First, set up the patient's payers:

If Medicare needs to be billed as secondary, on the **Referral** screen>**Payers** tab, make the other insurance as **payer#1** and Medicare as **payer#2**; then (if this is the first time that insurance has been used for MSP claims) go to **Billing** > **HIPAA Transactions** > **Edit HIPAA Payers** and select that payer; make sure the senderid and receiverid have the actual name of the insurance (no blanks) and that the Loop 2000 SBR Qualifier is a valid code. A **list of valid codes can be revealed by hitting the box beside the Loop 2000B SBR09 field.** To close this listing, hit the box again.

Any time a payer listed as primary or secondary is a PPS payer, when the 485 is printed, it creates an episode in PPS tracking. This serves as a reminder, when you see it on the tracking report, that when the primary payer is not PPS, and they either pay or deny, it's worth investigating to see if billing the PPS payer as secondary can generate revenue.
If Medicare is listed as secondary for the patient, the OASIS should have M0150 listed with two payers. If M0150 is marked as private insurance only, this would prevent you from billing Medicare as secondary, because the Oasis does not get transmitted unless M0150 indicates Medicare (or HMO) or Medicaid (or HMO). If your contract with a private insurer is to accept their reimbursement as "full and complete" payment, then Medicare would never be billed secondary, and should not be on the patient screen.

Creating MSP Claims

1. Go to **Billing** > **PPS Billing** > **Edit PPS Episodes** and make sure that the episode hasn't already had an EOE created (if so, cancel it). Now you can actually create the MSP claim.

2. Go to **Billing** > **PPS Billing** > **Create EOE MSP Claims**.

3.Type the first 3 digits of the chart#, the chart/episode(s) should appear. If the chart# does not show up: A. Verify that Medicare is listed in the Payer 2 spot in the Referral > Payer screen, and B. All visits in the episode have been changed to Medicare.

4.Select the episode.

5.Fill in all the applicable codes that are needed for your claim. If a payment was made, enter the correct value code(s) and fill in the amount paid. **ENTERING THE OTAF AMOUNT**: This amount entered should total: The amount primary paid + any amounts the patient is liable for (ex: copays, deductibles). Click here on information regarding how to calculate OTAF (Obligation To Accept as Payment In Full). There is no need to enter the adjusted off amounts. The system will generate that amount based on the amounts you enter for payment(s), copay, deductible etc. This creates the CAS line on the MSP electronic claim, see examples below. **NOTE**: Due to the requirement to place the Home Health Location on the claim (Q code), each Q code listed on your claim represents 1¢ that will be added to the adjusted off amount of the claim, which is automatically generated based on the dollar amounts you enter on the MSP billing screen as previously mentioned.

6.Click the **Mark this episode as EOE created** button.

7.Click the **Create This One MSP Claim** button. It's ready to transmit.

Adjustment CAS Field: You do not have to fill in this field. The software will generate the codes based on the information you fill in at the top. Here is what it would look like on the electronic version of the claim.

- PI - Payer initiated reductions

- CO - Contract Obligation
- OA - Other Adjustment
- PR - Patient Responsibility
- CR - Correction and Reversals

CAS Examples:

- Billing the patient deductible - CAS*PR*1*1250.36
- Billing the patient coinsurance - CAS*PR*2*1420.12
- Billing the patient copayment - CAS*PR*3*456.78
- Billing the patient deductible and coinsurance - CAS*PR*1*1452.02**2*123.69
- Amount Adjusted off of claim: CAS*CO*45*2791.01

Occurrence code: Documents when things that need to be noted for billing purposes have occurred. For example, a denial is an occurrence and the date listed would be the date of the denial.

Adjustment Reason Code:

Only exists on the DDE screen, which you can't use for MSP claims. You may use the **Remarks** field to include the adjustment reason code.

Value Codes:

12 = working aged beneficiary/spouse with EGHP (employer group

health plan)

13 = ESRD (end stage renal disease) beneficiary with EGHP

14 = no-fault, including auto/other

15 = worker's comp

41 = black lung

42 = VA

43 = disabled beneficiary under age 65 with LGHP (large group health plan)

Click here for MSP Billing tips.

Here are some references on MSP Billing:

PalmettoGBA MSP Coding: MSP Coding (palmettogba.com)

CGS Medicare Secondary Payer Overview: Medicare Secondary Payer (MSP) Overview (cgsmedicare.com)

Medicare Secondary Payer: Billing and Adjustments Codes Sheet - Medicare Secondary Payer Billing & Adjustments (Home Health & Hospice) (cgsmedicare.com)

CGS Medicare: Home Health Billing Codes Sheet - Home Health Medicare Billing Codes Sheet (Home Health & Hospice) (cgsmedicare.com)