (DRG)
- D5 - Cancel only to correct a patient's Medicare ID number or provider number
- D6 - Cancel only - duplicate payment, outpatient to inpatient overlap, OIG overpayment
- D7 - Change to make Medicare secondary payer
- D8 - Change to make Medicare primary payer
- D9 - Any other changes

Palmetto GBA

Completing the UB-04: Condition Codes

D0 (zero)	Use when the from and thru date of the claim is changed. • When you are only changing the admit date use condition code D9.
D7	Use used when the original claim shows Medicare on the primary payer line and now the adjustment claim shows Medicare on the secondary payer line. • Use D9 when adjusting primary payer to bill for conditional payment.
D8	Use when the original claim shows Medicare on the secondary payer line and now the adjustment claim shows Medicare on the primary payer line.
D2	Use when there is a change to the revenue codes, HCPCS code, RUG code, or HIPPS code. • If only removing procedure codes or diagnosis codes, D9 would be more appropriate.
D3	Use for a second or subsequent interim claim by inpatient PPS hospitals only.
D4	Change in grouper input (ICD-9/ICD-10 Diagnosis codes and ICD-9/ICD-10 Procedure codes) • Only use if the provider is changing or adding an ICD-9/ICD-10 code. • If the provider is only deleting these codes, then the D9 with remarks would be more appropriate.
D5	Use when canceling a claim to correct the Medicare ID or provider number. • Condition code only applicable on a xx8 type of bill.

D6	Use when canceling a claim for reasons other than the Medicare ID or provider number. Use when canceling a claim to repay a payment. • Condition code only applicable to a xx8 type of bill.
D1	If one of the above condition codes does not apply and there is a change to the COVERED charges this code should be used. • Use when adding a modifier to a line that would make the charges covered on the adjustment that were non-covered on the previous claim. • Use when the previous claim rejected for home health, hospice, HMO and other overlap reasons that have been updated.
E0 (Zero)	Use when the only change on the claim is a correction to the patient status code.
D9	Used for adjustments not described in any other condition codes. Remarks are required when using the D9 condition code to make a change. • Use in place of the D7 when adjusting the claim for conditional payment. • Use if adding a modifier to change liability and there is no change to the covered charge amount. • Use when adding or changing occurrence, occurrence span and/or value codes that do not affect the covered charges. • Use when changing the last 2 digits of the RUG code.

Noridian: Condition Codes

Completing the UB-04

Form Field	Required?	Description	Notes
31-34	N	Occurrence Code & Date	Situational but normally not used unless related to MSP
35-36	N	Occurrence Span Codes	Typically not used in RHCs

Occurrence Codes (OCs) and Dates (UB-04 FLs 31 – 34)

Code	Description
01	Accident/Medical Payment Coverage – Date of accident/injury for which there is medical payment coverage. Reported with VC 14 or VC 47. If filing for a Conditional Payment, report with Occurrence Code 24.
02	No-Fault Insurance (including automobile and other accidents) – Date of accident/injury for which the state has applicable No-Fault laws. Reported with VC 14 or 47. If filing for a Conditional Payment, report with Occurrence Code 24.
03	Accident/Tort Liability - Date of an accident/injury resulting from a third party's action that may involve a civil court action in an attempt to require payment by third party, other than No-Fault. Reported with VC 47.
04	Accident/Employment-Related - Date of an accident/injury related to beneficiary's employment. Reported with VC 15 or VC 41. If filing for a Conditional Payment, report with Occurrence Code 24.
05	Accident/No Medical Payment, No-Fault or Liability Coverage – Date of accident/injury for which there is no Medical Payment or other third-party liability coverage
06	Crime victim - Date on which a medical condition resulted from alleged criminal action committed by one or more parties
18	Date of retirement (beneficiary)
19	Date of retirement (spouse)
24*	Date Insurance denied - Date of receipt of a denial of coverage by a higher priority payer. This could be date of primary payer's Explanation of Benefit (EOB) statement, letter or other documentation. Date is required on all Conditional Payment claims.
25	Date Coverage No Longer Available – Date on which coverage, including Workers' Compensation benefits or No-Fault coverage, is no longer available to beneficiary
33	First day of MSP ESRD coordination period for ESRD beneficiaries covered by an EGHP

* Maintain documentation on file that supports the request for conditional payment from Medicare, such as the primary payer's EOB statement, denial/rejection letter, etc.

[CGS: Medicare Secondary Payer (MSP): Condition, Occurrence, Value, and Patient Relationship, and Remarks Field Codes]

Completing the UB-04

Form Field	Required?	Description	Notes
39-41	N	Value Codes and Amounts	Situational but normally not used unless related to MSP

Value Codes (VCs) and Amounts (UB-04 FLs 39-41) When entering amounts for VCs (except for VC 44), the following applies:

- Enter the amount provider received from primary payer toward Medicare-covered charges on claim
- If requesting conditional payment, enter zeros (00.00)
- If no payment or reduced payment was received due to failure of filing a proper claim with primary payer, enter amount provider would have received had it filed a proper claim with primary payer.

Code	Description
12	Working aged beneficiary/spouse with an EGHP (beneficiary over 65). Beneficiary must have Medicare Part A entitlement (enrolled in Part A) for this provision to apply. Primary Payer Code = A.
13	ESRD beneficiary with EGHP in MSP/ESRD 30-month coordination period. Primary Payer Code = B.
14	No-Fault including automobile/other. Examples: Personal injury protection (PIP) and medical payment coverage. Requires OC 01 or 02 with date of accident/injury. Primary Payer Code = D. If filing for a Conditional Payment, report with Occurrence Code 24.
15	Workers Compensation (WC). Requires CC 02 and OC 04 with date of accident/injury. Primary Payer Code = E. If filing for a Conditional Payment, report with Occurrence Code 24.
16	Public health services (PHS) or other federal agency. Conditional billing does not apply. Primary Payer Code = F.
41	Federal Black Lung (BL) Program. Primary Payer Code = H.
42	Veterans Administration (VA). Conditional billing does not apply. Primary Payer Code = I.
43	Disabled beneficiary under age 65 with an LGHP. Beneficiary must have Medicare Part A entitlement (enrolled in Part A) for this provision to apply. Primary Payer Code = G.
44	Amount provider was obligated/required to accept from a primary payer as payment in full due to contract/law when that amount is less than charges but higher than amount actually received. An MSP payment may be due. **Note:** When applicable, this VC is reported in addition to MSP VC.
47	Any Liability Insurance. Requires OC 02 with date of accident/injury. Primary Payer Code = L. If filing for a Conditional Payment, report with Occurrence Code 24.

CGS: Medicare Secondary Payer (MSP): Condition, Occurrence, Value, and Patient Relationship, and Remarks Field Codes
CGS: Medicare Secondary Payer Billing & Adjustments

Completing the UB-04: Revenue Codes

RHC Services FL 42 - <u>Required</u>

- 0521 - Clinic Visit by member to RHC
- 0522 - Home visit by RHC practitioner
- 0524 - Visit by RHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
- 0525 - Visit by RHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
- 0527 - RHC Visiting Nurse Service(s) to a member's home when in a home health Shortage Area
- 0528 - Visit by RHC practitioner to other non RHC site (e.g., scene of accident)
- 0900 - Behavioral Health Treatments/Services
- 0001 = Total charges for all line items

Completing the UB-04

Form Field	Required?	Description	Notes
43	N	Revenue Description	“Clinic Visit” most common
44	Y	HCPCS/Rate/HIPPS Code	HCPCS codes are required for RHC claims effective 4/1/2016
45	Y	Service Date	Same as dates in FL 6
46	Y	Service Units	Only one visit is billed per day unless the patient leaves and later returns with a different illness or injury suffered later on the same day.

Completing the UB-04

Form Field	Required?	Description	Notes
47	Y	Total Charges	All services performed that day to include office visit, procedures, additional supplies, injections, and drugs that are bundled into the first line minus copayments.
48	N	NonCovered Charges	Used rarely
49	N	Not Used	
50	Y	Payer Name	Insurance Payer Name as it exists in your software system

Completing the UB-04

Form Field	Required?	Description	Notes
51	Y	Health Plan ID	National Health Plan ID typically assigned by Medicare or Clearinghouse
52	Y	Release of Information	Usually “Y” – Yes, patient signed statement for data release, could be “I” – Informed consent to release data regulated by statue.
53	Y	Assignment of Benefits	“Y” – Payment to provider is authorized “N” – Payment to provider is not authorized
54	N	Prior Payments	Left blank for initial RHC claim

Completing the UB-04

Form Field	Required?	Description	Notes
55	N	Est. Amount Due from Patient	
56	Y	NPI of Billing Provider	RHC NPI Number
57	N	Other provider ID	May be necessary for crossover to Medicaid secondary
58	Y	Insured's Name	Patient Relationship to Insured
59	Y	Patient Relationship to Insured	Typically 18 (self)

Completing the UB-04

Field 59 Patient Relationship

Patient Relationship Codes (UB-04 FL 59A, B, C)

Code	Description
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

CGS: Medicare Secondary Payer (MSP): Condition, Occurrence, Value, and Patient Relationship, and Remarks Field Codes

Completing the UB-04

Form Field	Required?	Description	Notes
60	Y	Insured's Unique Identification	Typically Medicare beneficiary identifier
61	N	Insured Group Name	RHC NPI Number
62	N	Insurance Group Number	May be necessary for crossover to Medicaid secondary
63	N	Treatment Authorization Code	May be required for HMO or PPO claims when preauthorization is required
64	N	Document Control Number	Situational. The control number assigned to the original bill. Used in conjunction with adjustment or cancel Condition Codes

Completing the UB-04

Form Field	Required?	Description	Notes
65	N	Employer Name	
66	N	Diagnosis and Procedure Code Qualifier	The qualifier that denotes the version of International Classification of Diseases (ICD) reported
67	Y	Principal Diagnosis Code and Present on Admission Indicator (ICD-9-CM code)	Some V-codes are appropriate as primary codes; list as many as provider addressed and also those that were considered in the treatment of the patient
68	N	Not Used	

Completing the UB-04

Form Field	Required?	Description	Notes
69	N	Admission Diagnosis	Not required for outpatient claims
70	N	Patient Reason Diagnosis	Not required for RHCs
71-73	N	Not Used	
74	N	Principal Procedure Codes and Dates	Not used for RHCs
75	N	Not Used	

Completing the UB-04

Form Field	Required?	Description	Notes
76	Y	Attending Provider NPI, Last Name, First Name	Sometimes legacy IDs and qualifiers are needed in addition to the NPI but are rare
77-79	N	Other Providers	Not used with RHC claim
80	N	Remarks	Use only if need additional information to the payer. Must have a remark if claim is adjusted, canceled, or two visits on the same day.

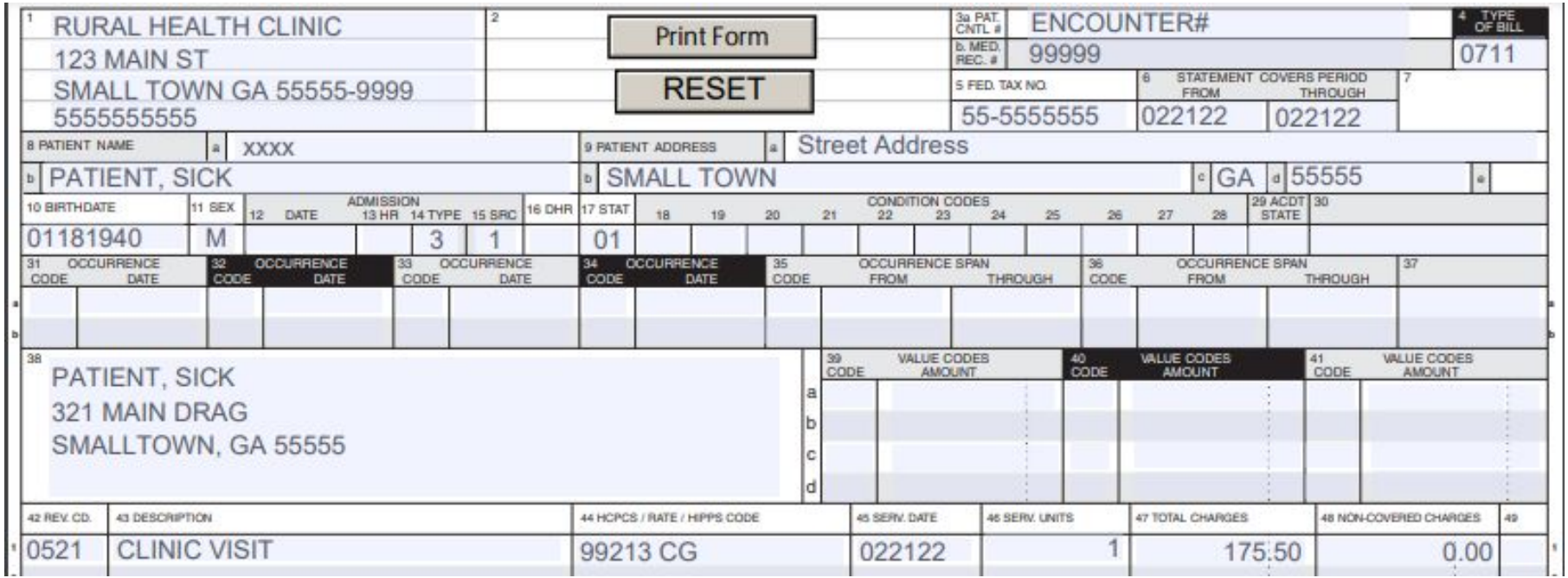
Completing the UB-04

Form Field	Required?	Description	Notes
81CCa	N	Code-Code Field	This will show if there is a marital status for the patient, ie B2 for single. This is not required.
81CCb	Y	Code-Code Field	This is the Taxonomy code for the facility. RHC = B3 (noting taxonomy code) 261QR1300X (taxonomy code)

Completing the UB-04: Corrected Claims

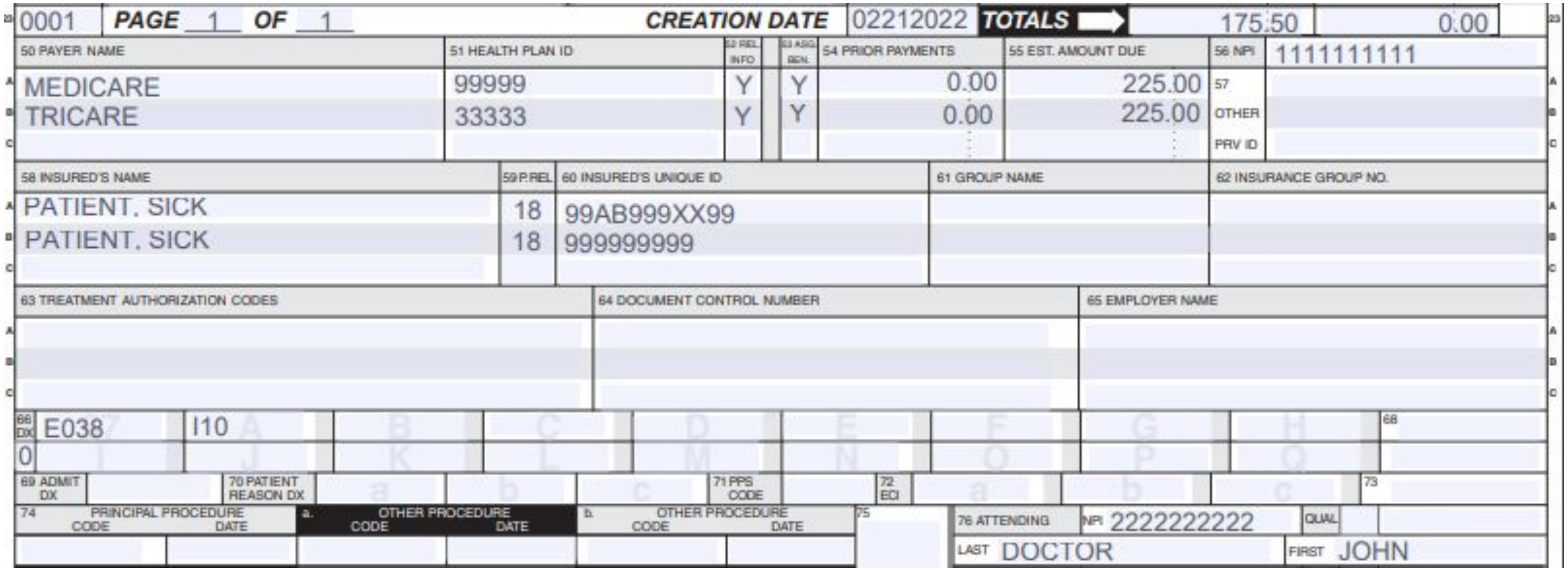
- **Return to Provider (RTP) -** Send a clean claim
- **Suspended Status -** Do not rebill until claim RTP or Rejected. (Send a clean claim when claim status changes to RTP or Reject)
- **Denied Claim** - Rebill a corrected claim with the following UB04 FLs
    - FL 4 - 0717 Bill Type
    - FL 18 - Condition Code
    - FL 64a - Original Claim Number

Completing the UB-04



[Novitas: CMS 1450 UB 04]

Completing the UB-04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50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1111111111
A MEDICARE	99999	Y	Y	0.00	225.00	57
B TRICARE	33333	Y	Y	0.00	225.00	OTHER
C						PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A PATIENT, SICK	18	99AB999XX99		
B PATIENT, SICK	18	999999999		
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX 0 | E038 | I10 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

76 ATTENDING NPI 2222222222 QUAL

LAST DOCTOR FIRST JOHN

[Novitas: CMS 1450 UB 04]

Completing the UB-04 - EDI[1]

837I (electronic) vs CMS-1450 (aka UB-04 paper)

- **837I** - The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically.
- **CMS-1450 (UB-04)** - The Form CMS-1450, also known as the UB-04, is the standard claim form to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed
- Data elements in the CMS uniform electronic billing specifications are consistent with the hard copy data set to the extent that 1 processing system can handle both.
- **ANSI ASC X12N 837I** - The ANSI ASC X12N 837I (Institutional) Version 5010A2 is the current electronic claim version. To learn more, visit the ASC X12 website.

[1] Medicare Billing: Form CMS-1450 and the 837 Institutional

UB04 - 837I Crosswalk[1]

ASC 837I version 5010A2 Institutional Health Care Claim to the CMS-1450 Claim Form Crosswalk

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for administrative simplification. HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. The ASC 837I v5010A2 health care claim for institutional providers was established in accordance with these HIPAA regulations.

The implementation of the ASC 837I v5010A2 presents substantial changes in the content of the data Institutional providers will submit with their claims. In order to help Institutional providers prepare for these changes, Palmetto GBA has created a CMS-1450 Claim Form Crosswalk to ASC 837I v5010A2 Institutional Health Care Claim. This crosswalk will help institutional providers with correct claims submission during and after the transition to the ASC 837I v5010A2.

CMS-1450 Claim Form Crosswalk to ASC 837I v5010A2 Institutional Health Care Claim

Form Locator #	Description	ASC 837I v5010A2 Loop, Segment
01	Billing Provider, Name, Address and Telephone Number	Loop 2010AA, NM1/85/03, N3 segment, N4 segment
02	Pay-to-Name and Address (required when different from form locator 01)	Loop 2010AB, NM1/85/03, N3 segment, N4 segment
03a	Patient Control Number	Loop 2300, CLM01
03b	Medical Record Number	Loop 2300, REF/EA/02
04	Type of Bill	Loop 2300, CLM05-1, CLM05-3
05	Federal Tax ID Pay-to-provider = to the Billing Provider Pay-to-provider not = to the Billing PROV	 Loop 2010AA, NM109, REF/EI/02 Loop 2010AB, NM109, REF/EI/02
06	Statement Covers Period (MMDDYY)	Loop 2300, DTP/434/03
07	Reserved for future use	
08a	Patient Name When patient = Subscriber When patient is not = Subscriber	 Loop 2010BA, NM1/IL/03, 04, 05, 07 Loop 2010CA, NM1/QC/03, 04, 05, 07
08b	Patient Identifier When patient = Subscriber When patient is not = Subscriber	 Loop 2010BA, NM1/IL/09 Loop 2010CA, NM1/QC/09

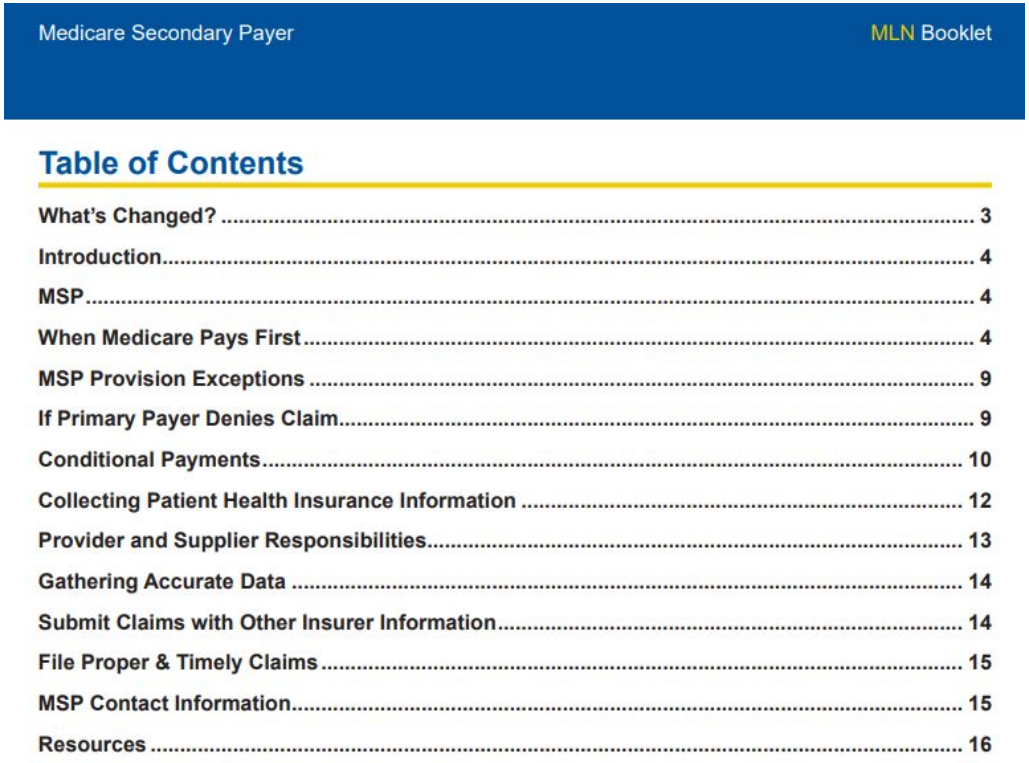
[1] CMS-1450 Claim Form Crosswalk to ASC X12 837I v5010A2

Medicare Secondary Payer

Medicare Secondary Payer

[MLN Booklet: Medicare Secondary Payer]

Medicare Secondary Payer



Medicare Secondary Payer MLN Booklet

Table of Contents

Medicare Secondary Payer (MSP)

- **Medicare Secondary Payer (MSP)** is the term generally used when the Medicare program does not have primary payment responsibility - that is, when another entity has the responsibility for paying before Medicare.
- The Medicare Secondary Payer (MSP) provisions protect the **Medicare Trust Fund** from making payments when another entity has the responsibility of paying first.
- CMS developed an **MSP questionnaire** for providers to use as a guide to help identify other payers that may be primary to Medicare.
- CMS recommends that providers retain MSP information for **10 years**.

[1] CMS: Medicare Secondary Payer

Medicare Secondary Payer (MSP)

MSP

MSP provisions prevent Medicare paying items and services when patients have other primary health insurance coverage. In these cases, the MSP Program contributes:

- **National program savings:** CMS MSP provisions enforcement saved the Medicare Program about $8.5 billion in FY 2018.
- **Increased provider, physician, and other supplier revenue:** Billing a primary plan before Medicare may offer you better payment rates, and coordinated health coverage may expedite the payment process and reduce administrative costs.
- **Avoiding Medicare recovery efforts:** Filing claims correctly the first time prevents future claim recovery efforts.

To get these benefits, it's important to ask or access accurate, current information about your patient's health insurance coverage. Medicare regulations require providers submitting claims to determine if we are the primary or secondary payer for patient items or services given.

When Medicare Pays First

Primary payers must pay a claim first. Medicare pays first for patients who don't have other primary insurance or coverage. In certain situations, Medicare pays first when the patient has other insurance coverage.

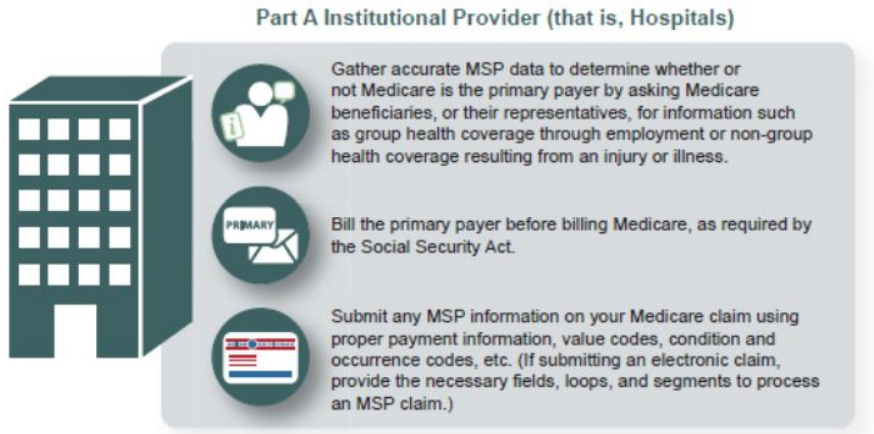
Table 1 lists common situations when a patient has Medicare, other health plan coverage, and which entity pays first (primary payer) and which pays second (secondary payer).

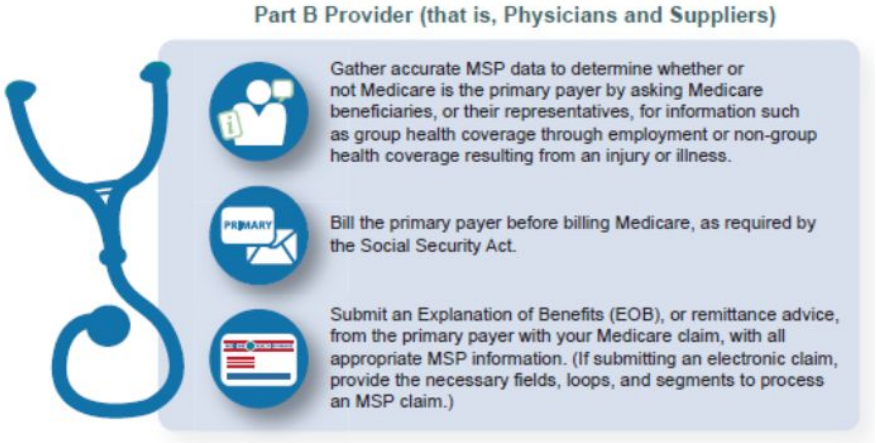
Stay Up to Date

To sign up for automatic updates, enter your email address in the Receive Email Updates box at the bottom of the Coordination of Benefits & Recovery (COB&R) Overview webpage.

MLN Booklet: Medicare Secondary Payer

Medicare Secondary Payer (MSP)





[MLN Booklet: Medicare Secondary Payer]

Medicare Secondary Payer

Table 1. Common MSP Coverage Situations

Individual	Condition	Pays First	Pays Second
65 or older and covered by a Group Health Plan (GHP*) through current employment or spouse's current employment	Entitled to Medicare Employer has **less** than 20 employees	Medicare	GHP
65 or older and covered by a GHP through current employment or spouse's current employment	Entitled to Medicare Employer has 20 or **more** employees or is part of a multiple or multi-employer group with at least 1 employer employing 20 or **more** individuals	GHP	Medicare
65 or older, has an employer retirement GHP, and isn't working	Entitled to Medicare	Medicare	Retiree Coverage
Under 65, disabled, and covered by a GHP through their current employment or a family member's current employment	Entitled to Medicare Employer has **less** than 100 employees	Medicare	GHP
Under 65, disabled, and covered by a GHP through their current employment or a family member's current employment	Entitled to Medicare Employer has 100 or **more** employees or is part of a multiple or multi-employer group with at least 1 employer employing 100 or **more** individuals	GHP	Medicare

Table 1. Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Coverage under Federal Black Lung Program (FBLP)	Entitled to coverage under the FBLP Medicare covers services or items **not** related to black lung diagnosis	FBLP	Medicare
End-Stage Renal Disease (ESRD) and GHP coverage was primary before individual became eligible and entitled to Medicare based on ESRD diagnosis	Before 30 months of Medicare eligibility or entitlement	GHP	Medicare
ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	Medicare	GHP
ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage before becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement	COBRA	Medicare
ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	Medicare	COBRA
Parts A and B coverage under Medicare Advantage (MA) Plan	Also has a GHP Health Reimbursement Account (HRA)	Contact MA Plan for billing guidance.	None; employer pays individual from HRA for out-of-pocket expenses

Medicare Secondary Payer

Table 1. Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
Workers' Compensation (WC) coverage because of job-related illness or injury	Entitled to Medicare	WC pays health care items or job-related illness or injury services first. See Conditional Payments section.	Medicare
In an accident or other incident, including automobile accidents, where there's no-fault or liability insurance	Entitled to Medicare	No-fault or liability insurance pays accident- or other incident-related health care services first. See Conditional Payments section. WC, Liability, or no-fault pays first when there's Ongoing Responsibility for Medicals (ORM) reported. Medicare doesn't make a payment. Accident	Medicare **NOTE:** For ORM, Medicare doesn't make a payment until ORM funds exhaust.
In an accident or other incident where there's no-fault or liability insurance involved	Patient has no-fault or liability insurance but refuses to give the information	For Part A claims only, use condition code 08 to prevent the claim from returning to the provider. The Part A claim should reject and **assign the patient responsibility**.	None

Table 1. Common MSP Coverage Situations (cont.)

Individual	Condition	Pays First	Pays Second
65 or older **or** disabled and covered by Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Dual eligible patient regardless of eligibility reason	Entitled to Medicare and Medicaid	Medicare	Medicaid
Covered by Medicare **and** has a Medigap or Medicare supplement plan	Entitled to Medicare	Medicare	Medigap or Medicare Supplemental Plan
Active-duty status military member	Entitled to Medicare and TRICARE	TRICARE	Medicare
Inactive status military member treated by civilian providers	Entitled to Medicare and TRICARE	Medicare	TRICARE
Inactive status military member treated at a military hospital or by other federal providers	Entitled to Medicare and TRICARE	TRICARE	Medicare

* A GHP is any arrangement of, or contribution from, 1 or more employers or employee organizations providing insurance to current or former employees or their families.

Medicare Secondary Payer (MSP)

Section 20.2.1, "Admission Questions to Ask Medicare Beneficiaries," is a model questionnaire that may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: Providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. The model questionnaire in Section 20.2.1 lists the type of questions that should be asked of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1, 3 and 6.

[1] CMS: Medicare Secondary Payer

Medicare Secondary Payer (MSP)

2. Policy for Recurring Outpatient Services (page 5 CMS MSP)

Policy for Recurring Outpatient Services Hospitals must collect MSP information from the beneficiary or his/her representative for hospital outpatients receiving recurring services. Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his/her representative. **Following the initial collection, the MSP information should be verified once every 90 days.** If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for recurring outpatient services furnished by hospitals. **This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist**

[1] CMS: Medicare Secondary Payer

Official MSP Questionnaire

[20.2.1 - Admission Questions to Ask Medicare Beneficiaries]

20.2.1 - Admission Questions to Ask Medicare Beneficiaries

(Rev.)

The following *questionnaire contains* questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers *may use this* as a guide to help identify other payers that may be primary to Medicare. *This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.*

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: *MM/DD/CCYY*

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work related accident/condition?

___ Yes; Date of injury/illness: *MM/DD/CCYY*

Name and address of WC plan:

_____

Policy or identification number: _____

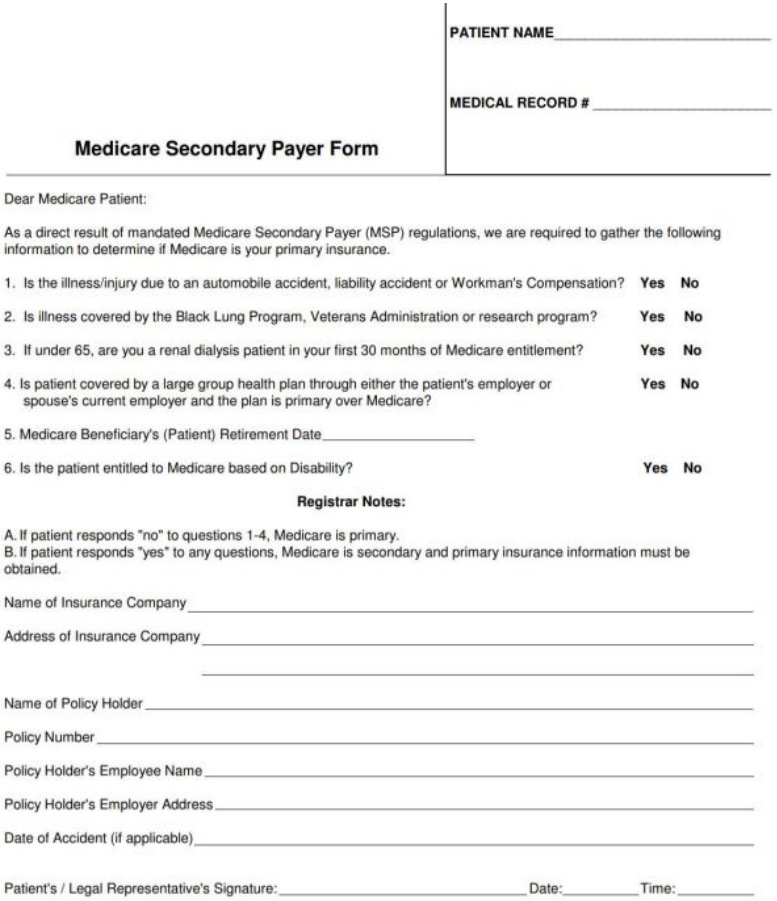
Name and address of your employer:

_____

Official MSP Questionnaire

20.2.1 - Admission Questions to Ask Medicare Beneficiaries

Build a condensed version



PATIENT NAME_____

MEDICAL RECORD # _____

Medicare Secondary Payer Form

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? **Yes No**
2. Is illness covered by the Black Lung Program, Veterans Administration or research program? **Yes No**
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? **Yes No**
4. Is patient covered by a large group health plan through either the patient's employer or spouse's current employer and the plan is primary over Medicare? **Yes No**
5. Medicare Beneficiary's (Patient) Retirement Date_____
6. Is the patient entitled to Medicare based on Disability? **Yes No**

Registrar Notes:

A. If patient responds "no" to questions 1-4, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____

Address of Insurance Company _____

_____

Name of Policy Holder _____

Policy Number _____

Policy Holder's Employee Name _____

Policy Holder's Employer Address _____

Date of Accident (if applicable) _____

Patient's / Legal Representative's Signature: _____ Date: _____ Time: _____

Medicare Secondary Payer (MSP) Online Tool

Medicare is a secondary payer when the beneficiary is covered by group insurance, Workers' Compensation, or if other third-party liability (auto, no-fault, liability) applies. To determine if a beneficiary has an MSP record, you will need to check the beneficiary's eligibility file. Eligibility information can be accessed by using the HIPAA Eligibility Transaction System (HETS) EXT, the CGS web portal, myCGS, or the Interactive Voice Response (IVR) PDF system. MSP claims can be submitted using the ANSI ASC X12N 837 format, or via the Fiscal Intermediary Standard System (FISS) via Direct Data Entry (DDE). This tool is an online decision tree where you answer specific questions to determine appropriate billing of MSP claims to Medicare. CGS also offers the Medicare Secondary Payer Billing & Adjustments PDF quick resource tool as a resource for appropriate MSP billing. Proceed with the questions below to determine appropriate Medicare billing of your claim.

NOTE: In order for this tool to function correctly, please ensure that your pop-up blocker is enabled and javascript is turned on.

1. Does an MSP record appear on the beneficiary's eligibility file?

(●) Yes ( ) No

2. Do your dates of service fall within the effective and termination dates on the MSP record?

(●) Yes ( ) No

3. From the list below, select the type of MSP record that appears on the eligibility file that falls within the dates of services. If multiple records apply, follow the process that is most relevant and add remarks to your claim to address additional MSP records. Group health plans should always be acknowledged first, and then any non-group health plans.

12 (Working Aged)

Start over

Print this page

FEEDBACK

CGS:Medicare Secondary Payer (MSP) Online Tool

Medicare Secondary Payer (MSP) Lookup Tool

Unsure if Medicare should pay as the primary or secondary insurer for your patient? By answering a few simple questions this tool will help you determine if Medicare is the primary or secondary insurer.

Is the patient receiving Black Lung benefits?

- ○ Yes
- ◉ No

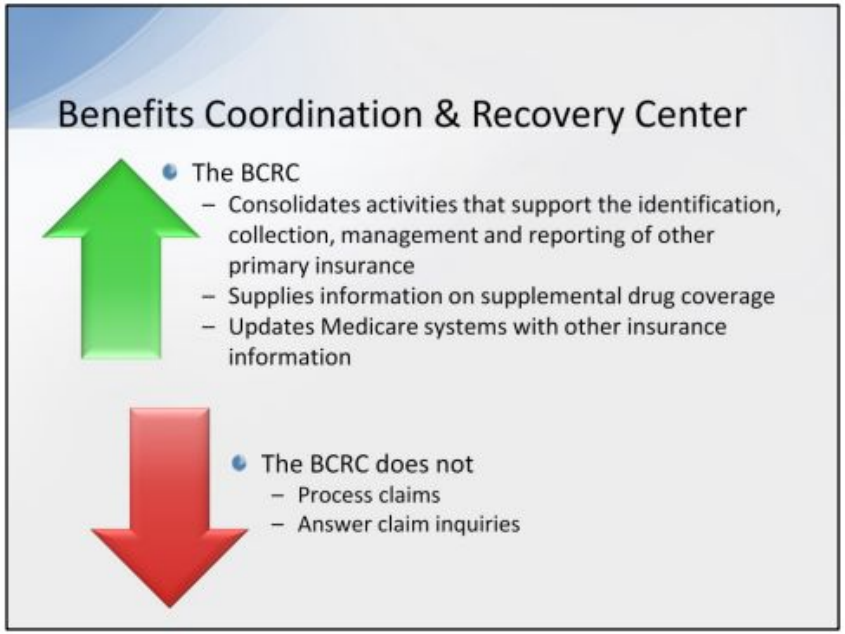
Is the care authorized by the Department of Veterans Affairs?

- ◉ Yes
- ○ No

Department of Veterans Affairs is PRIMARY for this service.

Medicare Secondary Payer (MSP) Lookup Tool

The Benefits Coordination & Recovery Center (BCRC)



BCRC Claims Investigation

If you don't provide us records of other health insurance or coverage that may be primary to Medicare on any claim and there's a sign of possible MSP considerations, the BCRC may request the patient, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire when the:

- MAC gets a claim with EOB or remittance advice from an insurer other than Medicare
- MAC gets electronic claim with other insurance payment information in loops and segments
- Patient self-reports or patient's attorney identifies an MSP situation
- Third-party payer submitted MSP information to MAC or BCRC

Find more information on Secondary Claim Development on the Reporting Other Health Insurance webpage.

Submit Claims with Other Insurer Information

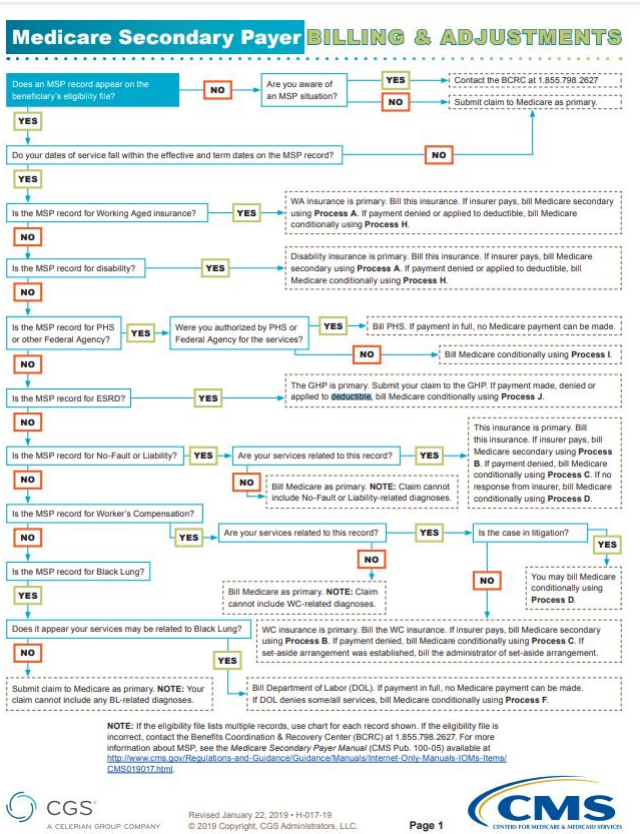
Medicare may mistakenly pay a claim as primary if it meets all billing requirements, including coverage and medical necessity guidelines. However, if the patient's CWF MSP record shows another insurer should pay primary to Medicare, we deny the claim.

If a MAC doesn't have complete information on the claim about other primary insurance, it is instructed to forward the information to the BCRC. Then the BCRC may send the patient, employer, insurer, or an attorney the SCD Questionnaire for additional information. The BCRC reviews the questionnaire responses and takes action.

Get more information on proper MSP billing in Medicare Secondary Payer Manual, Chapter 3.

Medicare Secondary Payer Overview
MLN Booklet: Medicare Secondary Payer

MSP Claims



Medicare Secondary Payer BILLING & ADJUSTMENTS

Does an MSP record appear on the beneficiary's eligibility file? NO → Are you aware of an MSP situation? YES → Contact the BCRC at 1.855.798.2627. NO → Submit claim to Medicare as primary.

YES

Do your dates of service fall within the effective and term dates on the MSP record? NO

YES

Is the MSP record for Working Aged insurance? YES → WA insurance is primary. Bill this insurance. If insurer pays, bill Medicare secondary using **Process A**. If payment denied or applied to deductible, bill Medicare conditionally using **Process H**.

NO

Is the MSP record for disability? YES → Disability insurance is primary. Bill this insurance. If insurer pays, bill Medicare secondary using **Process A**. If payment denied or applied to deductible, bill Medicare conditionally using **Process H**.

NO

Is the MSP record for PHS or other Federal Agency? YES → Were you authorized by PHS or Federal Agency for the services? YES → Bill PHS. If payment in full, no Medicare payment can be made. NO → Bill Medicare conditionally using **Process I**.

NO

Is the MSP record for ESRD? YES → The GHP is primary. Submit your claim to the GHP. If payment made, denied or applied to deductible, bill Medicare conditionally using **Process J**.

NO

Is the MSP record for No-Fault or Liability? YES → Are your services related to this record? YES → This insurance is primary. Bill this insurance. If insurer pays, bill Medicare secondary using **Process B**. If payment denied, bill Medicare conditionally using **Process C**. If no response from insurer, bill Medicare conditionally using **Process D**. NO → Bill Medicare as primary. **NOTE:** Claim cannot include No-Fault or Liability-related diagnoses.

NO

Is the MSP record for Worker's Compensation? YES → Are your services related to this record? YES → Is the case in litigation? YES → You may bill Medicare conditionally using **Process D**. NO → Bill Medicare as primary. **NOTE:** Claim cannot include WC-related diagnoses.

NO

Is the MSP record for Black Lung? YES → Does it appear your services may be related to Black Lung? YES → Bill Department of Labor (DOL). If payment in full, no Medicare payment can be made. If DOL denies some/all services, bill Medicare conditionally using **Process F**. NO → Submit claim to Medicare as primary. **NOTE:** Your claim cannot include any BL-related diagnoses.

WC insurance is primary. Bill the WC insurance. If insurer pays, bill Medicare secondary using **Process B**. If payment denied, bill Medicare conditionally using **Process C**. If set-aside arrangement was established, bill the administrator of set-aside arrangement.

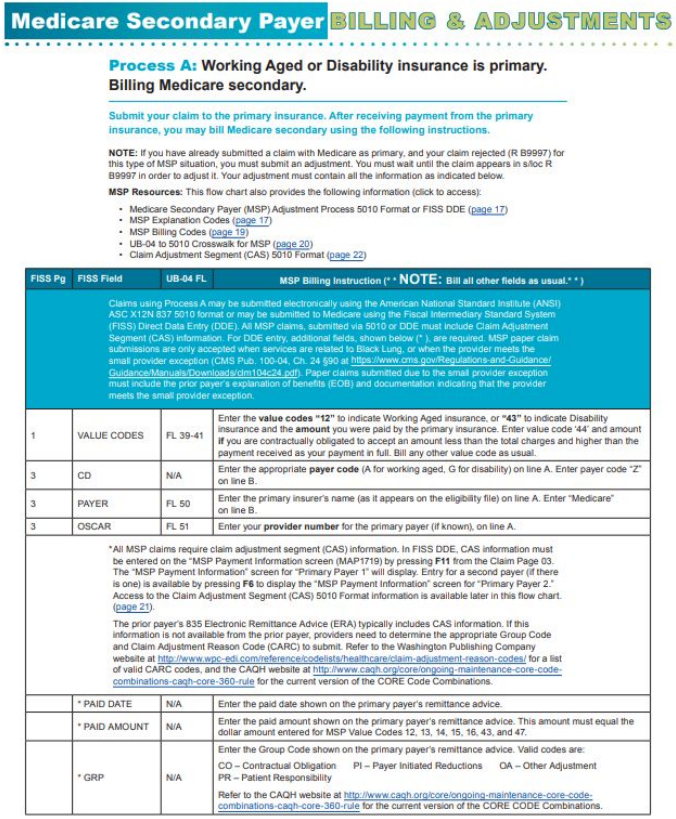
NOTE: If the eligibility file lists multiple records, use chart for each record shown. If the eligibility file is incorrect, contact the Benefits Coordination & Recovery Center (BCRC) at 1.855.798.2627. For more information about MSP, see the *Medicare Secondary Payer Manual* (CMS Pub. 100-05) available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html.

CGS A CELERIAN GROUP COMPANY

Revised January 22, 2019 • H-017-19

Page 1

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES



Medicare Secondary Payer BILLING & ADJUSTMENTS

Process A: Working Aged or Disability insurance is primary. Billing Medicare secondary.

Submit your claim to the primary insurance. After receiving payment from the primary insurance, you may bill Medicare secondary using the following instructions.

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

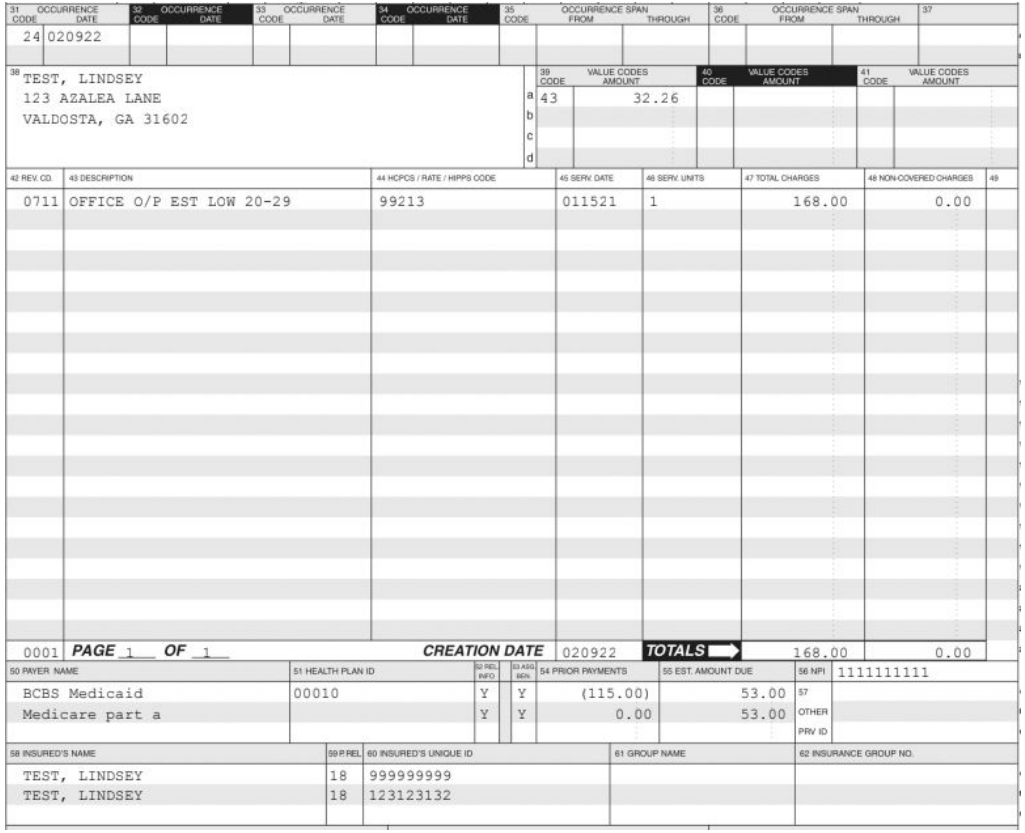
- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* • **NOTE: Bill all other fields as usual.** *)
			Claims using Process A may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.
1	VALUE CODES	FL 39-41	Enter the **value codes "12"** to indicate Working Aged insurance, or **"43"** to indicate Disability insurance and the **amount** you were paid by the primary insurance. Enter value code '44' and amount **if** you are contractually obligated to accept an amount less than the total charges and higher than the payment received as your payment in full. Bill any other value code as usual.
3	CD	N/A	Enter the appropriate **payer code** (A for working aged, G for disability) on line A. Enter payer code "Z" on line B.
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
			*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.
	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.

[CGS: Medicare Secondary Payer (MSP): Condition, Occurrence, Value, and Patient Relationship, and Remarks Field Codes]

[CGS: Medicare Secondary Payer Billing & Adjustments]

Medicare Secondary Payer (MSP) UB-04 Example



31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
24	020922													

38 TEST, LINDSEY
123 AZALEA LANE
VALDOSTA, GA 31602

	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
a	43	32.26				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0711	OFFICE O/P EST LOW 20-29	99213	011521	1	168.00	0.00	
0001	PAGE 1 OF 1	CREATION DATE	020922	TOTALS	168.00	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
BCBS Medicaid	00010	Y	Y	(115.00)	53.00	1111111111	
Medicare part a		Y	Y	0.00	53.00		OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
TEST, LINDSEY	18	999999999		
TEST, LINDSEY	18	123123132		

MSP Electronic Claim Filing Requirements[1]

Medicare Secondary Payer (MSP) Electronic Claim Filing Requirements

The following tables of loops, segments and elements should assist programmers, software vendors and clearinghouses with billing Part B Medicare Secondary Payer (MSP) claims electronically. These instructions include only the segments and elements required for submitting MSP claims.

Subscriber Information - Secondary Payer (Medicare)

Loop, Segment, Element	Description	Value(s)	Comments
2000B, SBR, 01	Payer Responsibility Code	S	
2000B, SBR, 02	Relationship Code	18	
2000B, SBR, 09	Claim Filing Indicator Code	MA	
2010BA, NM1/IL, 08	Subscriber Primary Identifier Code	MI	
2010BA, NM1/IL, 09	Subscriber Primary Identifier	Medicare Beneficiary Identifier (MBI)	

[1] PalmettoGBA: Medicare Secondary Payer (MSP) Electronic Claim Filing Requirements

Medicare Secondary Payer (MSP)

Resources

- Billing for Services when Medicare is a Secondary Payer
- Medicare Secondary Payer (MSP) Manual
  - 20.2.1 - Model Admission Questions to Ask Medicare Beneficiaries (pg 16)
  - 20.2.1 Admission Questions to Ask Medicare Beneficiaries
- MLN Booklet: Medicare Secondary Payer
- Sample MSP Questionnaires
  - MAC Jurisdiction C
- National Government Services Medicare Secondary Payer Guides
- Medicare Secondary Payer Overview - Presentation Slides
- Noridian MSP Compliance & Payer Types - VIDEO

[1] CMS: Medicare Secondary Payer