EDI Support Services

Billing Medicare Secondary Payer (MSP) Claims

For all Medicare Part B Trading Partners

In this document:

X12 837 MSP ANSI Requirements:

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 are required when billing these types of claims.

The requirements listed below are **additional** elements required within the Standard HIPAA X12 837.

The X12 MSP requirements for X12 837 Claim file:

2000B Subscriber Information

SBR01*:* has to be an "S" (indicating Secondary)

SBR05: Insurance Type Code required

SBR09: Claim Filing Indicator Code

2320 Other Subscriber Information

SBR01: has to be "P" (indicating Primary)

SBR02: Individual Relationship Code

SBR09: Claim Filing Indicator Code

CAS: Claim Level Adjustments

Required when the claim has been adjudicated by the payer identified in this loop, and the claim has claim-level adjustment information. If remittance advice was adjudicated at the service line level apply information to 2430 Line Adjudication Information.

CAS01: Claim Adjustment Group Code

Provider Discount (Contractual Obligation)

Deductible (Patient Responsibility)

Coinsurance (Patient Responsibility)

CAS02: Claim Adjustment Reason Code

Provider Discount (Contractual Obligation)

Deductible (Patient Responsibility) Reason Code: 1

Coinsurance (Patient Responsibility) Reason Code: 2 or 3

CAS03: Monetary Amount

AMT: Coordination of Benefits (COB) Payer Paid Amount (AMT*D)

2330A Other Subscriber Name

NM1: Other Subscriber Name

N3: Other Subscriber Address

N4: Other Subscriber City, State, Zip Code

2330B Other Payer Name

NM1: Other Payer Name

DTP: Line Check or Remittance Date

DTP*573

Note: If Remittance Date is sent in the 2330 B it cannot be sent in the 2430 DTP

2430 Line Adjudication Information

Note: All Medicare Secondary claims must include Claim level adjustments at the service line level (2430 Loop) for adjudication purposes.

SVD: Line Adjudication Information

CAS: Claim Level Adjustments

Required when the payer identified in the Loop 2330B made service line level adjustments on the primary explanation of benefit.

CAS01: Claim Adjustment Group Code

Provider Discount (Contractual Obligation)

Deductible (Patient Responsibility)

Coinsurance (Patient Responsibility)

CAS02: Claim Adjustment Reason Code

Provider Discount (Contractual Obligation)

Deductible (Patient Responsibility) Reason Code: 1

Coinsurance (Patient Responsibility) Reason Code: 2 or 3

CAS03: Monetary Amount

DTP: Line Check or Remittance Date

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