CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12114	**Date: June 29, 2023**
	Change Request 13230

SUBJECT: Modifications to the Automated Duplicate Primary Payment (DPP) Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modify the Multi-Carrier System (MCS) to accommodate DPP claim records where the primary payer's Total Charges and Paid Amount are identical and there is no associated Claim Adjustment Reason Code. This may happen for DPP records where the Claims Processing Indicator value is "S." Additionally, CMS is taking action to remove older MCS code tied to receipt of Medicare Secondary Payer (MSP) information in the Healthcare Utilization Duplicate Payment (HUDP) at the header level in association with Part B Medicare claims.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 12114	Date: June 29, 2023	Change Request: 13230

SUBJECT: Modifications to the Automated Duplicate Primary Payment (DPP) Process

EFFECTIVE DATE: January 1, 2024
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IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to modify the Multi-Carrier System (MCS) to accommodate DPP claim records where the primary payer's Total Charges and Paid Amount are identical and there is no associated Claim Adjustment Reason Code (CARC). This may happen for DPP records where the Claims Processing Indicator value is "S" (secondary payment). Additionally, CMS is requiring MCS to remove older MCS code tied to receipt of Medicare Secondary Payer (MSP) information in the Healthcare Utilization Duplicate Payment (HUDP) at the header level in association with Part B Medicare claims. This change is needed because the Medicare Secondary Payer Systems Contractor (MSPSC) will always generate Part B DPP claims information at the detail line level.

Through CR 12687, the Centers for Medicare & Medicaid Services (CMS) implemented the automated DPP process on March 13, 2023. The process ensures that, with very limited exceptions, the Benefits Coordination & Recovery Center (BCRC) and Commercial Repayment Center (CRC) will no longer need to mail DPP documentation to individual A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) to initiate adjustments to recover Medicare's mistaken primary payment.

B. Policy: No changes to the DPP operational policy as already implemented.

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	
13230.1	MCS shall accommodate DPP claim records where the primary payer's Total Charges and Paid Amount are identical and there is no associated CARC reported.						X			
13230.1.1	MCS shall set an error if a DPP record is received with an "S" in the Claims Processing Indicator field when:						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The primary insurer's Paid Amount is equal to the Total Charges (Total Billed Amount); and • A CARC <u>and</u> associated Claim Adjustment Segment (CAS) Group Code are received.									
13230.1.2	MCS shall set an error if a DPP record is received with an 'S' in the Claim Processing Indicator field when**:** • The primary insurer paid less than the Total Charges (or Total Billed Amount); and • A CARC is not received on the DPP record **or** the monetary amount for the CARC included is less than **.01** (1 cent)**.**						X			
13230.2	MCS shall remove the code that maps the header MSP information from the HUDP CWF file if there is not any detail information.						X			
13230.2.1	MCS shall reject the claim if there is not any DPP claim detail information received in the HUPD file. (**Note**: This scenario applies when the Claims Processing Indicator equals "S.")						X			
13230.3	MCS shall remove hard-coded header edit (327M) that fails when the primary payer's Allowed and/or Paid Amount is greater than the claim Total Billed Amount. (**Note:** This edit is <u>not</u> needed because the DPP information is received at the detail level (hard-coded edit (327L)) and will fail if the claim detail primary payer Allowed and/or Paid amount is greater than the claim detail Billed Amount.)						X			
13230.4	MCS shall remove the DPP-related logic that calculates the detail Primary Payer Allowed Amount. (**Note:** This logic is <u>not</u> needed because there is an edit on the HUDP file that will <u>not</u> allow the record to be brought into MCS without the Primary Payer Allowed Amount when the Claims Processing						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Indicator equals "S.")									
13230.5	Part B Medicare Administrative Contractors shall use the MCS-created DPP response generator to create claims needed to test the requirements in this instruction.		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

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