

PC-ACE Pro32 Medicare as Secondary Payer (MSP)

This document is meant to assist in setting up and building a Medicare as Secondary Payer claim. This document includes:

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This document is intended as a help guide for setting up a Medicare as Secondary Payer (MSP) claim in the PC-ACE Pro32 software. It is not intended to replace the general help (accessible by the F1 key) or specific item help (accessible by right-clicking or selecting the F2 key on a specific item) functions, or the PC-ACE Pro32 User Manual itself. For help with any questions not covered here, please consult these documents.

In addition, the CEDI technical support staff is not trained in billing. 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.

PC-ACE Pro32 was designed for both Institutional (Medicare Part A, or hospital) and Professional (Medicare Part B, or office visits, and Durable Medical Equipment, or DME) billing. Since this is a DME support document, we will not be covering Medicare Part A or Part B functions.

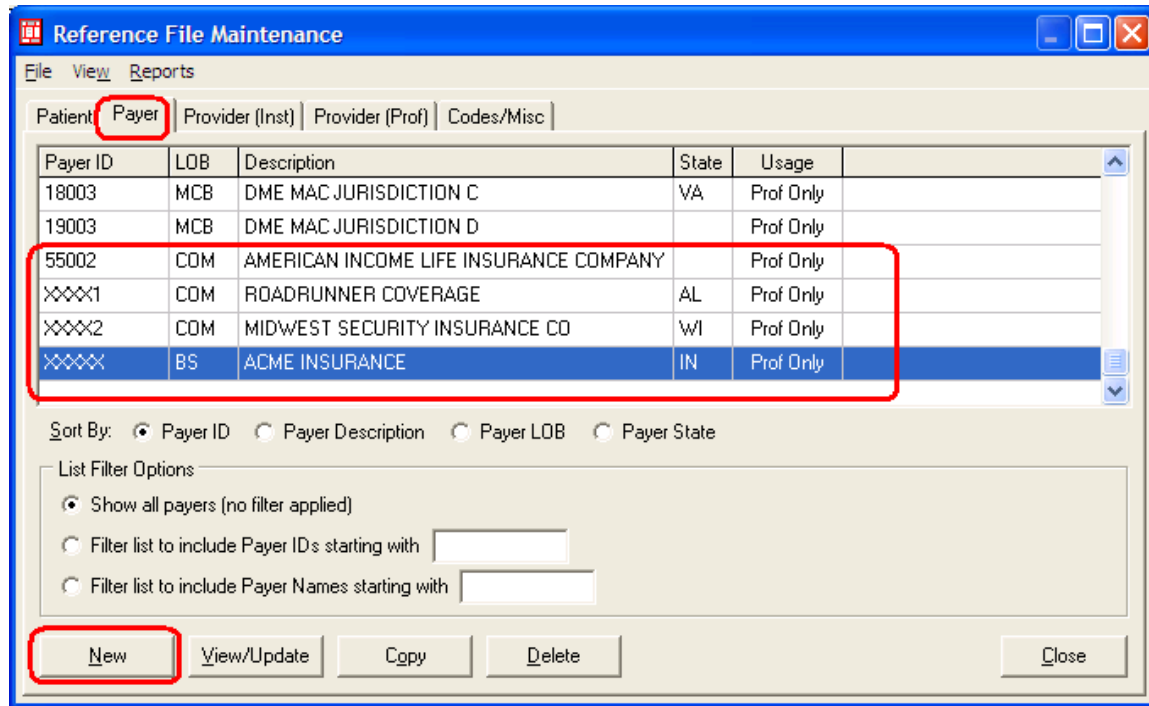
If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Payers (Insurance) Setup

When entering a Medicare as Secondary Payer (MSP) claim in PC-ACE Pro32, the first step is to verify that the primary insurance is loaded into the software. To check this, go to “Reference File Maintenance,” and the “Payer” tab. The insurance should be listed with the “Usage” set to “Prof Only.”

If the primary is already on the list, you can proceed directly to “Patient Selection.”

If it is not on the list, the primary insurance will have to be added. Select the “New” button in the lower left.



This will produce the “Payer Information” screen (see a completed example below):

Payer Information Screen:

The screenshot shows a software window titled "Payer Information". It contains several input fields and sections:

- Payer ID:** A text box containing "XXXXX".
- LOB:** A dropdown menu with "COM" selected.
- Receiver ID:** An empty text box.
- ISA08 Override:** An empty text box.
- Full Description:** A text box containing "ACME INSURANCE".
- Address & Contact Information:**
 - Address:** A text box containing "1 E ST".
 - City:** A text box containing "INDIANAPOLIS".
 - State:** A dropdown menu with "IN" selected.
 - Zip:** A text box containing "46250-___".
 - Contact Name:** An empty text box.
 - Phone:** A text box with a format of "() ___-___".
 - Ext:** An empty text box.
 - Fax:** A text box with a format of "() ___-___".
- Flags:** A section with three dropdown menus:
 - Source:** A dropdown menu with "CI" selected.
 - Media:** A dropdown menu with "E" selected.
 - Usage:** A dropdown menu with "H" selected.

At the bottom of the window, there are three buttons: "PrintLink Matching Descriptions", "Save", and "Close".

Note: Only the fields entered in the example above should be filled in.

Payer ID: This is a five character identification number used to identify the payer, or insurance company, in electronic transactions. This field is required, but the primary insurance may not have a Payer ID. The field has to have a unique entry for every insurance company entered into PC-ACE Pro32. It is recommended that the real Payer ID be obtained, if possible, from the primary insurance. If it is not possible to obtain that ID, enter the payer ID for the first insurance as XXXXX, with subsequent insurances entered as XXXX1, XXXX2, etc. These values are not important in the Medicare processing system, but are required in the electronic claims format. Instead, the name of the primary insurance is used by the payment systems to confirm that it went to the correct primary.

LOB: This is the abbreviation for Line of Business. It identifies what type of insurance company the primary was, and will most likely be COM for commercial, or BS for Blue Shield.

Full Description: This is the name of the primary insurance, and it is used to confirm the claim was submitted to the correct primary insurance in the Medicare payment systems. The address should be entered for the primary insurance after the "Full Description."

Flags: These control how the software makes use of the payer entry.

- **Source:** This is also used to identify the type of insurance, and will most likely be CI for commercial insurance or BL for Blue Cross/Blue Shield. Right-click on this field to be sure that the correct entry is being selected.
- **Media:** This is used to determine how this insurance will be used for claim billing. Use the F2 look-up feature to select E for electronic or P for paper.
- **Usage:** This controls when the insurance will be displayed as an option during the entry of patient information. Select H to limit the payer to Professional claims only.

Once the insurance is loaded, click the Save button and close Reference File Maintenance.

Patient Selection and Setup

Open the “Professional Claims Processing” menu and select “List Claims” to enter the claim management area. Click on the “New” button in the lower left corner to enter a new claim. This will pop up a blank “Professional Claim Form”. Right-click in either “Patient Control Number” or “Patient Name” to bring up the “Patient Selection” screen.

If the patient is listed already, highlight them, click on the “Select” button, and proceed to “Claim Entry.”

If the patient is not listed, click on the “New” button in the lower left corner to bring up the “Patient Information” tabs. The “General Information” tab will be filled in the same as it would be for a Medicare Primary claim. The “Primary Insured (Prof)” tab will be the information for the primary, or non-Medicare, insurance. The following is an example of what the information may look like.

Setting up the Patient’s Insurance Information

The screenshot shows a software window titled "Patient Information" with a blue header and a close button (X) in the top right corner. The window has several tabs: "General Information", "Extended Info", "Primary Insured (Inst)", "Primary Insured (Prof)", and "Secondary Insured (I)". The "Primary Insured (Prof)" tab is currently selected. The form contains the following fields and values:

Field	Value
Payer ID	XXXX2
Payer Name	MIDWEST SECURITY INSURANCE
LOB	COM
Group Name	TEST GROUP INC.
Group Number	MI00000
Claim Office	
Insured Information (F7)	Rel: 18, Last Name: DOE, First Name: JOHN, MI: , Gen: , Insured ID: MI0213
Employer Information (F8)	Address: 1234 CHERRY TREE LN, Sex: M, Assign of Benefits: Y, Release of Info: Y, City: MELVIN, State: MI, Zip: 48454-__, DOB: 01/01/1901, Employ Status: 9, ROI Date: __/__/__, Retire Date: __/__/__, Country: , Phone: ()__-__

At the bottom of the window, there are "Save" and "Cancel" buttons. A "Clear All Fields For Insured" button is also present near the top right of the form area.

Right-click in the “Payer ID” field to select the primary insurance. This should fill in the “Payer Name” and “LOB” fields, based on what was entered in the “Payer” tab of “Reference File Maintenance.”

“Group Name” and “Group Number” should be entered based on what is present on the patient’s ID card for the primary insurance. If these fields are not on the card, they may be left blank.

Insured Information: The “Rel” field should be selected by right-clicking on the box and selecting the appropriate code for the patient’s relationship to the actual policyholder. Thus, if the primary insurance is under the spouse’s name, 01 would be selected, as an example. The required fields above will need to be entered for the policyholder.

If 18 (for Self) is selected, the name, address information, and other general information fields will automatically populate from the “General Information” tab. Two of the fields will not fill in automatically even if 18 (Self) is selected. These will need to be entered manually.

Insured ID: This is the identification number used by the primary insurance to identify the patient.

Assign of Benefits: This indicates whether or not the patient has authorized payment to the provider.

Now go to the “Secondary Insured” tab. It should look like this:

The screenshot shows a software window titled "Patient Information" with a blue header and a close button (X) in the top right corner. The window has several tabs: "General Information", "Extended Info", "Primary Insured (Inst)", "Primary Insured (Prof)", and "Secondary Insured". The "Secondary Insured" tab is currently selected. The form contains the following fields and options:

- Payer Information:** Payer ID, Payer Name, LOB, Group Name, Group Number, Claim Office.
- Insured Information Options:** A group box containing two radio buttons: "Common Inst & Prof" (selected) and "Separate Inst & Prof" (circled in red).
- Clear All Fields For Insured:** A button located below the options group box.
- Insured Information (F7) | Employer Information (F8):** A section with the following fields:
 - Rel (dropdown), Last Name, First Name, MI, Gen, Insured ID.
 - Address (text area).
 - Sex (checkbox), Assign of Benefits (checkbox).
 - DOB (date field), Release of Info (checkbox).
 - City, State, Zip, Employ Status (checkbox), ROI Date (date field).
 - Country, Phone, Retire Date (date field).
- Buttons:** "Save" and "Close" buttons are located at the bottom right of the window.

This tab needs to be separated into two tabs, one for “Institutional,” and one for “Professional.” Click in the radio button for “Separate Inst & Prof” in the upper right corner of this screen to do this. The screen should now look like this:

The screenshot shows a software window titled "Patient Information" with a blue title bar and a close button. The window contains several tabs: "Primary Insured (Inst)", "Primary Insured (Prof)", "Secondary Insured (Inst)", "Secondary Insured (Prof)", and "Tertiary". The "Primary Insured (Inst)" tab is selected. The form is divided into sections: "Payer Information" (with fields for Payer ID, Payer Name, LOB, Group Name, Group Number, and Claim Office), "Insured Information (F7)", and "Employer Information (F8)". The "Insured Information (F7)" section contains fields for Rel, Last Name, First Name, MI, Gen, Insured ID, Address, Sex, DOB, Release of Info, City, State, Zip, Employ Status, ROI Date, Retire Date, Country, and Phone. The "Assign of Benefits" checkbox is also present. The "Employer Information (F8)" section is currently empty. A "Clear All Fields For Insured" button is located between the Payer and Insured sections. At the bottom of the window are "Save" and "Cancel" buttons. Four red rectangular boxes highlight the "Payer ID" field, the "Rel" radio button, the "Insured ID" field, and the "Assign of Benefits" checkbox.

This will be where the Medicare information is entered. The same four areas entered for a typical Medicare as Primary patient are entered here: Payer ID, Rel, Insured ID, and Assign of Benefits. When these are entered, it should look more like this:

Patient Information ✖

Primary Insured (Inst) | Primary Insured (Prof) | Secondary Insured (Inst) | Secondary Insured (Prof) | Terti ◀ ▶

Payer ID: 18003 Payer Name: DME MAC JURISDICTION C LOB: MCB

Group Name: Group Number: Claim Office:

Insured Information (F7) | Employer Information (F8)

Rel	Last Name	First Name	MI	Gen	Insured ID
18	DOE	JOHN			222222200A

Address: 1234 CHERRY TREE LN

Sex: M Assign of Benefits: Y

DOB: 01/01/1901 Release of Info: Y

City: MELVIN State: MI Zip: 48454-____ Employ Status: 9 ROI Date: __/__/__

Country: Phone: () ____-____ Retire Date: __/__/__

Click on the “Save” button to save the patient record. This will return the display to the “Patient Selection” screen, where the “Select” button will be clicked to choose the patient that was just entered. The “Professional Claim Form” will be displayed again, this time with the patient’s data in it.

MSP Claim Entry (Line Level)

Once the patient is selected, there are two more fields that must be entered on the “Patient Info & General” tab. They are “Patient Condition Related To Employment” and “COB?”. The “COB?” field will be entered as Y in order to turn on the MSP tabs elsewhere in the claim form. These two fields are indicated and entered in the example below:

The screenshot shows the "Professional Claim Form" window with the "Patient Info & General" tab selected. The form contains the following fields and values:

- LOB: MCB
- Billing Provider: 1111111111
- 26 - Patient Control No.: MSPTEST
- 2 - Patient Last Name: DOE
- First Name: JOHN
- MI: []
- Gen: []
- 3 - Birthdate: 01/01/1901
- Sex: M
- 8 - Pat. Status: MS [] ES [] SS []
- Death Ind: []
- 12 - SDF: B
- Legal Rep.: N
- NPI Exempt: []
- 5 - Patient Address 1: 1234 CHERRY TREE LN
- Patient Address 2: []
- Patient City: MELVIN
- State: MI
- Patient Zip: 48454- []
- Country: []
- Patient Phone: () - [] - []
- 10 - Patient Condition Related To Employment: N (circled in red)
- Accident: []
- ROI: Y
- ROI Date: 04/01/2010
- Other Ins.: 1
- 14 - Date/Ind of Current: []/[]/[]
- 15 - First Date: []/[]/[]
- 16 - UTW/Disability Dates & Type: []/[]/[] to []/[]/[]
- 17 - Referring Phys Name (Last/Org, First, Mid, 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: 101111119
- SSN/EIN: E
- 27 - Provider Accepts Assignment?: A
- PIN No.: 1111111111
- 31 - Provider SDF: Y
- Date: 01/01/2010
- Facility?: []
- Dental?: []
- COB?: Y (circled in red)
- Frequency: []
- 33 - GRP No.: []

Buttons: Save, Cancel

Proceed to the “**Billing Line Items**” tab, where the “**Line Item Details**” sub-tab will be displayed. The “**Line Item Details**” sub-tab is where the diagnosis code(s) and charge line(s) will be entered. This example will demonstrate how to enter an MSP claim with three charge lines.

Please keep in mind that CEDI does not handle questions related to medical policy or coding, and the example’s use of a diagnosis code and procedure codes without modifiers is not intended to demonstrate a payable claim. This is merely to illustrate how to enter the information in the software.

Enter the diagnosis code and **first** charge line information to get something like this:

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c EMG	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	24h EP	24h FP	24h AT	24j Rendering Phys.
1	05/01/2010	05/01/2010	12		K0823			1	5000.00	1.0				
2														
3														
4														
5														
6														

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

Diagnosis Code: The diagnosis code will be entered without the decimal. The example uses diagnosis code 344.9, but it is entered as 3449, for example.

Box 24b: This is the Place of Service. The example uses 12 for “Home,” but the proper place of service for the patient should be selected.

Box 24e: This is a pointer telling the claim to look at the row of diagnosis codes and use the one in the box indicated for this charge line. Since there is one diagnosis code in the example, 1 is entered. If two are listed in the row of diagnosis codes, valid entries in box 24e would be 1, 2, or 12.

Box 24f: This is for the total charges of the line item. This is not to be adjusted based on what the primary insurance did with the claim. It is the original item charge. Thus in the example above, the item is billed originally as a \$5,000 item.

Box 24h: This may be used if there is a Certificate of Medical Necessity (CMN), or the supplier-signed DME MAC Information Form (DIF), for this charge line. Enter a C in the box under column “AT” to have the CMN tab added to the row of sub-tabs. CMN entry will not be covered further in this document.

Once the information for Line 1 is entered, and with the cursor still flashing in the first charge line, click on the “Extended Details (Line 1)” sub-tab. This tab is where any third or fourth modifiers would be added. More importantly, on every charge line for Medicare DME, the Ordering Provider must be selected.

Right-click in the Ordering Provider name field to bring up the “Physician Setup” screen. Here you can either select a previously entered Ordering Provider or add a new Ordering Provider by selecting “New” in the bottom left corner. Use the “Select” option to add the Ordering Provider to the claim. When finished, it should look like this (the entry area for the modifiers is indicated as well, although it is not used in this example):

The screenshot shows the 'Professional Claim Form' window with the following details:

Miscellaneous Extended Details

24d - Modifiers 3 & 4 Hospice Employed? Purch. Charges Sales Tax
 Anesthesia/Other Minutes Co-Pay Status Initial Treatment Postage Claim
 Units Type Code Purchased Services? Shipped Date

Line-Level Supporting Provider Information

	Last/Org Name	First Name	MI	Suffix	Provider IDs / Types / Payer IDs
Rendering					
Purch. Service					
Supervising					
<u>Ordering</u>	SMITH	JOHN			1231231231 ☒
Referring					
Referring (2nd)					
Asst. Surgeon					

Buttons: Save, Cancel

Note: If a narrative is required for this charge line, enter it on the “Ext Details 3 (Line 1)” sub-tab. Instructions on narrative entry are not included with this document.

The “**MSP/COB (Line 1)**” sub-tab is where information from the primary insurance’s explanation of benefits (EOB) will be entered. Depending on how the primary EOB lists information, the values may be listed or may need to be calculated, so having a calculator nearby may come in handy. Here is a completed sub-tab.

The screenshot shows the 'Professional Claim Form' window with the 'MSP/COB (Line 1)' sub-tab selected. The 'Common Line MSP Amounts' section has 'Approved' and 'OTAF' both set to 0.00. The 'Service Line Adjudication (SVD) Information' table has one row with the following data: SVD 1, P/S: P, Proc. Qual.: HC, Code: K0823, Paid Amount: 2913.12, Paid Units: 1.000. The 'Line Adjustment (CAS) & Miscellaneous Adjudication Info' section shows an 'Adj/Payment Date' of 05/15/2010 and a 'Remaining Owed' of 0.00. The 'Line Level Adjustments (CAS)' table has two rows: Row 1 with Group CO, Reason 45, Amount 1358.60, and Units 0.000; Row 2 with Group PR, Reason 2, Amount 728.28, and Units 0.000.

The “**Approved**” and the **OTAF** are no longer required and should be omitted.

Service Line Adjudication (SVD) Information: Click in the line for **SVD 1**. You will only enter information on the SVD 1 line. In this area, each SVD represents payment by a different insurance, NOT information for different charge lines.

P/S: Enter P to indicate payment information in this row is for the primary insurance.

Proc Qual: Enter HC for all HCPCS codes.

Code: Enter the HCPCS code from the charge line. Enter Modifiers if entered on the charge line.

Paid Amount: Enter what the primary insurance actually paid for this charge line.

Verify that the **Line Adjustment (CAS) & Miscellaneous Adjudication Info** reads for **SVD 1 above**. This should always state for SVD1 even when entering multiple charge lines as they will go on separate tabs.

Line Level Adjustments (CAS): This is where the difference between the item’s total cost and what was actually paid by the primary is explained. There is a lot of variation in what will be entered here, and the primary EOB may not supply exactly what is needed. In this example, for instance, there are two adjustments. There may be one, or there may be more than two. Take a look at the primary EOB and search for every reason why the primary marked down their reimbursement amount to get to what they paid.

In this example, the item cost \$5,000, but the primary insurance paid \$2,913.12. This leaves \$2,086.88 unaccounted for. The first adjustment is probably a CO, or contractual obligation, adjustment that explains the amount that was written off as being not-approved (or disallowed or ineligible). Right-click in the “**Group**” and “**Reason**” boxes to find a list of valid entries. Find a “Reason” that best describes the reason the amount was not allowed. Be aware that these codes can have end-dates, and only select codes that are still active. For the example, 45 is selected to explain the disallowed amount. This amount may or may not be listed on the primary EOB, but it can be calculated by taking the item’s full cost and subtracting the allowed amount. This example’s equation for this line is $\$5,000 - \$3641.40 = \$1,358.60$. CO, 45, and 1358.60 are entered.

Next, the example has the primary insurance paying 80% of what was allowed, with the remaining 20% left for the patient to pay. The patient’s responsibility may be displayed on the primary EOB, or it can also be calculated. For the example, the allowed (\$3641.40) minus the paid (\$2,913.12) equals patient responsibility (\$728.28). The example presumes this patient responsibility is all in one type, and is added as PR, 2, and 728.28.

CAUTION: Be careful with what is entered in the claim adjustment, or CAS, section to explain the adjustments. What is entered here can directly impact Medicare payment. CEDI does not have any guidance for what to select for the reason codes.

It is also important to understand that if the primary paid nothing on this line, then the adjustments will have to total the ENTIRE amount of the claim. If the primary paid zero in our example, the CAS entries for CO and PR would have to total \$5,000.

The final thing to enter on this sub-tab is the date the primary determined payment or non-payment on this charge line in the box for “**Adj/Payment Date.**”

Return to the “**Line Item Details**” sub-tab. To enter a second charge line, click in the second row under “**LN**” and enter the charge line. Note that the other sub-tabs change to display “(Line2).”

Professional Claim Form

Patient Info & General | Insured Information | **Billing Line Items** | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

Line Item Details | Extended Details (Line 2) | Ext Details 2 (Line 2) | Ext Details 3 (Line 2) | MSP/COB (Line 2)

Diagnosis Codes (1 - 8): 3449

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c EMG	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	24h EP	24h FP	24h AT	24j Rendering Phys.
1	05/01/2010	05/01/2010	12		K0823			1	5000.00	1.0				
2	05/01/2010	05/01/2010	12		E2365			1	264.74	1.0				
3	///	///												
4	///	///												
5	///	///												
6	///	///												

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

Save Cancel

Follow the instructions above to enter the information for this charge line on all three of the required tabs.

- **Line Item Details**
- **Extended Details (Line 2)**
- **MSP/COB (Line 2)** Be sure to enter all information on the SVD 1 line for all charge lines you enter.

Repeat as needed for any additional charge lines.

When all charge lines are entered, complete with Ordering Provider and MSP/COB information on each line, return to the “**Line Item Details**” sub-tab to enter any patient paid amount (leave Amount Paid as 0.00 if the patient did not pay on this claim) and click on the “**Recalculate**” button. See below:

Professional Claim Form

Patient Info & General | Insured Information | **Billing Line Items** | Ext. Patient/General | Ext. Pat/Gen (2) | Ext. Payer/Insured

Line Item Details | Extended Details (Line 3) | Ext Details 2 (Line 3) | Ext Details 3 (Line 3) | MSP/COB (Line 3)

Diagnosis Codes (1 - 8): 04521

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c EMG	24d Proc	24d - Modifiers 1	24d - Modifiers 2	24e Diagnosis	24f Charges	24g Units	24h EP	24h FP	24h AT	24j Rendering Phys.
1	07/01/2009	07/01/2009	12		K0823			1	5000.00	1.0				
2	07/01/2009	07/01/2009	12		E2365			1	264.74	1.0				
3	07/01/2009	07/01/2009	12		E0990			1	334.32	1.0				
4	/ /	/ /												
5	/ /	/ /												
6	/ /	/ /												

28 - Total Charge 5599.06 **Recalculate**

29 - Amount Paid **0.00** 30 - Balance Due 5599.06

Save Cancel

Once the “**Recalculate**” button has been clicked, go to the “**Ext. Payer/Insured**” tab and select the “**Secondary Payer/Insured**” sub-tab. Right-click in the “**Insurance Type**” box to select the reason why Medicare is the second payer. These values are all numeric and are listed first. Insurance Type “47” has been selected in the example below:

Professional Claim Form

Patient Info & General | Insured Information | Billing Line Items | Ext. Patient/General | Ext. Pat/Gen (2) | **Ext. Payer/Insured**

Primary Payer/Insured | **Secondary Payer/Insured** | Tertiary Payer/Insured | COB Info (Primary) | COB Info (Secondary)

Miscellaneous Secondary Payer / Insured Information

Payer Address

City/St/Zip

Payer Source MB

Insurance Type 47

Insured's Contact

Patient ID

Payer / Insured Reference IDs / Types

Save Cancel

Also on the “**Ext. Payer/Insured**” tab, information will need to be added to the “**COB Info (Primary)**” sub-tab. “**COB / MOA Amounts**” is where claim level values for what the primary paid and what the primary allowed will be entered.

The screenshot shows the 'Professional Claim Form' window with the following details:

- Tab: **Ext. Payer/Insured**
- Sub-tab: **COB Info (Primary)**
- Section: **COB / MOA Amounts**
- Table 1: **Claim Level Adjustments (CAS)**

Num	Group	Reason	Amount	Units
1				
2				
3				

- Table 2: **COB / MOA Amounts**

Num	Code	Amount
1	D	0.00
2		
3		

- Other fields: OTAF (0.00), Zero Payment Ind (checkbox), Medicare Outpatient Adjudication (MOA) Remarks Codes (5 empty boxes), Claim Adjudication Date (/ /)

Code D is used for the primary paid amount.

Use the F2 key or right-click option to begin up a list of codes. Select D – Payer paid amount.

See above for a completed “**COB Info (Primary)**” sub-tab.

Once this tab is completed, the claim should be ready to save.

MSP Claim Entry (Claim Level)

If there is any line level information, it should be submitted as described above. However, sometimes, the information from the primary insurance only indicates payment information at the claim level. When this happens, the “**Billing Line Items**” “**MSP/COB**” sub-tab will not be used.

Instead, additional information will be added to the “**Ext. Payer/Insured**” “**COB Info (Primary)**” sub-tab. The adjustment amounts for the entire claim will be added, as well as the date the primary determined payment or non-payment. See below:

The screenshot shows the 'Professional Claim Form' window with the 'COB Info (Primary)' sub-tab selected. The form is divided into several sections:

- Common Payer MSP Information:** OTAF (0.00), Zero Payment Ind (checkbox).
- Additional Adjustment / COB Amounts / MDA Information (ANSI-837 Only):**
 - Claim Level Adjustments (CAS):** A table with columns Num, Group, Reason, Amount, and Units. Rows 1 and 2 are highlighted with red boxes. Row 1: Num 1, Group CD, Reason 45, Amount 1554.26, Units 0.000. Row 2: Num 2, Group PR, Reason 2, Amount 808.96, Units 0.000.
 - COB / MDA Amounts:** A table with columns Num, Code, and Amount. Row 1: Num 1, Code D, Amount 80.00. Row 2: Num 2, Code, Amount 0.00. Row 3: Num 3, Code, Amount.
- Medicare Outpatient Adjudication (MOA) Remarks Codes:** Five empty input fields.
- Claim Adjudication Date:** 05/15/2010 (highlighted with a red box).

Buttons for 'Save' and 'Cancel' are located at the bottom right of the window.

CAUTION: Do not enter adjustments at both claim and line level. This will throw the claim out of balance, and the claim will not be savable as a clean claim until one set of adjustments or the other is removed.