EDI Support Services

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

This document describes required MSP/tertiary 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, ABILITY|PC-ACE. If you are not an ABILITY|PC-ACE 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.

In this document:

- Required ANSI X12 Fields
- Billing MSP Claims Using ABILITY|PC-ACE
- Billing Tertiary Claims Using ABILITY|PC-ACE

Required ANSI X12 Fields

The basic principle behind filing a 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, secondary and tertiary 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, S for secondary or T for tertiary.

Syntax of the SBR Segment in 2000B loop for MSP (secondary payer information):

Example: 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

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

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):

Example: 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

Note: *For a tertiary claim, both the primary and secondary payer information would be located in the 2320 loop with Medicare as the tertiary in the 2000B loop.*

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 the 2300 loop:

Value codes

Example: HI*BE>12>>>1287.14

HI01:01 = 'ABE' 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

Note: If the claim is tertiary, an additional value code would be entered for the secondary payer. If both the primary and secondary payer indicate the same value code, add the total amounts paid together.

Condition Codes (if applicable)

Example: HI*BG>02

HI01:01 = 'BG' indicating Condition Code
HI01:02 = '02' condition code representing 'Condition is employment related'

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

Occurrence Codes (if applicable)

Example: 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 ABILITY|PC-ACE

When ABILITY|PC-ACE is used to bill an MSP claim the primary payer paid information is entered in several different fields.

Prior to entering claims in ABILITY|PC-ACE, the beneficiary should be built into the Patient Reference File Maintenance.

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.

Institutional Claim Form
Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer
LOB MCA FL 1 FL 2 Patient Control No. Type of Bill
Patient Last Name First Name MI Suffix Fed Tax ID Statement Covers Period
Patient Address 1 Patient Address 2 Patient City State Patient Zip Country Patient Phone FL 38
Birthdate Sex MS Admission A-Hour Typ Src D-Hour Stat Medical Record No. Condition Codes
Occurrence Code Date | Occurrence Code Date | Occurrence Code Date | Occurrence Code Date | Occurrence Span Code From Thru | Occurrence Span Code From Thru
Value Code Amount | Value Code Amount | Value Code Amount | Value Code Amount | Value Code Amount | Value Code Amount
UB-04 Data is copyright 2019 American Hospital Association (AHA).
Save Cancel

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

Payer Info Tab

Verify that the information that populated on the Payer Info Tab is accurate. This information is populated based on what was entered in the Patient Reference File Maintenance.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

Sub	Payer ID	Payer Name	Provider No.	ROI	AOB	Prior Payments	Amount Due	
☐						0.00	0.00	Clear Payer
☐						.	.	Clear Payer
☐						.	.	Clear Payer
			Due From Patient >>			0.00	0.00	

P.Rel	Insured's Last/Org Name	First Name	MI	Suffix	Insured's ID	Group Name	Group Number

Authorization Code / Type		ESC	Employer Name

Save | Cancel

Diagnosis/Procedure Tab

Enter Y in the COB field. This will trigger additional required MSP tabs to populate within the instructional Claim Form.

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

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.

Syntax of 2430 loop SVD segment for Line Adjudication Information:

Example: SVD*00813*48*HC>99213**1~

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.

Syntax of 2430 loop CAS segment for Line Adjustment Information:

Example: CAS*CO*42*10*1*16*5*1~

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

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 Segment – Date Primary Claim Paid

Syntax of 2430 loop DPT segment for Line Check or Remittance date:

Example: DTP*573*D8*20040203~

DTP01 = indicates Date/Time Qualifier
DTP02 = Indicates Date Time Period Format Qualifier
DTP03 = indicates Date Time Period

Billing Line Items/MSP COB (Line 1) Tab

1. Service Line Adjudication (SVD) Information – Enter the line adjudication information for the primary payer
2. Line Level Adjustment – List the primary payer's CAS Segment
3. Adj/Payment Date – Add the primary payer's remittance date

Note: *This tab will need to be completed for each additional service line located on the Billing Line Items/Line Item Details tab.*

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

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 Coordination of Benefits (COB) Payer Paid Amount:

Example: AMT*D*60~

AMT01 = 'D' Amount Qualifier Code
AMT02 = Monetary Amount

Note: *If the claim contains only one service line, the primary payer adjustments can be reported in the 2320 loop.*

Extended Payer/COB Info (Primary) Tab

On the Extended Payer/COB Info (Primary) tab enter the AMT COB Payer Paid Amount for the primary payer under the COB/MIA/MOA Amounts.

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

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

Claim Adjustments / COB Amounts / MIA - MOA Information (ANSI-837 Only)

Claim Level Adjustments (CAS)

Num	Group	Reason	Amount	Units
1				
2				
3				

COB / MIA / MOA Amounts

Num	Code	Amount
1		
2		
3		

Medicare Inpatient Adjudication (MIA) Remarks Codes

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date __/__/____

Save Cancel

Billing Tertiary Claims Using ABILITY|PC-ACE

When ABILITY|PC-ACE is used to bill a tertiary claim the secondary payer paid information is entered in several different fields.

The tertiary claim would be built as the the secondary was above with the addition of the secondary payer paid informtaion outlined below.

Payer Info Tab

Verify that the information that populated on the Payer Info Tab is accurate. This information is populated based on what was entered in the Patient Reference File Maintenance.

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

Sub | Payer ID | Payer Name | Provider No. | ROI | AOB | Prior Payments | Amount Due

0.00 | 0.00 | Clear Payer

Clear Payer

Clear Payer

Due From Patient >> 0.00 | 0.00

P.Rel | Insured's Last/Org Name | First Name | MI | Suffix | Insured's ID | Group Name | Group Number

Authorization Code / Type | ESC | Employer Name

Save | Cancel

Billing Line Items/MSP COB (Line 1) Tab

1. Service Line Adjudication (SVD) Information – Enter the line adjudication information for the secondary payer
2. Line Level Adjustment – List the secondary payer's CAS Segment
3. Adj/Payment Date – Add the secondary payer's remittance date

Note: *This tab will need to be completed for each additional line of service located the Billing Line Items/Line Item Details.*

Billing Part A Medicare Secondary Payer (MSP) and Tertiary Claims Electronically

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

Line Item Details | Extended Details (Line 1) | Ext Details 2 (Line 1) | MSP/COB (Line 1)

Line-level Adjudication / COB Information (ANSI-837 Use Only)

Service Line Adjudication (SVD) Information

SVD P/S Rev. Cd. Proc. Qual / Code Modifiers 1 thru 4 Paid Amount Paid Units B/U Line

1 P

2 S

3

Line Adjustment (CAS) & Miscellaneous Adjudication Info (for SVD 2 above)

Procedure Code Description

Line Level Adjustments (CAS)

Num Group Reason Amount Units

1

2

3

Adj/Payment Date __/__/____

Remaining Amt Owed 0.00

Save Cancel

Extended Payer/COB Info (Primary) Tab

On the Extended Payer/COB Info (Secondary) tab, enter the AMT COB Payer Paid Amount for the secondary payer under the COB/MIA/MOA Amounts.

Institutional Claim Form

Patient Info & Codes | Billing Line Items | Payer Info | Diagnosis/Procedure | Diag/Proc (2) | Extended General | Ext. General (2) | Extended Payer

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

Claim Adjustments / COB Amounts / MIA - MOA Information (ANSI-837 Only)

Claim Level Adjustments (CAS)

Num Group Reason Amount Units

1

2

3

COB / MIA / MOA Amounts

Num Code Amount

1

2

3

Medicare Inpatient Adjudication (MIA) Remarks Codes

Medicare Outpatient Adjudication (MOA) Remarks Codes

Claim Adjudication Date __/__/____

Save Cancel