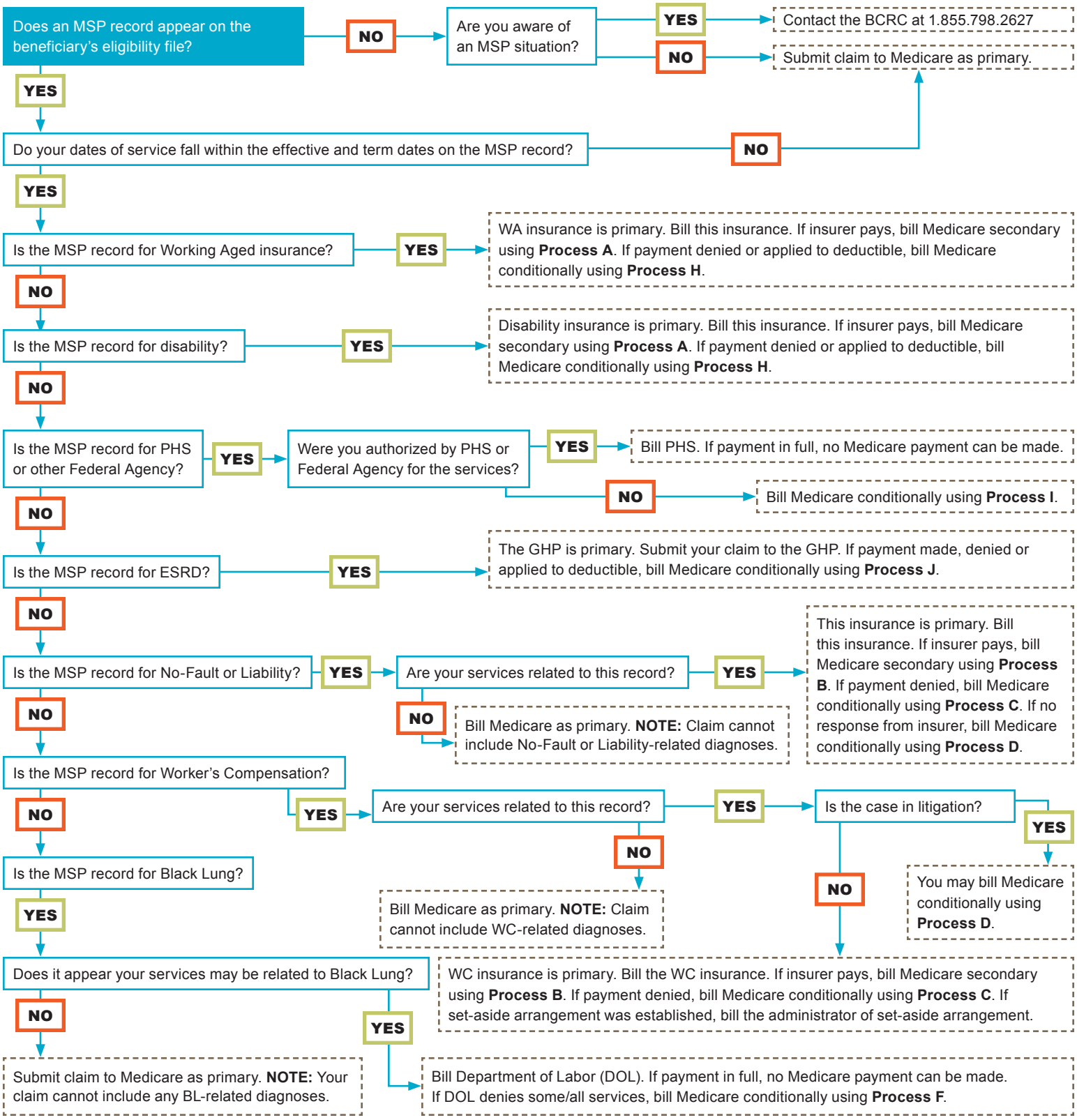
Medicare Secondary Payer BILLING & ADJUSTMENTS



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 contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
Claims using Process A may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.			
1	VALUE CODES	FL 39-41	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.
3	CD	N/A	Enter the appropriate **payer code** (A for working aged, G for disability) on line A. Enter payer code "Z" on line B.
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.			
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.
	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.

	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field.
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed** If Value Code 44 is billed, the dollar amount entered in the AMT field must be the difference between the total charges and the VC 44 amount.
4	REMARKS	FL 65/80	Enter the **employer's name and address** that provides the primary insurance.
5	INSURED NAME	FL 58	Enter the **insured's name** (the name of the employee that carries the working aged/disability insurance) on line A.
5	REL	FL 59	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on page 19.)
5	CERT-SSN-MID	FL 60	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's MID number on line B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	GROUP NAME	FL 61	Enter the **group name** or plan through which the insurance is provided on line A (if known).
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	INS GROUP NUMBER	FL 62	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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 contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
Claims using Process B may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.			
1	OCC CDS/DATE	FL 31-34	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 page 19).
1	VALUE CODES	FL 39-41	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.
3	CD	N/A	Enter the appropriate **payer code** (D for no fault/med-pay, L for liability, E for WC) on line A. Enter payer code "Z" on line B.
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.			
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.
	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.

	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed** If Value Code 44 is billed, the dollar amount entered in the AMT field must be the difference between the total charges and the VC 44 amount.
4	REMARKS	FL 65/80	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).
5	INSURED NAME	FL 58	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.
5	REL	FL 59	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 19.)
5	CERT-SSN-MID	FL 60	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's MID number on line B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	GROUP NAME	FL 61	Enter the **group name** or plan through which the insurance is provided on line A (if known).
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	INS GROUP NUMBER	FL 62	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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 contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
Claims using Process C may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. However, if your conditional claim is related to the MSP Explanation Codes "DA" or "DP", CAS information would not be available, therefore, it is not required. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.			
1	OCC CDS/ DATE	FL 31-34	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 page 19). Bill any other occurrence codes as usual.
1	VALUE CODES	FL 39-41	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.
3	CD	N/A	Enter **payer code 'C'** on line A. Enter payer code "Z" on line B. **NOTE:** Value Code 44 should not be reported with payer code 'C'.
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.			
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.

	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.
	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field.
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed**
4	REMARKS	FL 65/80	Enter the appropriate MSP Explanation Code (below) to indicate why services denied by primary insurer. If WC, also enter employer name and address.
5	INSURED NAME	FL 58	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.
5	REL	FL 59	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 19.)
5	CERT-SSN-MID	FL 60	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's MID number on line B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	GROUP NAME	FL 61	Enter the **group name** or plan through which the insurance is provided (if known).
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	INS GROUP NUMBER	FL 62	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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.

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.

MSP Resources: This flow chart also provides the following information:

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
			Claims using Process D may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. However, if your conditional claim is related to the MSP Explanation Codes "DA" or "DP," CAS information would not be available, therefore, it is not required. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.
1	COND CODES	FL 18-28	If WC, enter condition code '02' to indicate the condition is employment related.
1	OCC CDS/ DATE	FL 31-34	Enter **occurrence code '24'** and the **date** of the 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.
1	VALUE CODES	FL 39-41	Enter the appropriate **value code** (14 for no-fault, 47 for liability, 15 for WC). Enter zeros (0000.00) for the amount.
3	CD	N/A	Enter **payer code 'C'** on line A. Enter payer code "Z" on line B. **NOTE:** Value Code 44 should not be reported with payer code 'C.'
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
			*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Valud Codes 12, 13, 14, 15, 16, 43, and 47.

	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.
	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field.
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed**
4	REMARKS	FL 65/80	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.
5	INSURED NAME	FL 58	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.
5	REL	FL 59	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 19.)
5	CERT-SSN-MID	FL 60	Enter the **primary payer's policy number (if available on the eligibility file)** on line A. Enter the beneficiary's MID number on line B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	GROUP NAME	FL 61	Enter the **group name** or plan through which the insurance is provided on line A (if known).
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	INS GROUP NUMBER	FL 62	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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.

MSP Resources: This flow chart also provides the following information:

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

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 MID 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

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 contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 29)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
Claims using Process H may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.			
1	OCC CDS/DATE	FL 31-34	Enter **occurrence code '24'** and the **date** of the Explanation of Benefits (EOB) or date of last contact with the insurer.
1	VALUE CODES	FL 39-41	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 Coe 44" (http://www.cgsmedicare.com/hhh/education/materials/MSP_VC44.html) for additional information.
3	CD	N/A	Enter **payer code 'C'** on line A. Enter payer code "Z" on line B. **NOTE:** Value Code 44 should not be reported with payer code 'C.'
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.			
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.
	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.

	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field.
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed**
4	REMARKS	FL 65/80	Enter the appropriate MSP Explanation Code (below) to indicate why services denied by primary insurer. Enter the employer's name and address that provides the primary insurance.
5	INSURED NAME	FL 58	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.
5	REL	FL 59	Enter the code for the **patient's relationship to the insured** on line A. (See "MSP Billing Codes" on pg 19.)
5	CERT-SSN-MID	FL 60	Enter the **primary payer's policy number** on line A. Enter the beneficiary's MID number on line B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	GROUP NAME	FL 61	Enter the **group name** or plan through which the insurance is provided (if known).
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	INS GROUP NUMBER	FL 62	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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.

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 contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
Claims using Process I may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.			
1	OCC CDS/ DATE	FL 31-34	Enter **occurrence code '24'** and the **date** the services were denied.
1	VALUE CODES	FL 39-41	Enter the **value code '16'** to indicate PHS. Enter zeros (0000.00) in the amount field.
3	CD	N/A	Enter **payer code 'C'** on line A. Enter payer code "Z" on line B. **NOTE:** Value Code 44 should not be reported with payer code 'C.'
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.			
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.
	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.
	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.

	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field.
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed**
4	REMARKS	FL 65/80	Enter a remark to indicate reason why services were not covered by PHS/other Federal Agency.
5	INSURED NAME	FL 58	Enter the beneficiary's name in the **insured's name** field on line A and B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	REL	FL 59	Enter the **patient's relationship code '18'** on line A.
5	CERT-SSN-MID	FL 60	Enter the PHS/Federal Agency identification number on line A. Enter the beneficiary's MID number on line B.
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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 contain all the information as indicated below.

MSP Resources: This flow chart also provides the following information (click to access):

- Medicare Secondary Payer (MSP) Adjustment Process 5010 Format or FISS DDE (page 17)
- MSP Explanation Codes (page 17)
- MSP Billing Codes (page 19)
- UB-04 to 5010 Crosswalk for MSP (page 20)
- Claim Adjustment Segment (CAS) 5010 Format (page 22)

FISS Pg	FISS Field	UB-04 FL	MSP Billing Instruction (* * NOTE: Bill all other fields as usual.* *)
Claims using Process J may be submitted electronically using the American National Standard Institute (ANSI) ASC X12N 837 5010 format or may be submitted to Medicare using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE). All MSP claims, submitted via 5010 or DDE must include Claim Adjustment Segment (CAS) information. For DDE entry, additional fields, shown below (*), are required. MSP paper claim submissions are only accepted when services are related to Black Lung, or when the provider meets the small provider exception (CMS Pub. 100-04, Ch. 24 §90 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf). Paper claims submitted due to the small provider exception must include the prior payer's explanation of benefits (EOB) and documentation indicating that the provider meets the small provider exception.			
1	OCC CDS/ DATE	FL 31-34	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.
1	VALUE CODES	FL 39-41	Enter the **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) Web page for additional information. Do not report value code 44 if the primary insurer denied or applied to deductible.
3	CD	N/A	Enter **payer code 'B'** on line A if primary insurer paid. Enter payer code "C" if primary insurer payment denied or applied to deductible. Enter payer code "Z" on line B. **NOTE:** Value Code 44 should not be reported with payer code 'C.'
3	PAYER	FL 50	Enter the primary insurer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	FL 51	Enter your **provider number** for the primary payer (if known), on line A.
*All MSP claims require claim adjustment segment (CAS) information. In FISS DDE, CAS information must be entered on the "MSP Payment Information screen (MAP1719) by pressing **F11** from the Claim Page 03. The "MSP Payment Information" screen for "Primary Payer 1" will display. Entry for a second payer (if there is one) is available by pressing **F6** to display the "MSP Payment Information" screen for "Primary Payer 2." Access to the Claim Adjustment Segment (CAS) 5010 Format information is available later in this flow chart. (page 21). The prior payer's 835 Electronic Remittance Advice (ERA) typically includes CAS information. If this information is not available from the prior payer, providers need to determine the appropriate Group Code and Claim Adjustment Reason Code (CARC) to submit. Refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/ for a list of valid CARC codes, and the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE Code Combinations.			
	* PAID DATE	N/A	Enter the paid date shown on the primary payer's remittance advice.

	* PAID AMOUNT	N/A	Enter the paid amount shown on the primary payer's remittance advice. This amount must equal the dollar amount entered for MSP Value Codes 12, 13, 14, 15, 16, 43, and 47.
	* GRP	N/A	Enter the Group Code shown on the primary payer's remittance advice. Valid codes are: CO – Contractual Obligation PI – Payer Initiated Reductions OA – Other Adjustment PR – Patient Responsibility Refer to the CAQH website at http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule for the current version of the CORE CODE Combinations.
	* CARC	N/A	Enter the Claim Adjustment Reason Code (CARC) shown on the primary payer's remittance advice. NOTE: The CARC code must be a valid code. This is a 4-digit field; however if the CARC code is a 2, enter a "2", not "02" or "0002." **NOTE:** CARC codes explain why there is a difference between the total billed amount and the paid amount. The word 'adjustment' in relation to a CARC code is not the same as a "claim adjustment" (type of bill 327 or 817). For a current list of valid CARC codes, refer to the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/. A list of CARC codes is also available by accessing the FISS DDE Inquiry screen option 68 (ANSI REASON CODES) and type "C" in the RECORD TYPE field.
	* AMT	N/A	Enter the dollar amount associated with the group code (GRP) and CARC. The total amount entered in the PAID AMOUNT field, plus the adjusted amount(s) entered in the AMT field for each GRP and CARC combination, must equal the total submitted charges on the claim. **PAID AMOUNT + AMT (adjusted charge) = Total Billed** If Value Code 44 is billed, the dollar amount entered in the AMT field must be the difference between the total charges and the VC 44 amount. **NOTE:** Value Code 44 should not be reported with payer code 'C.'
4	REMARKS	FL 65/80	If payment denied or applied to deductible, enter the appropriate MSP Explanation Code (below). Enter the **employer's address** that provides the primary insurance.
5	INSURED NAME	FL 58	Enter the **insured's name** (the name of the person that carries this insurance) on line A. Enter the beneficiary's name on line B.
5	SEX	FL 11	Enter the insured's sex code (F or M) on line A. Enter the beneficiary's sex code on line B.
5	DOB	FL 10	Enter the insured's date of birth (MMDDCCYY) on line A. Enter the beneficiary's DOB on line B.
5	REL	FL 59	Enter the **patient's relationship to the insured** on line A.
5	CERT-SSN-MID	FL 60	Enter the **primary payer's policy number** on line A. Enter the beneficiary's MID number on line B.
5	GROUP NAME	FL 61	Enter the **group name** or plan through which the insurance is provided on line A (if known)
5	INS GROUP NUMBER	FL 62	Enter the **insurance group number** of the plan through which the insurance is provided on line A (if known).
5	TREAT AUTH CODE	FL 63	**Home health providers only:** Enter the Claim-OASIS Matching Key code on line B.

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.

Medicare Secondary Payer (MSP) Adjustment Process

5010 Format or FISS DDE

Adjustments with MSP information must be submitted using the 5010 format or FISS DDE, and contain all the information as indicated in the MSP Billing Process (A-J). If using FISS DDE, providers must ensure the MSP information is entered on the "MSP Payment Information" screen (MAP 1719).

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 in the first available COND CODES field. If changing to make Medicare secondary, enter D7. If changing to make Medicare primary, enter D8. Refer to the Adjustments/Cancels (https://www.cgsmedicare.com/hhh/education/materials/adjustments_cancels.html) Web page for additional Claim Change Reason Code. Only use D9, when no other code best describes the adjustment request (e.g. conditional payment), or when there are multiple changes. An explanation must be entered in the REMARKS field when D9 is entered.
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.

FISS DDE Adjustments	
Step 1	From the FISS Main Menu, choose option 03 Claim Correction
Step 2	From the Claims and Attachments Correction Menu, choose option 33 (Home Health) or 35 (Hospice).
Step 3	Enter your NPI and the patient's MID number.
Step 4	If the claim you want to adjust was rejected, change the "P" in the S/LOC field to an "R."
Step 5	Change the 2nd digit of your type of bill, if needed (ex, 33 changed to a 32, 81 changed to an 82). Press Enter.
Step 6	Select the claim you want to adjust
Step 7	On FISS Page 01, enter a Claim Change Reason Code in the first available COND CODES field. If changing to make Medicare secondary, enter D7. If changing to make Medicare primary, enter D8. Refer to the Adjustments/Cancels (https://www.cgsmedicare.com/hhh/education/materials/adjustments_cancels.html) Web page for additional Claim Change Reason Code. Only use D9, when no other code best describes the adjustment request (e.g. conditional payment), or when there are multiple changes. An explanation must be entered in the REMARKS field when D9 is entered.
Step 8	On FISS Page 02, delete each revenue code line and rekey all revenue code lines, ensuring units and charges appear as covered. (For information on deleting revenue code lines, refer to the 'Claims Correction' (http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf) section of the FISS Guide.
Step 9	On FISS Page 03, enter an adjustment reason code "RM" in the ADJUSTMENT REASON CODE field. (If the field already contains data, key the RM over the top of the existing data.)
Step 10	Enter the MSP information as indicated in the table for the appropriate MSP Process (A-J) above.
Step 11	Submit the adjustment to Medicare by pressing 'F9'

MSP Explanation Codes

MSP Explanation Codes are used in conditional payment situations to assist CGS with claim processing.

Code	Description
BE	Benefits are exhausted.
CD	Charges applied to co-payment, coinsurance or deductible.

Code	Description
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)

Refer to the Hospice Medicare Billing Codes Sheet at https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_medicare_billing_codes_sheet.pdf or the Home Health Medicare Billing Codes Sheet at https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf for additional billing information.

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)
02	No-fault insurance involved-including auto accident/other
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	Payer Codes: PAYER/FL 50	Remarks FL 80 MSP Explanation Codes*
Working aged beneficiary/spouse with GHP	12	A	BE, CD, FG, NB, PC
ESRD beneficiary in 30-month coordination period with GHP	13	B	BE, CD, FG, NB, PC
No-fault, including auto/other	14	D	BE, CD, DA, NB, PE
Workers' compensation	15	E	BE, DA, FG, NB
Public health service (PHS) or other federal agency (Ex: crime victim, drug trial)	16	F	
Black lung	41	H	BE, NB
Disabled beneficiary under age 65 with large group health plan (LGHP)	43	G	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.) **NOTE:** Value Code 44 should not be reported with payer code 'C.'	44	Use appropriate Payer Code A-H or L	
Liability insurance	47	L	BE, DA, DP, LD PP
Conditional payment (payment denied or applied to deductible)**NOTE:** Do not submit value code 44 with Payer Code 'C.' (conditional payment).	Any of the above	C	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 17 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 (HI06-1= 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) HI12-5

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
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
All MSP Processes A - J	FL80	REMARKS	Loop 2300, NTE/ADD/01 Loop 2300, NTE02 (NTE01=ADD)

Claim Adjustment Segment (CAS) 5010 Format

MSP claims/adjustments submitted electronically (5010 format) must include Claim Adjustment Segment (CAS) information. When submitting via 5010, CAS information is reported in Loops 2320 – 2330I as follows:

PAID DATE	• 2330B DTP segment Primary Adjudication or Payment Date
PAID AMOUNT	• 2320 AMT segment Primary Payer Paid Amount
GRP	• 2320 CAS segment Claim Level Adjustments • CAS01 CO PR OA
CARC	• 2320 CAS segment Claim Level Adjustments • CAS02 Adjustment Reason Code • CAS05, CAS08, CAS11, CAS14, CAS17 if multiple CARCs for the same group code
AMT	• 2320 CAS segment Claim Level Adjustments • CAS03 Adjustment Amount • CAS06, CAS09, CAS12, CAS15, CAS18 if multiple CARCs for the same group code