

# EDI Support Services

## ***Medicare Secondary Payer (MSP) ANSI Specifications***

This document describes the required fields in relation to the ASC X12N Implementation Guide (IG). Use the information below to assist you and your software vendor report the appropriate MSP information in the correct ANSI fields.

### ***REQUIRED MSP DATA***

When billing MSP claims electronically include the following information for the claim to process and pay correctly:

- Indication of Medicare as the secondary payer
- Insurance Type
- Coordination of Benefits (COB) Payer Paid Amount – Claim Level
- Coordination of Benefits (COB) Allowed Amount – Claim Level
- Claim Contract Information (OTAF) – Claim Level
- Claim Adjudication Date – Claim Level
- Line Adjudication Information
- Line Adjustments
- Line Adjudication Date

As a note, MSP claims with multiple primary payers cannot be sent electronically. If this uncommon scenario exists, submit the claims via paper.

### ***INDICATION OF MEDICARE AS THE SECONDARY PAYER***

All MSP claims are built around the assumption that Medicare is the secondary payer (e.g., the beneficiary has other insurance that pays the health care claim prior to Medicare). The basic principle behind filing a MSP claim to Medicare is to report all payment information provided by the primary payer and indicate that Medicare is the secondary payer. The ANSI X12 Implementation Guide indicates primary, secondary, and tertiary payers by using the SBR segment. For MSP claims, the first occurrence of the SBR segment must appear in loop 2000B. An additional SBR segment is needed in the 2320 loop to report the primary payer information. Use the SBR01 element, Payer Responsibility Sequence Number Code, to report what type of claim is being submitted. The valid values for the SBR01 element are:

- P = Primary
- S = Secondary
- T = Tertiary

#### **In this document:**

- Lists the required fields in relation to the ASC X12N Implementation Guide (IG)

## ***Medicare Secondary Payer (MSP) ANSI Specifications Continued...***

Report the SBR01 element in loop 2000B with the value of S and report the SBR01 element in loop 2320 with the value of P.

The SBR09 element, Claim Filing Indicator Code, indicates the type of payer.

The example below demonstrates Medicare as a secondary payer.

2000B/SBR Segment Syntax: SBR\*S\*18\*\*\*12\*\*\*\*MB~

The value of S is reported in SBR01, indicating a secondary payer. The value of MB is reported in SBR09 indicating Medicare Part B as the secondary payer. See the IG for additional Claim Filing Indicator Codes.

### ***INSURANCE TYPE CODE***

Submit the insurance type code in the SBR05 element. In the above example, the submitted value is 12, indicating Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan. Please note that it is important to submit the correct MSP type code to prevent denial of your claim. See the IG for additional Insurance Type Codes.

### ***COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT – CLAIM LEVEL***

The ANSI X12 Implementation Guide indicates COB payer paid amounts by using an AMT segment in loop 2320, Other Subscriber Information. Use a qualifier of D to define the amount submitted as the Payer Paid Amount. The amount reported in the AMT segment is the **total** amount the primary payer paid on the claim. The COB payer paid amount **is required** if the claim has a service line approved amount and a service line paid amount. It is acceptable to show “0” (zero) as an amount paid. The example below displays the COB payer paid amount.

2320/AMT Segment Syntax: AMT\*D\*20~

### ***COORDINATION OF BENEFITS (COB) ALLOWED AMOUNT – CLAIM LEVEL***

The ANSI X12 Implementation Guide indicates COB allowed amounts by using an AMT segment in loop 2320, Other Subscriber Information. Use a qualifier of B6 to define the amount submitted as the Allowed Amount. This is the **total** amount approved/allowed by the primary payer on the claim.

## ***Medicare Secondary Payer (MSP) ANSI Specifications Continued...***

The Coordination of Benefits allowed amount **is required** if the claim has an approved/allowed amount on the service line and a paid amount on the service line.

The example below displays the COB allowed amount.

2320/AMT Segment Syntax: AMT\*B6\*519.21~

### ***CLAIM CONTRACT INFORMATION (OTAF) – CLAIM LEVEL***

The Obligated to Accept as Payment in Full (OTAF) amount is that which the provider agreed to accept as payment in full for a claim under the provisions of the contract with the primary insurance. The reporting of this information is only **required** when OTAF amounts are greater than zero.

**Example of OTAF:** A provider billed the patient \$150.00 for health care services. The patient's primary insurance company is a commercial insurer. On service line 1 of the claim, \$100.00 was billed to the commercial insurer, however because of a provider agreement with the commercial insurer \$25.00 was written off. On service line 2 of the claim, \$50.00 was billed to the commercial insurer, however because of a provider agreement with the insurer \$5.00 was written off. The amount entered into the OTAF field would be \$120.00, the difference between what was billed to the primary insurance and the amount that was written off.

The ANSI X12 Implementation Guide indicates OTAF amounts by using a CN1 segment in loop 2300, Claim Information. The CN101 element will contain the contract type code and the CN102 element will contain the OTAF amount.

The example below displays the OTAF amount.

2300/CN1 Segment Syntax: CN1\*04\*410.5~

See the IG for additional Contract Type Codes.

### ***CLAIM ADJUDICATION DATE – CLAIM LEVEL***

The ANSI X12 Implementation Guide indicates the Claim Adjudication date by using a DTP segment in loop 2330B. The DTP01 element will contain qualifier 573, Date Claim Paid, to indicate the type of date that follows. DTP02 will contain qualifier D8 to indicate the format of the date. The DTP03 element will contain the claim adjudication date. The Claim Adjudication Date **is required** on all MSP

## **Medicare Secondary Payer (MSP) ANSI Specifications Continued...**

claims and is used to report the date a claim was adjudicated or paid by the primary payer.

The example below displays the adjudication date.

2330B/DTP Segment Syntax: DTP\*573\*D8\*20041116~

### **SERVICE LINE INFORMATION**

**OTAF** - The OTAF (Obligated to Accept as Payment in Full Amount) **must be reported** when this amount is available on the EOB from the primary payer for the service line. The OTAF is the amount the provider agreed to accept as payment in full for a service line under the provisions of the contract.

2400/CN1

Implementation Guide Specifics:

2400 Loop – Service Line, Contract Information

- Contract Type Code is reported in a **CN1** segment (See IG for complete list of codes)

Syntax of Segment: CN1\*04\*410.5~

**Approved Amount** - The Approved Amount, also known as the allowed amount, is the amount of money approved by the primary payer. The approved amount equals the amount for the service line that was approved by the payer. If the primary insurance does not show the approved amount, enter the billed amount in this element.

2400/AMT

Implementation Guide Specifics:

- 2400 Loop – Service Line, Approved Amount
- Amount Qualifier Code is reported in an AMT segment
- Approved Amount Qualifier of AAE is required

Syntax of Segment: AMT\*AAE\*125~

**Line Adjudication Information** – Use the line adjudication information to report the original services billed to the primary payer. This information is **required** if

## **Medicare Secondary Payer (MSP) ANSI Specifications Continued...**

the claim has been previously adjudicated by the payer identified in the 2330B loop and the service line has adjustments applied. The Line Adjudication Information is present on most MSP claims.

### 2430/SVD

Implementation Guide Specifics:

- 2430 Loop – Line Adjudication Information
- Report line adjudication information in the SVD segment including the specific service line items billed to the primary payer (procedure code, amount paid for the service, units billed, etc.)

Syntax of Segment: SVD\*00820\*20\*HC>98940\*\*1~

**Line Adjustments** – Line adjustments are required if the primary payer made line level adjustments which caused the amount paid by the primary insurance to differ from the amount originally charged to the primary insurance. Line Adjustments are present on most MSP claims.

### 2430/CAS

Implementation Guide Specifics:

- 2430 Loop – Line Adjudication Information, Line Adjustment
- Line adjustment information is reported in the CAS segment, including the claim adjustment group code, claim adjustment reason code and the monetary adjustment amounts (See IG for complete list of codes)

Syntax of Segment: CAS\*CO\*42\*5\*1\*2\*5\*1~

**Line Adjudication Date** – Use the Line Adjudication Date segment to report the date the claim was adjudicated/paid by the primary payer. This segment is required on all MSP claims.

### 2430/DTP

Implementation Guide Specifics:

- 2430 Loop – Adjustments Information, Line Adjudication Date
- Line Adjudication Date is reported in a **DTP** segment
- Date/Time Qualifier of '**573**' followed by a Date Time Period Format Qualifier of '**D8**'

Syntax of Segment: DTP\*573\*D8\*20041116~