Medicare Secondary Payer (MSP) Overview

Teleconference Number: (866) 699-3239

Note: Today's presentation is also available at **www.edissweb.com** under the Interactive Help Desk section of the Training and Help page.

Housekeeping

- Connecting to WebEx.
- When possible, use a quiet location.
- Phone line is muted upon login to workshop.
- Do not place the call on Hold.
- Identify yourself when asking questions.

Intent of EDI Workshops

- Interactive learning for providers and the employee's who work for them.
- An opportunity for providers to ask any EDI-related questions.
- An opportunity to see EDI specific demonstrations.

Medicare Secondary Payer (MSP) Overview

Agenda

- Why bill MSP electronically?
- Required fields for billing MSP claims electronically
- PC-ACE Pro32 and MSP (Part B and A)
  - Screens used for billing MSP data
  - Mapping from remit to MSP fields
- 837 X12 file output examples
- Batch Detail Control Listing (BDCL) rejections

Why Bill MSP Electronically?

- Don't need copy of Primary payer's remittance
- Electronic fields in ANSI hold required information
- Software doesn't support MSP?
  - EDI Support Services offers PC-ACE Pro32
- Administrative Simplification Compliance Act (ASCA)
  - CMS began enforcement of ASCA July 5, 2005
  - Requires Medicare providers, with limited exceptions, to submit all initial Medicare claims for reimbursement electronically
  - States no payments can be made for expenses incurred for items or services submitted in a Medicare claim in a non-electronic format

Required Information from Primary Payer Remittance

- Approved (allowed) amount
- Deductible amount
- Co-Insurance amount
- Primary Paid amount
- Obligated to Accept as Payment in Full (OTAF) amount

Definitions of Required Information

- **Allowed Amount:** 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.
- **Deductible:** Amount you must pay for health care costs prior to the insurance company making a payment.

Definitions of Required Information (cont.)

- **Coinsurance:** Percent of the insurance company's approved amount the beneficiary has to pay after they pay the deductible for Part B. The coinsurance amount is generally a percentage of the approved amount for the service.
- **Primary Paid:** Actual amount paid by the payer for a service line under the provisions of the contract.
- **Obligation to Accept Payment in Full (OTAF):** Amount the provider agreed to accept as payment in full for this claim under the provisions of the contract.

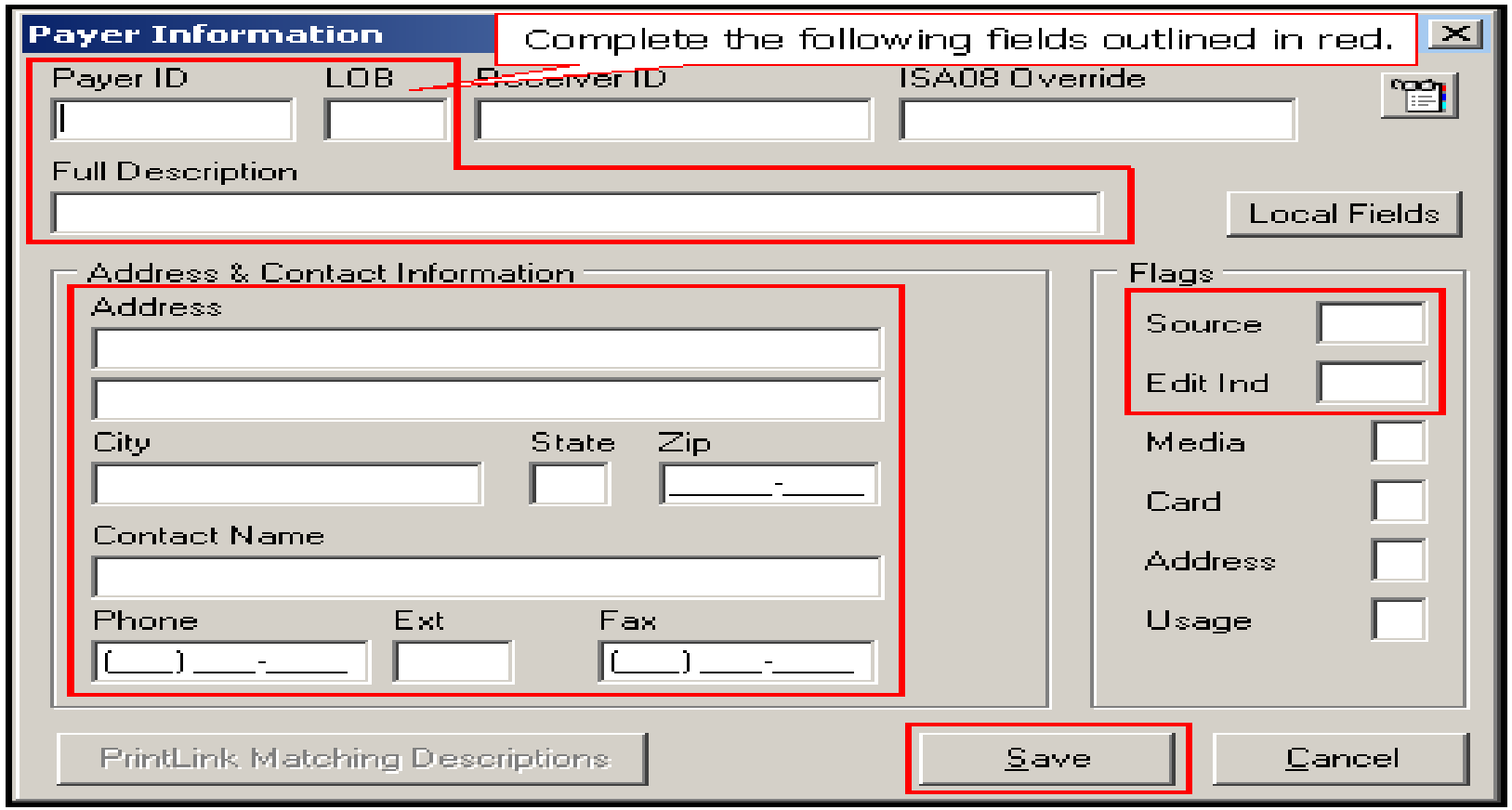
Billing Medicare Part B Claims Using PC-ACE Pro32

- Payer File Setup
- Entering MSP Claim Data

Payer File Set Up

- Select **Reference File Maintenance** from PC-ACE Pro32 Main Toolbar.
- Select the **Payer** tab.
- Click on the **New** button.
- Complete the fields on **Payer Information** screen.
- Select **Save**.

Entering Payer File Set Up in PC-ACE Pro32

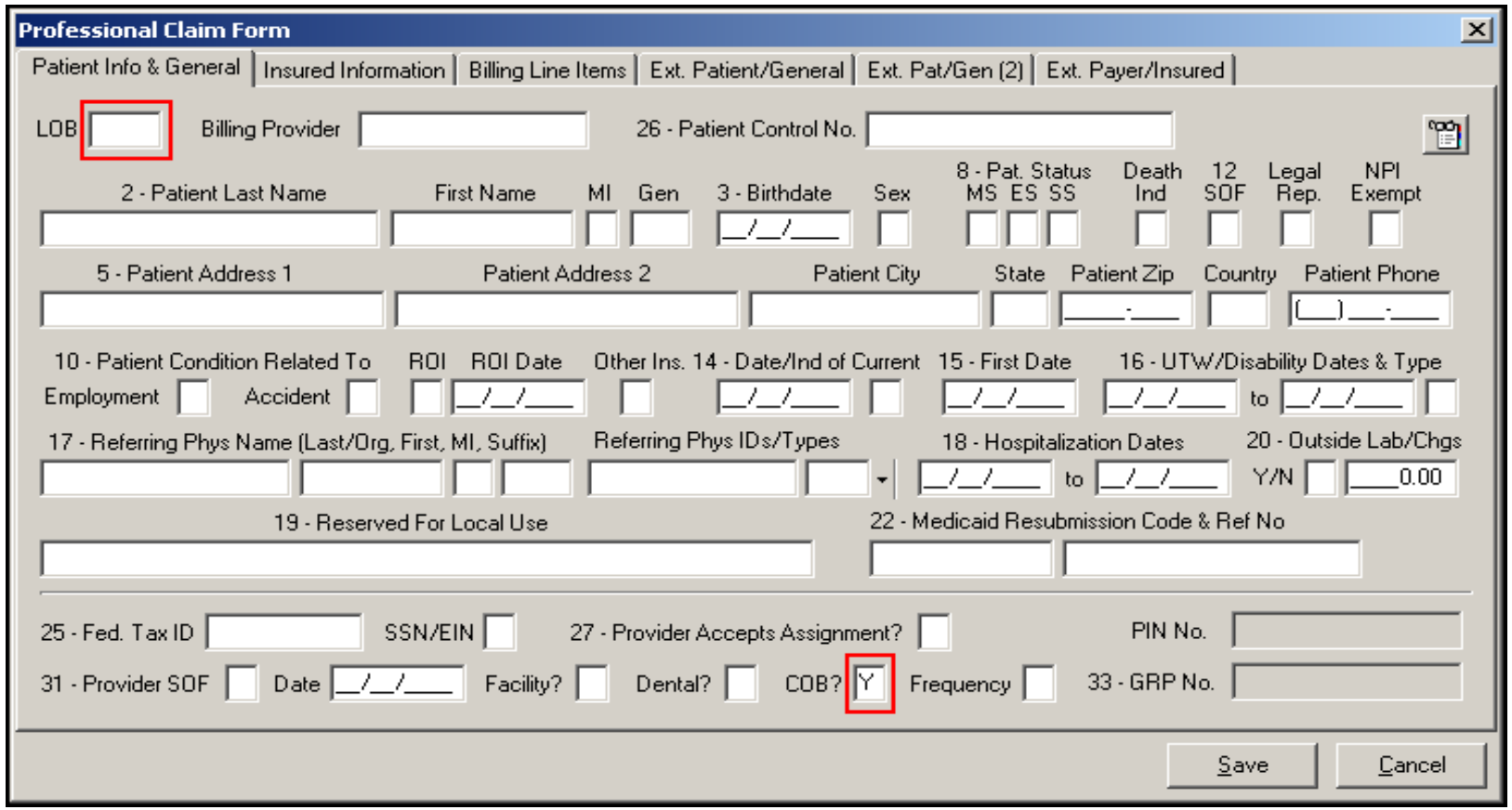


Entering MSP Claim Data

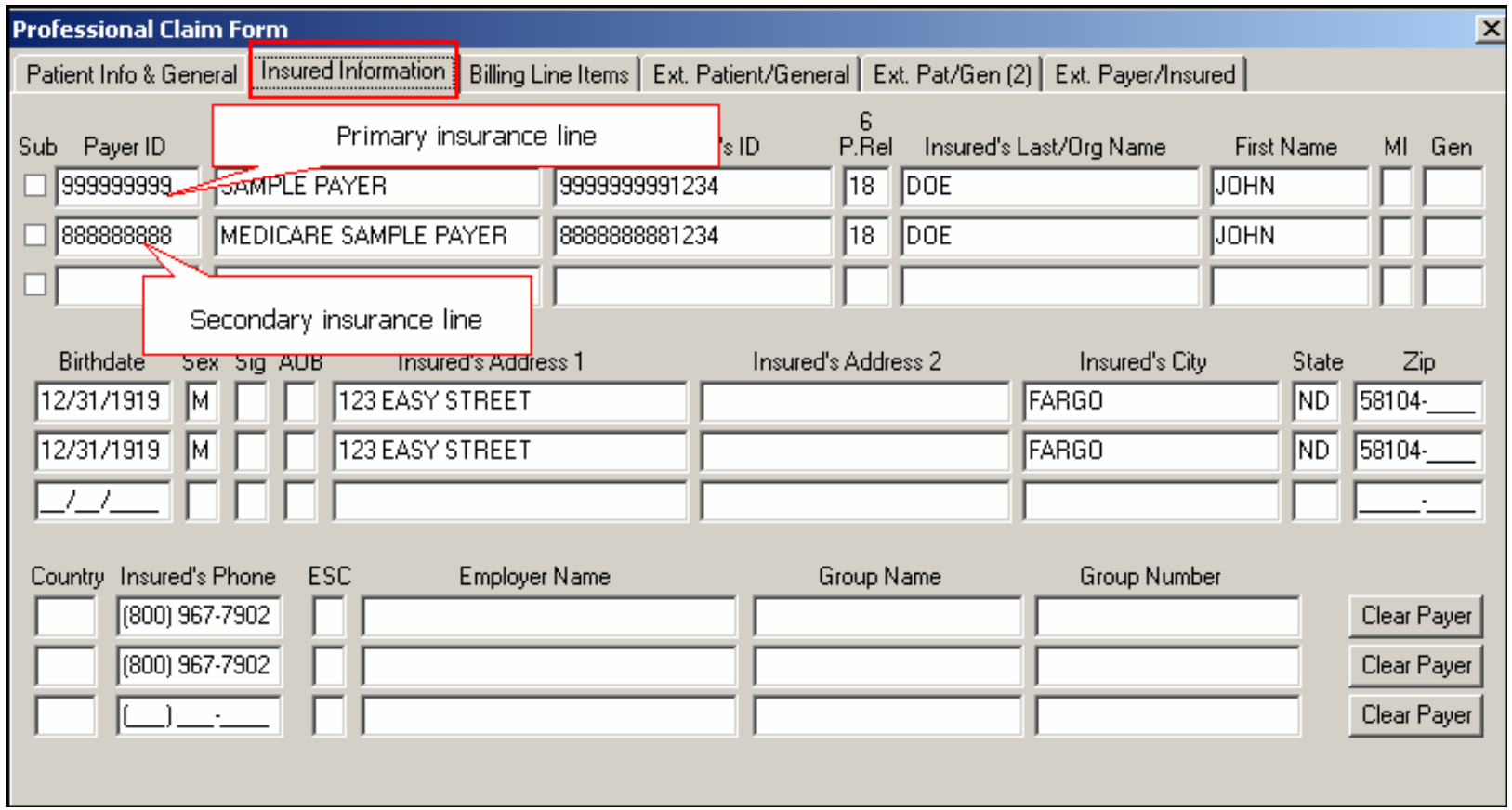
Before entering claim data, an MSP tab must be created in your claim file.

- Open a new claim in your Prof. Claim form.
- On the Patient Info & General tab, enter a Y in the blank field next to ‘COB?’.
  - This will create a MSP/COB tab under your Billing Line Items
- Proceed with claim creation.

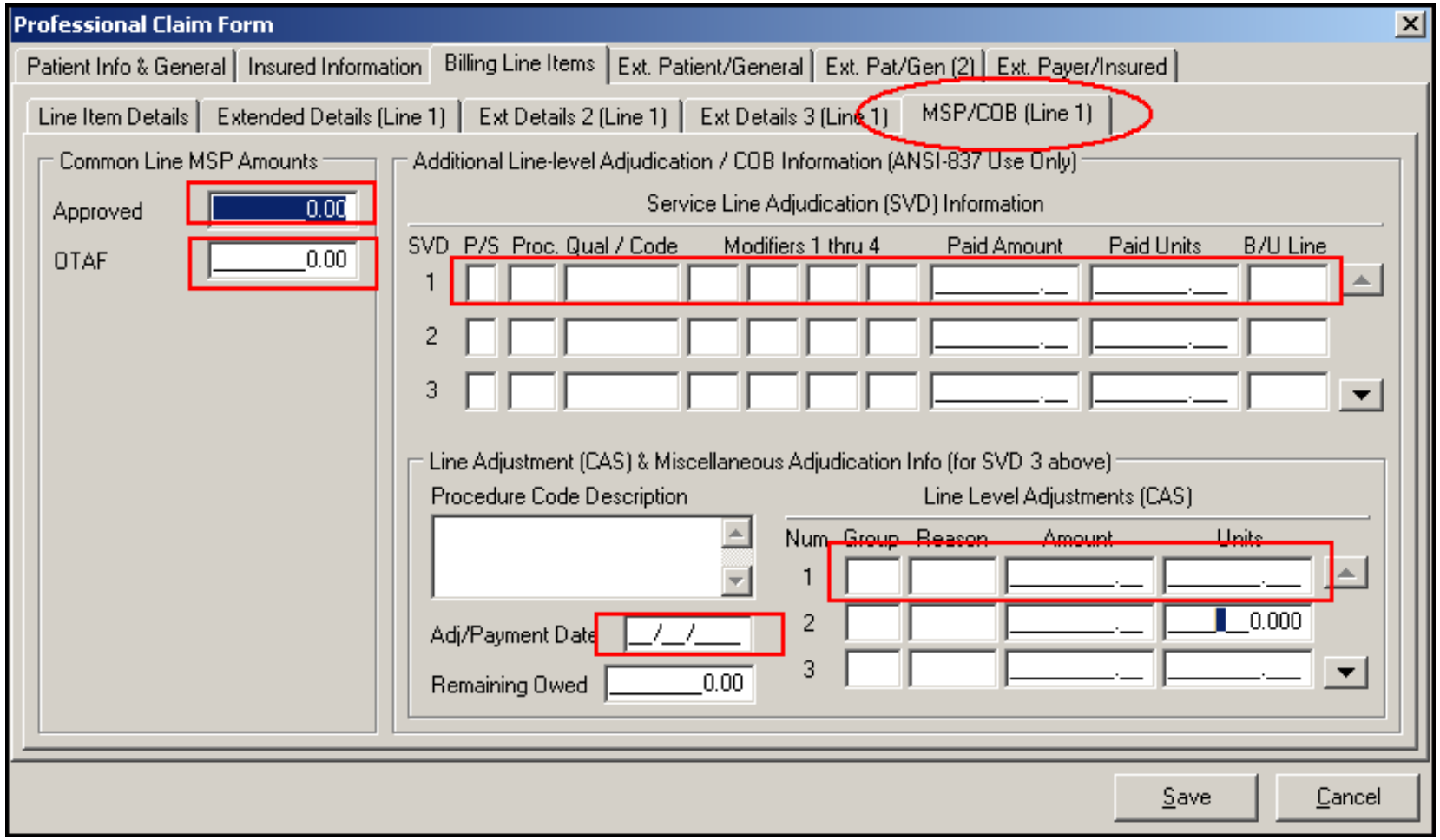
Entering MSP Claim Data in PC-ACE Pro32



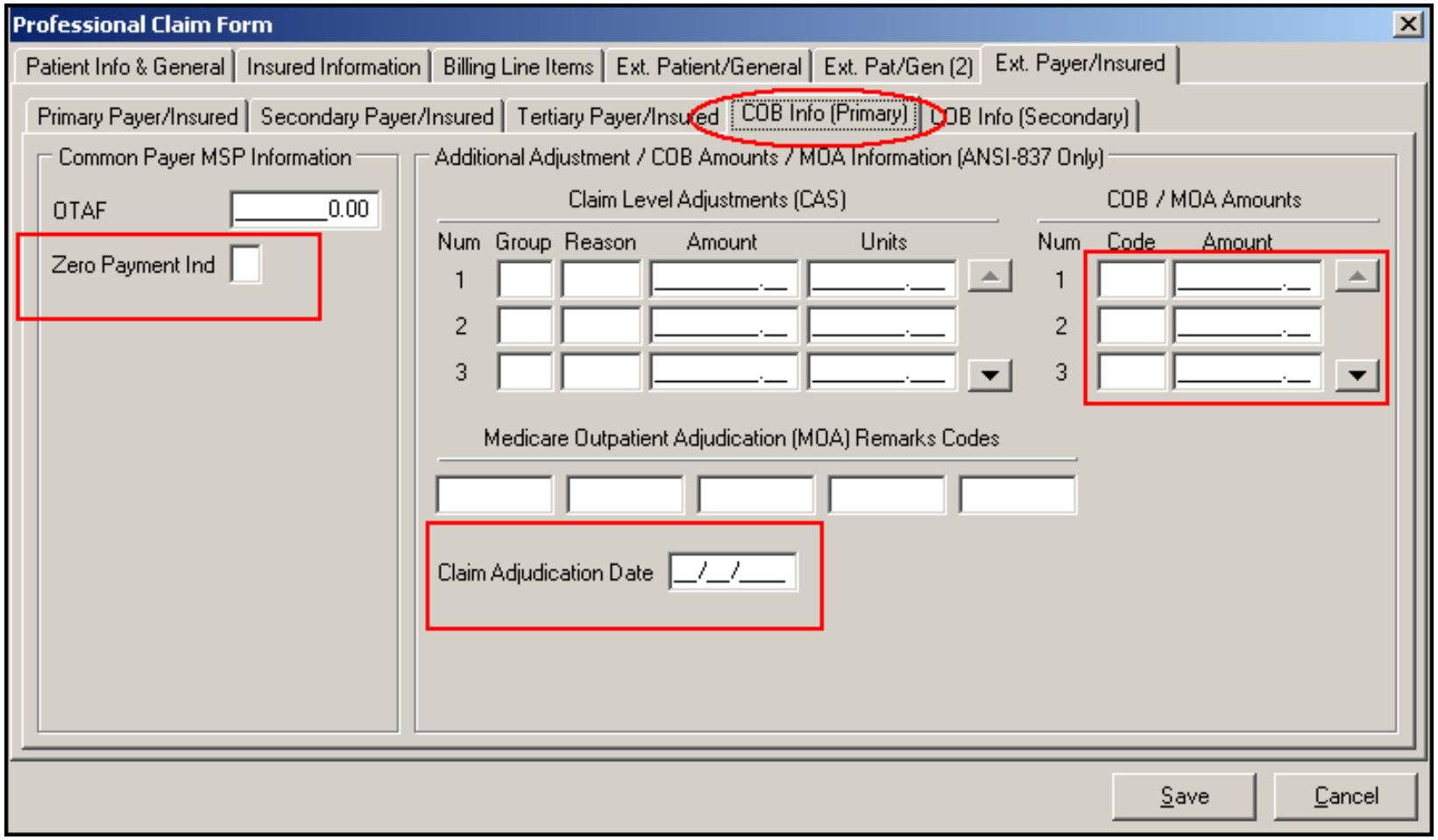
Entering MSP Claim Data in PC-ACE Pro32 [2]



Entering MSP Claim Data in PC-ACE Pro32 [3]



Entering MSP Claim Data in PC-ACE Pro32 [4]



Claim Level – Required Information

2000B Indication of Medicare as Secondary Payer

SBR01 Payer Responsibility Sequence Number Code S

SBR05 Insurance Type Code Depend on Beneficiary

SBR09 Claim Filing Indicator Code MB

Segment Syntax: SBR*S*18***12****MB~

2320 Payer Paid Amount

AMT01 Amount Qualifier Code D

AMT02 Monetary Amount $$

Segment Syntax: AMT*D*20~

Claim Level – Required Information (cont.)

2320 Allowed Amount

AMT01 Amount Qualifier Code B6

AMT02 Monetary Amount $$

Segment Syntax: AMT*B6*519.21~

2300 OTAF

CN101 Contract Type Code depends

CN102 Monetary Amount $$

Segment Syntax: CN1*04*410.5~

Claim Level – Required Information (cont.)

2330B Claim Adjudication Date

DTP01 Date/Time Qualifier 573

DTP02 Date Time Period Format Qualifier D8

DTP02 Date Time Period Format Qualifier 20040611

Segment Syntax: DTP*573*D8*20041116~

Service Level – Required Information

2400 OTAF

CN101 Contract Type Code Depends

CN102 Monetary Amount $$

Segment Syntax: CN1*04*410.5~

2400 Approved Amount

AMT01 Amount Qualifier Code AAE

AMT02 Monetary Amount $$

Segment Syntax: AMT*B6*519.21

Service Level – Required Information (cont.)

2400 Line Adjudication Information

SVD01 Identification Code This number should match NM109 in Loop ID-2330B identifying Other Payer.

SVD02 Monetary Amount $$

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

2430 Claim Adjudication Date

DTP01 Date/Time Qualifier 573

DTP02 Date Time Period Format Qualifier D8

DTP02 Date Time Period Format Qualifier 20040611

Segment Syntax: DTP*573*D8*20041116~

Electronic MSP Types
2-Digit Codes

12	Working Aged/Spousal Working Age
13	End Stage Renal Disease
14	No Fault (Auto/Liability)
15	Worker's Compensation
41	Federal Black Lung
42	Veteran' Administration (VA)
43	Disability/OBRA (Disabled Beneficiary)
47	Other Liability (other than No Fault/Auto)
**2 digit MSP types are not indicated on paper claims	

Batch Detail Control Listing (BDCL) Rejections

- **M384 - INVALID VALUE 2300/CLM02**

  If there is a Primary Paid amount on the claim, the paid amount plus all line level and claim level adjustment amounts must equal the total claim charge.

- **M304 - REQUIRED INFO MISSING 2320/AMT**

  If a claim level allowed amount and primary payer paid amount submitted on a claim, either the line level allowed amount or line level adjudication information is missing.

Batch Detail Controls Listing (BDCL) Rejections (cont.)

- **M312 - INVALID MSP AMOUNTS 2320/AMT**

  If the payer being billed is the Primary or Secondary payer, Secondary or Tertiary Payer Paid information cannot be submitted on the claim as the Secondary or Tertiary would not have paid on the claim yet.

- **M301 - REQUIRED INFO MISSING 2400/SVD**

  MSP claim approved amount has been submitted but the line level primary paid is missing.

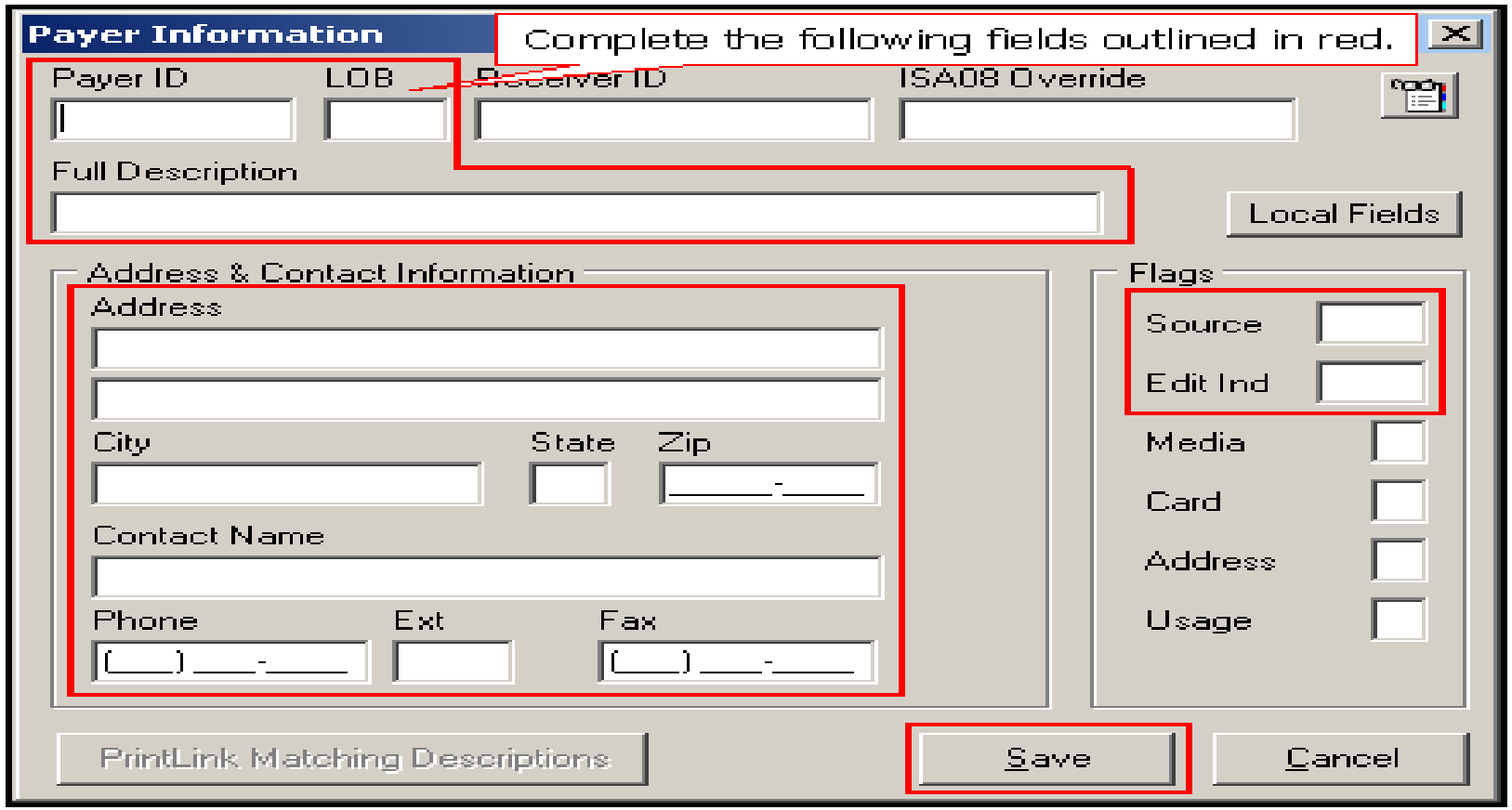
Billing Medicare Part A Claims Using PC-ACE Pro32

- Payer File Setup
- Entering MSP Claim Data

Payer File Set Up

- Select **Reference File Maintenance** from PC-ACE Pro32 Main Toolbar.
- Select the **Payer** tab.
- Click on the **New** button.
- Complete the fields on **Payer Information** screen.
- Select **Save**.

Entering Payer File Set Up in PC-ACE Pro32

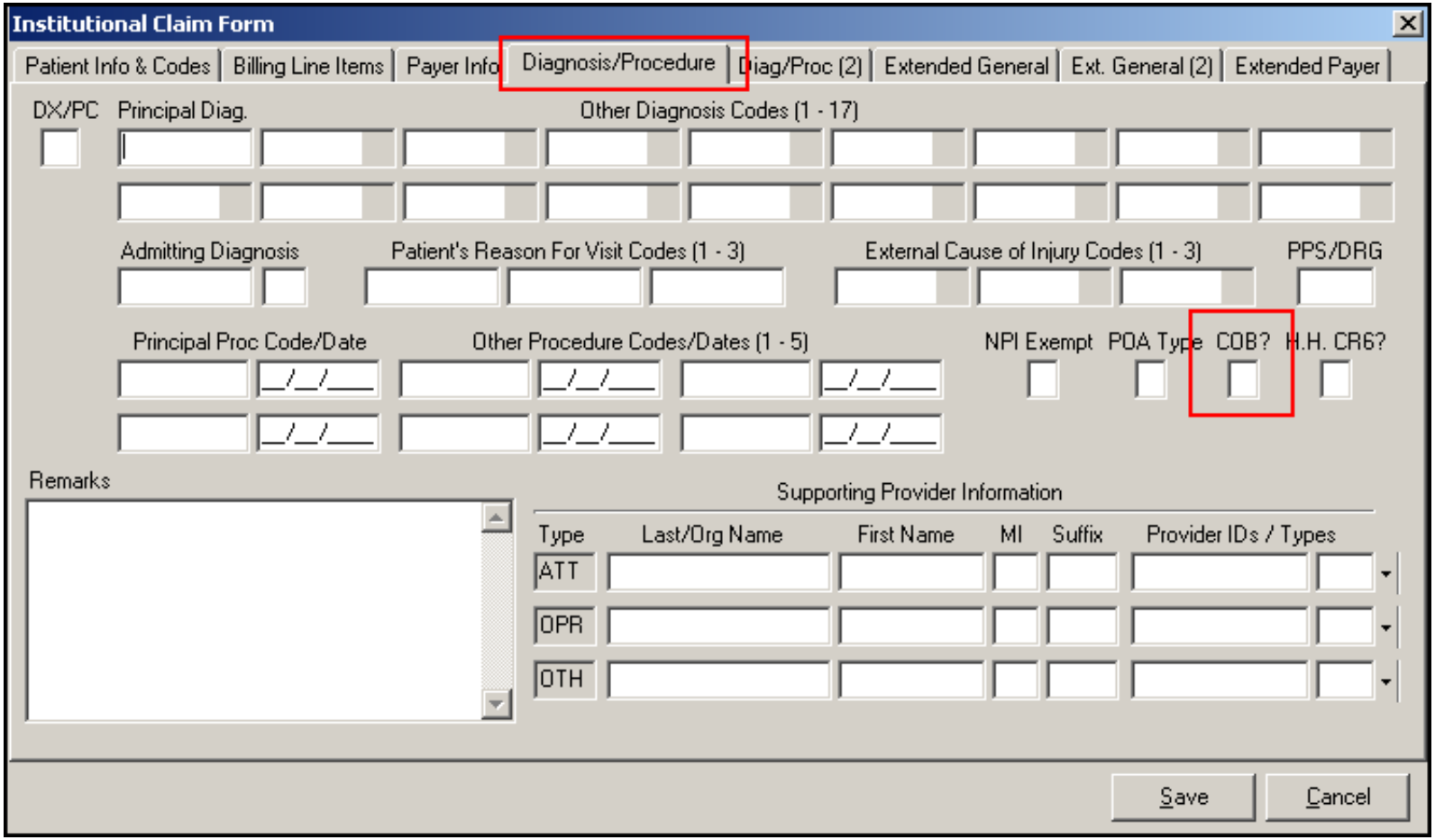


Entering MSP Claim Data

Before entering claim data, an MSP tab must be created in your claim file.

- Open a new claim in your Inst. Claim form.
- On the Diagnosis/Procedure tab, enter a Y in the blank field under ‘COB?’.
  - This will create a MSP/COB tab under your Billing Line Items
- Proceed with claim creation.
  - Be sure to enter appropriate data in the COB Info (Primary) fields under the Extended Payer tab.

Entering MSP Claim Data in PC-ACE Pro32



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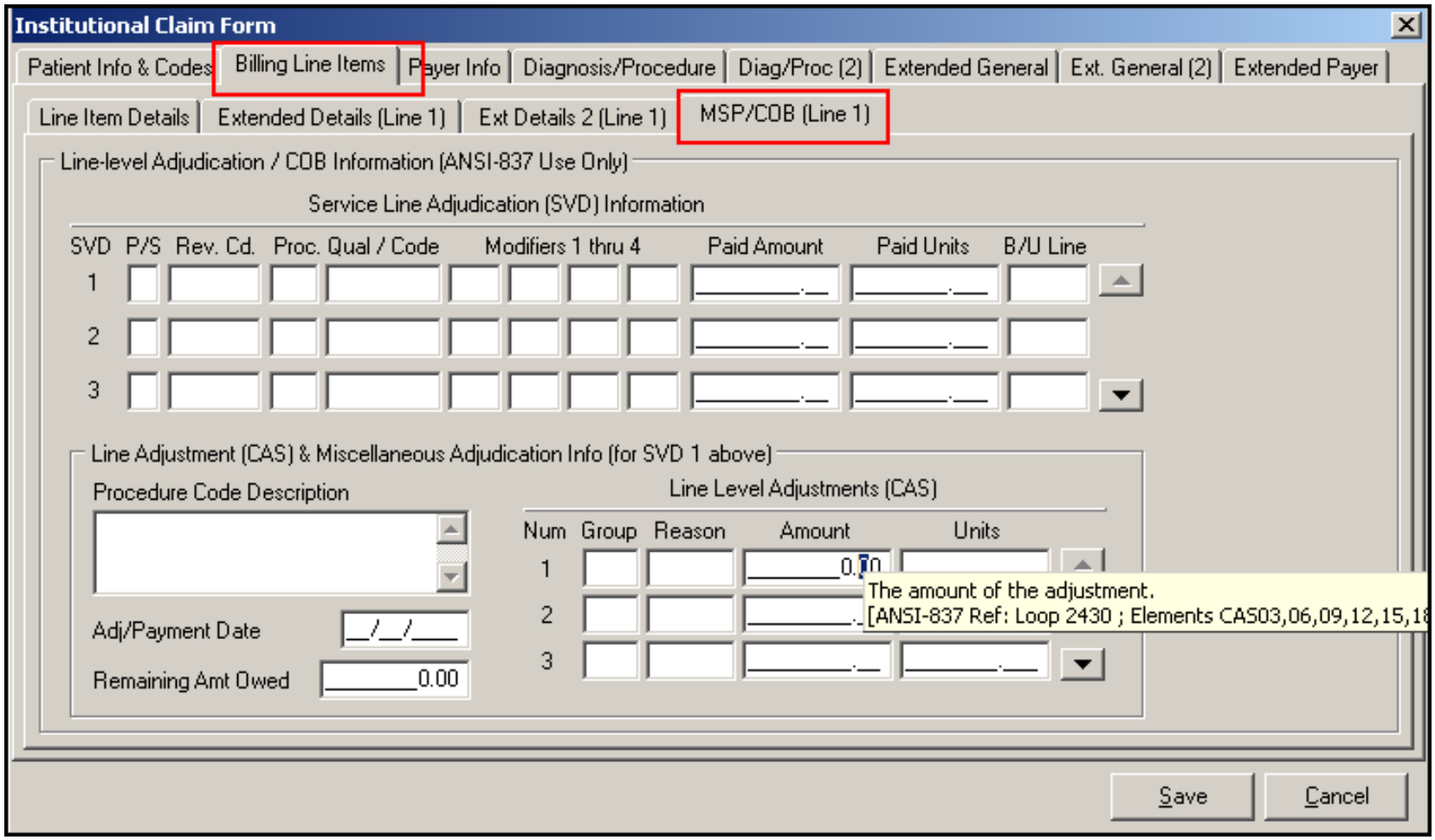
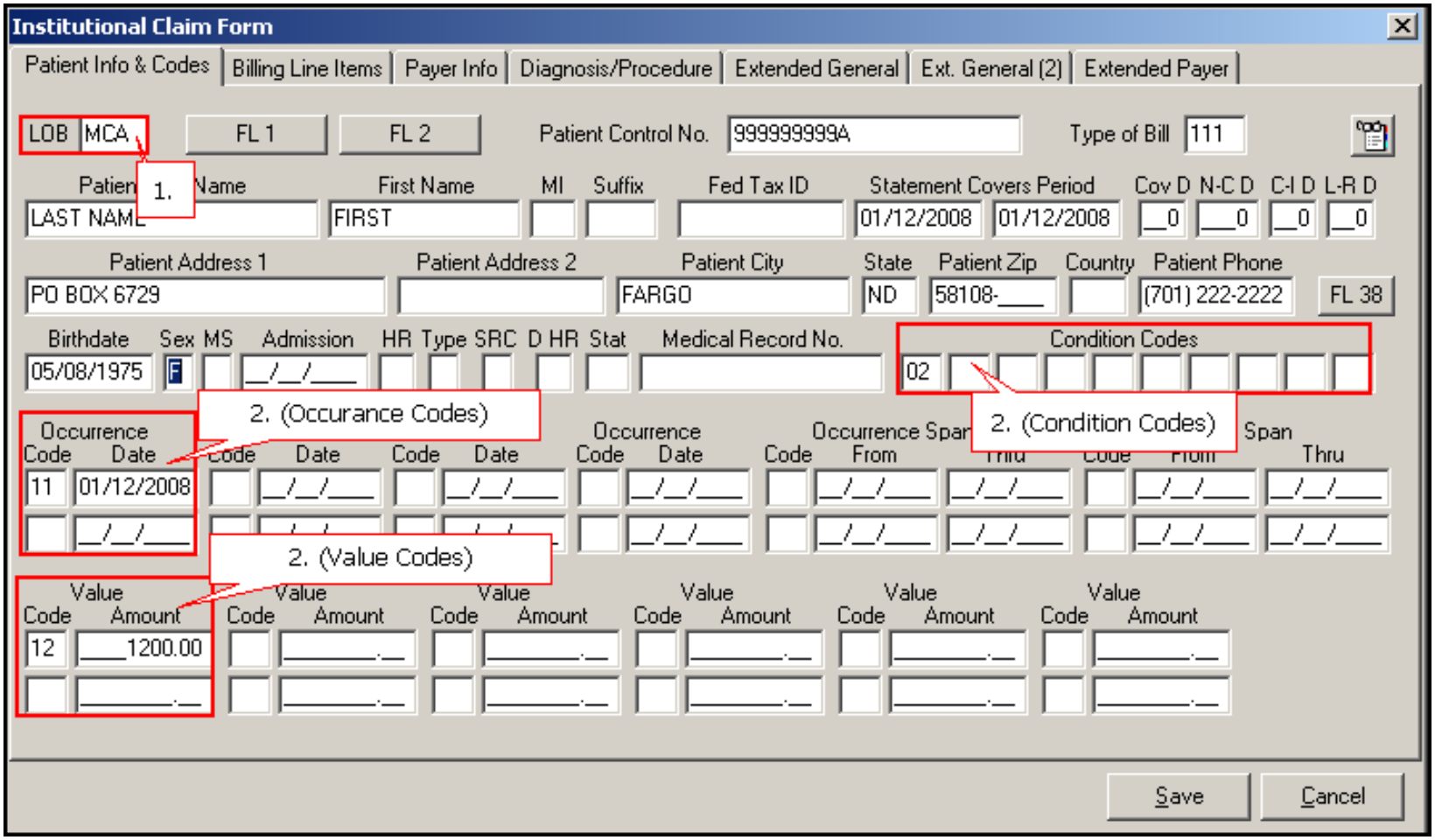
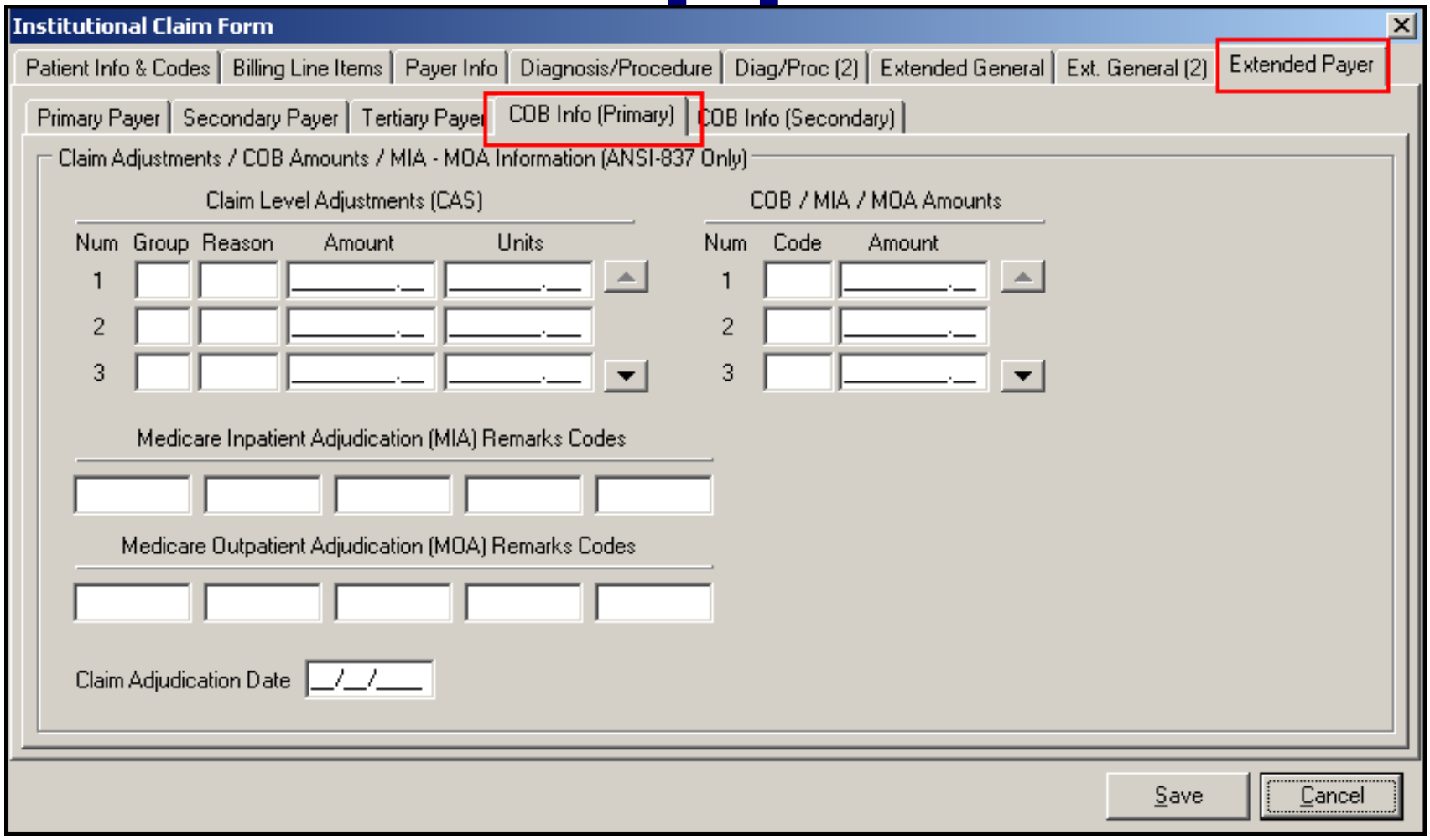


Entering MSP Claim Data in PC-ACE Pro32 [3]



Entering MSP Claim Data in PC-ACE Pro32 [4]



Claim Level – Required Information

- 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.
- For assistance with utilizing the appropriate codes contact the Part A Call Center at: 1-877-908-8437

Claim Level – Required Information [2]

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’

Claim Level – Required Information [3]

- The CAS segment in the 2320 loop should be used to report prior payers claim level adjustments that caused the amount paid to differ from the amount originally charged. This segment should be 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)

Claim Level – Required Information [4]

- 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

Claim Level – Required Information [5]

NOTE:

EDI Support Services is able to provide assistance with the location of the CAS segments within the electronic file. However, EDISS is unable to provide a Claim Adjustment Reason Code to submit in the CAS segments. That information needs to be located on the remit provided by the primary insurer.

For information on adjustment reason codes please visit WPC services at http://www.wpc-edi.com. On the left hand side of the home page, click on code lists under the "Health Care" title and select 'Claim Adjustment Reason Code'.

Claim Level – Required Information [6]

AMT Segments – 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)

Claim Level – Required Information [7]

- AMT01 = ‘C4’ indicating Prior Payment - Actual
- AMT02 = Monetary Amount
- AMT*T3*126~ (example)
- AMT01 = ‘T3’ indicating Total Submitted Charges
- AMT02 = Monetary Amount

Claim Level – Required Information [8]

- 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).

Service Level – Required Information

- SVD Segment – Line Adjudication
- Line adjudication information should be provided if the service line has adjustments applied by the primary payer. This information should be 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

Service Level – Required Information [2]

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

Note: The CAS segments will have the same structure as at the claim level.

Additional Resources

- EDI Website (www.edissweb.com)
  - Training and Help Page
    - Billing Guides Section
      - Billing Medicare Secondary Payer (MSP) Claims Electronically
      - Medicare Secondary Payer (MSP) ANSI Specifications

Medicare Secondary Payer (MSP) Overview
Question & Answer Session

Thank you for attending!

Medicare Secondary Payer (MSP) Overview

Phone: 1-800-967-7902
Fax: 1-877-269-1472
Email: support@edissweb.com
Website: www.edissweb.com