Interactive MSP Process

Medicare Secondary Payer (MSP) is the term given to describe situations where Medicare does not pay first on a claim. Medicare is the secondary payer for beneficiaries who are covered by other types of health insurance or plan. This interactive tool directs you to the appropriate information required on your claim depending on your current scenario. Review the scenarios below for more information.

You are aware of an MSP situation, but the beneficiary's eligibility file does not show an MSP record...
- Contact Benefits Coordination & Recovery Contractor (BCRC) at 1.855.798.2627

You are not aware of an MSP situation and the beneficiary's eligibility file does not show an MSP record...
- Submit claim to Medicare as primary

The beneficiary's eligibility file shows an MSP record for **End Stage Renal Disease (ESRD)**...
- You must bill the Group Health Plan (GHP) as primary
  - If GHP makes payment, bill Medicare as secondary
  - If GHP denies payment or applies entire payment to beneficiary deductible, coinsurance or copayment, submit claim to Medicare as secondary
  - **Select this link** for more information

The beneficiary's eligibility file shows an MSP record for **Workers' Compensation (WC)** and the services are related to this record...
- You must bill the WC insurer as primary. If insurer pays, you may bill Medicare secondary. **Select this link** for more information.
- If a set-aside arrangement has been established, bill the administrator of the set-aside arrangement
- You may bill Medicare conditionally if WC insurer does not respond within 120-day prompt payment period or the case is in litigation. **Select this link** for more information.
- If WC insurer denies payment, bill Medicare as primary. Enter remarks on the claim to indicate why payment was not made.
  - If WC plan denies payment because a proper claim was not filed, Medicare cannot make payment
  - If WC plan denies payment due to benefit exhaustion, contact the BCRC to update MSP records. The claim can be filed to Medicare as primary when the records are updated.

The beneficiary's eligibility file shows an MSP record for **Workers' Compensation (WC)** and the services are not related to this record...
- You must bill Medicare as primary. The claim cannot include WC-related diagnoses.

The beneficiary's eligibility file shows an MSP record for **Black Lung**...
- If the services are related to Black Lung, bill Department of Labor (DOL). Bill Medicare as secondary if DOL does not make full payment for the services rendered. If DOL pays in full, no Medicare secondary payment will be made. **Select this link** for more information.
  - If claim contains Black Lung diagnosis codes and DOL denies payment for all services, bill Medicare as primary. Enter remarks on the claim to indicate why payment was not made. If DOL denies payment because a proper claim was not filed, Medicare cannot make payment.
- If the services are not related to Black Lung, bill Medicare as primary. The claim cannot include Black Lung-related diagnoses.

The beneficiary's eligibility file shows an MSP record, but the date of service (DOS) is not within the MSP effective and termination dates...
- Submit claim to Medicare as primary

The beneficiary's eligibility file shows an MSP record for **Working Aged (WA)** or **disability** insurance...
- You must bill the other insurer as primary
  - If insurer pays, bill Medicare as secondary
  - If insurer denies payment or applies entire payment to beneficiary deductible, coinsurance or copayment, submit claim to Medicare as secondary
  - **Select this link** for more information

The beneficiary's eligibility file shows an MSP record for **No-fault** or **liability** insurance and the services are related to this record...
- You must bill the no-fault/liability insurer as primary. If insurer pays, bill Medicare secondary. **Select this link** for more information.
- You may bill Medicare conditionally if insurer does not respond within 120-day prompt payment period. **Select this link** for more information.
- If insurer denies payment and there are related diagnosis codes on the claim, bill Medicare as primary. Enter remarks on the claim to indicate why payment was not made.
  - If primary plan denies payment because a proper claim was not filed, Medicare cannot make payment
  - If primary plan denies payment due to benefit exhaustion, contact the BCRC to update MSP records. The claim can be filed to Medicare as primary when the records are updated.

The beneficiary's eligibility file shows an MSP record for **No-fault** or **liability** insurance, but the services are not related to this record...
- You must bill Medicare as primary. The claim cannot include no-fault or liability-related diagnoses.

The beneficiary's eligibility file shows an MSP record for **Public Health Services (PHS)** or another **Federal agency**...
- If you were authorized by PHS/Federal agency for the services, bill PHS and then bill Medicare secondary. **Select this link** for more information.
- If you were not authorized by PHS/Federal agency for the services or payment was denied, bill Medicare as primary. Enter remarks on the claim to indicate why payment was not made. If PHS/Federal agency denies payment because a proper claim was not filed, Medicare cannot make payment.

Interactive MSP Process

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ESRD – GHP is Primary
Bill Medicare Secondary

After the GHP has processed the claim and issued a payment determination, the claim is submitted to Medicare as secondary using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "77" if you are contractually obligated to accept primary paid amount as payment in full
1	OCC CDS/Date	31-34	Enter Occurrence Code "33" and date 30-month coordination period began. If payment for services denied, enter Occurrence Code "24" and date of Explanation of Benefits/Remittance Advice (EOB/RA). If full payment was applied to the patient's deductible, coinsurance or copayment, Occurrence Code "24" and date are omitted from claim.
1	Value Code	39-41	Enter Value Code "13" and amount paid by GHP. Enter zeroes if full payment for the services was denied by the GHP or applied to the deductible, coinsurance or copayment. 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. If Condition Code "77" is entered, omit Value Code "44."
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (13) entered on the claim. If your software does not auto-populate, enter Payer Code "B" on line A if primary insurer paid or applied the full amount to the patient's deductible, coinsurance or copayment. Enter Payer Code "C" if primary insurer denied payment. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks to indicate reason why no payment was made (if applicable)
5	Insured Name	58	Enter insured's name (if available, name of person that carries insurance) on line A. Enter beneficiary's name on line B.
5	Sex	N/A	Enter insured's sex code (F/M) on line A. Enter beneficiary's sex code on line B.
5	DOB	N/A	Enter insured's date of birth (MMDDCCYY) on line A. Enter beneficiary's DOB on line B.
5	REL	59	Enter code for patient's relationship to insured on line A (01 - Spouse, 18 - Self). The eligibility files will display different codes, but the codes on the claim must match the information in the eligibility file. Enter "18" on line B.
5	CERT-SSN-HIC	60	Enter primary payer's policy number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file

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Workers' Compensation Insurance Primary
Bill Medicare Secondary

After the WC has processed the claim and issued a payment, the claim is electronically submitted to Medicare as secondary using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "02" to show condition is related to employment. Enter Condition Code "77" if you are contractually obligated to accept primary paid amount as payment in full.
1	OCC CDS/Date	31-34	Enter Occurrence Code "04" and date of accident. If unknown, enter effective date on MSP record.
1	Value Code	39-41	Enter Value Code "15" and amount you were paid by WC. 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. If Condition Code "77" is entered, omit Value Code "44."
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (15) entered on the claim. If your software does not auto-populate, enter Payer Code "E" on line A. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks (if applicable)
5	Insured Name	58	Enter insured's name (if available, name of person/business that carries insurance) on line A. Enter beneficiary's name on line B.
5	Sex	N/A	Enter insured's sex code (F/M) on line A. Enter beneficiary's sex code on line B.
5	DOB	N/A	Enter insured's date of birth (MMDDCCYY) on line A. Enter beneficiary's DOB on line B.
5	REL	59	Enter code for patient's relationship to insured on line A (01 - Spouse, 18 - Self). The eligibility files will display different codes, but the codes on the claim must match the information in the eligibility file. Enter "18" on line B.
5	CERT-SSN-HIC	60	Enter primary payer's policy number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file

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Workers' Compensation Insurance – No Insurer Response
Bill Medicare Conditionally

If the WC case is in litigation, or the plan does not make payment within the 120-day prompt payment period, the claim can be submitted to Medicare for conditional payment. The claim must be submitted electronically using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "02" to show condition is related to employment
1	OCC CDS/Date	31-34	Enter Occurrence Code "24" and date (120 days past the through date on the claim). Enter Occurrence Code "04" and date of accident. If unknown, enter effective date on MSP record.
1	Value Code	39-41	Enter Value Code "15." Enter zeroes in the amount field.
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (15) entered on the claim. If your software does not auto-populate, enter Payer Code "C" on line A. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks to indicate payment not received within 120-day prompt payment period
5	Insured Name	58	Enter insured's name (if available, name of person/business that carries insurance) on line A. Enter beneficiary's name on line B.
5	Sex	N/A	Enter insured's sex code (F/M) on line A. Enter beneficiary's sex code on line B.
5	DOB	N/A	Enter insured's date of birth (MMDDCCYY) on line A. Enter beneficiary's DOB on line B.
5	REL	59	Enter code for patient's relationship to insured on line A (01 - Spouse, 18 - Self). The eligibility files will display different codes, but the codes on the claim must match the information in the eligibility file. Enter "18" on line B.
5	CERT-SSN-HIC	60	Enter primary payer's policy number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file

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DOL Primary Payment Made
Bill Medicare Secondary

After the DOL has processed the claim and issued a payment, the claim must be submitted electronically using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "77" if you are contractually obligated to accept primary paid amount as payment in full
1	Value Code	39-41	Enter Value Code "41" and amount paid by DOL. 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. If Condition Code "77" is entered, omit Value Code "44."
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (41) entered on the claim. If your software does not auto-populate, enter Payer Code "H" on line A. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks (if applicable)
5	Insured Name	58	Enter beneficiary's name in insured's name field on lines A and B
5	Sex	N/A	Enter beneficiary's sex code (F/M) on lines A and B
5	DOB	N/A	Enter beneficiary's date of birth (MMDDCCYY) on lines A and B
5	REL	59	Enter Patient Relationship Code "18" on lines A and B
5	CERT-SSN-HIC	60	Enter patient's Black Lung Identification number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter DOL address, city, state and zip as it appears on eligibility file

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Working Aged/Disability Insurance – GHP is Primary
Bill Medicare Secondary

After the GHP has processed the claim and issued a payment determination, the claim is electronically submitted to Medicare as secondary using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "77" if you are contractually obligated to accept primary paid amount as payment in full
1	OCC CDS/Date	31-34	If payment for services was denied, enter Occurrence Code "24" and date of Explanation of Benefits/Remittance Advice (EOB/RA). If full payment was applied to the patient's deductible, coinsurance or copayment, Occurrence Code "24" is omitted from claim.
1	Value Code	39-41	Enter Value Code "12" for WA or "43" for disability insurance and amount paid by GHP. Enter zeroes if payment for services was denied by the GHP or applied to the deductible, coinsurance or copayment. 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. If Condition Code "77" is entered, omit Value Code "44."
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (12 or 43) entered on the claim. If your software does not auto-populate, enter Payer Code "A" (WA) or "G" (disability) on line A if primary insurer paid or applied the full amount to the patient's deductible, coinsurance or copayment. Enter Payer Code "C" on Line A if primary insurer denied payment. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks to indicate reason why no payment was made (if applicable)
5	Insured Name	58	Enter insured's name (if available, name of person that carries insurance) on line A. Enter beneficiary's name on line B.
5	Sex	N/A	Enter insured's sex code (F/M) on line A. Enter beneficiary's sex code on line B.
5	DOB	N/A	Enter insured's date of birth (MMDDCCYY) on line A. Enter beneficiary's DOB on line B.
5	REL	59	Enter code for patient's relationship to insured on line A (01 - Spouse, 18 - Self). The eligibility files will display different codes, but the codes on the claim must match the information in the eligibility file. Enter "18" on line B.
5	CERT-SSN-HIC	60	Enter primary payer's policy number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file

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No-Fault or Liability Insurance Primary
Bill Medicare Secondary

After the No-Fault or liability plan has processed the claim and issued a payment, the claim is electronically submitted to Medicare as secondary using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "77" if you are contractually obligated to accept primary paid amount as payment in full
1	OCC CDS/Date	31-34	Enter Occurrence Code "01" for liability or "02" for No-Fault and include the date of accident/injury. If unknown, use the effective date on the MSP record.
1	Value Code	39-41	Enter Value Code "14" for No-Fault/Med-pay or "47" for liability and amount paid by 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. If Condition Code "77" is entered, omit Value Code "44."
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (14 or 47) entered on the claim. If your software does not auto-populate, enter Payer Code "D" (No-Fault/Med-pay) or "L" (liability) on line A. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks (if applicable)
5	Insured Name	58	Enter insured's name (if available, name of person/business that carries insurance) on line A. Enter beneficiary's name on line B.
5	Sex	N/A	Enter insured's sex code (F/M) on line A. Enter beneficiary's sex code on line B.
5	DOB	N/A	Enter insured's date of birth (MMDDCCYY) on line A. Enter beneficiary's DOB on line B.
5	REL	59	Enter code for patient's relationship to insured on line A (01 - Spouse, 18 - Self). The eligibility files will display different codes, but the codes on the claim must match the information in the eligibility file. Enter "18" on line B.
5	CERT-SSN-HIC	60	Enter primary payer's policy number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file

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No-Fault or Liability Insurance – No Insurer Response
Bill Medicare Conditionally

If the No-Fault or liability plan does not make payment within the 120-day prompt payment period, the claim can be submitted to Medicare for conditional payment. The claim must be submitted electronically using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format. These claims cannot be billed using FISS Direct Data Entry (DDE).

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

DDE/FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	OCC CDS/Date	31-34	Enter Occurrence Code "24" and date (120 days from through date on claim). Enter Occurrence Code "01" for liability, "02" for No-Fault and include the date of accident. If unknown, enter the effective date of the MSP record.
1	Value Code	39-41	Enter Value Code "14" for No-Fault or "47" for liability. Enter zeroes in the amount field.
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (14 or 47) entered on the claim. If your software does not auto-populate, enter Payer Code "C" on line A. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks to indicate payment not received within 120-day prompt payment period
5	Insured Name	58	Enter insured's name (if available, name of person/business that carries insurance) on line A. Enter beneficiary's name on line B.
5	REL	59	Enter code for patient's relationship to insured on line A (01 - Spouse, 18 - Self). The eligibility files will display different codes, but the codes on the claim must match the information in the eligibility file. Enter "18" on line B.
5	CERT-SSN-HIC	60	Enter primary payer's policy number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key (treatment authorization) code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file

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PHS or Other Federal Agency is Primary Payment Made
Bill Medicare Secondary

After the PHS or other Federal plan has processed the claim and issued a payment, the claim must be submitted electronically using FISS Direct Data Entry (DDE). These claims cannot be billed using the American National Standard Institute (ANSI) ASC X 12N 837 5010 format.

Providers must check with their software vendor to determine if their software has the capability to submit MSP claims. These claims require specific codes on the UB-04 claim form and Claim Adjustment Segments (CAS). If your software does not have the capability to submit MSP claims or report the CAS information, you can download the PC-ACE Pro32 software from the Palmetto GBA website. Paper submission of a claim is only accepted for providers who qualify for the electronic submission waiver (25 or less employees and do not have an Electronic Data Interchange agreement on file).

FISS Page	FISS Field	UB-04 FL	Billing Instructions
1	COND CODES	18-28	Enter Condition Code "77" if you are contractually obligated to accept primary paid amount as payment in full
1	Value Code	39-41	Enter Value Code "16" and amount paid by the plan. 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. If Condition Code "77" is entered, omit Value Code "44."
3	CD	N/A	Most electronic billing software will automatically populate the Payer Code field based on the specific MSP Value Code (16) entered on the claim. If your software does not auto-populate, enter Payer Code "F" on line A. Enter Payer Code "Z" on line B.
3	Payer	50	Enter primary payer's name (as it appears on the eligibility file) on line A. Enter "Medicare" on line B.
3	OSCAR	51	Enter your provider number for the primary payer (if available) on line A
4	Remarks	80	Enter remarks (if applicable)
5	Insured Name	58	Enter beneficiary's name in insured's name field on lines A and B
5	Sex	N/A	Enter beneficiary's sex code (F/M) on lines A and B
5	DOB	N/A	Enter beneficiary's date of birth (MMDDCCYY) on lines A and B
5	REL	59	Enter Patient Relationship Code "18" on lines A and B
5	CERT-SSN-HIC	60	Enter PHS/Federal Agency identification number (if available) on line A. Enter beneficiary's HIC number on line B.
5	Group Name	61	Not required. Enter primary payer's group name (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	INS Group Number	62	Not required. Enter primary payer's group number (if available) on line A. If information is entered, it must match the information on the eligibility file. If you do not know exact information on eligibility file, leave this field blank.
5	Treat Auth Code	63	Enter Outcome and Assessment Information Set (OASIS) matching key code on line B (for Home Health providers only)
6	1st Insurer's Address	N/A	Enter primary payer's address, city, state and zip as it appears on eligibility file