EDI Support Services

Billing Medicare Secondary Payer (MSP) Claims Electronically

For All Medicare Part A Trading Partners
To bill Medicare Secondary Payer (MSP) claims electronically, the following four fields must be included on the claim for processing: Indication of Medicare as the secondary payer, Value Codes, Condition Codes, and Occurrence Codes. For assistance with utilizing the appropriate codes please contact the Part A Call Center at: 1-877-908-8431.

This document describes these fields in relation to the ASC X12N 5010 Technical Report Type 3 (TR3), and how to enter the fields in EDI Support Services' (EDISS) low-cost billing software, PC-ACE Pro32. If you are not a PC-ACE Pro32 user, this information will assist you and your software vendor in assuring the appropriate information is reported in the correct ANSI fields.

The use of non-standard codes limits EDISS' ability to read or interpret other payers' remittances. EDISS can assist in referring providers to www.wpc-edi.com, which will describe the Claim Adjustment Reason codes required to process the MSP claim. If the provider needs more information on these codes they should contact the primary payer for assistance in identifying the data on the primary payer's remittance.

Indication of Medicare as Secondary Payer

The basic principle behind filing an MSP claim with Medicare is to report all information the primary payer provided and indicate that Medicare is the secondary payer. The ANSI X12 TR3 indicates primary and secondary payers by using the SBR01 segments in the 2000B and 2320 loops.
Use the SBR segment in the 2000B loop to report what type of claim is being submitted. The values for SBR01 are P for primary and S for secondary. (Medicare tertiary claims cannot be billed electronically.)
Syntax of the SBR Segment in 2000B loop for MSP (secondary payer information):
SBR*S*18**MEDICARE*****MA
SBR01 = 'S' indicating secondary payer

SBR02 = ‘18’ indicating Self. The insured is always the subscriber for Medicare
SBR04 = ’Medicare‘ indicating Medicare Name
SBR09 = ‘MA’ indicating Medicare Part A
The SBR segment in the 2320 loop reports the primary payer information. The SBR01 element is reported with the value of ‘P’ for primary payer. SBR09 indicates the type of primary payer.
Syntax of the SBR segment in 2320 loop for MSP (primary payer information):
SBR*P*01**Blue Cross*****BL
SBR01 = ‘P’ indicating primary payer
SBR02 = ‘01’ indicating Spouse1
SBR04 = ‘Blue Cross’ indicting primary payer
SBR09 = ‘BL’ indicating Blue Cross/Blue Shield

HI Segments - Occurrence/Value/Condition Codes

To prevent claim processing delays, all available coding options should be used. This includes occurrence, condition, and value codes when appropriate. The codes are contained in the 2300 loop HI segments, identified by individual qualifiers.

Syntax of the HI segment in 2300 loop:

Value codes

HI*BE>12>>>1287.14
HI01:01 = ‘BE’ indicating Value Code
HI01:02 = ’12‘ value code representing ‘Working Aged Beneficiary’
HI01:04 = ’1287.14’ indicating the total amount paid by the primary payer

Condition Codes

HI*BG>02
HI01:01 = ’BG’ indicating Condition Code
HI01:02 = ‘02’ condition code representing ‘Condition is employment related’

Occurrence Codes

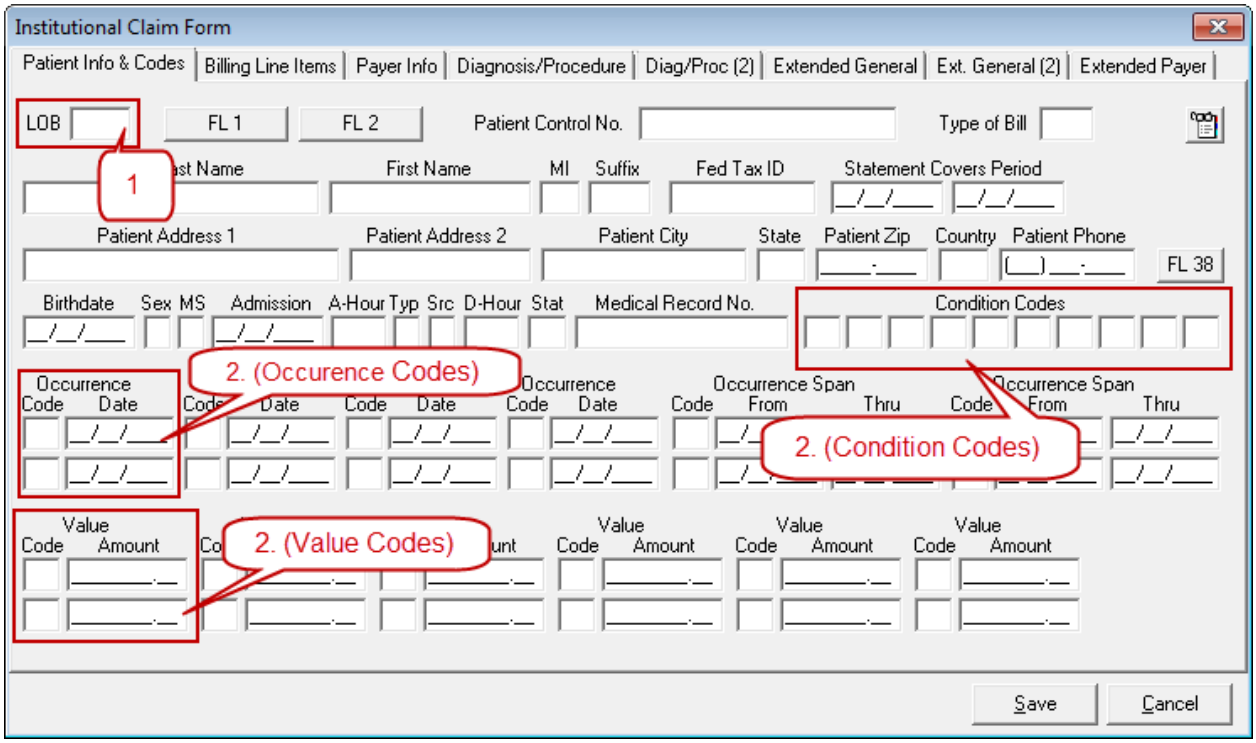
HI*BH>11>D8>20071017
HI01:01 = ‘BH’ indicating Occurrence Code
HI01:02 = ‘11’ occurrence code indicating ‘Onset of Symptoms/Illness’
HI01:03 = ‘D8’ indicating a CCYYMMDD format
HI01:04 = Date of occurrence

Billing MSP Claims Using PC-ACE Pro32

When PC-ACE Pro32 is used to bill an MSP claim the information is entered in several different fields.

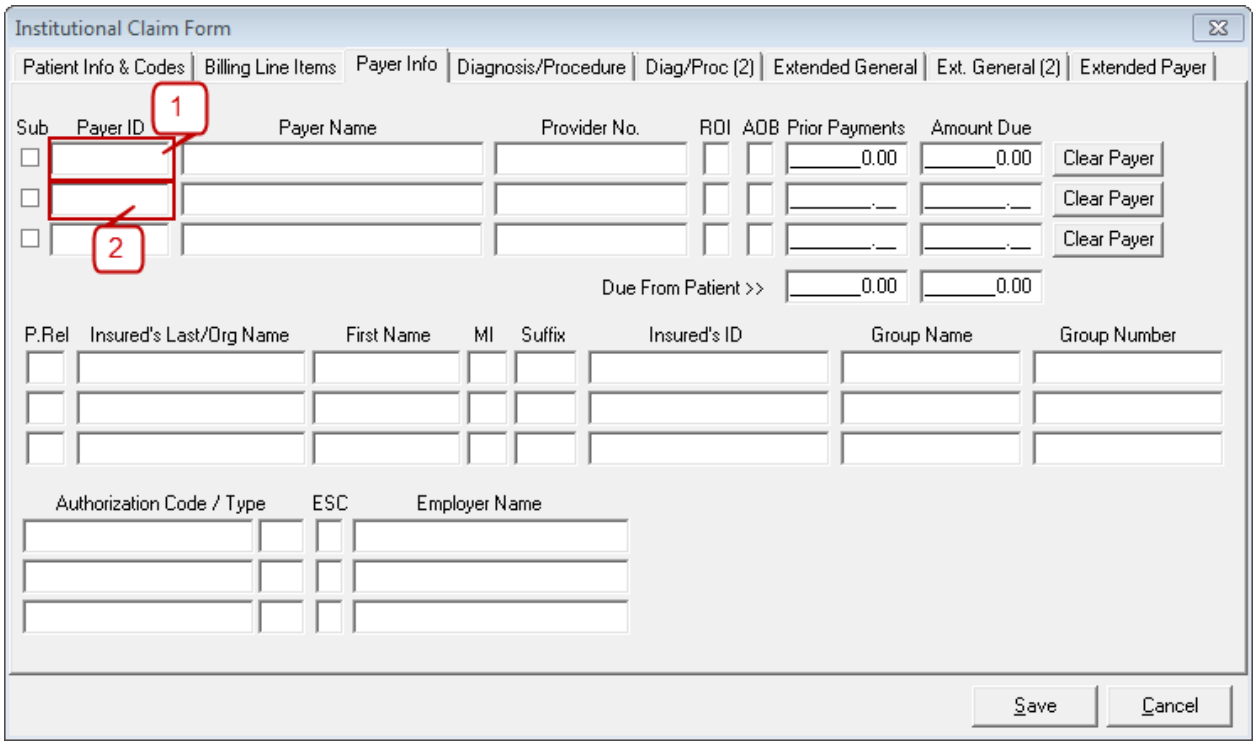
Note: The screen shots of the PC-ACE Pro32 software were generated using data from a SAMPLE payment listing from a fictitious primary payer. Throughout the guide, you will see a screen shot of the PC-ACE Pro32 followed by corresponding screen shots of the SAMPLE payment listing, if applicable.

Patient Info & Codes tab:



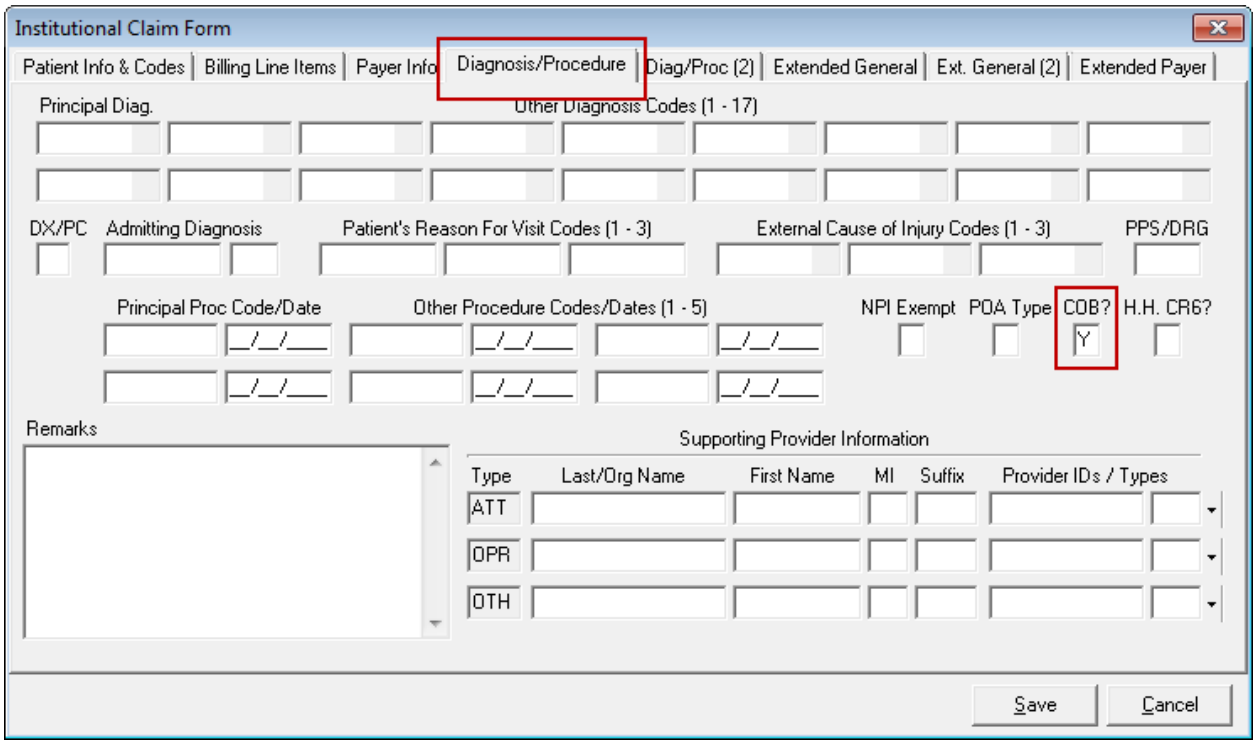
1. The LOB (Line of Business) field should contain MCA (Medicare A) when filing the claim to Medicare as an MSP claim.
2. Enter the appropriate codes in the Condition Codes, Occurrence Codes, and Value Codes sections. For assistance with utilizing the appropriate codes contact the Part A Call Center at: 1-877-908-8437

Payer Info tab:



1. On the Payer Info tab, enter the primary payer into the Payer ID field. You may need to add this payer in the Reference File Maintenance before you can select it in the claim. Also complete the other fields related to the insured's primary insurance.
2. Enter Medicare A as the secondary Payer ID. Also enter the applicable insured's information in the other fields.

Diagnosis/Procedure tab:



1. Enter Y in the COB field

CAS Segment – Claim Level Adjustment

The CAS segment in the 2320 loop is used to report prior payers claim level adjustments that caused the amount paid to differ from the amount originally charged. This segment is used if the payer in this loop has reported claim level adjustment information on the primary payer's remittance advice. This line can be repeated if there are multiple adjustment groups.

- Syntax of 2320 loop CAS segment for Claim Level Adjustment Information:

CAS*CO*42*10*1*16*5*1~ (EXAMPLE)

CAS01 = indicates Claim Adjustment Group Code

CAS01 valid values:

- CO = indicating Contractual Obligations
- CR = indicating Corrections and Reversals
- OA = indicating Other Adjustments
- PI = indicating Payer Initiated Reductions
- PR = indicating Patient Responsibility

CAS02 = indicates Claim Adjustment Reason Code
CAS03 = indicates Monetary Adjustment Amount
CAS04 = indicates Service Line Adjusted Units
CAS05 = indicates Claim Adjustment Reason Code
CAS06 = indicates Monetary Adjustment Amount
CAS07 = indicates Service Line Adjusted Units

Payer Paid Amount

This segment is required in this loop if the primary payer has adjudicated the claim. It is acceptable to show “0” (zero) as an amount paid.

• Syntax of the 2320 loop AMT segment for COB Payer Paid Amount:

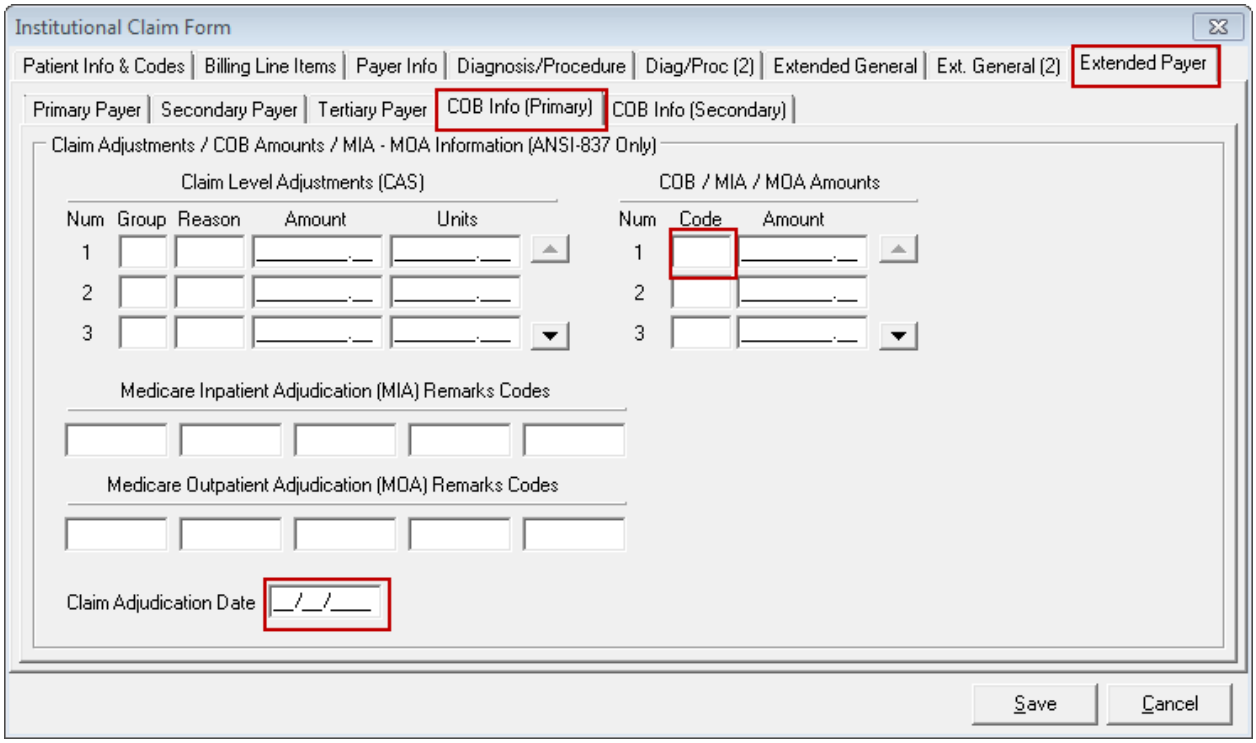
AMT*C4*60~ (EXAMPLE)

AMT01 = ‘C4’ indicating Prior Payment - Actual
AMT02 = Monetary Amount
AMT*T3*126~ (EXAMPLE)
AMT01 = ‘T3’ indicating Total Submitted Charges
AMT02 = Monetary Amount
DTP = indicates the Date Claim Paid

This monetary amount should match the claim total amount in the CLM 02.

If you are doing claim level reporting, the Total Primary Payer Paid amount (AMT*C4) plus the adjustment amounts in the claim CAS segments must equal the Total Submitted Charge (AMT*T3).

Extended Payer/COB Info (Primary) tab:



2430 - Service Line Level Reporting

SVD Segment – Line Adjudication

Line adjudication information is provided if the service line has adjustments applied by the primary payer. This information is reported at the service level but may be reported at the claim level if line level information is unavailable.

• Syntax of 2430 loop SVD segment for Line Adjudication Information:

SVD*00813*48*HC>99213**1~ (example)

SVD01 = indicates Other Payer Identifier Code

SVD02 = indicates Service Line Paid Amount

SVD03 = indicates Service Line Procedure Code

SVD05 = indicates Service Line Quantity/Units of Service

CAS Segment - Line Level Adjustment

Line adjustments are provided if the primary payer made line level adjustments that caused the amount paid to differ from the amount originally charged. This information is reported at the service level but may be reported at the claim level if line level information is unavailable.

• Syntax of 2430 loop CAS segment for Line Adjustment Information:

CAS*CO*42*10*1*16*5*1~ (example)

CAS01 = indicates Claim Adjustment Group Code

CAS01 valid values:

• CO = indicating Contractual Obligations

• CR = indicating Corrections and Reversals

• OA = indicating Other Adjustments

• PI = indicating Payer Initiated Reductions

• PR = indicating Patient Responsibility

CAS02 = indicates Claim Adjustment Reason Code 42

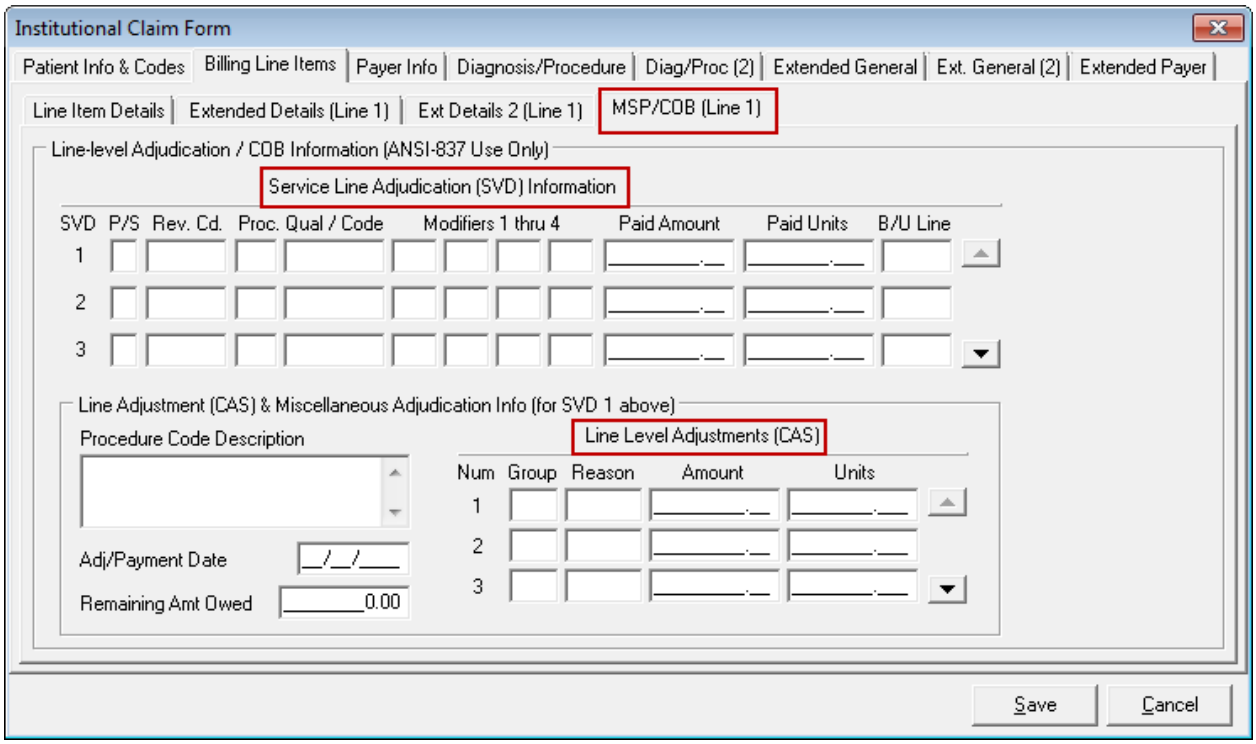
CAS03 = indicates Monetary Adjustment Amount

CAS04 = indicates Service Line Adjusted Units

CAS05 = indicates Claim Adjustment Reason Code

CAS06 = indicates Monetary Adjustment Amount

CAS07 = indicates Service Line Adjusted Units

DTP = indicates the Date Claim Paid

Billing Line Items/MSP COB (Line 1) tab: