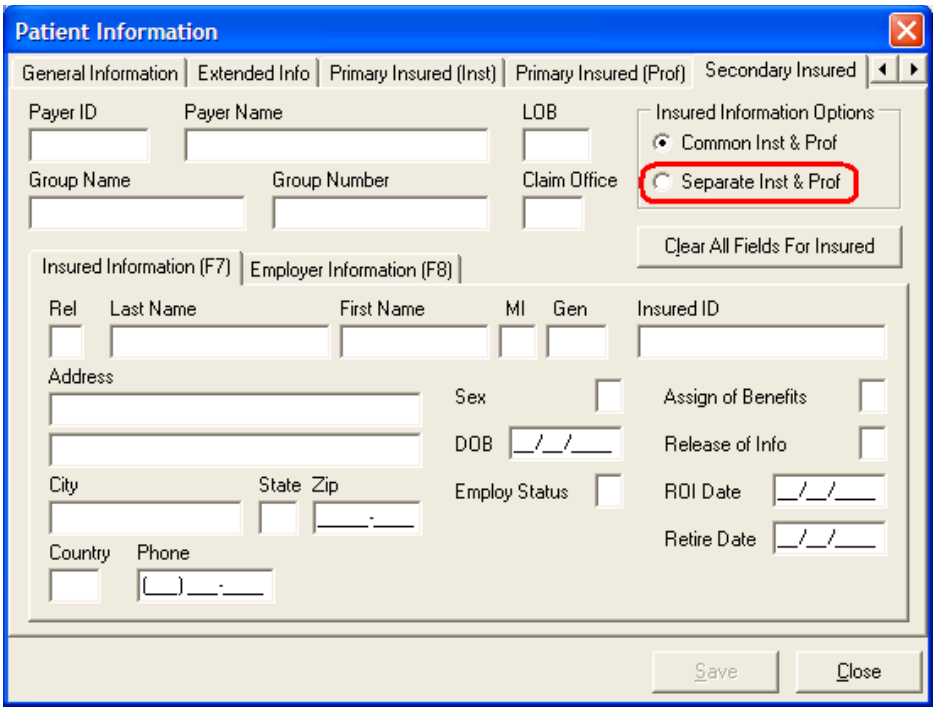
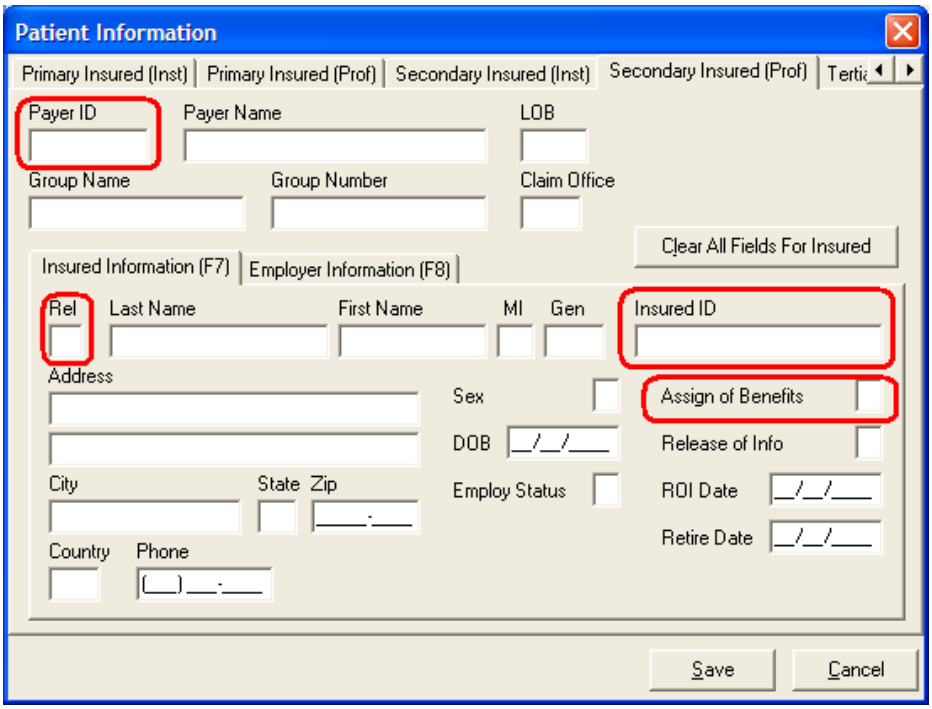


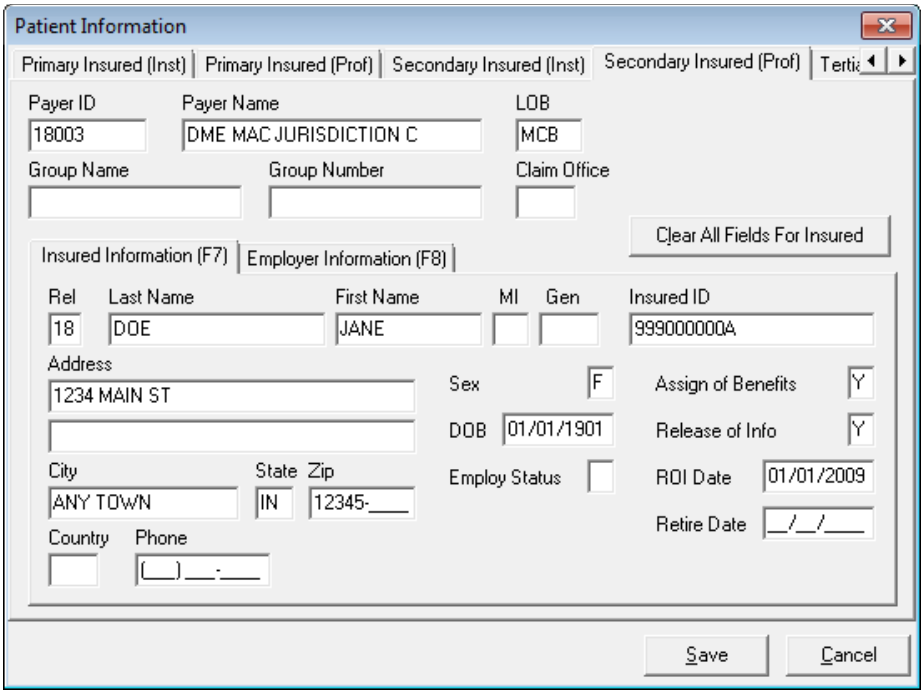
This tab needs to be separated into two tabs, one for **Institutional**, and one for **Professional**. Click in the radio button for "Separate Inst & Prof" in the upper right corner of the screen and it will display like this:



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*.

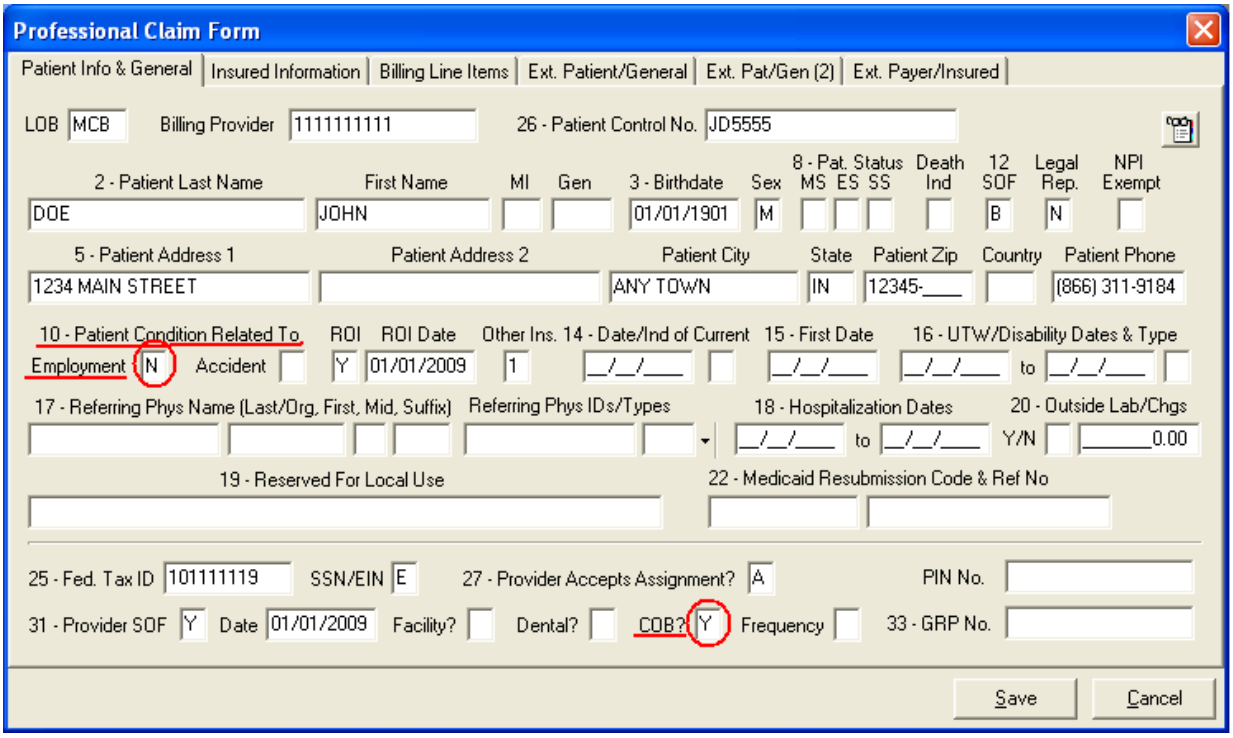
Following is an example of a completed **PATIENT INFORMATION** screen.



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 that was just entered. The **PROFESSIONAL CLAIM FORM** will be displayed again, this time with the patient's data.

MSP Claim Entry (Line Level)

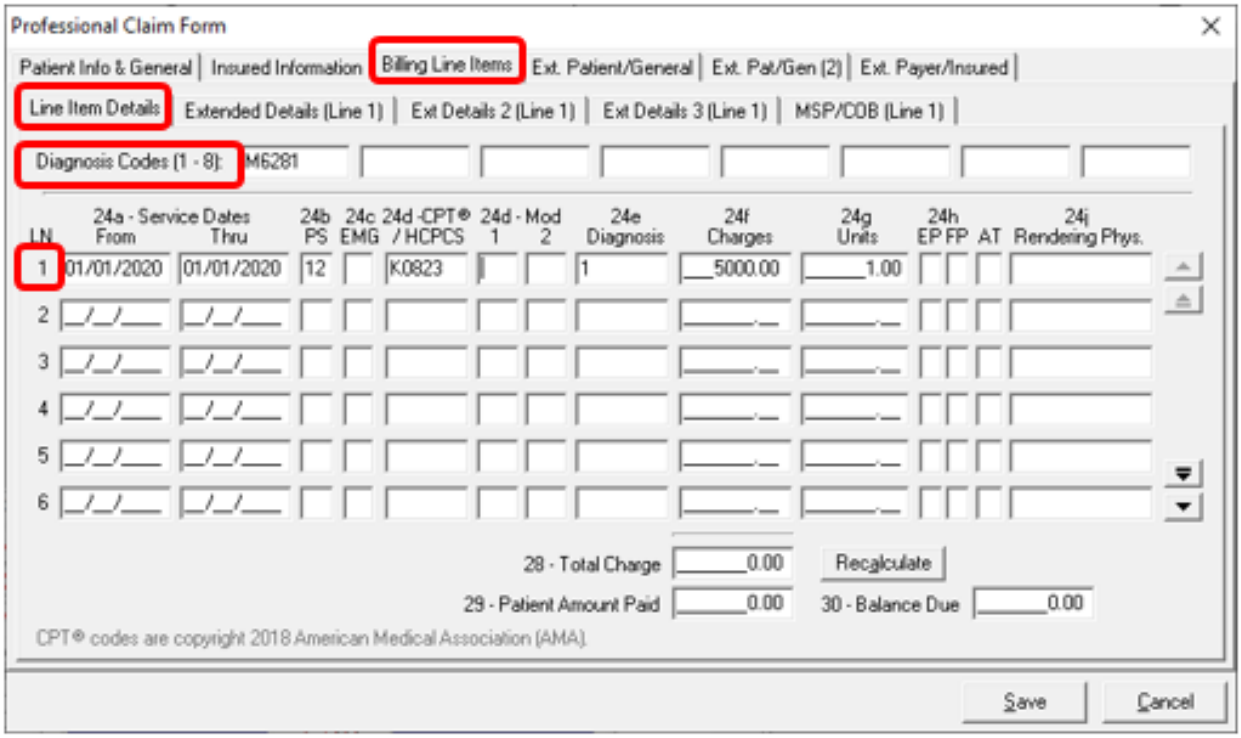
Once the patient is selected, there are two more fields that must be entered on the **Patient Info & General tab:** *Patient Condition Related To Employment* and *COB?*. The *COB?* field will be entered as "Y" in order to turn on the MSP tabs elsewhere in the claim form. These two fields are indicated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



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.

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".

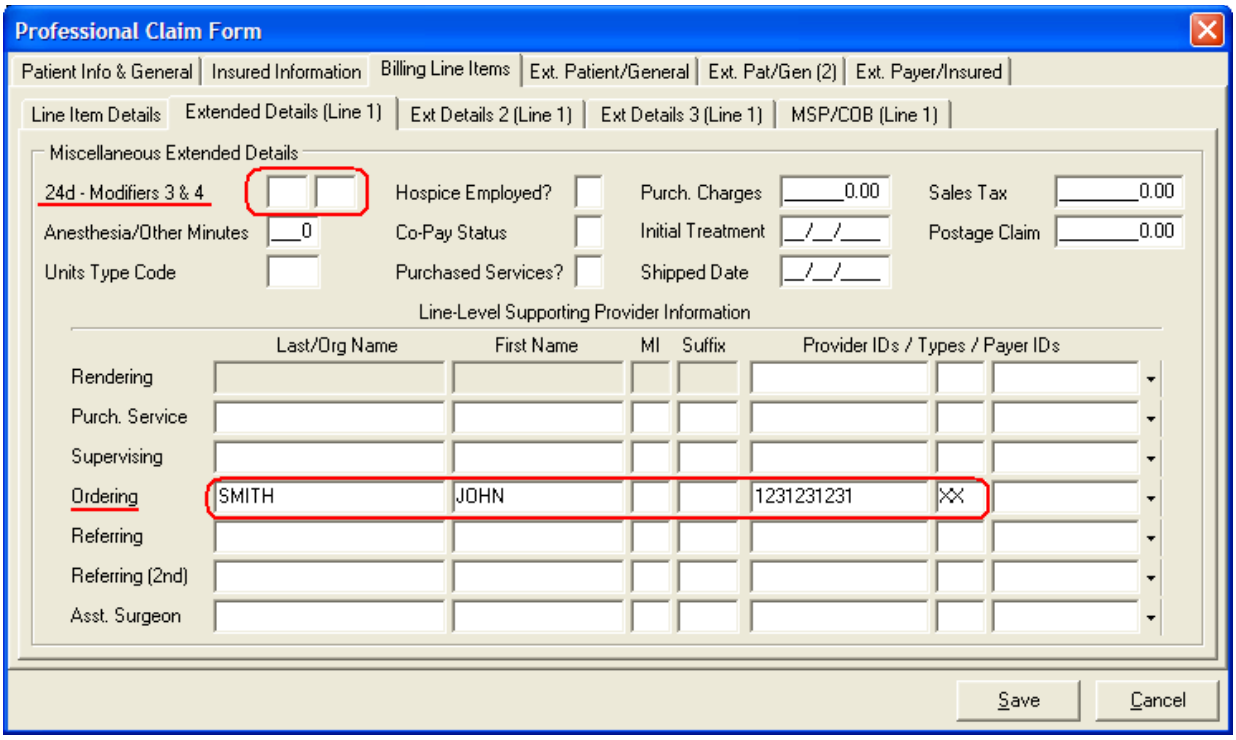
Box 24f: This is original charge for the line item and is not to be adjusted based on how the primary insurance processed the claim. In this example, the item was billed originally to the primary insurance with "$5,000" and the same dollar amount has been entered here.

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 Provider* 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.

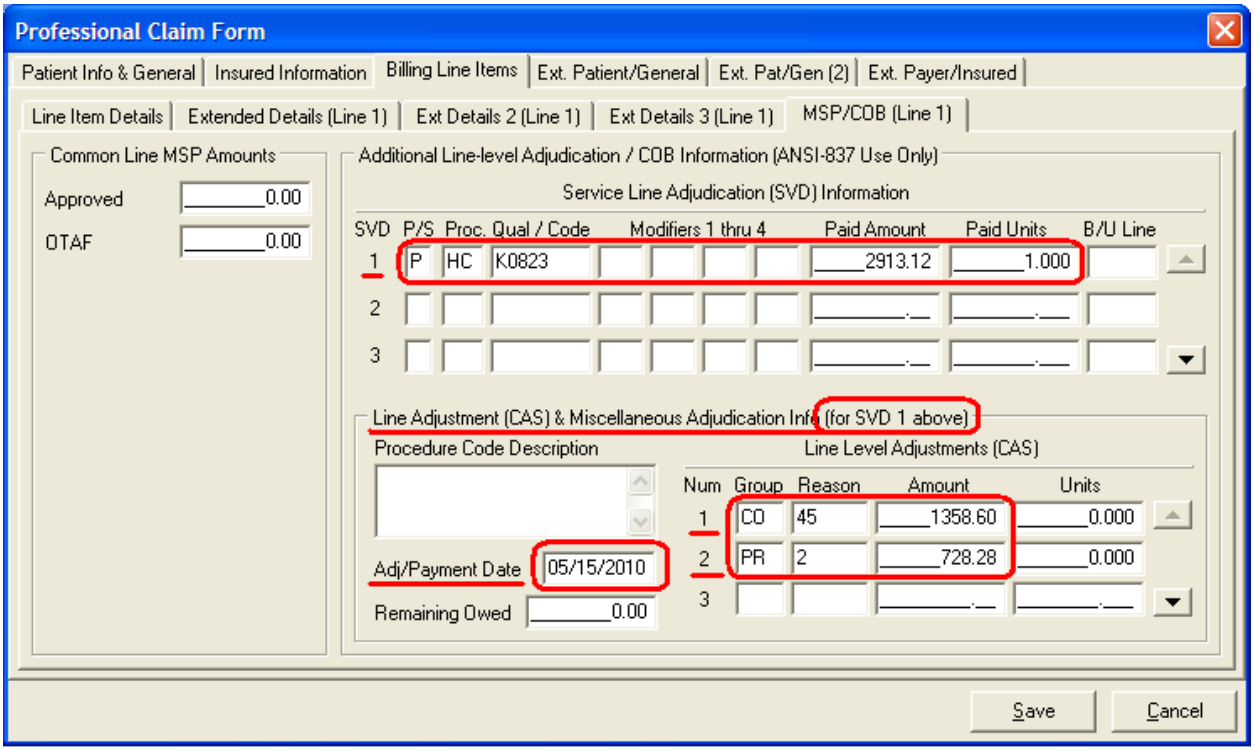
When finished, it should look like this (additional modifiers have not been used in this example):



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.



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.

Modifers 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 that explains 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 a "Reason" that best describes the reason the amount was not allowed. Be aware these codes can have end-dates, and only select codes that are still active. 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 - $,3641.40 = $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".

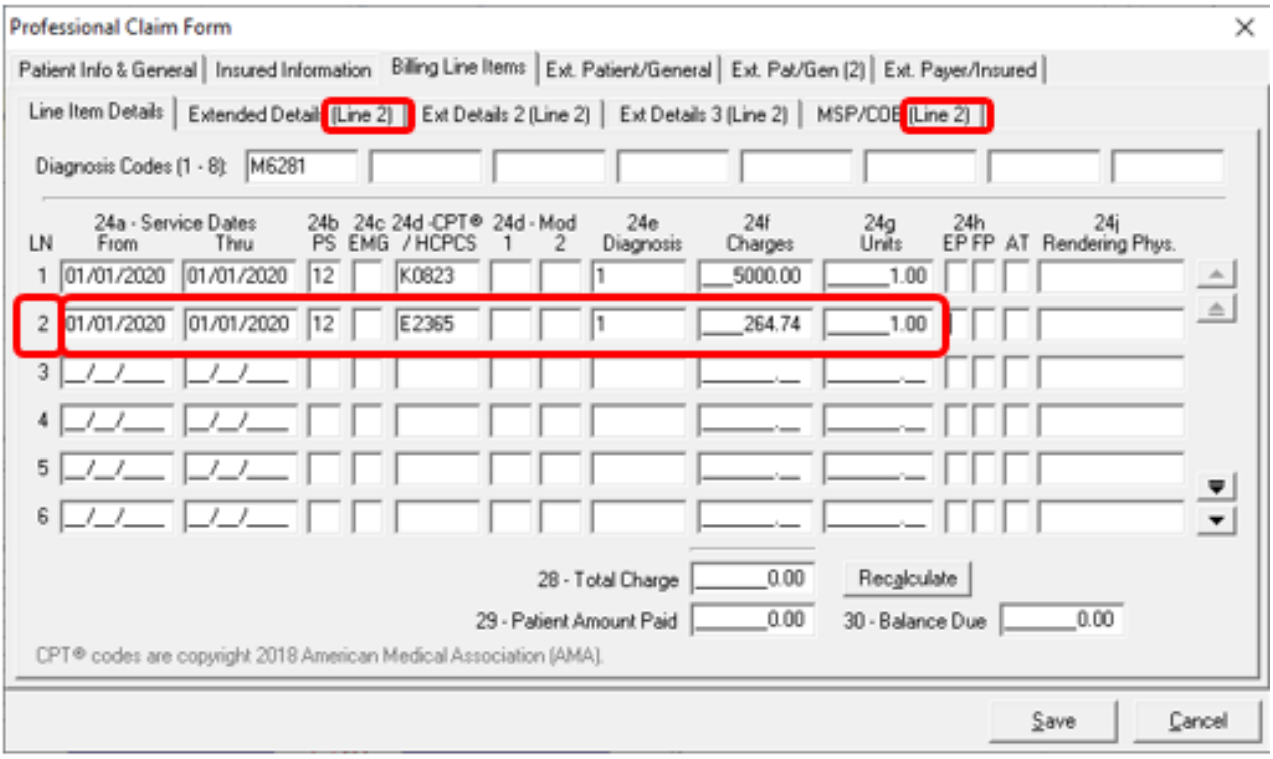
CAUTION: Be careful with what is entered in the claim adjustment, or CAS, section to explain the adjustments. What is entered here can directly impact Medicare payment. CEDI does not have any guidance for what to select for the reason codes.

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".

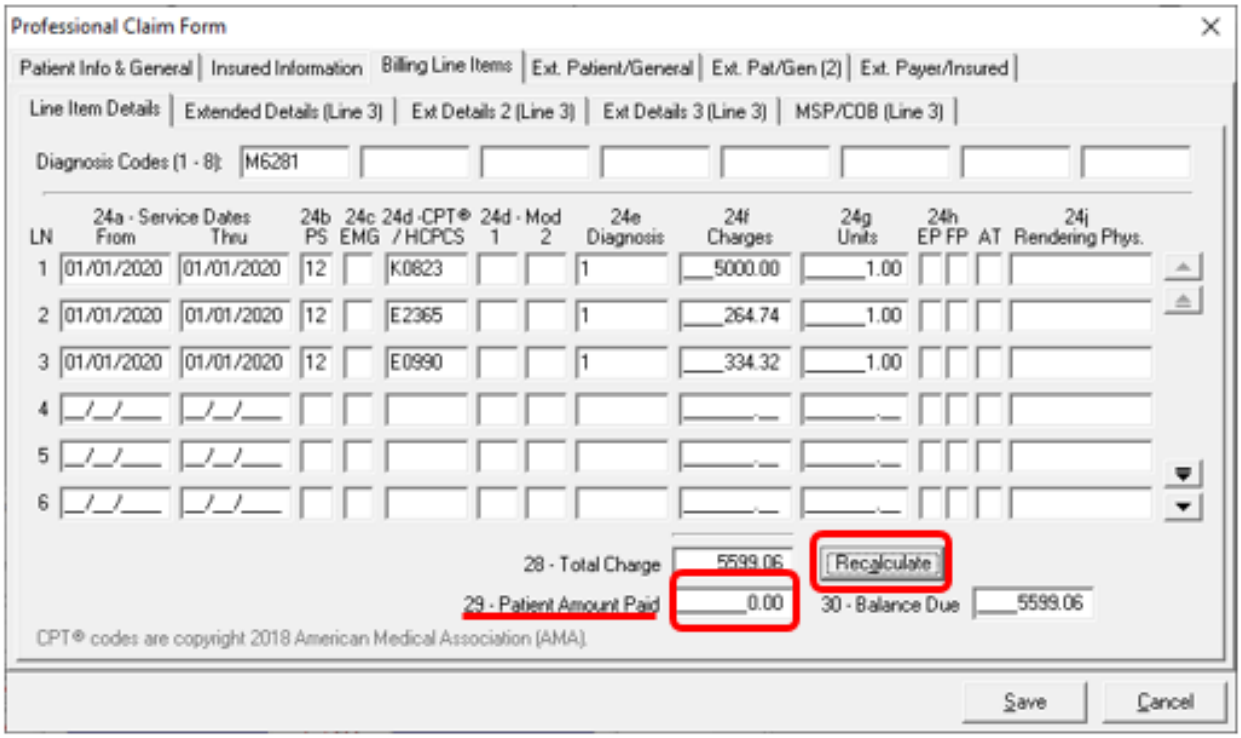


Follow the instructions above to enter the information for this charge line on all three of the required tabs.

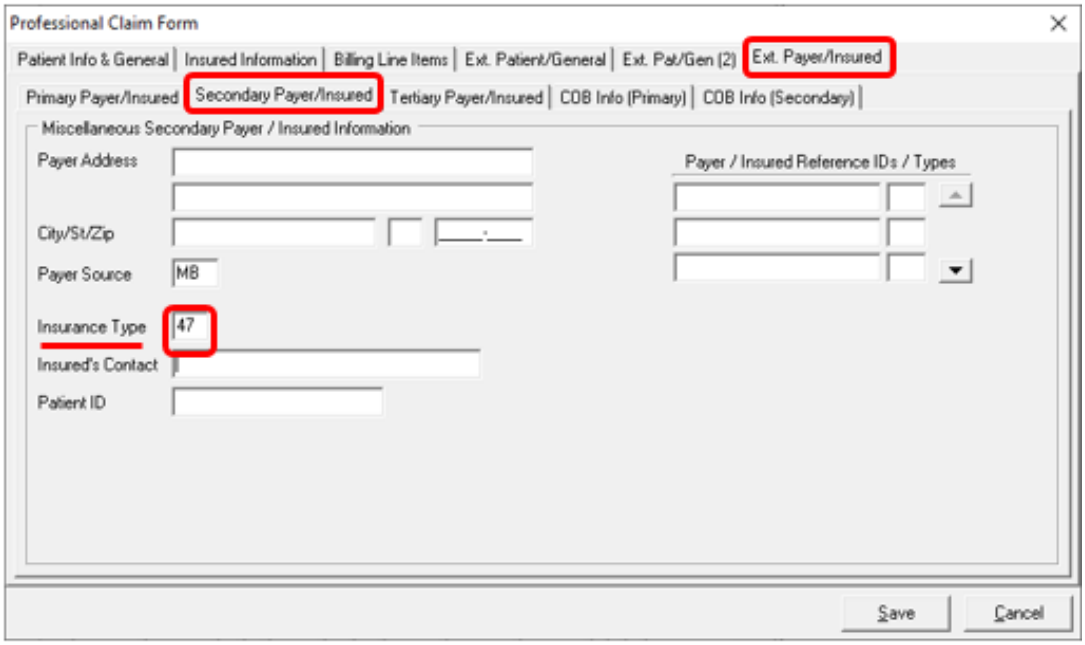
- ***Line Item Details***
- ***Extended Details (Line 2)***
- ***MSP/COB (Line 2)*** Be sure to enter all information on the "SVD 1" line for all charge lines entered.

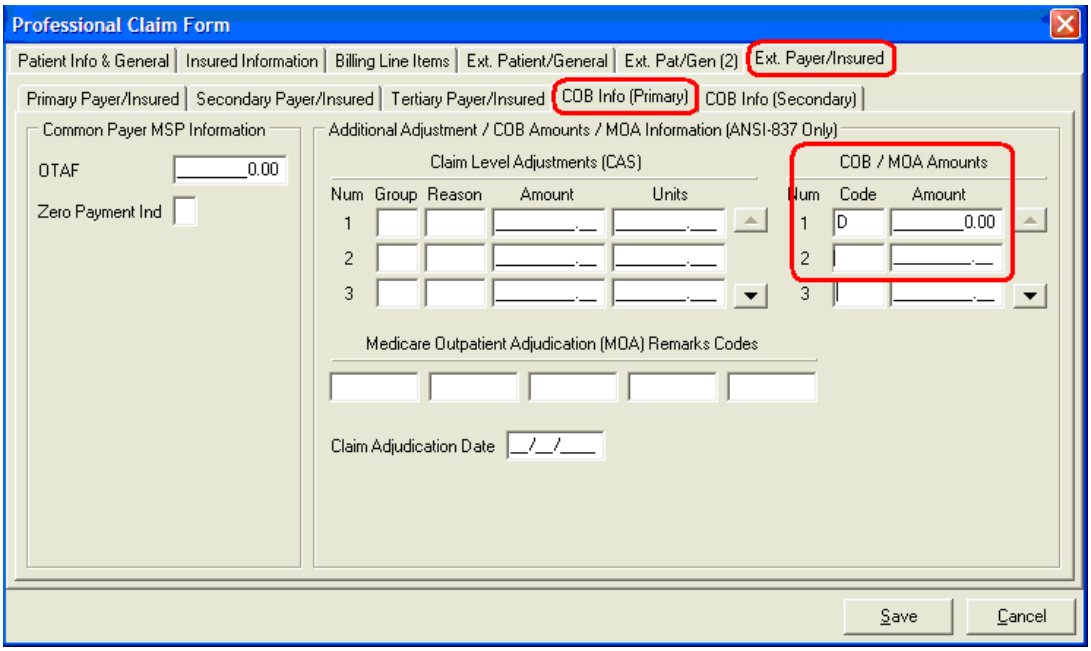
Repeat as needed for any additional charge lines.

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:



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:





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 D is used for the primary paid amount.

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

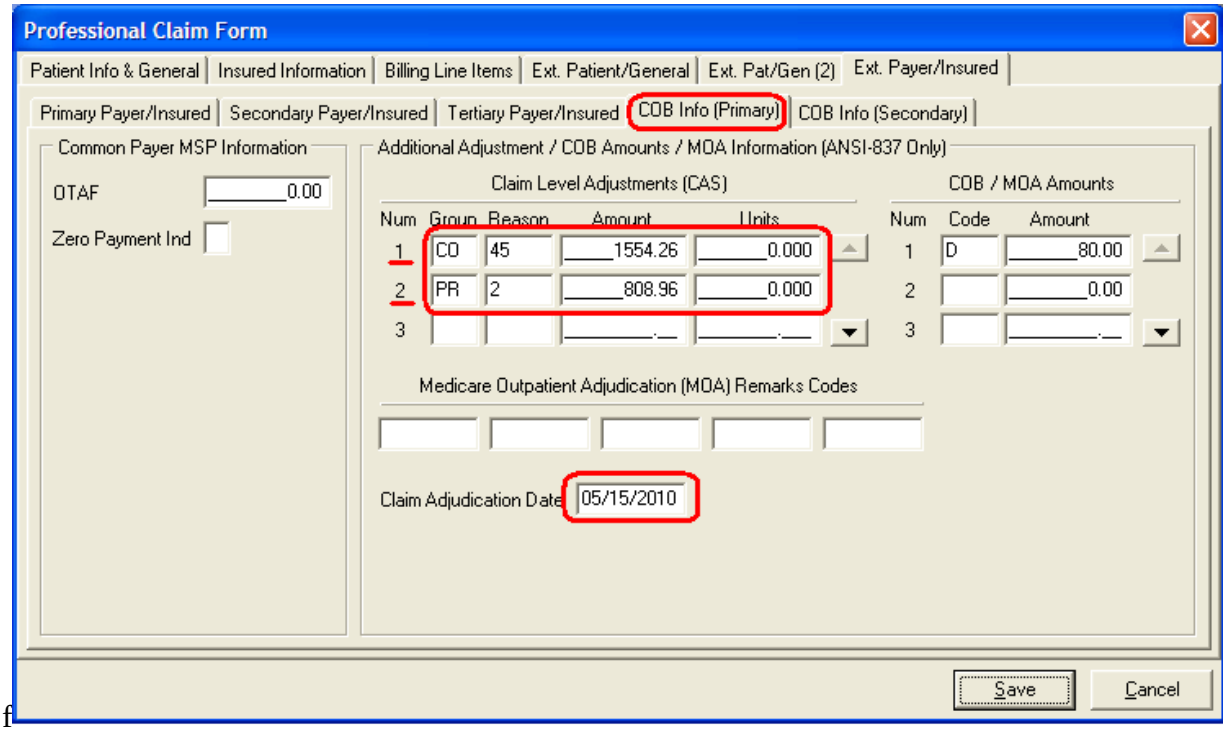
See above for a completed ***COB Info (Primary)*** sub-tab.

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:



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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.