

Billing of Provider-Initiated Claims to the IHCP for Dually Eligible Members

How to Bill for Services Submitting the 837 COB Transaction to the IHCP for Dually Eligible Members (Medicare and Medicaid) Model 1 (Provider-to-Payer-to-Provider)

The 837 transaction addresses two separate models of coordinating benefits with other payers. The following information is from the 837 implementation guide front matter.

In model 1, the provider originates the 837 transaction and sends the claim information to the primary payer (for example, Medicare). The subscriber loop (loop ID-2000B) contains information about the individual who holds the policy with the primary payer. Loop ID-2320 contains information about the secondary payer (for example, EDS) and the subscriber who holds the policy with the secondary payer (for example, the IHCP member). In this model, the primary payer adjudicates the claim and sends an electronic RA transaction (835) to the provider. The 835 transaction contains the claim ARC that applies to that specific claim, as well as the primary payer's payment to the provider. The claim ARCs detail what was adjusted and why.

Upon receipt of the 835 transaction, the provider sends a second health care claim transaction (837) to the secondary payer (for example, EDS). The subscriber loop (loop ID-2000B) now contains information about the subscriber who holds the policy from the secondary payer (for example, the IHCP member information). The information about the subscriber for the primary payer is now placed in loop ID-2320. Any claim level adjustment codes are retrieved from the 835 transaction from the primary payer and placed in the CAS (claims adjustment) segments in loop ID-2320. Claim level payments made by the prior payers are retrieved from the primary payer's 835 transaction and submitted to the COB payer paid amount (AMT segment) in loop ID-2320. Line level ARCs are retrieved in the same manner from the 835 transaction and are placed in the CAS segment in the 2430 loop. Line level payments made by the primary payer are retrieved from the 835 transaction and submitted in the SVD segment (SVD02 – service line paid amount). The secondary payer adjudicates the claim and sends the provider an electronic RA.

Example 1 – How to Bill the IHCP Using the Correct Identifiers so the Claim is Recognized as a Crossover Claim

The IHCP occasionally receives crossover claims (837 COB) that do not follow the IHCP companion guide instructions. The IHCP identifies a claim as a crossover claim based on information received in the 2320/2330 loops of the 837 COB transaction. In the SBR segment (other subscriber information) of loop ID-2320, SBR09 (claim filing indicator code) is required before mandated use of the plan ID. When submitting a Medicare Part B crossover claim, the SBR09 (claim filing indicator code) must be MB, and for Medicare Part A crossover claims it must be MB or MA. In the NM1 segment (other payer name) of the loop ID-2330B, the NM109 (other payer primary identification number) must be one of the Medicare payer IDs used in the IHCP companion guide. Refer to the IHCP 837I and 837P companion guides for NM109 Medicare payer ID in loop ID-2330B. Failure to provide the correct payer ID, when submitting a crossover claim to the IHCP, will result in rejection of the claim in the BSR.

CLM*04031234A*120***41::1*Y*A*N*N~

2300 - Billed amount \$120

SBR*P*18*405363499A**MP***MB~

2320 - SBR09+MB (Primary Payer is Medicare Part B)

DMG*D8*19261001*F~

OI***N***N~

NM1*IL*1*ROBERT JONES****MI*999999999A~

N3*COMMUNITY HOME~

N4*FREELANDVILLE*IN*47535~

NM1*PR*2*MEDICARE PART B*****PI*00630

2330B – Since SBR09=MB, the Payer ID should be from the list of Medicare payer IDs listed in the 837P companion guide (loop 2330B)

DTP*573*D8*20040317~

Example 2 (837I) – Medicare Part A Claim in the 837I Format

When submitting a Medicare Part A crossover claim, the Medicare paid amount, coinsurance amount, deductible amount, and blood deductible amount must be provided at the claim level (loop ID-2320). Although the COB total Medicare paid amount (AMT with qualifier N1, net worth) in loop ID-2320, is a situational segment, the IHCP requires this segment to be used to submit the Medicare paid amount. Failure to provide the COB total Medicare paid amount segment when Medicare has paid an amount to the provider results in rejection of the claim in the BSR.

The CAS segment in loop ID-2320 provides the Medicare deductible amount (ARC 1), coinsurance amount (ARC 2), and blood deductible (ARC 66) amount.

CLM*04031234A*120***11:A:1*Y*A*N*N~

2300 - Billed amount \$120

SBR*P*18*405363499A**MP****MA~

2320 - SBR09=MA (Primary Payer is Medicare Part A)

CAS*PR*1*10**2*15**66*5*~

Deductible = \$10
Coinsurance = \$15
Blood Deductible = \$5

AMT*C4*90~

Payer Prior payment

AMT*N1*90~

Total Medicare Paid Amount = \$90

DMG*D8*19261001*F~

OI***N***N~

NM1*IL*1*ROBERT JONES****MI*99999999A~

N3*COMMUNITY HOME~

N4*FREELANDVILLE*IN*47535~

NM1*PR*2*MEDICARE PART A*****PI*00130~

Payer ID should be from the list of Medicare payer IDs in the 837I companion guide (loop 2330B)

DTP*573*D8*20040317

Example 3 (837P) – Medicare Part B Claim in the 837P Format

When submitting a Medicare Part B crossover claim, the Medicare adjudication information must be submitted at the detail level. SVD02 (service line paid amount) in the SVD segment (service line adjudication information) in loop ID-2430 provides the Medicare paid amount. The service line adjustment (CAS segment) in loop ID-2430 provides the Medicare deductible amount (ARC 1), coinsurance amount (ARC 2), psych deductible amount for Medicare Part B (ARC 122), and blood deductible amount for UB-92 Part B (ARC 66). The SVD01 (other payer primary identifier) identifies the Medicare payer that adjudicated the corresponding service line and must match the payer ID submitted in the NM109 (other

payer primary identification number) in the NM1 segment (other payer name). If the Medicare payer ID found in SVD01 is not in the 2330B loop, the claim is rejected in the BSR.

CLM*04031234A*120***13:A:1*Y*A*N*N~

2300 - Billed amount \$120

SBR*P*18*405363499A**MP***MB~

2320 - SBR09=MB (Primary Payer is Medicare Part B)

DMG*D8*19261001*F~

OI***N***N~

NM1*IL*1*ROBERT JONES****MI*99999999A~

N3*COMMUNITY HOME~

N4*FREELANDVILLE*IN*47535~

NM1*PR*2*MEDICARE PART B*****PI*00630~

Payer ID should be from the list of Medicare payer IDs in the 837P companion guide (loop 2330B)

LX*1~

SV1*381*HC:90806*120*UN*5~

DTP*472*D8*20040219~

SVD*00630*90*HC:90806**1~

2430 – Amount paid by payer 00630 (Medicare) for detail 1 = \$90.

CAS*PR*1*10**2*15**122*5*~

Deductible = \$10
Coinsurance = \$15
Psych = \$5

DTP*573*D8*20040317~

Example 4 (837I) – Medicare Part A Claim with TPL in the 837I Format

When submitting a Medicare Part A crossover claim with TPL, two occurrences of loop IDs-2320/2330 must be submitted in the 837I transaction. One occurrence of the loop IDs-2320/2330 provides the information about the primary payer (for example, private insurance) and the subscriber who holds the policy with the primary payer. Another occurrence of the loop IDs-2320/2330 provides the information about the secondary payer (for example, Medicare payer) and the subscriber who holds the policy with the secondary payer.

For Medicare Part A claims with TPL, in the occurrence of the loop IDs 2320/2330, representing non-Medicare payer, the COB prior payer payment (AMT with qualifier C4, prior payment – actual) in loop ID-2320 provides the TPL amount. In the occurrence of the loop IDs 2320/2330, representing Medicare payer, the COB Medicare paid amount (AMT with qualifier N1, net worth) in loop ID-2320 provides the Medicare payment.

CLM*04031234A*120***11:A:1*Y*A*N*N~

2300 - Billed amount \$120

SBR*P*18*405363499A**MP***ZZ~

2320 - SBR09=ZZ (Primary Payer is a non-Medicare payer)

AMT*C4*30~

2320 - Amount paid by the payer in the 2330A (will be calculated into the TPL)

DMG*D8*19261001*F~
OI***N***N~
NM1*IL*1*ROBERT JONES****MI*12345678~
N3*COMMUNITY HOME~
N4*FREELANDVILLE*IN*47535~
NM1*PR*2*SOME INSURANCE CO*****PI*99999~
DTP*573*D8*20040317~
SBR*S*18*405363499A**MP****MA~

2320 - SBR09=MA (Primary Payer is a Medicare payer)

CAS*PR*1*10**2*20~

AMT*C4*60~

2320 - Amount paid by the payer in the 2330A (prior payer payment)

AMT*N1*60~

2320 - Medicare Paid Amount

DMG*D8*19261001*F~
OI***N***N~
NM1*IL*1*ROBERT JONES****MI*999999999A~
N3*COMMUNITY HOME~
N4*FREELANDVILLE*IN*47535~
NM1*PR*2*MEDICARE PART A*****PI*00130~
DTP*573*D8*20040317~

Example 5 (837P) – Medicare Part B Claim with TPL in the 837P Format

For Medicare Part B claims, in the occurrence of loop IDs 2320/2330, represents non-Medicare payer, the COB prior payer payment (AMT with qualifier D, payer amount paid) in loop ID-2320 provides the TPL amount. Medicare adjudication information must be submitted at the detail level of the 837P transaction. The SVD02 (service line paid amount) in the SVD segment (service line adjudication information) in loop ID-2430 submits the Medicare paid amount. The SVD01 (other payer primary identifier) identifies the Medicare payer.

CLM*04031234A*120***11:A:1*Y*A*N*N~

2300 - Billed amount \$120

SBR*P*18*405363499A**MP****ZZ~

2320 - SBR09=ZZ (Primary Payer is a non-Medicare payer)

AMT*C4*30~

2320 - Amount paid by the payer in the 2330A (will be calculated into the TPL)

DMG*D8*19261001*F~
OI***N***N~
NM1*IL*1*ROBERT JONES****MI*12345678~
N3*COMMUNITY HOME~
N4*FREELANDVILLE*IN*47535~
NM1*PR*2*SOME INSURANCE CO*****PI*99999~
DTP*573*D8*20040317~
SBR*S*18*405363499A**MP****MB~

2320 - SBR09=MB (Primary Payer is a Medicare Payer)

DMG*D8*19261001*F~
OI***N***N~
NM1*IL*1*ROBERT JONES****MI*999999999A~

N3*COMMUNITY HOME~
N4*FREELANDVILLE*IN*47535~
NM1*PR*2*MEDICARE PART B*****PI*00630~
LX*1~
SV1*HC:99396*120*UN*1*23**1:2**Y~

DTP*472*D8*20040219~
SVD*00630*30*HC:99396**1~

CAS*PR*1*10**2*15**122*5*~

DTP*573*D8*20040317~

2430 - Amount paid by payer 00630
(Medicare) for detail 1 = \$30.

Deductible = \$10
Coinsurance = \$15
Psych = \$5