

This document will assist you in setting up and building a Medicare as Secondary Payer (MSP) claim in PC-ACE and includes:

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This document 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 in the PC-ACE software nor the PC-ACE User Manual itself. For help with any questions not covered here, please utilize these resources.

For questions on how to bill MSP claims, contact the DME MAC Jurisdiction which will be processing the claims for payment.

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

Questions related to use of the PC-ACE software should be directed to the CEDI Help Desk at ngs.cedihelpdesk@anthem.com or 866-311-9184.

Payers (Insurance) Setup

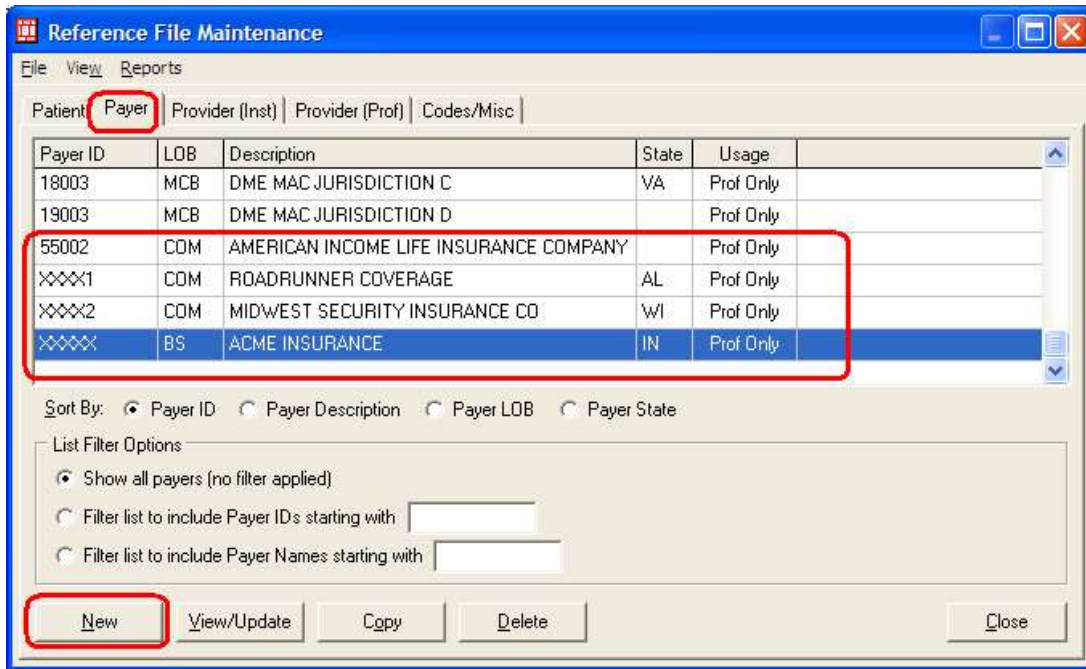
When entering a Medicare as Secondary Payer (MSP) claim in PC-ACE, the first step is to verify the primary insurance is loaded into the software.

Go to **REFERENCE FILE MAINTENANCE**, and the **Payer** tab. The primary insurance should be listed with the “Usage” set to “Prof Only.”

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

If it is not on the list, the primary insurance will need to be added.

Select the “New” button in the lower left.



Reference File Maintenance

File View Reports

Patient **Payer** Provider (Inst) Provider (Prof) Codes/Misc

Payer ID	LOB	Description	State	Usage
18003	MCB	DME MAC JURISDICTION C	VA	Prof Only
19003	MCB	DME MAC JURISDICTION D		Prof Only
55002	COM	AMERICAN INCOME LIFE INSURANCE COMPANY	VA	Prof Only
XXXX1	COM	ROADRUNNER COVERAGE	AL	Prof Only
XXXX2	COM	MIDWEST SECURITY INSURANCE CO	WI	Prof Only
XXXXX	BS	ACME INSURANCE	IN	Prof Only

Sort By: ☒ Payer ID ☐ Payer Description ☐ Payer LOB ☐ Payer State

List Filter Options

☒ Show all payers (no filter applied)

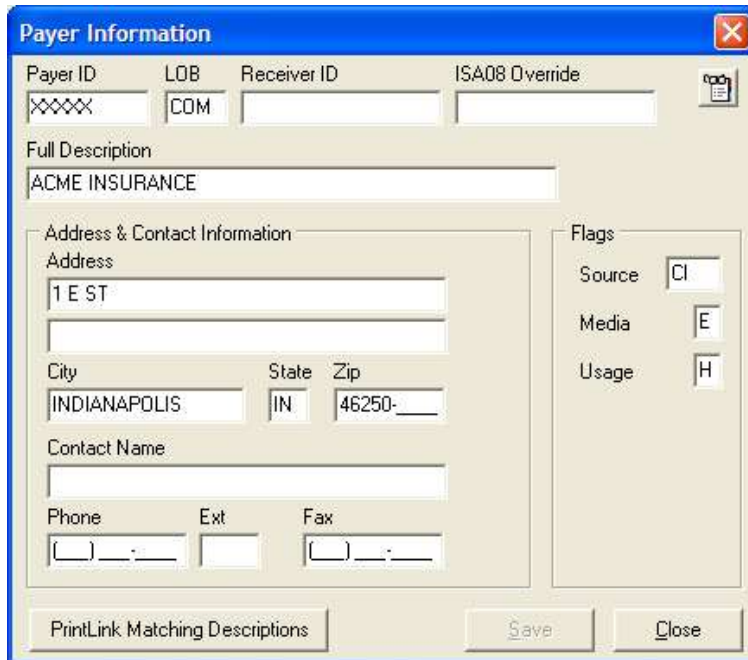
☐ Filter list to include Payer IDs starting with

☐ Filter list to include Payer Names starting with

New View/Update Copy Delete Close

This will display the **PAYER INFORMATION** screen.

Payer Information Screen:



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 primary payer, or insurance company, in electronic transactions. The Payer ID field has to have a unique entry for every insurance company entered into PC-ACE. This field is required, but the primary insurance may not have a Payer ID. It is recommended the real Payer ID be obtained, if possible, from the primary insurance. If it is not possible to obtain the 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. The Medicare system will use the name of the primary insurance to confirm the claim was processed and paid by the correct primary insurance.

LOB: This is the abbreviation for Line of Business. It identifies the primary insurance company type 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 primary insurance company's address should be entered in the "Address & Contact Information" fields following the "Full Description."

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

- **Source:** Identifies 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 the correct entry is being selected.

- **Media:** Determines 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:** 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 the **REFERENCE FILE MAINTENANCE**.

Patient Selection and Setup

Open the **PROFESSIONAL CLAIMS PROCESSING** menu and select **List Claims** to enter the claim management area.

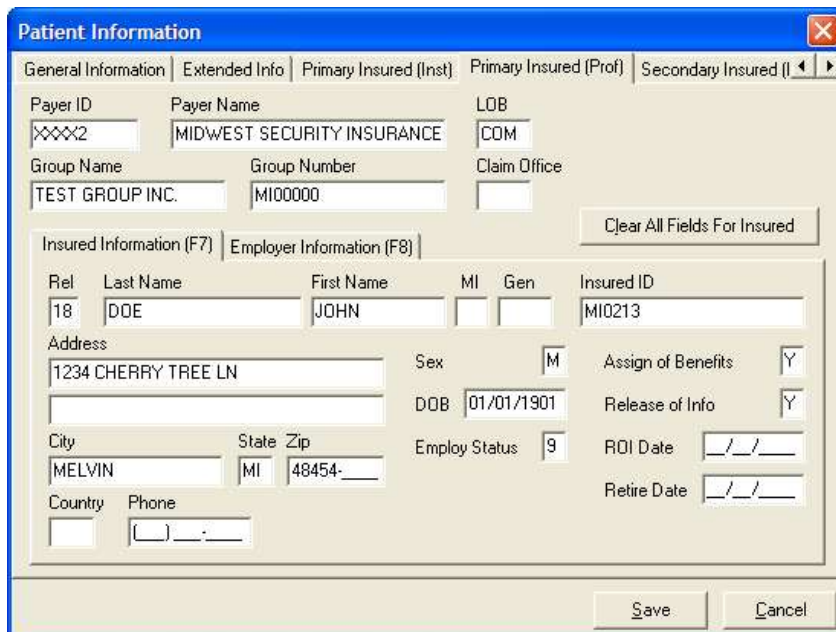
Click on the “New” button in the lower left corner to enter a new claim. This will display the **PROFESSIONAL CLAIM FORM**.

Right-click in either *Patient Control Number* or *Patient Name* to bring up the **Patient Selection** screen.

If the patient is already listed, highlight them, click on the “Select” button and proceed with entering claim information.

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 the "Patient Information" window with the following data:

Patient Information										
General Information			Extended Info		Primary Insured (Inst)		Primary Insured (Prof)		Secondary Insured (Inst)	
Payer ID	Payer Name		LOB							
XXXX2	MIDWEST SECURITY INSURANCE		COM							
Group Name	Group Number		Claim Office							
TEST GROUP INC.	MI00000									
Clear All Fields For Insured										
Insured Information (F7)					Employer Information (F8)					
Rel	Last Name	First Name	MI	Gen	Insured ID					
18	DOE	JOHN			MI0213					
Address			Sex		Assign of Benefits					
1234 CHERRY TREE LN				M	Y					
			DOB	01/01/1901	Release of Info		Y			
City	State	Zip	Employ Status	9	ROI Date		_/_/_			
MELVIN	MI	48454-			Retire Date		_/_/_			
Country	Phone									
	() _ _ - _ _									
Save Cancel										

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 primary insurance ID card. If these fields are not on the card, they may be left blank.

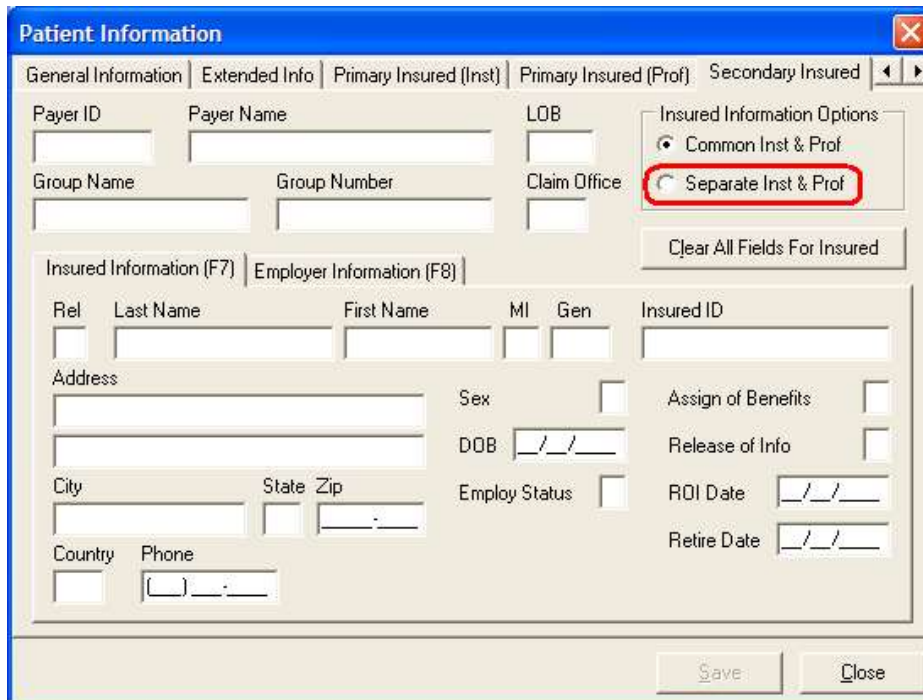
Insured Information: The “Rel” field should be selected by right-clicking on the box and selecting the appropriate code for the patient’s relationship to the policyholder. For example, if the patient’s spouse is the primary insurance policy holder, select “01” for Spouse. The required fields above will need to be entered for the policyholder.

If the patient is the primary insurance policy holder, select “18” for Self. The name, address information and other general information fields will automatically populate from the **General Information** tab. The “Insured ID” and “Assign of Benefits” fields will not fill in automatically even if “18” (Self) is selected and will need to be entered manually.

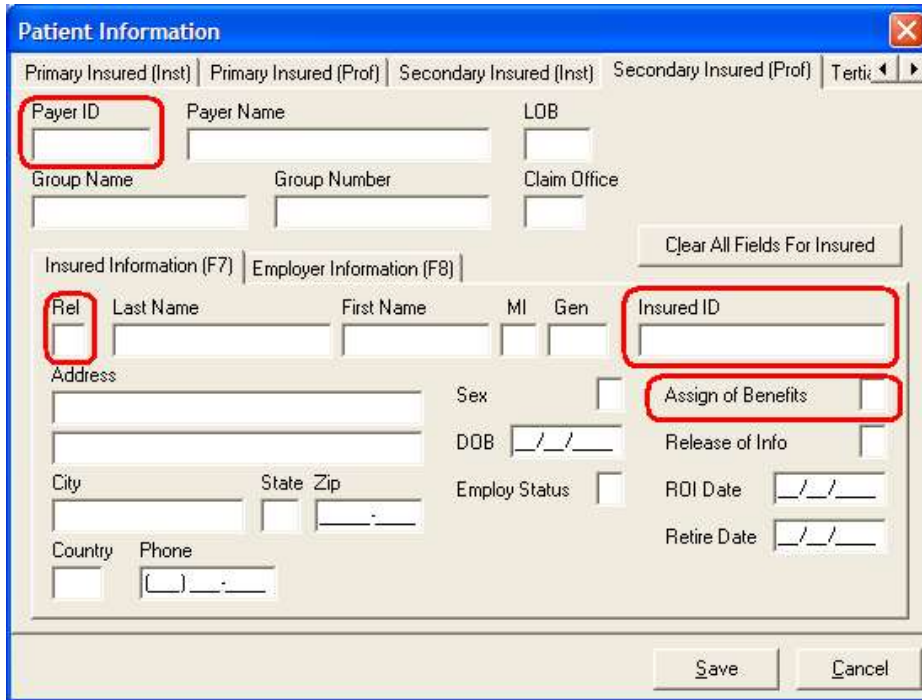
Insured ID: This is the primary insurance identification number used to identify the patient.

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

Next go to the **Secondary Insured** tab and the following screen will display.



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 the screen and it will display like this:



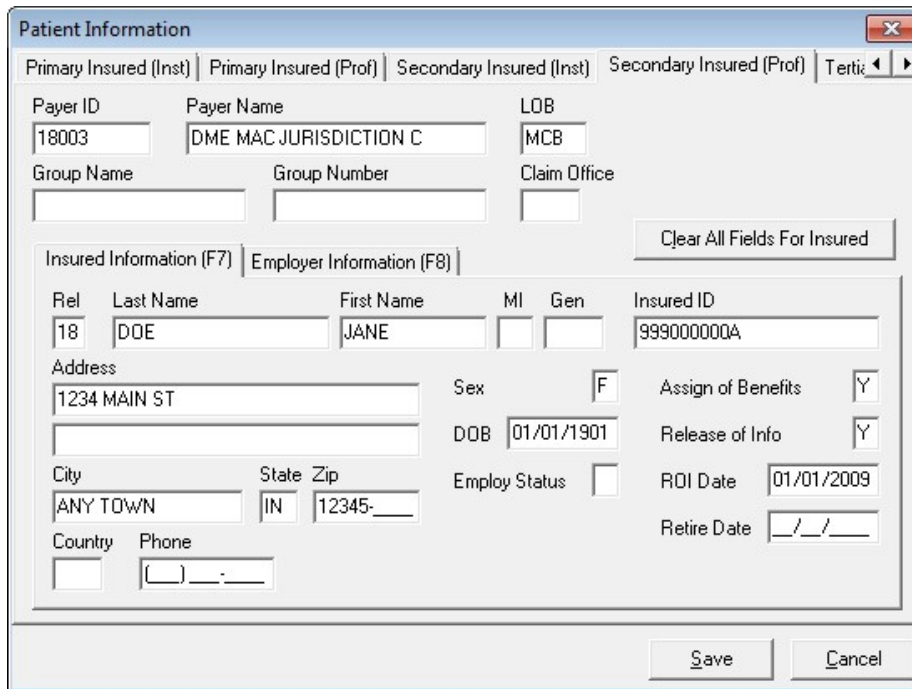
The screenshot shows the 'Patient Information' window with the following fields and tabs:

- Tabs:** Primary Insured (Inst), Primary Insured (Prof), Secondary Insured (Inst), Secondary Insured (Prof), Tertiary.
- Payer Information:**
 - Payer ID:** (Red box)
 - Payer Name:** (Text field)
 - LOB:** (Text field)
 - Group Name:** (Text field)
 - Group Number:** (Text field)
 - Claim Office:** (Text field)
- Insured Information (F7) / Employer Information (F8):**
 - Rel:** (Red box)
 - Last Name:** (Text field)
 - First Name:** (Text field)
 - MI:** (Text field)
 - Gen:** (Text field)
 - Insured ID:** (Red box)
 - Address:** (Text field)
 - Sex:** (Text field)
 - DOB:** (Text field)
 - City:** (Text field)
 - State:** (Text field)
 - Zip:** (Text field)
 - Country:** (Text field)
 - Phone:** (Text field)
 - Employ Status:** (Text field)
 - Assign of Benefits:** (Red box)
 - Release of Info:** (Text field)
 - ROI Date:** (Text field)
 - Retire Date:** (Text field)
- Buttons:** Clear All Fields For Insured, Save, Cancel.

Enter the patient's Medicare information on this screen.

The same four areas entered for a typical Medicare as Primary patient are entered here: "Payer ID", "Rel", "Insured ID", and "Assign of Benefits".

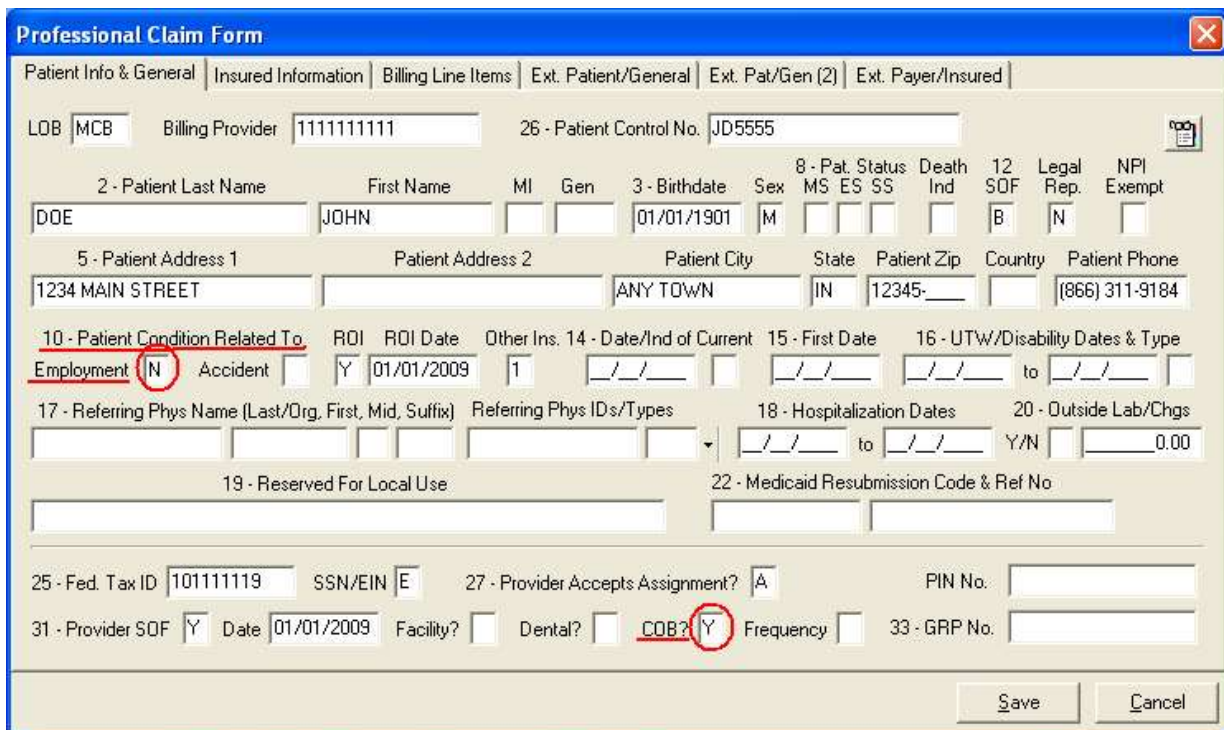
Following is an example of a completed **PATIENT INFORMATION** screen.



Click the “Save” button to save the patient record. This will return the display to the **PATIENT SELECTION** screen, where the “Select” button is used to choose the patient. The **PROFESSIONAL CLAIM FORM** will be displayed again, this time with the patient’s data.

MSP Claim Entry (Line Level)

Once the patient is selected, there are two more fields which must be entered on the **Patient Info & General** tab: "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, with information entered, are shown 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

LOB: MCB Billing Provider: 1111111111 26 - Patient Control No.: JD5555

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 SOF: B Legal Rep.: N NPI Exempt:

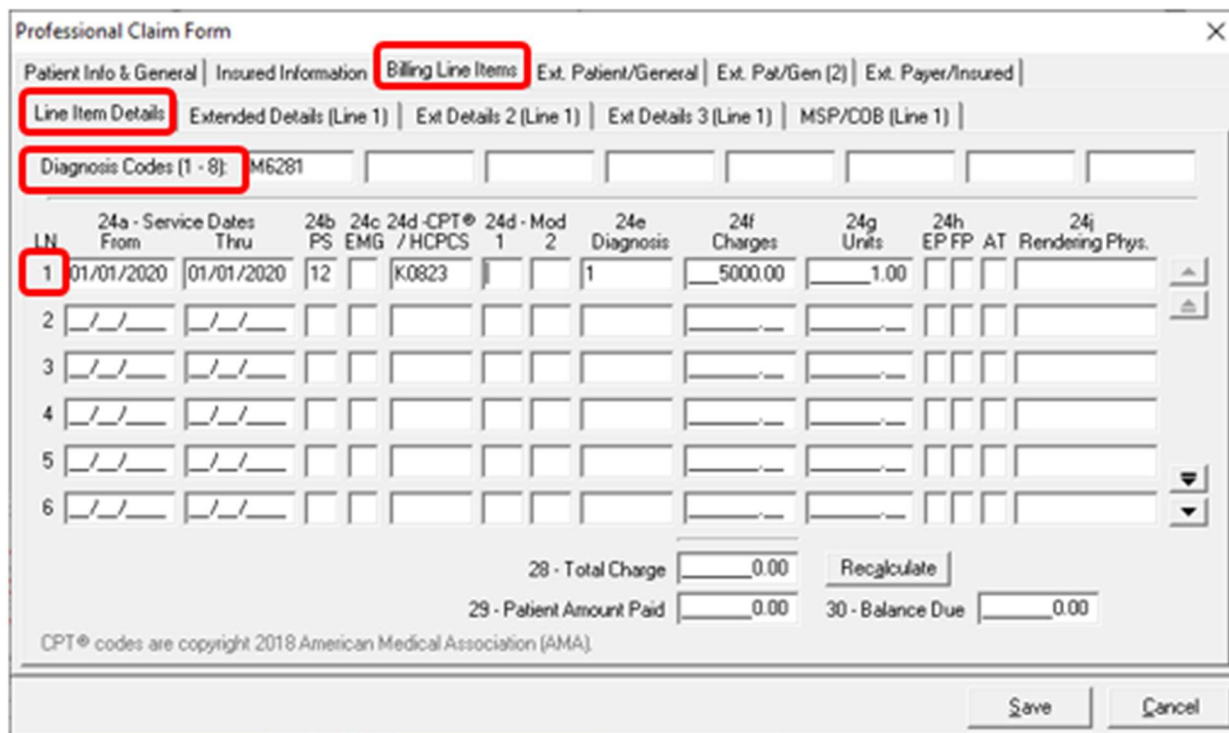
5 - Patient Address 1: 1234 MAIN STREET Patient Address 2: Patient City: ANY TOWN State: IN Patient Zip: 12345- Country: Patient Phone: (866) 311-9184

10 - Patient Condition Related To: Employment **N** Accident: ROI: Y ROI Date: 01/01/2009 Other Ins.: 14 - Date/End 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: Y/N: 20 - Outside Lab/Chgs: 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.: 31 - Provider SOF: Y Date: 01/01/2009 Facility?: Dental?: **COB?: Y** Frequency: 33 - GRP No.: 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 demonstrates how to enter an MSP claim with three charge lines.

NOTE: CEDI cannot answer questions related to medical policy or coding. The example is to illustrate how to enter the information in the software and not intended to reflect a payable claim.

Enter the diagnosis code and **first** charge line information, similar to the example below.



Diagnosis Code: Enter the diagnosis code without the decimal. The example uses diagnosis code M62.81 which has been entered as “M6281”.

Box 24b: Enter 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” has been entered. If two diagnosis codes are listed in the row, valid entries in Box 24e would be “1”, “2”, or “12”.

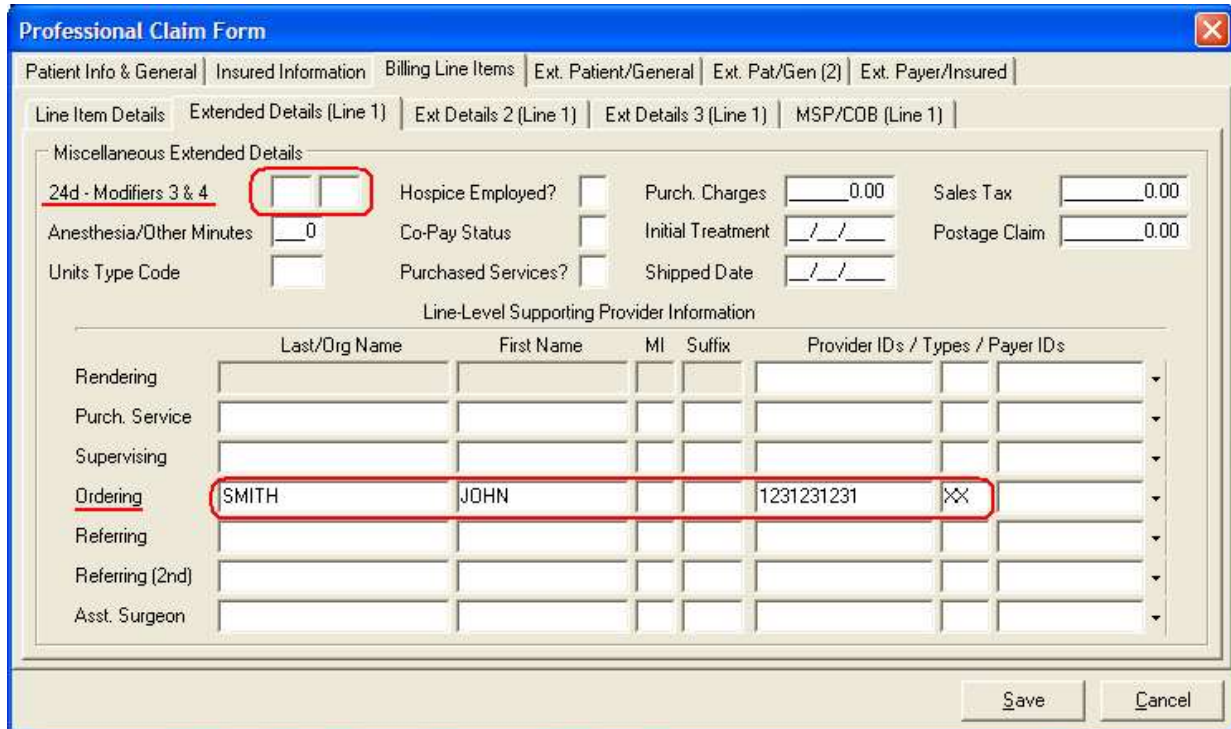
Box 24f: This is the original charge for the line item and is not to be adjusted based on how the primary insurance processed the claim. In this example, the item was billed originally to the primary insurance with “\$5,000” and the same dollar amount has been entered here.

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

Once the information for Line 1 has been 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 HCPCS modifiers would be added. More importantly, the Ordering Provider must be selected on every charge line for Medicare DME claims.

Right-click in the “Ordering” name field to bring up the **PHYSICIAN SETUP** screen. 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 (additional modifiers have not been used in this example):



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 1) | Ext Details 2 (Line 1) | Ext Details 3 (Line 1) | **MSP/COB (Line 1)**

Miscellaneous Extended Details

24d - Modifiers 3 & 4 Hospice Employed? ☐ Purch. Charges 0.00 Sales Tax 0.00

Anesthesia/Other Minutes 0 Co-Pay Status ☐ Initial Treatment / / Postage Claim 0.00

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					
Ordering	SMITH	JOHN			1231231231
Referring					
Referring (2nd)					
Asst. Surgeon					

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.

Below is a completed sub-tab.

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 1) | Ext Details 2 (Line 1) | Ext Details 3 (Line 1) | **MSP/COB (Line 1)**

Common Line MSP Amounts

Approved: 0.00

OTAF: 0.00

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

Service Line Adjudication (SVD) Information

SVD	P/S	Proc.	Qual / Code	Modifiers 1 thru 4	Paid Amount	Paid Units	B/U Line
1	P	HC	K0823		2913.12	1.000	
2							
3							

Line Adjustment (CAS) & Miscellaneous Adjudication Info (for SVD 1 above)

Procedure Code Description

Line Level Adjustments (CAS)

Num	Group	Reason	Amount	Units
1	CO	45	1358.60	0.000
2	PR	2	728.28	0.000
3				

Adj/Payment Date: 05/15/2010

Remaining Owed: 0.00

Save Cancel

The “Approved” and the “OTAF” are no longer required and should be not be entered.

Service Line Adjudication (SVD) Information: Click in the line for “SVD 1”. 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: Enter “HC” for all HCPCS codes.

Qual / Code: Enter the HCPCS code from the charge line.

Modifiers 1 thru 4: Enter the HCPCS modifiers on the charge line.

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

Verify 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 the Line Level Adjustments (CAS) information will go on separate tabs.

Line Level Adjustments (CAS): This is where the difference between the item’s total originally billed amount and what was actually paid by the primary insurance is explained. The primary EOB may not supply exactly what is needed to be entered. Review 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 to explain the amount 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 the “Reason” which best describes why the amount was not allowed. Be aware, these codes can have end-dates and only select active codes. For this 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 $\$5,000 - \$3,641.40 = \$1,358.60$, thus “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 primary allowed amount (\$3,641.40) minus the primary paid amount (\$2,913.12) equals the patient responsibility (\$728.28). The example presumes this patient responsibility is all in one type and is added as “PR”, “2”, and “728.28”.

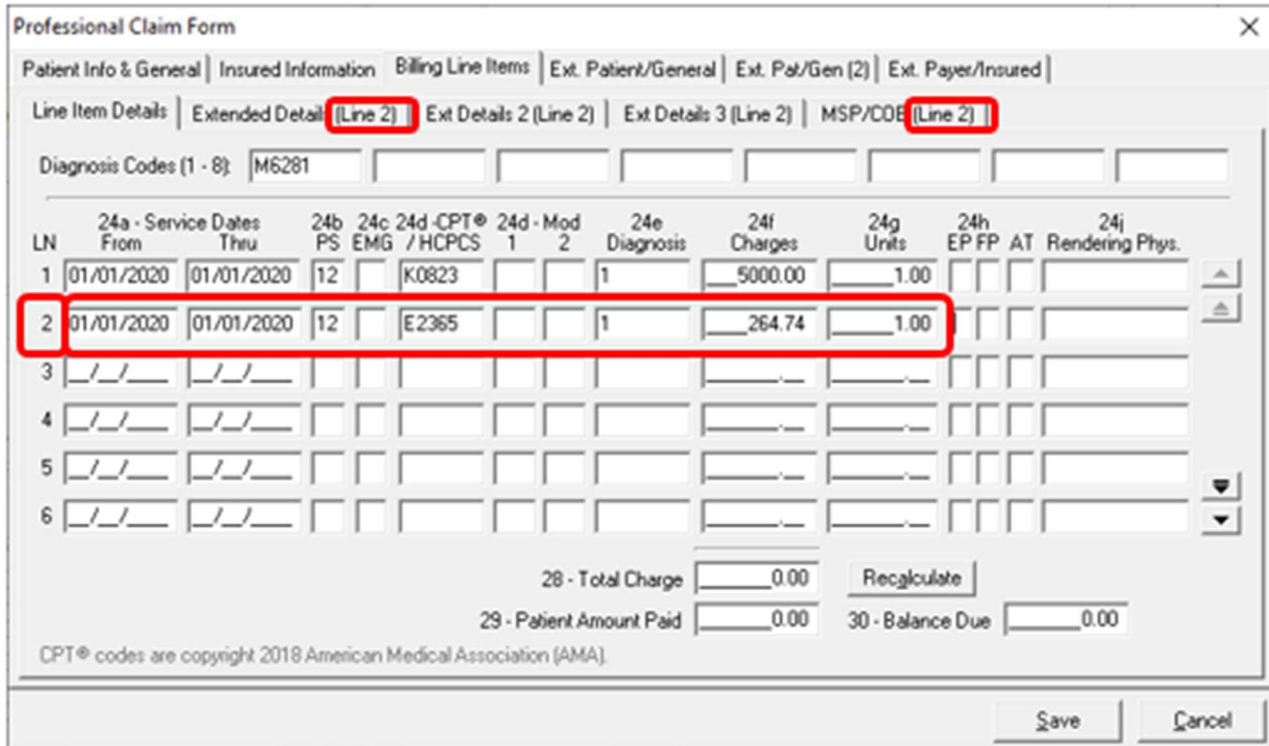
CAUTION: Be careful with what is entered in the claim adjustment, or CAS, section to explain the adjustments. What is entered here can directly impact Medicare payment. CEDI does not have any guidance for what reason codes to select.

It is also important to understand if the primary insurance did not pay, 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” must equal \$5,000.

Finally, the last information to enter on the 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 the other sub-tabs change to display “Line 2”.



LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c EMG	24d - CPT® / HCPCS	24d - Mod 1	24d - Mod 2	24e Diagnosis	24f Charges	24g Units	24h EP FP AT	24j Rendering Phys.
1	01/01/2020	01/01/2020	12		K0823			1	5000.00	1.00		
2	01/01/2020	01/01/2020	12		E2365			1	264.74	1.00		
3												
4												
5												
6												

28 - Total Charge: 0.00 Recalculate

29 - Patient Amount Paid: 0.00 30 - Balance Due: 0.00

CPT® codes are copyright 2018 American Medical Association (AMA).

Save Cancel

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

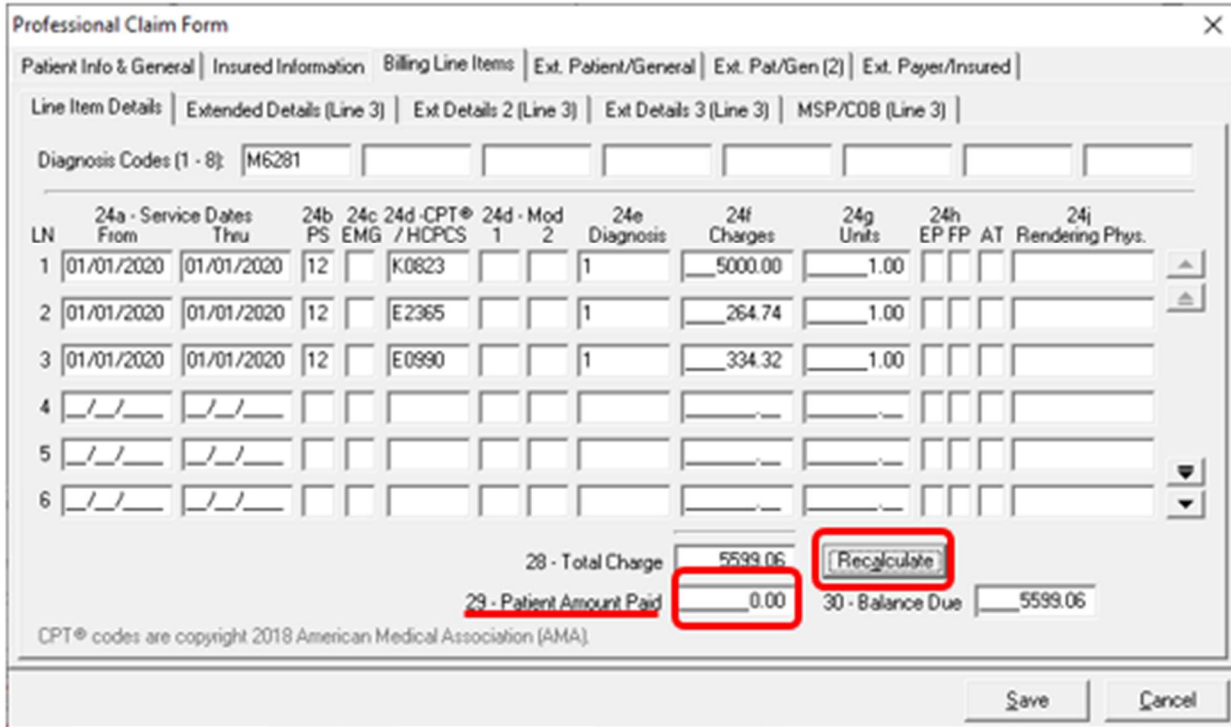
Line Item Details

Extended Details (Line 2)

MSP/COB (Line 2) - Be sure to enter all information on the "SVD 1" line for all charge lines entered.

Repeat as needed for any additional charge lines.

When all charge lines have been 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 example 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): M6281

LN	24a - Service Dates From	24a - Service Dates Thru	24b PS	24c EMG	24d - CPT® / HCPCS	24d - Mod 1	24d - Mod 2	24e Diagnosis	24f Charges	24g Units	24h EP FP	AT	24j Rendering Phys.
1	01/01/2020	01/01/2020	12		K0823			1	5000.00	1.00			
2	01/01/2020	01/01/2020	12		E2365			1	264.74	1.00			
3	01/01/2020	01/01/2020	12		E0990			1	334.32	1.00			
4													
5													
6													

28 - Total Charge 5599.06 **Recalculate**

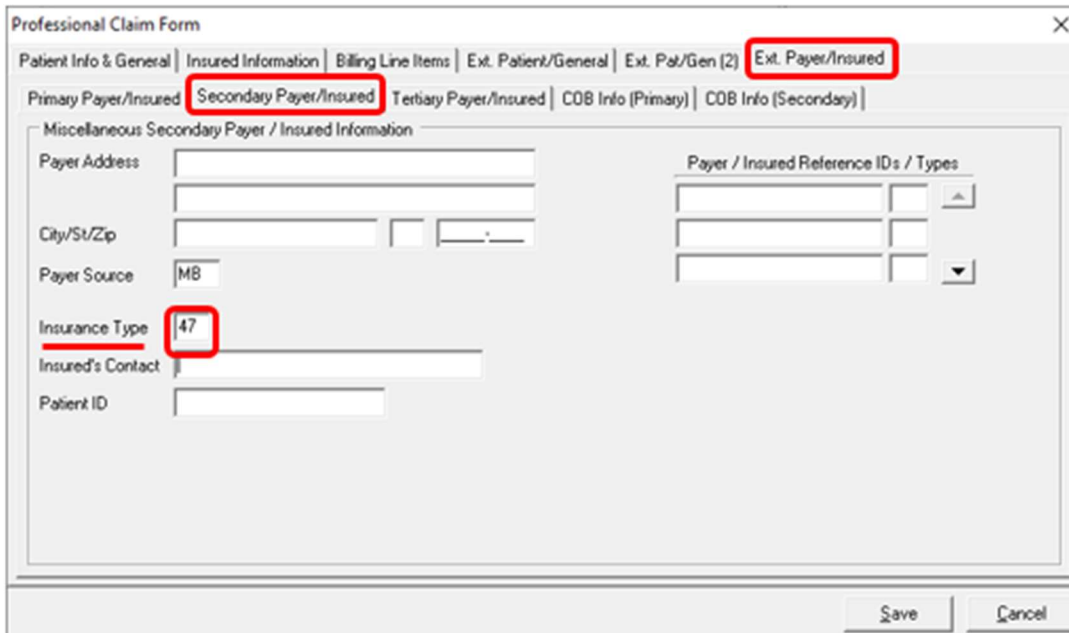
29 - Patient Amount Paid 0.00

30 - Balance Due 5599.06

CPT® codes are copyright 2018 American Medical Association (AMA).

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” field to select the reason why Medicare is the second payer. 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

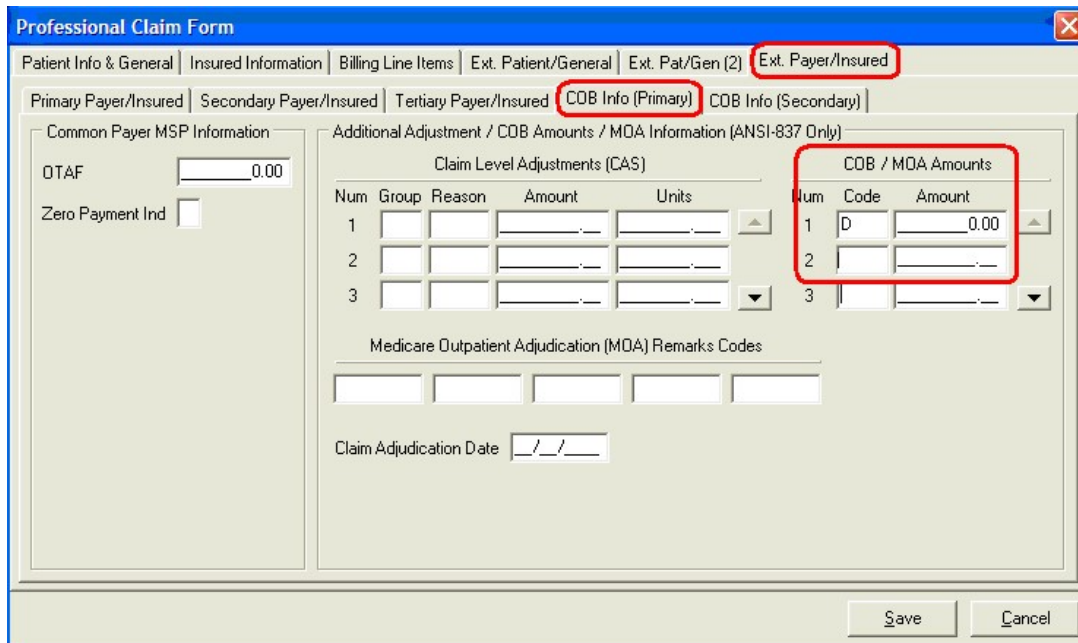
Insurance Type 47

Insured's Contact

Patient ID

Payer / Insured Reference IDs / Types

Save Cancel



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 insurance allowed and paid will be entered.

Code: Use the F2 key or right-click option to bring up a list of codes. Select **D** – Payer paid amount".

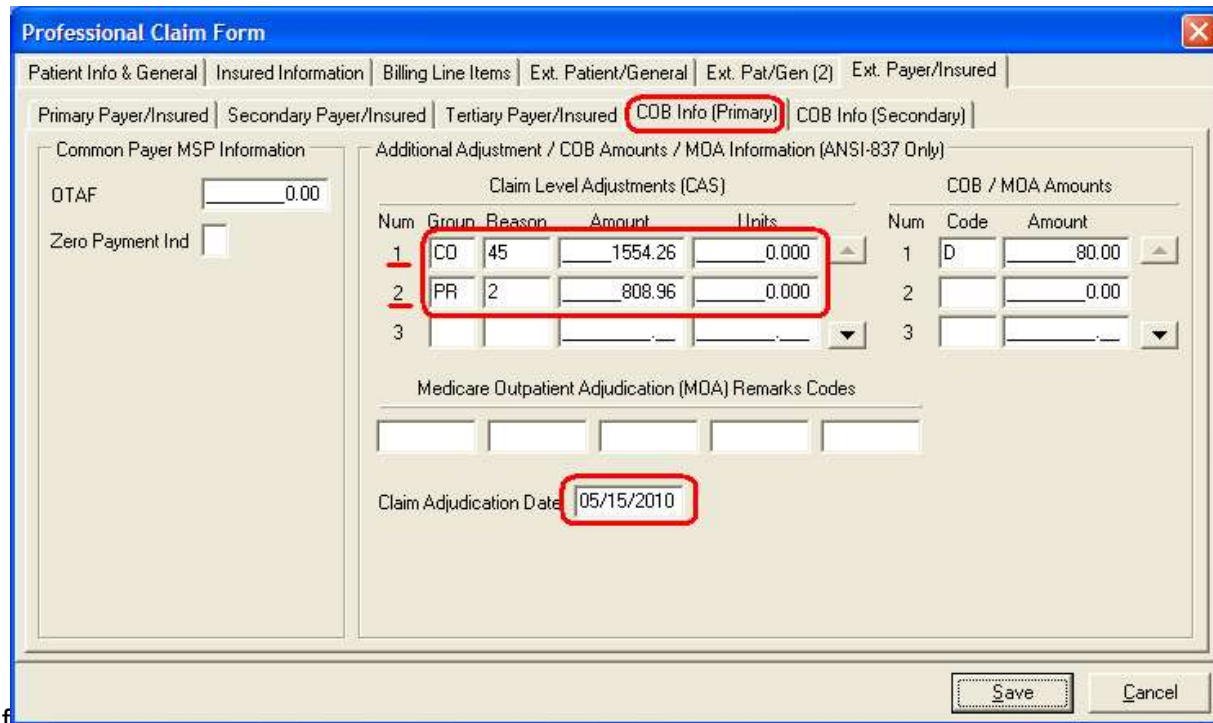
See above for a completed **COB Info (Primary)** sub-tab.

Once this tab is completed, the claim is 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 insurance determined payment or non-payment. See 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)

Common Payer MSP Information

OTAF: 0.00

Zero Payment Ind: ☐

Additional Adjustment / COB Amounts / MDA Information (ANSI-837 Only)

Claim Level Adjustments (CAS)					COB / MDA Amounts		
Num	Group	Reason	Amount	Units	Num	Code	Amount
1	CO	45	1554.26	0.000	1	D	80.00
2	PR	2	808.96	0.000	2		0.00
3					3		

Medicare Outpatient Adjudication (MDA) Remarks Codes

Claim Adjudication Date: 05/15/2010

Save Cancel

CAUTION: Do not enter adjustments at both the claim and the line level. This will throw the claim out of balance and the claim will not be able to be saved until one set of adjustments (claim level or line level) is removed.