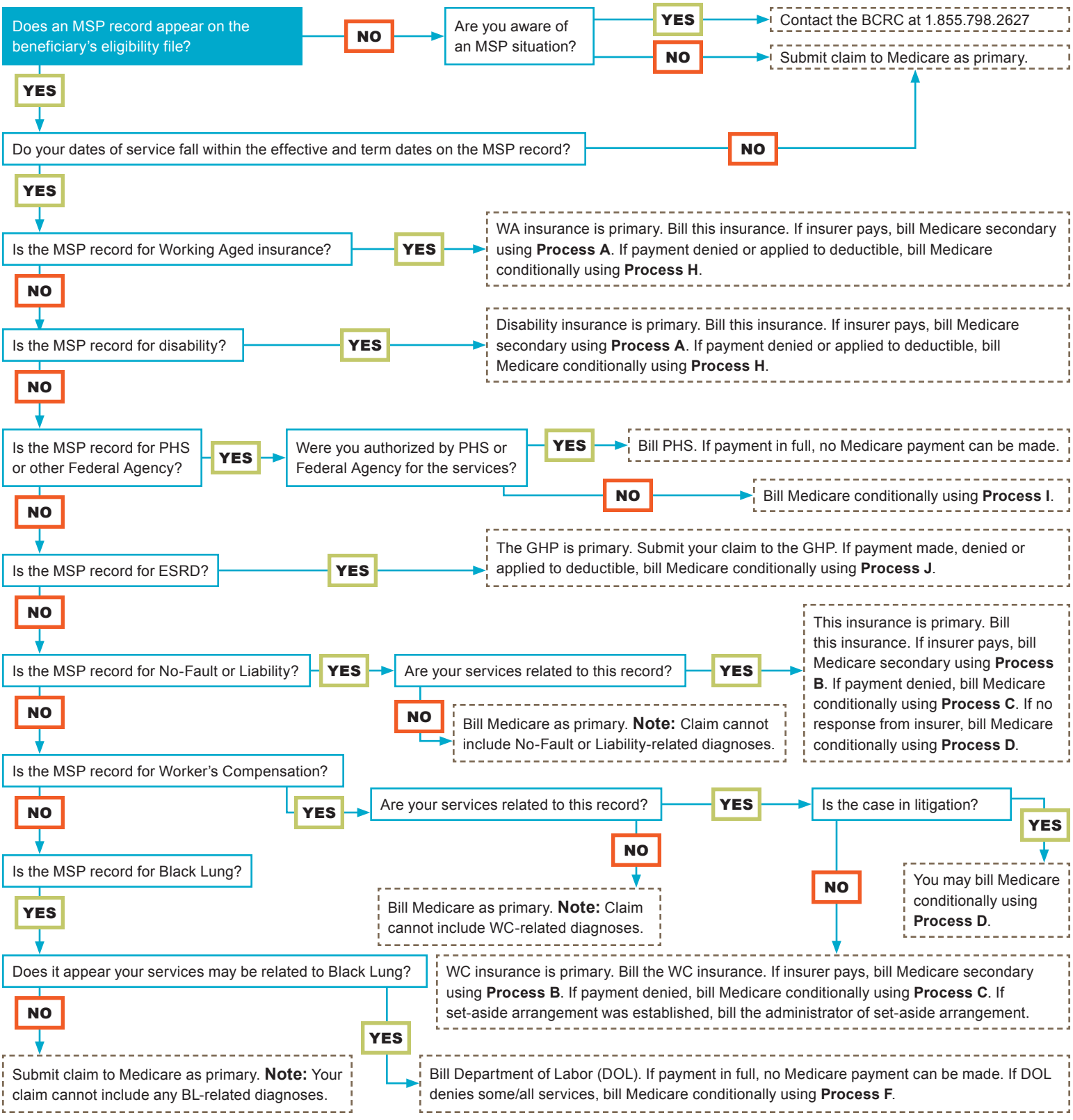
Medicare Secondary Payer BILLING & ADJUSTMENTS



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

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

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

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted using the 5010 format and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process A must be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 39-41	VALUE CODES/AMOUNT	Enter the **value codes "12"** to indicate Working Aged insurance, or **"43"** to indicate Disability insurance and the **amount** you were paid by the primary insurance. Enter value code '44' and amount **if** you are contractually obligated to accept an amount less than the total charges and higher than the payment received as your payment in full. Bill any other value code as usual.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your provider number for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the **insured's name** (the name of the employee that carries the working aged/disability insurance) on line A. Enter the beneficiary's name on line B.
FL 59	P. REL	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 11.)
FL 60	INSURED'S UNIQUE ID	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the **group name** or plan through which the insurance is provided on line A (if known).
FL 62	INSURANCE GROUP NO	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 80	REMARKS	Enter the **employer's name and address** that provides the primary insurance.

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process B: Services RELATED to No-fault, Liability or Workers' Compensation (WC) record. Primary insurer billed and payment received. Billing Medicare secondary.

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted using the 5010 format and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process B must be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 31-34	OCCURRENCE CODE/DATE	Enter the appropriate occurrence code (01 for med-pay, 02 for no fault, 03 for liability, under- or un-insured, or 04 for WC) **and date of accident/injury** based on the MSP record. (See "MSP Billing Codes" on pg 11.)
FL 39-41	VALUE CODES/AMOUNT	Enter the appropriate **value code** (14 for no-fault/med-pay, 47 for liability or 15 for WC) and the **amount** you were paid by the insurer. Enter value code '44' and amount **if** you are contractually obligated to accept an amount less than the total charges and higher than the payment received as your payment in full.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the **insured's name** (the name of the person/business that carries this insurance) on line A. Enter the beneficiary's name on line B.
FL 59	P. REL	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 11.)
FL 60	INSURED'S UNIQUE ID	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the group name or plan through which the insurance is provided on line A (if known).
FL 62	INSURANCE GROUP NO	Enter the **insurance group number** of the plan through which the insurance is provided on line A if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 80	REMARKS	Enter remarks indicating services related to accident. Billing Medicare secondary. If WC, also enter employer's name and address. Include any other pertinent information (i.e. claim number).

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process C: Services RELATED to No-fault, Liability, or Workers' Compensation (WC) record. Primary insurer billed and denial received (e.g. insurance denied payment, benefits exhausted). Billing Medicare conditionally.

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted using the 5010 format and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 FIELD	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process C must be billed electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 31-34	OCCURRENCE CODE/ DATE	Enter **occurrence code '24'** and the **date** the insurer denied payment. Enter the appropriate **occurrence code** (01 for med-pay, 02 for no fault, 03 for liability, under- or un-insured, or 04 for WC) **and date** based on the MSP record (see "MSP Billing Codes" on pg 11). Bill any other occurrence codes as usual.
FL 39-41	VALUE CODES/AMOUNT	Enter the appropriate **value code** (14 for no-fault, 47 for liability, 15 for workers' compensation). Enter zeros (0000.00) in the **amount** field. Bill any other value codes as usual.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the **insured's name** (the name of the person/business that carries this insurance) on line A. Enter the beneficiary's name on line B.
FL 59	P. REL	Enter the code for the **patient's relationship to the insured** on line A (see "MSP Billing Codes" on page 11).
FL 60	INSURED'S UNIQUE ID	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the **group name** or plan through which the insurance is provided (if known).
FL 62	INSURANCE GROUP NO	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 65	EMPLOYER NAME	If WC, enter the **employer name**.
FL 80	REMARKS	Enter the appropriate MSP Explanation Code (below) to indicate why services denied by primary insurer. If WC, also enter **employer address**.

MSP Explanation Codes	
Code	**Description**
BE	Benefits are exhausted.
CD	Charges applied to co-payment, coinsurance or deductible.
DA	120 days have passed since the primary payer was billed.
DP	Delay in payment from liability insurer.
FG	Beneficiary did not follow guidelines of their primary health plan. Use only for out of network, untimely filing or no prior authorization. Note: Indicate which of these guidelines was not followed.
LD	Response received from liability insurer stating they are not responsible for claim.
NB	Not a covered benefit.
PE	*No-Fault (also known as PIP) has been exhausted toward medical expenses.
PP	Beneficiary paid by liability insurer. Note: May not be used for medical payment insurance payments to the beneficiary (VC 14). Providers are required to pursue those dollars.

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process D: Services RELATED to No-fault, Liability or Workers' Compensation (WC) record. Primary insurer billed, and no response received from insurer. If WC, case is in litigation. Billing Medicare conditionally.

If you have submitted your claim to the primary insurance, and have not received a response from the no-fault/liability/WC insurer **AND** 120 days have passed since the claim was filed with the primary insurer (**or** it is 120 days after your claim's 'TO' date), you may bill Medicare conditionally using the following instructions. If WC, you must withdraw any lien filed against a pending settlement.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process D must be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 18-28	CONDITION CODES	If WC, enter **condition code '02'** to indicate the condition is employment related.
FL 31-34	OCCURRENCE CODE/DATE	Enter **occurrence code '24'** and the **date** of last contact with the insurance/attorney. Enter the appropriate **occurrence code** (01 for med-pay, 02 for no fault, 03 for liability, under- or un-insured, or 04 for WC) and **date** based on the MSP record.
FL 39-41	VALUE CODE/AMOUNT	Enter appropriate **value code** (14 for no-fault, 47 for liability or 15 for WC). Enter zeros (0000.00) for the **amount**.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the **insured's name** (The name of the person/business that carries this insurance) on line A. Enter the beneficiary's name on line B.
FL 59	P. REL	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 11.)
FL 60	INSURED'S UNIQUE ID	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the **group name** or plan through which the insurance is provided on line A (if known).
FL 62	INSURANCE GROUP NO	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 80	REMARKS	Enter the appropriate MSP Explanation Code (below). If WC, also enter **employer name and address**. If an attorney is involved, enter the name and address. • **DA** - 120 days have passed since the primary payer was billed. • **DP** - Delay in payment from liability insurer.

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process E has been eliminated.

Process F: Services related to Black Lung and some/all services were denied by Department of Labor (DOL) (see Note below). Billing Medicare conditionally.

NOTE: If you have already submitted a claim, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted on paper (see table below) and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
If the services are related to BL or the claim includes a BL-related diagnosis, the claim must be submitted hardcopy (paper UB-04) with a copy of DOL's denial notice.		
FL 31-34	OCCURRENCE CODE/DATE	If services were denied by DOL, enter **occurrence code '24'** and the **date** of the denial.
FL 39-41	VALUE CODES/AMOUNT	Enter **value code '41'**. Enter zeros (0000.00) if all services denied. If DOL denied some services, enter the **amount** paid by DOL.
FL 50	PAYER NAME	Enter name of black lung insurer (as it appears on the Eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known) on line A.
FL 58	INSURED'S NAME	Enter the beneficiary's name in the **insured's name** field on line A and B.
FL 59	P. REL	Enter the **patient's relationship code '18'** on line A.
FL 60	INSURED'S UNIQUE ID	Enter the patient's **Black Lung Identification number** on Line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the group name or plan through which the insurance is provided on Line A (if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 80	REMARKS	Enter the appropriate MSP Explanation Code (below) indicating why services were denied by DOL. • **BE** – Benefits are exhausted. • **NB** – Not a covered benefit. See Note below.

NOTE: If the services appear to be related to Black Lung, they must be billed to Department of Labor (DOL) before billing Medicare. If services are denied by DOL, a **hardcopy** claim must be submitted to Medicare. A copy of DOL's denial notice and a copy of workers' compensation insurers denial notice (if applicable), giving the specific reason for nonpayment, must be included with your hardcopy claim, and mailed to:

J15 – HHH Claims
CGS
PO Box 20019
Nashville, TN 37202

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process G has been eliminated.

Process H: Disability insurance OR Working Aged insurance is primary and payment denied or applied to deductible. Billing Medicare conditionally.

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted using the 5010 format and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process H must be billed electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 31-34	OCCURRENCE CODE/DATE	Enter **occurrence code '24'** and the **date** of the Explanation of Benefits (EOB) or date of last contact with the insurer.
FL 39-41	VALUE CODES/AMOUNT	Enter the appropriate **value code** (43 for disability or 12 for Working Aged). Enter zeros (0000.00) in the **amount** field. Also, enter value code '44' and amount **if** you are contractually obligated to accept an amount less than the total charges and higher than the payment received as your payment in full. Refer to the "Billing MSP Claims With Value Code 44" (http://www.cgsmedicare.com/hhh/education/materials/MSP_VC44.html) for additional information.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the **insured's name** (the name of the person that carries the disability insurance) on line A. Enter the beneficiary's name on line B.
FL 59	P. REL	Enter the code for the **patient's relationship to the insured** on line A (see "MSP Billing Codes" on page 11).
FL 60	INSURED'S UNIQUE ID	Enter the **primary payer's policy number** on line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the **group name** or plan through which the insurance is provided (if known).
FL 62	INSURANCE GROUP NO	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 65	EMPLOYER NAME	Enter the employer's name that provides the primary insurance.
FL 80	REMARKS	Enter the appropriate MSP Explanation Code (below) to indicate why services denied by primary insurer.

MSP Explanation Codes	
Code	**Description**
BE	Benefits are exhausted.
CD	Charges applied to co-payment, coinsurance or deductible.
FG	Beneficiary did not follow guidelines of their primary health plan. Use only for out of network, untimely filing or no prior authorization. Note: Indicate which of these guidelines was not followed.
NB	Not a covered benefit.
PC	Pre-existing condition.

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process I: Public Health Services (PHS) or other Federal Agency is primary. Services were not authorized by PHS/ Federal Agency. Billing Medicare conditionally.

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted using the 5010 format and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process I must be billed electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 31-34	OCCURRENCE CODE/DATE	Enter **occurrence code '24'** and the **date** the services were denied.
FL 39-41	VALUE CODES/AMOUNT	Enter the **value code '16'** to indicate PHS. Enter zeros (0000.00) in the amount field.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the beneficiary's name in the **insured's name** field on line A and B.
FL 59	P. REL	Enter the **patient's relationship code '18'** on line A.
FL 60	INSURED'S UNIQUE ID	Enter the PHS/Federal Agency identification number on line A, if available. Enter the beneficiary's HIC number on line B.
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 80	REMARKS	Enter a remark to indicate reason why services were not covered by PHS/other Federal Agency.

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Process J: Group Health Plan (GHP) is primary for 30-month ESRD coordination period. Primary insurer billed and payment/denial received or applied to deductible. Billing Medicare conditionally. (Services after the 30-month coordination period are billed to Medicare as primary.)

NOTE: If you have already submitted a claim with Medicare as primary, and your claim rejected (R B9997) for this type of MSP situation, you must submit an adjustment. You must wait until the claim appears in s/loc R B9997 in order to adjust it. Your adjustment must be submitted using the 5010 format, and contain all the information as indicated below. See the 'MSP Adjustments' process found on page 10 of this tool for more information on submitting an MSP adjustment.

UB-04 FL	UB-04 Field	MSP Billing Instruction (**NOTE: Bill all other fields as usual.**)
Claims using Process J must be billed electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry.		
FL 31-34	OCCURRENCE CODE/ DATE	Enter **occurrence code '33' and date** 30-month coordination period started. If services denied or applied to deductible, also enter occurrence code **'24'** and the **date** of the explanation of benefits (EOB) or **date** of last contact with primary insurer.
FL 39-41	VALUE CODES/AMOUNT	Enter **value code '13.'** Enter the **amount** paid by GHP. Enter zeros (0000.00) if the services were denied by the GHP or applied to deductible. Enter value code '44' and amount **if** you are contractually obligated to accept an amount less than the total charges and higher than the payment received as your payment in full. Refer to the "Billing MSP Claims With Value Code 44" (http://www.cgsmedicare.com/hhh/education/materials/MSP_VC44.html) for additional information.
FL 50	PAYER NAME	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
FL 51	HEALTH PLAN ID	Enter your **provider number** for the primary payer (if known), on line A.
FL 58	INSURED'S NAME	Enter the **insured's name** (the name of the person that carries this insurance) on line A. Enter the beneficiary's name online B.
FL 59	P. REL	Enter the **patient's relationship to the insured** on line A.
FL 60	INSURED'S UNIQUE ID	Enter the **primary payer's policy number** on line A. Enter the beneficiary's HIC number on line B.
FL 61	GROUP NAME	Enter the **group name** or plan through which the insurance is provided on Line A (if known).
FL 62	INSURANCE GROUP NO	Enter the **insurance group number** of the plan through which the insurance is provided on Line A (if known).
FL 63	TREATMENT AUTHORIZATION CODES	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.
FL 65	EMPLOYER NAME	Enter the **employer's name** that provides the primary insurance
FL 80	REMARKS	If payment denied or applied to deductible, enter the appropriate MSP Explanation Code (below). Enter the **employer's address** that provides the primary insurance.

MSP Explanation Codes	
Code	**Description**
BE	Benefits are exhausted.
CD	Charges applied to co-payment, coinsurance or deductible.
FG	Beneficiary did not follow guidelines of their primary health plan. Use only for out of network, untimely filing or no prior authorization. Note: Indicate which of these guidelines was not followed.
NB	Not a covered benefit.
PC	Pre-existing condition.

NOTE: Refer to pages 12-13 for a crosswalk between the UB-04 form locators and the ASC 837 Version 5010A2 Loop and Segment information required for MSP billing and adjustments.

Medicare Secondary Payer (MSP) Adjustment Process

Adjustments with MSP information must be submitted using the 5010 format and contain all the information as indicated in the MSP Billing Process (A-J).

If your adjustment is related to **Black Lung**, the adjustment must be submitted on paper. Refer to Process F for additional information.

American National Standard Institute (ANSI) ASC X12N 837 5010 Format Adjustments	
Step 1	Enter all claim information as usual for your type of bill, noting the exceptions below. • Ensure your type of bill (FL 4) ends in a "7" (i.e. 327 or 817) • Ensure all service units (FL 46) and total charges (FL 47) appear as covered.
Step 2	Enter the MSP information as indicated in the table for the appropriate MSP Process (A-J) above.
Step 3	Enter a claim change reason code 'D9' in the first blank condition code field (FL 18-28).
Step 4	Enter the original claim's document control number (DCN) (FL 64). (The DCN can be found in the ICN field on the RA for the original claim, or in FISS on MAP171D of the original claim.)
Step 5	Enter Remarks (FL 80) to indicate the reason for the adjustment.
Step 6	Submit the adjustment to Medicare.

Paper UB-04 Adjustments	
Step 1	Enter all claim information as usual for your type of bill, noting the exceptions below. • Ensure your type of bill (FL 4) ends in a "7" (i.e. 327 or 817) • Ensure all service units (FL 46) and total charges (FL 47) appear as covered.
Step 2	Enter the MSP information as indicated in the table for the appropriate MSP Process (A-J) above.
Step 3	Enter a claim change reason code 'D9' in the first blank condition code field (FL 18-28).
Step 4	Enter Remarks (FL 80) to indicate the reason for the adjustment.
Step 5	Enter the original claim's document control number (DCN) (FL 64). (The DCN can be found in the ICN field on the RA for the original claim, or in FISS on MAP171D of the original claim
Step 6	Mail the paper UB-04 adjustment to: J15 – HHH Claims CGS PO Box 20019 Nashville, TN 37202

MSP Explanation Codes

Code	Description
BE	Benefits are exhausted.
CD	Charges applied to co-payment, coinsurance or deductible.
DA	120 days have passed since the primary payer was billed.
DP	Delay in payment from liability insurer.
FG	Beneficiary did not follow guidelines of their primary health plan. Use only for out of network, untimely filing or no prior authorization. Indicate which of these guidelines was not followed.
LD	Response received from liability insurer stating they are not responsible for claim.
NB	Not a covered benefit.
PC	Pre-existing condition.
PE	*No-Fault (also known as PIP) has been exhausted toward medical expenses.
PP	Beneficiary paid by liability insurer. **Note:** May not be used for medical payment insurance payments to the beneficiary (VC 14). Providers are required to pursue those dollars.

Medicare Secondary Payer (MSP) Billing Codes
(UB-04 FL)

Condition Codes (FL18-28)	
Code	**Description**
02	Condition is employment related
05	Lien has been filed
06	ESRD patient in first 30 months of entitlement
08	Beneficiary would not provide information concerning other insurance coverage
09	Neither patient nor spouse is employed
10	Patient and/or spouse is employed but no GHP coverage exists
11	Disabled beneficiary but no GHP coverage
28	Patient and/or spouse's GHP is secondary
29	Disabled beneficiary and/or family member's GHP is secondary to Medicare
77	Provider accepts or is obligated/required due to a contractual agreement or law to accept payment by a primary payer as payment in full. No Medicare payment will be made.

Occurrence Codes (FL31-34)	
Code	**Description**
01	Accident/Med pay (use with VC 14 or 47)
03	Accident - liability (includes underinsured and uninsured) (use with VC 47)
04	Accident/employment related (use with VC 15)
06	Crime victim
18	Date of retirement patient/beneficiary (use with VC 12, 13, or 43)
19	Date of retirement spouse (use with VC 12, 13, or 43)
24	Date insurance denied
25	Date benefit terminated (use with VC 14 or 15)
33	First day of coordination period for ESRD beneficiaries covered by GHP (use with VC 13)
A3	Benefits exhausted (payer A) (use with VC 12, 13, or 43)

Description	Value Codes: FL39-41	Remarks FL 80 MSP Explanation Codes*
Working aged beneficiary/spouse with GHP	12	BE, CD, FG, NB, PC
ESRD beneficiary in 30-month coordination period with GHP	13	BE, CD, FG, NB, PC
No-fault, including auto/other	14	BE, CD, DA, NB, PE
Workers' compensation	15	BE, DA, FG, NB
Public health service (PHS) or other federal agency (Ex: crime victim, drug trial)	16	
Black lung	41	BE, DA, NB
Disabled beneficiary under age 65 with large group health plan (LGHP)	43	BE, CD, FG, NB, PC
Amount provider agreed to accept from primary payer when this amount is less than charges, but higher than payment received. (Enter the total amount you agreed to or are obligated to accept.)	44	
Liability insurance	47	DA, DP, LD PP
Conditional payment (payment denied or applied to deductible)	Any of the above	BE, CD, DA, DP, FG, LD, NB, PC, PE, PP

* MSP Explanation Codes are used in conditional payment situations to assist CGS with claim processing. Refer to page 10 for the codes/descriptions, or the MSP Processes for applicable codes/descriptions.

Relationship Codes (REL/FL59)							
Code	**Description**	**Code**	**Description**	**Code**	**Description**	**Code**	**Description**
01	Spouse	17	Stepson/stepdaughter	23	Sponsored dependent	39	Organ donor
04	Grandfather/grandmother	18	Self	24	Dependent of minor dependent	40	Cadaver donor
05	Grandson/granddaughter	19	Child	29	Significant other	41	Injured plaintiff
07	Nephew/niece	20	Employee	32	Mother	43	Child where insured has no financial responsibility
10	Foster child	21	Unknown	33	Father	53	Life partner
15	Ward	22	Handicap dependent	36	Emancipated minor	G8	Other relationship

For a complete list of all UB-04 codes, go to the National Uniform Billing Committee website, http://www.nubc.org.

UB-04 to 5010 Crosswalk for MSP

The following crosswalk provides ASC 837 Version 5010A2 Loop and Segment information that corresponds to the UB-04 form locators required for each of the Medicare Secondary Payer (MSP) processes.

MSP Process	UB-04 FL	UB-04 Field	ASC837 v5010A2 Loop, Segment
Process D	FL 18-28	CONDITION CODES	Loop 2300, HI01-2 (HI01-1=BG) Loop 2300, HI02-2 (HI02-1=BG) Loop 2300, HI03-2 (HI03-1=BG) Loop 2300, HI04-2 (HI04-1=BG) Loop 2300, HI05-2 (HI05-1=BG) Loop 2300, HI06-2 (HI06-1=BG) Loop 2300, HI07-2 (HI07-1=BG)
Process B Process C Process D Process F Process H Process I Process J	FL 31-34	OCCURRENCE CODE/DATE	Loop 2300, HI01-2 (HI01-1= BH) HI01-4 Loop 2300, HI02-2 (HI02-1= BH) HI02-4 Loop 2300, HI03-2 (HI03-1= BH) HI03-4 Loop 2300, HI04-2 (HI04-1= BH) HI04-4 Loop 2300, HI05-2 (HI05-1= BH) HI05-4 Loop 2300, HI06-2 (HI06-2= BH) HI06-4 Loop 2300, HI07-2 (HI07-1= BH) HI07-4 Loop 2300, HI08-2 (HI08-1= BH) HI08-4
All MSP Processes A - J	FL 39-41	VALUE CODES/AMOUNT	Loop 2300, HI01-2 (HI01-1= BE) HI01-5 Loop 2300, HI02-2 (HI02-1= BE) HI02-5 Loop 2300, HI03-2 (HI03-1= BE) HI03-5 Loop 2300, HI04-2 (HI04-1= BE) HI04-5 Loop 2300, HI05-2 (HI05-1= BE) HI05-5 Loop 2300, HI06-2 (HI06-1= BE) HI06-5 Loop 2300, HI07-2 (HI07-1= BE) HI07-5 Loop 2300, HI08-2 (HI08-1= BE) HI08-5 Loop 2300, HI09-2 (HI09-1= BE) HI09-5 Loop 2300, HI10-2 (HI10-1= BE) HI10-5 Loop 2300, HI11-2 (HI11-1= BE) HI11-5 Loop 2300, HI12-2 (HI12-1= BE) HI12-

UB-04 to 5010 Crosswalk for MSP

MSP Process	UB-04 FL	UB-04 Field	ASC837 v5010A2 Loop, Segment
All MSP Processes A - J	FL 50	PAYER NAME	Loop 2330B, NM1/PR/03
All MSP Processes A - J	FL 51	HEALTH PLAN ID	Loop 2330B, NM1/PR/09
All MSP Processes A - J	FL58	INSURED'S NAME	Loop 2010BA, NM1/IL/03, 04, 05 Loop 2330A, NM1/IL/03, 04, 05
All MSP Processes A - J	FL59	P. REL	Loop 2000B, SBR02
All MSP Processes A - J	FL60	INSURED'S UNIQUE ID	Loop 2010BA, NM1/IL/09, REF/SY/02
Process A Process B Process C Process D Process F Process H Process J	FL61	GROUP NAME	Loop 2000B,SBR04
Process A Process B Process C Process D Process F Process H Process J	FL62	INSURANCE GROUP NO	Loop 2000B,SBR03
Home Health Providers Only All MSP Processes A - J	FL63	TREATMENT AUTHORIZATION CODES	Loop 2300,REF/G1/02
Process C Process H Process J	FL65	EMPLOYER NAME	Loop 2320
All MSP Processes A - J	FL80	REMARKS	Loop 2300, NTE/ADD/01 Loop 2300, NTE02 (NTE01=ADD)