Secondary Billing and Tribal Self-Funded Plans

August 2019

Disclaimer

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Acronyms

AR	Accounts Receivable
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
EDI	Electronic Data Interchange
HCPCS	Healthcare Common Procedure Coding System
IT	Information Technology
MAC	Medicare Administrative Contractor
MSP	Medicare Secondary Payer
RPMS	Resource Patient Management System
SAR	Standard Adjustment Reason
TPB	Third Party Billing

Overview

- Posting and Rolling
- Secondary Claims Billing
- Medicare Secondary Payer Claims
- Tribal Self Insured and Medicare
- Troubleshooting and Issues
- Questions/Discussion

Posting and Rolling

IHS Policy – Indian Health Manual

Part 5 - Management Services

Chapter 1 - Third-Party Revenue Accounts Management And Internal Controls

Section 5-1.3 Procedures

G. Claims and Billing

https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p5c1#5-1.3G

4. Billing for Services

b. *Secondary and tertiary claims must be billed within three (3) business days of the primary payment/denial.*

RPMS Process for Rollbacks

- Transaction data is posted into Accounts Receivable
- Rollback sends transaction data to 3PB and marks bill as COMPLETE
- Claims with other payer resources are re-opened with ROLLED-IN EDIT MODE status
- The bill must be posted to a zero balance ($0.00) for the roll-back to occur
- A/R Technician responsible for posting must have sufficient access
  - Fileman Access Code: M
  - Required Keys: ABMDZ EDIT CLAIM AND EXPORT, BARZROLL
- Rollback must occur daily for each posting
- Rollback Bills Option (**AR** > **ROL**) should be ran on a regular basis

Rollback Prompt Displaying Other Coverage

```
Original bill approved with the following:

     P: PRESBYTERIAN HEALTH PLAN
     S:
     T:



CHECKING FOR UNBILLED SOURCES.
                  [1]  NON-BENEFICIARY PATIENT
                  [2]  DELTA DENTAL OF NEW MEXICO INC

Re-open claim for further billing? (Y/N)? YES
```

Secondary Claims Billing

Identifying Secondary and Tertiary Claims

Manual tracking

- A/R Technician posts transactions to bill that result in a zero balance
- Once rolled, remittance is forwarded to biller to bill to next payer

Brief Claims Listing (BRRP)

- Generate a claims listing for claims in the Rolled-In Edit Mode status

Rollback Detail (AR > RPT > RRM > ROD)

- Generate a list of claims rolled for a specified time period

Claims Listing Displaying Rolled Claim

```
PATIENT:  ONE,PATIENT        F  06/15/1964  505-92-3584  HRN: 1122
==========================================================================
==

(1)  Claim# 31376   01/13/2018 OUTPATIENT              GENERAL
      INDIAN HOSP    PRESBYTERIAN HEALTH PLAN     Status: ROLLED-In Edit Mode

(2)  Claim# 31338   07/10/2017 OUTPATIENT              DERMATOLOGY
      INDIAN HOSP    BCBS OF NEW MEXICO           Status: Uneditable (Billed)

(3)  Claim# 31299   04/17/2017 OUTPATIENT              GENERAL
      INDIAN HOSP    BCBS OF NEW MEXICO           Status: Uneditable (Billed)
```

Claim Editor – Page 0

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,PATIENT                [HRN:1122]                    Claim Number: 31376
..................................... (CLAIM SUMMARY) .....................................
_______ Pg-1 (Claim Identifiers) ____________________ Pg-5A (Diagnosis) __________
Location..: INDIAN HOSP                              | 1) Flu Virus with COPD
Clinic....: GENERAL                                  |_________ Pg-8 (CPT Procedures) _________
Visit Type: OUTPATIENT                               | 1) OFFICE/OUTPATIENT VISIT EST
Bill From: 01-13-2018 Thru: 01-13-2018               | 2) INFLUENZA A AG IF
_________ Pg-2 (Billing Entity) _________            | 3) INFLUENZA B AG IF
BCBS OF NEW MEXICO                  COMPLETE         | 4) IIV4 VACC NO PRSV 0.5 ML IM
PRESBYTERIAN HEALTH PLAN            ACTIVE           |
NON-BENEFICIARY PATIENT             PENDING          |
____________ Pg-3 (Questions) ____________           |
Release Info: YES   Assign Benef: YES                |
___________ Pg-4 (Providers) ___________             |
 Attn: WELBY,MARCUS                                  |
_____________________________________________________|_____________________________________
```

Editing the Secondary/Tertiary Claim

- Recommended to use visit types to reflect secondary billing
- Do not add or remove charges, providers, diagnosis codes unless fulfilling a payer requirement
- Add applicable value codes, occurrence codes, or condition codes if required by the payer
- Remember, prior payments/adjustments must add up to the total billed amount

```
200     PI PRIMARY
201     CROSSOVER (INPT)
202     CROSSOVER (OUTPT)
204     CROSSOVER (PROF)
```

Approving to an Electronic Format

Claim Editor Page A – Prior Payments/Adjustments

- Page displays only when a completed insurer is listed and the export mode is set to an electronic format (837I, 837P or 837D)
- Page must be reviewed for accuracy
- Standard Adjustment Reason (SAR) codes are listed for each adjustment
  - If missing, enter a valid SAR code
  - SAR Code entries may be located in Accounts Receivable, IADJ Option
- **All Payment and Adjustment entries must add up to the Current Bill Amount!**

Prior Payments/Adjustments

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,PATIENT          [HRN:1122]                      Claim Number: 31376
.......................... (PRIOR PAYMENTS/ADJUSTMENTS) ........................

Payment Amount....: (    214.87)        ORIGINAL BILL AMOUNT:     372.00
Deductible Amount.:       50.00         Current Charges.....:     372.00
Co-pay/ins Amount.:       32.73         Current Bill Amount.:     157.13
Write Off.........:        0.00
Non-Covered Amount:       74.40
Penalty Amount....:        0.00
Grouper Allowance.:        0.00
Refund............:        0.00
Payment Credits...:        0.00

[1] INSURER: BCBS OF NEW MEXICO         PRIORITY ORDER: 1     STATUS: COMPLETED
      PAYMENT: (    214.87)
   ADJUSTMENT:       50.00  [13] DEDUCTIBLE     [29] Deductible Amount     [1]
   ADJUSTMENT:       74.40  [4] NON PAYMENT     [802] Contractual Adjust   [A2]
   ADJUSTMENT:       32.73  [14] CO-PAY         [602] Coinsurance Amount   [2]

[2] INSURER: PRESBYTERIAN HEALTH PLAN   PRIORITY ORDER: 2     STATUS: ACTIVE
------------------------------------------------------------------------------
**Use the EDIT option to populate the Standard Adjustment Reason Code**

Desired ACTION (Add/Edit/Quit): Q//
```

Add the Check/Remit Date

```
1] INSURER: BCBS OF NEW MEXICO          PRIORITY ORDER: 1     STATUS: COMPLETED
      PAYMENT: (    214.87)
   ADJUSTMENT:        50.00  [13] DEDUCTIBLE     [29] Deductible Amount     [1]
   ADJUSTMENT:        74.40  [4] NON PAYMENT     [802] Contractual Adjust   [A2]
   ADJUSTMENT:        32.73  [14] CO-PAY         [602] Coinsurance Amount   [2]

[2] INSURER: PRESBYTERIAN HEALTH PLAN   PRIORITY ORDER: 2     STATUS: ACTIVE
-------------------------------------------------------------------------------
**Use the EDIT option to populate the Standard Adjustment Reason Code**

Desired ACTION (Add/Edit/Quit): Q// E

Which insurer are you editing:  (1-2): 1
Ok, let's edit BCBS OF NEW MEXICO

CLAIM CHECK OR REMIT DATE: 2/12/2018
```

Review Current Bill Amount

```
..................... (PRIOR PAYMENTS/ADJUSTMENTS) .....................

Payment Amount....: (    214.87)        ORIGINAL BILL AMOUNT:     372.00
Deductible Amount.:       50.00         Current Charges.....:     372.00
Co-pay/ins Amount.:       32.73         Current Bill Amount.:     157.13
Write Off.........:        0.00
Non-Covered Amount:       74.40
Penalty Amount....:        0.00
Grouper Allowance.:        0.00
Refund............:        0.00
Payment Credits...:        0.00
```

Determine if Adjustment Should be Included in Balance

```
Which insurer are you editing:  (1-2): 1
Ok, let's edit BCBS OF NEW MEXICO

CLAIM CHECK OR REMIT DATE: FEB 12,2018//
  [4] PAYMENT         214.87
  [1] ADJUSTMENT       50.00   [13]DEDUCTIBLE       [29]Deductible Amount    [1]
  [2] ADJUSTMENT       74.40   [4]NON PAYMENT       [802]Contractual Adjust  [A2]
  [3] ADJUSTMENT       32.73   [14]CO-PAY           [602]Coinsurance Amount  [2]
Which transaction:  (1-4): 2
AMOUNT:  (-99999.99-99999.99): 74.4//
ADJUSTMENT CATEGORY: 4//   NON PAYMENT
ADJUSTMENT REASON: 802//   Contractual Adjustment
STANDARD REASON: A2//
Do you want to include in secondary balance? Y// N
```

Updated Current Bill Amount

```
..................... (PRIOR PAYMENTS/ADJUSTMENTS) .....................

Payment Amount....: (    214.87)        ORIGINAL BILL AMOUNT:     372.00
Deductible Amount.:       50.00         Current Charges.....:     372.00
Co-pay/ins Amount.:       32.73         Current Bill Amount.:      82.73
Write Off.........:        0.00
Non-Covered Amount:       74.40
Penalty Amount....:        0.00
Grouper Allowance.:        0.00
Refund............:        0.00
Payment Credits...:        0.00
```

Approving to the Next Payer

```
Desired ACTION (Add/Edit/Quit): Q// Q

Do You Wish to APPROVE this Claim for Billing? YES

Transferring Data....

Bill Number 31376B Created.  (Export Mode: 837I (UB) 5010)
```

Approving to a paper claim

Claim Editor Summary Page

- Charges should reflect what was billed to the primary payer
- Write-offs column reflects all Non Payment, Adjustment, and Penalty transaction types
- User has the ability to include adjustments in billed amount
- Amount in first line under BILL AMOUNT is what is uploaded to A/R
- **All Payment and Adjustment entries must add up to the Current Bill Amount!**

Claim Editor Summary Page

SUMMARY

Active Insurer: NON-BENEFICIARY PATIENT

Form	Charges	Previous Payments	Write-offs	Non-cvd	Bill Amount
CMS-1500 (02/12)	198.00	**98.00**	**80.00**	0.00	**20.00**
	198.00	98.00	80.00	0.00	198.00

Do You Wish to APPROVE this Claim for Billing? YES

Including Adjustment in Billed Amount

- System will display a summary of posted adjustments
- System will not include NON PAYMENT and WRITE OFF adjustment types in balance
- User may decide to include in balance
  - Non-covered items billable to the next payer or non-Indian patient

```
CURRENT ADJUSTMENTS:
         Write-off:  80
      Non-covered:  80              Co-insurance:  20
Include any adjustments in billed amount?? Y// N
```

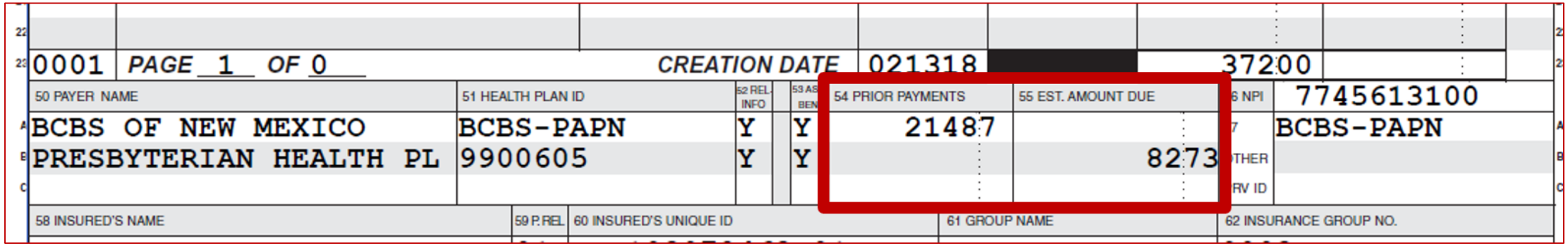
Including Adjustment in Billed Amount (cont.)

```
Do You Wish to APPROVE this Claim for Billing? YES

CURRENT ADJUSTMENTS:
          Write-off:  80
      Non-covered:  80                Co-insurance:  20
Include any adjustments in billed amount?? Y// YES
Write-off Amount to bill:  80// 53   <- ADDING NON-COVERED CHARGE TO BILL

Ok, I will add $53 to $20 for a total billed amount of $73
OK?? Y// YES
```

Printing to the Paper CMS-1500



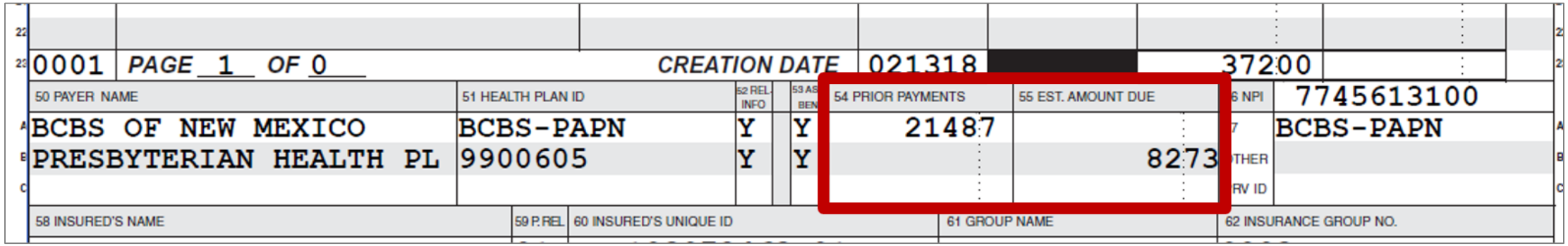
0001	PAGE 1 OF 0			CREATION DATE	021318		37200		
50 PAYER NAME		51 HEALTH PLAN ID	52 REL. INFO	53 AS BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	6 NPI	7745613100	
BCBS OF NEW MEXICO		BCBS-PAPN	Y	Y	21487		7	BCBS-PAPN	
PRESBYTERIAN HEALTH PL		9900605	Y	Y		8273	THER		
							RV ID		
58 INSURED'S NAME		59 P. REL	60 INSURED'S UNIQUE ID			61 GROUP NAME		62 INSURANCE GROUP NO.	

- Form Locator 28 reflects total charge amount
- Block 29 is blank but can be set in the Visit Type section of the Insurer File -->

```
BLOCK 29: ??

      Choose from:
        DO          PRINT
        DONT        DO NOT PRINT
BLOCK 29:
```

Printing to the Paper UB-04



0001	PAGE 1 OF 0		CREATION DATE	021318		37200	
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 AS BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	7745613100
BCBS OF NEW MEXICO	BCBS-PAPN	Y	Y	21487		57	BCBS-PAPN
PRESBYTERIAN HEALTH PL	9900605	Y	Y		8273	OTHER	
						PRV ID	
58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	

- Prior payments print in Form Locator 54
- Estimated amount due reflects copay, deductible, and coinsurance amounts
  - If included, non covered or write offs are added to the estimated amount due

Medicare Secondary Payer (MSP) Claims

Medicare Secondary Payer

- MSP applies to:
  - An Employer Group Health Plan (EGHP) for working aged beneficiaries.
  - A Large Group Health Plan (LGHP) for disabled beneficiaries.
  - Beneficiaries eligible for End Stage Renal Disease (ESRD).
  - Auto/medical/no-fault/liability insurance.
  - A Workers' Compensation plan. The Federal Black Lung Program.
  - Veterans Administration – in certain scenarios.
- Individuals not subject to the MSP provision include:
  - Individuals enrolled in Part B only.
  - Individuals enrolled in Part A on the basis of a monthly premium.

Billing for MSP Claims

- Confirm MSP Insurance Type code is valid for the service billed
- Verify the cumulative amounts paid by the primary [for all service lines] equals the *total amount paid* by the primary insurance
- Follow guidance for billing electronic secondary claims

Insurers

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,DEMO     [HRN:99095]                          Claim Number: 31379
................................. (INSURERS) .................................

                          PAGE 2 - INSURER INFORMATION

To: NOVITAS SOLUTIONS, INC.              Bill Type...: 131
    PO BOX 3111                          Proc. Code..: ICD
    MECHANICSBURG, PA  17055-1857        Export Mode.: 837I (UB) 5010
    (855)252-8782                        Flat Rate...: 383.00
..............................................................................
MSP STATUS AS OF JAN 14, 2018: [E]-EMPLOYER GROUP HEALTH PLAN (EGHP)
..............................................................................

              BILLING ENTITY             STATUS       POLICY HOLDER
     ============================  ==========  ==============================
[1]  BEWARE INSURANCE              COMPLETED   OLDAGE,LADY
[2]  MEDICARE                      ACTIVE      OLDAGE,LADY M
------------------------------------------------------------------------------
WARNING:073 - EMPLOYER NAME UNSPECIFIED
------------------------------------------------------------------------------

Desired ACTION (Add/Del/Pick/View/Next/Jump/Back/Quit): N//
```

Claim Identifiers

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,DEMO     [HRN:99095]                          Claim Number: 31379
.......................... (CLAIM IDENTIFIERS) ..........................

                 [1] Clinic.............: DIABETIC
                 [2] Visit Type.........: OUTPATIENT
                 [3] Bill Type..........: 131
                 [4] Billing From Date..: 01/14/2018
                 [5] Billing Thru Date..: 01/14/2018
                 [6] Super Bill #.......:
                 [7] Mode of Export.....: 837I (UB) 5010
                 [8] Visit Location.....: INDIAN HEALTH HOSPITAL
------------------------------------------------------------------------------
WARNING:071 - EMPLOYMENT INFORMATION UNSPECIFIED
------------------------------------------------------------------------------

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N// E

Desired FIELDS:  (1-8): 1-8// 2

[2] Visit Type......: OUTPATIENT// PI PRIMARY
```

Insurers (cont.)

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 2  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,DEMO         [HRN:99095]                        Claim Number: 31379
................................. (INSURERS) .................................

                          PAGE 2 - INSURER INFORMATION

To: NOVITAS SOLUTIONS, INC.             Bill Type...: 131
    PO BOX 3111                         Proc. Code..: CPT4
    MECHANICSBURG, PA  17055-1857       Export Mode.: 837I (UB) 5010
    (855)252-8782                       Flat Rate...: N/A
.............................................................................
MSP STATUS AS OF JAN 14, 2018: [E]-EMPLOYER GROUP HEALTH PLAN (EGHP)
.............................................................................

             BILLING ENTITY            STATUS       POLICY HOLDER
     ============================  ==========  ==============================
[1]  BEWARE INSURANCE              COMPLETED   OLDAGE,LADY
[2]  MEDICARE                      ACTIVE      OLDAGE,LADY M
-----------------------------------------------------------------------------
WARNING:073 - EMPLOYER NAME UNSPECIFIED
-----------------------------------------------------------------------------

Desired ACTION (Add/Del/Pick/View/Next/Jump/Back/Quit): N//
```

Claim Editor Occurrence Codes - Part A

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,DEMO     [HRN:99095]                              Claim Number: 31379
..................................... (OCCURRENCE CODES).....................................

      OCCR
      CODE                      OCCURRENCE DESCRIPTION                        DATE
      ====    ============================================================  ========
[1]    18     DATE OF RETIREMENT (PATIENT)                                  04-01-2002


Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Claim Editor Value Codes – Part A

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9D ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: ONE,DEMO        [HRN:99095]                                Claim Number: 31379
..................................... (VALUE CODES).....................................

      VALU
      CODE                  VALUE CODE DESCRIPTION                                AMOUNT
      ====    ============================================================   ========
[1]    12     WORKING AGED BENEFICIARY/SPOUSE W/ EMPL GROUP HLTH PLAN    50.00


Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Medicare and Tribal Self-Insured Plans

Process

1. Identify the self-insured plan
2. Identify Part A claim
3. Identify Part B claim
4. Approve claims to Tribal Self Insured plan
5. Adjust balance in Accounts Receivable
6. Roll back adjustments to complete bill in Third Party Billing
7. Edit Medicare Claim
8. Approve and Export

Identify the Self-Insured Plan
(3PB > TMTP > INTM > EDIN)

- Review Insurer File entry for Tribal Self-Insured plan
  Plans must be marked correctly for claim edits to apply

```
72 HOUR RULE:
NPI USAGE: NPI ONLY//
TRIBAL SELF-INSURED?: ??
     Choose from:
       Y         YES, TRIBAL SELF-INSURED
       N         NO, NOT TRIBAL SELF-INSURED
TRIBAL SELF-INSURED?: YES, TRIBAL SELF-INSURED
ICD-10 EFFECTIVE DATE: OCT 1,2015//
```

Approving to the Tribal Self-Insured Plan

- Make sure the MSP status has been updated in the Medicare section of the Registration Editor
- Use the split claim option to split off Part A or Part B claim (if applicable)
- Edit claim and approve to the tribal self-insured plan
- Export claim but do not mail out to payer
  - Can export to screen

Posting in Accounts Receivable

Medicare Part A Claims

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005810&_afrLoop=1659582923645984#!%40%40%3F_afrLoop%3D1659582923645984%26contentId%3D00005810%26_adf.ctrl-state%3Dlg71ftgg9_189

- (Optional) Create Zero-Pay Collection batch and use this to post a zero-payment against the bill
- Post the adjustment to cover the amount of the bill
  - Adjustment Amount: **Enter amount to cover the amount of the bill**
  - Adjustment Category: **4 – Non Payment**
  - Adjustment Type: **645 – Chgs Excd Contrct fee Arrngmt**
- Current balance must be $0.00
- Type **Q** to Quit and **P** to Post

Display of Posted Adjustment for TSI

```
Claims for TWO,PATIENT          from 01/13/2018 to 01/13/2018          Page: 1

                                      Billed      Current     Current        Current
Line #  DOS         Claim #           Amount      Payments    Adjust.        Balance
-------------------------------------------------------------------------------
--
1     01/13/2018  31378A-IH-1019          515.00    0.00        0.00
515.00

Select Command (Line # 1) : A
Adjustment Amount: 515
Adjustment Category: 4  NON PAYMENT      NONPAY
Adjustment Type: 645  Chrgs Excd Contrct Fee Arrngmt
```

Posting in Accounts Receivable (cont.)

Medicare Part B Claims

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005811&_afrLoop=1661609202703174#!%40%40%3F_afrLoop%3D1661609202703174%26contentId%3D00005811%26_adf.ctrl-state%3Dlg71ftgg9_305

- (Optional) Create Zero-Pay Collection batch and use this to post a zero-payment against the bill
- Post the adjustment to cover the amount of the bill
  - Adjustment Amount: **Enter amount to cover the amount of the bill**
  - Adjustment Category: **4 – Non Payment**
  - Adjustment Type: **696 – Non-covered Charge(s)**
- Current balance must be $0.00
- Type **Q** to Quit and **P** to Post

Display of Posted Adjustment for TSI (cont.)

```
Claims for TWO,PATIENT       from 01/13/2018 to 01/13/2018       Page: 1

                                    Billed      Current     Current       Current
Line #  DOS         Claim #         Amount      Payments    Adjust.       Balance
-------------------------------------------------------------------------------
1     01/13/2018  31378A-IH-1019        515.00    0.00       0.00          0.00
2     01/13/2018  31378B-IH-1019        383.00    0.00       0.00        383.00
3     01/13/2018  31377A-IH-1019        335.00    0.00       0.00        335.00


Line #: 3
Select Command (Line # 3) : A
Adjustment Amount: 335
Adjustment Category: 4  NON PAYMENT     NONPAY
Adjustment Type: 696  Non-covered Charge(s)
```

Do Not Forget to Roll Back the Adjustment!

```
 Original bill approved with the following:

     P: TRIBAL HEALTH PARTNERS
     S: MEDICARE
     T:

Enter RETURN to continue:

CHECKING FOR UNBILLED SOURCES.
                  [1]  MEDICARE

Re-open claim for further billing? (Y/N)? YES

Claim Number: 31378 is now Open for Editing!
```

Approving the Part A Claim to Medicare

- Follow Medicare Part A billing requirements
- Occurrence Code 24 must be used along with the date of denial
  - Use the date after the discharge or end date of the claim
- Add the Value Code that reflects the patient's MSP status along with zero dollars ($0.00) to reflect payment of zero
- Add Remarks to the Remarks to indicate the patient has Tribal Self-Funded Insurance
- Approve and export the claim
- Secondary claim may be submitted electronically

Claim Summary

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: TWO,PATIENT          [HRN:1019]                SPLIT Claim Number: 31378
.............................. (CLAIM SUMMARY) ..............................
_______ Pg-1 (Claim Identifiers) ____________________ Pg-4 (Providers) ___________
Location..: INDIAN HOSP                   | Attn: WELBY,MARCUS
Clinic....: GENERAL                       |
Visit Type: OUTPATIENT                    |
Bill From: 01-13-2018 Thru: 01-13-2018    |
                                          |__________ Pg-5A (Diagnosis) __________
________ Pg-2 (Billing Entity) _________  | 1) PERICARDITIS
TRIBAL HEALTH PARTNERS          COMPLETE  |
MEDICARE                        ACTIVE    |
                                          |
___________ Pg-3 (Questions) ____________ |_______ Pg-5B (ICD Procedures) _______
Release Info: YES   Assign Benef: YES     |
                                          |
                                          |
__________________________________________|_____________________________________
WARNING:191 - OP VISIT(S) WITHIN 72 HOURS OF ADMISSION OR DISCHARGE
WARNING:250 - DOS after ICD Indicator Date
------------------------------------------------------------------------------
Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N//
```

Part A – Adding Occurrence Code

Note: Date of Service for this claim is January 13, 2018 so denial will be listed as January 14, 2018.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: TWO,PATIENT          [HRN:1019]                SPLIT Claim Number: 31378
.............................. (OCCURRENCE CODES) ..............................

      OCCR
      CODE                    OCCURRENCE DESCRIPTION                    DATE
      ====    ============================================  ========
[1]    24     DATE INSURANCE DENIED                         01-14-2018
-------------------------------------------------------------------------------
WARNING:130 - DATE SPECIFIED
```

Part A – Adding Value Code to Reflect MSP

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9D ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: TWO,PATIENT    [HRN:1019]                        SPLIT Claim Number: 31378
..................................... (VALUE CODES)
.....................................

      VALU
      CODE                  VALUE CODE DESCRIPTION                              AMOUNT
      ====    ============================================================  ========
[1]    12     WORKING AGED BENEFICIARY/SPOUSE W/ EMPL GROUP HLTH PLAN    0.00


Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N//
```

Add Remark to Indicate TSI

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9F  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: TWO,PATIENT      [HRN:1019]                SPLIT Claim Number: 31378
..................................... (REMARKS) ....................................

                REMARKS
       ========================================
        (48 characters x 4 lines max)
      ----------------------------------------------
[1]  PATIENT HAS TRIBAL SELF-FUNDED INSURANCE
[2]
[3]
[4]
      ----------------------------------------------

Desired ACTION (Next/Jump/Back/Quit): N//
```

Medicare Part A – 837 Institutional File

Loop 2000A

- Medicare Subscriber Information
- SBR-05 reflects MSP Status

```
HL*2*1*22*0~
SBR*S*18***12****MA~
NM1*IL*1*GRUNDY*GERALDINE****MI*301928304A~
N3*PO BOX 3924~
N4*FT WINGATE*NM*87404~
DMG*D8*19290722*F~
NM1*PR*2*MEDICARE*****PI*04411~
```

Loop 2300

- NTE Segment displays TSI Remark
- HI*BH Segment displays Occurrence Code value
- HI*BE Segment displays Value Code showing MSP Status

```
CLM*31378B-IH-1019*383.00***13:A:1**A*Y*Y~
DTP*434*RD8*20180113-20180113~
CL1*2*1*01~
REF*EA*1019~
NTE*ADD*PATIENT HAS TRIBAL SELF-FUNDED INSURANCE~
HI*ABK:I010~
HI*BH:24:D8:20180114~
HI*BE:12:::0.00~
```

Medicare Part A – 837 Institutional File (cont.)

Loop 2320

- CAS Segment reflects
  - CAS01: CO – Contractual Adjustment
  - CAS02: Standard Adjustment Reason code 45
  - CAS03: Amount of claim – must match claim amount in CLM02
- AMT Segment reflects zero dollar claim amount
- AMT Segment reflects Remaining Patient Liability
  - AMT01: EAF or Patient Liability Amount

```
SBR*P*18*TRIBAL SELF******HM~
CAS*CO*45*383*1~
AMT*D*0~
AMT*EAF*383~
OI***Y***Y~
.
.
DTP*573*D8*20180212~
```

Loop 2430

- DTP Segment reflects denial date

Approving the Part B Claim to Medicare

- Follow Medicare Part B billing requirements
- Add Remarks to the Remarks to indicate the patient has Tribal Self-Funded Insurance
- Approve and export the claim
- Secondary claim may be submitted electronically

Claim Summary (cont.)

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 0  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: TWO,PATIENT          [HRN:1019]                    Claim Number: 31377
.............................. (CLAIM SUMMARY) ..............................
_______ Pg-1 (Claim Identifiers) ___________________ Pg-4 (Providers) ___________
Location..: INDIAN HOSP                   | Attn: WELBY,MARCUS
Clinic....: GENERAL                       |__________ Pg-5A (Diagnosis) __________
Visit Type: PROFESSIONAL COMPONENT         | 1) PERICARDITIS
Bill From: 01-13-2018 Thru: 01-13-2018    |________ Pg-8 (CPT Procedures) ________
                                          | 1) OFFICE/OUTPATIENT VISIT NEW
________ Pg-2 (Billing Entity) _________ | 2) DOPPLER ECHO EXAM HEART
TRIBAL HEALTH PARTNERS          COMPLETE|
MEDICARE                        ACTIVE  |
                                        |
___________ Pg-3 (Questions) ___________|
Release Info: YES   Assign Benef: YES   |
                                        |
________________________________________|_________________________________________
WARNING:191 - OP VISIT(S) WITHIN 72 HOURS OF ADMISSION OR DISCHARGE
WARNING:250 - DOS after ICD Indicator Date
------------------------------------------------------------------------------
Desired ACTION (View/Appr/Pend/Next/Jump/Quit): N//
```

Add Remark to Indicate TSI (cont.)

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 9F  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: TWO,PATIENT            [HRN:1019]                      Claim Number: 31377
..................................... (REMARKS) ....................................

      ========================================
       (48 characters x 4 lines max)
     ----------------------------------------------
[1]  TRIBAL SELF-FUNDED INSURANCE
[2]
[3]
[4]
     ----------------------------------------------
REMARKS:
TRIBAL SELF-FUNDED INSURANCE

  Edit? NO//
```

Medicare Part B – 837 Professional File

Loop 2000A

- Medicare Subscriber Information
- SBR-05 reflects MSP Status

```
HL*2*1*22*0~
SBR*S*18***12****MB~
NM1*IL*1*GRUNDY*GERALDINE****MI*301928304A~
N3*PO BOX 3924~
N4*FT WINGATE*NM*87404~
DMG*D8*19290722*F~
NM1*PR*2*MEDICARE*****PI*04412~
```

Loop 2300

- NTE Segment displays TSI Remark

```
CLM*31377B-IH-1019*335.00***22:B:1*Y*A*Y*Y~
REF*EA*1019~
NTE*ADD*TRIBAL SELF-FUNDED INSURANCE~
HI*ABK:I010~
```

Medicare Part B – 837 Professional File (cont.)

Loop 2320

- CAS Segment reflects
  - CAS01: CO – Contractual Adjustment
  - CAS02: Standard Adjustment Reason code 45
  - CAS03: Amount of claim – must match claim amount in CLM02
- AMT Segment reflects zero dollar claim amount

Loop 2330B

- DTP Segment to reflect denial date

```
SBR*P*18*TRIBAL SELF******HM~
CAS*OA*96*335*1~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*10~
N3*PO BOX 3924~
N4*FT WINGATE*NM*87404~
NM1*PR*2*TRIBAL HLTH*****PI*99999~
DTP*573*D8*20180212~
```

Issues and Troubleshooting

Rollback not Asking for Claim to be Opened

- User receives message that there are no other billable sources even though a secondary payer is listed
- Check date of service on claim
  - Make sure backbilling check covers the service date
- Check the patient's eligibility for open coverage
- Claim may be opened in 3PB

```
Reviewing Bill 31053A-IH-10010                                          6578
BILL      31053A-IH-10010>PAYMENTS<              >ADJUSTMENTS<
BILLED        212.00     3-P CRD         0.00     NON-PAY        60.00
PAY TOT       127.00     PAYMENTS      127.00     DED             0.00
ADJ TOT        85.00     PAY CRD         0.00     CO-PAY         25.00
                         WR OFFS         0.00     PENALTY         0.00
                         GROUPER         0.00     STC             0.00
                         REFUND          0.00     TOTAL ADJ*     85.00
ROLLOVER       85.00     TOTAL PAY*    127.00

Pat:      ONE, PATIENT                  Visit Type.: OUTPATIENT
                                        Bill Status:

  Original bill approved with the following:

     P: BCBS OF NEW MEXICO
     S: NEW MEXICO MEDICAID
     T:



Enter RETURN to continue:


CHECKING FOR UNBILLED SOURCES.
NONE

Since there are no unbilled sources no further billing is possible.
```

Standard Adjustment Reason Code (SAR) Blank on Payment/Adjustment Page

- Posting technician used a local code to post an adjustment
- Review the Standard Adjustment Reason Inquiry Option (**AR** > **PST** > **IADJ**)
- Locate applicable adjustment code

Standard Adjustment Reason Inquiry Option

```
================================================================================
Standard Adjustment Reason Code Inquiry            FEB 12,2018@19:32   Page 1
================================================================================

STANDARD                          SHORT
    CODE: A2                      DESC: Contractual adjustment

    RPMS  4                       RPMS    802
CATEGORY: NON PAYMENT             REASON: Contractual Adjustment

FULL STANDARD CODE DESCRIPTION:

     Contractual adjustment. Notes: Use Code 45 with Group Code 'CO' or use
     another appropriate specific adjustment code.
```

Questions and Discussion

Issues and Feedback

- Tiered System of Support
  - Local IT
  - Area Office IT Service Desk
    https://www.ihs.gov/itservicedesk/areait/
  - National IT Service Desk
    https://www.ihs.gov/itservicedesk/ihs-it-service-desk/

- Feedback
  - https://www.ihs.gov/feedbackform/