



Answers to Frequently Asked Questions about Medicare Secondary Payer

Q: How do providers bill for MSP Conditional Payments?

A: The following conditions must be present if requesting a conditional payment:

- MSP value code must be present with no amount listed.
- Occurrence code 01, 02, 03, 04 or 24 must be present
- First payer ID on page 4 must = C
- Insurer name must be present and matches CWF
- Remarks must be present with a valid reason for requesting conditional payment

***If adjusting a claim for a conditional payment, a D9 condition code must be used. The D9 is only to be used when it is an adjustment for a conditional payment. The conditional payment is given when the primary insurance (GHP or a Liability insurance) denies the claim in whole or when the liability insurance has not responded to the provider and it has been over 120 days since the date of the claim. All other situations should either be a D7-adjustment to make Medicare Secondary (MSP value code and amount of the primary payment is more than \$0.00) or D8-adjustment to make Medicare primary (CWF is closed).

***If remarks are not valid the claim will be returned to the provider.

***If requesting a conditional payment due to the 120 day rule, a 24 occurrence code can not be used because insurance has not denied the claim. Must use the appropriate accident/injury occurrence code 01, 02, 03 or 04.

Example of valid reason for requesting a conditional payment:

1. GHP denies a properly filed claim in whole
2. The claim is 120 days past the date of accident and a conditional payment is being requested.

Q: If there is an open Worker's Compensation screen on CWF, does it need to be closed if not Worker's Compensation related?

A: No, just put your claim information in remarks (not related to Worker's Compensation) and the MSP department will work these claims. If the claim is worked incorrectly, refer to MSP to have claim adjusted.

Q: When can Conditional Primary Medicare Benefits be Paid?

A:

- The beneficiary, provider, physician, or supplier has filed a proper claim with a Group Health Plan in the case of services for which payment under Workers Comp, or liability, or no-fault insurance can reasonably be expected, and the contractor determines that the Group Health Plan insurer will not pay promptly (within 120 days of receipt of the claim) for any reason except when the Group Health Plan claims that its benefits are secondary to Medicare; or
- The beneficiary or provider, physician, or supplier that has accepted assignment filed a proper claim with a Group Health Plan or Large Group Health Plan denied the claim in whole or in part; or
- Because of physical or mental incapacity of the beneficiary, the physician, the supplier or beneficiary failed to file a proper claim with the Group Health Plan.

When such conditional Medicare payments are made, they are made on condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the Group Health Plan.



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Q: What if the Insurance name on the claim does not match Common Working File?

A: As the provider, you are responsible for checking the MSP screen on Common Working File (CWF) to ensure the information is accurate before you submit your claim to Medicare. If the information is correct, you may proceed with submitting your claim. If the screen is incorrect, you must contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 to update the CWF. Once the screen has been updated by the COBC you may proceed with submitting your claim. However, if you do not have access to CWF you may contact the MSP Department at 1-866-518-3284 and we will check CWF for you.

For IRS/SSA/Datamatch you or the employer must send a letter (on the employer's letterhead) to the COBC at the following address:

Coordination of Benefits Contractor
PO Box 5041
New York, NY 10274-5041

Q: How do I proceed with a claim that has been rejected with an MSP reason code in the 34000 range?

A: When a claim has been rejected with a reason code in the 34000 range, you must either bill the other insurance company or contact the Coordination of Benefit Contractor (COB) to update the MSP record on CWF. If you receive a payment or a denial from the other insurance company, you can request an adjustment be made on the original claim. You can also request an adjustment to the original claim after the COB has corrected the MSP record on CWF. Please do not request a cancel on the original claim. Only an adjustment should be completed on a rejected MSP claim.

Q: How do you use Value Code 44 when billing MSP claims?

A: A value code 44 is used when a primary payer pays less than actual charges and less than the amount a provider is contractually obligated to accept as payment in full from an insurance company. A 44 code should only be used for claims where there is a contractual agreement with an insurance company. The value code 44 is used with the amount the provider was obligated to accept. Use the appropriate value code (12, 13, or 43) with the amount actually received from the insurance company.

Q: How do I bill a claim to Medicare that has been denied by the primary insurance?

A: If the primary insurance denied the claim use an Occurrence Code 24 with the date the primary insurance denied the claim, use the appropriate value code with a \$0.00 dollar amount. The primary payer code should be a "C with the primary insurance name and the secondary line should show a payer code "Z and Medicare. Include in remarks the reason the primary insurance denied the claim (i.e., insurance denied services not covered).

Q: What required " claim change condition code do I use when adjusting a denied claim to make Medicare the secondary payer?

A: You must use a condition code D7 along with the appropriate adjustment reason code (i.e., BL (Black Lung), DB (Disability), LI (Liability), WC, (Workers Compensation), etc.

Q: What required "claim change condition code do I use when adjusting a denied claim to make Medicare the primary payer?

A: You must use a condition code D8 along with the appropriate adjustment reason code (i.e., BL (Black Lung), DB (Disability), LI (Liability), WC, (Workers Compensation), WE (Working Elderly), etc.)



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Q: Can MSP adjustments be submitted electronically?

A: MSP Adjustments can be submitted electronically or hardcopy, but for faster processing of your adjustments we encourage you to submit them electronically. You are responsible for checking the MSP screen on Common Working File (CWF) to ensure the information is accurate. If the information is correct, you may proceed with requesting your adjustment. If the screen is incorrect, you must call the Coordination of Benefits Contractor (COB) at 1-800-999-1118 to update the CWF. Once the screen has been updated by (COB) you may proceed with requesting your adjustment.

Q: Who do I contact if the beneficiary's admission questionnaire does not match the information on HIQA/CWF?

A: If you have a situation where the MSP information does not match HIQA/CWF the Coordination of Benefits (COB) Contractor must be contacted at 1-800-999-1118. Your MSP claims should be submitted after the COB Contractor has updated HIQA/CWF with the information you provided. The following tips were provided to us by the COB:

Q: Updating an Employer Group Health Plan (EGHP) or Large Group Health Plan (LGHP) record

A: If your provider number is on file with the COB you may update a regular group record. You must be able to provide the insurance name, address, policy number, and the termination date. If you are trying to change the name and number of the insurance (i.e., "Prudential to "Anthem) you must provide correct insurance name, address, policy number, and telephone number. COB will ask you for information about the patient such as the patient's name, address, date of birth, possible effective dates to Medicare, etc. You should already have this information according to their records and the MSP admission questionnaire.

Q: Updating a liability, no-fault, or worker's compensation record

A: If your provider number is on file with the COB and you want to update a liability, no fault or worker's comp record you will need to contact the lead contractor assigned by the COB. The COB should be able to give the provider the name and number of the contractor who can update this record. CMS has assigned certain states (where the patient currently lives) to each Medicare office that initiates for subrogation. This will happen when a patient is involved in a slip/fall, auto accident, malpractice, or worker's comp injury.

Q: Updating a Datamatch record

A: If you call COB and your provider number is in the system and you want to update a group record, you may be told that the record is a Datamatch record. In this situation COB will instruct you to call the patient and have the patients employer fax information to their office that contains a termination date or any information that is needed to update this record, so a claim can be processed correctly.