BILLING MEDICARE SECONDARY PAYER (MSP) CLAIMS IN 837 VERSION 5010A1

NOTE: MSP claims are not an ASCA (Administrative Simplification Compliance Act) exception and must be sent electronically.

The 837 version 5010A1 professional TR3 (Technical Report-Type 3) guide requires that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer must equal the billed amount for the services in the claim.

The electronic media claims (EMC) system reviews every claim for initial edits to ensure that claim data is valid. If a claim contains missing or incorrect information, one of two things will happen because of initial editing.

1. The claim may reject on the 999. If rejected, the claim goes no further.

2. If a claim is accepted or accepted with errors on the 999, then it is sent to the Common Edit Module (CEM) for additional editing. The claim can be accepted and passed into the adjudication system or be rejected. This will be communicated to the submitter via a 277CA.

The chart below applies to all providers and identifies the segments and data elements that you must use to report: (1) the submitted charges, (2) the primary payer paid amount, and (3) the adjustment amounts by the primary payer.

	837 v 5010A1	**Comments**
Insurance Type Code	2000B SBR05	Required when the destination payer is Medicare and Medicare is not the primary payer.
Policy # of Patient	2330A NM109	Other insured identifier
Group #	2320 SBR03	This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber.
Patient Relationship	2320 SBR02	Required
Primary Payer Name	2330B NM103	Name of the Primary Payer.
Primary Payer Address	2330B N3 & 2330B N4	The address of the Primary Payer.
Total Claim Charge Amount	2300 CLM02	Must balance to the sum of all service line charge amounts reported in the SV1 segments for this claim.
Claim Primary Payer Paid Amount	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines (2430 SVD02). Zero "0" is an acceptable value for this element.

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Claim Level Adjustment Group Code	2320 CAS01	Code identifying the general category of payment adjustment.
Claim Level Adjustment Reason Code	2320 CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Used to report prior payers **claim** level adjustments that cause the amount paid to differ from amount originally charged.
Claim Level Adjustment Monetary Amount	2320 CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Amount of adjustment. The amount paid by the primary payer plus the amounts adjusted by the primary payer must equal the billed amount for the claim.
Line Item Charge Amount	2400 SV102	Required
Line Primary Payer Paid Amount	2430 SVD02	Service line paid amount. Zero "0" is an acceptable value for this element.
Line Level Adjustment Group Code	2430 CAS01,	Code identifying the general category of payment adjustment.
Line Level Adjustment Reason Code	2430 CAS02, CAS05, CAS08, CAS11, CAS14, CAS17	Used to report prior payers **line** level adjustments that cause the amount paid to differ from amount originally charged.
Line Level Adjustment Monetary Amount	2430 CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Amount of line level adjustment.
Line Check or Remittance Date	2430 DTP02 (573)	Date claim paid by primary payer.

Claim Adjustment Reason codes are located on the Washington Publishing Company web site: http://www.wpc-edi.com

How To Avoid Delays And Unprocessable Claims

- When determining the beneficiary's insurance coverage, it is important to determine the correct insurance type code.
- **Always** give the MSP insurance type code.

- Give the complete primary payer's name and address.
- Don't confuse the payers. You should not report Medigap or Medicaid information in the primary insurance record. Medigap, Medicaid and Crossover occur after Medicare has considered the claim, not before.
- If the patient is only responsible for the managed care plan's co-pay amount, indicate this by including an electronic equivalent of box 19 "Billing for $_____ co-pay only," insert the co-pay amount, and leave the primary paid as zeros. Use the appropriate CAS code information and amounts to indicate copay amount.
- If the primary paid amount is zero, include an explanation in the electronic equivalent of box 19, e.g. "Primary approved, but did not pay because total approved amount applied to deductible" or "Primary denied because…" Use the appropriate CAS code information and amounts to indicate denied amount.
- The primary paid amount should not exceed the billed amount.
- The primary paid amounts at the claim level should agree with the amounts submitted at the line level.

If you need additional information you may contact the WPS EDI Helpdesk:
J5 866-518-3285
J8 866-234-7331