Medicare Secondary Payer

FAQ

Prepared for

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Overview

A one-time Notice of Admission (NOA) is required at the time of home health admission for billing periods beginning 1/1/2022 and after for active and newly admitted Medicare/MSP patients. The NOA can be generated via the Electronic Claims menu or can be entered via DDE. Medicare no longer requires RAPs for periods beginning 1/1/2022 or after.

For 2021 MSP RAPs, it's recommended to submit via DDE to ensure meeting the 5-day submission requirement so late penalties are not incurred.

Per CR8486 effective 1/1/2016 MSP claims for Medicare Part A will be accepted via DDE. Review MM8486 for detailed instructions (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8486.pdf).

MSP claims for Home Health can be billed using a unique Medicare Secondary insurance. Hospice MSP claims can be billed using the standard Medicare Hospice insurance. Balances are transferred from the primary payer to MSP after the primary denial or payment is received. The Billing Codes tab in Payments/Transfers is used to enter MSP claim specific information. This document lays out the one-time setup of an insurance and claim Option Sets as well as the process for transferring charges, entering claim Billing Codes and creating claim files.

One-Time Setup

Home Health MSP Insurance

In the Clinical Insurance Library, create a new Insurance for Medicare Secondary Payer (MSP) and complete the setup in Billing.

Go to **File > File Maintenance > Entity** press **Change Type** and set to **Insurance.** Click on the **Insurance** tab and setup the same as you regular Medicare insurance but leave **PPS Billing** unchecked.

Hospice billing does not require the use of a unique insurance for MSP.

Home Health MSP RAP Option Set

Note: This step is only needed for billing periods prior to 1/1/2022.

Go to **Billing > Electronic Claims** and select the Medicare Electronic Claims Option Set.

Click '**Options'** then '**Copy**,' select a Destination ID # and enter the Description as **MSP RAP**.

Close and reopen Electronic Claims.

Select the new MSP RAP option set, click '**Options**" and change the following locators:

- **2300.05 CLM05 Type of Bill:** '322'
- **2300.50 REF*G1 Treatment Authorization Codes:** set to 'Bypass'

- **9000.30 Bill Processing Type:** 'PPS Secondary'
- **9000.50 Include Pat-Ins-Bill Data:** set to 'Bypass this Data Element'

Home Health MSP Final Option Set

Go to **Billing > Electronic Claims** and select the Medicare Electronic Claims Option Set.

Click '**Options'** then '**Copy**,' select a Destination ID # and enter the description as **MSP Final.**

Close and reopen Electronic Claims.

Select the new MSP Final option set, click '**Options**" and change the following locators:

- **2300.05 CLM05 Type of Bill:** '329'
- **2300.50 REF*G1 Treatment Authorization Codes:** set to 'Bypass'
- **2320.30 COB Coordination of Benefit Loops (Secondary Ins):** 'Patient Bill Data Value1 Amount'
- **2320.32 COB Insurance Sequence:** 'Billed Insurance is secondary (COB insurance is primary)'
- **2320.33 COB SBR*09 Claim Indicator:** 'Default Value to (MA, CI) based on prior paid'
- **2320.34 COB CAS*01/02 Claim Adjustment Group/Reason:** 'Patient-Ins Bill Data Adjustment Reason(s)'
- **2330.10 COB NM1*PR Insurance Payor ID:** 'Insurance Submitter Number (Default)'
- **2330.20 DTP*03 Claim Adjudication Date:** 'Pat-Ins Bill Data Occurrence1 Date'
- **9000.30 Bill Processing Type:** 'PPS Secondary'
- **9000.50 Include Pat-Ins-Bill Data:** set to 'Include All Patient-Insurance Bill Data Items'

Hospice MSP Option Set

Go to **Billing > Electronic Claims** and select the Medicare Hospice Electronic Claims Option Set.

Click '**Options'** then '**Copy**,' select a Destination ID # and enter the Description as **MSP Hospice**.

Close and reopen Electronic Claims.

Select the new MSP Hospice option set, click '**Options**" and change the following locators:

- **2320.30 COB Coordination of Benefit Loops (Secondary Ins):** 'Patient Bill Data Value1 Amount'
- **2320.32 COB Insurance Sequence:** 'Billed Insurance is secondary (COB insurance is primary)'
- **2320.33 COB SBR*09 Claim Indicator:** 'Default Value to (MA, CI) based on prior paid'

- **2320.34 COB CAS*01/02 Claim Adjustment Group/Reason:** 'Patient-Ins Bill Data Adjustment Reason(s)'
- **2330.10 COB NM1*PR Insurance Payor ID:** 'Insurance Submitter Number (Default)'
- **9000.50 Include Pat-Ins-Bill Data:** set to 'Include All Patient-Insurance Bill Data Items'

Billing Process

MSP NOAs (2022)

For period start date 1/1/2022 and later, Medicare requires an NOA for active and newly admitted patients which must be submitted within 5 calendar days after the Admission Date. RAPs are no longer required for billing periods starting in 2022 or later.

In addition to being required for new admissions in 2022, an NOA is required for patients on service in 2021 who continue service in 2022.These continuing patients will have an NOA created with an "artificial" admit date that is equal to the first day of their first 2022 billing period. Users should NOT enter this artificial admit date as the patient's admit date in the patient file. The NOA and all claims for that patient's admission will automatically populate this artificial admit date without any user intervention.

MSP NOAs can be created and submitted at the same time as Medicare primary NOAs. Review the NOA Creation FAQ for detailed instructions.

Use the PPS Activity report for RAPs/NOAs Not Done to track MSP patients whose NOA haven't been submitted.

MSP RAPs (2021)

MSP RAPs must be submitted within 5 days of the admission start date or the agency will incur a payment reduction. As a result, it is highly recommended to submit them via DDE to avoid late penalties.

To identify MSP patients, run the **Patient > Patient List** report. A Report Group can be setup for this since it should be run daily to ensure timely RAP submissions. Use this list to submit MSP NOAs directly in DDE (recommended):

Selection Type: Insurance (on Specific Includes tab, specify MSP)

Report Type: Active

Date range: select a date range wide enough to capture periods within the next 60-days as well as any potential late periods.

More Options tab: check **Show Admission Detail,** set **Insurance Selection** to **Any Active** and check **Current Certification Period** and **Insurances** options.

Transfer Balance Due from primary to MSP

In **A/R > Payments/Transfers**, transfer the balance to MSP for claim billing after the primary payment has been applied or a denial received.

On the **Summary** tab, select the primary insurance record.

Click on the **Detail** tab and check **Allow Transfer**.

Leave today's date as the **To Bill Date**. Use a unique Bill Date for each MSP claim period so they can be billed to Medicare separately.

Set the **To Insurance** to MSP. If the MSP insurance isn't shown, add it to the patient record in the Clinical Patient Profile.

In the **Transfer** column enter the balance amount to be billed to MSP for each charge. If the visit was paid in full, transfer $0 for that visit. (**Pro Tip:** if transferring the exact Net amount for all charges, check the **Xfer All Chgs** setting and press the **Xfer** button.)

For **Home Health**, do not transfer an amount for visits that fall outside the 30-day period.

For **Hospice**, transfer a dollar amount for the Per Diem charges. Transfer zero dollars for visits and medications.

Enter MSP Claim Data

In **A/R > Payments/Transfers**, select the MSP claim record and click the **Billing Codes** tab.

Select the Medicare Process from the **Process Type** drop-down.

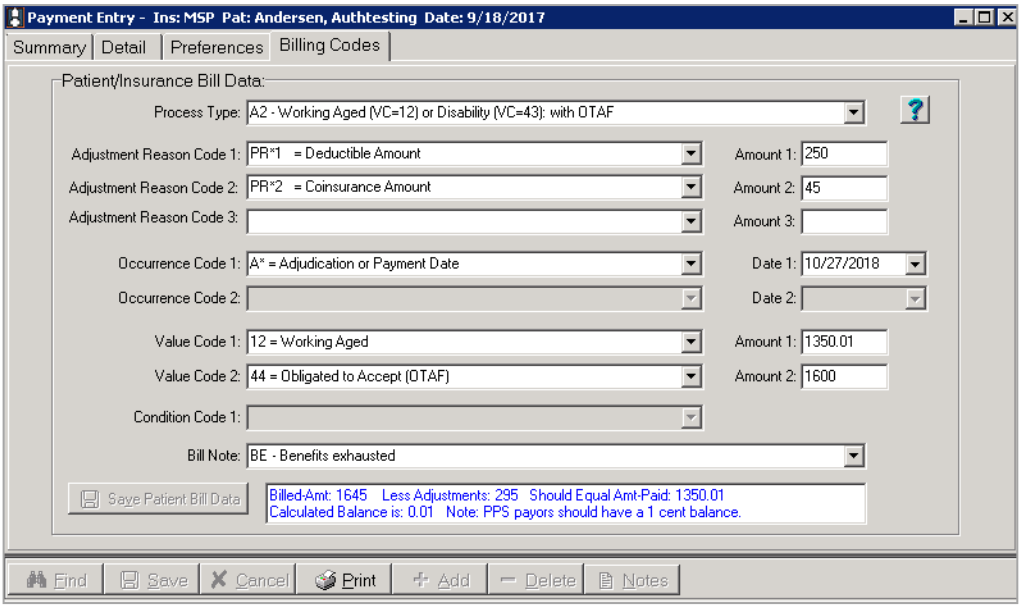
Fill in the necessary fields based on the MSP Process being followed and if an Obligated to Accept as Payment in Full (OTAF) amount is needed.

Fields not needed for the selected Process type are grayed out by default.

If billing an atypical scenario (see last page of FAQ) and a grayed-out field is needed, change the **Process Type** to **Custom Bill Data**.

Reference the CGS Medicare online tool to assist with determining which process should be followed:

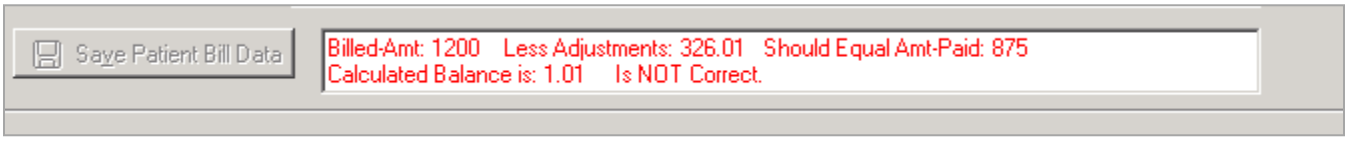
https://www.cgsmedicare.com/hhh/education/materials/pdf/msp_billing.pdf



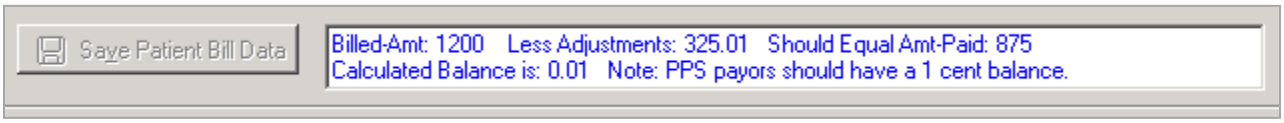
- **Adjustment Reason Code 1:** select the Patient Responsibility (PR) Claim Adjustment Reason Code (CARC) from the drop-down based on the primary payer EOB or type in the desired code (required, except for Process D). If more than one Patient Responsibility CARC needed, see Adjustment Reason Code 3 below.
- **Amount 1:** enter the Adjustment Reason Code 1 Patient Responsibility (PR) amount (**plus one penny**) based on the information provided on the primary payer EOB (required if Adjustment Reason Code 1 is used). For PPS, a penny is added here to accommodate the Medicare Q code line.
- **Adjustment Reason Code 2:** Enter a second PR code if needed or if billing with OTAF, select CO*45 from the drop-down or type in the desired code (required if billing OTAF, except for Process D).
- **Amount 2:** enter the Contractual Obligation adjustment amount from the primary payer EOB. If unavailable, try the Stats > Services Provided report run for the claim period to review the Primary insurance Allowed amount (required if Adjustment Reason Code 2 is used).
- **Adjustment Reason Code 3**: Use only if more than one Patient Responsibility CARC received from primary (atypical). Select Reason Code from the drop-down based on the primary payer EOB or type in the desired code (optional).
- **Amount 3**: enter the Adjustment Reason Code 3 amount based on the information provided on the primary payer EOB (required if Adjustment Reason Code 3 is used).
- **Occurrence Code 1:** select the Occurrence Code from the drop-down based on the MSP Process requirement (required if not grayed out). Note: For Process Types A1, A2, B1 and B2 this will default to A* for Adjudication Date and this value will only populate the COB Date Paid segment, not the Occurrence Code field.

- **Date 1:** enter the Occurrence date for Occurrence Code 1 (required if Occurrence Code 1 is used).
- **Occurrence Code 2:** select the Occurrence Code from the drop-down based on the MSP Process requirement (required if not grayed out).
- **Date 2:** enter the Occurrence date for Occurrence Code 2 (required if Occurrence Code 2 is used).
- **Value Code 1:** defaults based on Process Type selected (except for Custom) but can be changed. Do not use this field for Value Code 44, use Value Code 2 instead (required if not grayed out).
- **Amount 1:** enter the amount paid by the primary payer. If no payment received, enter '0'. (required if Value Code 1 is used). Do not use this field for Value Code 44 Amount, use Amount 2 field instead (required if Value Code 1 is used).
- **Value Code 2:** defaults based on Process Type selected (except for Custom) but can be changed. When billing with OTAF, this should be used for Value Code 44 (required if not grayed out).
- **Amount 2:** enter the OTAF amount. This should equal the Primary insurance paid amount plus any Patient Responsibility amount. (required if Value Code 2 is used).
- **Condition Code 1:** enabled only for Process Type "Custom Bill Data." Select from the drop-down (optional).
- **Bill Note:** select a Bill Note from the drop-down or type in the desired note (optional but recommended).
- Press **Save** when done.
    - The system performs a claim balancing check and alerts the user if data elements are incorrect. Make corrections as necessary since out of balance claims will be rejected by Medicare. Note that PPS claims should have a penny difference due to the penny Q code line on the Final claim.

Incorrect claim balance warning:



Correct claim balance message:



If a Late RAP/NOA exception is being requested, enter the KX modifier, period date and note in the Patient file Insurance > Bill Data tab. Review the myUnity Essentials PDGM Billing 2022 FAQ for details.

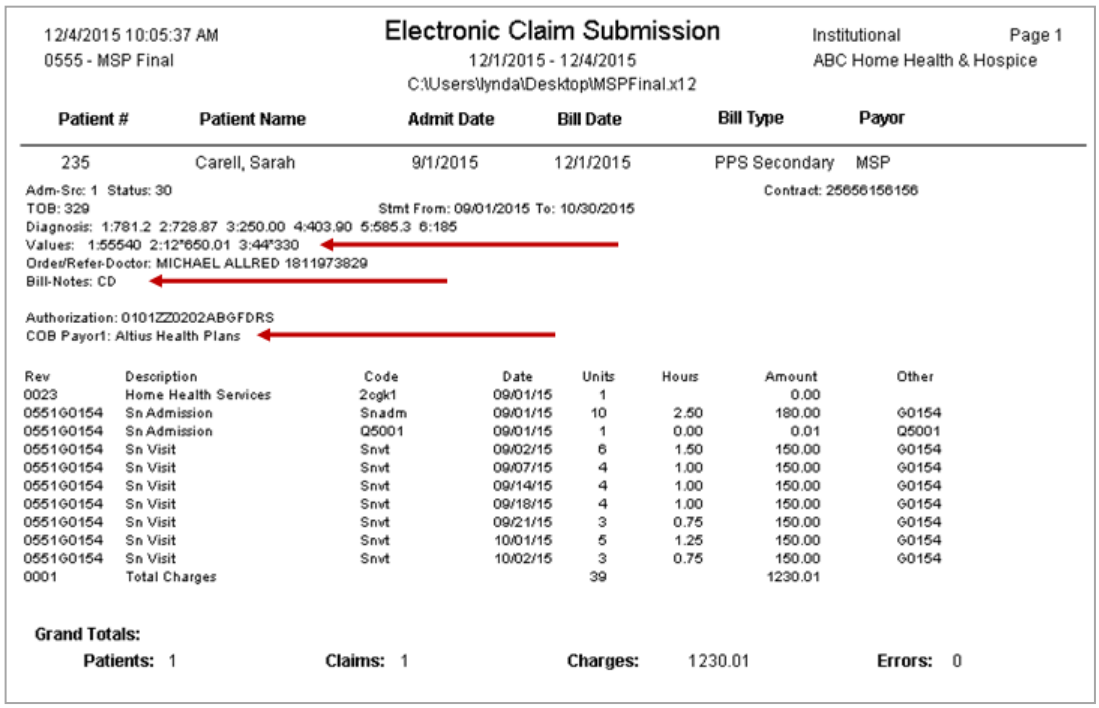
MSP Claim Creation

Home Health NOAs should have already been submitted for MSP patients as part of the standard NOA submission process. Late NOAs will incur a payment penalty from Medicare.

Go to **Billing > Electronic Claims**.

Select the **MSP Option Set** for Finals or Hospice and follow the normal process for creating claims.

Review the Electronic Claim Submission Report for Value, Occurrence, Condition Codes as well as the Bill Note and COB Payer information.



12/4/2015 10:05:37 AM
0555 - MSP Final

Electronic Claim Submission
12/1/2015 - 12/4/2015
C:\Users\lynda\Desktop\MSPFinal.x12

Institutional Page 1
ABC Home Health & Hospice

Patient #	Patient Name	Admit Date	Bill Date	Bill Type	Payor
235	Carell, Sarah	9/1/2015	12/1/2015	PPS Secondary	MSP

Adm-Src: 1 Status: 30 Contract: 25656156156
TOB: 329 Stmt From: 09/01/2015 To: 10/30/2015
Diagnosis: 1:781.2 2:728.87 3:250.00 4:403.90 5:585.3 6:185
Values: 1:55540 2:12*650.01 3:44*330
Order/Refer-Doctor: MICHAEL ALLRED 1811973829
Bill-Notes: CD

Authorization: 0101ZZ0202ABGFDRS
COB Payor1: Altius Health Plans

Rev	Description	Code	Date	Units	Hours	Amount	Other
0023	Home Health Services	2cgk1	09/01/15	1		0.00	
055160154	Sn Admission	Snadm	09/01/15	10	2.50	180.00	G0154
055160154	Sn Admission	Q5001	09/01/15	1	0.00	0.01	Q5001
055160154	Sn Visit	Snvt	09/02/15	6	1.50	150.00	G0154
055160154	Sn Visit	Snvt	09/07/15	4	1.00	150.00	G0154
055160154	Sn Visit	Snvt	09/14/15	4	1.00	150.00	G0154
055160154	Sn Visit	Snvt	09/18/15	4	1.00	150.00	G0154
055160154	Sn Visit	Snvt	09/21/15	3	0.75	150.00	G0154
055160154	Sn Visit	Snvt	10/01/15	5	1.25	150.00	G0154
055160154	Sn Visit	Snvt	10/02/15	3	0.75	150.00	G0154
0001	Total Charges			39		1230.01	

Grand Totals:
Patients: 1 **Claims:** 1 **Charges:** 1230.01 **Errors:** 0

Special Billing Instructions

Scenario 1

MSP RAP was billed via DDE with 1AA11 and MSP OASIS Final HIPPS doesn't match so you need a Final claim HIPPS override. Prior to creating the electronic claim, go to the Patient file, Insurance > Bill Data tab. Click the + button to create a new record and select the HippsRugOvr Type. In the Bill-Date field, enter the bill date used during the Transfer process. In the Code field enter the HIPPS. In the Date field, enter the Period Start Date. After this record is saved the MSP Final can be created and submitted.

Scenario 2

Medicare was billed as Primary but was rejected for MSP. You have determined the claim should in fact be billed as primary. The claim needs to be resubmitted as an adjustment claim with appropriate explanatory codes. Billing an adjustment Medicare Primary claim requires setting up a new 'Medicare Adjustment Claim (D9)' option set (if one does not yet exist), by copying it from the Medicare option set. In the Medicare Adjustment option set, change Locator 2300.05 CLM05 Type of Bill to '327'. Change Locator 2300.53 REF*F8 Original Reference Code to 'Claim Reference Number (DCN#)' which pulls the DCN from Payments. Change Locator 2300.70 HI*BG Condition Code 1 to 'Constant Value (entered)' and enter 'D9' as the value. Other Occurrence codes such as OC 05 with Date of Accident or OC 18 with Retirement Date (NEVER use OC 24 when billing Medicare primary), additional Condition codes (ex. 10 if employed but not EGHP) and Remarks (ex: "Not related to open VC 14 MSP record in CWF") should be entered for the patient in the Payments> Billing Codes tab. Use the 'Medicare Adjustment (D9)' option set to send these Medicare adjustment claims.

Scenario 3

Patient was billed as Medicare primary but was rejected for MSP. You have determined MSP record is correct. Add the primary insurance for this patient to the patient record. Un-bill the charges from Medicare via the Payments screen and bill them to the primary insurance following normal billing procedures. If a balance needs to be billed to Medicare after the primary pays, follow the MSP process as described under Billing Instructions. The MSP insurance will need to be added to the patient record if balance billing. Billing an adjustment Medicare Primary claim requires setting up a new 'Medicare Adjustment Claim (D7)' option set, by copying it from the Medicare option set. In the Medicare Adjustment option set, change Locator 2300.05 CLM05 Type of Bill to '327'. Change Locator 2300.53 REF*F8 Original Reference Code to 'Claim Reference Number (DCN#)' which pulls the DCN from Payments. Change Locator 2300.70 HI*BG Condition Code 1 to 'Constant Value (entered)' and enter 'D7' as the value. D7 indicates, "Change to make Medicare the secondary payer." Use this option set to send these Medicare adjustment claims.

Scenario 4

An MSP Final claim was billed and a corrected claim to change to Medicare primary needs to be submitted to Medicare. Billing an adjustment for MSP to Medicare Primary requires setting up a new MSP Final Adjustment (D8) option set, by copying it from the MSP Final option set. In the MSP Final Adjustment option set, change Locator 2300.05 CLM05 Type of Bill to '327'. Change Locator 2300.53 REF*F8 Original Reference Code to 'Claim Reference Number (DCN#)' which pulls the DCN from Payments. Change Locator 2300.70 HI*BG Condition Code 1 to 'Constant Value (entered)' and enter D8 as the value. D8 indicates, "Change to make Medicare the primary payer." Use this option set to send these adjusted Final claims.

Scenario 5

An MSP Final claim was billed and a corrected MSP Final claim needs to be submitted to Medicare. Billing an adjustment for MSP to Medicare Primary requires using an MSP Final Adjustment (D9) option set, by copying it from the MSP Final option set. In the MSP Final Adjustment option set, change Locator 2300.05 CLM05 Type of Bill to '327'. Change Locator 2300.53 REF*F8 Original Reference Code to 'Claim Reference Number (DCN#)' which pulls the DCN from Payments. Change Locator 2300.70 HI*BG Condition Code 1 to 'Constant Value (entered)' and enter D9 as the value. Enter any necessary remarks in the Notes field in Payments>Billing codes tab. D9 indicates, "Any other/multiple change (s)" and must include remarks/notes. Use this option set to send these adjusted MSP Final claims.

Scenario 6

Patient RAP was billed to Medicare as Medicare Primary (not using MSP option set) but Final needs to billed as MSP; patient's primary insurance is NOT going to be billed from HAS. Add the primary insurance for this patient to the patient record and add necessary claim codes to the Payments>Billing Codes tab. Create a Final electronic claim using the MSP Finals option set but first change Locator 9000.30 Bill Processing Type to 'PPS' (contact Support for assistance if needed). The Bill Processing Type should be set back to 'PPS Secondary' when done.

Scenario 7

Patient was billed to Medicare primary and they were determined to have alternate primary insurance; payment is not expected from the primary insurance. Add the primary insurance for this patient to the patient record. Go to AR>Payments/Transfers and transfer the charges to the primary using a '0' amount for each charge. Submit the claim to the primary insurance and bill Medicare secondary after the denial is received. A new option set will need to be setup for use in this scenario OR you may use your MSP Final option set but change Locator 9000.30 Bill Processing Type to 'PPS' (contact Support for assistance if needed). The Bill Processing Type should be set back to 'PPS Secondary' when done if using this method.