CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 70	**Date: JUNE 26, 2009**
	Change Request 6426

Transmittal 66, Change Request 6426, dated March 27, 2009, is rescinded and replaced with Transmittal 70. The implementation date for the FISS shared system and its users is changed from July 6, 2009, to October 5, 2009. All other information remains the same.

Subject: Instructions on utilizing 837 Institutional CAS segments for Medicare Secondary Payer (MSP) Part A Claims

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to alert the Medicare contractors and shared systems to the changes necessary to derive MSP payment calculations from incoming 837 4010-A1 claims transactions.

New / Revised Material

Effective Date: April 1, 2009 Analysis and Design (CWF + FISS)
July 1, 2009 Analysis and Design (CWF + FISS)
October 1, 2009 Implementation (CWF, FISS, and FISS USERS)

Implementation Date: April 6, 2009 Analysis and Design (CWF + FISS)
July 6, 2009 Analysis and Design (CWF + FISS)
October 5, 2009 Implementation (CWF + FISS, and FISS USERS)

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N	5/40.7/40.7.3.2/Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-05	Transmittal: 70	Date: June 26, 2009	Change Request: 6426

Transmittal 66, Change Request 6426, dated March 27, 2009, is rescinded and replaced with Transmittal 70. The implementation date for the FISS shared system and its users is changed from July 6, 2009, to October 5, 2009. All other information remains the same.

SUBJECT: Instructions on utilizing 837 Institutional CAS segments for Medicare Secondary Payer (MSP) Part A Claims

Effective Date: April 1, 2009 Analysis and Design (CWF + FISS)
July 1, 2009 Analysis and Design (CWF +FISS)
October 1, 2009 Implementation (CWF, FISS, and FISS USERS)

Implementation Date: April 6, 2009 Analysis and Design (CWF +FISS)
July 6, 2009 Analysis and Design (CWF + FISS)
October 5, 2009 Implementation (CWF, FISS, and FISS USERS)

I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to alert the Medicare contractors and shared systems to the changes necessary to derive MSP payment calculations from incoming 837 4010-A1 claims transactions. The CR is limited to Part A contractors and associated systems. (**NOTE:** Contractors and the shared systems will follow most of the same MSP claims processing instructions as outlined in this CR when version 837 5010 goes live. Any other substantial changes resulting from transitioning to 5010 will be identified in another change request). The changes herein addressed are necessary to ensure Medicare's compliance with the Health Insurance Portability Act (HIPAA) transaction and code set requirements and to ensure that MSP claims are properly calculated by the Medicare contractors and their associated shared systems using payment information derived from the incoming 837 Institutional claim. Medicare's secondary payment is based on provider charges or the amount the provider is obligated to accept as payment in full (OTAF), whichever is lower; what Medicare would have paid as the primary payer; and the primary payer's payment. MSP policy also dictates what the shared systems and contractors must take into consideration when processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the CAS segments on the 835 electronic remittance advice (ERA) or paper remittance. The provider must take the CAS segment adjustments, as found on the 835, and report these adjustments on the 837, unchanged, when sending the claim to Medicare for secondary payment. The Part A contractors must use CAS segment adjustment amounts in determining MSP payment on MSP claims using instructions discussed below.

B. Policy: All Part A contractors and associated shared systems must utilize CAS segment adjustments on the 837 when adjudicating MSP claims.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A /	D M	F I	C A	R H	Shared-System Maintainers	OTHER

		B MAC	E MAC		R RIER	H I	F ISS	MCS	VMS	CWF	
6426.1	The Medicare contractors and shared systems shall continue to recognize and use all CAS segment adjustment amounts applicable for MSP claims.	X		X		X	X				
6426.2	The shared systems shall differentiate from those MSP claims payment amounts that should be sent or not sent to MSPPAY based upon the CAS segment reason codes, as stated in business requirements 6426.6, 6426.7, 6426.8, 6426.9 and 6426.10 below.						X				
6426.3	The shared systems shall utilize CAS segment information that is attributable to the primary payer by adding or subtracting the adjustment amounts, as appropriate, from the primary payer's payment amount, as found in the HI Value Information (VI), prior to sending payment amounts to MSPPAY.						X				
6426.4	The shared systems shall identify both the primary payment amount and Value Code 44 OTAF amount in the HI VI.						X				
6426.4.1	If VC 44 information is not found in the HI VI, the shared system shall search for Group Code CO in the CAS segment.						X				
6426.4.2	If CO is present in the CAS then the shared system shall utilize CAS segment information that is attributable to the primary payer in determining the contractual obligation amount ("OTAF")—the amount qualified by group code CO and the applicable CARC—by subtracting the adjustment amount, as appropriate, from the charges prior to sending the OTAF amount to MSPPAY.						X				
6426.4.3	The Part A shared systems shall send the calculated OTAF amount, based on the CAS segment adjustment calculations, to MSPPAY for MSP payment calculation.						X				
6426.4.3.1	If a CO and VC 44 appear on the claim the shared system shall subtract the CO adjusted amount from the charges and compare both the adjusted amount to the VC 44 amount which must be greater than zero.						X				
6426.4.3.2	When the shared system subtracts the CO from the charges and it matches the VC 44 amount send the VC 44 amount to MSPPAY.						X				
6426.4.3.3	When the shared system subtracts the CO from the charges and the calculated CO amount does not match the VC 44 amount, which must be greater than zero, then return the claim indicating to the provider that CO calculated amount and VC 44 amount in the HI VI do not match.						X				
6426.4.4	When services are reported at the line level and primary payment amounts are reflected at the claim level, the shared systems shall send the line level						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	amounts and claim level payment amounts to MSPPAY for apportionment to each given service line.										
6426.5	If claim adjustment reason code (CARC) "1" "2" "3" or "66" appears in the CAS segments and the claim contains both a primary payer and Medicare covered service and the primary payer payment is equal to zero on all lines of service, the Medicare contractors shall make a primary payment.						X				
6426.5.1	If CARC 1 and CARC 66 appears in the CAS segments with an adjustment amount and the claim contains both a primary payer and Medicare covered service and the primary payer makes a payment greater than zero, the shared system shall process the claim as Medicare secondary for those lines of service where payment was made.						X				
6426.6	The shared systems shall add the following claim CARC amounts to the primary payer payment amount if one of the listed CARCs is submitted on a claim: 15, 17, 29, 58, 61, 95, 112, 117, 125, 130, 150, 163, 164, 179, 181, 182, 197, 210, 223, B4, B5, B7, B8, B10, B16.						X				
6426.6.1	The shared system shall send the paid amount identified in requirement 6426.6 as the paid amount to MSPPAY.						X				
6426.6.2	The shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.						X				
6426.6.3	The shared system shall send the adjusted payment amount as the "paid amount" on the claim to CWF. (**NOTE:** The adjusted payment amount is the incoming payment amount or the apportioned incoming payment amount) plus the CARC adjustment.						X			X	
6426.6.4	The contractors shall store the adjusted payment amount.	X		X			X				
6426.7	The contractors and shared systems shall deny and not make a Medicare payment for a line item when the following CARCs are found on an MSP claim and the primary payer did not make a payment: 4, 10, 11, 13, 14, 16, 19, 20, 21, 34, 39, 54, 101, 110, 111, 114, 115, 128, 129, 133, 136, 140, 146, 155, 158, 165, 174, 175, 176, 177, 180, 188, 189, 201, 206, 207, 208, A1, B15, B18, B23.						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6426.7.1	Medicare shall make a secondary payment if the primary payer made a payment greater than zero for the service line and the service is a Medicare covered service.	X		X			X				
6426.7.2	The shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.						X				
6426.7.3	The shared systems shall create and populate a new Worker's Compensation indicator field with a Y on the CWF HUIP, HUOP, HUHH, and HUHC claim transactions at the claim level when there is a CARC 19, 20 or 21 on an incoming MSP claim.						X			X	
6426.7.4	The contractor shared systems shall populate a "space" on all HUIP, HUOP, HUHH, and HUHC claim transactions when CARC 19, 20, 21 are not found on incoming MSP claims.						X			X	
6426.7.5	When CWF receives the new Worker's Compensation indicator CWF shall search for an MSP occurrence for Worker's Compensation indicator field to determine if the diagnosis codes on the claim are related to the diagnosis codes on the MSP auxiliary file occurrence for worker's compensation.									X	NCH NGD MBD
6426.7.6	If CWF does not find an non-GHP MSP occurrence for Worker's Compensation, liability or no fault, or the diagnosis codes on the claim does not match the diagnosis codes, or the codes within the same category, found on the MSP auxiliary file, the CWF system shall reject the claim to the contractor's claim system.									X	
6426.7.6.1	The CWF shall issue an over-rideable MSP error code 68xx for non-GHP claims where an MSP claim does not match an MSP occurrence on CWF or the diagnosis codes on the claim are not related to the diagnosis codes found in CWF.									X	
6426.7.6.2	Upon receipt of the returned claim, the affected contractor shall send an ECRS inquiry request to the COBC, including the worker's compensation, liability or no-fault information as found on the claim.	X		X		X					
6426.8	The contractors and their shared systems shall make a primary payment for services if the following CARCs are found on the claim and if the service is covered by Medicare and the primary payer did not make a payment: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 204, B1 (if a	X		X		X	X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Medicare covered visit), B14, W1. Note: for W1 Medicare shall pay conditionally when the "E" Workers' Comp record is open on CWF and payment will not be made within the promptly period.										
6426.8.1	Medicare shall make a secondary payment if the primary payer made a payment greater than zero for the service line and the service is a Medicare covered service.	X		X		X	X			X	
6426.8.2	The shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.						X				
6426.8.3	In relation to CARC W1, the Medicare contractors, or the shared system, shall not make a primary payment if there is an open WCSA on the MSP auxiliary file.	X		X		X	X				
6426.8.4	In relation to 6426.8.2, if the Medicare contractor, or shared system, determines that the WCSA auxiliary record is closed, the Medicare contractor shall make a primary payment.	X		X		X	X				
6426.8.5	The shared systems shall send the M override code, for GHP claims, to CWF when the CAS segment includes the CARC codes in requirement 6426.8, thereby ensuring that the contractors are able to make a primary payment.						X			X	
6426.9	Unless contractors have edits in place in its system to recognize the following CARC situations, the shared systems shall suspend claims so that contractors may review claims to determine whether they shall make a Medicare payment, taking into consideration applicable MSP and claims processing rules and procedures when the following CARCs appear on claims: 5, 6, 7, 8, 9, 12, 18, 23, 24, 33, 38, 40, 97, 107, 109, 116, 138, 148, 171, 172, 178, 183, 185, 191, 193, 224, A7, B11, B12, B13.	X		X		X	X				
6426.9.1	The contractors shall apply the appropriate MSP and claims processing rules to determine whether Medicare shall make a primary payment, a secondary payment or deny/reject the claim for the CARCs in requirement 6426.9.	X		X		X	X				
6426.10	The Medicare contractors shall 1) make a secondary payment for a given service, or group of services, and 2) utilize the primary payer's payment amount when the following CARC adjustments appear an incoming MSP claim and the service is covered and payable by Medicare: 44, 45, 59, 90, 91, 94, 100, 102, 103, 106,	X				X	X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	118, 131, 147, 151, 152, 153, 154, 160, 156, 157, 159, 173, 190, 192, 194, 198, 202, 203, B9, B20, B22.										
6426.10.1	The shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.						X				
6426.11	CARC 223: The shared system shall add or subtract the associated adjustment amount from the payment amount depending on whether the CARC amount contains a negative or positive sign.						X				
6426.12	CARC 225: Contractors shall deny and return the claim to the provider when CARC 225 appears on the claim.						X				
6426.13	The Medicare contractors and their affiliated shared systems shall continue to the apply appropriate remarks codes to the providers remittance advice and to the beneficiary Medicare Summary Notice (MSN).	X		X		X	X				
6426.14	CMS shall issue and the Medicare contractors and shared systems shall implement any future instructions for those CARCs that are added, modified, or deactivated when such CARCs impact MSP claims.	X		X		X	X				
6426.15	The contractors and shared systems shall not accept Data Direct Entry (DDE) MSP claims from providers since CAS segment adjustments are not utilized in the DDE environment.	X		X		X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6426.16	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, Richard.Mazur2@cms.hhs.gov, (410) 786-1418

Post-Implementation Contact(s): Richard Mazur, Richard.Mazur2@cms.hhs.gov, (410) 786-1418

VI. FUNDING

SECTION A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Secondary Payer (MSP) Manual

Chapter 5 - Contractor Prepayment Processing Requirements

(Rev. 70, 06-26-09)

40.7.3.2 - Medicare Secondary Payment Part A Claims Determination for Services Received in the 837 Institutional Electronic or Hardcopy Claims Format

40.7.3.2 - Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format

(Rev. 70; Issued: 06-26-09; Effective Dates: April 1, 2009 Analysis and Design (CWF + FISS), July 1, 2009 Analysis and Design (CWF + FISS, October 1, 2009, Implementation (CWF, FISS, and FISS USERS); Implementation Dates: April 6, 2009 Analysis and Design (CWF + FISS), July 6, 2009 Analysis and Design (CWF + FISS), October 5, 2009 Implementation (CWF + FISS, and FISS USERS))

Medicare's secondary payment for Part A MSP claims is based on Medicare covered charges, or the amount the physician or other supplier is obligated to accept as payment in full (OTAF), which ever is lower; what Medicare would have paid as the primary payer; and the primary payer(s) payment. MSP policy also dictates what the shared systems and contractors must take into consideration in processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the Claims Adjustment (CAS) segments on the 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the primary payer remittance advice and report these adjustments on the 837 when sending the claim to Medicare for secondary payment. 837 claims transaction examples are cited below.

***Example 1**: A Medicare beneficiary visits a hospital charges $10,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is primary to Medicare. The beneficiary's Medicare deductible had already been met. The provider participates under the primary payer's employer group health plan. The contract amount, a.k.a. obligated to accept as payment in full amount, is the same as Medicare's fee schedule amount of $8000. The primary payer ultimately pays $7200 for the services. The service amounts are broken down:*

Medicare Fee schedule Procedure	*$8000*
Charges	*$10,000*
Payer 1 Allowed Amount	*$8000 (not sent to MSPPAY)*
Payer 1 Contracted Agreement (OTAF)	*$8000*
Payer 1 Patient Co-Insurance @ 10%	*$ 800*
Payer 1 Payment Amount	*$7200*

The VC 44 OTAF amount is found in the VI segment on the 837 I and this amount is sent to MSPPAY. If the OTAF is not found in the VI segment, but there is a group code CO in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY.

Medicare payment is calculated as follows:

1) *The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8000- 0= $8000*
2) *The gross amount payable by Medicare minus the primary payment: $8000- $7200 = $800*
3) *The obligated to accept payment in full minus the primary payment: $8000 - $7200 = $800*

4) *The obligated to accept payment in full minus the Medicare deductible: $8000 – 0 = $8000*
5) *Pay $800 (lowest of amounts in steps 1, 2, 3, or 4)*

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:
*CLP*200725638901*1*10000*7200*800*12*07256000236520**1~*
*CAS*CO*45*2000~*
*CAS*PR*2*800~*
Provider Abbreviated Secondary Claim to Medicare
*SBR*P*18*ABCGROUP******CI*
*CAS*CO*45*2000~*
*CAS*PR*2*800~*
*AMT*C4*7200~*

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 10000-2000=8000. (NOTE: Although the primary payer allowed amount is not used to determine Medicare's secondary payment it is shown here because it will appear on incoming 837 in the CAS. The allowed amount is shown her and is used for purposes of balancing the remittance advice.)

Since VI did not contain OTAF the CO adjusted amount in the CAS is used to determine the OTAF. OTAF amount equals charge minus CO group code adjustments – $10000-$2000=$8000

Medicare Abbreviated 835 to Provider

*CLP*200725638901*2*10000*800**MB*0725600110236520**1~*
*CAS*OA*23*9200~*

***Example 2**: The same patient receives the same service from the provider. However, in this case the provider fails to follow plan procedures and is assessed a $500 penalty under the contract for not following plan procedures. Medicare bases its payment on the amount the primary payer would have paid if the provider followed plan procedures.*

Medicare Fee schedule	*$8000*
Charges	*$10000*
Payer 1 Contracted Agreement (OTAF)	*$8000*
Payer 1 CO Plan Procedures not followed	*$ 500*
Payer 1 Patient Responsibility @ 10%	*$ 750*
Payer 1 Payment Amount	*$6750*

Medicare's Payment is calculated in the usual manner:

1) *The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8000- 0= $8000*
2) *The gross amount payable by Medicare minus the primary payment: $8000- $7250 = $750*

3) *The obligated to accept payment in full minus the primary payment: $8000 - $7250 = $750*
4) *The obligated to accept payment in full minus the Medicare deductible: $8000 – 0 = $8000*
5) *Pay $750 (lowest of amounts in steps 1, 2, 3, or 4)*

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:

*CLP*200725638901*1*10000*6750*750*12*07256000236520**1~*
*CAS*CO*45*2000**95*500~*
*CAS*PR*2*750~*

Physician Abbreviated Secondary Claim to Medicare

*SBR*P*18*ABCGROUP******CI*
*CAS*CO*45*2000**95*500~*
*CAS*PR*2*750~*
*AMT*C4*6750~*

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 10000-2000 - 500=7500
OTAF amount equals submitted charge minus CO group code adjustments – 10000-2000=8000

Medicare Abbreviated 835 to Provider

*CLP*200725638901*2*10000*750**MB*0725600110236520**1~*
*CAS*OA*23*9250~*