

EDI Support Services

Billing Medicare Secondary Payer (MSP) Electronically Using PC-ACE Pro32

For all Medicare Part B Trading Partners

What is an MSP Claim?

In some situations, another payer or insurer may pay on a patient's claim prior to Medicare. The first payer is determined by the patient's coverage. There are different conditions that determine if Medicare is the Primary (pays on the claim first), Secondary (pays on the claim second), or Tertiary (pays on the claim third). Conditions include age of the beneficiary, whether they have group plan coverage in addition to Medicare, the size of the group plan, Veteran status, or if the beneficiary has certain medical conditions.

Note: Medicare tertiary claims must be submitted via paper.

Before an MSP claim can be submitted to Medicare, some information from the Primary payer's remittance advice is required to be sent in the claim:

- Deductible amount
- Co-Insurance amount
- Primary Paid amount
- Obligated to Accept as Payment in Full (OTAF)
Amount (OTAF is situational)

Please note: The healthcare industry does not yet have a standard codes set used by all payers that indicate payment, patient responsibility, or miscellaneous coverage. EDI Support Services (EDISS) is not able to read or interpret other payers' remittances. They are only able to state what fields are needed to process an MSP claim and not where this information can be found on the other payers' remittance advice. If necessary, it is the responsibility of the provider to contact the primary payer to identify which data represents the required data. The paid amount entered in the Service Line Adjudication field plus the adjustments listed in the Line Level adjustment fields must equal the total amount billed for that service line.

Medicare does not need a copy of the primary payer's remittance. The information submitted on the claim is used for processing and cross-referencing the remittance is not necessary. With some basic information, the MSP claim can process as the secondary insurer.

Another reason to submit MSP claims electronically is the Administrative Simplification Compliance Act (ASCA). The ASCA requires Medicare providers, with limited exceptions, to submit all initial Medicare claims for reimbursement electronically. The ASCA states that no payments can be made for any expenses incurred for items or services submitted in a Medicare claim in a non-electronic format.

Locating Requirement Information for MSP Claims

The use of non-standard codes limits EDIIS' ability to read or interpret other payers' remittances. However, EDIIS can assist in collecting the information required to process the MSP claim. This allows the provider to contact the primary payer for assistance in identifying the data on the primary payer's remittance.

Billing MSP Claims Using PC-ACE Pro32

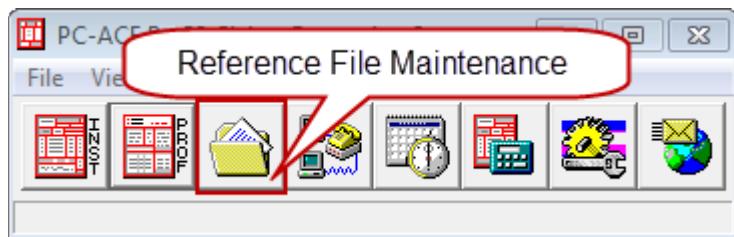
If you use PC-ACE Pro32 to bill MSP, you only need to be aware of the fields in the software that are required to be completed. PC-ACE Pro32 creates a compliant ANSI X12 file to submit to EDIIS electronically.

Setting Up Trading Partner Information

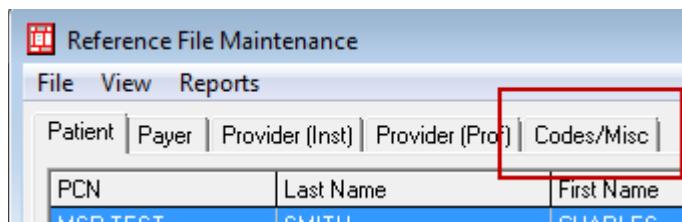
Submitter Set Up

PC-ACE Pro32 must be updated with the submitter information assigned by EDIIS. This information is faxed to the provider/billing office when EDIIS sets the provider up for testing. Complete the following steps to create a submitter record.

1. Select Reference File Maintenance from the PC-ACE Pro32 main toolbar.

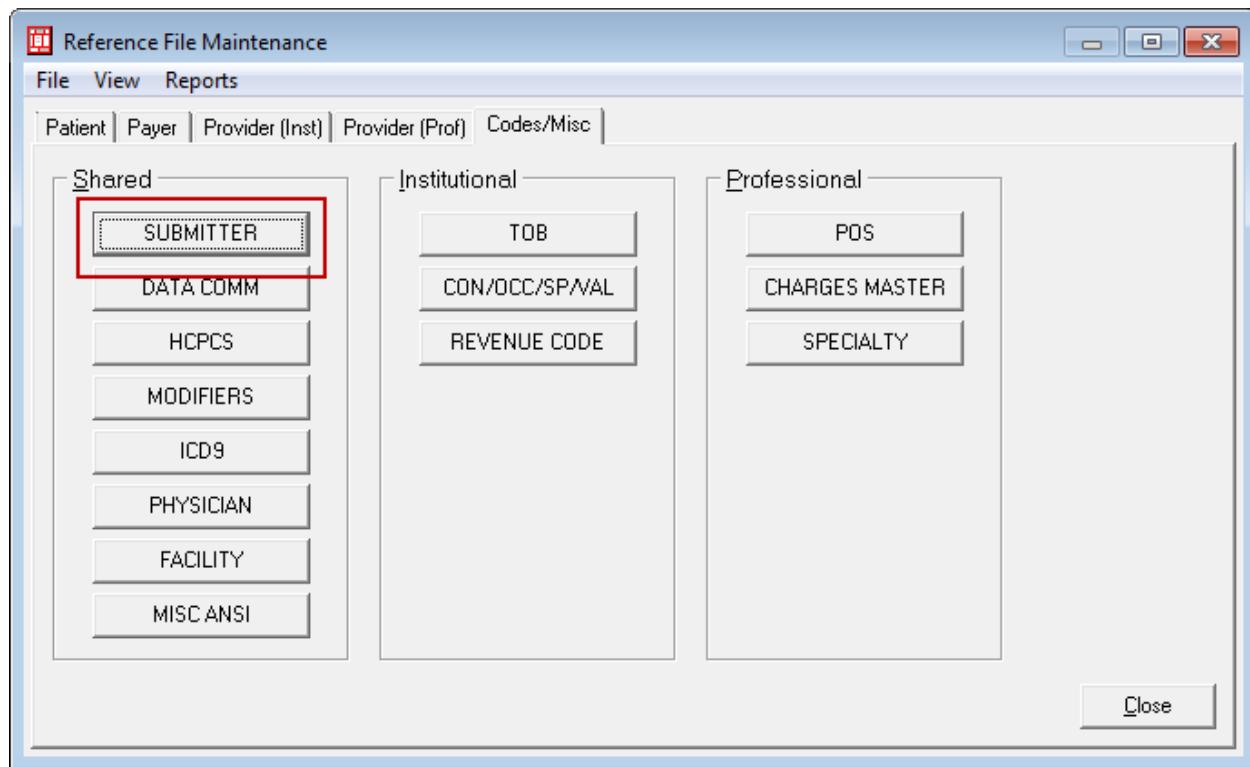


2. Select the Codes/Misc tab.



Note: PC-ACE Pro32 allows one Trading Partner ID (Submitter ID).

3. Click on the Submitter button.



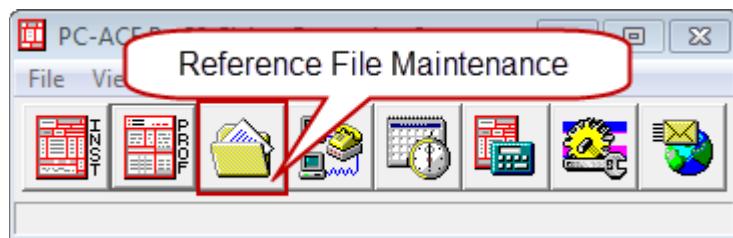
4. Click on the example Submitter ID, click on View/Update and change the information to your facility's information.

The screenshot shows the 'Institutional Submitter Information' dialog box. The title bar says 'Institutional Submitter Information' with a close button. The tabs at the top are 'General', 'Prepare', 'ANSI Info', 'ANSI Info (2)', and 'ANSI Info (4)'. The 'General' tab is selected. The form fields include:
LOB: [empty text box]
Payer ID: [empty text box] with a browse icon
ID: [text box containing 'SUBMITTER ID']
EIN: [empty text box]
Name: [text box containing 'SUBMITTER NAME HERE']
Address: [text box containing 'SUBMITTER ADDRESS']
City: [text box containing 'ANY TOWN']
State: [dropdown menu showing 'ND']
Zip: [text box containing '58103-']
Phone: [text box containing '(701) 123-4567']
Fax: [text box containing '() - -']
Country: [empty text box]
Contact: [text box containing 'CONTACT NAME HERE']
E-Mail: [text box containing 'CONTACT EMAIL HERE']
At the bottom are 'Save' and 'Cancel' buttons.

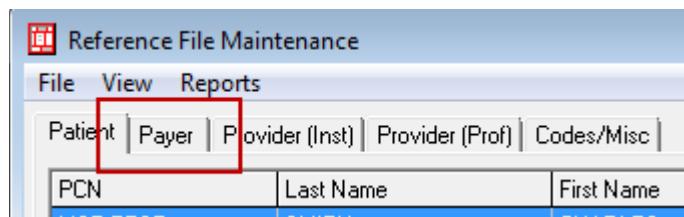
Payer File Setup

A payer record must be created for each primary insurance payer. When insurance coverage other than Medicare Part B needs to be recorded, a payer record must exist for the primary plan before entering claim information. Complete the following steps to create a payer file record for a primary insurance plan/benefit.

Select Reference File Maintenance from the PC-ACE Pro32 main toolbar



1. Select the Payer Tab.



Note: A list of existing payers appears. If your payer is not on the list, click on 'New' to add your payer.

Reference File Maintenance/Payer tab:

Payer ID	LOB	Description	State	Usage
000110001	COM	METLIFE	WV	
003200001	BC	BC - SEND TO NORTH DAKOTA	ND	Inst Only
003200001	TRI	ND TRICARE		
003200005	WCP	ND WORKFORCE SAFETY & INSURANCE	ND	
003200006	MCD	MEDICAID FOR NORTH DAKOTA	ND	
003200008	TRI	TRIWEST ND - SEND TO WPS	WI	Inst Only

Sort By: Payer ID Payer Description Payer LOB Payer State

List Filter Options

- Show all payers (no filter applied)
- Filter list to include Payer IDs starting with
- Filter list to include Payer Names starting with

New **View/Update** **Copy** **Delete** **Close**

4. Complete the following fields on the Payer Information screen. All fields are required unless indicated otherwise.

Payer Information

Payer ID **A** LOB **B** Receiver ID ISA08 Override

Full Description **C**

D Address & Contact Information

Address
City State Zip
Contact Name
Phone Ext Fax

Local Fields

Source **F** Media **G** Usage

PrintLink Matching Description **E** Save **H** Cancel

- A. Payer ID: Enter the Payer ID assigned to this Payer.
Note: If unable to locate the Payer ID, press <F1> for more information.
- B. LOB: Right-click or press <F2> while the cursor is in the field to select a valid Line of Business value.
- C. Full Description: Enter the Payer (Insurance Plan/Benefit) name.
- D. Address/City/State/Zip: This information is not required, however, EDISS recommends completing the information if known.
- E. Contact Name/Phone/Ext/Fax: Enter the information if known.
- F. Source: Right-click or press <F2> to obtain a list of valid values.
Select the most appropriate value for this payer.
- G. Usage: Leave blank or enter B.
- H. Click on the Save button.

Note: The validation feature in PC-ACE Pro32 determines if any fields need to be corrected. If errors exist, they must be fixed before the payer can be used. If changes need to be made to the payer record after entering the information, select the payer from the list and click on the View/Update button.

Entering MSP Claim Data

When patients insurance is Primary to Medicare, there is information that must be submitted on the MSP claim.

1. Select Professional Claims Processing from the PC-ACE Pro32 main toolbar.



2. Click on the Enter Claims button.



3. On the Patient Info & General tab, enter a Y in the COB? field.

A screenshot of the "Professional Claim Form" window. The top navigation bar shows tabs: "Patient Info & General" (which is highlighted with a red box), "Insured Information", "Billing Line Items", "Ext. Patient/General", "Ext. Pat/Gen (2)", and "Ext. Payer/Insured". The form contains various input fields for patient information, including last name, first name, address, city, state, zip, phone, and medical details. At the bottom of the form, there is a section for provider information. The "COB?" field, located in this section, is highlighted with a red box and contains the letter "Y".

4. On the Insured Information tab, enter the Primary insurance information in the first line and the Medicare information in the second line.

Sub	Payer ID	Payer Name	Primary Insurance Line	Insured's Last/Org Name	First Name	MI	Gen
<input type="checkbox"/>	999999999	SAMPLE PAYER	55599999991234	18	DOE	JOHN	
<input type="checkbox"/>	999999999	MEDICARE SAMPLE PAYER	8888888881234	18	DOE	JOHN	
<input type="checkbox"/>							

Birthdate	Sex	Sig	AOB	Insured's Address 1	Insured's Address 2	Insured's City	State	Zip
01/10/1899	M			123 EASY STREET		FARGO	ND	58103-__
01/10/1899	M			123 EASY STREET		FARGO	ND	58103-__
__/_/_								

Country	Insured's Phone / Ext.	ESC	Employer Name	Group Name	Group Number
<input type="checkbox"/>	(800) 967-7902	<input type="checkbox"/>			
<input type="checkbox"/>	(800) 967-7902	<input type="checkbox"/>			
<input type="checkbox"/>	(__) __-__	<input type="checkbox"/>			

5. On the Extended Payer/Insured tab, select the Primary Payer/Insured tab.

A. Insurance Type: Right-click or select <F2> to obtain a list of valid Insurance Type code values. If the submitted code is not the correct code for the patient, the claim will be denied. Please contact the patient or the primary insurance company for this information.

Primary Payer/Insured Secondary Payer/Insured Tertiary Payer/Insured COB Info (Primary) COB Info (Secondary)

Miscellaneous Primary Payer / Insured Information

Payer Address	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="text"/>	
<input type="text"/>	
<input type="checkbox"/> Insurance Type	<input type="button" value="▼"/>
<input type="text"/> Insured's Contact	
<input type="text"/> Patient ID	

Payer / Insured Reference IDs / Types

<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>

Professional Claim Form

Patient Info & General | Insured Information | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | **Ext. Payer/Insured**

Primary Payer/Insured | Secondary Payer/Insured | Tertiary Payer/Insured | COB Info (Primary) | COB Info (Secondary)

Common Payer MSP Information

OTAF	0.00
Zero Payment Ind	<input type="checkbox"/>

Additional Adjustment / COB Amounts / MOA Information (ANSI-837 Only)

Claim Level Adjustments (CAS)				
Num	Group	Reason	Amount	Units
1				
2				
3				

COB / MOA Amounts		
Num	Code	Amount
1		
2		
3		

Medicare Outpatient Adjudication (MOA) Remarks Codes

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Claim Adjudication Date / / B

A C

Save | Cancel

- A. Zero Payment Ind: Enter Z if payment amount was zero. Enter N if payment amount was non-zero.
- B. Claim Adjudication Date: Enter the date the claim was adjudicated by the primary payer. (Date is not required here if the date is on the MSP/COB tab, see #H on page 10.)
- C. COB/MOA Amounts: Enter the total paid amount for the entire claim. Right-click or select <F2> to select the correct code to denote this value.

MSP/COB Tab

Enter the line level MSP information for each line of service.

Note: Ensure the line number in parenthesis coordinates to the correct service line on the Billing Line Items tab. To do this, place the cursor on the service line on the Billing Line Items tab.

Billing Line Items: MSP/COB (Line)

The screenshot shows the 'Professional Claim Form' dialog box with the 'MSP/COB (Line)' tab selected. The interface is divided into several sections:

- Common Line MSP Amounts:** Contains fields for 'Approved' (A) and 'OTAF' (B).
- Service Line Adjudication (SVD) Information:** A grid for three service lines (1, 2, 3) with columns for SVD, P/S, Proc., Qual / Code (C, D, E), Modifiers 1 thru 4, Paid Amount (F), Paid Units (G), and B/U Line.
- Line Adjustment (CAS) & Miscellaneous Adjudication Info:** Includes fields for 'Procedure Code Description' (H) and 'Adj./Payment Date'. It also contains a table for 'Line Level Adjustments (CAS)' with columns for Num, Group, Reason (I), Amount (K), and Units (L).
- Buttons:** 'Save' and 'Cancel' at the bottom right.

- Approved: (This can be left blank as it is no longer required for 5010 MSP claims.)
- OTAF: If this is an OTAF claim, enter the dollar amount you are obligated to accept from the Primary insurance. This means if you are contracted or participating with the primary insurance and you are obligated to accept the eligible amount that becomes the OTAF amount.
- P/S: Enter P (for Primary).
- Proc: Right-click or select <F2> and select HC.
- Qual/Code: Enter the procedure describing the service to which this adjustment is applicable. This is typically duplicated from the original claim service line on the Billing Line Items tab.

- F. Paid Amount: Enter the amount paid by the Primary payer for this line of service only. An MSP/COB tab must be completed for each line of service on the Billing Line Items tab.
- G. Paid Units: Enter the unit(s) that was/were paid for this service line.
- H. Adj/Payment Date: Enter the date this service line was adjudicated by the payer.
- I. Group: Right-click or select <F2> to activate the options. Select the code that identifies the general group/category of payment adjustment.
- J. Reason: Right-click or select <F2> to activate the options. Select the code that identifies the detailed reason the adjustment was made. For example, if the adjustment is due to the patient's deductible, choose PR for the Group code and choose 1 for the Reason code.

Note: If there are multiple line level adjustments on the claim such as coinsurance, a deductible amount and provider discounts or write-offs they are all reported here.

- K. Amount: Enter the amount of the adjustment.
- L. Units: Enter the units of service being adjusted.

MSP Terminology

A glossary of the common terms used throughout this document is included below.

Allowed: The maximum amount determined by the payer as being "allowable" for this service line under the provisions of the contract prior to the determination of actual payment. (This is not required on an MSP claim.)

Approved: The approved amount for this service line by the primary insurance. (This is not required on an MSP claim.)

Coinurance: The percent of the insurance company's approved amount that the beneficiary has to pay after they pay the deductible for Part B.

Co-payment: This is the amount paid for each medical service, such as a doctor's visit. A co-payment is usually a set dollar amount you pay for a service. An example of this would be a \$10 or \$20 payment for a doctor's visit.

Deductible: The amount you must pay for health care costs prior to the insurance company making a payment.

Discount Amount: The discount amount should be subtracted from the allowed amount reported on the primary payer's Explanation of Benefits (EOB). This is done only if the discount is reported as an adjustment and the discount is not already subtracted from the allowed amount on the primary payer EOB. Medicare should not calculate the Medicare payment based on amounts that need to be written off by the provider. If the discount amount is not subtracted from the allowed amount, Medicare is overpaying on claims.

Explanation of Benefits (EOB): A listing of what an insurance company paid and denied on a claim and the reason why.

Insurance Type: Medicare Secondary Payer (MSP) "Reason Code" used to identify the type of insurance policy. This value must be correct or the claim will deny.

Medicare Secondary Payer: Any situation where another payer or insurance pays medical bills before Medicare.

Obligation to Accept Payment in Full (OTAF) – The amount the provider agreed to accept as payment in full for a claim under the provisions of the contract.

PC-ACE Pro32 – EDI Support Services' free/low-cost billing software. Providers can use PC-ACE Pro32 to create and submit electronic MSP health care claims, view and print ERAs, and create status requests for health care claims and receive status responses.

Primary Paid: The actual amount paid by the payer for a service line under the provisions of the contract.

Primary Payer - An insurance policy, plan or program that is first in line to pay on a claim.

Provider: A hospital, health care professional or health care facility.

Secondary Payer - An insurance policy, plan or program that is second in line to pay on a claim.

Tertiary Payer - An insurance policy, plan or program that is third in line to pay on a claim.