

PC-ACE Pro32 Medicare as Secondary Payer (MSP)

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

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

In addition, the CEDI technical support staff is not trained in billing. The information in this document is accurate to the best of our knowledge, but there may be specifics required for billing that we are unaware of. If you have questions on how to bill MSP claims, contact the jurisdiction that will be processing the claims for payment.

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

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



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Payers (Insurance) Setup

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

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

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



This will produce the "Payer Information" screen.

Payer Information Screen:



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



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Payer ID: This is a five character identification number used to identify the payer, or insurance company, in electronic transactions. This field is required, but the primary insurance may not have a Payer ID. The field has to have a unique entry for every insurance company entered into PC-ACE Pro32. It is recommended that the real Payer ID be obtained, if possible, from the primary insurance. If it is not possible to obtain that ID, enter the payer ID for the first insurance as XXXXX, with subsequent insurances entered as XXXX1, XXX2, etc. These values are not important in the Medicare processing system, but are required in the electronic claims format. Instead, the name of the primary insurance is used by the payment systems to confirm that it went to the correct primary.

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

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

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

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

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

Patient Selection and Setup

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

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

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



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Setting up the Patient's Insurance Information

Patient Information	
General Information Extended Info Primary Insured	d (Inst) Primary Insured (Prof) Secondary Insured (I 💶 🕨
Payer ID Payer Name Payer ID Payer Name XXXX2 MIDWEST SECURITY INSURA	
Group Name Group Number TEST GROUP INC. MI00000	Claim Office
Insured Information (F7) Employer Information (F8	Clear All Fields For Insured
Rel Last Name First Name 18 DOE JOHN	MI Gen Insured ID
Address 2234 CHERRY TREE LN	Sex M Assign of Benefits Y
City State Zip	DOB 01/01/1901 Release of Info Y Employ Status 9 ROI Date _/_/
MELVIN MI 48454 Country Phone	Retire Date/_/
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Right-click in the "Payer ID" field to select the primary insurance. This should fill in the "Payer Name" and "LOB" fields, based on what was entered in the "Payer" tab of "Reference File Maintenance."

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

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

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

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

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



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

Patient Information	×
General Information Extended Info Primary Insur	red (Inst) Primary Insured (Prof) Secondary Insured • •
Payer ID Payer Name	LOB Insured Information Options
Group Name Group Number	Claim Office C Separate Inst & Prof
Insured Information (F7) Employer Information (F	F8) Clear All Fields For Insured
Rel Last Name First Name	MI Gen Insured ID
Address	Sex Assign of Benefits
	DOB// Release of Info
City State Zip	Employ Status ROI Date _/_/
Country Phone	Retire Date //
	<u>S</u> ave Close

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

Patient Information		
Primary Insured (Inst) Primary Insured (Prof) Seco	ondary Insured (Inst)	Secondary Insured (Prof) Tertia
Payer ID Payer Name	LOB	
Group Name Group Number	Claim Offic	e .
Insured Information (F7) Employer Information (F	8)]	Clear All Fields For Insured
Rel Last Name First Name	MI Gen	Insured ID
Address	Sex [Assign of Benefits
	DOB _/_/_	Release of Info
City State Zip	Employ Status	R0I Date _/_/
Country Phone		Retire Date _/_/
		Save Cancel

This will be where the Medicare information is entered.

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



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Patient Information	
Primary Insured (Inst) Primary Insured (Prof) Seco	ondary Insured (Inst) Secondary Insured (Prof) Tertit
Payer ID Payer Name Payer ID Payer Name 17003 DME MAC JURISDICTION B	
Group Name Group Number	Claim Office
Insured Information (F7) Employer Information (F7)	Clear All Fields For Insured
Rel Last Name First Name 18 DDE JOHN	MI Gen Insured ID 999000000A
Address 1234 MAIN STREET	Sex M Assign of Benefits Y
	DOB 01/01/1901 Release of Info Y
City State Zip ANY TOWN IN 12345	Employ Status ROI Date 01/01/2009
Country Phone (866) 311-9184	Retire Date _/_/
	Save Cancel

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 in it.

MSP Claim Entry (Line Level)

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

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
8 - Pat. Status Death 12 Legal NPI 2 - Patient Last Name First Name MI Gen 3 - Birthdate Sex MS ES SS Ind SOF Rep. Exempt DDE JOHN 01/01/1101 M B N B N
5 - Patient Address 1 Patient Address 2 Patient City State Patient Zip Country Patient Phone 1234 MAIN STREET ANY TOWN IN 12345 [0866) 311-9184
IO - Patient Condition Related To ROI ROI Date Other Ins. 14 - Date/Ind of Current 15 - First Date 16 - UTW/Disability Dates & Type Employment N Accident Y [01/01/2009] 1
17 - Referring Phys Name (Last/Org, First, Mid, Suffix) Referring Phys IDs/Types 18 - Hospitalization Dates 20 - Outside Lab/Chgs V _//
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 SDF Y Date 01/01/2009 Facility? Dental? CDB2 Y Frequency 33 - GRP No.
Save

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)



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will be entered. This example will demonstrate how to enter an MSP claim with three charge lines.

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

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)	
Diagnosis Codes (1 - 8); 3449	
24a - Service Dates 24b 24c 24d 24d - Modifiers 24e 24f 24g 24h 24j LN From Thru PS EMG Proc 1 2 Diagnosis Charges Units EP FP AT Rendering Phys.	
28 - Total Charge0.00 Rec <u>a</u> lculate	
29 - Amount Paid0.00 30 - Balance Due0.00	
<u>Save</u>	

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

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

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

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

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

Box 24h: This may be used if there is a Certificate of Medical Necessity (CMN), or the suppliersigned DME MAC Information Form (DIF), for this charge line. Enter a C in the box under



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column "AT" to have the CMN tab added to the row of sub-tabs. CMN entry will not be covered further in this document.

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

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

Professional Claim	Form				×		
Patient Info & General Insured Information Billing Line Items Ext. Patient/General Ext. Pat/Gen (2) Ext. Payer/Insured							
Line Item Details Ext	ended Details (Line 1)	Ext Details 2 (Line 1) Ex	t Details 3 (Line 1) MSP/COB (L	ine 1)			
Miscellaneous Exten	ded Details						
24d - Modifiers 3 & 4	. (ГГГ) н	lospice Employed?	Purch. Charges0.00	Sales Tax0.00			
Anesthesia/Other Mir	nutes C	o-Pay Status	Initial Treatment	Postage Claim0.00			
Units Type Code	P	urchased Services?	Shipped Date _/_/				
		Line-Level Supporting Pro	vider Information				
	Last/Org Name	First Name	MI Suffix Provider ID:	s / Types / Payer IDs			
Rendering				•			
Purch. Service							
Supervising							
Ordering	змітн	JOHN	1231231231	× ·			
Referring							
Referring (2nd)							
Asst. Surgeon							
					<u> </u>		
				<u>Save</u> <u>C</u> ancel			

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

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



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Here is a completed sub-tab.



The "Approved" and the OTAF are no longer required and should be omitted.

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

P/S: Enter P to indicate payment information in this row is for the primary insurance. **Proc Qual:** Enter HC for all HCPCS codes.

Code: Enter the HCPCS code from the charge line. Enter Modifiers if entered on the charge line. **Paid Amount:** Enter what the primary insurance actually paid for this charge line.

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

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

In this example, the item cost \$5,000, but the primary insurance paid \$2,913.12. This leaves \$2,086.88 unaccounted for. The first adjustment is probably a CO, or contractual obligation, adjustment that explains the amount that was written off as being not-approved (or disallowed or ineligible). Right-click in the "**Group**" and "**Reason**" boxes to find a list of valid entries. Find a "Reason" that best describes the reason the amount was not allowed. Be aware that these codes can have end-dates, and only select codes that are still active. For the example, 45 is selected to



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explain the disallowed amount. This amount may or may not be listed on the primary EOB, but it can be calculated by taking the item's full cost and subtracting the allowed amount. This example's equation for this line is 5,000 - 3641.40 = 1,358.60. CO, 45, and 1358.60 are entered.

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

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

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

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

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

Professional Claim Form
Patient Info & General Insured Information Billing Line Items Ext. Patient/General Ext. Pat/Gen (2) Ext. Payer/Insured
Line Item Details Extended Details(Line 2) Ext Details 2 (Line 2) Ext Details 3 (Line 2) MSP/COB (Line 2)
Diagnosis Codes (1 - 8): 3449
24a - Service Dates 24b 24c 24d - Modifiers 24e 24f 24g 24h 24j LN From Thru PS EMG Proc 1 2 Diagnosis Charges Units EP FP AT Rendering Phys. 1 05/01/2010 05/01/2010 12 K0823 1 5000.00 1.0
2(05/01/2010 05/01/2010 12 E2365 1264.741.0
28 · Total Charge0.00 Rec <u>a</u> lculate
29 · Amount Paid0.00 30 · Balance Due0.00
Save Cancel



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

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

Repeat as needed for any additional charge lines.

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

Professional Cla	im Form									
Patient Info & Gene	ral 🛛 Insured In	formation	Billing Lir	ie Items	Ext. Patient/Gene	ral Ext. Pat/G	en (2) Ext.	Payer/Insure	d	
Line Item Details	Extended Del	ails (Line :	8) Ext D	etails 2 (L	.ine 3) Ext Deta	ils 3 (Line 3)	MSP/COB (L	ine 3)		
Diagnosis Codes	(1 - 8): 04521									
24a - Serv LN From	Thru	245 240 PS EM	a Proc	24d · M 1	odifiers 24e 2 Diagnosis	24f Charges	24g Units	24h EP FP AT	24j Rendering Phys.	
1 07/01/2009	07/01/2009	12	K0823		1	5000.00	1.0			
2 07/01/2009	07/01/2009	12	E2365		1	264.74	1.0			
3 07/01/2009	07/01/2009	12	E0990		1	334.32	1.0			
4 _/_/	_/_/					·	·			1
5 _/_/							·			I Ţ
6 _/_/							·	ГГГ		Ī
				:	28 · Total Charge	5599.06	Recalcu	ulate		
				i i	29 - Amount Paid	0.00	30 · Balar	nce Due	_5599.06	
									Save C	ancel

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

Professional Claim Form		
Patient Info & General Insured Information Billing Line Items Ext. Patient/General	Ext. Pat/Gen (2) (Ext. Payer/Insured)	
Primary Payer/Insured Secondary Payer/Insured Tertiary Payer/Insured COB In	to (Primary) COB Info (Secondary)	
Miscellaneous Secondary Payer / Insured Information		
Payer Address	Payer / Insured Reference IDs / Types	
City/St/Zip		
Payer Source MB	▼	
Insurance Type 47		
Insured's Contact		
Patient ID		
	<u>Save</u> <u>C</u> ance	cel
		National Governm
		Services.

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

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 (S	Secondary)
Common Payer MSP Information	Additional Adjustment / COB Amounts / MOA Information (ANSI-8	
0TAF0.00	Claim Level Adjustments (CAS)	COB / MOA Amounts
Zero Payment Ind	Num Group Reason Amount Units 1	Lum Code Amount 1 D 0.00 2 3
		<u>S</u> ave <u>C</u> ancel

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 should be ready to save.



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MSP Claim Entry (Claim Level)

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

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

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 Additional Adjustment / COB Amounts / MOA Information (ANSI-837 Only) OTAF
Zero Payment Ind Num Group Beason Amount Units Num Code Amount 1 CO 45 1554.26 0.000 1 D 80.00 Image: Second secon
2 PR 2 808.96 0.000 2 0.00
Medicare Outpatient Adjudication (MOA) Remarks Codes Claim Adjudication Date 05/15/2010
<u>Save</u>

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



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