



Part A MSP Billing Requirements

Form Locator (FL)	FL 18-28	FL 38	FL 39abcd - 41abcd	FL 50	FL 51	FL 58	FL 59	FL 60	FL 61	FL 62	FL 80
Description	Occurrence Code (OC)/ Date	Employer's Name and Address	Value Code (VC)/ Amount	Payment Indicator/ Payer ID	Health Plan ID Number	Insured's Name	Patient's Relationship	ID Number	Group Name	Group Number	Remarks
Working Aged	Optional	Required	VC 12/ Actual payment in 0000.00 format	"A" Employer Group Health Plan (EGHP) insurance company name	Required	Line A – Employee name	*	Line A – Employer ID	Line A – Employer group name	Line A – Employer group number	Optional
						Line B – Medicare beneficiary name		Line B – Medicare Health Insurance Claim Number (HICN)			
End Stage Renal Disease	Optional	Required	VC 13/ Actual payment in 0000.00 format	"B" Group Health Plan (GHP) insurance company name	Required	Line A – Employee name	*	Line A – Employer ID	Line A – Employer group name	Line A – Employer group number	Optional
						Line B – Medicare beneficiary name		Line B – Medicare HICN			
Conditional Payment Request	OC 24/date of denial	Required only in group coverage cases	Appropriate VC/ payment shown as 0000.00	"C" Appropriate insurance name	Required only in group coverage cases	As it appears in non-conditional claims	As it appears in non-conditional claims	As it appears in non-conditional claims	As it appears in non-conditional claims	As it appears in non-conditional claims	List reason primary insurance plan did not make a payment

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Liability	Define accident by OC 1–5	N/A	VC 14/47/ Actual payment in 0000.00 format	"D" Liability insurer name	N/A	Line A – Medicare beneficiary name	*	Line A – Insurance ID	Not used on non-group cases	Not used on non-group cases	Optional
						Line B – Medicare beneficiary name		Line B – Medicare HICN			
Workers' Compensation	Define accident by OC 1–5	N/A	VC 15/ Actual payment in 0000.00 format	"E" Workers' compensation carrier name	N/A	Line A – Medicare beneficiary name	*	Line A – Insurance ID	Not used on non-group cases	Not used on non-group cases	Optional
						Line B – Medicare beneficiary name		Line B – Medicare HICN			
Disability	Optional	Required	VC 43/ Actual payment in 0000.00 format	"G" Liability Group Health Plan (LGHP) insurance company name	Required	Line A – Employee name	*	Line A – Employer ID	Line A – Employer group name	Line A – Employer group number	
						Line B – Medicare beneficiary name		Line B – Medicare HICN			
Federal Black Lung Program	Optional	N/A	VC 41/ Actual payment in 0000.00 format	"H" Black lung	N/A	Line A – Medicare beneficiary name	*	Line A – Insurance ID	Not used on non-group cases	Not used on non-group cases	Optional
						Line B – Medicare beneficiary name		Line B – Medicare HICN			

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Veterans Affairs	Optional	N/A	VC 42/ Actual payment in 0000.00 format	"I" Veterans Affairs	N/A	Line A – Medicare beneficiary name	*	Line A – Insurance ID	Not used on non-group cases	Not used on non-group cases	Optional
						Line B – Medicare beneficiary name		Line B – Medicare HICN			

*A complete list of patient relationship codes is available from the National Uniform Billing Committee (NUBC) via NUBC's *Official UB-04 Data Specifications Manual* at: <http://www.nubc.org>.

Electronic Claims Filing Requirements for All MSP Types

Section 3 of the Administrative Simplification Act (ASCA), Public Law (PL) 107-105, and Code of Federal Regulations 42 CFR 424.32 require that all initial claims for reimbursement under Medicare (except small providers) be submitted electronically, effective October 16, 2003, with limited exceptions. An MSP claim with more than one primary payer (Medicare tertiary) is an exemption to electronic billing.

Submitting a Medicare Secondary Payer (MSP) claim electronically requires submission of the following additional data elements:

- Primary insurance type code.
- Amount paid by primary payer.
- Amount allowed primary payer.
- Obligated to Accept as Payment in Full (OTAF) amount (if applicable).
- Claim Adjustment Segment (CAS) codes (if applicable)

CAS Codes

Claim status codes communicate information about the status of a claim (i.e., paid, denied, rejected, non-covered). The CAS codes inform Medicare of the claim processing decision of the primary insurance company in place of submitting the primary insurance remittance notice. The CAS codes should be taken from the primary payer's remittance advice. All of the CAS codes, along with a narrative description, may be found on the Washington Publishing Company Web site at:

<http://www.wpc-edi.com/codes>.

Change Request (CR) 6426 instructed providers to use the CAS segment in the 837I when submitting MSP claims. CR 6426 also indicated that providers would not be able to submit MSP claims using Direct Data Entry (DDE) since the DDE process does not support the CAS segment adjustments as found in the 837. CR 6426 elicited questions from providers that CMS has addressed in Special Edition (SE) article 0928.

Providers who normally submit claims via DDE should be aware that they may use the PC-ACE Pro32 free billing software, which has MSP billing capabilities, including the required CAS segment to identify CAS segment adjustments. However, providers may use any 837 billing software deemed warranted to submit MSP claims.

In addition to submitting MSP claims with the CAS segments via the billing software, MSP adjustments should be submitted for MSP claims that were originally submitted via DDE on or before October 4, 2009, using the 837 transaction and billing software as noted above. DDE MSP adjustment claims will not be accepted.

Providers should refer to the "Background" and "Additional Information" sections of the article for further details regarding these changes.

The article, titled "Further Clarification of Instructions on Using 837 Institutional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part A Claims," is available at:

<http://www.cms.gov/MLNMArticles/downloads/SE0928.pdf>.

All MSP claims can be submitted electronically. Providers with access to Electronic Media Claims (EMC) will continue to be able to submit MSP claims electronically; however, providers who use only DDE to submit claims electronically are no longer able to enter MSP claims via DDE. DDE-only providers should consider accessing the free electronic claims submission software, PC-ACE Pro32.

PC-ACE Pro32 is a complete, self-contained electronic processing system for claims submission and management. It can be used in a stand-alone configuration or in conjunction with existing claims management systems. Features include:

- User-friendly system with extensive help screens.
- Manual with step-by-step instructions.
- No charge when downloaded from the TrailBlazer Software and Manuals Web page at: <http://www.trailblazerhealth.com/Electronic Data Interchange/Software - Manuals>.
- Nominal charge when requested via CD-ROM.
- Claims transmission via telephone lines with modem speeds ranging from 9600 bps to 56k bps.
- Transmission lines available 24 hours a day, seven days a week.

More information on electronic billing is available on the TrailBlazer EDI Web page at: <http://www.trailblazerhealth.com/Electronic Data Interchange>.