MEDICARE SECONDARY PAYER (MSP)

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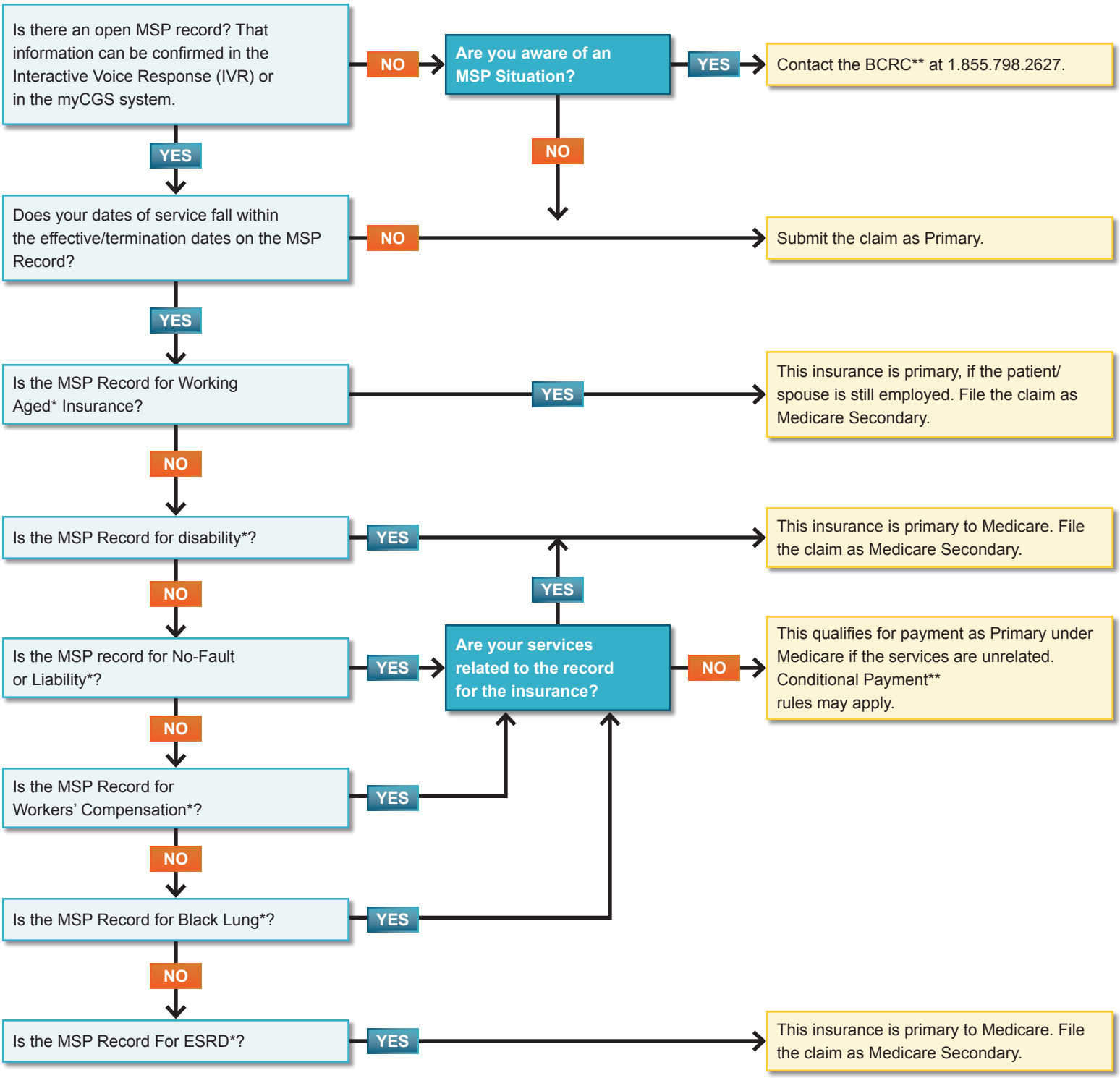

* Insurance Types

** Definitions of these terms on page 2/3

Insurance Types

Working Aged Group Health Insurance
MSP Type 12 (employer has 20 or more employees): This insurance is provided by an employer to a policyholder who is actively working with an employer that has 20 or more employees, or covered under their working spouse of any age who meets that employee status.

Disability Insurance
MSP Type 43: Medicare benefits are secondary payer to "large group health plans" (LGHP) for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status with an employer that has 100 employees or more or the current employment status of a family member with such employer.

Automobile or Liability Insurance
MSP Type 14/47: This insurance is coverage for beneficiaries who are in accidents and payable under an alternative policy. Medicare can make a conditional payment if the no-fault or liability insurance will not pay promptly. These payments are conditioned upon reimbursement to the trust fund if the primary has/had the responsibility to make primary payment.

Workers' Compensation (WC)
MSP Type 15: This insurance is coverage under an employer for injuries sustained on the job. Medicare can make a conditional payment if the worker's compensation insurance will not pay promptly. These payments are conditioned upon reimbursement to the trust fund if the primary has/had the responsibility to make primary payment.

Federal Black Lung Program
MSP Type 41: This program covers Black Lung claims. Medicare cannot pay claims submitted with a Black Lung Diagnosis code unless the information was included on the electronic claim with appropriate information or a copy of the Black Lung Explanation of Benefits is attached to the paper claim.

End Stage Renal Disease (ESRD)
MSP Type 13: For beneficiaries covered through an employer sponsored health plan through their own or a family member's current or former employment, Medicare is secondary for 30 months for those beneficiaries entitled to Medicare based solely on ESRD from March 1, 1996.

Benefits Coordination and Recovery Center (BCRC)

The BCRC collects, manages, and reports insurance coverage for Medicare Beneficiaries. They will verify the insurance information for the patient and, in the case of multiple insurers, determine the proper payment arrangement in order to prevent mistaken payment of Medicare benefits.

If the insurance information for the patient needs to be updated, the best course of action is to ask the beneficiary to contact the BCRC directly at 1.855.798.2627. In some cases the BCRC may be able to accept information directly from the providers; in most cases, however, the beneficiary should call the BCRC directly.

Conditional Payment for Medicare Beneficiaries

Medicare may not may payment on an MSP claim where payment has been made or can reasonably be expected to be made by (or based on) a WC law or plan, or liability, or no-fault insurance. However, Medicare can make a conditional payment for WC, no-fault, or liability if payment has not be made or cannot be expected to be made by these insurance and the promptly billed period has expired.

These payments are made based "on the condition" that the Medicare Trust Fund be reimbursed if the insurance is responsible for making the primary payment, based on a judgment, waiver, or release. The instructions for billing Conditional Payment are included in the Job Aid.

Filing Medicare Secondary Payer Claims

If Medicare is not the primary insurance, you must submit complete information regarding the primary payment from the other insurer in order for any additional payment to be paid. Medicare secondary benefits may be payable if all the following conditions are met:

- The primary insurer's payment is less than the provider's charges for Medicare covered services, and
- The primary insurer's payment is less than the maximum amount payable by Medicare, and
- The provider does not accept and is not obligated to accept the primary insurer's primary payment as payment in full.

In some cases, the primary insurer's payment and allowed amount exceed the amount that may be payable by Medicare. We strongly recommend that you file a Medicare secondary claim in these situations, even though no Medicare payment can be made. Filing a timely claim is important in the event that, at a later date, it is determined that Medicare should have been the primary payer for that claim.

Filing MSP Claims: CMS-1500 Claim Form

MSP claims that are filed on paper must be submitted with a copy of the primary insurance remittance notice. We require all elements to be on the primary insurance's explanation of benefits (EOB) in order to process Medicare secondary claims:

- The EOB must be legible and complete.
- If the primary insurer's EOB does not include an explanation of any denials, then any denial codes that you received from the primary insurer must be submitted with the claim, even if this information is on another page.
- The date of service on the EOB must match the date of service on the CMS-1500 form.
- If the primary insurance has been updated, cancelled, or terminated, include this information with your Medicare claim. (We strongly recommend that you advise your patients to contact the BCRC directly in these situations in order to update their Medicare records.)

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Filing MSP Claims: Electronic Billing

When filing for Medicare secondary payer for an electronic claim, complete the specific loops and segments as noted in the following chart:

Loop 2000B – Subscriber Information			
Usage	**Segment**	**Value**	**Comment**
Required	SBR01	P = Primary S = Secondary T = Tertiary; Use to indicate "payer of last resort"	Code identifying the insurance carrier's level of responsibility for payment of a claim (to identify whether Medicare is primary, secondary or tertiary). Use "S" for Medicare Secondary Payer (MSP) claims being sent to Medicare Part.
Situational	SBR02	18	Specifies the relationship to the person insured
Situational	SBR03		Policy or group number
Situational	SBR04		The name of group plan
Situational	SBR05	12 = Working Aged 13 = ESRD 14 = No-fault Insurance including Auto is Primary 15 = Workers' Compensation 16 = Workers' Compensation 41 = Black Lung 42 = Veterans Administration 43 = Disability 47 = Liability Insurance	Code to identify the type of insurance policy within a specific insurance program

Loop 2320 – Other Subscriber Information Required if other payers are known to potentially be involved in paying this claim.			
Usage	**Segment**	**Value**	**Comment**
Required	SBR01	P = Primary S = Secondary T = Tertiary Use to indicate "payer of last resort"	Code identifying the insurance carrier's level of responsibility for payment of a claim. Use "P" for claims sent to Medicare Part B to identify primary information.
Required	SBR02	01 = Spouse 04 = Grandfather or Grandmother 05 = Grandson or Granddaughter 07 = Nephew or Niece 10 = Foster Child 15 = Ward 17 = Stepson or Stepdaughter 18 = Self 19 = Child 20 = Employee 21 = Unknown 22 = Handicapped Dependent	Specifies the relationship to the insured.

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Loop 2320 – Other Subscriber Information Required if other payers are known to potentially be involved in paying this claim.			
Usage	**Segment**	**Value**	**Comment**
Required	SBR02	23 = Sponsored Dependent	Specifies the relationship to the insured.
		24 = Dependent of a Minor Dependent	
		29 = Significant Other	
		32 = Mother	
		33 = Father	
		36 = Emancipated Minor	
		39 = Organ Donor	
		40 = Cadaver Donor	
		41 = Injured Plaintiff	
		43 = Child Where Insured has No Financial Responsibility	
		53 = Life Partner	
		G8 = Other Relationship	
Situational	SBR03		Policy or group number. Must not match the value in 2330A NM109.
Situational	SBR04		Name of plan
Required	SBR05	12 = Working Aged	Code to identify the type of insurance policy within a specific insurance program.
		13 = ESRD	
		14 = No-fault Insurance, including Auto, is primary.	
		15 = Workers' Compensation	
		41 = Black Lung	
		41 = Medicare Secondary Black Lung	
		42 = Veterans Administration	
		43 = Disability	
		47 = Liability Insurance	
Required	SBR09	11 = Other Non-Federal Programs	Code to identify the type of claim.
		12 = Preferred Provider Organization (PPO)	
		13 = Point of Service (POS)	
		14 = Exclusive Provider Organization (EPO)	
		15 = Indemnity Insurance	
		16 = Health Maintenance Organization (HMO) Medicare Risk	
		AM = Automobile Medical	
		BL = Blue Cross/Blue Shield	
		CH = Champus	
		CI = Commercial Insurance Co	
		DS = Disability	
		HM = Health Maintenance Organization	
		LM = Liability Medical	

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Loop 2320 – Other Subscriber Information Required if other payers are known to potentially be involved in paying this claim.			
Usage	**Segment**	**Value**	**Comment**
Required	SBR09	MB = Medicare part B	Code to identify the type of claim.
		MC = Medicaid	
		OF = Other Federal Program	
		TV = Title V	
		VA = Veteran Administration Plan Refers To Veterans Affairs Plan	
		WC = Workers' Compensation Health Claim	
		ZZ = Mutually Defined Unknown	

Loop 2320 – Other Subscriber Information			
Coordination of Benefits (COB) Payer Paid Amount			
Usage	**Segment**	**Value**	**Comment**
Required	AMT01	D	Code to identify the primary paid amount.
Required	AMT02		Total amount paid by the primary payer.
Subscriber Demographic Information			
Usage	**Segment**	**Value**	**Comment**
Required	DMG01	D8	Code indicating the format of the date.
Required	DMG02		Date of birth (CCYYMMDD)
Required	DMG03	F = Female	Code indicating the sex of the individual.
		M = Male	
		U = Unknown	
Other Insurance Coverage Information			
Usage	**Segment**	**Value**	**Comment**
Required	OI03	N = No	A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. Use "W" when the patient refuses to assign benefits.
		W = Not Applicable	
		Y = Yes	
Situational	OI04	P = Signature generated by provider because the beneficiary was not physically present for services.	Indicates how the beneficiary or subscriber authorization signature was obtained and how it is being retained by the provider.
Required	OI06	I = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statues	
		Y = Yes, provider has a signed statement permitting release of medical billing data related to a claim	

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Loop 2330A Other Subscriber Name and Address			
Usage	**Segment**	**Value**	**Comment**
Required	NM101	IL	Code identifying the insured or subscriber.
Required	NM102	1 = Person 2 = Non-person Entity	Code qualifying the type of entity.
Required	NM103		Last Name or Organization Name
Situational	NM104		Subscriber first name
Situational	NM105		Subscriber middle
Situational	NM107		Subscriber generation (suffix)
Required	NM108	MI = Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.	Code to indicate Member ID
Required	NM109		Identification Number
Required	N301		Address information (address 1)
Situational	N302		Address information (address 2) required if second address exists.
Situational	N401		City name required when information is available.
Situational	N402		State or Province code required when information is available.
Situational	N403		Postal code required when information is available.
Situational	N404		Country Code, required if the address is out of the U.S.

Loop 2330B – Other Payer Name			
Usage	**Segment**	**Value**	**Comment**
Required	NM101	PR = Payer	Code to identify an organizational entity or other payer.
Required	NM102	2 = Non-person Entity	Code to identify type of entity
Required	NM103		Organization Name
Required	NM108	PI = Payer Identification XV = CMS National Plan ID	Code to identify Payer or organization.
Required	NM109		Payer Identification Code

Loop 2430 – Line Adjudication Information			
Usage	**Segment**	**Value**	**Comment**
Required	SVD01		Payer Identification Code
Required	SVD02		The amount paid by the primary payer for each service line. Zero (0) is an acceptable value for this element.
Required	SVD03-1	HC = Healthcare Common Procedure Coding System (HCPCS) Codes IV = Home Infusion EDI Coalition (HIEC) Product/Service Code ZZ = Mutually Defined	Code to identify the type of medical procedure.
Required	SVD03-2		Procedure Code
Situational	SVD03-3		Procedure Code Modifier Procedure Modifier 1
Situational	SVD03-4		Procedure Code Modifier Procedure Modifier 2
Situational	SVD03-5		Procedure Code Modifier Procedure Modifier 3
Situational	SVD03-6		Procedure Code Modifier Procedure Modifier 4
Required	SVD05		Paid units of service
Situational	SVD06		Assigned Number (used only for bundling of service lines)

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Line Adjustment			
Usage	**Segment**	**Value**	**Comment**
Required	CAS01	CO = Contractual Obligations CR = Correction and Reversals OA = Other Adjustments PI = Payer Initiated Reductions PR = Patient Responsibility	Code to identify the general category of payment adjustment.
Required	CAS02		Claim Adjustment Reason codes are located on the Washington Publishing Company website at http://www.wpc-edi.com
Required	CAS03		Monetary Amount***
Situational	CAS04		Quantity***
Situational	CAS05		Claim Adjustment Reason Code***
Situational	CAS06		Monetary amount***
Situational	CAS07		Quantity***
Situational	CAS08		Claim Adjustment Reason Code (CARC)***
Situational	CAS09		Monetary amount***
Situational	CAS10		Quantity***
Situational	CAS11		Claim Adjustment Reason Code (CARC)***
Situational	CAS12		Monetary amount***
Situational	CAS13		Quantity***
Situational	CAS14		Claim Adjustment Reason Code (CARC)***
Situational	CAS15		Monetary amount***
Situational	CAS16		Quantity***
Situational	CAS17		Claim Adjustment Reason Code (CARC)***
Situational	CAS18		Monetary amount***
Situational	CAS19		Quantity***

*** *Use as needed to show payer adjustment.*

Line Adjudication Date			
Usage	**Segment**	**Value**	**Comment**
Required	DTP01	573	Date/Time Qualifier
Required	DTP02	D8	Date (CCYYMMDD)
Required	DTP03		Date Time Period

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Instructions for Filing Conditional Payment

When submitting MSP claims for conditional payment, we will need information regarding why that payment is being requested. Any MSP claim that does not have additional information will be returned. For both paper and electronic claims, the words "Conditional Payment" must be in the appropriate field, along with the primary explanation of benefits. For example, the comment could indicate "Conditional Payment: Unrelated to Liability/No-Fault/Workers' Compensation (whichever is appropriate)" or "Conditional Payment- Non- Prompt Payment."

For paper claims, enter this information in block 19. For electronic claims, enter this information in the following loops and segments listed.

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/ Liability	2320 or 2430 - valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 - valid information why NGHP or GHP did not make payment	15	WC	$0.00	02-Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

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