EDI Connection

Fall 2012

Online Help Available for Your EDI Questions

Due to the large number of requests for assistance with issues regarding EDI products and services, user guides and/or manuals have been created. We ask that you reference the resources below before calling our EDI helpdesk as they provide ready, 24-hour-a-day answers to many of the calls we receive.

Medicare Remit Easy Print (MREP):
http://www.cms.gov/AccesstoDataApplication/Downloads/EasyPrintUserGuide.pdf

PC-Print Software – View and Print Medicare Part A Electronic Remittance Advices (ERAs):
http://www.cgsmedicare.com/hhh/pubs/news/2011/0611/cope15043.html

Medicare Remit Easy Print (MREP) Software – View and Print Medicare Part B Electronic Remittance Notices (ERNs):
http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html

EDI forms – EDI Application and Other EDI Forms:
http://www.cgsmedicare.com/pdf/EDI_Enroll_Packet.pdf

Professional Provider Telecommunication Network (PPTN) Manual – Part B Submitters:

- http://www.cgsmedicare.com/kyb/claims/edi/pdf/EDI_PPTN_manual.pdf
- http://www.cgsmedicare.com/ohb/claims/edi/pdf/EDI_PPTN_manual.pdf

Direct Data Entry (DDE) Manual – Part A and HH+H Submitters:
http://www.cgsmedicare.com/parta/edi/DDE.html

PC-Ace Pro32 Software Manual
A ZIP archive containing the latest user's manual (i.e., online Help system in PDF format) is available at:
http://www.cgsmedicare.com/edi/Pro32/pcacepdf.zip.

myCGS
Self Service Web Portal Access claim status, beneficiary eligibility, MSP information, payment information, remittance advices and much more:
http://www.cgsmedicare.com/myCGS/index.html

Electronic Claim Filing and Administrative Simplification Compliance Act (ASCA)

CGS would like to inform providers who are filing their Medicare claims electronically about when or if they can send paper claims. ASCA requires that all claims for reimbursement under Medicare be submitted electronically.

The **only** exceptions per the Centers for Medicare & Medicaid Services (CMS) in which you may file paper claims are:

- **Small providers** with less than 10 full-time employees (including the physicians) for **Part B** submitters
- **Small providers** with less than 25 full-time employees (including the provider) for **Part A/HHH** submitters
- **Roster bill** flu and pneumonia claims
- **Tertiary** claims
- **Dental** claims
- **Black Lung** claims

The two most common rejected requests to file paper claims are:

1. **Medicare Secondary Payer claims (MSP) –** Does not fall under the criteria of an exception per CMS – must be electronic.
2. **Vendor System Change – Dual Submission –** Your office needs to send claims from your old vendor system via paper because

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Updated September 19, 2012.
If you have comments or suggestions for future issues of the *EDI Connection*, please email us from our website at: http://www.cgsmedicare.com/.

CENTERS for MEDICARE & MEDICAID SERVICES

you changed/switched to a new vendor system before the old claims completed processing.

- The claims from your old vendor system must be re-keyed into your new vendor system.
- A temporary waiver will not be granted to submit paper claims because this would not fall under the criteria of an exception per CMS.

If you have questions regarding ASCA or electronic claim filing, please call the Electronic Data Interchange (EDI) helpdesk at 1.866.758.5666.

DDE Applications

TIPS FOR DDE ONLINE INQUIRY FORMS

When submitting Online Inquiry Forms for DDE access, please make sure to indicate your existing RACFID, if you have one. Failure to do so will cause a delay in granting access due to the further research that will need to be done.

Always list the first, middle and last name

The RACFID for HHH will not be the same for Part A or B (if you have or had a HHH RACFID and know you need one for Part A or B this will be considered as a new setup)

TIPS for all other EDI Enrollment Applications.

Please use the updated Provider Authorization. Updated 6/12

Please do not check all regions on the application this will cause a delay in application being processed

Please list the submitter name on the application

Please list your software vendor. If you don't have one there is a free download for PC ACE Pro32 billing software on our website at http://www.cgsmedicare.com.

Resetting User ID and Password for Direct Data Entry (DDE) and Provider Professional Telecommunications Network (PPTN)

CGS EDI does not handle the resetting of DDE/PPTN user IDs or passwords. You must email our security department at CGS.Medicare.OPID@cgsadmin.com with the following information:

- User ID
- First and last name of user
- PIN# (if applicable)
- Message you are receiving when trying to log in

Contact Numbers for Jurisdiction 15 A/B MAC Contract

Home Health & Hospice **States:** Colorado, Delaware, DC, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, N Dakota, S Dakota, Pennsylvania, Utah, Virginia, West Virginia, and Wyoming	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred method)	1.615.664.5947
Interactive Voice Response (IVR) System IVR User Guide	1.877.220.6289
Home Health Complex Inquiries	1.877.299.4500 8:00 a.m. – 4:30 p.m. (CT)
Hospice Complex Inquiries	1.866.539.5592 8:00 a.m. – 4:30 p.m. (CT)
Telecommunications Devices for the Deaf	1.866.854.1876
Kentucky & Ohio Part A	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred method) KY	1.615.664.5943
Fax number for EDI applications and forms (preferred method) OH	1.615.664.5945
Interactive Voice Response (IVR) System IVR User Guide	1.866.289.6501
Provider Customer Service	1.866.590.6703 8:00 a.m. – 5:00 p.m. (ET)
Telecommunications Devices for the Deaf	1.855.294.9889
Kentucky Part B	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred Method)	1.615.664.5917
Interactive Voice Response (IVR) System IVR User Guide	1.866.290.4036
Provider Customer Service	1.866.276.9558 8:00 a.m. – 5:00 p.m. (ET)
Ohio Part B	
Electronic Data Interchange (EDI)	1.866.758.5666 8:00 a.m. – 4:30 p.m. (CT)
Fax number for EDI applications and forms (preferred Method)	1.615.664.5927
Interactive Voice Response (IVR) System IVR User Guide	1.866.290.4036
Provider Customer Service	1.866.276.9558 8:00 a.m. – 5:00 p.m. (ET)

Top 10 Errors and Resolution - Kentucky and Ohio Part B

Kentucky Part B				
#	**Edit Number**	**Edit Description**	**999/277CA Rejection Description**	**Comments/ Resolution**
1	X222.087. 2010AA. NM109.050	This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	"CSCC - A8 - Acknowledgement/Rejected for relational field in error" "CSC - 496 - Submitter not approved for electronic claim submissions on behalf of this entity." "EIC - 85 - Billing Provider"	Please verify that the Billing Provider's Submitter ID has been approved to submit Billing Provider's claims in the 5010 format for production with CGS.
2	X222.121. 2010BA. NM109.020	This Claim is rejected for Invalid Information for a Subscriber's contract/ member number	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 164 - Entity's contract/member number" "EIC - IL - Subscriber"	Medicare number can only be 10 to 11 characters only. Here are the valid formats: NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where "A" represents an alpha character and "N" represents a numeric digit. If the patient's Medicare number is not in these formats. Your claim will reject on the 277CA
3	X222.351. 2400.SV101-2.020	This Claim is rejected for relational field Information within the HCPCS	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 507 - HCPCS"	Please verify that the HCPCS code is valid and active for the date of service sent on your claims electronically. Some HCPCS codes are no longer valid or active for Medicare.
4	X222.094. 2010AA. REF02.050	This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	"CSCC - A8 - Acknowledgement/Rejected for relational field in error" "CSC - 562 - Entity's National Provider Identifier (NPI)" "CSC - 128 - Entity's tax id" "EIC - 85 - Billing Provider"	Please verify that the tax ID and Billing Provider NPI matches what we have on file with Provider Enrollment at CGS. If your Tax ID and Billing Provider NPI information (Address, City/State/Zip code) does not match, it will cause your claims to reject.
5	X222.351. 2400.SV101-7.020	This Claim is rejected for relational field Information within the Detailed description of service	"CSCC - A8 - Acknowledgement/Rejected for relational field in error" "CSC - 306 - Detailed description of service"	For NOC or non-specific procedure codes used, a description of the service rendered is required. This description must be sent on the Service Line (2400 SV101-7). See example below. If this description is sent on Line Note (2400 NTE) or Claim Note description (2300 NTE), your claim will still reject on the 277CA. For a copy of the 2012 NOC codes, please visit http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp#TopOfPage **Correct way to submit** LX*7~ SV1*HC>J3301>>>>>CORTISZONE 10 MG*210*UN*1***1>2>3~ **Incorrect way to submit (will cause your claim to reject)** LX*7~ SV1*HC>J3301*210*UN*1***1>2>3~
6	X222.262. 2310B. NM109.030	This Claim is rejected for Invalid Information for a Rendering Provider's National Provider Identifier (NPI).	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 562 - Entity's National Provider Identifier (NPI)" "EIC - 82 - Rendering Provider"	Please verify that the rendering provider NPI is linked to the Billing Provider NPI submitted in your EDI file. Once verified, please verify the rendering provider NPI effective date linked to Billing Provider/ Group Provider is on or after the Date of service he or she rendered the service.
7	X222.087. 2010AA. NM109.030	This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 562 - Entity's National Provider Identifier (NPI)" "EIC - 85 - Billing Provider"	Please verify that the Billing Provider NPI is valid and on the Medicare Crosswalk for Payer ID 15102. Once verified, please verify the Billing provider NPI effective date at CGS is on or after the Date of service before submitting your EDI file.
8	X222.157. 2300. CLM05-3.020	This Claim is rejected for Invalid Information within the Claim Frequency Code	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 535 - Claim Frequency Code"	Part B Medicare only accepts original claims. ****CLM05-3 must be 1 for Medicare Part B claims only****
9	X999.DUPE	Rejected due to duplicate ST/SE submission	No description given	If you have previously submitted this file to CGS, please create a new file (with new batch numbers) then resubmit the file to CGS.
10	X222.351. 2400.SV101-3.010	This Claim is rejected for relational field information within the Procedure Code Modifier(s) for Service(s) Rendered	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 453 - Procedure Code Modifier(s) for Service(s) Rendered"	Please verify that the modifier sent with the procedure code is valid for the date of service on the claim(s). If invalid, please correct and resubmit the claim(s).

Ohio Part B				
#	**Edit Number**	**Edit Description**	**999/277CA Rejection Description**	**Comments/ Resolution**
1	X222.087. 2010AA. NM109.050	This Claim is rejected for relational field due to Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	"CSCC - A8 - Acknowledgement/Rejected for relational field in error" "CSC - 496 - Submitter not approved for electronic claim submissions on behalf of this entity." "EIC - 85 - Billing Provider"	Please verify that the Billing Provider's Submitter ID has been approved to submit Billing Provider's claims in the 5010 format for production with CGS.
2	X222.094. 2010AA. REF02.050	This Claim is rejected for relational field Billing Provider's NPI (National Provider ID) and Tax ID	"CSCC - A8 - Acknowledgement/Rejected for relational field in error" "CSC - 562 - Entity's National Provider Identifier (NPI)" "CSC - 128 - Entity's tax id" "EIC - 85 - Billing Provider"	Please verify that the tax ID and Billing Provider NPI matches what we have on file with Provider Enrollment at CGS. If your Tax ID and Billing Provider NPI information (Address, City/State/Zip code) does not match, it will cause your claims to reject.
3	X222.121. 2010BA. NM109.020	This Claim is rejected for Invalid Information for a Subscriber's contract/ member number	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 164 - Entity's contract/member number" "EIC - IL - Subscriber"	Medicare number can only be 10 to 11 characters only. Here are the valid formats: NNNNNNNNNA or NNNNNNNNNAA or NNNNNNNNNAN where "A" represents an alpha character and "N" represents a numeric digit. If the patient's Medicare number is not in these formats. Your claim will reject on the 277CA.
4	X222.262. 2310B. NM109.030	This Claim is rejected for Invalid Information within the Rendering Provider's National Provider Identifier (NPI)	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 562 - Entity's National Provider Identifier (NPI)" "EIC - 82 - Rendering Provider"	Make sure to verify that the service level rendering provider NPI is linked to the Billing Provider NPI. Once verified, please verify the rendering provider NPI effective date linkage to Billing Provider/ Group Provider is on or after the Date of service.
5	X222.351. 2400.SV101-7.020	This Claim is rejected for relational field Information within the Detailed description of service	"CSCC - A8 - Acknowledgement/Rejected for relational field in error" "CSC - 306 - Detailed description of service"	For NOC or non-specific procedure codes used, a description of the service rendered is required. This description must be sent on the Service Line (2400 SV101-7). See example below. If this description is sent on Line Note (2400 NTE) or Claim Note description (2300 NTE), your claim will still reject on the 277CA. For a copy of the 2012 NOC codes, please visit www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp#TopOfPage **Correct way to submit** LX*7~ SV1*HC>J3301>>>>>CORTISZONE 10 MG*210*UN*1***1>2>3~ **Incorrect way to submit (will cause your claim to reject)** LX*7~ SV1*HC>J3301*210*UN*1***1>2>3~
6	X999.DUPE	Rejected due to duplicate ST/SE submission	No description given	If you have previously submitted this file to CGS, please create a new file (with new batch numbers) then resubmit the file to CGS.
7	X222.351. 2400.SV101-2.020	This Claim is rejected for relational field Information within the HCPCS	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 507 - HCPCS"	Please verify that the HCPCS code is valid and active for the date of service. Some HCPCS codes are no longer valid or active for Medicare
8	X222.087. 2010AA. NM109.030	This Claim is rejected for Invalid Information in the Billing Provider's NPI (National Provider ID)	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 562 - Entity's National Provider Identifier (NPI)" "EIC - 85 - Billing Provider"	Make sure to verify that the Billing Provider NPI is valid and on the Medicare Crosswalk for Payer ID 15202. Once verified, please verify the Billing provider NPI effective date is on or after the Date of service submitted in your EDI file.
9	X222.133. 2010BB. NM109.025	This Claim is rejected for Invalid Information for Missing or Invalid Information with the Payer's ID Number and Receiver's ID Number	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 21 - Missing or Invalid Information" "CSC - 153 - Entity ID Number" "EIC - PR - Payer" "CSC - 153 - Entity ID Number" "EIC - 40 - Receiver"	Please make sure that the Payer ID in the Primary or Secondary Insurance Information matches the Payer ID sent in the Receiver information. If the information does not match, your claim will reject.
10	X222.351. 2400.SV101-3.010	This Claim is rejected for relational field information within the Procedure Code Modifier(s) for Service(s) Rendered	"CSCC - A7 - Acknowledgement/Rejected for Invalid Information…" "CSC - 453 - Procedure Code Modifier(s) for Service(s) Rendered"	Please verify that the modifier sent with the procedure code is valid for the date of service on the claim(s). If invalid, please correct and resubmit the claim(s).

myCGS User IDs: o vs. O

When you register for myCGS (our new web portal) as a Provider Administrator, or when a Provider Administrator registers other users in the office as provider users, the portal automatically assigns a system-generated user ID. In some cases, user IDs begins with what appears to be the letter "O." Please note – myCGS **user IDs will never begin with a letter "O."** Instead, this is the number zero (0). Using the letter "O" instead of the number "0" will not allow you access to myCGS.

Urgent Update Needed for PC-ACE Pro 32 Users

The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing new Medicare version 5010 claim edits which require that the Subscriber Group Number (SBR03/2000B) and Subscriber Group Name (SBR04/2000B) elements be empty. For historical reasons, PC-ACE Pro32 allows (and even auto-populates in many situations) these elements.

As such, changes are needed to the PC-ACE Pro32 claim prepare modules to force these elements to always be empty for Medicare claims prepared in version 5010 errata format. Failure to apply these changes will result in claim rejections beginning September 4, 2012 when the new edits are activated.

Resolution: Close PC-ACE Pro32 and click on the following link to download and install a patch that will correct this problem.

Download Update Patch Now
(http://www.system-designs.com/pro32prv/updtsbr.exe)

The download must be performed from the computer used to bill your claims. You can run the program directly from the browsers download dialog or save the program file to your Windows desktop and then execute it from there. Once the update program is running, simply click the "Next" button several times to perform the update. Click the "Finish" button to complete the process. If you saved the UPDTSBR.EXE program file to your desktop, you should delete it once it has been successfully installed.

Registration Tip!

It has been discovered that when using the Mozilla Firefox Browser to register for the myCGS Portal, users may come to a blank screen where you would usually enter the answers to security questions during the registration process. If this occurs please stop the registration process and switch to a different Browser such as Internet Explorer 8.0 or higher and start the registration process over. This should resolve your issue.

Medicare Remit Easy Print Helpful Hint

Are you getting one of these error messages when attempting to print from MREP?

"An Unhandled exception occurred in a component in your application"

"Object reference not set to an instance of on object"

"Error occurred while attempting to display"

Any error message similar to this is possibly indicative of an improperly installed printer or the lack of any printer installed at all.

The printer driver generates the Print Preview within MREP, so this requires a properly installed printer in order to preview any reports. This can often be fixed by ensuring that you have the most recent drivers for your printer.

Submitting Medicare Secondary Payer (MSP) Claims and Adjustments

The instructions below will assist you in determining how your MSP claims and adjustments must be submitted to Medicare (i.e. electronically, direct data entry (DDE) or on paper). For detailed instructions on billing MSP claims, including the required data elements (value codes, occurrence codes, primary insurer information, etc.) refer to the CGS 'Medicare Secondary Payer (MSP) Billing and Adjustments' quick resource tool.

When anotherinsurance has made a payment primary to Medicare, CMS requires that Claim Adjustment Segments (CAS) be submitted on the MSP claim or adjustments. CAS segments are only utilized when MSP claims and adjustments are submitted electronically (using the American National Standard Institute (ANSI) ASC X12N 837 format). Therefore, it is important to understand the rules for submitting MSP claims to Medicare.

General Rule:

If the primary insurer did not/will not make a payment (i.e. services are unrelated to the MSP record, or the primary insurer denied payment), the claim **must** be submitted to Medicare DDE {i.e. keyed directly into the Fiscal Intermediary Standard System (FISS)}. In this case, the claim must include MSP coding to acknowledge the MSP record, **even if the services are unrelated**. If the claim is submitted with Medicare as primary, and an open MSP record exists, the claim may be rejected.

If the primary insurer did/will make a payment, the claim **must** be submitted to Medicare electronically (837 format). If the claim is submitted to Medicare DDE, and indicates a payment by the primary insurer, the claim will be returned to the provider (RTP) with reason code 31265 (MSP claims and adjustments cannot be entered via direct data entry (DDE) thru FISS).

Exception to General Rule: If an open Black Lung record exists, and the claim includes a Black Lung diagnosis, a paper (UB-04) claim must be submitted, along with a denial notice from the Federal Black Lung Program. For more information about Black Lung, refer to the Federal Black Lung Program Web page (http://www.cgsmedicare.com/hhh/education/materials/BL_Program.html).

The table below provides a summary of various MSP situations, and how the claim must be submitted (FISS DDE, electronically, or paper). Detailed instructions for billing MSP claims, including the required data elements (value codes, occurrence codes, primary insurer information, etc.) can be found on the CGS "Medicare Secondary Payer (MSP) Billing and Adjustments" (http://www.cgsmedicare.com/hhh/education/materials/pdf/MSP_Billing.pdf) quick resource tool.

MSP Situation	MSP Claims/Adjustments must be submitted via:
Services are **unrelated** to an open MSP record (liability, workers' compensation, no-fault, Federal Black Lung, etc.).	FISS DDE, including MSP coding
The primary insurance* denied payment for the services. *Claims denied by the Black Lung Program must be submitted on a paper (UB-04) claim. (See Black Lung situation below).	FISS DDE, including MSP coding
Another insurer is primary and, the primary insurer has paid some or all of the services.	**Electronically** {i.e., a billing software in the American National Standard Institute (ANSI) ASC X12N 837 5010-A1 format (e.g., PC-Ace Pro32 v. 2.14)}, including MSP coding
Another insurer is primary and there is a possibility/ expectation that the primary insurer will make a payment in the future. (Example: Services are related to a liability record; however, there was no prompt response/payment (within 120 days) from the primary insurer after submitting your claim to them.)	**Electronically** including MSP coding {if software allows billing a zero dollar amount ($0000.00) with a value code} **OR** **Paper claim,** including MSP coding {if your agency meets the small provider exception, (CMS Pub. 100-04, Ch. 24, §90)} **OR** **FISS DDE** without MSP coding. The claim will reject to R B7501 or R B7516. Approximately 75 days later, the claim will move to R B9997, and a paper adjustment must then be submitted, including the MSP coding
Another insurer is primary; however the charges were applied to the deductible.	**Electronically** including MSP coding {if software allows billing a zero dollar amount ($0000.00) with a value code} **OR** **Paper claim,** including MSP coding {if your agency meets the small provider exception, (CMS Pub. 100-04, Ch. 24, §90)} **OR** **FISS DDE** without MSP coding. The claim will reject to R B7501 or R B7516. Approximately 75 days later, the claim will move to R B9997, and a paper adjustment must then be submitted, including the MSP coding
The beneficiary has coverage through Black Lung (BL), and your claim includes black lung diagnoses.	**Paper claim,** including MSP coding and the BL Explanation of Benefits (EOB)

Correcting MSP Claims and Adjustments

The above rules will also hold true when you are correcting a claim that has been returned to you (RTP file, status location T B9997). Claims that are corrected out of the RTP file are considered to be submitted DDE, regardless of whether they were originally submitted electronically (5010 format). Therefore, **rather than correcting a claim (from the RTP file) that was required to be submitted electronically, it must be resubmitted electronically** (with the error corrected) in order to meet the electronic billing requirement.

References

- Change Request 6426 —Instructions on utilizing 837 Institutional CAS segments for Medicare Secondary Payer (MSP) Part A Claims: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R70MSP.pdf
- Medicare Learning Network (MLN) MM6426 article: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6426.pdf

Medicare Secondary Payer (MSP) Payment Information

A Claim Adjustment Reason Code (CARC) is a code used to communicate an adjustment, meaning that you must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

The adjustment codes are placed in the CAS segment on an electronic claim which CGS uses to determine MSP payment. A list of these codes may be found on the Washington Publishing Company (WPC) website: http://www.wpc-edi.com/content/view/711/401/.

If you are required to submit Medicare claims electronically, there is no exception for MSP claims unless there are multiple primary payers. Providers who are fully capable of submitting MSP to the Medicare program in the HIPAA Standard should review the required steps to ensure that the primary payer data is correctly submitted to avoid delays in claims processing and payment consideration.

The following information is available on the CGS website (http://www.cgsmedicare.com/hhh/education/materials/MSP.html):

- Medicare Secondary Payer Manual (CMS Pub. 100-05)
- CMS Guidelines and Resources for Medicare Secondary Payer (MSP)
- Identifying MSP Records
- Submitting MSP Claims to Medicare
- Billing MSP Claims to Medicare
- Claims Suspended for MSP
- Medicare Payment for MSP Claims
- MSP Frequently Asked Questions (FAQs)
- Black Lung (BL) Program

You will also find links on the website above for MSP resources from the Centers for Medicare & Medicaid Services (CMS); such as:

- MSP Payer Fact Sheet
- CMS Guidelines and Resources for MSP
- Other valuable information and resources for MSP

Medicare Secondary Payer (MSP)

MSP Insurance Types:

MSP Type 12 Working Aged Group Health Insurance (employer has 20 or more employees): This insurance is provided by an employer to a policyholder who is actively working with an employer that has 20 or more employees, or covered under their working spouse of any age who meets that employee status.

MSP Type 43 Disability Insurance: Medicare benefits are secondary payer to "large group health plans" (LGHP) for individuals under age 65 entitled to Medicare on the basis of disability and whose LGHP coverage is based on the individual's current employment status with an employer that has 100 employees or more or the current employment status of a family member with such employer.

MSP Type 14/47 Automobile or Liability Insurance: This insurance is coverage for beneficiaries who are in accidents and payable under an alternative policy. Medicare can make a conditional payment if the no-fault or liability insurance will not pay promptly. These payments are conditioned upon reimbursement to the trust fund if the primary has/had the responsibility to make primary payment.

MSP Type 15 Workers' Compensation (WC): This insurance is coverage under an employer for injuries sustained on the job. Medicare can make a conditional payment if the worker's compensation insurance will not pay promptly. These payments are conditioned upon reimbursement to the trust fund if the primary has/had the responsibility to make primary payment.

MSP Type 41 Federal Black Lung Program: This program covers Black Lung claims. Medicare cannot pay claims submitted with a Black Lung Diagnosis code unless the information was included on the electronic claim with appropriate information or a copy of the Black Lung Explanation of Benefits is attached to the paper claim.

MSP Type 13 End Stage Renal Disease (ESRD): For beneficiaries covered through an employer sponsored health plan through their own or a family member's current or former employment, Medicare is secondary for 30 months for those beneficiaries entitled to Medicare based solely on ESRD from March 1, 1996.

Coordination of Benefits Contractor (COBC)

The COBC collects, manages, and reports insurance coverage for Medicare Beneficiaries. They will verify the insurance information for the patient and, in the case of multiple insurers, determine the proper payment arrangement in order to prevent mistaken payment of Medicare benefits.

If the insurance information for the patient needs to be updated, the best course of action is to ask the beneficiary to contact the COBC directly at 1.800.999.1118. In some cases, the COBC may be able to accept information directly from providers; in most cases, however, the beneficiary should call the COBC directly.

Conditional Payment for Medicare Beneficiaries

Medicare may not may payment on an MSP claim where payment has been made or can reasonably be expected to be made by (or based on) a WC law or plan, or liability, or no-fault insurance. However, Medicare can make a conditional payment for WC, no-fault, or liability if payment has not be made or cannot be expected to be made by these insurance and the promptly billed period has expired.

These payments are made based "on the condition" that the Medicare Trust Fund be reimbursed if the insurance is responsible for making the primary payment, based on a judgment, waiver, or release. The instructions for billing Conditional Payment are included in the Job Aid.

Filing Medicare Secondary Payer Claims

If Medicare is not the primary insurance, you must submit complete information regarding the primary payment from the other insurer in order for any additional payment to be paid. Medicare secondary benefits may be payable if all the following conditions are met:

- The primary insurer's payment is less than the provider's charges for Medicare covered services, and
- The primary insurer's payment is less than the maximum amount payable by Medicare, and
- The provider does not accept and is not obligated to accept the primary insurer's primary payment as payment in full.

In some cases, the primary insurer's payment and allowed amount exceed the amount that may be payable by Medicare. We strongly recommend that you file a Medicare secondary claim in these situations, even though no Medicare payment can be made. Filing a timely claim is important in the event that, at a later date, it is determined that Medicare should have been the primary payer for that claim.

Filing MSP Claims: CMS-1500 Claim Form

MSP claims that are filed on paper must be submitted with a copy of the primary insurance remittance notice. We require all elements to be on the primary insurance's explanation of benefits (EOB) in order to process Medicare secondary claims:

- The EOB must be legible and complete.
- If the primary insurer's EOB does not include an explanation of any denials, then any denial codes that you received from the primary insurer must be submitted with the claim, even if this information is on another page.
- The date of service on the EOB must match the date of service on the CMS-1500 form.
- If the primary insurance has been updated, cancelled, or terminated, include this information with your Medicare claim. (We strongly recommend that you advise your patients to contact the COBC directly in these situations in order to update their Medicare records.)

Filing MSP Claims: Electronic Billing

When filing for Medicare secondary payer for an electronic claim, complete the specific loops and segments as noted in the following chart:

Loop 2000B – Subscriber Information			
Usage	Segment	Value	Comment
Required	SBR01	P = Primary	Code identifying the insurance carrier's level of responsibility for payment of a claim (to identify whether Medicare is primary, secondary or tertiary). Use "S" for Medicare Secondary Payer (MSP) claims being sent to Medicare Part.
Required	SBR01	S = Secondary	
Required	SBR01	T = Tertiary; Use to indicate "payer of last resort"	
Situational	SBR02	18	Specifies the relationship to the person insured
Situational	SBR03		Policy or group number
Situational	SBR04		The name of group plan
Situational	SBR05	12 = Working Aged	Code to identify the type of insurance policy within a specific insurance program
		13 = ESRD	
		14 = No-fault Insurance including Auto is Primary	
		15 = Workers' Compensation	
		16 = Workers' Compensation	
		41 = Black Lung	
		42 = Veterans Administration	
		43 = Disability	
		47 = Liability Insurance	

Loop 2320 – Other Subscriber Information Required if other payers are known to potentially be involved in paying this claim.			
Usage	Segment	Value	Comment
Required	SBR01	P = Primary	Code identifying the insurance carrier's level of responsibility for payment of a claim. Use "P" for claims sent to Medicare Part B to identify primary information.
		S = Secondary	
		T = Tertiary Use to indicate "payer of last resort"	
Required	SBR02	01 = Spouse	Specifies the relationship to the insured
		04 = Grandfather or Grandmother	

Loop 2320 – Other Subscriber Information Required if other payers are known to potentially be involved in paying this claim.			
Usage	Segment	Value	Comment
Required	SBR02	05 = Grandson or Granddaughter	Specifies the relationship to the insured
		07 = Nephew or Niece	
		10 = Foster Child	
		15 = Ward	
		17 = Stepson or Stepdaughter	
		18 = Self	
		19 = Child	
		20 = Employee	
		21 = Unknown	
		22 = Handicapped Dependent	
		23 = Sponsored Dependent	
		24 = Dependent of a Minor Dependent	
		29 = Significant Other	
		32 = Mother	
		33 = Father	
		36 = Emancipated Minor	
		39 = Organ Donor	
		40 = Cadaver Donor	
		41 = Injured Plaintiff	
		43 = Child Where Insured has No Financial Responsibility	
		53 = Life Partner	
		G8 = Other Relationship	
Situational	SBR03		Policy or group number. Must not match the value in 2330A NM109.
Required	SBR05	**12** = Working Aged	Code to identify the type of insurance policy within a specific insurance program
		13 = ESRD	
		14 = No-fault Insurance, including Auto, is primary.	
		15 = Workers' Compensation	
		41 = Black Lung	
		41 = Medicare Secondary Black Lung	
		42 = Veterans Administration	
		43 = Disability	
		47 = Liability Insurance	
Required	SBR09	**11** = Other Non-Federal Programs	Code to identify the type of claim
		12 = Preferred Provider Organization (PPO)	
		13 = Point of Service (POS)	
		14 = Exclusive Provider Organization (EPO)	
		15 = Indemnity Insurance	
		16 = Health Maintenance Organization (HMO) Medicare Risk	
		AM = Automobile Medical	
		BL = Blue Cross/Blue Shield	

Loop 2320 – Other Subscriber Information Required if other payers are known to potentially be involved in paying this claim.			
Usage	Segment	Value	Comment
Required	SBR09	**CH** = Champus	Code to identify the type of claim
		CI = Commercial Insurance Co	
		DS= Disability	
		HM = Health Maintenance Organization	
		LM = Liability Medical	
		MB = Medicare part B	
		MC = Medicaid	
		OF = Other Federal Program	
		TV = Title V	
		VA = Veteran Administration Plan Refers To Veterans Affairs Plan	
		WC = Workers' Compensation Health Claim	
		ZZ = Mutually Defined Unknown	

Loop 2320 – Other Subscriber Information Coordination of Benefits (COB) Payer Paid Amount			
Usage	Segment	Value	Comment
Required	AMT01	D	Code to identify the primary paid amount
Required	AMT02		Total amount paid by the primary payer

Loop 2320 – Other Subscriber Information Subscriber Demographic Information			
Usage	Segment	Value	Comment
Required	DMG01	D8	Code indicating the format of the date
Required	DMG02		Date of birth (CCYYMMDD)
Required	DMG03	**F** = Female	Code indicating the sex of the individual
		M = Male	
		U = Unknown	

Loop 2320 – Other Subscriber Information Other Insurance Coverage Information			
Usage	Segment	Value	Comment
Required	OI03	**N** = No	A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. Use "W" when the patient refuses to assign benefits.
		W = Not Applicable.	
		Y = Yes	
Situational	OI04	**P** = Signature generated by provider because the beneficiary was not physically present for services	Indicates how the beneficiary or subscriber authorization signature was obtained and how it is being retained by the provider
Required	OI06	**I** = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statues	
		Y = Yes, provider has a signed statement permitting release of medical billing data related to a claim	

Loop 2330A Other Subscriber Name and Address			
Usage	Segment	Value	Comment
Required	NM101	IL	Code identifying the insured or subscriber
Required	NM102	**1** = Person	Code qualifying the type of entity
		2 = Nonperson Entity	

Loop 2330A Other Subscriber Name and Address			
Usage	Segment	Value	Comment
Required	NM103		Last Name or Organization Name
Situational	NM104		Subscriber first name
Situational	NM105		Subscriber middle
Situational	NM107		Subscriber generation (suffix)
Required	NM108	**MI** = Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.	Code to indicate Member ID
Required	NM109		Identification Number
Required	N301		Address information (address 1)
Situational	N302		Address information (address 2) required if second address exists
Situational	N401		City name required when information is available
Situational	N402		State or Province code required when information is available
Situational	N403		Postal code required when information is available
Situational	N404		Country Code
			Required if the address is out of the U.S.

Loop 2330B – Other Payer Name			
Usage	Segment	Value	Comment
Required	NM101	PR = Payer	Code to identify an organizational entity or other payer.
Required	NM102	**2** = Nonperson Entity	Code to identify type of entity
Required	NM103		Organization Name
Required	NM108	**PI** = Payer Identification	Code to identify Payer or organization
		XV = CMS National Plan ID	
Required	NM109		Payer Identification Code

Loop 2430 – Line Adjudication Information			
Usage	Segment	Value	Comment
Required	SVD01		Payer Identification Code
Required	SVD02		The amount paid by the primary payer for each service line. Zero (0) is an acceptable value for this element.
Required	SVD03-1	**HC** = Healthcare Common Procedure Coding System (HCPCS) Codes	Code to identify the type of medical procedure
		IV = Home Infusion EDI Coalition (HIEC) Product/Service Code	
		ZZ = Mutually Defined	
Required	SVD03-2		Procedure Code
Situational	SVD03-3		Procedure Code Modifier Procedure Modifier 1
Situational	SVD03-4		Procedure Code Modifier Procedure Modifier 2
Situational	SVD03-5		Procedure Code Modifier Procedure Modifier 3
Situational	SVD03-6		Procedure Code Modifier Procedure Modifier 4
Required	SVD05		Paid units of service
Situational	SVD06		Assigned Number (used only for bundling of service lines)

Line Adjustment			
Usage	Segment	Value	Comment
Required	CAS01	**CO** = Contractual Obligations	Code to identify the general category of payment adjustment
		CR = Correction and Reversals	
		OA = Other Adjustments	
		PI = Payer Initiated Reductions	

Line Adjustment			
Usage	Segment	Value	Comment
Required	CAS01	**PR** = Patient Responsibility	Code to identify the general category of payment adjustment
Required	CAS02		Claim Adjustment Reason codes are located on the Washington Publishing Company website at http://www.wpc-edi.com
Required	CAS03		Monetary Amount
			Use this amount for the adjustment amount
Situational	CAS04		Quantity
			Use as needed to show payer adjustment
Situational	CAS05		Claim Adjustment Reason Code
			Use as needed to show payer adjustment
Situational	CAS06		Monetary amount: use as needed to show payer adjustment
Situational	CAS07		Quantity: use as needed to show payer adjustment
Situational	CAS08		Claim Adjustment Reason Code (CARC): use as needed to show payer adjustment
Situational	CAS09		Monetary amount: use as needed to show payer adjustment
Situational	CAS10		Quantity: use as needed to show payer adjustment
Situational	CAS11		Claim Adjustment Reason Code (CARC): use as needed to show payer adjustment
Situational	CAS12		Monetary amount: use as needed to show payer adjustment
Situational	CAS13		Quantity: use as needed to show payer adjustment
Situational	CAS14		Claim Adjustment Reason Code (CARC): use as needed to show payer adjustment
Situational	CAS15		Monetary amount: use as needed to show payer adjustment
Situational	CAS16		Quantity: use as needed to show payer adjustment
Situational	CAS17		Claim Adjustment Reason Code (CARC): use as needed to show payer adjustment
Situational	CAS18		Monetary amount: use as needed to show payer adjustment
Situational	CAS19		Quantity: use as needed to show payer adjustment

Line Adjudication Date			
Usage	Segment	Value	Comment
Required	DTP01	573	Date/Time Qualifier
Required	DTP02	D8	Date (CCYYMMDD)
Required	DTP03		Date Time Period

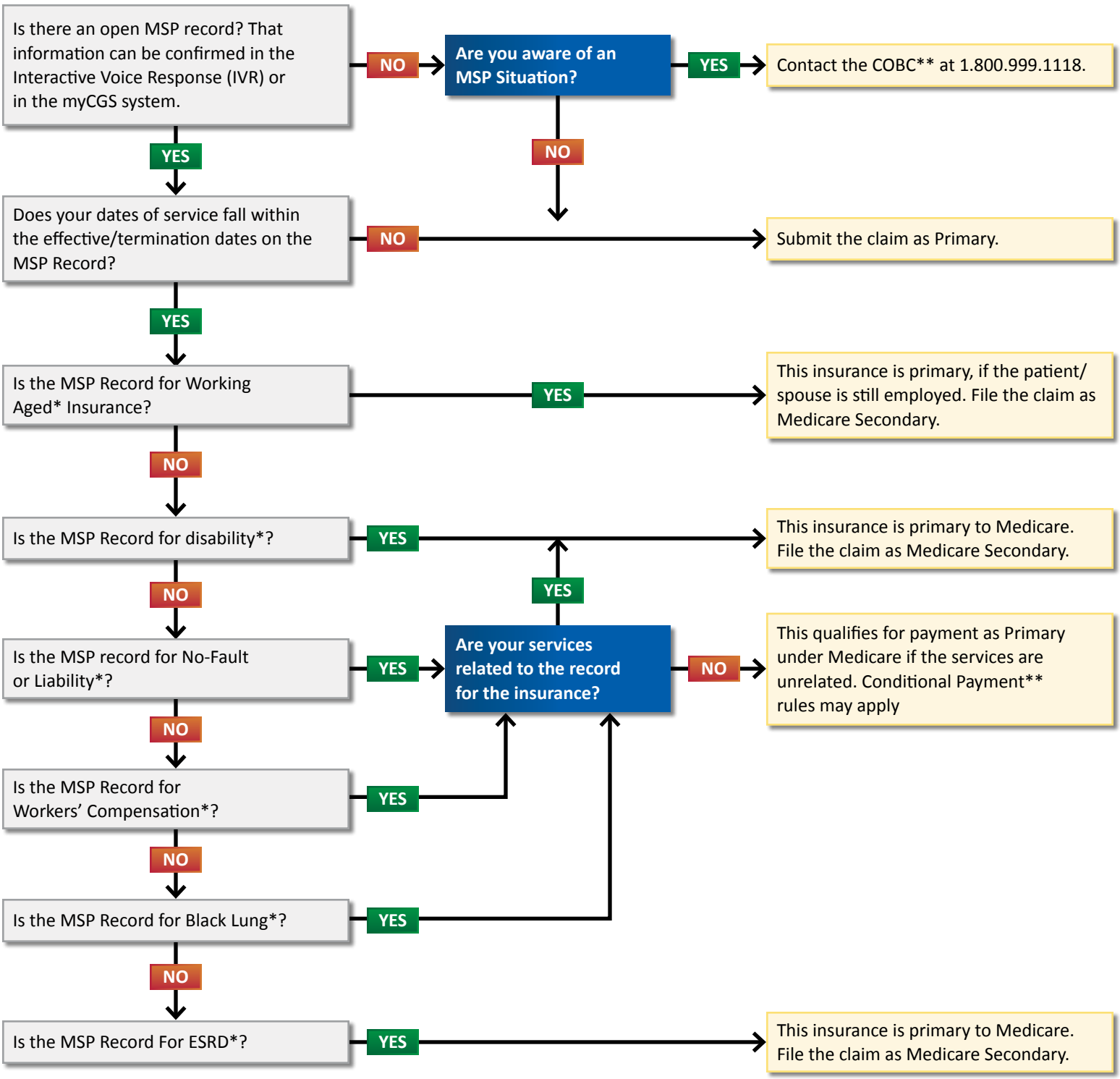
Instructions for Filing Conditional Payment

When submitting MSP claims for conditional payment, we will need information regarding why that payment is being requested. Any MSP claim that does not have additional information will be returned. For both paper and electronic claims, the words “Conditional Payment” must be in the appropriate field, along with the primary explanation of benefits. For example, the comment could indicate “Conditional Payment: Unrelated to Liability/No-Fault/Workers’ Compensation (whichever is appropriate) or “Conditional Payment- Non- Prompt Payment”.

For paper claims, enter this information in block 19. For electronic claims, enter this information in the following loops and segments listed.

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/ Liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14/47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02 - Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Medicare Secondary Payer (MSP) Flow Chart



* Insurance Types

** Definitions of these terms on page 2/3