

PC-ACE Pro32 Medicare as Secondary Payer

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

- Insurance Setup
- Patient Setup
- MSP Claim Entry

This document is intended as a help guide for setting up an 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.

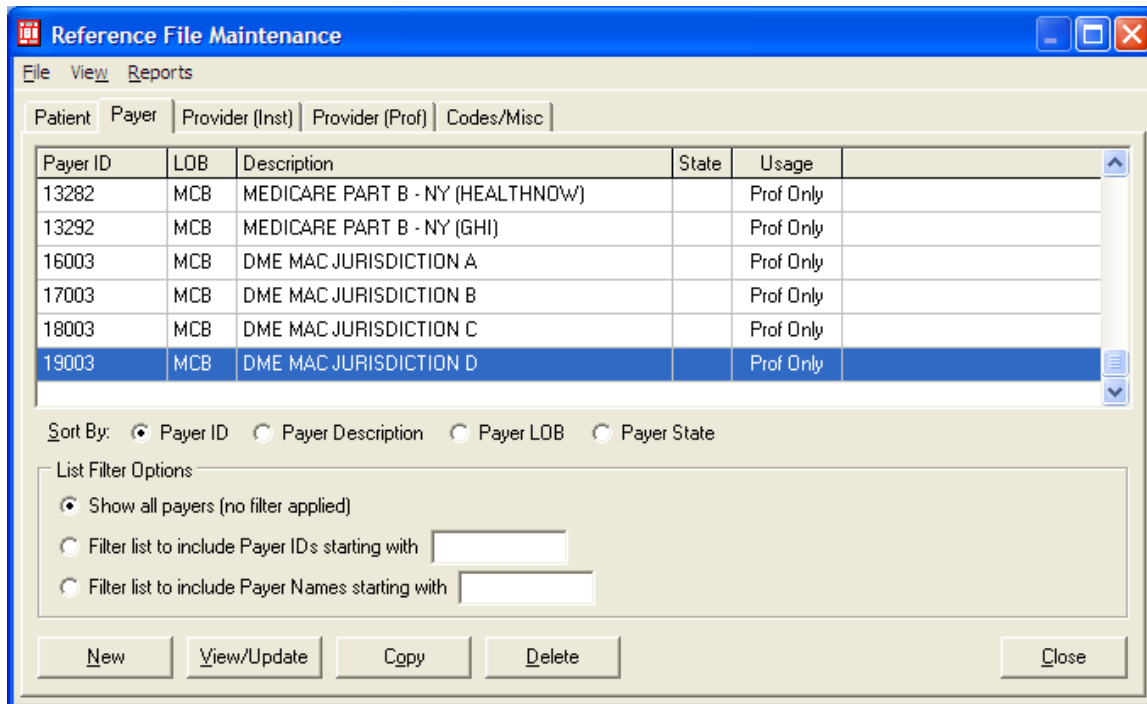
If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.

Setting up the Medicare Secondary Payers

The **Payer** tab on the **Reference File Maintenance** menu is where the insurances that will be entered in the software.

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

Note: By default, all Medicare Payer IDs that are valid for this build of PC-ACE Pro32 are listed here.



Payer Information Screen:

The screenshot shows a software window titled "Payer Information". At the top, there are four input fields: "Payer ID" (containing "55002"), "LOB" (containing "COM"), "Receiver ID" (empty), and "ISA08 Override" (empty). Below these is a "Full Description" field containing "AMERICAN INCOME LIFE INSURANCE COMPANY". The "Address & Contact Information" section includes fields for "Address" (two lines), "City", "State", "Zip", "Contact Name", "Phone", "Ext", and "Fax". The "Flags" section has three dropdown menus: "Source" (set to "CI"), "Media" (set to "E"), and "Usage" (set to "H"). At the bottom, there are three buttons: "PrintLink Matching Descriptions", "Save", and "Cancel".

Payer ID: 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/.

- A five digit Payer ID obtained from the second insurance company
- A gap-fill ID of XXXXX for cases where a Payer ID is not available

LOB (line of business): Use the right click or F2 key lookup function for valid entries.

- Most Primary insurances will likely be **COM** for Commercial insurance
- Some entries may trigger edit validation errors

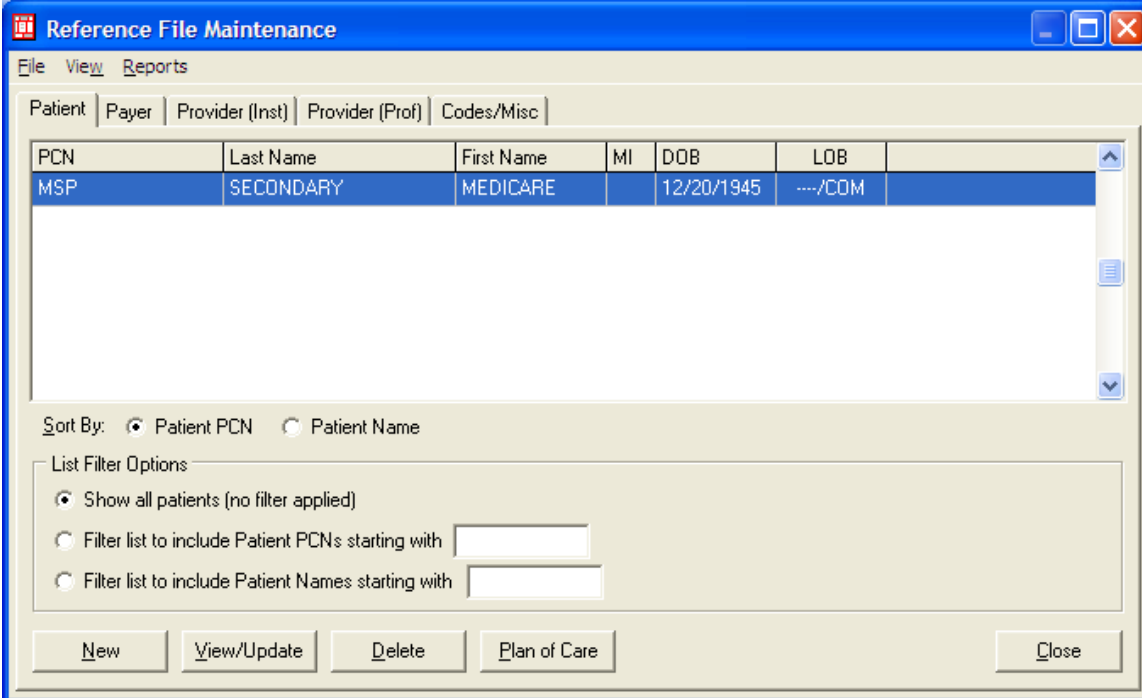
Note: The **Payer ID** and **LOB** (line of business) combination must be unique. Every effort to obtain a valid Payer ID should be made, as multiple entries for the gap-fill ID XXXXX will not work.

Use the right-click or F2 key lookup function to fill out the other fields indicated in the screenshot above. Address information may be entered if available.

Blank fields in the screenshot (shown above) should only have data entered at the direction of CEDI technical support.

Setting Up the Patient

The **Patient** tab of the **Reference File Maintenance** menu is where patient information is added.



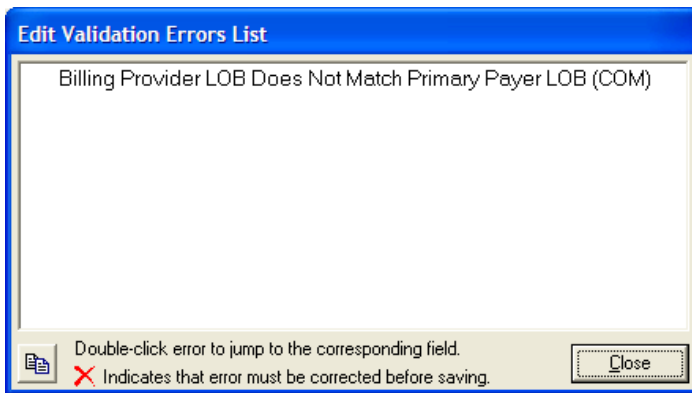
The screenshot shows the 'Reference File Maintenance' application window. The 'Patient' tab is selected, displaying a table with one patient record. The table has columns for PCN, Last Name, First Name, MI, DOB, and LOB. Below the table, there are radio buttons for 'Sort By' (Patient PCN selected, Patient Name) and a 'List Filter Options' section with three radio buttons: 'Show all patients (no filter applied)' (selected), 'Filter list to include Patient PCNs starting with', and 'Filter list to include Patient Names starting with'. At the bottom, there are buttons for 'New', 'View/Update', 'Delete', 'Plan of Care', and 'Close'.

PCN	Last Name	First Name	MI	DOB	LOB
MSP	SECONDARY	MEDICARE		12/20/1945	----/COM

There are two ways to establish the patient as a Medicare as a Secondary Payer (MSP) patient, indicating that they have an insurance primary to Medicare.

Setting up the Patient Option 1:

- Enter the non-Medicare insurance data under the **Primary Insured (Prof)** tab.
- The Medicare insurance information is listed as the **Secondary Insured (Prof)**.
- If the Billing Provider is entered under the **Extended** Info tab, then a validation edit may fire indicating the Billing Provider line of business (LOB) does not match the Primary Payer LOB. This error is a non fatal error. Select **Save With Errors** to override the edit.
- When entering a claim, the Billing Provider will most likely have to be selected manually.



Note: The Billing Provider does not need to be entered in the **Extended Info** tab as it will need to be selected when entering the claim information. This will allow you to save the patient information without errors.

Setting up the Patient Option 2:

Enter Medicare (the secondary payer) as the **Primary Insured (Prof)** and the non-Medicare (the primary payer) insurance information as **Secondary Insured (Prof)**. This will avoid Validation Edits for a mismatched Payer and Billing Provider line of business.

Note: When entering claims, the Billing Provider will be automatically selected if it is entered on the **Extended Info** tab.

Warning: During claims entry, special care is needed to make sure the correct insurance and insured ID is listed for both payers.

If further information about entering multiple payers is need, please refer to the PC-ACE Pro32 User Guide or the PC-ACE Pro32 Secondary Insurance help document located on the CEDI Web site www.ngscedi.com under Resource Materials.

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

Claims Entry

Claims entry instructions here are designed as a supplement to the basic claims entry instructions to show the additional information needed for MSP claims. Please refer to the PC-ACE Pro32 User Guide or Claims Management help Document for more information about basic claim entry.

Patient Info & General Tab:

Along the bottom row is an entry for "COB?".

Enter a Y here to bring up COB tabs for entering MSP claims.

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

Patient Info & General		Insured Information	Billing Line Items	Ext. Patient/General	Ext. Pat/Gen (2)	Ext. Payer/Insured																		
LOB	MCB	Billing Provider	1231230001	26 - Patient Control No.	MSP																			
2 - Patient Last Name	SECONDRARY	First Name	MEDICARE	MI		Gen		3 - Birthdate	12/20/1945	Sex	M	8 - Pat. Status	MS	ES	SS	Ind		12	SOF	B	Legal Rep.	N	NPI Exempt	
5 - Patient Address 1	11080 KNUE	Patient Address 2		Patient City	INDIANAPOLIS	State	IN	Patient Zip	46250	Country		Patient Phone	(866) 311-9184											
10 - Patient Condition Related To	Employment	N	Accident		ROI	M	ROI Date	10/19/2009	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	222552222	SSN/EIN	E	27 - Provider Accepts Assignment?	A	PIN No.	1231230001																	
31 - Provider SOF	Y	Date	10/28/2009	Facility?		Dental?		COB?	Y	Frequency		33 - GRP No.												

Buttons: Save, Cancel

Insured Information Tab:

Professional Claim Form

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

Sub	Payer ID	Payer Name	Insured's ID	P.Rel	Insured's Last/Org Name	First Name	MI	Gen
<input type="checkbox"/>	55002	AMERICAN INCOME LIFE INSU	MSP111111	18	SECONDARY	MEDICARE		
<input checked="" type="checkbox"/>	17003	DME MAC JURISDICTION B	123456789B	18	SECONDARY	MEDICARE		
<input type="checkbox"/>								

Birthdate	Sex	Sig	DOB	Insured's Address 1	Insured's Address 2	Insured's City	State	Zip
12/20/1945	M	B	Y	11080 KNUE		INDIANAPOLIS	IN	46250-____
12/20/1945	M	B	Y	11080 KNUE		INDIANAPOLIS	IN	46250-____
/ /								

Country	Insured's Phone / Ext.	ESC	Employer Name	Group Name	Group Number	
	(866) 311-9184		5			Clear Payer
	(866) 311-9184		5			Clear Payer
	() -					Clear Payer

Save Cancel

If **Option 1** was selected when Setting Up the Patient, where the patient information was entered with the non-Medicare insurance entered as the **Primary Insured (Prof)** and the Medicare insurance entered as the **Secondary Insured (Prof)**, then no adjustment should be needed.

If **Option 2** was selected when Setting Up the Patient, where the patient information was entered with Medicare as the **Primary Insured (Prof)** and the true primary insurance company was entered as the **Secondary Insured (Prof)**, the insurance information will need to be corrected.

- 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.
- Verify that the correct **Insured's ID** is on the correct line for the correct insurance.

Billing Line Items Tab:

Multiple tabs under Billing Line Items will need to be completed.

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	10/01/2008	10/30/2008	12		B4185			1	50.00	1.0				
2														
3														
4														
5														
6														

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

Save Cancel

Charges and Units:

- The item charge will be the actual cost of the item, not the remainder after the primary has paid.

Example: Item costs \$50 and the primary paid \$30. The charges entered would be \$50.

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

This tab is only available if the **COB?** field on the **Patient Info & General** tab is a **Y**.

The screenshot shows the 'Professional Claim Form' window with the 'Billing Line Items' tab selected. The 'MSP/COB (Line 1)' sub-tab is active. On the left, 'Common Line MSP Amounts' shows 'Approved' and 'OTAF' both set to 0.00. The main area is titled 'Additional Line-level Adjudication / COB Information (ANSI-837 Use Only)'. It contains a table for 'Service Line Adjudication (SVD) Information' with columns: SVD, P/S, Proc. Qual / Code, Modifiers 1 thru 4, Paid Amount, Paid Units, and B/U Line. Row 1 is populated with P, HC, B4185, 30.00, 1.000, and an arrow. Below this is a table for 'Line Adjustment (CAS) & Miscellaneous Adjudication Info (for SVD 1 above)'. It has columns: Procedure Code Description, Line Level Adjustments (CAS), Num, Group, Reason, Amount, and Units. The table shows three rows of adjustments: (1, PR, 2, 15.00, 0.000), (2, CD, 45, 5.00, 0.000), and (3, , , , ,). At the bottom, 'Adj/Payment Date' is 11/15/2008 and 'Remaining Owed' is 0.00. 'Save' and 'Cancel' buttons are at the bottom right.

The information entered on the **MSP/COB (Line #)** will only be entered on the **Line #** indicated. If adjustments are needed for multiple charge lines, enter the information on the corresponding **MSP/COB (Line #)**.

- Data is entered on this tab if the adjustments reported by the primary insurance were made on a charge line by charge line basis.
- If the adjustments were reported as a sum total for the claim, this area will not be filled in.
- Each charge line on a claim will enter information on a separate tab. Verify that the **(Line #)** indicates the charge line under **Line Items Details** you wish to add the adjustment information. Multiple procedure codes should not be placed on the same **MSP/COB (Line #)** tab.

Common Line MSP Amounts:

- **Approved:** This is the only field in this group that should be filled out and is the amount the primary approved for payment consideration on this line.

Service Line Adjudication (SVD) Information: Use only line 1. Lines 2 and 3 should not be used.

- **P/S** will always be **P** for Primary
- **Proc. Qual / Code**
 - The qualifier will be **HC** for HCPCS codes.
 - The code will be the HCPCS procedure code.
- **Modifiers:** Enter modifiers as needed
- **Paid Amount:** This is how much the primary insurance actually paid.
- **Paid Units:** Enter the units submitted for payment.

Line Level Adjustments (CAS): These are used to explain the difference between what the item cost and what the primary insurance paid. The Line Level Adjustment (CAS) will be added to the SVD indicated. This can be verified where it states **Line Adjustments (CAS) & Miscellaneous Adjudications Info (for SVD # above)**.

Note: MSP claims must balance in order to be saved.

- Entering CAS information in both claim and line level CAS entries can produce balancing errors. Be sure to enter CAS information only at one level, either claim or line, but not both.
- For line level balancing, the formula is Item Charge = Primary Paid Amount for Item + all adjustments. Or, Item Charge minus Primary Paid Amount for the Item equals the dollar amount that needs to be explained in this section.
- 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.

Group: The Group codes are available by right-clicking or using the F2 key lookup utility. Primary insurance explanation of benefits (EOBs) should list these codes, but not all do. You may have to select the most appropriate one on this list that matches what was actually sent.

Reason Codes: Enter the reason code by right-clicking or using the F2 lookup utility. Primary insurance explanation of benefits (EOBs) should list these codes, but not all do. You may have to select the most appropriate one on this list that matches what was actually sent.

- In PC-ACE Pro32, claim adjustment reason codes are maintained under the **Reference File Maintenance** tab for **Codes/Misc**.
- To confirm current usage of a Reason Code, or to see the dates when codes became effective or were discontinued, check the current list at www.wpc-edi.com, under HIPAA Code Lists

Amount: This is the dollar amount that was subtracted from the item cost for this reason code.

- **Example:** The primary EOB indicates the patient owes a \$20 co-pay. The dollar amount would be entered as 20.

Adj/Payment Date: This is used to indicate the date the primary insurance adjudicated the claim. This date is required either at line level or claim level.

Ext. Payer/Insured Tab:

Only the Secondary Payer/Insured and the COB Info (Primary) will require MSP information.

Secondary Payer/Insured tab:

The screenshot shows a software window titled "Professional Claim Form" with a blue title bar and a close button. The window contains several tabs: "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)", and "COB Info (Secondary)". The "Secondary Payer/Insured" tab is selected. The form area is titled "Miscellaneous Secondary Payer / Insured Information" and contains the following fields:

- Payer Address: [Text Field]
- City/St/Zip: [Text Field]
- Payer Source: [Dropdown Menu] (Selected: MB)
- Insurance Type: [Dropdown Menu] (Selected: 47)
- Insured's Contact: [Text Field]
- Patient ID: [Text Field]

To the right of these fields is a table titled "Payer / Insured Reference IDs / Types":

Reference ID	Type
[Text Field]	[Dropdown Menu]
[Text Field]	[Dropdown Menu]
[Text Field]	[Dropdown Menu]

At the bottom right of the window are "Save" and "Close" buttons.

Insurance Type will need to be selected. Use the right-click or F2 lookup feature to select the appropriate type code for Medicare as the Secondary Payer.

COB Info (Primary) tab:

The following fields are used to indicate claim level Medicare as Secondary Payer (MSP) information.

Claim Level Adjustments (CAS)					COB / MDA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1					1	D	30.00
2					2	B6	30.00
3					3		

Common Payer MSP Information: Not required.

Claim Level Adjustments (CAS): These are used to explain the difference between what the total claim charge was and what the primary insurance paid.

Note: MSP claims have to balance in order to be saved.

- Entering CAS information in both claim and line level CAS entries can produce balancing errors. Be sure to enter CAS information only at one level, either claim or line, but not both. If this information was entered in the earlier section that covered line level entry, do not enter information here.
- For claim level balancing, the formula is Total Claim Charge = Primary Paid Amount for Claim + all adjustments. Or, Total Claim Charge minus Primary Paid Amount for the Claim equals the dollar amount that needs to be explained in this section.
- 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.

Group: The Group codes are available by right-clicking or using the F2 key lookup utility. Primary insurance explanation of benefits (EOBs) should list these codes, but not all do. You may have to select the most appropriate one on this list that matches what was actually sent.

Reason Codes: Enter the reason code by right-clicking or using the F2 lookup utility. Primary insurance explanation of benefits (EOBs) should list these codes, but not all do. You may have to select the most appropriate one on this list that matches what was actually sent.

- In PC-ACE Pro32, claim adjustment reason codes are maintained under the **Reference File Maintenance** tab for **Codes/Misc**.
- To confirm usage of a Reason Code , or see to 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.

Amount: This is the dollar amount that was subtracted from the total claim charge for this reason code.

- **Example:** The primary EOB indicates the patient owes a \$20 co-pay. The dollar amount would be entered as 20.

COB / MOA Amounts: Use the right click or F2 lookup features to select the correct value for the **Code**

- **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
- **B6** for Primary Allowed is another required claim level amount
- Other codes on this list may be required in different situations.

Adj/Payment Date: This is used to indicate the date the primary insurance adjudicated the claim.

Note: This date is required either at line level or claim level.

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

Once all claim information has been entered, select **Save** to save the claim.