



Medicare Secondary Payer (MSP) Billing - When Primary Payer Made Payment

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NHIC, Corp.

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Acronyms

CC	Condition Code
CMS	Centers for Medicare & Medicaid Services
COBC	Coordination of Benefits Contractor
CWF	Common Working File
DDE	Direct Data Entry
DOA	Date of Accident
DOS	Date of Service
EGHP	Employer Group Health Plan

Acronyms

EOB	Explanation of Benefit
ESRD	End-Stage Renal Disease
FISS	Fiscal Intermediary Standard System
FL	Field Locator
ID	Identification
IOM	Internet-Only Manual
IP	Inpatient
LGHP	Large Group Health Plan

Acronyms

MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
OC	Occurrence Code
OP	Outpatient
RA	Remittance Advice
TOB	Type of Bill
UB	Uniform Bill
VC	Value Code

Objective

Educate providers on how to prepare accurately-coded MSP claims following the receipt of payment from the primary payer.

Agenda

- MSP claim types
- Life of an MSP claim
- Preparing MSP claims
- Situations that affect MSP Value Code (VC) amount
- Special claim coding for contractual arrangement/law
- UB-04/CMS-1450 Claim Scenarios A-F
- Payment, benefit day utilization and beneficiary responsibility on MSP claims
- What you should do now
- Open question and answer segment

Types of MSP Claims

- Claims submitted to Medicare after primary payer makes payment
 - Two types
 - MSP partial-payment claims
 - MSP full-payment claims

MSP Partial-Payment Claim – Defined

Claim partially paid by primary payer is known as an MSP partial-payment claim

- Balance remains after primary payer's payment

Did You Know...

A provider may consider a payment made by the primary payer to be payment in full on a claim even if that payment amount is less than the total amount of Medicare-covered charges on the claim. Typically, this is due to a contractual arrangement or an obligation under law.

MSP Partial-Payment Claim – Why a Balance Remains

- Primary payer's payment amount is
 - Less than full payment of Medicare-covered charges on claim
 - Less than expected amount
 - Expected amount = amount considered to be full payment of Medicare-covered charges on claim
 - Due to contractual arrangement or obligation under law

Reasons Providers Receive Less Than Charges or Amount Expected

- Portion of claim was
 - Noncovered by primary plan
 - Applied toward primary plan's
 - Deductible
 - Coinsurance
 - Copayment

MSP Partial-Payment Claim – When to Submit

Submit all claims, both inpatient (IP) and outpatient (OP), that have only been partially paid by the primary payer (MSP partial-payment claims) since there is a balance remaining for Medicare to consider.

MSP Full-Payment Claim – Defined

Claim fully paid by primary payer is known as an MSP full-payment (or no-payment) claim

- No balance remains after primary payer's payment

MSP Full-Payment Claim – Why No Balance Remains

Primary payer's payment amount is

- Equal to full payment of Medicare-covered charges on claim
- Equal to full payment of expected amount
 - Expected amount = amount considered to be full payment of Medicare-covered charges on claim
 - Due to contractual arrangement or obligation under law

MSP Full-Payment Claim – When to Submit

Submit MSP full-payment claims for

– IP stays

- Tracks benefit periods
- Primary payer's payment used to satisfy applicable IP Medicare deductible and/or coinsurance amounts

– OP services when beneficiary has not met his/her annual Medicare Part B deductible

- Primary payer's payment used to satisfy applicable OP Medicare deductible and/or coinsurance amounts

Did You Know...

Providers can check the Common Working File (CWF) to determine whether or not a beneficiary has met his/her annual Medicare Part B deductible.

Life of an MSP Claim

- Determine primary payer and submit claim to them
- Apply payment to account
- Prepare MSP claim if required
- Add special claim coding if contractual arrangement/law exists obligating provider to accept certain amount from primary payer as payment in full
 - Check primary payer's Explanation of Benefits (EOB) statement and/or Remittance Advice (RA)
 - Provider may maintain internal listing
 - Ask supervisor or manager

Life of an MSP Claim (cont.)

- Check for matching online MSP file in CWF
- Contact Coordination of Benefits Contractor (COBC) if
 - There is no online MSP file or
 - There is no matching online MSP file
- Submit MSP claim once a matching online MSP file is in CWF

Preparing MSP Claims



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References for MSP Claim Submission

- CMS Internet-Only Manual (IOM) Publication 100, available on CMS' Web site at www.cms.hhs.gov/manuals/
 - Claim fields and billing codes
 - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25 "Completing and Processing the Form CMS-1450 Data Set," Section 75
 - MSP billing
 - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3 "MSP Provider, Physician, and Other Supplier Billing Requirements"
- Handouts
 - Preparing MSP Claims
 - MSP and Conditional Claims Billing Code Chart

Claim Submission

CMS-1450 (UB-04) form

– Electronic (837I)

- Cannot submit conditional or MSP claims in the Fiscal Intermediary Standard System (FISS)/Direct Data Entry (DDE)
- See MM6426
 - » <http://www.cms.hhs.gov/MLNMArticles/downloads/MM6426.pdf>

– Hardcopy

Did You Know....

All of Medicare's technical requirements, medical necessity guidelines, frequency of billing policies, and other billing policies apply to MSP claims just as they do to claims for which Medicare is primary.

General Instructions

Complete claims in usual manner

- Report all coding usually required including all Medicare-covered charges
 - Do not report just balance remaining after primary payer's payment
- Follow frequency of billing guidelines with Medicare
 - For example, if provider required to submit to Medicare every 30 or every 60 days, then this does not change simply because Medicare is secondary

General Instructions

Report

- Covered Type of Bill (TOB); do not use TOB XX0
- Total covered and noncovered charges/days as if there had been no other payment (inpatient claims)
- All other applicable MSP billing codes
 - Use Preparing MSP Claims (handout)
 - Use MSP Billing Code Chart (handout)
 - Use information gathered during MSP screening

FLs to Complete

Code	UB-04 FLs
Condition codes (CC) (including CC 77 if applicable)	18–28
Occurrence codes (OC) and dates (must be present for accidents)	31–34
MSP value code and primary payment (and VC 44 if applicable)	39–41
Patient's relationship to insured	59A

FLs to Complete

Code	UB-04 FLs
Payer name (actual name)	50A
Insured's name	58A
Insured's unique ID	60A
Insurance group name	61A
Insurance group number	62A
Employer name, if applicable	65
Remarks (insurance address)	80

Condition Codes FL 18-28

Occurrence Codes FL 31-34

Value Codes FL 39a-41d

Payer Name FL 50a,b,c

Insured's Name

Diagnosis Codes FL 66-69

Remarks FL 80

1 PATIENT NAME										2 PATIENT ADDRESS										3a DAT. CNTL #		4 TYPE OF BILL																	
10 BIRTHDATE										11 SEX		12 DATE		13 HL		14 TYPE		15 SRC		16 DHR		17 STAT		18 CONDITION CODES															
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE DATE		37 OCCURRENCE CODE		38 OCCURRENCE DATE		39 OCCURRENCE CODE		40 OCCURRENCE DATE		41 OCCURRENCE CODE		42 OCCURRENCE DATE																	
39a CODE		39b VALUE CODES AMOUNT		39c CODE		39d VALUE CODES AMOUNT		40a CODE		40b VALUE CODES AMOUNT		40c CODE		40d VALUE CODES AMOUNT		41a CODE		41b VALUE CODES AMOUNT		41c CODE		41d VALUE CODES AMOUNT																	
42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
50 PAYER NAME										51 HEALTH PLAN ID										52 REL. INFO		53 APR. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID									
58 INSURED'S NAME										59 R REL		60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																			
74 ADMIT DX		76 PATIENT REASON/DX		77 OTHER PROCEDURE DATE		78 OTHER PROCEDURE DATE		79 OTHER PROCEDURE DATE		74a PRINCIPAL PROCEDURE CODE		74b OTHER PROCEDURE CODE		74c OTHER PROCEDURE CODE		74d OTHER PROCEDURE CODE		74e OTHER PROCEDURE CODE		74f OTHER PROCEDURE CODE		74g OTHER PROCEDURE CODE																	
80 REMARKS										81a CC		81b		81c		81d		75 ATTENDING NPI		76 QUAL		77 LAST		78 FIRST		79 LAST		80 FIRST											
82 REMARKS										82a		82b		82c		82d		75 OTHER NPI		76 QUAL		77 LAST		78 FIRST		79 LAST		80 FIRST											

Did You Know...

Although all MSP billing codes are important, accurate MSP claim coding depends on understanding how to correctly report the MSP VC, value amount, and the special coding necessary for contractual arrangements/law.

MSP VC and Amount

MSP VC for MSP Provision

- Report appropriate MSP VC that accurately represents applicable MSP Provision

MSP VC associated amount

- Report actual amount received from primary payer that applies toward Medicare-covered charges on MSP claim

Situations That Affect Value Code Amount

- Primary payer makes payment to provider in more than one check for services provider must bill to Medicare on one claim
- Provider must total all applicable primary payer's payment when reporting MSP VC amount on one Medicare claim
- Example
 - Provider required to report OP services on IP claim when preadmission services window policy applies
 - Provider must add primary payer's payment for OP service to primary payer's payment for IP service when submitting one IP Medicare claim

Situations That Affect Value Code Amount

- Primary payer makes payment to provider in one check for services provider must bill to Medicare in more than one claim
- Provider must split out primary payer's payment amount when reporting MSP VC amounts on more than one Medicare claim
- Example
 - Provider required to submit monthly claims to Medicare
 - Primary payer paid provider for a three-month stay in one check
 - Provider must split out primary payer's payment amount appropriately when submitting three monthly Medicare claims

Did You Know...

If the provider cannot determine how much of the primary payer's payment was made toward Medicare-covered charges on the MSP claim, it may apply the following formula from CMS IOM Publication 100-05, *MSP Manual*, Chapter 3, Section 40.2.

$$\begin{aligned} & \text{(Covered Charges } \div \text{ Total Charges)} \\ & \times \text{(Primary Payment Amount)} = \\ & \text{MSP VC Amount} \end{aligned}$$

Coding Required for Contractual Arrangement/Law

Provider expects to receive a certain amount from primary payer

- Certain amount = expected amount

Having Medicare as secondary does not null/void this arrangement

Special coding must be reported on MSP claims

- CC 77 if received expected amount
- VC 44 (and expected amount) if received less than expected amount

Submitting claims without this coding when required can cause Medicare overpayments

Example #1 – Report CC 77

Scenario (Contract/law = YES)

- Medicare-covered charges = \$5,000
- Provider expects from primary payer = \$4,000
- Provider receives from primary payer = \$4,000

Report

- Medicare-covered charges = \$5,000
- MSP VC _____ and amount = \$4,000
- CC 77

Medicare will not make payment on this claim

Situations in Which CC 77 Should Not Be Reported

- There is contractual arrangement/law between provider and primary payer but less than full payment from primary payer was received
- There is no contractual arrangement/law between provider and primary payer
- Claim being submitted is not an MSP claim (e.g., Medicare primary or conditional claim)

VC 44 Amount

Report amount provider expected to receive from primary payer as payment in full toward Medicare-covered services but before the primary payer's deductible, coinsurance, and/or co-payment was applied.

Example #2 – Report VC 44

Scenario (Contract/law = YES)

- Medicare-covered charges = \$5,000
- Provider expects from primary payer = \$4,000
- Provider receives from primary payer = \$3,000
- Primary payer applied deductible = \$1,000

Report

- Medicare-covered charges = \$5,000
- MSP VC _____ and amount = \$3,000
- VC 44 = \$4,000 (\$3,000 payment + \$1,000 deductible)

Medicare considers making payment toward \$1,000

Situations in Which VC 44 Should Not Be Reported

- There is a contractual arrangement/law between provider and primary payer and provider did receive less than expected amount, however, the amount received was still more than Medicare-covered charges on claim
- There is contractual arrangement/law between provider and primary payer but full payment from primary payer was received
- There is no contractual arrangement/law between provider and primary payer
- Claim being submitted is not an MSP claim (e.g., Medicare primary or conditional claim)

Example #3 – Do Not Report VC 44

Scenario (Contract/law = YES)

- Medicare-covered charges on claim = \$4,000
- Provider expects from primary payer = \$5,000
- Provider receives from primary payer = \$4,000
- Primary payer applied deductible = \$1,000

Report

- Medicare-covered charges = \$4,000
- MSP VC ____ and amount = \$4,000
- Do not report VC 44 and \$5,000 since already received more than Medicare-covered charges

Medicare will not make payment on this claim

Payment from Primary Reduced for Not Filing Proper Claim

- If provider fails to follow plan procedures and is assessed a penalty under the contract for not following plan procedures. Medicare bases its payment on the amount the primary payer would have paid if the provider followed plan procedures.
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.7.3.2

MSP Claim Scenarios

Keep MSP Billing Code Chart handy!



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MSP Claim Scenario A

Contractual arrangement or law?	NO
Beneficiary	Vera Slippery
TOB (Part B deductible not met)	OP
Date of service (DOS)	04/01/09
Date of accident (DOA)	04/01/09, fall at store
Total Medicare-covered charges	\$2,000
Primary payer	Liability insurance (Responsible Company)
Primary payer's payment	\$1,500

Coding For MSP Claim Scenario A

In **MSP Claim Scenario A**, the following coding is required:

- OC 03 and DOA 04/01/09
- VC 47 and \$1500

Refer to claim handout for **MSP Claim Scenario A**

MSP Claim Scenario B

Contractual arrangement or law?	No
Beneficiary	Ben Hurt
TOB	IP
DOS	04/02/09-4/25/09
DOA	03/25/09, hurt at work
Total Medicare-covered charges	\$10,000
Primary payer	Workers' Compensation (Carrier Company)
Primary payer's payment	\$10,000

Coding For MSP Claim Scenario B

In **MSP Claim Scenario B**, the following coding is required:

- CC 02
- OC 04 and DOA 03/29/09
- VC 15 and \$10,000
- Note: CC 77 may be reported but is not required since no contractual arrangement/law between provider and primary payer exists

Refer to claim handout for **MSP Claim Scenario B**

MSP Claim Scenario C

Contractual arrangement or law?	No
Beneficiary	Inna Crash
TOB (Part B deductible not met)	OP
DOS	03/01/09
DOA	02/15/09, automobile accident
Total Medicare covered charges	\$500
Primary payer	No-Fault (Drive Safe Company)
Primary payer's payment	\$500

Coding For MSP Claim Scenario C

In **MSP Claim Scenario C**, the following coding is required:

- OC 02 and DOA 02/15/09
- VC 14 and \$500

Refer to claim handout for **MSP Claim Scenario C**

MSP Claim Scenario D

Contractual arrangement or law?	Yes
Beneficiary	W. King Aged (age 67)
TOB	IP
DOS	04/01/09-04/09/09
Total Medicare-covered charges	\$12,000
Primary payer	Employer Group Health Plan (EGHP) – 25 employees (Blue Care)
Primary payer's payment	\$10,000
Expected to receive	\$11,000

Coding For MSP Claim Scenario D

In **MSP Claim Scenario D**, the following coding is required:

- VC 12 and \$10,000 and VC 44 and \$11,000

Refer to claim handout for **MSP Claim Scenario D**

MSP Claim Scenario E

Contractual arrangement or law?	Yes
Beneficiary	D. S. Abled (age 44)
TOB	IP
DOS	04/10/09-04/19/09
Total Medicare-covered charges	\$20,000
Primary payer	Large Group Health Plan (LGHP) - 125 employees (Blue Care)
Primary payer's payment	\$15,000
Expected to receive	\$15,000

Coding For MSP Claim Scenario E

In **MSP Claim Scenario E**, the following coding is required:

- CC 77
- VC 43 and \$15,000

Refer to claim handout for **MSP Claim Scenario E**

MSP Claim Scenario F

Contractual arrangement or law?	Yes
Beneficiary	E. S. Reed
TOB (Part B deductible not met)	OP
DOS	03/01/09-03/31/09
Total Medicare-covered charges	\$2,500
Primary payer	EGHP - former employer; in End Stage Renal Disease (ESRD) coordination period (Blue Care)
Primary payer's payment	\$2,000
Expected to receive	\$2,000

Coding For MSP Claim Scenario F

In **MSP Claim Scenario F**, the following coding is required:

- CC 06
- CC 77
- OC 33 and first date of ESRD/MSP coordination period
- VC 13 and \$2,000

Refer to claim handout for **MSP Claim Scenario F**

MSP Payment Facts

- Medicare will consider making payment on MSP partial-payment claims
- MSP payment may be made if:
 - Primary payer's payment for Medicare-covered services is less than provider's charges for those services and less than gross amount payable by Medicare in absence of a primary payment, and
 - Provider does not accept and is not obligated to accept primary payment as payment-in-full
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Sections 40 and 50

MSP Payment Amount

Lowest of the following six calculations

- Gross amount payable minus Medicare deductible and coinsurance
- Gross amount payable minus primary payer's payment
- Provider's charges minus Medicare deductible and coinsurance
- Provider's charges minus primary payer's payment
- VC 44 amount minus Medicare deductible and coinsurance
- VC 44 amount minus primary payer's payment

Medicare Benefit Day Utilization

- Medicare makes determination regarding beneficiary's utilization of Medicare benefit days at time MSP claim is processed
- Medicare benefit days
 - Utilized if MSP payment is made
 - Not utilized if no MSP payment is made
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.8.8

Did You Know...

Providers must not bill beneficiaries for primary payer's deductible, coinsurance or co-payment amounts. These amounts are not their responsibility.

Beneficiary Responsibility on MSP Claims

- Beneficiary's responsibility is limited to
 - Any Medicare deductible and/or Medicare coinsurance applied to MSP claim minus any primary payer's payment amount
- References
 - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 1, Section 40, Chapter 3, Section 10.2 and Chapter 5, Section 40.8

What You Should Do Now...

- Check internal systems/processes to ensure that your facility submits accurately-coded MSP claims and does not bill beneficiaries if not appropriate
- Refer to CMS' references when necessary
- Contact appropriate entity (see following slides) for MSP information when necessary
- Continue to attend MSP education

CMS References Available at

www.cms.hhs.gov

CMS IOM Publications

- 100-02, *Medicare Benefit Policy Manual*, Chapter 16
- 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75
- 100-05, *Medicare Secondary Payer Manual*, Chapters 1-8

COBC and Medicare Secondary Payer Recovery Contractor (MSPRC) information

MSP Fact Sheet dated April 2009

- www.cms.hhs.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf

“Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers”

- www.cms.hhs.gov/mlnproducts/downloads/ra_guide_full_03-22-06.pdf

When to Contact COBC

Telephone Inquiries - 1 (800) 999-1118

- Report employment changes, any other insurance coverage information
- Report liability, automobile/no-fault, Workers' Compensation case
- General MSP questions/concerns
- Questions regarding MSP development letters and MSP questionnaires

<http://www.cms.hhs.gov/COBGeneralInformation/>

When to Contact NHIC, CORP.

Customer Care Center

- Part A - (877) 757-7783
- RHHI - (866) 289-0423

- Ask questions on submitting claims

- Processing claims for primary or secondary payment

- Accepting return of inappropriate Medicare payment

- Regarding Medicare claim/service denials, adjustments

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