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JK: Billing Compliant Conditional Claims (Part 2) – The Examples!

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Today's Presenter

- Christine Janiszcak, Provider Outreach & Education Consultant

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Acronyms

AAPC – American Academy of Professional Coders
ADR – Additional documentation request
ASCA – Administrative Simplification Compliance Act
BCRC – Benefits Coordination & Recovery Center
CAGC – Claim adjustment group code
CARC – Claim adjustment reason code
CAS – Claim adjustment segment
CBT – Computer-based training
CC – Condition code
CEU – Continuing education credit
CMS – Centers for Medicare & Medicaid Services
CR – Change Request

Acronyms

CWF – Common Working File

DDE – Direct Data Entry

DOA – Date of accident

DOS – Date of service

EGHP – Employer group health plan

EOB – Explanation of benefit

ERA – Electronic remittance advice

ESRD – End-stage renal disease

FISS – Fiscal Intermediary Standard System

FL – Form locator

GHP – Group heath plan

HETS – HIPAA Eligibility Transaction System

Acronyms

HHA – Home health agency

HIPAA - Health Insurance Portability & Accountability Act

HIQA – Health Insurance Query Access

HIQA – Health Insurance Query Access for Home Health

ID – Identification

IEQ – Initial enrollment questionnaire

IOM – Internet-Only Manual

IVR – Interactive voice response

LGHP – Large group health plan

MLN – Medicare Learning Network

MSP – Medicare Secondary Payer

MUC – Medicare University Credit

Acronyms

NOE – Notice of election

OC – Occurrence code

RAP – Request for anticipated payment

RTP – Return to provider

SCD – Secondary claim development

SE – Special Edition

TOB – Type of bill

UB – Uniform bill

VC – Value code

WC – Workers' compensation

Objective

- Explain why and how to prepare and submit compliant conditional claims after you receive no payment from the primary payer by reviewing claim examples

Agenda

- Recap of JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time Webinar
- Conditional claim billing and coding reminders from Part 1
- Conditional claim examples
- MSP resources
- Wrap-up
- Question and answer segment

Polling Question #1

- Did you attend the JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time Webinar on 09/22/14 or 09/26/14?
  - Yes
  - No

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Recap of JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time!

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Recap of JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time!

- General MSP information
  - What is MSP?
  - MSP Provisions
  - Your MSP responsibilities per Medicare provider agreement
  - Online MSP records
  - Determine proper order of payers
  - Submit claims according to your determination
  - Submit claims when you determined Medicare is primary
  - Submitting claims when you determined another payer is primary
  - Claim types

Recap of JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time!

- Conditional claims
  - Definition of conditional claim
  - Definition of promptly
  - Billing conditionally when GHP is primary
  - Billing conditionally when non-GHP is primary
  - Billing conditionally when liability insurance is primary
  - Situations in which Medicare can make conditional payment
  - Situations in which Medicare cannot make conditional payment
  - CR 7355
  - Finding out another payer is primary after Medicare paid

Recap of JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time!

- Preparing conditional claims
  - Life of a conditional claim
  - Instructions for coding conditional claims
  - Claim fields
- Submitting conditional claims and tertiary claims
- Correcting and adjusting claims
  - Correcting RTP conditional claims
  - Correcting processed conditional claims via adjustments
  - Correcting primary claims rejected for MSP to conditional via adjustments
- Questions and answers

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Conditional Claims Preparation and Submission Reminders

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Conditional Claims - Defined

- Claims submitted to Medicare requesting conditional payment because
  - **Primary payer did not pay for valid reason**
    - Applies to all MSP VCs except VCs 16 and 42
      - For VCs 16 and 42, if primary payer does not pay, you may submit Medicare primary claim
  - **Primary payer did not pay promptly**
    - Applies to MSP VCs 14, 15, 41, and 47 (accidents)
    - Generally, promptly means within 120 days
- If Medicare can make conditional payment
  - Payment and beneficiary responsibility is same as if Medicare were primary

Promptly - Defined

- For no-fault insurance and WC
  - Promptly means payment within 120 days after receipt of claim by no-fault insurer or WC carrier
- For liability insurance (including self-insurance)
  - Promptly means payment within 120 days after earlier of:
    - Date a general liability claim filed with insurer or lien filed against potential liability settlement (Medicare considers this date to be date liability record was created on CWF); **or**
    - Date service furnished or date of discharge (for inpatient)

Conditional Billing When Primary Payer is a GHP

- If beneficiary has a GHP as primary (MSP VCs 12, 13 and 43)
  - To bill Medicare conditionally, you must have a response from GHP
    - This is applicable in situations where
      - beneficiary has only GHP
      - beneficiary has GHP and was involved in an accident and has no-fault, WC or liability coverage available

Conditional Billing When Primary Payer is a Non-GHP

- If beneficiary has a non-GHP as primary (MSP VCs 14, 15, 41 and 47)
  - To bill Medicare conditionally **within promptly period**
    - You **must have a response from non-GHP**
  - To bill Medicare conditionally **after promptly period expired**
    - You **do not need to have a response from non-GHP**
      - Once promptly period expires and you have no response from non-GHP, you have a **choice:**
        - » Maintain claim with non-GHP **or**
        - » Bill Medicare conditionally
          - » If beneficiary also has a primary GHP, you must bill them before billing Medicare

Conditional Billing When Primary Payer is Liability

- If you choose to bill Medicare conditionally after promptly period has expired and primary payer is **liability**, you must **withdraw** liability claim/lien
  - If you receive payments from Medicare and from liability claim/lien, see CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 2, Section 40.2E for instructions

Situations in Which Conditional Payment Can be Made

- When reason primary payer did not make payment is considered a valid reason
  - Report **two-digit code** in “Remarks” that summarizes why primary payer did not make payment
    - Additional claim coding is required

Situations in Which Conditional Payment Can be Made

- For accident situations (MSP VCs 14, 15, 41 or 47)
  - When payment has not been made or cannot reasonably expected to be made and promptly period has expired
    - Report two-digit code “DA” with date primary payer was billed in “Remarks” (indicates you have billed primary payer, have waited promptly period but have not received response)
      - Additional claim coding is required
      - Do not bill conditionally if there is also GHP coverage

CR7355

- Per CR7355, for conditional claims with no-fault, WC or liability insurance that did not pay during the promptly period, Medicare must review the claim and the CWF
- Medicare must
  - ensure there is/was no GHP record on CWF as of the DOS,
  - look for information on claim or CWF that indicates no-fault, WC or liability is involved,
  - look for information on claim that shows it was sent to no-fault or WC first, and
  - look for information on claim that shows no-fault, WC or liability insurance did not pay during the promptly period.

Situations in Which Conditional Payment Cannot Be Made

- Primary payer(s) was not billed or has not paid because
  - beneficiary refuses to file a claim with insurer, or cooperate with provider in filing claim
  - provider/beneficiary failed to file proper claim with insurer resulting in no payment
    - You may submit a claim but primary payer's payment amount must reflect amount you would have received had claim been properly filed (thus, an MSP claim)
      - See CMS IOM Publication 100-05, *Medicare Secondary Payer Manual,* Chapter 5, Section 40.7.5

Situations in Which Conditional Payment Cannot Be Made

- For no-fault, WC or liability claims
  - Medicare rejects conditional claims in situations in which you billed no-fault, WC or liability and they did not pay but
    - there is/was also a GHP that is primary to Medicare and
    - you did not send claim to GHP first or GHP denied claim stating no-fault, WC or liability should pay first

Finding Out Another Payer is Primary After Medicare Paid

- If Medicare paid and you learn another payer is primary; do not cancel Medicare claim
  - **Primary payer is not liability Insurance**
    - **Bill that payer and submit MSP adjustment** within 60 days of receiving payment from that payer
      - See CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 10.4
  - **Primary payer is liability insurance**
    - **Notify BCRC** about liability information you received
      - See CMS IOM, Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 10.3

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Preparing Conditional Claims

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Life of an Conditional Claim

- Prepare conditional claim
  - If GHP is primary, you must have response from them
  - If non-GHP is primary, you must have response from them or promptly period must have expired (MSP VCs 14, 15, 41 or 47)
- Report required coding on conditional claim
- Check for matching MSP record in CWF
- Contact BCRC if necessary
- Submit conditional claim once MSP record in CWF
- Use appropriate method to submit claim
- Maintain documentation to support conditional billing

General Instructions

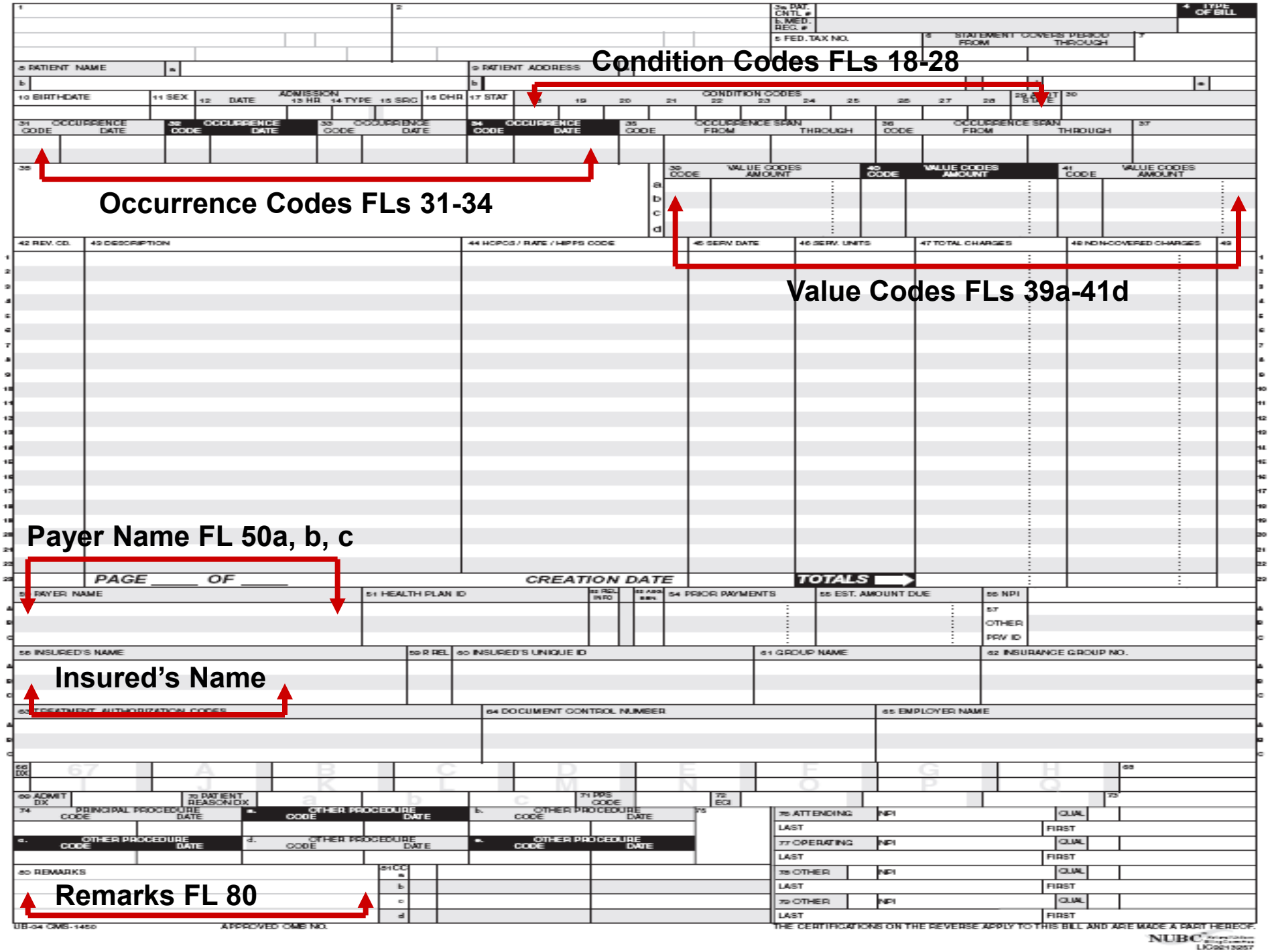
- Follow all Medicare requirements
  - Medicare requirements apply to all Medicare claims including conditional claims
    - Billing requirements including frequency of billing
      - If primary payer made payment but then stopped for a valid reason, submit an MSP claim through end of that billing period and begin conditional claim at start of next billing period (based on provider type and services)
    - Technical requirements including timely filing, etc.
    - Medical requirements

Home Health and Hospice Providers

- In MSP situations
  - HHAs
    - Submit RAP showing Medicare as primary
    - Not reimbursed on RAP
    - Insurer information reported on final claim
  - Hospice
    - Submit NOE showing Medicare as primary
    - Insurer information reported on claim(s)

Instructions for Conditional Claims

- Complete claims in usual manner; report:
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered days as usual
  - Covered/noncovered charges as usual
  - Primary payer as first payer
  - Medicare as second payer
  - Appropriate billing codes in applicable claim fields (FLs) to indicate claim is MSP


Condition Codes FLs 18-28
Occurrence Codes FLs 31-34
Value Codes FLs 39a-41d
Payer Name FL 50a, b, c
Insured's Name
Remarks FL 80
PAGE _____ OF _____
CREATION DATE
TOTALS
UB-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC

Coding Requirements for Conditional Claims is Similar to MSP Claims

- Same coding as MSP claims except
  - Do not report CC 77 or VC 44 and OTAF amount
  - Report on all conditional claims:
    - MSP VC with zero payment amount
    - OC 24 and date of primary payer's rejection/denial
      - Exception: Do not report when claim is for accident and primary payer did not pay promptly
    - Remarks
      - **First line:** Two-digit explanation code (10 options) and date (when a date is required, place it one space over)
      - **Second line:** Primary payer's address

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
CCs: • **02** = condition is employment related • **06** = ESRD beneficiary in first 30 months of entitlement covered by EGHP • Do not report CC 77	18 - 28	2300.HI (BG)

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
OCs and dates: • **01** with DOA when med-pay is primary • **02** with DOA when no-fault is primary • **03** with DOA when liability is primary • **04** with DOA when WC is primary • **33** with date ESRD coordination period began • **24** with date of primary payer's letter, remittance, EOB statement indicating rejection/denial (always report in conditional billing except when accident and billing because primary payer did not pay promptly)	31 - 34	2300.HI (BH)

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
VC and zero payment: • **12** = Working aged with EGHP (age 65 or over, 20 or more employees) • **13** = ESRD with EGHP/30 months • **14** = No-fault, medical-payment • **15** = Workers Compensation • **41** = Federal Black Lung Program • **43** = Disabled with LGHP (under age 65, 100 or more employees) • **47** = Liability Insurance • **Do not report VC 44 and OTAF amount**	39 - 41	2300.HI (BE)

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
• **Patient's Relationship to Insured:** • **01** = Spouse • **18** = Self • **19** = Child • **20** = Employee • **21** = Unknown • **53** = Life partner • **G8** = Other relationship	59A	2320.SBR02

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
Remarks: • **First line** = Two-digit explanation code = NB, PC, CD, FG, BE, PE, DA, DP, LD or PP with date in mmddyyyy format if date required • **Second line** = Primary insurer address	80	2300.NTE

Remarks: Explanation Codes NB, PC or CD

Code	Description	Can use with MSP VCs
NB	Not a covered benefit	12, 13, 14, 15, 41, and 43
PC	Pre-existing condition	12, 13, and 43
CD	Primary payment applied toward plan deductible, copayment or coinsurance	12, 13, 14, and 43

Remarks: Explanation Code FG

Code	Description	Can use with MSP VCs
FG	Beneficiary did not follow rules of GHP or of WC 1. untimely filing with primary payer, 2. out of network (we pay once only) or 3. no prior authorization (we will not make payment) Next to code FG, indicate **which above rule** was not followed	12, 13, 15, and 43

Remarks: Explanation Code BE

Code	Description	Can use with MSP VCs
BE	**Benefits exhausted** *Automobile No-Fault use BE*	12, 13, 14, 15, 41, and 43

Requires **date on which benefits exhausted** in MM/DD/YY format (not necessarily same date as you report with OC 24 when applicable). If primary payer did not indicate this date, contact them. This is the date BCRC will use as MSP record termination date.

For accident situations including medical-payment (med-pay):

- You may bill conditionally when you receive no payment from primary payer, claim's DOS is **prior** to exhaustion date and no other insurance exists
- You may bill as primary when you receive no payment from primary payer, claim's DOS is **after** exhaustion date and no other insurance exists

For GHP situations:

- You may bill conditionally when you receive no payment from primary GHP whether claim's DOS is prior to or after exhaustion date; do not bill Medicare as primary.

Remarks: Explanation Code PE

Code	Description	Can use with MSP VCs
PE	**PIP** exhausted toward other medical expenses (**automobile No-Fault states:** Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania, and Utah. Also, Puerto Rico)	14

Requires **date on which benefits exhausted** in MM/DD/YY format (not necessarily same date as you report with OC 24 when applicable). If primary payer did not indicate this date, contact them. This is the date BCRC will use as MSP record termination date.

For accident situations (Automobile No-Fault only):

- You may bill conditionally when you receive no payment from primary payer, claim's DOS is **prior** to exhaustion date and no other insurance exists
- You may bill as primary when you receive no payment from primary payer, claim's DOS is after exhaustion date and no other insurance exists

Remarks: Explanation Code DA

Code	Description	Can use with MSP VCs
DA	120 days have passed (applicable promptly period has ended)	14, 15, 41, and 47

Requires **date primary payer was billed** in MM/DD/YY format

Reminder: Do not report OC 24 and date on conditional claim when reporting Remarks with explanation code DA

Remarks: Explanation Codes DP, LD & PP – for Liability Only

Code	Description (Report only with MSP VC 47)
DP	Response received from liability stating they need more time so there will be a delay in their payment
LD	Response received from liability insurer stating they feel they are not responsible for claim
PP	Patient paid by liability insurer

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
Primary Insurer Name	50A	2320.SBR04
Insured's Name	58A	2330A.NM104
Insured's Unique ID	60A	2330A.NM109
Insurance group name	61A	2320.SBR04
Insurance group number	62A	2320.SBR03
Employer name	65A	N/A

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Conditional Claim Examples – Help Code These Claims

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Assumption for all Claim Examples

- All patients are fictitious; are assumed to have Medicare
- There is a matching MSP record in CWF for each example
- All of Medicare's usual claim filing guidelines are met for the specific provider/claim type
- Provider submitted claim using appropriate method, via 837I or hardcopy with approved ASCA waiver
- Provider completed/reported
  - Appropriate patient relationship code in FL 59A
  - Primary insurer address in FL 80
  - A primary payer name as first payer and Medicare as second
    - FLs 50, 58, 60, 61, 62, and 65 (or electronic equivalent fields when applicable)
  - All appropriate CAGCs and CARCs from primary payer's remittance if submitting via 837I

Claim Example A

Beneficiary	Beneficiary A, age 67
Employment	Actively Working Company (over 20 employees)
Insurance	GHP through XYZ Insurance
Service	Outpatient facility
DOS	12/10/13
Charges	$600
Expected	$450
Primary paid	**$0** (Per EOB dated 01/10/14, $450 payment applied to deductible)

Polling Question #2

- Other than VC 12 and $0, what coding is required on conditional claim example A?
  1. OC 24 = 12/10/13; Remarks code = NB
  2. OC 24 = 12/10/13; Remarks code = CD
  3. OC 24 = 01/10/14; Remarks code = NB
  4. **OC 24 = 01/10/14; Remarks code = CD**
  5. No OC; Remarks code = CD

Claim Example B

Beneficiary	Beneficiary B, age 72 (retired)
DOA	03/09/14 (fall in grocery store)
Insurance	Sorry you Fell Company (Liability Insurer). Note: no medical-payment coverage was available
Service	Inpatient hospital
DOS	03/10/14 – 03/13/14
Charges	$39,000
Filed Claim	03/16/14 but was not paid within 120 days
Primary paid	**$0** (no response within 120 days; provider withdraws claim with Liability Insurer and bills Medicare conditionally)

Polling Question #3

- Other than OC 03 and 03/09/14, what coding is required on conditional claim example B?
  1. VC 14 = $0; Remarks code = DA 03/16/14
  2. VC 14 = $0; Remarks code = DA 03/10/14
  3. **VC 47 = $0; Remarks code = DA 03/16/14**
  4. VC 47 = $0; Remarks code = DA 03/10/14

Claim Example C

Beneficiary	Beneficiary C, age 25 with ESRD (30-month coordination period began 01/01/14)
Employment	Parent works at Sally's Salon
Insurance	GHP through CurlyQ Insurance
Service	Home Health
DOS	11/15/14 - 01/04/14
Charges	$3,000
Expected	$3,000
Primary paid	**$0** (Per EOB dated 03/10/14, no prior authorization, provider wants to submit to obtain rejection)

Polling Question #4

- Other than CC 06 and OC 33 = 01/01/14, what coding is required on conditional claim example C?
  1. OC 24 = 01/04/14; VC 13 = $0; Remarks code = FG "No Prior Authorization"
  2. **OC 24 = 03/10/14; VC 13 = $0; Remarks code = FG "No Prior Authorization"**
  3. OC 24 = 01/04/14; VC 13 = $0; Remarks code = NB
  4. OC 24 = 03/10/14; VC 13 = $0; Remarks code = NB

Claim Example D

Beneficiary	Beneficiary D, age 69
Employment	Spouse works at The Rumor Mill (over 20 employees)
Insurance	GHP through Hearsay Insurance
Service	Hospice
DOS	11/02/13 - 11/29/13
Charges	$5,500
Primary paid	**$0** (per EOB dated 12/24/13, no payment made, hospice services not covered)

Polling Question #5

- Other than OC 24 and 12/24/13, what coding is required on conditional claim D?
  1. **VC 12 = $0; Remarks code = NB**
  2. VC 43 = $0; Remarks code = NB
  3. VC 12 = $0; Remarks code = CD
  4. VC 43 = $0; Remarks code = CD
  5. VC 12 = $0; Remarks code = BE

Claim Example E

Beneficiary	Beneficiary E, age 53
Employment	Current Employment Agency (over 100 employees)
Insurance	LGHP through Ability Health Plan
Service	Inpatient SNF (SNFs submit monthly claims)
DOS	11/01/13 – 12/13/13
Charges	$85,000
Primary paid	**$55,000** through 11/25/13, then $0 (per EOB dated 01/01/14, no further payment made because LGHP's SNF benefits exhausted for 2013 on 11/25/13)

Polling Question #6

- Which answer best describes the claims that should be submitted for claim example E?
  1. MSP claim from 11/01/13 to 11/25/13 and conditional claim from 11/26/13 to 12/13/13
  2. **MSP claim from 11/01/13 to 11/30/13 and conditional claim from 12/01/13 to 12/13/13**
  3. MSP claim from 11/01/13 to 11/30/13 and Medicare primary claim from 12/01/13 to 12/13/13

Polling Question #7

- Other than VC 43 and $0, what coding is required on **conditional** claim example E?
  1. **OC 24 = 01/01/14; Remarks code = BE 11/25/13**
  2. OC 24 = 11/25/13; Remarks code = BE 11/25/13
  3. OC 24 = 01/01/14; Remarks code = PE 11/25/13
  4. OC 24 = 11/25/13; Remarks code = PE 11/25/13

Claim Example F

Beneficiary	Beneficiary F, age 71 (retired)
DOA	07/09/13 (auto accident in No-Fault state)
Insurance	Crash Insurance Company (No-Fault Carrier). No liability.
Service	Outpatient facility
DOS	02/03/14
Charges	$550
Filed Claim	02/15/14
Primary paid	$0 (per EOB statement from No-Fault dated 03/20/14, benefits exhausted on 02/20/14). Exhausted AFTER DOS.

Polling Question #8

- Other than VC 14 and $0, what coding is required on conditional claim example F?
  1. OC 01 = 07/09/13; OC 24 = 03/20/14; Remarks code = PE 02/20/14
  2. OC 01 = 07/09/13; OC 24 = 03/20/14; Remarks code = BE 02/20/14
  3. **OC 02 = 07/09/13; OC 24 = 03/20/14; Remarks code = PE 02/20/14**
  4. OC 02 = 02/03/14; OC 24 = 03/20/14; Remarks code = PE 02/20/14

Did You Know…

- Regarding claim example F, if No-Fault benefits were exhausted prior to the claim's DOS (02/03/14), you would submit a Medicare primary claim for services on/after 02/03/14 (after contacting BCRC to terminate VC 14 MSP record in CWF).

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Submitting Conditional Claims

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Submitting Conditional Claims

- You must submit electronically via 837I
  - Ensures Medicare's compliance with HIPAA transaction and code set requirements and ensures Medicare's payments are properly calculated
- Report primary payer's adjustment amounts that explain why primary payer did not pay in full for billed amount
  - Located in CAS segment on 835 ERA or on paper remittance
    - Look for CAGC paired with CARC
      - CAGCs:
        - CO = Contractual Obligations
        - CR = Corrections and Reversals
        - OA = Other Adjustments
        - PI = Payer Initiated Reductions
        - PR = Patient Responsibility
      - CARCs: http://www.wpc-edi.com

Submitting Conditional Claims

- You may submit in hardcopy format (UB-04/ CMS-1450) if you have or obtain approved ASCA waiver
  - Refer to our website, http://www.NGSMedicare.com,
    - Claims > **ASCA**
    - Resources > Contact Us > PO Box Mailing Addresses > **Claims Department**
- You may not submit via FISS DDE per CR 6426
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R70MSP.pdf

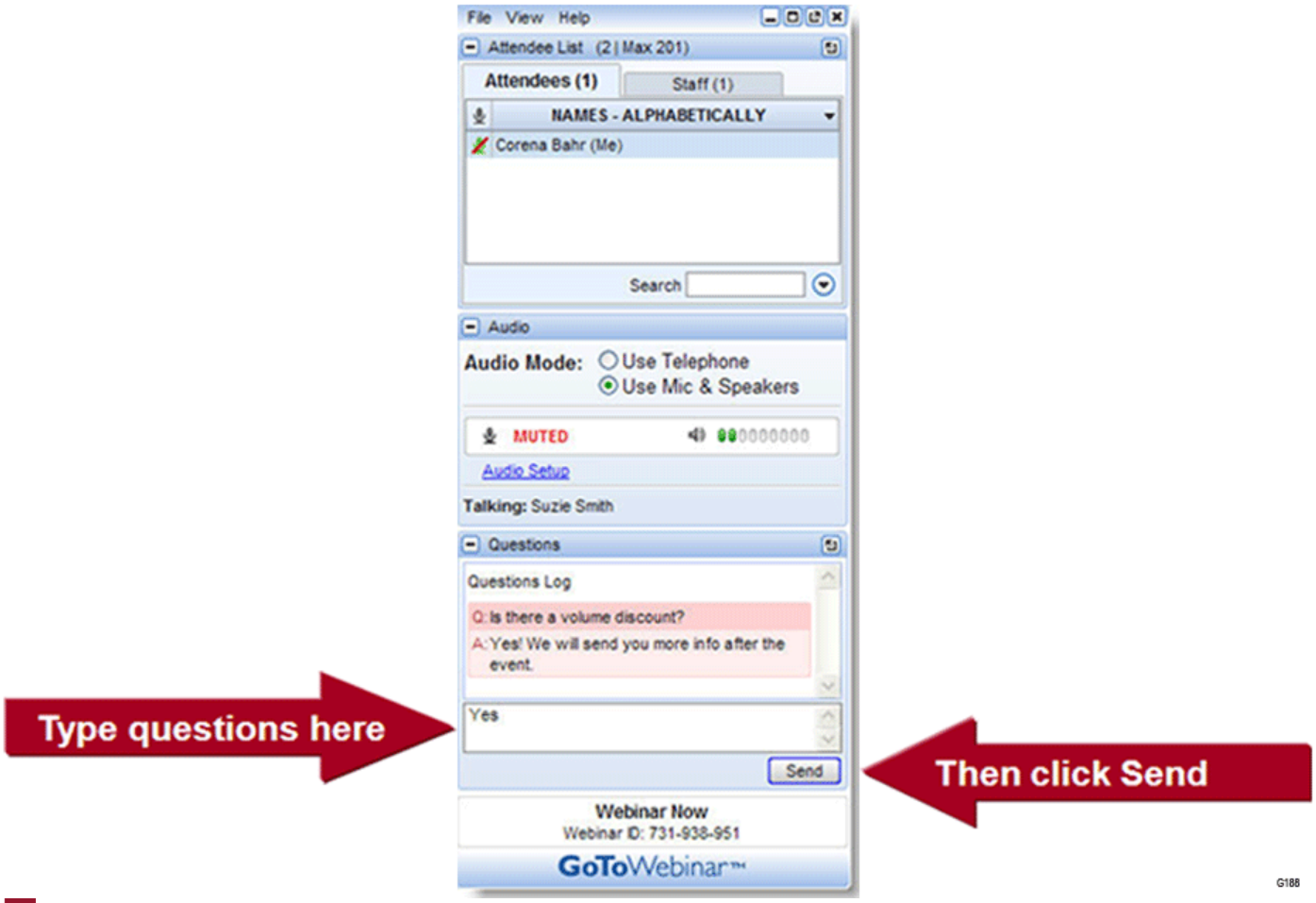
Submitting Medicare Tertiary Claims

- Submit Medicare tertiary claims with Medicare as third payer (or greater)
  - Hardcopy (UB-04/CMS-1450 claim form) to our **Claims Department**
    - You must have or obtain **approved ASCA waiver**

What You Should Do Now…

- Review MSP Resources slides including CMS *MLN Matters* article MM7355
- Review Wrap Up slides
- Share information with staff
- Develop and implement policies that ensure you are meeting your MSP responsibilities including submission of correctly coded conditional claims
- Continue to attend educational sessions
- Sign up for our E-mail Updates on our website

To Ask a Question Using the Question Box



Thank You!

- Follow-up email
  - We send to registered attendees following presentation
    - Provides Medicare University catalog number, course code for this course and
    - Asks you to complete an online assessment
- Questions?
  - Questions in Webinar question box will now be addressed
  - Contact our Provider Contact Center with any claim specific inquiries

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MSP Resources

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- Refer to our newly redesigned website at http://www.NGSMedicare.com where you can find:
  - Provider Contact Center phone numbers
    - Contact us to
      - Answer questions on claim denials, adjustments and submitting claims
      - Process claims for payment
      - Accept return of inappropriate Medicare payments
  - Claim's Department addresses
  - Information on ASCA waivers
  - Instructions on how to prepare conditional claims and much more about MSP!

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- Instructions on signing up for our E-mail Updates
- Provider Outreach & Education information
- Our Events Calendar
- Medicare University
  - MSP CBT courses in Medicare University
    - Fundamentals of MSP CBT (PTA-C-0024)
    - Identifying Primary Payers (PTA-C-0039)
    - Non-GHPs (PTA-C-0044)
    - No-Fault and Liability (PTA-C-0043)
    - Working Aged with GHP (PTA-C-0035)
    - Disabled with LGHP (PTA-C-0042)

Who is the BCRC?

- Contracted by CMS effective 02/01/14
- Consolidates activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries
- Takes actions to identify health benefits available to a Medicare beneficiary and coordinates payment process to prevent Medicare mistaken payments
- Maintains MSP records and handles most updates to such records
  - **Fact:** BCRC does not process claims or handle claim-specific inquiries

When to Contact the BCRC

- Ask a general MSP question
- Ask a question regarding MSP letters and questionnaires (i.e., initial enrollment and secondary claim development questionnaires)
- Report employment or insurance changes, or any other insurance coverage information
- Report a liability, no-fault (including medical-payment), or workers' compensation case
- For updates to MSP records, follow instructions in *MLN Matters* article SE1416
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf

BCRC Contact Information

- BCRC Contacts page:
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html
- Customer Service Representatives are available:
  - Monday through Friday, 8:00 a.m.-8:00 p.m. ET, except holidays
  - 855-798-2627
  - TTY/TDD: 1-855-797-2627 (hearing and speech impaired)
  - Fax for general correspondence: 405-869-3307
- MSP general correspondence:
  - Medicare – MSP General Correspondence
    P.O. Box 138897
    Oklahoma City, OK 73113-8897

MSP Resources - CMS

- HETS
  - http://cms.hhs.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html
- CR6426
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R70MSP.pdf

MSP Resources - CMS

- CMS IOM Publications
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
    - 100-05, *Medicare Secondary Payer Manual*
      - MSP Provisions, Chapters 1 and 2
      - Identifying MSP, Chapter 3, Section 20
      - Conditional claim coding, Chapter 3, Section 40.3

MSP Resources - CMS

- CR7355 Revised "Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims"
  - Transmittal 87
  - Issued 08/03/12
  - Implemented 01/07/13
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R87MSP.pdf
- MLN Matters MM7355 Revised
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7355.pdf

MSP Resources - CMS

- Medicare and Other Health benefits: Your Guide to Who Pays First
  - http://www.medicare.gov/publications/pubs/pdf/02179.pdf
- Web-based training course
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
    - At bottom of page, click Web-based training courses, select MSP Provisions (100 minutes)
- MSP Fact Sheet for Providers
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf

medicare university

National Government Services

Wrap Up

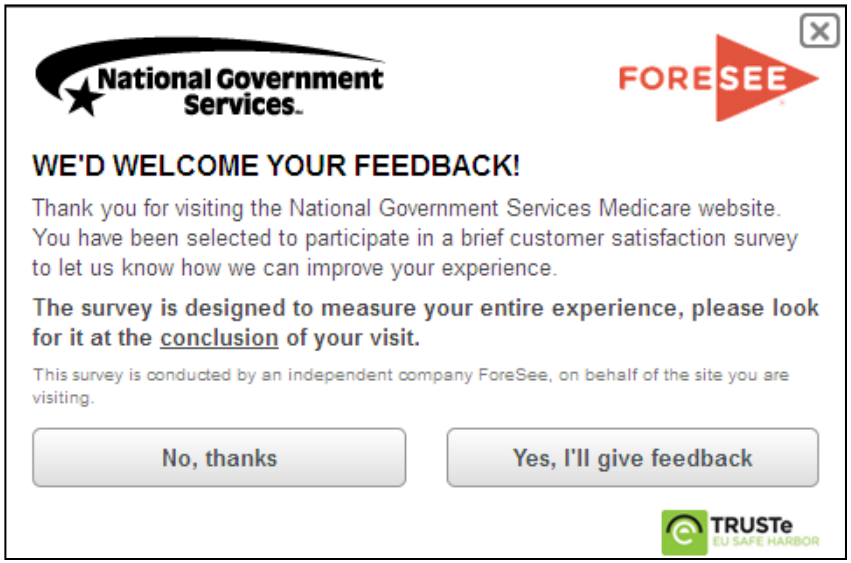
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Research Tool

- Calendar of Articles by Effective Date
  - Organizes *MLN Matters* articles by effective date with descriptive information
  - Represents 12 months (rolling months) of posted articles
  - Updated weekly to reflect posted articles and CRs
  - Helpful tool for reviewing upcoming Medicare changes!
    - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html

Website Survey

- This is your chance to have your voice heard—Say “yes” when you see this pop-up so National Government Services can make your job easier!



Medicare University Information

- For self-reporting your attendance in Medicare University:
  - Topic = **JK: Billing Compliant Conditional Claims (Part 2) – The Examples!**
  - Medicare University Credits (MUCs) = 2
  - Catalog Number = **To be sent via e-mail**
  - Course Code = **To be sent via e-mail**

Continuing Education Credits

- All National Government Services JK Part A and Part B Provider Outreach and Education attendees can now receive 1 CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs