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

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Today's Presenter

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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

OTAF – Obligated to accept as payment in full

RAP – Request or anticipated payment

RTP – Return to provider

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

Agenda

- General MSP information
- Conditional claims
- Preparing conditional claims
- Submitting conditional claims, Medicare tertiary claims and adjustment claims
- Test Your Knowledge questions
- MSP resources
- Wrap-up
- Question and answer segment

Polling Question #1

- I have been billing Medicare for
  - less than 1 year
  - 1 to 5 years
  - 6 to 9 years
  - 10 years or more

Polling Question #2

- I have been billing Medicare as the secondary payer for
  - Less than 1 year
  - 1 to 5 years
  - 6 to 9 years
  - 10 years or more

General MSP Information

What is MSP?

- MSP refers to situations in which Medicare does not have primary responsibility for paying for a beneficiary's health care services
  - Beneficiary has other coverage that is primary to Medicare per federal laws known as **MSP Provisions**
    - Help determine proper order of payers
    - Also known as MSP categories
    - Each has set of criteria or conditions that must be met

MSP Provisions

- Working aged with EGHP
- Disabled with LGHP
- ESRD with EGHP in 30-month coordination period
- Federal Black Lung Program
- Research grants
- Workers' compensation
- No-fault (automobile and other)
- Liability

Your MSP Responsibilities Per Medicare Provider Agreement

- Determine appropriate order of payers for beneficiaries services
  - Identify payers primary to Medicare by conducting MSP screening process
    - Ask beneficiaries questions using questionnaire
    - Check Medicare's records (FISS/DDE via CWF Part A selections HIQA or HIQH, HETS, IVR or NGSConnex)
- Bill other primary payers before Medicare
- Submit MSP claims when required

Did You Know...

- Providers who know the MSP Provisions, are familiar with their MSP-related responsibilities and know how to accurately submit MSP claims to Medicare are less likely to receive returned claims.

Online MSP Records

- HIQA, HIQH or HETS available information
  - MSP VC that represents MSP Provision/category
  - MSP effective and termination dates
  - Subscriber name & policy number
  - Patient relationship
  - Insurer information

MSP VC, Provisions and Primary Payer Code Chart

MSP VC	MSP Provision	Primary Payer Code on Claim
12	Working aged, age 65 & over, EGHP, 20 or more employees	A
13	ESRD with EGHP in coordination period	B
14	No-Fault (automobile and other types)	D
15	Workers' Compensation or Set-Aside	W
16	Public Health Services; research grants	F
41	Federal Black Lung Program	H
43	Disabled, under age 65, LGHP, 100 or more employees	G
47	Liability Insurance	L

Determine Proper Order of Payers

- Determine primary, secondary, tertiary, etc. payer by comparing collected MSP information to information in Medicare's records and by applying your knowledge of MSP Provisions
  - Medicare is primary when beneficiary
    - Has no other coverage
    - Has coverage but it does not meet MSP Provision criteria
    - Has coverage that meets MSP Provision criteria but it is no longer available
  - Another payer is primary when beneficiary
    - Has coverage that meets MSP Provision criteria

Submit Claims According to Your Determination – Medicare is Primary

- If you determine Medicare is primary
  - Contact BCRC to update MSP record in CWF if applicable
  - Submit Medicare primary claim once record updated
  - Examples of Medicare primary situations (not conditional):
    - No GHP or GHP terminated
    - Beneficiary/spouse retired
    - Employer size not met
    - Claim related to a prior accident but insurance exhausted or case settled before DOS and no dollars for future medicals
    - Not related to a prior accident
    - Claim is for a current accident but no other insurance

Submit Claims According to Your Determination – Another Payer is Primary

- If you determine another payer is primary
  - Submit claim to that payer first and Medicare second (conditional claim when appropriate)
- If you determine more than one payer is primary
  - Submit claims to those payers first (in proper order) and to Medicare third, etc. (conditional claim when appropriate)
- Follow-up often; Medicare's timely filing applies

Claim Types

If Primary Payer…	Submit…
Makes partial payment	MSP partial-payment claim
Makes full payment	MSP full-payment claim – No-payment claim
Does not make payment for a valid reason or does not make payment promptly (120 days; accidents only)	**Conditional claim** (look like MSP claims but primary payer's payment is zero)
Does not make payment because Medicare is primary	Medicare primary claim

Conditional Claims

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

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 Claims – Payment and Beneficiary Responsibility

- If Medicare can make conditional payment
  - Payment and beneficiary responsibility is same as if Medicare were primary

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

Preparing Conditional Claims

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

Did You Know...

- If you submit a conditional claim for which there is no matching MSP record on CWF, your claim will suspend for up to 100 days in Medicare's claim processing system while we contact BCRC to set up the MSP record. A matching record means that the MSP record contains the same insurance information that you will report on the claim.

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

Claim Fields – Conditional Claims

Code	UB-04 FLs	Electronic Field
CCs	18 - 28	2300.HI (BG)
OCs and dates	31 - 34	2300.HI (BH)
VC and zero payment	39 - 41	2300.HI (BE)
Patient's Relationship to Insured	59A	2320.SBR02
Remarks for explanation code (and date if required) and primary insurer address	80	2300.NTE

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

1 | 2 | 3a PAT. CNTL # | 4 TYPE OF BILL
b. MED. REC. #
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a | 9 PATIENT ADDRESS a
b | b | c | d | e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

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

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a
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
	PAGE _____ OF _____	CREATION DATE		TOTALS			

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI
57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 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
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC LIC9213257

Coding Requirements For Conditional 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 (EOB statement, letter, ERA, etc.)
      - 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

Condition Codes

- Two-digit indicator to describe condition or event that applies to claim
- Report applicable MSP-related CCs:
  - **02** = Condition is employment-related
  - **06** = ESRD beneficiary in first 30 months of entitlement covered by an EGHP

Occurrence Codes and Dates

- Two-digit indicator with associated date to describe event that applies to claim
- Report applicable MSP-related OCs and dates:
  - **01** and DOA if medical-payment plan is primary
  - **02** and DOA if no-fault is primary
  - **03** and DOA if liability is primary
  - **04** and DOA if workers' compensation is primary
  - **24** and date of primary payer's rejection/denial
  - **33** and date ESRD coordination period began

MSP Value Codes and Amounts

- Two-digit indicator for MSP Provision and dollar amount
- Report MSP VC with zero payment from primary payer
- MSP VCs:
  - 12, 13, 14, 15, 16, 41, 43, or 47
  - Refer to MSP VC chart

Patient Relationship Codes

- Report relationship of patient to identified insured (two-digit field):
  - 01 = Spouse
  - 18 = Self
  - 19 = Child
  - 20 = Employee
  - 21 = Unknown
  - 53 = Life partner
  - G8 = Other relationship

Remarks: Explanation Code NB

Code	Description	Can use with MSP VCs
NB	Not a covered benefit	12, 13, 14, 15, 41 and 43

Remarks: Explanation Code PC

Code	Description	Can use with MSP VCs
PC	Pre-existing condition	12, 13 and 43

Remarks: Explanation Code CD

Code	Description	Can use with MSP VCs
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)**	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

Did You Know…

- Automobile no-fault states include Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, North Dakota, New Jersey, New York, Pennsylvania, and Utah. Puerto Rico, a U.S. commonwealth, is also no-fault.

Remarks: Explanation Code DA

<table>
<tr><th>Code</th><th>Description</th><th>Can use with MSP VCs</th></tr>
<tr><td>DA</td><td>120 days have passed (applicable promptly period has ended)</td><td>14, 15, 41 and 47</td></tr>
<tr><td colspan="3">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</td></tr>
</table>

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

Submitting Conditional, Medicare Tertiary and Adjustment Claims

Submitting Conditional Claims

- Submit conditional claims
  - Electronically via 837I or
  - Hardcopy (UB-04/CMS-1450 claim form) to our **Claims Department**
    - You must have or obtain **approved ASCA waiver**

Did You Know…

- Per CR6426, you cannot use FISS DDE to submit, correct or adjust conditional claims.

Submitting Conditional Claims

- CR6426 requires conditional claims to be submitted electronically
- Change necessary to ensure
  - Medicare's compliance with HIPAA transaction and code set requirements
  - MSP claims are properly calculated using payment information from 837I
- Medicare uses primary payer's adjustment amounts when processing MSP claims for payment
  - Explain why billed amount was not fully paid
  - In CAS segment on 835 ERA or paper remittance
  - CAGC paired with CARC (communicates primary payer's adjustments)

Submitting Conditional Claims

- CAGC
  - Identifies general category of payment adjustment
  - Required when primary payer adjusts billed charges
  - **Options:** CO (Contractual Obligations), CR (Corrections and Reversals, OA (Other Adjustments), PI (Payer Initiated Reductions) and PR (Patient Responsibility)
- CARC
  - Communicates an adjustment
  - Explains why primary payer paid differently from amount billed to them
  - http://www.wpc-edi.com

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**

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Correcting Conditional Claims

- If your conditional claims are **RTP** (FISS status location TB9997) and you want to **make corrections**
  - **Resubmit** new corrected claims
    - Electronically via 837I or
    - Hardcopy (UB-04/CMS-1450 claim form) to our **Claims Department**
      - You must have or obtain **approved ASCA waiver**

Adjusting Conditional Claims

- If your conditional claims are **processed** (FISS status location PB9997) and you **want to make changes**
  - **Adjust** claims (TOB XX7); submit adjustments
    - Electronically via 837I or
    - Hardcopy (UB-04/CMS-1450 claim form) to our **Claims Department** (you do **not** need approved ASCA waiver)

Adjusting Primary or Conditional Claims to Make Medicare Secondary

- If your primary or conditional claims are **processed** (FISS status location PB9997) and you **want to change claims to MSP**
  - **Adjust** claims (TOB XX7); submit adjustments
    - Electronically via 837I or
    - Hardcopy (UB-04/CMS-1450 claim form) to our **Claims Department** (you do **not** need approved ASCA waiver**)**
      - **Fact:** You must adjust within 60 days of receipt of primary payer's payment; we can accept beyond one year timely filing

Adjusting Primary Claims That Rejected for MSP

- If a Medicare primary claim is **rejected for MSP** due to an open MSP record in CWF (FISS status location RB9997; reason code range 34xxx) and you **want to make changes**
  - **Adjust** claim (TOB XX7); submit adjustments
    - Electronically via 837I or
    - Hardcopy (UB-04/CMS-1450 claim form) to our **Claims Department** (you do **not** need approved ASCA waiver)
    - In FISS DDE if you are changing Medicare back to primary payer
    - **Tip:** Do not resubmit new claims; they reject as duplicates

Polling Question #3

- Will you attend a Conditional Billing Part 2 – The Examples session?
  - Yes
  - No
  - Undecided

Test Your Knowledge Question #1

- You can bill Medicare conditionally instead of billing the payer that is primary to Medicare.
  - True
  - False

Test Your Knowledge Question #2

- All conditional claims require an MSP VC and a primary payer’s payment amount of zero.
  - True
  - False

Test Your Knowledge Question #3

- All conditional claims require an OC 24 and the date of the primary payer’s denial.
  – True
  – False

Test Your Knowledge Question #4

- All conditional claims require a two-digit code in Remarks that explains why the primary payer did not pay.
  - True
  - False

Test Your Knowledge Question #5

- You can submit conditional claims to Medicare if, for **any** reason, the primary payer does not pay for services.
  - True
  - False

What You Should Do Now…

- Review MSP Resources slides
- Review CMS *MLN Matters* article MM7355
- Review Wrap Up slides
- Share information with staff
- Develop and implement policies that ensure providers MSP responsibilities are met
- Continue to attend educational sessions
- Sign up for our E-mail Updates

To Ask a Question Using the Question Box

File View Help
Attendee List (2 | Max 201)
Attendees (1) Staff (1)
NAMES - ALPHABETICALLY
Corena Bahr (Me)
Search
Audio
Audio Mode: Use Telephone
Use Mic & Speakers
MUTED
Audio Setup
Talking: Suzie Smith
Questions
Questions Log
Q: Is there a volume discount?
A: Yes! We will send you more info after the event.
Yes
Send
Webinar Now
Webinar ID: 731-938-951
GoToWebinar™

Type questions here

Then click Send

G188

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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

MSP Resources

National Government Services

- 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!

National Government Services

- 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

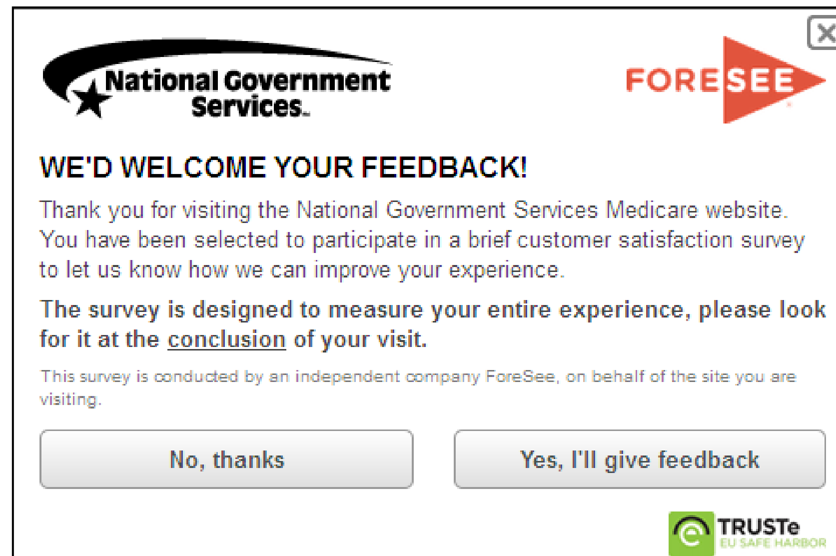
Wrap Up

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!



mu
medicare university

Medicare University Information

- For self-reporting your attendance in Medicare University:
  - Topic = **JK: Billing Compliant Conditional Claims (Part 1) – Doing it Right the First Time!**
  - Medicare University Credits (MUCs) = 2
  - Catalog Number = To be sent via email
  - Course Code = To be sent via email

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