



How to file electronically when Medicare is the Secondary Payer

The 837 version 4010A1 institutional and professional implementation guides require 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 a number of pre-pass edits to ensure that claim data is valid. If a claim contains missing or incorrect information, one of two things will happen because of a pre-pass edit.

1. If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and alerts the submitter in order to correct future claims.
2. If a delete edit is in effect, the claim, batch, or file will not process normally; it deletes from the claims processing system and alerts the submitter to the error.

Effective July 3, 2006, inbound MSP claims will be rejected if the paid amounts and the adjusted amounts by the primary payer do not equal the billed amounts or if the claim lacks standard claim adjustment reason codes to identify adjustments

(<http://www.cms.hhs.gov/Transmittals/downloads/R831CP.pdf>,
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4261.pdf>).

A complete list of current 4010A1 pre-pass edits is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010A1.doc) or on the WPS web site:
http://www.wpsic.com/edi/med_macj5.shtml .

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, (3) the primary payer allowed amount, (4) the OTAF amount at the claim and the service line levels, and (5) the adjustment amounts by the primary payer.

	837 v 4010A1	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 (IL)	Other subscriber primary 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 (PR)	Name of the Primary Payer.
Primary Payer Address	2300 or 2400 Narrative Record	The address of the Primary Payer.
Claim Total Submitted	2300 CLM02	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or



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Charge		supplier.
Claim Primary Payer Paid Amount	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim Level Adjustment Group Code	2320 CAS01	Code identifying the general category of payment adjustment. Preferred use of the CAS segment would be at the 2430 loop.
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. NOTE: Adjustments are reported in either the Claim Adjustment segment (2320/CAS) or the Service Adjustment segment (2430/CAS), but not in both.
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.
Claim OTAF Amount	2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2400 SV102	Required
Line Primary Payer Paid Amount	2430 SVD02	Service line paid amount. Zero "0" is an acceptable value for this element.
Line Primary Payer Allowed Amount	2400 AMT02 AMT01 = AAE	If there is no value in the Allowed Amount field, use the value in the Approved Amount field.
Line OTAF	2400 CN102 CN101 = 09	None
Claim Level	2430 CAS01,	Code identifying the general category of payment



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Adjustment Group Code		adjustment. Preferred use of the CAS segment would be at the 2430 loop.
Claim 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. NOTE: Adjustments are reported in either the Claim Adjustment segment (2320/CAS) or the Service Adjustment segment (2430/CAS), but not in both.
Claim Level Adjustment Monetary Amount	2430 CAS03, CAS06, CAS09, CAS12, CAS15, CAS18	Amount of line level adjustment.
Line Adjudication Date	2430 DTP02 (573)	Date claim paid.

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

- Reporting of adjustment information is preferred at the 2430 level.
- 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 allowed and primary paid as zeros. Use the appropriate CAS code information and amounts to indicate copay amount.
- If either or both the primary paid amount or primary allowed are 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 primary allowed amount.
- The primary allowed or primary paid amounts should not exceed the billed amount.
- The primary allowed and primary paid amounts at the claim level should agree with the respective amounts submitted at the line level.

If you need additional information you may also contact the WPS EDI Hotline for IL, MI & WI: 877-567-7261, or for MN: 952-885-2811, 952-885-2881 or 952-885-2882.