

PC-ACE CEDI Medicare Second Payer Help Document

I) Introduction

This document is intended as a help guide for setting up a Medicare as Second Payer (MSP) claim in the PC-ACE software. It is not intended to replace the general help (accessible by the F1 key) or specific item help (accessible by right-clicking or hitting the F2 key on a specific item) functions, or the PC-ACE User Manual itself. For help with any questions not covered here, please consult these documents.

In addition, CEDI technical support staff are not trained in billing, MSP or otherwise. The information in this document is accurate to the best of our knowledge, but there may be specifics required for billing that we are unaware of. If you have questions on how to bill MSP claims, contact the jurisdiction that will be processing the claims for payment.

II) Setup

Setting up the Payers (Insurances)

The **Payer** tab on the **Reference File Maintenance** menu is where to set up the insurances that will be used in the software. By default, all Medicare Payer IDs that are valid for this build of PC-ACE are listed here.

The screenshot shows the 'Reference File Maintenance' window with the 'Payer' tab selected. The window contains a table with the following data:

Payer ID	LOB	Description	State	Usage
13282	MCB	MEDICARE PART B - NY (HEALTHNOW)		Prof Only
13292	MCB	MEDICARE PART B - NY (GHI)		Prof Only
16003	MCB	DME MAC JURISDICTION A		Prof Only
17003	MCB	DME MAC JURISDICTION B		Prof Only
18003	MCB	DME MAC JURISDICTION C		Prof Only
19003	MCB	DME MAC JURISDICTION D		Prof Only

Below the table, there are sorting options: 'Sort By:' with radio buttons for 'Payer ID' (selected), 'Payer Description', 'Payer LOB', and 'Payer State'. There are also 'List Filter Options' with radio buttons for 'Show all payers (no filter applied)', 'Filter list to include Payer IDs starting with', and 'Filter list to include Payer Names starting with'. At the bottom, there are buttons for 'New', 'View/Update', 'Copy', 'Delete', and 'Close'.

To add a non-Medicare insurance, for Medicare as Secondary Payer (MSP) purposes, select **New** to add the payer ID.

Payer Information

Payer ID	LOB	Receiver ID	ISA08 Override
55002	COM		

Full Description
AMERICAN INCOME LIFE INSURANCE COMPANY

Address & Contact Information

Address
[]
[]

City State Zip
[] [] []

Contact Name
[]

Phone Ext Fax
[] [] []

Flags

Source C

Media E

Usage H

PrintLink Matching Descriptions Save Close

Notes on the **Payer Information** screen

- 1) **Payer ID** needs to be
 - a. A valid Coordination of Benefits Agreement (COBA) ID obtained from the Coordination of Benefits Contractor or from the CMS Web site at www.cms.hhs.gov/COBAgreement/.
 - b. A five digit Payer ID obtained from the second insurance company
 - c. A gap-fill ID of XXXXX for cases where a Payer ID is not available
- 2) **LOB** (line of business)
 - a. Use the right click or F2 key lookup function for valid entries
 - b. Most Primaries will likely be **COM** for Commercial insurance
 - c. Some entries may trigger edit validation errors
 - d. The **Payer ID** and **LOB** (line of business) combination must be unique
 - i. Every effort to obtain a valid Payer ID should be made, as multiple entries for the gap-fill ID XXXXX will likely not work
- 3) Use the right click or F2 key lookup function to fill out the other fields indicated in the screenshot above.
- 4) Fields that are blank in the screenshot should only have data entered at the direction of CEDI technical support.

Medicare as Secondary Payer (MSP) Patient Setup

The **Patient** tab of the **Reference File Maintenance** menu is where patient information is added. There are two ways to establish that a patient is a Medicare as a Secondary Payer (MSP) patient, indicating that they have an insurance primary to Medicare.

- 1) Enter the non-Medicare insurance data as the **Primary Insured (Prof)**
 - a. Medicare is listed as the **Secondary Insured (Prof)** in this case
 - b. A validation edit may fire indicating the Billing Provider line of business (LOB) does not match the Primary Payer LOB
 - i. This error is a non fatal error
 - ii. Select **Save With Errors** to override the edit

- iii. When entering a claim, the Billing Provider will most likely have to be selected manually
- 2) Enter the non-Medicare (true primary) insurance information as **Secondary Insured (Prof)**
 - a. Medicare would be listed as the **Primary Insured (Prof)** in this case
 - b. This will avoid Validation Edits for a mismatched Payer and Billing Provider line of business.
 - c. When entering claims, the Billing Provider will be automatically selected if it is entered on the **Extended Info** tab.
 - d. Warning: During claims entry, special care is needed to make sure the correct insurance and insured ID is listed for both payers.

Medicare does not allow tertiary insurance claims; this tab should be left blank.

III) Claims Entry

Claims entry instructions here are designed to supplement general claims entry instructions. In other words, this document shows the parts that are extra for MSP claims entry.

The screenshot shows the 'Professional Claim Form' interface with the following data entered:

- LOB: MCB
- Billing Provider: 1131490001
- 26 - Patient Control No.: CARTWRCHRI
- 2 - Patient Last Name: CARTWRIGHT
- First Name: CHRISTOPHER
- MI: [] Gen: []
- 3 - Birthdate: 08/24/1916
- Sex: M
- 8 - Pat. Status: MS [] ES [] SS []
- Death Ind: []
- 12 - SDF: B
- Legal Resp: N
- NPI Exempt: []
- 5 - Patient Address 1: 1193 JEFFERSON CT
- Patient Address 2: []
- Patient City: INDIANAPOLIS
- State: AZ
- Patient Zip: 46250- []
- Country: []
- Patient Phone: []
- 10 - Patient Condition Related To: Employment [N] Accident []
- ROI: [] ROI Date: []
- Other Ins. 14 - Date/Ind of Current: []
- 15 - First Date: []
- 16 - UTW/Disability Dates & Type: [] to []
- 17 - Referring Phys Name (Last/Org, First, MI, Suffix): []
- Referring Phys IDs/Types: []
- 18 - Hospitalization Dates: [] to []
- 20 - Outside Lab/Chgs: [] Y/N [] 0.00
- 19 - Reserved For Local Use: []
- 22 - Medicaid Resubmission Code & Ref No: []
- 25 - Fed. Tax ID: 860347659
- SSN/EIN: E
- 27 - Provider Accepts Assignment?: [C]
- PIN No.: 1131490001
- 31 - Provider SDF: N
- Date: []/[]/[]
- Facility?: []
- Dental?: []
- COB?: Y (circled in red)
- Frequency: []
- 33 - GRP No.: []

Notes on the **Patient Info & General** tab:

- 1) Along the bottom row is an entry for **COB?**.
- 2) Enter a **Y** here to bring up COB tabs for entering Medicare as Secondary Payer, or MSP, claims.

Notes on the **Insured Information** tab:

- 1) For Medicare as Secondary Payer (MSP) claims where patient information was entered with Medicare as the **Primary Insured (Prof)** and the true primary insurance company was listed as the **Secondary Insured (Prof)**
 - a. Use the right-click or F2 lookup functions to put the primary (non-Medicare) insurance on the first line and the Medicare payer on the second line.
 - b. Make sure the correct **Insured ID** is on the correct line for the correct insurance.

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c TS	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	EP	FP	EM	CB	AT	Rendering Phys.
1	06/01/2008	06/30/2008	12		B4185			1	50.00	1.0						C
2																
3																
4																
5																
6																

28 - Total Charge 50.00 Recalculate
29 - Amount Paid 0.00 30 - Balance Due 50.00

Entering **Charges** and **Units** for MSP claims:

- 1) The item charge will be the actual cost of the item, not the remainder after the primary has paid.
- 2) Example: Item costs \$200 and primary paid \$145. Charges entered would be \$200.

The screenshot shows the 'Professional Claim Form' window with the 'Billing Line Items' tab selected. The sub-tab is 'MSP/COB (Line 1)'. The interface includes the following sections:

- Common Line MSP Amounts:** A list of input fields for 'Approved', 'Allowed', 'Deductible', 'Co-Insurance', 'Primary Paid', 'OTAF', 'Disallow Cost', and 'Disallow Other', all currently set to 0.00.
- Service Line Adjudication (SVD) Information:** A table with columns: SVD, P/S, Proc, Qual / Code, Modifiers 1 thru 4, Paid Amount, Paid Units, and B/U Line. Row 1 contains: P, HC, B4185, [blank], [blank], 25.00, 1.000, [blank].
- Line Level Adjustments (CAS):** A table with columns: Num, Group, Reason, Amount, and Units. Row 1: 1, PR, 2, 20.00, 0.000. Row 2: 2, CO, 45, 5.00, 0.000.
- Procedure Code Description:** A dropdown menu.
- Adj./Payment Date:** 07/01/2008.

Buttons at the bottom include 'Error List', 'Save With Errors', 'Save', and 'Cancel'.

Notes on the **Billing Line Items** sub tab labeled **MSP/COB (Line #)**:

- 1) This tab is only available if the **COB?** field on the **Patient Info & General** tab is a **Y**.
- 2) Data is entered on this tab if the adjustments reported by the primary insurance were made on a charge line by charge line basis.
- 3) If the adjustments were reported as a sum total for the claim, this area will not be filled in.
- 4) Each charge line on a claim will have a separate tab.
- 5) **Common Line MSP Amounts**
 - a. Most of these fields were primarily used to report data in older claims formats.
 - b. **Approved** and **OTAF** (Obligated to Accept as Full payment) are the only fields in this group that should be filled out.
 - i. Approved is the amount the primary approved for payment consideration on this line.
 - ii. The OTAF should be filled out if the supplier has an agreement with the primary insurance to accept their allowed amount as full payment on the claim.
 1. This should only be completed if the supplier has agreed to accept this amount as full payment.
 2. The OTAF is not required if there is no agreement to accept the Approved amount as full payment.
- 6) **Service Line Adjudication (SVD) Information**
 - a. **P/S** will always be **P** for Primary
 - b. **Proc. Qual / Code**
 - i. The qualifier will be **HC** for HCPCS codes.
 - ii. The code will be the HCPCS procedure code.
 - c. Enter modifiers as needed
 - d. **Paid Amount** is how much the primary insurance actually paid.
 - e. **Paid Units** is required.
- 7) **Line Level Adjustments (CAS)**
 - a. These are used to explain the difference between what the item cost and what the primary insurance paid.

- b. MSP claims have to balance in order to be saved.
 - i. Entering CAS information in both claim and line level CAS entries will most likely produce balancing errors.
 - ii. Because of this, be sure to enter CAS information only at one level, either claim or line, and not both.
 - iii. For line level balancing, the formula is Item Charge = Primary Paid Amount for Item + all adjustments. In other words, Item Charge minus Primary Paid Amount for the Item equals the dollar amount that needs to be explained in this section.
 - iv. Multiple CAS segments may be (and usually are) required to explain the difference between the item charge and the primary paid amount for the item.
- c. **Group** codes
 - i. These are available by right-clicking or using the F2 key lookup utility.
 - ii. Primary insurance explanation of benefits (EOBs) should list these codes, but not all do.
 - iii. You may have to select the most appropriate one on this list that matches what was actually sent.
- d. **Reason Codes**
 - i. In PC-ACE, claim adjustment reason codes are maintained under the **Reference File Maintenance** tab for **Codes/Misc**.
 - ii. Codes sometimes change usage.
 - iii. To confirm current usage, or see the dates when codes became effective or were discontinued, check the current list on the internet at www.wpc-edi.com, under HIPAA Code Lists
 - iv. Primary insurance EOBs should list these codes, but not all do.
 - v. You may have to select the most appropriate one on this list that matches what was actually sent.
- e. **Amount**
 - i. This is the dollar amount that was subtracted from the item cost for this reason code.
 - ii. Example: The primary EOB indicates the patient owes a \$20 copay. 20 is entered as the dollar amount.

8) **Adj/Payment Date**

- a. This is used to indicate the date the primary insurance adjudicated the claim.
- b. This date is required either at line level or claim level.

Notes on the **Ext. Payer/Insured** tab:

- 1) The **COB Info (Primary)** tab is used to indicate claim level Medicare as Secondary Payer (MSP) information.
 - a. **Insurance Type** is required. Use the right-click or F2 lookup feature for a valid list of entries.
 - b. **OTAF** is the only other field under **Common Payer MSP Information** that is required in the current claims format.
 - i. The OTAF should be filled out if the supplier has an agreement with the primary insurance to accept their allowed amount as full payment on the claim.
 1. This should only be completed if the supplier has agreed to accept this amount as full payment.
 2. The OTAF is not required if there is no agreement to accept the Approved amount as full payment.
- 2) **Claim Level Adjustments (CAS)**
 - a. These are used to explain the difference between what the total claim charge was and what the primary insurance paid.
 - b. MSP claims have to balance in order to be saved.
 - i. Entering CAS information in both claim and line level CAS entries will most likely produce balancing errors.
 - ii. Because of this, be sure to enter CAS information only at one level, either claim or line, and not both.
 - iii. For claim level balancing, the formula is Total Claim Charge = Primary Paid Amount for Claim + all adjustments. In other words, Total Claim Charge minus Primary Paid Amount for the Claim equals the dollar amount that needs to be explained in this section.
 - iv. Multiple CAS segments may be (and usually are) required to explain the difference between the total claim charge and the primary paid amount for the claim.
 - c. **Group** codes
 - i. These are available by right-clicking or using the F2 key lookup utility.

- ii. Primary insurance EOBs should list these codes, but not all do.
- iii. You may have to select the most appropriate one on this list that matches what was actually sent.

d. **Reason Codes**

- i. In PC-ACE, they are maintained under the **Reference File Maintenance** tab for **Codes/Misc**.
- ii. Codes sometimes change usage.
- iii. To confirm current usage, or see dates when codes became effective or were discontinued, check the current list on the internet at www.wpc-edi.com, under HIPAA Code Lists
- iv. Primary insurance EOBs should list these codes, but not all do.
- v. You may have to select the most appropriate one on this list that matches what was actually sent.

e. **Amount**

- i. This is the dollar amount that was subtracted from the total claim charge for this reason code.
- ii. Example: The primary EOB indicates the patient owes a \$20 copay. 20 is entered as the dollar amount.

3) **COB / MOA Amounts**

- a. Use the right click or F2 lookup features to select the correct value for the **Code**
 - i. **D** for Primary Paid is required on all MSP claims, and is used to report the total amount the Primary Insurance paid on the claim
 - ii. **B6** for Primary Allowed is another required claim level amount
 - iii. Other codes on this list may be required in different situations.

4) **Adj/Payment Date**

- a. This is used to indicate the date the primary insurance adjudicated the claim.
- b. This date is required either at line level or claim level.

The **COB Info (Secondary)** tab is not used for Medicare DME.