CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 124	**Date: August 31, 2018**
	Change Request 10855

SUBJECT: Updates to Chapters 5 and 6 of Publication 100-05 to Further Clarify Medicare Secondary Payer (MSP) Processes that Include Electronic Correspondence Referral System (ECRS) Requests Submissions and Timely Submission of MSP I Records, General Inquiries and Hospital Reviews

I. SUMMARY OF CHANGES: This change request (CR) further clarifies several MSP processes that require implementation in the Internet Only Manual. This includes the time frame when the Medicare Administrative Contractors (MACs) shall create and send an "I" record to the CWF, situations when the MACs shall send ECRS requests to the Benefits Coordination & Recovery Center (BCRC) to update MSP records created by Section 111 contractor 11121 or 11122, and when the MACs shall send an interim response to an inquirer when the final response cannot be sent within 45 calendar days. An update to the time frame when MSP hospital reviews shall be reviewed and completed is also identified.

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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
	Table of Contents
R	5/10/Coordination with the Benefits Coordination & Recovery Center (BCRC)
R	5/10/10.1/Contractors MSP Auxiliary File Update Responsibility
R	5/10/10.2/10.2.1/ECRS Functional Description
R	5/10/10.5/Notification to Contractor of MSP Auxiliary File Updates
R	5/30/30.3/30.3.2/Develop ESRD Claims Where Basis for Medicare Entitlement Changes
R	5/70/70.1/Reviewing Hospital Files
R	5/70/70.1/70.1.1/Frequency of Reviews and Hospital Selection Criteria
R	5/70/70.1/70.1.2/Methodology for Review of Admission and Bill Processing Procedures
R	5/70/70.4 - Assessment of Hospital Review
R	5/70/70.5/70.5.4 - Exhibit 4: Entrance Interview Checklist: Billing Procedures
R	6/10/10.1/Overview of CWF MSP Processing
R	6/20/20.1/20.1.1 - MSP Add Transaction
R	6/20/20.2/Medicare Secondary Payer (MSP) Maintenance Transaction Record/Medicare Contractor MSP Auxiliary File Update Responsibility

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 124	Date: August 31, 2018	Change Request: 10855

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I. GENERAL INFORMATION

A. Background: Resulting from MSP Quality Assurance Surveillance Plan (QASP) reviews, it has been determined that Chapters 5 and 6 of Pub. 100-05 requires clarification, updating and implementation of policy and procedures that were issued in previous CMS Technical Direction Letters (TDLs). This CR updates the Internet Only Manual with the policy and procedures found in the CMS TDLs including updates to the time frames for completing MSP hospital reviews conducted by the Part A Medicare Administrative Contractors.

B. Policy: A/B MACs and Durable Medical Equipment MACs must adhere to CMS direction as found in CMS TDLs and the IOM when implementing MSP policy and procedures. This includes submitting timely MSP "I" records to CWF when appropriate and submitting ECRS requests to the BCRC, as necessary. It is also important to respond to MSP correspondence timely as well as Part A MACs completing all MSP hospital reviews in a timely manner.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10855.1	All A/B MACs and DME MACs shall implement all MSP "I" records policies and procedures, ECRS transmission updates and timely processing of MSP correspondence as found in the updated sections of Pub. 100-05, Chapters 5 and 6.	X	X	X	X					
10855.2	A/B MACs Part A shall implement the hospital review changes as identified in Pub. 100-05, Chapter 5, section 70 and respective subsections.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst, 410-786-2487 or brian.pabst@cms.hhs.gov , Richard Mazur, 410-786-1418 or richard.mazur2@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Secondary Payer (MSP) Manual

Chapter 5 - Contractor Prepayment Processing Requirements

(Rev. 124, Issued: 08-31-18)

10 - Coordination *with* the *Benefits Coordination & Recovery Center (BCRC)*

10 - Coordination *with* the *Benefits Coordination & Recovery Center (BCRC)*

(Rev.124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

Transfer of Initial Medicare Secondary Payer (MSP) Development Activities to the *Benefits Coordination & Recovery Center (BCRC)*

The *BCRC* consolidates activities that support the collection, management, and reporting of all other health insurance coverage of Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare. *The BCRC* assumed responsibility for virtually all initial MSP development activities formerly performed by contractors. The *BCRC* is charged with ensuring the accuracy and timeliness of updates to the Common Working File (CWF) MSP auxiliary file. The *BCRC* does not process claims, nor claims specific inquiries (telephone or written). The *BCRC* is responsible for developing to determine the existence or validity of MSP for Medicare beneficiaries. The *BCRC* handles all MSP related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries. These inquiries (verbal and written) can come from any source, including but not limited to beneficiaries, attorneys/beneficiary representatives, employers, insurers, providers, suppliers and contractors.

The *BCRC* is primarily an information gathering entity. The *BCRC* is dependent upon various sources to collect this information. With limited exceptions (e.g., claim clarification with provider to avoid returning the claim to the provider (RTP), contractors are no longer responsible for initiating MSP development and making MSP determinations. Following CMS' correspondence guidelines (found in Pub. 100-09 chapter *6, §60.3.2.1 and 60.3.2.2.* Timeliness); the Medicare contractors shall forward all information that they receive that might have MSP implications to the *BCRC*. This requirement includes filling out all fields in the Electronic Correspondence Referral System (ECRS) Web where the information is available. If the Medicare contractor does not have the information, and it is not a required field, the Medicare contractor shall leave the field blank. Only with this timely and accurate information can the *BCRC* evaluate all relevant information to make the correct MSP determination and appropriately update CWF for proper claims adjudication. Once the MSP record has been established on CWF by the *BCRC, the BCRC shall* be responsible for all MSP activities related to the identification and recovery of MSP-related debts.

There must be a very close working relationship between the *BCRC* and the contractors.

Contractor inquiries related to specific work activities shall contact their *BCRC* Consortia representative. Medicare contractors shall provide the *BCRC, through CMS,* with a list of names, private phone numbers, and fax numbers of each contractor's primary and backup MSP contact *so* the *BCRC may* follow-up with the contractor as needed.

The following provides a description of the activities that are included in MSP development and the necessary action(s) of contractors.

10.1 - Contractors MSP Auxiliary File Update Responsibility

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

The capability to update the CWF MSP auxiliary file is, essentially, a function of only the *BCRC*. Contractors do not have the capability to delete any MSP auxiliary file records, including those they have established. If they believe a record should be changed or deleted, they shall use the *BCRC* ECRS Web (discussed in §10.2).

Contractors retain the responsibility of adding termination dates to MSP auxiliary records already established on CWF with a "Y" validity indicator, where there is no discrepancy in the validity of the information contained on CWF. Contractors do not have the capability to alter an existing termination date.

There are only three instances in which the contractor shall retain the capability to update CWF. They are:

1 - The contractor receives a phone call or correspondence from a beneficiary representative, beneficiary, third party payer, provider, another insurer's explanation of benefits or other source that establishes, exclusive of any further required development or investigation that MSP no longer applies.

Examples of such contacts include a telephone call from a beneficiary to report retirement or cessation of group health insurance. The contractor shall post a termination date to the MSP auxiliary record using a "Y" validity indicator. While Contractors should update CWF as soon as possible so that proper payments can be made; contractors shall update CWF within the lesser of:

- Ten (10) calendar days from completion of the evaluation (i.e. comparing the incoming information with the existing CWF MSP record and determining that there are no discrepancies between the incoming data and the existing CWF MSP record allowing for a termination date to be posted), but no later than

- Forty-five (45) calendar days of the mailroom date-stamped receipt/date of phone call, as applicable

EXAMPLE 1

Scenario

Mr. Doe is calling to report that his employer group health coverage has ended.

Contractor Action

The contractor shall check for a matching auxiliary record on CWF and terminate the record if no conflicting data are present. If the contractor cannot add a termination date, the contractor shall submit a CWF assistance request (See §10.2 Attachment 1). The contractor shall not transfer the call to the *BCRC*.

EXAMPLE 2

Scenario

Mrs. X is calling to report that she has retired.

Contractor Action

The contractor shall check for a matching auxiliary record on CWF and terminate the record if no conflicting data are present. If the contractor cannot add a termination date or if the date on CWF needs to be altered, the contractor shall submit a CWF assistance request (See §10.2 Attachment 1). The contractor shall not transfer the call to the *BCRC*.

EXAMPLE 3

Scenario

Union Hospital is calling to report that the group health plan MSP period contained on the CWF for beneficiary X should be terminated.

Contractor Action

The contractor shall check for matching auxiliary record on CWF and terminate if no conflict in evidence is presented. If the contractor cannot add a termination date or if the date on CWF needs to be altered, the

contractor shall submit a CWF assistance request (See §10.2 Attachment 1). The contractor shall not transfer the call to the *BCRC*.

2 - The contractor receives a claim for secondary benefits and could, without further development (for example, the explanation of benefits from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim.

The contractor shall use a validity indicator of "I" to add any new MSP occurrences (only if no MSP record with the same MSP type already exists on CWF with an effective date within one hundred (100) days of the effective date of the incoming "I" record). *An "I" record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF. The contractor shall retain suspense dates and be able to provide either screen prints or create upon request a report reflecting all status dates of claim suspensions. Note, managing the MSP inventory of workload in such a way as to require all MSP related claims be processed within 10 calendar days from the date in which the claim suspends will ensure the CMS requirement for the creation of "I" records is consistently met. The MAC* shall not submit a new record with a "Y" or any record with an "N" validity indicator.

3 - The contractor receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development.

The contractor shall add the MSP occurrence using an "I" validity indicator. *An "I" record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF. The contractor shall retain suspense dates and be able to provide either screen prints or create upon request a report reflecting all status dates of claim suspensions. Note, managing the MSP inventory of workload in such a way as to require all MSP related claims be processed within 10 calendar days from the date in which the claim suspends will ensure the CMS requirement for the creation of "I" records is consistently met.*

The contractor transmits "I" records to CWF via the current HUSP transaction. The CWF treats the "I" validity indicator the same as a "Y" validity indicator when contractors process claims. "I" records shall only be submitted to CWF if no MSP record with the same MSP type already exists on CWF with an effective date within one hundred (100) calendar days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria shall be rejected with an SP 20 error code. *Since an "I" record should not be submitted under these circumstances, an ECRS Inquiry should be submitted with all pertinent information found on the claim. It would be the responsibility of the BCRC to establish the correct effective date.*

The *BCRC* shall receive a trigger from the CWF when an "I" record is transmitted and applied. The *BCRC* develops and confirms all "I" maintenance transactions established by the contractor. If the *BCRC* has not received information to the contrary within one hundred (100) calendar days, the "I" validity indicator will be converted to a "Y". If the *BCRC* develops and determines there is no MSP, the *BCRC* will delete the "I" record.

An "I" record should never be established when the mandatory fields of information are not readily available to the contractor on its claim or associated attachment (e.g., other payer's explanation of benefits (EOB) paid).

The following are to be used as default values when creating an "I" record:

(1) MSP Effective Date: Use the Part A entitlement date.

(2) Patient Relationship: Use "01" if no indication of other insured member, and use "02" if another member is shown but uncertain of relationship.

(3) MSP Type: For GHP, use the current reason for entitlement: working aged (12), disability (43), or ESRD (13). For NGHP, if not identified, the default to be used is No-Fault (14).

In addition, effective January 1, 2003, a refund or returned check is no longer a justification for submission of an "I" record. Since an "I" record does not contain the source (name and address) of the entity that returned the funds, *BCRC* lacks the information necessary to develop to that source. Follow the examples below to determine which ECRS transaction to submit:

1. An MSP inquiry should be submitted when there is no existing or related MSP record on the CWF.

2. The CWF assistance request should be submitted when the information on the CWF is incorrect or the MSP record has been deleted.

3. If the check or voluntary refund will open and close the case/MSP issue, the Medicare Contractors should submit an MSP inquiry. They should refer to ECRS manual for more information regarding closed cases.

The check should be deposited to unapplied cash until *BCRC* makes an MSP determination. Refer to Chapter 6, Section 20.2 for examples.

If the contractor has the actual date that Medicare became secondary payer or the date of the accident or incident, it shall use that as the MSP effective date. If that information is not available, the contractor shall use the Part A entitlement date as the MSP effective date. Contractors shall add termination dates when an “I” record is initially established, where applicable. A contractor shall not add a termination date to an already established "I" record.

The following are mandatory fields for MSP records with a validity indicator of "Y" and "I":

- *Medicare beneficiary identifier;*
- MSP type;
- Validity indicator;
- MSP effective date;
- Contractor identification number;
- Insurer name;
- Patient relationship; and
- Insurance type.

Chapter 6, §40.8, contains the CWF MSP utilization error codes, descriptions, and resolution for the contractor’s use in correcting MSP utilization error codes.

10.2.1 - ECRS Functional Description

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

In general, there are two ECRS submission processes. The MSP inquiry process is used to transmit information to the *BCRC* where no related MSP record exists on the CWF. The CWF assistance request is used to transmit information to the *BCRC* to modify or delete existing MSP information currently residing on the CWF for any type of MSP situation. *Assistance requests should be done only on "related" records (i.e., the existing MSP record is for the same insurer and part or all of the time span reflected on the claim).* Contractors shall refer to the ECRS Web User Guide-Attachment 1 for step-by-step instructions on how to submit MSP inquiry and CWF assistance request transactions to the *BCRC*, and how to perform status inquiries on previously submitted transactions. *Note: Some MACs utilize "screen scraping" (copying portions of internal or CWF data) into ECRS or the "I" record. This practice should not occur when there is a discrepancy in the insured name, insurer name, policy or group number. When entering the type of MSP record in ECRS, contractors shall enter the correct MSP information even if the provider submits an incorrect MSP information including the insurer information found on the claim.*

In the past MACs have sent ECRS requests to the BCRC requesting that section 111 records be updated. The BCRC has rejected most of these requests based on CMS hierarchy of Section 111 entities taking precedence on updating contractor number 11121 and 11122 MSP records. However, CMS has clarified that the BCRC shall accept MACs ECRS requests to update Section 111 contractor number 11121 and 11122 MSP records based on conditions below. MACs shall continue to submit ECRS requests to the BCRC for COB contractor numbers 11121 and 11122 for the following circumstances:

- *When the MAC receives information indicating the Group number or policy number of the primary payer has changed,*
- *When the MAC learns of a retirement date for the beneficiary and a termination date must be added to the MSP record,*
- *When the MAC receives information indicating the Insurance Type A, J or K has changed or conflicts with what is on the CWF MSP Auxiliary file, or*
- *When a MAC receives a primary payer EOB or remittance advice showing payment for a deleted or closed Section 111 GHP MSP record that should remain open. Note, the BCRC will not accept an NGHP record update request for this type of MSP claim situation.*

Please note it is to the discretion of the BCRC to approve these Section 111 ECRS requests upon review. Approval or denial of such ECRS requests shall be sent to the MACs by the BCRC.

ECRS Access:

- Contractors who require access to ECRS Web must register in the CMS Individuals Authorized Access to CMS Computer Services (IACS, request ECRS access, and have a contractor ID and access code. If you have an IACS ID and password and a contractor number and need assistance obtaining a contractor access code, *please contact the BCRC*.

- To request an IACS ID for access to ECRS WEB, follow the instructions below:

  New User Registration:

  - To obtain IACS Access, go to the CMS Applications Portal Website at the following link: *https://portal.cms.gov/wps/portal/unauthportal/home/*

  - Read the Warning / Reminder statements and select the **"Enter CMS Applications Portal"** button.

  - On the CMS Applications Portal Introduction screen, click on **"Account Management".**

  - On the Account Management screen, click on **"New User Registration"**.

- On the Individuals Authorized Access to the CMS Computer Services (IACS) screen, click on: **“Electronic Correspondence Referral System (ECRS) Web**.

- On the Terms and Conditions screen, read the Privacy Act and Rules of Behavior statements. Check the **"I Accept the Above Terms and Conditions"** box and then select the **"I Accept"** button. You must select both.

- On the New User Registration Screen, complete all required fields, being sure to enter an accurate email address. Required fields are indicated by an asterisk (*) to the right of the field.

- In the Role drop down box under Access Request, Select User Roles- **“ECRS Web User”**.

- In the Justification Box, **type** how you will be using ECRS Web and the associated Plan Contract Number.

- Click on **“Next”**, and continue to follow the instructions on the subsequent screens.

- If you already have an existing IACS ID, the next step in the process is to add ECRS Web to your CMS profile. You can do that by following the steps below:

  If you already have an IACS ID:

  - Go to: *https://portal.cms.gov/wps/portal/unauthportal/home/*

  - Read the Warning / Reminder statements and select the **"Enter CMS Applications Portal"** button.

  - On the CMS Applications Portal Introduction screen, select the "**Account Management**" hyperlink on the top menu bar.

  - On the Account Management screen, select the **"My Profile"** hyperlink

  - On the Terms and Conditions screen, read the Privacy Act and Rules of Behavior statements. Check the **"I Accept the Above Terms and Conditions"** box and then select the **"I Accept"** button. You must select both.

  - On the Login to IACS screen, enter your User ID and Password, and select the **"Login"** button.

  - On the My Profile Screen, Select **“Modify Account Profile”**

  - Under Access Request, Select **“Add Application”** from the drop down list

  - From the Application drop down list, Select **“ECRS Web”**

  - In the Role drop down list, select User Roles- **“ECRS Web User”**

  - In the Justification Box, **type** how you will be using ECRS Web and the associated Plan Contract Number.

  - Click on **“Next”**, and continue following the instructions on the subsequent screens.

  Next Steps:

- After you complete the IACS New User Registration or have added ECRS Web to your IACS profile, you will be sent an E-mail confirming that IACS has received your request and providing you with a Request Number. You should use that request number if you need to contact the *BCRC* EDI Hotline regarding your request.

- Once the Approver of the ECRS Web has approved the request, two separate E-mail messages will automatically be sent to the email address provided:

  - The first (Subject: FYI: User Creation Completed – Account ID Enclosed) will contain the IACS User ID.

  - The second (Subject: FYI: User Creation Completed – Password Enclosed) will contain the format of the initial password and instructions to change the initial password. You will be required to change your initial password the first time you logs in.

- If your request for registration is denied, you will receive an E-mail informing you that your request has been denied. The E-mail will also provide the justification for the denial.

- Note: If you have not received an approval or denial email within 7 calendar days, or are having difficulty registering for ECRS Web, contact the *BCRC* EDI Hotline.

- To begin using ECRS Web, follow the instructions below:

  - Contractor opens an Internet Browser and connects to ECRS URL https://www.cob.cms.hhs.gov/ECRS.

  - If the contractor has not logged on with his IACS User ID and Password, the system will route the contractor to the CMS Access Management Logon Page.

    - The contractor uses his IACS User ID and Password to log on.

    - The system will route the contractor to the ECRS Federal Systems Login Warning page.

  - The contractor will read the Federal Systems Login Warning and click [Accept] at the bottom of the page.

  - The system displays the COB ECRS Web Contractor Sign In page.

  - The contractor types his contractor number and access code and clicks [Continue].

  - The system displays the COB ECRS Web Main Menu web page.

  - A menu displays from which the contractor chooses from several options. These options allow the contractor to report MSP information, to request a change to an existing MSP record on the CWF, or to view workload tracking reports.

  - The applicable web pages display and the contractor enters data for his request. The application has built-in edits so that required data elements are entered before the request can be completed. Edits permit only valid values to be entered in each field. The ECRS Web user manual can be found at §10.2 Attachment 1.

- Once the contractor has completed the web entry, he clicks [Submit] and the information is stored on a database table or file on the *COB* mainframe.

- In the next batch cycle at the *BCRC* site, this request is processed. The *BCRC's* system updates a status field on the request in ECRS. Once a final determination has been made, the *BCRC* updates CWF as appropriate.

- Contractors should log back on to ECRS to check on the status of their request, including final determination.

10.5 - Notification to Contractor of MSP Auxiliary File Updates

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

Contractors have the capability to log on to ECRS Web to generate an ECRS report with a list of their submissions and status of those submissions. Contractors can also search by the beneficiary's HICN to see what Inquiries/Assistance Requests have been submitted by all contractors.

Contractors shall be cognizant that the CM (i.e., completed) status in ECRS and the associated ECRS completion date is the same as the CWF maintenance date. Contractors shall use this date to timely resolve pending correspondence and other such workloads to be in compliance with the CMS 45 calendar day correspondence timeframe or other prescribed timeframes for designated MSP workloads. *MACs shall not send combined interim and final response letters. The MACs shall follow the procedures cited in Pub. 100-05, Chapter 5 section 10.5 and Pub. 100-09, Chapter 6, Section 60.3 when responding to MSP incoming inquiries. This means the MACs shall send an interim response if the final correspondence response cannot be sent within 45 calendar days. A final response is also required when an ECRS response of CM (completed) is received from the BCRC. If claims are impacted, the final response shall be either a claim adjustment or, if necessary, direction that the provider contact the MAC directly regarding any claim adjustments resulting from an updated MSP record. Contact the BCRC if an ECRS response has not been received within 45 calendar days.*

30.3.2 - Develop ESRD Claims Where Basis for Medicare Entitlement Changes

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18

Medicare is the secondary payer throughout the entire 30-month ESRD coordination period. If the beneficiary becomes disabled or aged before the coordination period ends, see Chapter 2, §20.1.3, of this manual. To assist *contractors* in processing claims under these provisions, the *BCRC* determines the coordination period based upon information it develops, and updates the CWF (See Chapter 3). *Contractors are encouraged to use REMIS to determine and enter the correct ESRD COB period. However, contractors are permitted to show the actual or default effective date without an end date. If the contractor does enter the end date, they are held accountable for entering the correct COB period. Note, to being the process of access to REMIS, please have the requestor submit a ticket to the QualityNet Help Desk, information below. They will be able to walk the user through the process, which begins with establishing a CMS EIDM account:*

QualityNet Help Desk, CROWNWEB/REMIS/ESRD Systems, phone: (866) 288-8912, Fax (888) 329-7377, email: qnetsupport-esrd@hcqis.org

70.1 - Reviewing Hospital Files

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

In order to conduct an effective review, the contractor shall obtain complete files from the hospital on all beneficiaries represented in the bills selected for review. (See §70.2 concerning sample selections.) For the purposes of this review, a complete file must contain:

- A copy of the completed UB-*04* (Form CMS-1450) or its facsimile;

- A copy of the admission questionnaire (the beneficiary's signature on the questionnaire is not required; see §70.3.B). If the hospital uses an online query process, no hardcopy form need appear in the file. Screen prints may be used instead (see §70.1.2.B); and

- Beneficiary's MSN form for all secondary claims.

70.1.1 - Frequency of Reviews and Hospital Selection Criteria

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

Each year the contractor shall conduct a review of 10 percent of the hospitals (or a maximum of 20, whichever is the lesser of the two) in each state for which it has Medicare claims processing responsibility. Hospitals to consider for review include those which:

- Fail to develop MSP claims properly;

- Fail to submit "no payment" bills; and

- Do not submit auto accident cases (even if they have shock trauma units specializing in emergency admissions).

The contractor shall refrain from repeatedly selecting the same hospital for review each year. A hospital reviewed within the last 12 months is not to be reviewed the following year if there are hospitals that were not reviewed during the preceding 12 months, unless serious deficiencies are identified. The objective of hospital reviews is to review all hospitals in the contractor's geographic area. The review period generally lasts a maximum of two days.
Multiple contractors having a presence in one state shall communicate with each other to ensure that duplicate reviews do not occur and that, as a combined total, the multiple contractors do not review more hospital providers than would have been reviewed if only one contractor processed claims for all hospital providers in that state.

A/B MACs Part A shall complete all hospital reviews and submit the final hospital review report to the provider within 6 months from the start of the audit.

70.1.2 - Methodology for Review of Admission and Bill Processing Procedures

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

A Entrance Interview

The contractor shall conduct an entrance interview with the admissions staff (including inpatient, outpatient, and emergency) to determine whether the hospital established:

1. Policies identifying other payers primary to Medicare; and

2. A system in which such policies are carried out in practice.

Contractors shall use the checklist found in §70.5.3, Exhibit 3 to conduct the entrance interview. During the interview, the contractor shall request a descriptive walk-through of the admissions process. It is not necessary to observe an actual admission of a beneficiary.

B Review of Hospital Admission Questionnaire

The contractor shall review copies of the hospital's inpatient, outpatient, and emergency room (ER) hospital admission questionnaires. If the hospital uses an online admission query process, the contractor shall review the system screen prints. If the hospital has both hard copy questionnaires and online questionnaire responses, the reviewer may exercise discretion in deciding whether to review hard copy questionnaires or online responses (or both, if desired). The reviewer shall compare the hospital's admissions questionnaire to the model found in the Medicare Secondary Payer Manual, Chapter 3, § 20.2.1) to ensure that the appropriate questions are being asked to identify other payers that may be primary to Medicare.

Analysis of the admission questionnaire for purposes of insuring that it matches the information billed should be undertaken during the review of billing procedures. (See §70.3.B for instructions.)

70.4 - Assessment of Hospital Review

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

The reviewer shall complete the assessment form (§70.5.1, Exhibit 1) for each hospital reviewed. The reviewer shall include selection criteria for the hospital, findings, and suggested recommendations, if appropriate. The reviewer shall include any discrepancies between the hospital's MSP policies and practices, as well as any hospital innovations that have been/are being devised to determine primary plan resources. The reviewer shall note any discrepancies between the hospital's MSP policies and those required by law. The reviewer shall complete the Survey of Bills Reviewed, provided as an attachment to the assessment form. (See §70.5, Exhibit 2.) The reviewer shall indicate whether any follow-up action is needed in the appropriate column. If no follow-up action is needed, the reviewer shall enter "none." If action is needed, the reviewer shall briefly describe action required and time frame within which follow-up will commence. It is not necessary to estimate when action will be completed. The contractor shall send a copy of the assessment form, with its attachment, to the MSP Coordinator in the RO within 30 days of the date the review is completed.

The contractor shall send the hospital a copy of the assessment form as well. It shall follow-up every 30 days until appropriate corrective action is taken. It shall report continued problems after three months to the RO MSP Coordinator. *The MAC may contact the RO MSP Coordinator within its jurisdiction after 90 days if the hospital has not implemented any of its action plans. The RO shall follow-up with the provider as necessary to discuss when the action plans will be implemented.*

70.5.4 - Exhibit 4: Entrance Interview Checklist: Billing Procedures

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

1 Does the hospital bill for all bill types?

2 Are all claims electronically billed?

3 Is the information pertaining to a payer primary to Medicare contained on the admission questionnaire, or in an online database, available in its entirety to the billing department? (The billing department must be made aware of a payer primary to Medicare, e.g., working aged, ESRD, liability insurance.)

4 Do circumstances arise where the billing department obtains information directly from the patient? How is it obtained? Is the regular admissions form used to obtain the information in these situations?

5 Where there is the possibility of payment by a Federal government grant program, how does the hospital bill Medicare? (Determine whether the hospital bills both the

grant program and Medicare, or only Medicare.)

6 How does the hospital bill the Department of Labor where the services are covered by the Federal Black Lung (BL) program? (The hospital should bill the black lung program first.)

7 Does the hospital have the ability to track workers' compensation (WC) cases on succeeding visits to the hospital or the outpatient department? Describe the tracking mechanism. How does the hospital bill for the succeeding visits? (Many times individuals may have to return to the hospital for additional medical services as a result of a WC occurrence.)

8 Does the hospital bill more than one primary insurer simultaneously? (Providers are prohibited from billing more than one insurer for primary payment. *The reviewer shall* request a credit balance report for this aspect of the review.)

9 Where the patient is in the ESRD coordination period and an employer has paid in part, or should pay for the services, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

10 What is the hospital's policy on submission of no-pay bills?

11 Where a GHP or LGHP is the primary payer because the beneficiary is either working aged or disabled, or is involved in a no-fault or liability case, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP) CWF Process
(Rev. 124, Issued: 08-31-18)

10.1 - Overview of CWF MSP Processing
(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

The CWF, MSP auxiliary file is updated with maintenance transactions from the *BCRC*, except for the following situations:

1. If the contractor receives a phone call or correspondence from an attorney/other beneficiary representative, beneficiary, third party payer, provider, another insurer's Explanation of Benefits (EOB) or other source that establishes, exclusive of any further required development or investigation, that MSP no longer applies, it must add termination dates to MSP auxiliary records already established by the *BCRC* on CWF with a "Y" validity indicator where there is no discrepancy in the validity of the information contained on CWF. (See §20.1.4)

2. If the *contractor* receives a claim for secondary benefits and could, without further development (for example, the EOB from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim, it submits a validity indicator of "I" to add any new MSP occurrences (only if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record). *An "I" record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF*. It cannot submit a new record with a "Y" or any record with an "N" validity indicator.

3. If the *contractor* receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development, it must add the MSP occurrence using an "I" validity indicator (only if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record). *An "I" record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF.*

It shall transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. "I" records should only be submitted to CWF if no MSP record with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria will be rejected with an SP 20 error code. Receipt of an "I" validity indicator will result in a CWF trigger to the *BCRC*. The *BCRC* will develop and confirm all "I" maintenance transactions established by the *contractor*. If the *BCRC* has not received information to the contrary within 100 calendar days, the *BCRC* will automatically convert the "I" validity indicator to a "Y". If the *BCRC* develops and determines there is no MSP, the *BCRC* will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to the *contractor* on its claim attachment or unsolicited refund documentation. If the *contractor* has the actual date that Medicare became secondary payer, it shall use that as the MSP effective date. If that information is not available, it shall use the Part A entitlement date as the MSP effective date. It may include a termination date when it initially establishes an "I" record. It may not add a termination date to an already established "I" record.

Prior to April 1, 2002, *the contractors* post MSP records to CWF where beneficiaries were entitled to Part B benefits, but not entitled to Part A benefits. An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF edits to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. If a contractor submits an Electronic Correspondence Referral System (ECRS) transaction to the *BCRC* to add a GHP MSP record

where there is no Part A entitlement, reason code of 61 will be returned. *Contractors* should not submit an ECRS request to *BCRC* to establish a GHP MSP record when there is no Part A entitlement. Contractors that attempt to establish an "I" record will receive a CWF error.

The CWF will continue to allow the posting of MSP records where there is no Part A entitlement when non-employer GHP situations exists, such as automobile, liability, and workers' compensation. Where a non-employer GHP situation exists, *contractors* should continue to submit ECRS transactions and establish "I" records, as necessary. *Note, in the past MACs have sent ECRS requests to the BCRC requesting that section 111 records be updated. The BCRC has rejected most of these requests based on CMS hierarchy of Section 111 entities taking precedence on updating contractor number 11121 and 11122 MSP records. However, CMS has clarified that the BCRC shall accept MACs ECRS requests to update contractor number 11121 and 11122 MSP records based on conditions below. MACs shall continue to submit ECRS requests to the BCRC for COB contractor numbers 11121 and 11122 for the following circumstances:*

- *When the MAC receives information indicating the Group number or policy number of the primary payer has changed,*
- *When the MAC learns of a retirement date for the beneficiary and a termination date must be added to the MSP record,*
- *When the MAC receives information indicating the Insurance Type A, J or K has changed or conflicts with what is on the CWF MSP Auxiliary file, or*
- *When a MAC receives a primary payer EOB or remittance advice showing payment for a deleted or closed Section 111 GHP MSP record that should remain open. Note, the BCRC will not accept an NGHP record update request for this type of MSP claim situation.*

Please note it is to the discretion of the BCRC to approve these Section 111 ECRS requests upon review. Approval or denial of such ECRS requests shall be sent to the MACs by the BCRC.

MSP Auxiliary maintenance transactions, for the four situations listed above, and claims for payment approval may be submitted to CWF in the same file. The CWF processes the MSP maintenance transactions before processing claims. This procedural flow is to assure processing for claim validation against the most current MSP data. If the MSP claim is accepted, the CWF host will return all MSP data on a beneficiary's auxiliary file to the submitting contractor via an "03" trailer. If the claim is rejected, the host will return only those MSP records that fall within the dates of service on the claim. A maximum of 17 MSP auxiliary records may be stored in CWF for each beneficiary. The validity indicator field of each CWF, MSP auxiliary record indicates confirmation that:

- Another insurer is responsible for payment ("Y" in the field); or
- Medicare is the primary payer ("N" in the field, IEQ record).

Medicare contractors may access the MSP auxiliary file through the online CWF file display utility Health Insurance Master Record (HIMR).

Medicare contractors cannot delete MSP auxiliary records. They send such requests to the *BCRC* via the Electronic Correspondence Referral System (ECRS). (See Chapter 5, §§10.)

20.1.1 - MSP Add Transaction

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

The two situations in which the "add" maintenance transaction is used are:

- There is no MSP auxiliary file record for a beneficiary. In this case, the "add" transaction creates an MSP auxiliary record containing the new MSP transaction and sets the MSP indicator on the beneficiary's master record; or

- There is an MSP auxiliary file record but no matching occurrence for the beneficiary. In this case, the "add" transaction adds the maintenance transaction as a new occurrence.

The following fields are mandatory for a validity indicator of "Y" or "I" (Another insurer is responsible for payment):

- *Medicare beneficiary identifier*;
- MSP type (MSP code);
- Validity indicator;
- MSP effective date;
- Contractor identification number;
- Insurer name (CWF will allow a space in the second position provided the third position contains a valid character other than a space.);
- Patient relationship; and
- Insurance type.

A "Y" or "I" record CANNOT be established without the insurer name. *Note, if the Insurance Company Name is blank, or contains one of the abbreviated values that should not be used as found in the ECRS manual, then it is considered an error.*

NOTE: Although the insurer address cannot be MANDATORY, it should be provided whenever possible.

The following are to be used as default values when creating an "I" record:

(1) MSP Effective Date: Use the Part A entitlement date.

(2) Patient Relationship: Use "01" if no indication of other insured member, and use "02" if another member is shown but uncertain of relationship.

(3) MSP Type: For GHP, use the current reason for entitlement: working aged (12), disability (43), or ESRD (13). For NGHP, if not identified, the default to be used is No-Fault (14).

20.2 - Medicare Secondary Payer (MSP) Maintenance Transaction Record/Medicare Contractor MSP Auxiliary File Update Responsibility

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

Effective January 1, 2001, the capability to update the CWF Medicare Secondary Payer (MSP) auxiliary file is essentially a function of only the *BCRC*. Medicare Contractors will not have the capability to delete any MSP auxiliary file records, including those that a specific Medicare Contractor has established. If it is believed that a record should be changed or deleted, Medicare Contractors use the COB Contractor Electronic Correspondence Referral System (discussed in the Medicare Secondary Payer (MSP) Manual, Chapters 4 and 5, CWF Assistance Request option, to notify the COB Contractor. Medicare Contractors process claims in accordance with existing claims processing guidelines.

There are only two instances in which Medicare Contractors will retain the capability to update CWF. They are:

A. A claim is received for secondary benefits and the contractor could, without further development (for example, the EOB from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim. Medicare Contractors must use a validity indicator of "I" to add new MSP occurrences and update CWF. *An "I" record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF.* Medicare Contractors cannot submit a new record with a "Y" or any record with an "N" validity indicator.

B. A claim is received for conditional payment, and the claim contains sufficient information to create an "I" record without further development. Medicare Contractors add the MSP occurrence using an "I" validity indicator. *An "I" record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF.*

Medicare Contractors will transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. Receipt of an "I" validity indicator will result in a CWF trigger to the COB Contractor. The COB Contractor will develop and confirm all "I" maintenance transactions established by Medicare Contractors. If the COB Contractor has not received information to the contrary within 100 calendar days, the COB Contractor will automatically convert the "I" validity indicator to a "Y." If the COB Contractor develops and determines there is no MSP, the COB Contractor will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to a Medicare Contractors on a claim attachment. If they have the actual date that Medicare became secondary payer, they use that as the MSP effective date. If that information is not available, they use the Part A entitlement date as the MSP effective date. Medicare Contractors may include a termination date when they initially establish an "I" record. They may not add a termination date to an already established "I" record.

Effective January 1, 2003, CWF accepts an "I" record only if no MSP record (validity indicator of either "I" or "Y;" open, closed or deleted status) with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria will reject with an SP 20 error code. The resolution for these cases is to transfer **all** available information to the *BCRC* via the Electronic Correspondence Referral System (ECRS) CWF assistance request screen. It will be the responsibility of the *BCRC* to reconcile the discrepancy and make any necessary modifications to the CWF auxiliary file record.

In addition, effective January 1, 2003, a refund or returned check is no longer a justification for submission of an "I" record. Since an "I" record does not contain the source (name and address) of the entity that returned the funds, *BCRC* lacks the information necessary to develop to that source. Follow the examples below to determine which ECRS transaction to submit:

1. An MSP inquiry should be submitted when there is no existing or related MSP record on the CWF. *A "related" record means if an MSP record on CWF has the same relationship code, is for the same insurer, and has part or all of the MSP time span reflected on the claim.*

2. The CWF assistance request should be submitted when the information on the CWF is incorrect or the MSP record has been deleted.

3. If the check or voluntary refund will open and close the case/MSP issue, the Medicare Contractors should submit an MSP inquiry. They should refer to the ECRS manual for more information regarding closed cases.

The check should be deposited to unapplied cash until *BCRC* makes an MSP determination.