Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P

This document describes the required fields in relation to the ASC 5010X222A1 Technical Report Type 3 (TR3) for 837P. Use the information below to assist you and your software vendor report the appropriate Medicare Secondary Payer (MSP) information in the correct American National Standards Institute (ANSI) fields.

This document lists the required fields in relation to the Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3).

Required MSP Data

When billing MSP claims electronically include the following information for the claim to process and pay correctly:

- Indication of Medicare as the secondary payer
- Insurance Type
- Coordination of Benefits (COB) Payer Paid Amount – Claim Level
- Coordination of Benefits (COB) Allowed Amount – Claim Level
- Claim Contract Information (OTAF) – Claim Level
- Claim Adjudication Date – Claim Level
- Line Adjudication Information
- Line Adjustments
- Line Adjudication Date

Indication of Medicare as the Secondary Payer

All MSP claims are created around the assumption that Medicare is the secondary payer (e.g., the beneficiary has other insurance that pays the health care claim prior to Medicare). The basic principle behind filing a MSP claim to Medicare is to report all payment information provided by the primary payer and indicate that Medicare is the secondary payer. The ANSI X12 IG indicates primary, secondary, and tertiary payers by using the SBR segment. For MSP claims, the first occurrence of the SBR segment must appear in loop 2000B. An additional SBR segment is needed in the 2320 loop to report the primary payer information. Use the SBR01 element, Payer Responsibility Sequence Number Code, to report what type of claim is being submitted. The valid values for the SBR01 element are:

P	Primary
S	Secondary
T	Tertiary

Report the SBR01 element in loop 2000B with the value of "S" and report the SBR01 element in loop 2320 with the value of "P."

The SBR09 element, Claim Filing Indicator Code, indicates the type of payer.

The example below demonstrates Medicare as a secondary payer.

2000B/SBR

Segment Syntax: SBR*S*18***12****MB~

The value of "S" is reported in SBR01, indicating a secondary payer. The value of "MB" is reported in SBR09 indicating Medicare Part B as the secondary payer. The most common Claim Filing Indicator Codes are:

09 **Self-pay**
10 Central Certification
11 Other Non-Federal Programs
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
CH Champus
CI Commercial Insurance Co.
DS Disability
HM Health Maintenance Organization
LI Liability
LM Liability Medical
MB Medicare Part B
MC Medicaid
OF Other Federal Program
TV Title V
VA Veteran Administration Plan
WC Workers' Compensation Health Claim
ZZ Mutually Defined Unknown

Insurance Type Code

Submit the insurance type code in the SBR05 element. In the above example, the submitted value is "12", indicating Medicare Secondary Working Aged Beneficiary or Spouse with Employer group health plan (GHP). Please note that it is important to submit the correct MSP type code to prevent denial of your claim. The most common MSP type codes are:

12 Working Aged Beneficiary Age 65 or Over with Employer GHP Through Self or Spouse
13 End-stage renal disease beneficiary in 30-month coordination period with an Employer GHP
14 No-Fault Insurance including Automobile and Other Types
15 Worker's Compensation
16 Public health service (PHS) or Other Federal Agency
41 Federal Black Lung Program
42 Veteran's Administration
43 Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47 Liability Insurance

Coordination of Benefits (COB) Payer Paid Amount – Claim Level

The ANSI X12 IG indicates COB payer paid amounts by using an AMT segment in loop 2320, Other Subscriber Information. Use a qualifier of "D" to define the amount submitted as the Payer Paid Amount. The amount reported in the AMT segment is the total amount the primary payer paid on the claim. The COB payer paid amount is required if the claim has a service line approved amount and a service line paid amount. It is acceptable to show "0" (zero) as an amount paid.

The example below displays the COB payer paid amount.

2320/AMT

Segment Syntax: AMT*D*20~

Coordination of Benefits (COB) Allowed Amount – Claim Level

The ANSI X12 IG indicates COB allowed amounts by using an AMT segment in loop 2320, Other Subscriber Information. Use a qualifier of "B6" to define the amount submitted as the Allowed Amount. This is the **total** amount approved/allowed by the primary payer on the claim.

The COB allowed amount is **required** if the claim has an approved/allowed amount on the service line and a paid amount on the service line.

The example below displays the COB allowed amount.

2320/AMT

Segment Syntax: AMT*B6*519.21~

Claim Contract Information (OTAF) – Claim Level

The Obligated to Accept as Payment in Full (OTAF) amount is that which the provider agreed to accept as payment in full for a claim under the provisions of the contract with the primary insurance. The reporting of this information is only required when OTAF amounts are greater than zero.

OTAF Example: A provider billed the patient $150 for health care services. The patient's primary insurance company is a commercial insurer. On service line 1 of the claim, $100 was billed to the commercial insurer, however because of a provider agreement with the commercial insurer $25 was written off. On service line 2 of the claim, $50 was billed to the commercial insurer; however because of a provider agreement with the insurer $5 was written off. The amount entered into the OTAF field would be $120, the difference between what was billed to the primary insurance and the amount that was written off.

Effective April 6, 2009, The Medicare processing system shall determine the OTAF amount by subtracting the contractual obligation amount (CO) group code amount from the submitted charges.

Claim Adjudication Date – Claim Level

The ANSI X12 indicates the Claim Adjudication date by using a DTP segment in loop 2330B. The DTP01 element will contain qualifier "573," Date Claim Paid, to indicate the type of date that follows. DTP02 will contain qualifier "D8" to indicate the format of the date. The DTP03 element will contain the claim adjudication date. The Claim Adjudication Date is required on all MSP claims and is used to report the date a claim was adjudicated or paid by the primary payer.

The example below displays the adjudication date.

2330B/DTP

Segment Syntax: DTP*573*D8*20041116~

Service Line Information

Effective April 6, 2009, The Medicare Processing system shall determine the OTAF amount by subtracting the contractual obligation amount (CO) group code amount from the submitted charges.

Approved Amount - The Approved Amount, also known as the allowed amount, is the amount of money approved by the primary payer. The approved amount equals the amount for the service line that was approved by the payer. If the primary insurance does not show the approved amount, enter the billed amount in this element.

Line Adjudication Information – Use the line adjudication information to report the original services billed to the primary payer. This information is **required** if the claim has been previously adjudicated by the payer identified in the 2330B loop and the service line has adjustments applied. The Line Adjudication Information is present on most MSP claims.

2430/SVD Implementation Guide Specifics:

2430 Loop – Line Adjudication Information

Report line adjudication information in the SVD segment including the specific service line items billed to the primary payer (procedure code, amount paid for the service, units billed, etc.)

Syntax of Segment: SVD***00820***20*HC>98940**1~

Note: the information found in the SVD01 (00820) MUST match the payer ID for the primary payer.

Line Adjustments – Line adjustments are required if the primary payer made line level adjustments which caused the amount paid by the primary insurance to differ from the amount originally charged to the primary insurance. Line Adjustments are present on most MSP claims.

2430/CAS Implementation Guide Specifics:

2430 Loop – Line Adjudication Information, Line Adjustment

Line adjustment information is reported in the CAS segment, including the claim

adjustment group code, claim adjustment reason code and the monetary adjustment amounts (See IG for complete list of codes)

Syntax of Segment: CAS*CO*42*5*1*52*5*1~
CAS*PR*2*20~

Line Adjudication Date – Use the Line Adjudication Date segment to report the date the claim was adjudicated/paid by the primary payer. This segment is r**equired** on all MSP claims.

2430/DTP Implementation Guide Specifics:

2430 Loop – Adjustments Information, Line Adjudication Date
Line Adjudication Date is reported in a DTP segment
Date/Time Qualifier of "573" followed by a Date Time Period Format Qualifier of "D8"

Syntax of Segment: DTP*573*D8*20041116~