

Medicare Secondary Payer (MSP) Billing Code Chart

Primary Reference: Publication 100-04, Chapter 25, Section 75

| Condition Codes (CCs) (UB-04 FLs 18-28) | |
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| Code | Description |
| 02 | Condition is employment related |
| 06 | End-Stage Renal Disease (ESRD) beneficiary in first 30 months of entitlement covered by an Employer Group Health Plan (EGHP) |
| 08 | Beneficiary would not provide information concerning other insurance coverage |
| 09 | Neither the beneficiary nor spouse is employed |
| 10 | Beneficiary and/or spouse is employed but no EGHP |
| 11 | Disabled beneficiary and/or family member is employed but no Large Group Health Plan (LGHP) |
| 28 | Beneficiary's and/or spouse's EGHP is secondary to Medicare. Beneficiary and/or spouse are employed and there is an EGHP that covers beneficiary but either: <ol style="list-style-type: none"> 1. EGHP is a single employer plan and employer has fewer than 20 full- and/or part-time employees; or 2. EGHP is a multi- or multiple-employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees. |
| 29 | Disabled beneficiary and/or family member's LGHP is secondary to Medicare. Beneficiary and/or family member(s) are employed and there is a LGHP that covers beneficiary but either: <ol style="list-style-type: none"> 1. LGHP is a single employer plan and employer has fewer than 100 full- and/or part-time employees; or 2. LGHP is a multi- or multiple employer plan and all employers participating in plan have fewer than 100 full- and/or part-time employees. |
| 63 | Services rendered to beneficiary in State or local custody (prisoner) meets requirements of 42 CFR 411.4(b) for payment |
| 77 | Provider accepts or is obligated/required, due to a contractual arrangement/law, to accept payment by primary payer as payment in full (and that amount has been received and no Medicare payment is due). MSP claim is being filed because claim is an inpatient claim or claim is an outpatient claim and the beneficiary has not yet met his/her annual Medicare Part B deductible. |
| D7 | Change to make Medicare the secondary payer (report on adjustment when original claim was processed as a Medicare primary claim, conditional claim or was rejected for MSP.) |
| D8 | Change to make Medicare the primary payer (report on adjustment when original claim was processed as an MSP claim or as a conditional claim). |
| D9 | Any other change (report on adjustment claim when original claim was rejected for MSP but Medicare is primary or when original claim was processed as an MSP or conditional claim and a change needs to be made to the claim such as a change in the MSP VC amount). |



| 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. |
| 02 | No-Fault Insurance (including automobile and other accidents) – Date of accident/injury for which the State has applicable No-Fault laws. |
| 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 |
| 04 | Accident/Employment-Related - Date of an accident/injury related to beneficiary's employment |
| 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. Required on all conditional claims unless reporting Remarks "DA." |
| 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 |

| Value Codes (VCs) and Amounts (UB-04 FLs 39-41) | |
|---|--|
| When entering amounts for VCs (except for VC 44) the following applies: | |
| <ul style="list-style-type: none"> ▪ Enter amount provider received from primary payer toward Medicare covered charges on claim. ▪ If requesting conditional payment, enter six zeros (0000.00). ▪ If no payment or reduced payment received because of failure to file a proper claim with primary payer, enter amount provider would have received had it filed a proper claim. ▪ Primary payer code must be C (see Primary Payer codes below). | |
| Code | Description |
| 12 | Working Aged beneficiary/spouse with an EGHP (beneficiary over 65). Beneficiary must have Medicare Part A entitlement for this provision to apply. |
| 13 | ESRD beneficiary in an MSP/ESRD 30-month coordination period with an EGHP |
| 14 | No-Fault including automobile/other. Examples: Personal Injury Protection (PIP) and Medical Payment Coverage. Requires OC 01 or 02. |
| 15 | Workers Compensation (WC). Requires CC 02 and OC 04. |
| 16 | Public Health Services (PHS) or other federal agency. Conditional billing does not apply. |
| 41 | Federal Black Lung (BL) Program |
| 42 | Veterans Administration (VA). Conditional billing does not apply. |



Value Codes (VCs) and Amounts (UB-04 FLs 39-41)

When entering amounts for VCs (except for VC 44) the following applies:

- Enter amount provider received from primary payer toward Medicare covered charges on claim.
- If requesting conditional payment, enter six zeros (0000.00).
- If no payment or reduced payment received because of failure to file a proper claim with primary payer, enter amount provider would have received had it filed a proper claim.
- Primary payer code must be C (see Primary Payer codes below).

| Code | Description |
|------|---|
| 43 | Disabled beneficiary under age 65 with an LGHP. Beneficiary must have Medicare Part A entitlement for this provision to apply. |
| 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 the amount actually received. An MSP payment may be due. Note: This VC is used in addition to an MSP VC. |
| 47 | Any Liability Insurance. Requires OC 03. |

Primary Payer Codes (FISS only)

- Primary Payer Codes of A to L (except C) must match MSP VC reported on claim.
 For example, MSP VC 12 = Primary Payer Code A, etc.

| Code | Description | MSP VC |
|------|---|--------|
| A | Working Aged with EGHP | 12 |
| B | ESRD with GHP in 30-month coordination period | 13 |
| C | Conditional Payment | Any |
| D | No-Fault including Automobile/other insurance | 14 |
| E | Workers' Compensation (WC) | 15 |
| F | Public Health Service (PHS) or other federal agency | 16 |
| G | Disabled with LGHP | 43 |
| H | Federal Black Lung (BL) Program | 41 |
| I | Veteran's Administration (VA) | 42 |
| L | Liability | 47 |
| Z | Medicare | None |

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

| Code | Description | Code | Description | Code | Description |
|------|-------------|------|-------------|------|--------------------|
| 01 | Spouse | 20 | Employee | 40 | Cadaver Donor |
| 18 | Self | 21 | Unknown | 53 | Life partner |
| 19 | Child | 39 | Organ Donor | G8 | Other relationship |



| Remarks (Two-position explanation code used for conditional claims – no payment received from primary payer) (UB-04 FL 80) | | |
|--|---|---|
| Code | Description | Acceptable with VC(s) |
| BE | Benefits are exhausted. Always requires date benefits were exhausted in MM/DD/YY format. Automobile No-Fault states should not use this code on automobile accident claims. <i>See code PE.</i> | 12, 13, 14, 15, 41, 43 |
| CD | Charges applied to co-payment, coinsurance or deductible. | 12, 13, 43 |
| DA | 120 days have passed since the primary payer was billed. Always requires date primary payer was billed in MM/DD/YY format. Do not report OC 24 when reporting code DA. | 14, 15, 41, 47 <ul style="list-style-type: none"> ▪ For VC 47, provider must have withdrawn claim with Liability. |
| DP | Delay in payment from Liability Insurer. | 47 |
| FG | Beneficiary did not follow guidelines of their primary health plan. FG is only used for out of network, untimely filing or no prior authorization. | 12, 13, 15, 43 |
| LD | A response is received from Liability Insurer stating they feel they are not responsible for the claim. | 47 |
| NB | Not a covered benefit. | 12, 13, 14, 15, 41, 43 |
| PC | Pre-existing condition. | 12, 13, 43 |
| PE | No-Fault (also known as PIP) has been exhausted toward medical expenses. Always requires date benefits were exhausted in MM/DD/YY format. Provider must have copy of PIP on file. | 14 |
| PP | Beneficiary paid by Liability Insurer. To be used only for conditional claims involving Liability Insurance payments to the beneficiary where the provider is not expecting any payment from the beneficiary. It may not be used for medical payment insurance payments to the beneficiary (VC 14). Providers are required to pursue those dollars. | 47 |