CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12894	**Date: October 17, 2024**
	Change Request 12743

SUBJECT: Migration of the Contractor Reporting of Operational and Workload Data (CROWD) to the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal – Internet-Only Manual (IOM) Updates

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the IOMs to reflect the changes being implemented via the One-Time Notification (OTN) CMS CR 12742 that requires the contractors to utilize the CMS Enterprise Portal for CROWD and discontinue use of the legacy system.

Chapters 5 and 6 of the IOM Publication (Pub.) 100-05 and Chapter 6 of the IOM Pub. 100-06 have been updated to reflect this change.

EFFECTIVE DATE: November 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 1, 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
R	5/Table of Contents
R	5/10/10.8/MSP Contractor Numbers
R	5/60/60.1/Monthly Part A Report (Form CMS-1563) and Monthly Part B Report (Form CMS-1564) on Medicare Secondary Payer Savings
R	5/60/60.1.1/Overview of Report
R	5/60/60.1.2/Savings Calculations
R	5/60/60.1.3/Recording Savings
R	5/60/60.1.3.3/Electronic Submission
R	5/60/60.1.3.3.1/Submission of the Forms CMS-1563 and CMS-1564
R	5/60/60.1.3.3.2/System Calculations for Forms CMS-1563 and CMS-1564
R	5/60/60.1.3.4/Exhibit 1: Medicare Secondary Payer (MSP) Savings Report
R	5/60/60.1.3.5/Exhibit 2: CWF Source Codes and Corresponding CROWD Special Project Numbers
R	6/10/10.2/Definition of MSP/CWF Terms
R	6/50/50.2/MSP “W” Records and Accompanying Processes

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: 12894**	**Date: October 17, 2024**	**Change Request: 12743**

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the IOMs to reflect the changes being implemented via the One-Time Notification (OTN) CMS CR 12742 that requires the contractors to utilize the CMS Enterprise Portal for CROWD and discontinue use of the legacy system.

Chapters 5 and 6 of the IOM Publication (Pub.) 100-05 and Chapter 6 of the IOM Pub. 100-06 have been updated to reflect this change.

II. GENERAL INFORMATION

A. Background: CMS is migrating CROWD to the CMS Enterprise Portal and decommissioning the legacy system.

B. Policy: Contractors shall utilize the CMS Enterprise Portal for CROWD, effective November 1, 2024, and discontinue use of the legacy system, effective October 16, 2024, in accordance with the OTN CMS CR 12742.

Chapters 5 and 6 of the IOM Pub. 100-05 has been updated accordingly to reflect this change.

III. 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	
12743 - 05.1	Contractors shall be aware of the updates	X	X	X	X					BCRC, CRC, CROWD,

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	to Pub. 100-05, Chapters 5 and 6.									RRB-SMAC

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
12743 - 05.1	Refer to the OTN CMS CR 12742 for more information regarding the migration of CROWD to the CMS Enterprise Portal.

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

VI. CONTACTS

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

VII. 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 MSP Claims Prepayment Processing Requirements

Table of Contents

(Rev.12894; Isssued:10-17-24)

60.1.3.3.1 - *Submission* of the Forms CMS-1563 and CMS-1564

60.1.3.4 – Exhibit 1*:* Medicare Secondary Payer (MSP) Savings Report

60.1.3.5 – Exhibit 2*:* CWF Source Codes and Corresponding CROWD Special Project Numbers

10.8 - MSP Contractor Numbers

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

The MSP Contractor accretes MSP records using designated COB contractor numbers. Different numbers have been assigned for each MSP Contractor activity for purposes of separately capturing savings attributable to each activity. See Chapter 6, §10.2, for a complete list of MSP Contractor COB *N*umbers and corresponding Non-payment/Payment Denial *C*odes*,* and *Contractor Reporting of Operational and Workload Data (*CROWD*)* Special Project *N*umbers.

When the A/B MACs submit an "I" record to CWF, *its* A/B MAC contractor number is shown as the originating A/B MAC contractor. If the MSP Contractor converts the record to a "Y" with no change to the information, the originating A/B MAC contractor number remains on the record. If the record is changed to a "Y" and any of the data elements change, one of the MSP Contractor COB numbers shows as the originating contractor.

60.1 - Monthly Part A Report (Form CMS-1563) and Monthly Part B Report (Form CMS-1564) on Medicare Secondary Payer Savings

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

Each month the MSP Contractor, A/B MACs (Part A), A/B MACs (Part B), and A/B MACs (Part HHH) (collectively referred to as A/B MACs) and DME MACs must electronically transmit to CMS central office a *M*onthly Part A *R*eport (Form CMS-1563) and a *M*onthly Part B *R*eport (Form CMS-1564) on Medicare Secondary Payer *(MSP)* Savings *via CROWD*. (See §60.1.3.3.) Hard-copy reports are not required. *The MSP Contractor,* A/B MACs*,* and DME MACs transmit a separate report for each office assigned a separate contractor number *and Business Segment Identifier (BSI)*.

60.1.1 - Overview of Report

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

A. Purpose and Scope

The Monthly Part A Report and Monthly Part B Report on Medicare Secondary Payer *(MSP)* Savings supplies CMS with current data on MSP savings and MSP pending workloads.

B. Due Date

Form CMS-1563 or Form CMS-1564 is due in CO as soon as possible after the end of the month being reported, but not later than the15th of the following month. Non-receipt of the report by the 15th will result in a telephone contact to the respective A/B MAC*,* DME MAC*, and MSP Contractor* to obtain required information.

C. Form Heading

Each A/B MAC, DME MAC, and MSP Contractor *submits the appropriate information for the reporting period and CROWD Special Project for each office assigned a separate contractor number and BSI*.

60.1.2 - Savings Calculations

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

A/B MACs, DME MACs, and the MSP Contractor, shall report savings on the Forms CMS-1563 and CMS-1564 only for the actual amount (principal dollars only) of savings realized, plus Medicare's share of the procurement costs. Under no circumstances shall the MSP Contractor, A/B MACs and DME MACs claim more savings than Medicare actually paid in benefits. The MSP Contractor, A/B MACs and DME MACs shall not claim interest dollars recovered as savings. Interest collected goes to the General Revenue Fund and is not returned to the Medicare Trust Funds.

A/B MACs and DME MACs shall report cost-avoided savings through their shared systems. However, A/B MACs and DME MACs shall not update the claims history in connection with post pay recoveries received except when the re-establishment of exhaustible benefits is required. This rule applies to GHPs as well as non-GHPs

The MSP *C*ontractor and A/B MACs and DME MACs for non-GHP cases shall report savings attributable to the recoveries (regardless of who the processing contractor is) associated with a liability, no fault or workers compensation case recovery. A/B MACs and DME MACs shall not update the shared systems paid claims history (via claims adjustments) with the recovery amounts, unless there is a need to re-establish exhaustible benefits. The MSP *C*ontractor, A/B MACs and DME MACs pursuing recovery of GHP debts or DPPs, shall, upon case closure, report savings associated with the GHP recoveries in the appropriate categories.

A/B MACs and DME MACs shall re-establish exhaustible benefits for post pay recoveries associated with GHP **and** non-GHP cases if the restoration of benefits will be beneficial to the beneficiary. The A/B MACs and DME MACs shall take the necessary actions to restore exhaustible benefits and claim the savings with respect to the claims associated with the exhaustible benefits. If the A/B MACs and DME MACs determines that restoration of benefits is not beneficial, the A/B MACs and DME MACs shall still report savings on the claims referred to them. The recovery MSP *C*ontractor, or A/B MAC and DME MAC, shall not report the savings associated with the claims referred for possible restoration of benefits.

Exception to reporting manual savings: A/B MACs and DME MACs having responsibility for a provider, physician, or other supplier DPP recovery shall recover and update their paid claims history files (via a claims adjustment) with information regarding the collection and subsequent MSP savings.

When notified by CMS, the MSP *C*ontractor, A/B MACs and DME MACs shall report additional savings manually, as requested by CMS.

A/B MACs, DME MACs and the MSP Contractor utilize the HIGLAS system to determine MSP Savings. These reports detail all debts that have been closed and collected on for MSP Contractor, A/B MAC and DME MAC. These reports will be inclusive of the original demand amount, Medicare's procurement costs where applicable (that is, the pro rata share of the procurement costs associated with the actual amount recovered), collected amounts (principal and interest), etc. The MSP Contractors, A/B MACs, and DME MACs must use these reports to *identify* the savings figures recovered via HIGLAS, as applicable, *for* CROWD.

A. Savings Priority

A/B MACs and DME MACs shall report MSP savings in the following order: (1) exhaustible Part A benefits, (2) exhaustible Part B benefits, (3) the remaining (non-exhaustible) Part A benefits, and (4) the remaining (non-exhaustible) Part B benefits. In each separate type of benefit listed above, savings are applied to the highest dollar claim first.

Exhaustible Benefits are benefits where their restoration would affect payment for a subsequent claim of the same type. Some examples of exhaustible benefits include: hospital inpatient lifetime reserve days (60 days), inpatient skilled nursing facility care, and inpatient lifetime reserve psychiatric days (190 days).

Additionally, claims adjustments for exhaustible benefits are not necessary if it is clear that their restoration could have no beneficial effect for the beneficiary; for example, if the issue is lifetime reserve days where the beneficiary is deceased and did not exhaust his lifetime reserve days without taking into account such restoration.

B. Reporting Dollar Values

The MSP Contractor, A/B MACs, and DME MACs shall round **all** dollar values to the nearest whole dollar.

C. Checking Reports/Report Equations

- Line 7 must equal the sum of lines 1 + 3 + 5 for all columns;
- Line 8 must equal the sum of lines 2 + 4 + 6 for all columns;
- Line 13 must equal the sum of lines 9 + 11 for all columns;
- Line 14 must equal the sum of lines 10 + 12 for all columns;
- Line 15 equals line 1 for all columns;
- Line 16 equals line 2 for all columns;
- Line 17 equals the sum of lines 3 + 9 for all columns;
- Line 18 equals the sum of lines 4 + 10 for all columns;

- Line 19 equals the sum of lines 5 + 11 for all columns;
- Line 20 equals the sum of lines 6 + 12 for all columns;
- Line 21 equals the sum of lines 15 + 17 + 19 for all columns;
- Line 22 equals the sum of lines 16 + 18 + 20 for all columns.

60.1.3 - Recording Savings

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The A/B MACs and DME MACs control all claims from which MSP savings are extracted and verifies all amounts recorded on the Forms CMS-1563 or CMS-1564 when requested. All prepay and post pay MSP Savings must be uploaded *to* CROWD.

A. MSP Savings File

The A/B MACs and DME MACs retain specific key identifying information on each claim counted as savings on the Forms CMS-1563 or CMS-1564. At a minimum, it records the beneficiary's name, Medicare beneficiary identifier, type and dates of service, claim control number, billed charges and savings amounts reported.

B. Savings Data from Non-Medicare Sources

If savings are recorded from data obtained from the A/B MACs and DME MACs "corporate side" records or any other "outside" source, the A/B MACs and DME MACs extract the same claims specific information noted above, i.e., verifies that Medicare covered services are involved and that it is able to calculate "what Medicare would have paid." In addition, A/B MACs and DME MACs must compare this data with the data contained in the MSP savings file to ensure that savings have not previously been recorded for the same claims. If savings have not previously been taken for the claim, the A/B MACs and DME MACs count them as savings on the Forms CMS-1563 or CMS-1564 and *reports* them in the A/B MACs and DME MACs MSP savings file *for CROWD as Contractor Savings via Special Project SAVE*.

C. Total Savings for Special Projects

The MSP Contractor, A/B MACs, and DME MACs shall total each respective Special Project Savings and *report* these totals under their respective special project columns in the Special Project Savings Total in the CROWD Savings Report. A/B MACs and DME MACs and the

designated shared system shall apply the correct MSP cost avoided indicator that pertains to the incoming claim, including subsequent adjustments, and apply the savings to the originating contractor under the appropriate special project and MSP type in CROWD. Note, for savings reporting purposes the term contractor is identified to mean the MSP Contractor or A/B MAC and DME MAC number unless specified. The A/B MACs and DME MACs and designated shared systems shall apply the appropriate MSP indicator that pertains to each service line on the incoming claim. This includes applying the MSP savings to the originating contractor of the MSP record under the appropriate special project and MSP type in CROWD at the line level for cost avoided claims, full and partial recoveries, and total savings for prepay and post pay MSP. If there are different MSP lines on the same claim, the service lines shall be counted under each MSP type, by the originating contractor, for each service line in CROWD. For example, there are three MSP occurrences on CWF. Occurrence 1 is an open working aged record created by contractor 11101. Occurrence 2 is an open Workers' Compensation Set Aside (WCMSA) record created by contractor 11119. Occurrence 3 is a closed workers' compensation record. A claim is received for two services: one service is for a routine checkup and the second service is for the workers' compensation injury for which the beneficiary has a WCMSA. MSP savings related to the routine physical would be applied to originating contractor 11101, special project 6010, under the working aged column in the savings report. Savings related to the WCMSA would be applied to originating contractor 11119, special project 7019, under the workers' compensation column in the savings report.

60.1.3.3 - Electronic Submission

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

The Monthly Part A Report (Form CMS-1563) and Monthly Part B Report (Form CMS-1564) on Medicare Secondary Payer (MSP) Savings are referenced as Forms L and K, respectively, for CROWD. To submit *F*orms *L* and *K*, the MSP Contractor, A/B MAC*,* and DME MAC must *access CROWD via* the CMS *Enterprise Portal*.

60.1.3.3.1 - *Submission* of the Forms CMS-1563 and CMS-1564

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

For MSP savings *submission and upload* instructions, please reference the "CROWD User Guide" *available via the CMS Enterprise Portal and note that:*

- *A valid 5-digit MSP Contractor or A/B MACs (Part A) number is required on the Form CMS-1563 or;*
- *A valid 5-digit MSP Contractor or A/B MACs (Part B) number is required on the Form CMS-1564; and;*
- *An appropriate reporting period is required;*
- *A valid 3-position alpha BSI is required.*

60.1.3.3.2 – System Calculations for Forms CMS-1563 and CMS-1564

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

The following system calculations are performed on the Forms CMS-1563 and CMS-1564;

- Line 7 must equal the sum of lines 1 + 3 + 5 for all columns;
- Line 8 must equal the sum of lines 2 + 4 + 6 for all columns;
- Line 13 must equal the sum of lines 9 + 11 for all columns;
- Line 14 must equal the sum of lines 10 + 12 for all columns;
- Line 15 equals line 1 for all columns;
- Line 16 equals line 2 for all columns;
- Line 17 equals the sum of lines 3 + 9 for all columns;
- Line 18 equals the sum of lines 4 + 10 for all columns;
- Line 19 equals the sum of lines 5 + 11 for all columns;
- Line 20 equals the sum of lines 6 + 12 for all claims;
- Line 21 equals the sum of lines 15 + 17 + 19 for all columns;
- Line 22 equals the sum of lines 16 + 18 + 20 for all columns.

60.1.3.4 - Exhibit 1: Medicare Secondary Payer (MSP) Savings Report

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

NATIONAL TOTAL SPEC PROJ: GROUP HEALTH PLAN RECOVERY (7039)

DESCRIPTION	LINE NUMBER	TOTAL	WORKERS' COMP (including BL) (codes 15 & 41)	WORKING AGED (code 12)	ESRD (code 13)	AUTO MEDICAL / NO FAULT (code 14)	DISABLED (code 43)	Liability (including FTCA) (code 47)	VA/OTHER FEDERAL (codes 42 & 16)
Prepay Savings:									
Cost Avoid (# of claims)	1	0	0	0	0	0	0	0	0
Cost Avoid ($)	2	0	0	0	0	0	0	0	0
Full Recovery (# of claims)	3	0	0	0	0	0	0	0	0
Full Recovery ($)	4	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	5	0	0	0	0	0	0	0	0
Partial Recovery ($)	6	0	0	0	0	0	0	0	0
Total Prepay Savings (# of claims)	7	0	0	0	0	0	0	0	0
Total Prepay Savings ($)	8	0	0	0	0	0	0	0	0
Postpay Savings:									

Full Recovery (# of claims)	9	0	0	0	0	0	0	0	0
Full Recovery ($)	10	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	11	0	0	0	0	0	0	0	0
Partial Recovery ($)	12	0	0	0	0	0	0	0	0
Total Postpay Savings (# of claims)	13	0	0	0	0	0	0	0	0
Total Postpay Savings ($)	14	0	0	0	0	0	0	0	0

Total Savings:

Total Cost Avoid Savings (# of claims)	15	0	0	0	0	0	0	0	0
Total Cost Avoid Savings ($)	16	0	0	0	0	0	0	0	0
Total Full Recovery Savings (# of claims)	17	0	0	0	0	0	0	0	0
Total Full Recovery Savings ($)	18	0	0	0	0	0	0	0	0
Total Partial Recovery Savings (# of claims)	19	0	0	0	0	0	0	0	0
Total Partial Recovery Savings ($)	20	0	0	0	0	0	0	0	0

Total Savings (# of claims)	21	0	0	0	0	0	0	0	0
Total Savings ($)	22	0	0	0	0	0	0	0	0

NATIONAL TOTAL SPECIAL PROJ: NON-GROUP HEALTH PLAN NON-ORM (7041)

DESCRIPTION	**LINE NUMBER**	**TOTAL**	**WORKERS' COMP (including BL) (codes 15 & 41)**	**WORKING AGED (code 12)**	**ESRD (code 13)**	**AUTO MEDICAL / NO FAULT (code 14)**	**DISABLED (code 43)**	**Liability (including FTCA) (code 47)**	**VA/OTHER FEDERAL (codes 42 & 16)**
Prepay Savings:									
Cost Avoid (# of claims)	1	0	0	0	0	0	0	0	0
Cost Avoid ($)	2	0	0	0	0	0	0	0	0
Full Recovery (# of claims)	3	0	0	0	0	0	0	0	0
Full Recovery ($)	4	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	5	0	0	0	0	0	0	0	0
Partial Recovery ($)	6	0	0	0	0	0	0	0	0

Total Prepay Savings (# of claims)	7	0	0	0	0	0	0	0	0
Total Prepay Savings ($)	8	0	0	0	0	0	0	0	0
Postpay Savings:									
Full Recovery (# of claims)	9	0	0	0	0	0	0	0	0
Full Recovery ($)	10	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	11	0	0	0	0	0	0	0	0
Partial Recovery ($)	12	0	0	0	0	0	0	0	0
Total Postpay Savings (# of claims)	13	0	0	0	0	0	0	0	0
Total Postpay Savings ($)	14	0	0	0	0	0	0	0	0
Total Savings:									
Total Cost Avoid Savings (# of claims)	15	0	0	0	0	0	0	0	0
Total Cost Avoid Savings ($)	16	0	0	0	0	0	0	0	0
Total Full Recovery Savings (# of claims)	17	0	0	0	0	0	0	0	0
Total Full Recovery Savings ($)	18	0	0	0	0	0	0	0	0
Total Partial Recovery Savings (# of claims)	19	0	0	0	0	0	0	0	0

Total Partial Recovery Savings ($)	20	0	0	0	0	0	0	0	0
Total Savings (# of claims)	21	0	0	0	0	0	0	0	0
Total Savings ($)	22	0	0	0	0	0	0	0	0

NATIONAL TOTAL SPECIAL PROJ: NON-GROUP HEALTH PLAN ORM RECOVERY (7042)

DESCRIPTION	**LINE NUMBER**	**TOTAL**	**WORKERS' COMP (including BL) (codes 15 & 41)**	**WORKING AGED (code 12)**	**ESRD (code 13)**	**AUTO MEDICAL / NO FAULT (code 14)**	**DISABLED (code 43)**	**Liability (including FTCA) (code 47)**	**VA/OTHER FEDERAL (codes 42 & 16)**
Prepay Savings:									
Cost Avoid (# of claims)	1	0	0	0	0	0	0	0	0
Cost Avoid ($)	2	0	0	0	0	0	0	0	0
Full Recovery (# of claims)	3	0	0	0	0	0	0	0	0
Full Recovery ($)	4	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	5	0	0	0	0	0	0	0	0
Partial Recovery ($)	6	0	0	0	0	0	0	0	0

Total Prepay Savings (# of claims)	7	0	0	0	0	0	0	0	0
Total Prepay Savings ($)	8	0	0	0	0	0	0	0	0
Postpay Savings:									
Full Recovery (# of claims)	9	0	0	0	0	0	0	0	0
Full Recovery ($)	10	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	11	0	0	0	0	0	0	0	0
Partial Recovery ($)	12	0	0	0	0	0	0	0	0
Total Postpay Savings (# of claims)	13	0	0	0	0	0	0	0	0
Total Postpay Savings ($)	14	0	0	0	0	0	0	0	0
Total Savings:									
Total Cost Avoid Savings (# of claims)	15	0	0	0	0	0	0	0	0
Total Cost Avoid Savings ($)	16	0	0	0	0	0	0	0	0
Total Full Recovery Savings (# of claims)	17	0	0	0	0	0	0	0	0
Total Full Recovery Savings ($)	18	0	0	0	0	0	0	0	0
Total Partial Recovery Savings (# of claims)	19	0	0	0	0	0	0	0	0

Total Partial Recovery Savings ($)	20	0	0	0	0	0	0	0	0
Total Savings (# of claims)	21	0	0	0	0	0	0	0	0
Total Savings ($)	22	0	0	0	0	0	0	0	0

60.1.3.5 - Exhibit 2: CWF Source Codes and Corresponding CROWD Special Project Numbers

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

CWF Source Codes	MSP Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
B, D, T, U, V, or W	77777 = IRS/SSA/HCFA Data Match (I, II, III, IV, V, or VI)	Y	1000 *(Inactive)*
O	99999 = Initial Enrollment Questionnaire (IEQ)	T	2000 *(Inactive)*
P	55555 = HMO Rate Cell Adjustment	U	3000 *(Inactive)*
	33333 = Litigation Settlement	V	4000 *(Inactive)*
Q	88888 = Voluntary *Data Sharing* Agreements	Q	5000 *(Inactive)*
0	11100 = COB Contractor	00	6000
1	11101 = Initial Enrollment Questionnaire (IEQ)	T	6010
2	11102 = IRS/SSA/CMS Data Match	Y	6020
3	11103 = HMO Rate Cell	U	6030
4	11104 = Litigation Settlement	V	6040
5	11105 = Employer Voluntary Reporting	Q	6050
6	11106 = Insurer Voluntary Reporting	K	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080
9	11109 = Secondary Claims Investigation	G	6090

CWF Source Codes	MSP Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
10	11110 = Self Reports	H	7000
11	11111 = 411.25	J	7010
12	11112 = Blue Cross – Blue Shield Voluntary *Data Sharing* Agreements	12	7012
13	11113 = Office of Personnel Management (OPM) Data Match	13	7013
14	11114 = State Workers' Compensation (WC) Data Match	14	7014
15	11115 = WC Insurer Voluntary Data Sharing Agreements (WC VDSA)	15	7015
16	11116 = Liability Insurer Voluntary Data Sharing Agreements (LIAB VDSA)	16	7016
17	11117 = Voluntary Data Sharing Agreements (No Fault VDSA)	17	7017
18	11118 = Pharmacy Benefit Manager Data	18	7018
19	11119 = Workers' Compensation Medicare Set-Aside Arrangement	19	7019
20	11120 = To be determined	20	*N/A*
21	11121 = MIR Group Health Plan	21	7021
22	11122 = MIR *N*on-Group Health Plan	22	7022
“”	“”	“”	“”

CWF Source Codes	MSP Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
25	11125=Recovery Audit Contractor-California	25	7025
26	11126=Recovery Audit Contractor-Florida	26	7026
27	11127=To be Determined	27	7027 *(Inactive)*
39	11139 = Group Health Plan Recovery	39	7039
41	11141 = Non-Group Health Plan Non-ORM Recovery	41	7041
42	11142 = Non-Group Health Plan ORM Recovery	42	7042
43	11143 = MSP Contractor/Medicare Part C/Medicare Advantage	43	7043
44	11144 = Liability Medicare Set Aside Arrangement	44	7044
45	11145 = No-Fault Medicare Set Aside Arrangement	45	7045
99	11199 = To be determined	99	7099

Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP) *Common Working File (*CWF*)* Process

Table of Contents

(Rev.12894; 10-17-24)

10.2 - Definition of MSP/CWF Terms

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

Following is a list of terms and their definitions used in MSP/CWF processing.

MSP Auxiliary File - Up to 17 beneficiary MSP occurrences/records on the CWF database.

MSP Auxiliary Record - Record of beneficiary MSP information. One MSP record/occurrence within the beneficiary's MSP auxiliary file.

Occurrence - One MSP occurrence/record within the beneficiary's MSP auxiliary file.

MSP Effective Date - Effective date of MSP coverage.

MSP Termination Date - Termination date of MSP coverage.

Validity Indicator

- Y - Beneficiary has MSP coverage (there is a primary insurer for this period of time).
- N - No MSP coverage (the N validity indicator is no longer used, but will be seen on older MSP CWF records)
- I - See §10.1.
- D - Deleted MSP Record

MSP Types - Reason for other coverage entitlement.

- A = Working Aged
- B = End stage renal disease (ESRD)
- D = Automobile/Liability No-Fault
- E = Workers' Compensation (WC)
- F = Federal, Public Health (note: currently not used)
- G = Disabled
- H = Black Lung (BL)
- L = Liability
- W = Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)

NOTE: VA and other Federal payments are MSP exclusions rather than MSP non-payments. Where the VA authorized services, Medicare does not make payment for items or services furnished by a non-Federal provider pursuant to such an authorization. Although certain MSP billing procedures apply, VA is not an MSP provision.

Cost Avoided Claim - A claim returned without payment because CWF indicators indicate another insurer is primary to Medicare. (See Pub. 100-05, Chapter 5 for complete description.)

Transaction Type - Identifies type of maintenance record.

- 0 = Transaction type to add or change MSP data
- 1 = Transaction type to delete MSP data

Override Code - Code used to bypass CWF, MSP edit to allow primary Medicare payment. (See §40.4 for a detailed explanation.)

MSP Contractor Numbers

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
	33333 = Litigation Settlement	V	4000 *(Inactive)*
P	55555 = HMO Rate Cell Adjustment	U	3000 *(Inactive)*
B,D,T,U,V, or W	77777 = IRS/SSA/HCFA Data Match (I, II, III, IV, V, or VI)	Y	1000 *(Inactive)*
Q	88888 = Voluntary Data Sharing Agreements	Q	5000 *(Inactive)*
O	99999 = Initial Enrollment Questionnaire *(IEQ)*	T	2000 *(Inactive)*

MSP Contractor Numbers prior to January 1, 2001

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
0	11100 = *COB* Contractor		6000
1	11101 = Initial Enrollment Questionnaire *(IEQ)*	K	6010
2	11102 = IRS/SSA/CMS Data Match	E	6020
3	11103 = HMO Rate Cell	F	6030
4	11104 = Litigation Settlement	G	6040
5	11105 = Employer Voluntary Reporting	H	6050
6	11106 = Insurer Voluntary Reporting	H	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080
9	11109 = Secondary Claims Investigation	G	6090
X	11110 = Self Reports	H	7000
Y	11111 = 411.25	J	7010

NOTE: Effective January 1, 2001, the following MSP Contractor numbers and nonpayment/payment denial codes will be used.

MSP Contractor Numbers Effective January 1, 2001

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
0	11100 = *COB* Contractor	00 Effective 4/1/2020	6000
1	11101 = Initial Enrollment Questionnaire *(IEQ)*	T	6010
2	11102 = IRS/SSA/CMS Data Match	Y	6020
3	11103 = HMO Rate Cell	U	6030
4	11104 = Litigation Settlement	V	6040
5	11105 = Employer Voluntary Reporting	Q	6050
6	11106 = Insurer Voluntary Reporting	K	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080
9	11109 = Secondary Claims Investigation	G	6090
10 - Effective 4/1/2002	11110 = Self Reports	H	7000
11 - Effective 4/1/2002	11111 = 411.25	J	7010

11101, 11102, 11103, 11104, and 11105 use the same non-payment denial codes as their previous contractor numbers (i.e., 33333, 55555, 77777, 88888, 99999). Savings from the old and new numbers, if applicable will be reported together (e.g., 11101 and 99999, etc.). There must be a conversion of the MSP savings to the new non-payment/payment denial codes as of January 1, 2001.

Additional MSP Contractor Numbers Effective April 1, 2002

Effective April 1, 2002, CWF is expanding the source code field and the nonpayment/ payment denial code field from 1-position fields to 2-position fields.

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
12	11112 = Blue Cross-Blue Shield Voluntary Data Sharing Agreements	12	7012
13	11113 = Office of Personnel Management (OPM) Data Match	13	7013
14	11114 = State Workers' Compensation (WC) Data Match	14	7014
15	11115 = WC Insurer Voluntary Data Sharing Agreements (WC VDSA)	15	7015
16	11116 = Liability Insurer Voluntary Data Sharing Agreements (LIAB VDSA)	16	7016
17	11117 = Voluntary Data Sharing Agreements (No Fault VDSA)	17	7017

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
18	11118 = Pharmacy Benefit Manager Data	18	7018
19	11119 = Workers' Compensation Medicare Set-Aside Arrangement	19	7019
20	11120 = COBA	20	N/A
21	11121= MIR Group Health Plan	21	7021
22	11122= MIR Non-Group Health Plan	22	7022
23	11123 = To be determined	23	7023
24	11124 = To be determined	24	7024
25	11125 = Recovery Audit Contractor-California	25	7025
26	11126 = Recovery Audit Contractor-Florida	26	7026
27	11127 = To be determined	27	7027 *(Inactive)*
""	""	""	""
39	11139 = GHP Recovery	39	7039
41	11141 =NGHP Non-Ongoing Responsibility for Medicals (ORM)	41	7041
42	11142 = NGHP ORM Recovery	42	7042
43	11143 = MSP Contractor /Medicare Part C/Medicare Advantage	43	7043
""	""	""	""
99	11199 = To be determined	99	7099

50.2 - MSP "W" Records and Accompanying Processes

(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)

I. Common Working File Requirements (CWF)

CWF accepts an MSP code of "W" for Workers' Compensation Medicare Set-Aside Arrangements (WCMSA) for use on the HUSP records for application on the HUSP Auxiliary File. The CWF indicates the description name for an MSP code "W" record as "WC Medicare Set-Aside.

The CWF accepts a contractor number 11119 on incoming MSP "W" HUSP records for application on the MSP Auxiliary file. The CWF accepts a "19" in the source code field on both the HUSP, and HUST transactions for contractor 11119. The CWF shall accept the "Y" validity indicator for HUSP transactions created by contractor 11119. The CWF returns a "19" in the Source Code field of the '03' response trailer.

The CWF allows contractors 11100, 11101, 11102, 11103, 11104, 11105, 11106, 11107, 11108, 11109, 11110, 11111, 11112, 11113, 11114, 11115, 11116, 11117, 11118, 11119, 11122, 11125, 11126, 11139, 11140,11141, 11142, 11143, 33333, 55555, 77777, 88888, 99999, to update, delete, change records originated or updated by contractor 11119.

CWF will create and send a transaction to the contractor's shared systems that have processed claims for each beneficiary when an add or change transaction is received for contractor 11119 or from contractor 11119. The CWF uses the following address for contractor number 11119:

WCMSA Proposal/Final Settlement
P.O. Box 138899
Oklahoma City, OK 73113-8899

The CWF applies the same MSP consistency edits for Workers' Compensation (WC) code "E" to MSP code "W".

The CWF maintainer creates error code (6815). The message for this new error code (6815) reads "WC Set-Aside exists. Medicare contractor payment not allowed". CWF activates this error under the following conditions:

- A*n* MSP code "W" record is present.

- The record contains a diagnosis code related to the MSP code "W" occurrence.

The CWF ensures that error code 6815 is overridden by **MAC*s* (A/B) and MACs (DME)** with a code N or M, for claim lines or claims on which workers' compensation set-aside diagnosis do not apply. CWF accepts the new error code (6815) as returned on the 08 trailer.

The CWF creates a HUSP transaction error code, SP76, to set when an incoming HUSP transaction with MSP Code "W" is submitted and the beneficiary MSP Auxiliary file contains an open MSP occurrence with MSP code "E" with the same effective date and diagnosis code(s).

II. Shared Systems and MACs (A/B) and MAC*s* (DME)

A/B MACs and DME MACs shared systems accepts MSP Code "W" to identify a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) for use on HUSP records for application on the HUSP Auxiliary file. The Medicare shared systems utilizes the description name of 'WC Medicare Set-Aside' for MSP code "W" records.

The shared systems:

- Utilizes contractor number "11119" on incoming MSP *"*W*"* HUSP records for application on the MSP Auxiliary file.

- Accepts contractor number 11119 and MSP code "W" and source code "19" on the returned 03 CWF trailer.

- Accepts "19" in the source code field on the HUSP, and HUST transactions for contractor 11119.

- Accepts a "Y" validity indicator, as well as MSP code W for transactions created by contractor 11119.

- Accepts and processes HUST transactions when an add, change or delete transaction is received for contractor 11119 or from contractor 11119.

- Reflects *the Contractor Reporting of Operational and Workload Data (*CROWD*)* report special project number '7019' as Workers' Compensation Set-Aside Arrangements.

- Accepts "19" in the header Payment Indicator field and in the detail Payment Process Indicator field for Contractor 11119.

The MAC*s* (A/B) and MAC*s* (DME) and their systems continue to accept claims with value code 15 for Part A and Insurance Code (15) for Part B and DME MAC against an open “W” MSP Auxiliary file.

The shared systems accepts error code (6815) as returned with the 08 trailer. Following receipt of the utilization error code 6815, the A/B MACs and DME MACs systems deny all claims (including conditional payment claims) related to the diagnosis codes on the CWF MSP code “W”, when there is no termination date entered for the “W” code.

Upon denying the claim, all contractor shared systems create a “19” Payment Denial Indicator in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, HUDC claims.

Upon denying the claim the MACs (B) and MAC*s* (DME), MCS and VMS

- Populate a “W” in the MSP code field and

- Create a ‘19’ in the HUBC and HUDC claim header transaction and a ‘19’ in the claim detail process.

Upon denying the claim MACs (A) and the FISS system

- Populate a 15 in the value code field, in addition to the requirements referenced above.

For MSP verification purposes, and prior to overriding claims on which the A/B MAC or DME MAC contractor received error code 6815, it shall:

- check CWF to confirm that the date of service of the claim is after the termination date of the MSP “W” record.

- and confirm the diagnosis code on the claim is related to the diagnosis codes on the MSP W record.

MACs (B) and MACs (DME) overrides the payable lines with override code N.

The MACs (A) override the payable claims with override code N. If a claim is to be allowed, an ‘N’ is placed on the “001” Total revenue charge line of the claim.

The shared systems allows for an override of new error code 6815 with the code N.

The Comprehensive Error Rate Testing (CERT) contractor accepts the MSP code “W” in the claim resolution field.

The shared systems bypasses the MSPPAY module if there is an open MSP code “W”.

The shared systems does not make payment for those services related to diagnosis codes associated with the “W” Auxiliary record when the claims date of service is on or after the effective date and before or on the termination date of the record.

The shared systems makes payment for those services related to the diagnosis codes associated with the “W” auxiliary record when a terminate date is entered and the claims date for service is after the termination date.

The shared systems includes Reason Code 201, Group Code "PR", Remark Code N722 and "Alert" Remark Code MA01, when denying claims based on a *"*W*"* MSP auxiliary record on outbound 837 claims.

The shared systems utilize Group Code "PR"; Remark Code N722 and "Alert" Remark Code MA01, Reason Code 201, when denying claims based on a "W" MSP auxiliary record for 835 ERA and SPR messages.

The shared system will afford appeal rights for denied MSP code "W" claims.

III. The MAC*s* (A/B) and MACs (DME):

- Shall not make payment for those services related to diagnosis codes associated with an open "W" auxiliary record (not termed).

- Shall make payment for those services related to diagnosis codes associated with a termed auxiliary "W" record when the claims date of service is after the termination date.

The **MAC*s* (A/B) and MACs (DME)** will include Reason Code 201, Group Code "PR", Remark Code N722 and "Alert" Remark Code MA01, when denying claims based on a *"*W*"* MSP auxiliary record on outbound 837 claims.

The **MAC*s* (A/B) and MACs (DME)** utilize Group Code "PR"; Remark Code N722 and "Alert" Remark Code MA01, Reason Code 201, when denying claims based on a "W" MSP auxiliary record for 835 ERA and SPR messages.

The **MAC*s* (A/B) and MACs (DME)** and share systems shall afford appeal rights for denied MSP code "W" claims.

Those systems responsible for the HETS 270/271 transaction shall ensure that documentation concerning the EB value and qualifier WC is updated.

The CROWD *report* reflects special project number "7019" as Workers' Compensation Medicare Set-Aside Arrangement.

IV. Medicare Residual Payment When WCMSA benefits terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit.

There are situations where WCMSA benefits may terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit and a residual Medicare secondary payment is due. Under these circumstances Medicare may make a residual secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The A/B MACs (A/B), DME MACs and shared systems may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

The MACs (A/B), MACs (DME), and shared systems, receive, accept, and make a residual payment on MSP Type 15 (MSP Code E) WCMSA electronic claims when the CAS segment shows one of the following CARCs and primary payer benefits are terminated, exhausted or the claim contains a partial or zero payment:

27 – Expenses occurred after coverage terminated.
35 – Lifetime benefit maximum has been reached.
119 – Benefit maximum for this time period, or occurrence, has been reached.

149 – Lifetime benefit maximum has been reached for this source/benefit category.

The MACs (A/B), MACs (DME), and shared systems receive, accept, and make payment on MSP Type 15, WCMSA paper (hard copy) claims when the claim includes an attached remittance advice (RA)/Explanation of Benefits (EOB) that**:**

1) Shows the claim with a zero payment or was not paid in full by the primary payer and a residual payment is due;

2) Is a Medicare covered and reimbursable service; and

3) Contains a reason code for denial or similar verbiage if a reason code is not indicated:

- Expenses occurred after the coverage terminated;
- Lifetime benefit maximum has been reached;
- Benefit maximum for this time period, or occurrence, has been reached; or
- Lifetime benefit maximum has been reached for this source/benefit category.

NOTE: If an MSP Type 15, WCMSA electronic, or hard copy claim, is received and there is a corresponding WCMSA record on CWF and the claim contains a partial, or zero, payment from a primary insurer and the claim, or attached primary payer remittance advice/EOB, does not include a reason code for denial or similar verbiage if a reason code is not indicated, the A/B MACs, DME MACs and shared system deny the claim based on the CWF utilization 6815.

In order for the residual payment to occur, CWF performs the following functions:

CWF HUIP, HUOP, HUHH, HUHC (HBIP, HBOP, HBHH, and HBHC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level. Valid values for the field = X or space.

CWF HUBC and HUDC (HBBC and HBDC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level and at the detail level. Valid values for the field = X or space.

NOTE: The shared systems must ensure that the MACs are able to input an "X" in the header of their claims, and at the service line level, when applicable, that are sent to CWF, for situations when the claim is not paid, or not paid in in full, by the primary payer.

CWF shall override the 6815 WCMSA utilization error code when the MACs determine a residual payment should be made on the claim.

The MACs make a residual payment by placing the "X" at the header for the Part A claims, or an 'X' at either the header or detail line for Part B Professional and DME MAC claims.

The A/B MACs, DME MACs and shared systems must send the primary payer's MSP amounts, found on the incoming WCMSA claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare.

NOTE: When applicable, the A/B MACs and DME MACs send the attestation form/letter, it received from the reporting entity indicating WCMSA benefits are exhausted, to the MSP Contractor. For ORM, the Section 111 reporting entity shall report that benefits are exhausted via the normal quarterly data file process.