CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 125	**Date: March 22, 2019**
	Change Request 11193

SUBJECT: Update to Publication (Pub.) 100-05 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-05. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: April 22, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 22, 2019

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	1/100/Referral to the Regional Office
R	3/10.3/Provider, Physician, and Other Supplier Responsibility When a Request is Received From an Insurance Company or Attorney
R	3/50/Summary of MSP Data Elements for Form CMS-1450 (UB-92)
R	4/10.3/Contractors Claim Referrals to the COBC
R	5/10.2/COBC Electronic Correspondence Referral System (ECRS)
R	5/10.5/Notification to Contractor of MSP Auxiliary File Updates
R	5/20/Sources That May Identify Other Insurance Coverage
R	5/40.7/Carrier Processing Procedures for Medicare Secondary Claims
R	5/60.1.3/Recording Savings
R	5/70.3.1.1/General Review Requirements
R	5/70.5.2/Exhibit 2: Survey of Bills Reviewed
R	5/5.1- Electronic Correspondence Referral System (ECRS) Web User Guide
R	5/5.2- Electronic Correspondence Referral System (ECRS) Quick Reference Card
R	6/20.1.2/MSP Change Transaction
R	6/30.3/MSP Auxiliary File Errors
R	6/40.6/Online Inquiry to MSP Data

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: 125	Date: March 22, 2019	Change Request: 11193

SUBJECT: Update to Publication (Pub.) 100-05 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: April 22, 2019
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IMPLEMENTATION DATE: April 22, 2019

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This Change Request contains language-only changes for updating the New Medicare Card Project language related to the MBI in publication 100-05.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

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	
11193.1	MACs shall be aware of the updated language for the New Medicare Card Project in Publication 100-05.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

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): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@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 1 - Background and Overview

100 - Referral to the Regional Office
(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Since the CMS is responsible for enforcement of the age anti-discrimination provisions for coverage under group health plans, all complaints received that may reflect such discrimination by GHPs must be treated as possible violations of the Medicare law. This includes complaints that a GHP is "taking into account" that an individual is entitled to Medicare benefits and complaints that a GHP is not providing equal benefits under the same conditions for older and younger workers and spouses.

Contractors must refer any cases to the RO where a GHP or LGHP is a nonconforming plan. Cases are referred as a result of the GHP or LGHP performing the following actions:

- Offers secondary coverage for individuals for whom Medicare is secondary; or

- Refuses to reimburse Medicare for any primary benefits paid to, or on behalf of, a Medicare beneficiary.

In all potential discrimination cases, the contractor obtains documentation of the alleged discrimination, such as:

- A notice from the GHP and/or a copy of the plan policy;

- A written description of the alleged discriminatory action(s) by the GHP from the party or parties involved;

- The name and address of the individual's employer;

- The individual's name and *Medicare beneficiary identifier*;

- The name and address of the GHP or LGHP;

- The individual's group health plan identification number; and

- A full explanation of the reasons for the referral.

All available information concerning the matter must be sent to the RO, along with an analysis of the facts. If the RO believes that the GHP may have committed a discriminatory act, the case is referred to the Central Office for consideration of whether the plan is a nonconforming group health plan, i.e. a group health plan which at any time during a calendar year does not comply with the anti-discrimination provisions of the Act. The RO considers possible legal action to collect double damages from the nonconforming LGHP/GHP. The CO also refers nonconforming group health plans to the Internal Revenue Service for imposition of an excise tax penalty to assure compliance with the anti-discrimination provisions of the law.

If the GHP, LGHP, or employer has agreed to discontinue offering secondary coverage to Medicare individuals for whom it is primary payer or has agreed to reimburse Medicare the amount of incorrect Medicare primary benefits that should have been paid by the plan, the CO includes this information in its referral.

Once the CO refers a nonconforming LGHP/GHP to the IRS, it does not withdraw the referral solely because the plan has discontinued offering improper secondary coverage or has reimbursed Medicare the amount of incorrect primary benefits Medicare paid.

Medicare Secondary Payer (MSP) Manual
Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

10.3 - Provider, Physician, and Other Supplier Responsibility When a Request is Received From an Insurance Company or Attorney
(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 provider, physician, or other supplier notifies the Coordination of Benefits Contractor (COBC) promptly if a request is received from an attorney or an insurance company for a copy of a medical record or a bill concerning a Medicare patient. The COBC is given a copy of the request or, if it is unavailable, details of the request, including:

- The name and *Medicare beneficiary identifier* of the patient;
- Name and address of the insurance company and/or attorney; and,
- Date(s) of services for which Medicare has been or will be billed.

Contractors receiving MSP information from providers, physicians, and other suppliers should follow the procedures outlined in Chapter 4, "Coordination of Benefits Contractor (COBC) Requirements," §70.2.

50 - Summary of MSP Data Elements for Form CMS-1450 (UB-92)
(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 following table identifies the data elements that are submitted on bills to communicate the status of the primary payer and payment where Medicare is the secondary payer. See Medicare Claims Processing Manual, Chapter 25, "Completing and Processing UB-92 Data Set," for a crosswalk to the electronic data elements or segment names.

Data Element	Value for MSP	MSP Situation
Condition Code		
	02-Employment Related	Workers' Compensation and Black Lung
	05-Lien has been filed	WC, No-fault, Liability,
	06-ESRD Patient within coordination period and covered by GHP	End Stage Renal Disease and covered by a GHP
	08-Beneficiary would not furnish information concerning other insurance coverage	All MSP situations
	09-Neither patient nor spouse is employed	Working Aged, Disability, or ESRD
	11-Disabled Beneficiary but no GHP exists	Disability
	28-Patient and/or Spouse's GHP is Secondary to Medicare	Working Aged
	29-Disabled Beneficiary and/or Family Member's GHP is Secondary to Medicare	Disability
	77-Provider Accepts Payment by a Primary Payer as Payment in Full	All MSP Situations
	D7-Claim Change Reason Code for Adjustment Requests to Make Medicare the Secondary Payer	All MSP Situations
	D8-Claim Change Reason Code for Adjustment Requests to Make Medicare the Primary Payer	All MSP Situations
Occurrence Code and Date		
	01-Auto Accident	No-Fault or Liability
	02-No-fault Insurance including Auto accident/Other	No-Fault
	03-Accident/Tort Liability	Liability
	04-Accident/Employment Related	WC or BL
	05-Other Accident	Liability

Data Element	Value for MSP	MSP Situation
	18-Date of Retirement	Working Aged, Disability, or ESRD
	19-Date of Retirement Spouse	Working Aged, Disability, or ESRD
	24-Date Insurance Denied	All MSP Situations
	25-Date Benefits Terminated by Primary Payer	All MSP Situations
	33-First day of the Medicare coordination period for ESRD beneficiaries covered by GHP	ESRD
	A1-Birth date -Insured A	Working Aged, Disability, or ESRD
	A2-Effective Date-Insured A Policy	Working Aged, Disability, or ESRD
	A3- Benefits Exhausted for Payer A	Working Aged, Disability, or ESRD
	B1-Birth date -Insured B	Working Aged, Disability, or ESRD
	B2-Effective Date-Insured B Policy	Working Aged, Disability, or ESRD
	B3- Benefits Exhausted for Payer B	Working Aged, Disability, or ESRD
	C1-Birth date -Insured C	Working Aged, Disability, or ESRD
	C2-Effective Date-Insured C Policy	Working Aged, Disability, or ESRD
	C3- Benefits Exhausted for Payer C	Working Aged, Disability, or ESRD
Value Codes and Amounts		
	12- Working Aged Beneficiary/Spouse Group Health Plan	Working Aged
	13-ESRD Beneficiary in a Medicare Coordination Period with an Employer Health Plan	ESRD
	14-No-fault, including auto/other.	No-Fault
	15-Workers' Compensation Six zeros in the amount field indicates a request for a conditional Medicare payment.	WC
	16-PHS, Other Federal Agency	Other Federal Agency, VA
	41-Black Lung Six zeros in the amount field indicates a request for a conditional Medicare payment.	Black Lung
	42-Veterans Affairs	VA
	43-Disabled Beneficiary Under Age 65 with	Disability

Data Element	Value for MSP	MSP Situation
	GHP	
	44-Amount Provider Agreed to Accept from Primary Payer as Payment in Full	All MSP Provisions
	47- Any Liability Insurance	Liability Provisions
Insured's Name		
	For Primary Payer Information	All MSP Provisions
Patient's Relationship to Insured		
	01-Patient is Insured	All MSP Provisions
	02-Spouse	All MSP Provisions
	03- Natural Child/Insured has Financial Responsibility	Disability, ESRD
	08- Employee	Working Aged, ESRD, Disability
	15-Injured Plaintiff	Liability
Certificate/Social Security Number/*Medicare beneficiary identifier*		
	The involved claim number for the primary coverage is shown	All MSP Provisions
Insurance Group Number		
	Identification number	All MSP Provisions
Employment Status Code		
	1-Employed Full Time	Working Aged, ESRD, Disability
	2-Employed Part-Time	Working Aged, ESRD, Disability
	3-Not Employed	Working Aged, ESRD, Disability
	4-Self-employed	Working Aged, ESRD, Disability
	5-Retired	Working Aged, ESRD, Disability
Employer Name		
		WC, Working Aged, ESRD, Disability
Employer Location		
		WC, Working Aged, ESRD, Disability
Payer ID		
		All MSP Provisions

Data Element Value for MSP **MSP Situation**

Medicare Secondary Payer (MSP) Manual
Chapter 4 - Coordination of Benefits Contractor (COBC) Requirements

10.3 - Contractors Claim Referrals to the COBC
(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Contractors retain the responsibility to process claims for Medicare payment. The COBC is not responsible for processing any claims, nor will it handle any mistaken payment recoveries or claims specific inquiries (telephone or written).

Contractors should instruct providers not to forward claims or copies of claims to the COBC. All claims related activity (e.g., processing, adjustments) remains the contractor's jurisdiction (including claims submitted with value codes, primary payer information, EOB's, copies of checks). If claims are received that do not contain enough information to create an MSP record with an "I" validation indicator, contractors shall follow current claims processing guidelines and send the information through Electronic Correspondence Referral System (ECRS) (see Chapter 5, §10) as an MSP inquiry. They should send this information within one business day of processing the claim.

The COBC will return any claims received to the submitter indicating that claims should be sent to its Medicare contractor only for claims processing and payment.

In cases of claims clarification where the contractor would normally contact (telephone) the provider to complete the processing of a claim in order to avoid suspending or RTP'ing the claim back to the provider, it may continue this practice. However, if it finds that the clarification provided by the provider is still questionable or is in direct opposition to CWF, it must follow current claims processing guidelines and send the information through ECRS as an MSP inquiry (see Chapter 5, §10). It must send this information within one business day of processing the claim.

The following are examples of fields, or information missing, on an MSP claim and/or on CWF that may require clarification from a provider for Contractors to properly process MSP claims. The below list is not inclusive since there could be other reasons why a MSP claim cannot be processed without further clarification from the provider (NOTE: Contractors must continue to follow the claims processing procedures for Other Claims (other than clean) as outline in 100-04/1/80.3 to determine if a claim is unprocessable):

- *Medicare beneficiary identifier;*
- MSP type;
- Validity indicator;
- MSP effective date;
- Contractor identification number;
- Insurer name;
- Patient relationship;
- Insurance type; and
- Incomplete MSP data elements found on the claim.

Medicare Secondary Payer (MSP) Manual
Chapter 5 - Contractor Prepayment Processing Requirements

10.2 - COBC Electronic Correspondence Referral System (ECRS)
(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

As of January 1, 2001, the COBC assumed responsibility for virtually all activities related to establishing MSP periods of coverage at CWF that result from initial MSP development activities. Since contractors receive a great deal of MSP information, a system was needed to transfer that information to the COBC for its evaluation to determine if MSP development is necessary. In addition, since the contractors' ability to send update transactions to CWF had been severely restricted, there was a need for a system to allow it to easily submit requests to the COBC to apply changes to existing MSP records at CWF. In order to meet these requirements, the COBC developed and maintains Electronic Correspondence-Referral System (ECRS Web) application. This application allows contractor MSP representatives and Regional Office MSP staff to fill out various online forms and electronically transmit information to the COBC.

The ECRS is operational 24 hours a day, 7 days a week, except for maintenance. Contractors shall report connection problems or systems failures directly to the COBC EDI Hotline at 646-458-6740. If contractors are unable to receive technical assistance from the COBC EDI Hotline, or the issue has not been resolved,

please E-mail questions or issues should be forwarded to the COBC via Internet address at ECRSHELP@ehmedicare.com.

Attachment 1 - ECRS Web User Guide

To view Attachment 1, click here: Attachment 1, ECRS Web User Guide, User Guide

MAJOR CHANGES FROM ECRS 10 to ECRS Web

1. *Medicare beneficiary identifier* will be required for all assistance requests and inquiries.

2. Beneficiary information will be pre-filled for all assistance requests and inquiries.

3. Prescription Drug Coverage Inquiries will be included on the workload tracking report.

4. The user will be able to print and export, as comma delimited text, search results listings.

5. DCN will be system generated, but may be modified or user can use their own DCN number.

6. The user will be able to change contractor number without having to log out of the application.

7. Contractors will have the ability to upload batch file transactions and download response files via the web application.

8. New CWF Assistance Request Action Codes:

    a. 'AP' to add policy and or group number on drug records (EGHP Only).

    b. 'CP' to notify COBC of incorrect ESRD coordination period (MSP Type B Only).

    c. 'WN' to notify COBC of updates to WCMSA cases (Contractor 79001 Only).

    d. 'CD' to notify COBC of a change to injury/loss date (Contractor 79001 and Non EGHP Only).

9. CWF Assistance Request Action Codes removed:

    a. 'RR' which made documentation requests for generation of right of recovery letters

    b. 'CV' which changed the venue for lead contractor assignment

10. MSP Inquiry Action Codes removed:

    a. 'SC' which suppressed the sending of confirmation letters for EGHP MSP Types.

b. SL' which suppressed lead contractor assignment and the sending of Right of Recovery Letters.

c. 'SR' which suppressed the sending of Right of Recovery Letters.

11. Menu options removed:

a. **Document Copies** which allowed the user to submit requests to the COB contractor for copies of documents.

b. **Lead Contractor Assignment** which allowed the user to see cases assigned to a lead contractor for coordination of Medicare activities with other contractors and insurance companies.

c. **Developing Contractor Notification** which allowed the user to view cases in which the developing contractor or CMS Regional Office may have an interest or involvement, but the cases were assigned to another contractor for the coordination of Medicare activities.

d. **MSP Changed Record Notification** which allowed the user to view MSP occurrences in which the developing contractor or CMS Regional Office may have an interest or involvement, but the MSP occurrences have been added to, updated on, or deleted from CWF by the COB contractor.

e. **Workers Comp Set Aside Detail** which allowed the user to Add, View and Update Workers' Compensation Set-Aside Trust Cases.

f. **Workers Comp Set Aside List** which allowed the user to view a list of Workers' Compensation Set-Aside Trust Cases.

12. GHI will have their own access code which will give them the same authority as the Regional Offices.

13. Contractors will not be using the CICS application.

Attachment 2 – ECRS Web - Quick Reference Card

To view Attachment 2, click here: Attachment 2, ECRS Web User Guide Quick Reference Card

10.5 - Notification to Contractor of MSP Auxiliary File Updates

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

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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 *Medicare beneficiary identifier* 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.

20 - Sources That May Identify Other Insurance Coverage

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

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In the past, MACs used the following guidelines to identify claims for otherwise covered services when there was a possibility that payment had been made or can be made by an insurer primary to Medicare.

- Information is received from a provider, physician, supplier, the beneficiary, contractor operations (e.g., medical or utilization review), other non-Medicare counterparts, or any other source indicating Medicare has been billed for services when there is a possibility of payment by an insurer that is primary to Medicare;

- The health insurance claim form shows that the services were related to an accident (i.e., the diagnosis is due to trauma) or occupational illness (e.g., black lung disease) or were furnished while the beneficiary was covered by a GHP or an LGHP which is primary to Medicare;

- The CWF indicates a validity indicator value of "Y" showing the presence of MSP coverage;

- Information in a MAC's records indicate a primary payer;

- There is an indication that the beneficiary previously received benefits or had a claim pending for insurance that is primary to Medicare. The MAC assumes, in the absence of information to the contrary, that this coverage continues.

- Medicare has not made payment and the MAC is asked to endorse a check from another insurer payable to Medicare and some other entity. The MAC returns the check to the requester and advises that the insurer pay primary benefits to the full extent of the GHP's primary obligation. (The MAC follows the recovery instructions in Chapter 7, "Contractor MSP Recovery Rules," and Chapter 3 of Pub. 100-6, the Medicare Financial Management Manual, if the check relates to services for which Medicare paid primary.) As necessary, it follows up with the provider, physician, supplier, beneficiary, and/or attorney to find out if the beneficiary receives payment from the GHP;

- Medicare receives or is informed of a request from an insurance company or attorney for copies of bills or medical records. Providers are instructed to notify the COBC promptly of such requests and to send a copy of the request. If the request is unavailable, providers are to provide

full details of the request, including the name and *Medicare beneficiary identifier* of the patient, name and address of the insurance company and/or attorney, and date(s) of services for which Medicare has been billed or will be billed;

- Where a GHP's primary coverage is established because the individual forwards a copy of the GHP's explanation of benefits and the individual meets the conditions in Chapter 1, §10, the MAC processes the claim for secondary benefits; or

- Claim is billed as Medicare primary and it is the first claim received for the beneficiary and there is no indication that previous MSP development has occurred.

- The CWF MSP auxiliary detail screen contains a 1-byte Ongoing Responsibility for Medicals (ORM) indicator, where the value is "Y," which indicates that a Section 111 Medicare, Medicaid, and S-CHIP Extension Act (MMSEA) Responsible Reporting Entity (RRE) has accepted ongoing responsibility for a particular liability, no-fault, and workers' compensation incident. **NOTE:** Further details regarding ORM, the new 1-byte ORM indicator on CWF, and how to handle and process claims based on the value present within the CWF ORM field are in Section 2.4 below.

Other insurance that may be primary to Medicare is shown on the institutional claim as follows:

- A Value Code of 12, 13, 14, 15, 16, 41, 42, 43, 44, or 47;

- An Occurrence Code of 01, 02, 03, 04, 05, 24, 25, or 33;

- A Condition Code of 02, 05, 06, 08, 77, or D7;

- A trauma related diagnosis code is shown; or

- Another insurer is shown as the primary payer on line A of Payer Name .

Other insurance that may be primary to Medicare is shown on the Form CMS-1500 claim form when block 10 is completed. A primary insurer is identified in the "Remarks" portion of the bill.

With the installation of the Benefits Coordination & Recovery Center (BCRC), the MAC uses ECRS to advise the BCRC of the possibility of another insurer, and awaits BCRC development before processing the claim.

40.7 - Carrier Processing Procedures for Medicare Secondary Claims

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

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Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

B3-4301.1

A. Validity Edits

Carriers are responsible for validating the data submitted on Medicare claims including MSP data.

Carriers use the date of birth in CWF records to determine the month and year of birth. When the patient is the spouse of the worker, the carrier obtains the date of birth of both the worker and the spouse. The carrier presumes that the day of birth is not the first of the month unless information on the claim form indicates that it is. A person is considered 65 or 70 for the month if he "attains" 65 or 70 any time during the month. For Medicare entitlement purposes, a person attains a particular age on the day before his or her birthday. Therefore, if a person's 65th birthday is on the first day of a month, Medicare is secondary payer beginning with the first day of the preceding month.

B. Verify Part A entitlement

For purposes of reviewing working aged claims, the carrier presumes that Part A entitlement exists for all Medicare beneficiaries between 65 and 69 except *those who are uninsured*.

C. Determine if Group Health Plan Coverage Exists

Chapter 1 contains a complete discussion of "employer" and "employer group health plan." The COBC is now responsible for developing whether Group Health Plan (GHP) coverage exists. If the carrier becomes aware that GHP is involved in a claim, for example, through receipt of a claim for secondary benefits with an EOB, and this is not reflected in the CWF response for the claim, the carrier updates the CWF auxiliary file with an "I" indicator to add the new MSP occurrence (see §10.1, subsection 2).

60.1.3 - Recording Savings

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 Contractors control all claims from which MSP savings are extracted and verifies all amounts recorded on the Forms CMS-1563 or CMS-1564 when requested.

A. MSP Savings File

The Contractors 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 contractor's "corporate side" records or any other "outside" source, the Contractors 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, contractors 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 Contractors count them as savings on the Forms CMS-1563 or CMS-1564 and enters them into the contractor MSP savings file.

C. Total Savings for Special Projects

All Contractors shall total each respective Special Project Savings and place these totals under their respective special project columns in the Special Project Savings Total in the CROWD Savings Report. Part A Medicare contractors 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. The Part B and DME Medicare contractors 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 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.

70.3.1.1 - General Review Requirements

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 reviewer shall review the following items, which are not specific to a particular bill type.

A. Condition Codes: FLs 24 thru 30

The following condition codes must be completed where applicable:

- 08 - Beneficiary would not provide information concerning other insurance coverage;
- 09 - Neither patient nor spouse employed;
- 10 - Patient and/or spouse is employed, but no GHP; or,

- 28 - Patient and/or spouse's GHP is secondary to Medicare.

B. Occurrence Codes and Dates: FLs 32 thru 36

The following occurrence codes must be completed where applicable:

- 18 - Date of retirement (patient/beneficiary);
- 19 - Date of retirement (spouse);
- 24 - Date insurance denied; or,
- 25 - Date benefits terminated by primary payer (date on which coverage, including Workers' Compensation benefits or no-fault coverage, is no longer available to patient)

In relation to the reporting of occurrence codes 18 and 19, referenced above, hospitals are now instructed that when precise retirement dates cannot be obtained during the intake process, they should follow this policy:

When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, report his or her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his or her retirement date.

If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it has been at least five years since the beneficiary retired, enter the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, the provider reports the retirement date as January 4, 1997. As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

C. Value Codes and Amounts: FLs 39 thru 41

Value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services. Where the hospital is requesting conditional payment, zeros should be entered beside the appropriate value code in this item.

D. Payer Identification: FL 50A

Payer identification should be completed to show the identity of the other payer primary to Medicare. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A.

E. Payer Identification: FLs 50B, C

Payer identification should be completed to show when Medicare is the secondary or tertiary payer.

F. Insured's Name: FL 58A

The insured's name should be completed to show the name of the individual in whose name the insurance is carried. This information is of particular importance when Medicare is not the primary payer.

G. Patient's Name: FL 58B

In FL 58B, the hospital should have entered the patient's name as shown on the HI card or other Medicare notice or as annotated in the hospital's system.

H. Patient's Relationship to the Insured: FL 59

This item indicates whether the individual may have coverage based on the current employment status of a spouse or other family member.

I. Certification/SSN/*Medicare beneficiary identifier*: FLs 60A, B, C

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the hospital should have entered the patient's *Medicare beneficiary identifier*. If the hospital is reporting any other insurance coverage higher in priority than Medicare (e.g., employer coverage for the patient or the spouse or during the first 30 months of ESRD entitlement), the involved claim number for that coverage should be shown on the appropriate line.

70.5.2 - Exhibit 2: Survey of Bills Reviewed

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Name of Beneficiary	*Mbi*	Bill Type	Follow-Up Action Needed (Action Date)

Chapter 2: Introduction

2.6.5 Navigation Links

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 following navigation links are displayed on each page that is opened from the *Main Menu*.

Table 2-1: Navigation

Link	Description
HOME	Returns to the Main Menu page.

Link	Description
CMS	Links to the CMS website https://www.cms.gov/.
ABOUT	Displays information about the ECRS Web menu options.
SIGN OUT	Exits the ECRS web application.

Table 2-2: Left Side Bar

Link	Description
ACTION REQUESTED	Goes to the *Action Requested* page.
CWF AUXILIARY RECORD INFORMATION	Goes to the *CWF Auxiliary Record Data* page.
INFORMANT INFORMATION	Goes to the *Informant Information* page.
INSURANCE INFORMATION	Goes to the *Insurance Information* page.
EMPLOYMENT INFORMATION	Goes to the *Employment Information* page.
ADDITIONAL INFORMATION	Goes to the *Additional Information* page.
COMMENTS/REMARKS	Goes to the *Comments/Remarks* page.
SUMMARY	Goes to the *Summary* page.

The Right Side Bar displays four to six sections of links and fields, as well as different link combinations, depending on the page displayed.

For some pages, beneficiary and DCN Information is retrieved from the system using the Medicare ID entered on the *Action Requested* page (Section 3.2). The Medicare ID can be the *Medicare beneficiary identifier (Mbi)*. This information is then carried forward on subsequent pages opened from the Main Menu, and it will be displayed on the right side bar. This information will not be editable.

Table 2-3: Right Side Bar

Link	Description
QUICK HELP	-
Help About This Page	Click **Help About this Page** to display help information for completing the page.
CHANGE CONTRACTOR	-
Change Contractor	Click the link to change the contractor number and access code on the *Contractor Sign In* page. **Note:** You will lose all unsubmitted data for the current contractor.
CONTRACTOR	-
ID	Contractor Number or CMS ID entered on *Contractor Sign In* page *(protected field).*
Name	Name of Contractor associated with the Contractor Number, or Regional Office associated with the CMS ID *(protected field).*
USER	-
ID	User ID of person logged in *(protected field).*
Name	Name of person associated with User ID *(protected field).*
Phone	Phone number associated with the User ID *(protected field).*
BENEFICIARY	-
Medicare ID	*Mbi* of the beneficiary *(protected field).*
SSN	Social Security Number of the beneficiary *(protected field).*

Link	Description
Name	Name of the beneficiary *(protected field)*.
Address	Street address of the beneficiary *(protected field).*
City, State	City and State associated with the street address of the beneficiary *(protected field).*
Zip	Zip code associated with street address of beneficiary *(protected field).*
Sex	Gender of the beneficiary *(protected field)*.
DOB	Date of birth of the beneficiary *(protected field)*.
DCN	-
ID	Document Control Number assigned by the contractor to correspondence or paperwork associated with a transaction *(protected field).*
Origin Date	Date CWF Assistance Request transaction was submitted *(protected field).*
Status	Two-character code explaining where the CWF Assistance Request transaction is in the COB system process *(protected field).* CM: Completed DE: Delete (do not process ECRS CWF Assistance Request) HD: Hold, individual not yet a Medicare beneficiary IP: In process, being edited by COB NW: New, not yet read by COB **Note:** STATUS will always be NW until the transaction is processed.
Reason	Two-character code explaining why the CWF Assistance Request is in a particular status *(protected field)*. **Note:** REASON will always be 01 until the transaction is processed.

Chapter 3: CWF Assistance Request Transactions

3.1.1 Retrieving Beneficiary Information

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Beneficiary Information is automatically retrieved when the Medicare ID (*Mbi*) and other required data is entered and saved on the first page of the CWF Assistance Request (Action Requested page). The information is displayed on the right side bar, and carried forward on the CWF Assistance Request transaction.

3.2 Action Requested Page

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 *Action Requested* page is the first page displayed when adding a new CWF Assistance Request. The information entered on this page determines required information on subsequent pages.

From the *Main Menu* page, click the **CWF Assistance Request** link under Create Requests or Inquiries. The system displays the *Action Requested* page and navigation links (Figure 3-1).

Type/select data in all of *the required fields* on the *Action Requested* page, and click the **Continue** button. *Required fields* are noted with a red asterisk (*) and are as follows:

DCN

MEDICARE ID

ACTIVITY CODE

ACTION

SOURCE

Note: For information on importing HIMR MSP Data for CWF Assistance Requests, see Figure 3-2. If beneficiary information is not found for the Medicare ID you have entered, you will not be able to continue the CWF Assistance Request.

1. After all relevant fields have been entered, click **Continue** to go to the CWF Auxiliary Record Data page, or select a page link from the left side bar.
2. If you selected to import HIMR MSP data, clicking **Continue** displays the HIMR MSP Data List (Figure 3-2).
3. To exit the CWF Assistance Request Detail pages, click the **Home** link to return to the Main Menu or click **Sign Out** to exit the application.

Figure 3-1: CWF Assistance Request Action Requested

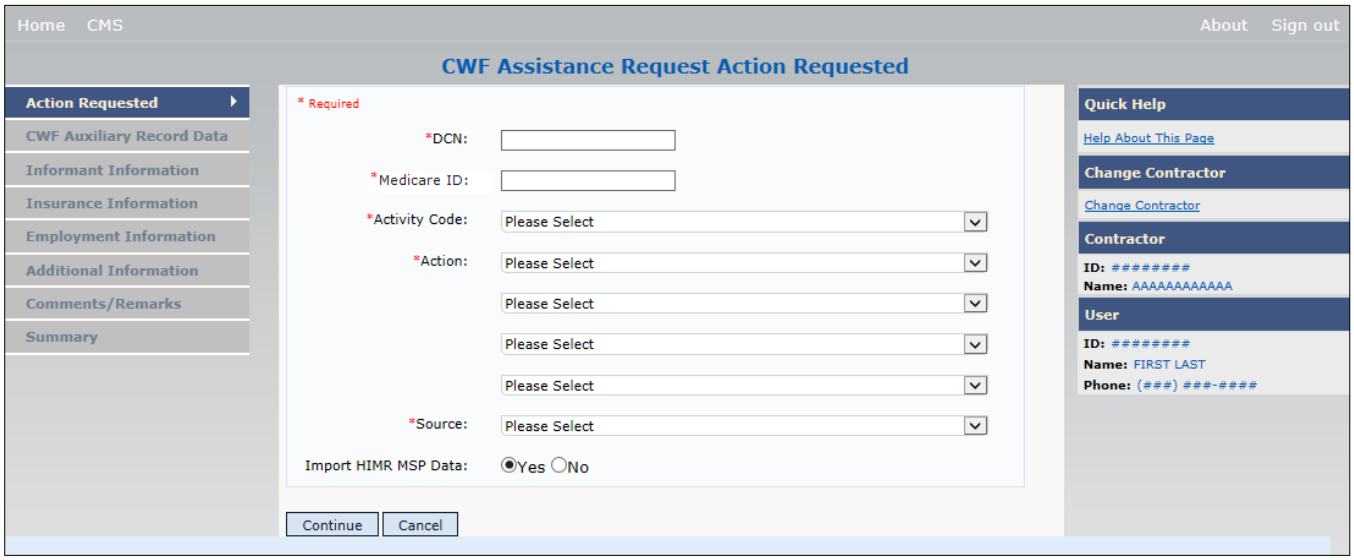

Table 3-4: CWF Assistance Request Action Requested

Field	Description
DCN	Document Control Number assigned by the contractor to correspondence and/or paperwork associated with transaction (*required field*) The system auto-generates the DCN, but it can be changed by the user.
MEDICARE ID	*Medicare beneficiary Identifier* (*Mbi*) of the beneficiary (*required field*). Enter the ID without dashes, spaces, or other special characters.
ACTIVITY CODE	Activity of the contractor (*required field*). Valid values are: C Claims (Pre-Payment) D Debt Collection/Referral G Group Health Plan I General Inquiries N Liability, No Fault, Workers' Compensation, and Federal Tort Claim Act
ACTION	Two-character code defining the action to take on the MSP auxiliary occurrence at CWF (*required field*). **Notes:** Enter up to four Actions unless the CWF Assistance Request is to: Delete occurrence (DO) Redevelop a deleted CWF record (DR) Investigate/ possible duplicate for deletion (ID) Note a vow of poverty (VP) Develop for Employer Information (DE) Develop for Insurer Information (DI) You cannot combine these six Actions with any other Actions. Action MT only applies when supplemental type is Primary.
SOURCE	Four-character code identifying source of the information (*required field*). Valid values are: CHEK = Unsolicited check LTTR = Letter PHON = Phone call SCLM = Claim submitted to Medicare contractor for secondary payment SRVY = Survey
IMPORT HIMR MSP DATA	Defaults to Yes, but can be changed to No. See Section 3.2.2 for more information.
CONTINUE	Command button. Click to go to the next page. **Note**: All *required field*s must be populated before clicking **Continue**.

Field	Description
CANCEL	Command button. Click to return to the Main Menu.

3.10.1 View Transactions

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

1. Type search criteria in the appropriate fields and click the **Submit** button.

   To create a list of all CWF Assistance Requests for a specific Medicare ID, enter the Medicare ID in the search criteria and leave the CONTRACTOR NUMBER field blank.

   When searching by Origin Date, User ID, Status, and/or Reason, you must also enter a DCN, Medicare ID, SSN or Contractor Number.

   The system displays a list of CWF Assistance Requests (Figure 3-12). There are up to 500 items per page; scroll through the records or use the **First**, **Prev**ious, **Next**, and **Last** navigation at the top of the list to view other transactions on other pages.

2. Change or delete search criteria to initiate a new search.

Figure 3-2: CWF Assistance Request Search Listing

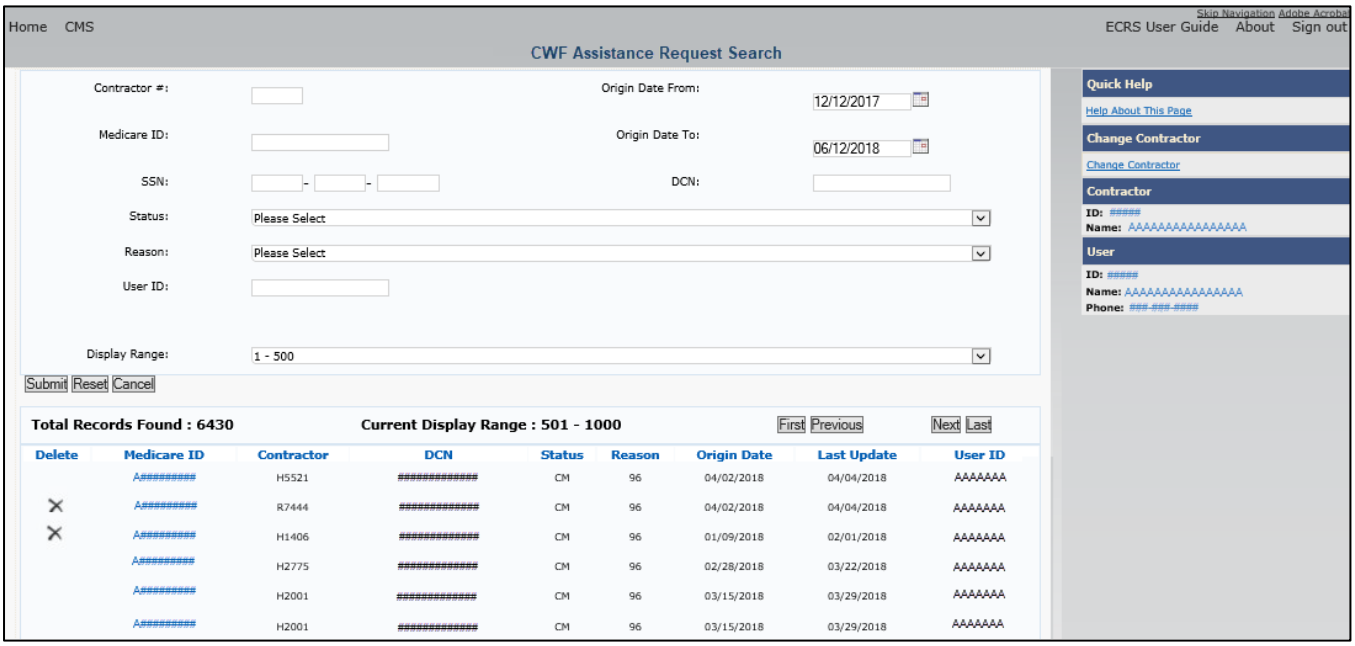

Table 3-5: CWF Assistance Request Search Listing

Field	Description
DISPLAY RANGE	Select a range to filter the display of records in the search results by a defined range. Note: This field is only visible if a search has been completed. The range in the DISPLAY RANGE field defaults to 1-500.
Total Records Found	Total number of records found.
Current Display Range	Defined display range for the records found. Note: This field defaults to 1-500.
DELETE	Click the delete [**X**] link to mark a transaction for deletion.
MEDICARE ID	Medicare ID (*Mbi*) for the CWF Assistance Request transaction. (*Protected field*). Click the **Medicare ID** link to view the *Summary* page
CONTRACTOR	Contractor number. (*protected field*)
DCN	Document Control Number assigned to the CWF Assistance Request transaction by the Medicare contractor. (*protected field*)
STATUS	Status of the CWF Assistance Request transaction. (*protected field*)
REASON	Two-character code explaining why the CWF Assistance Request is in a particular status. (*protected field*)
ORIGIN DATE	Originating date in MMDDCCYY format. (*protected field*)
LAST UPDATE	Date the CWF Assistance Request transaction was last changed in MMDDCCYY format. (*protected field*)
USER ID	User ID of the operator who entered CWF Assistance Request transaction. (*protected field*)
Export options	Click the link to export search results. Note: You may export all results returned, up to 500 records at a time, based on the records currently displayed.

Chapter 4: MSP Inquiry Transactions

4.1.1 Retrieving Beneficiary Information

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Beneficiary Information is automatically retrieved when Medicare ID (*Mbi*) and other required data is entered and saved on the first page of the MSP Inquiry (Action Requested page). The information is displayed on the right side bar, and carried forward on the MSP Inquiry transaction.

4.2.1 Navigation Links

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Several basic navigation links are displayed on every *Main Menu* page. See Section 2.6.4 for descriptions of the Heading Bar links and the Right Side Bar links and fields.

1. Enter data in all *required fields* on the *Action Requested* page then click the **Continue** button. The *required fields* on this web page are noted with a red asterisk (*) and are as follows:

   DCN
   MEDICARE ID
   ACTIVITY CODE
   SOURCE

   Note: If Beneficiary Information is not found for the Medicare ID you have entered you will receive a warning message, but will still be able to continue with the MSP Inquiry.

2. After all relevant fields have been entered, click **Continue** to go to the *MSP Information* page, or select a page link from the left side bar.

3. To exit the MSP Inquiry Detail pages, click the **Home** link to return to the Main Menu or **Sign Out** to exit the application.

Table 4-6: MSP Inquiry Action Requested

Field	Description
DCN	Document Control Number assigned by the contractor to correspondence and/or paperwork associated with the transaction (*required field*) The system auto-generates the DCN, but it can be changed by the user.
MEDICARE ID	Medicare ID (*Mbi*) of the beneficiary (*required field*). Enter the ID without dashes, spaces, or other special characters. **Note**: The system looks up the Medicare ID to ensure all related Medicare IDs are returned. Results show the Medicare ID you entered.
ACTIVITY CODE	Activity of contractor (*required field*). Valid values are: C Claims (Pre-Payment) D Debt Collection/Referral G Group Health Plan I General Inquiries N Liability, No-Fault, Workers' Compensation, and Federal Tort Claim Act
ACTION	Two-character code indicating the type of special processing to perform on the MSP Inquiry record. **Note:** You can use CA and CL together. You cannot combine any other Actions. Valid values are: CA Class Action Suit **Note**: This action code assigns the designated lead contractor according to the type of class action suit. The system does not send the beneficiary an MSP confirmation letter. CL Closed or Settled Case **Note**: This action code is only valid for closed and settled cases. This action code suppresses lead contractor assignment. The system does not send the beneficiary an MSP confirmation letter. DE Develop to the Employer **Note**: This action code sends a development letter to the employer. DI Develop to the Insurer **Note**: This action code sends a development letter to the insurer.
SOURCE	Four-character code identifying the source of the MSP Inquiry information (*required field*). Valid values are: CHEK Unsolicited check LTTR Letter PHON Phone call SCLM Claim submitted to Medicare contractor for secondary payment SRVY Survey
CONTINUE	Command button. Click to go to the *MSP Information* page. **Note:** *Required field*s must be typed/selected before clicking **Continue**.
CANCEL	Command button. Click to return to the Main Menu.

4.10.1 View Transactions

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

1. Type search criteria in the appropriate fields and click **Submit.**

   To create a list of all MSP Inquiries for a specific Medicare ID, enter the Medicare ID in the search criteria and leave the CONTRACTOR NUMBER field blank.

   When searching by Origin Date, User ID, Status, and/or Reason, you must also enter a DCN, Medicare ID, SSN, or Contractor Number.

   The system displays a list of MSP Inquiries (Figure 4-11). There are up to 500 items per page; scroll through the records or use the **First**, **Previous**, **Next**, and **Last** navigation at the top of the list to view other transactions on other pages.

2. Change or delete search criteria to initiate a new search.

Figure 4-3: MSP Inquiry Search Listing

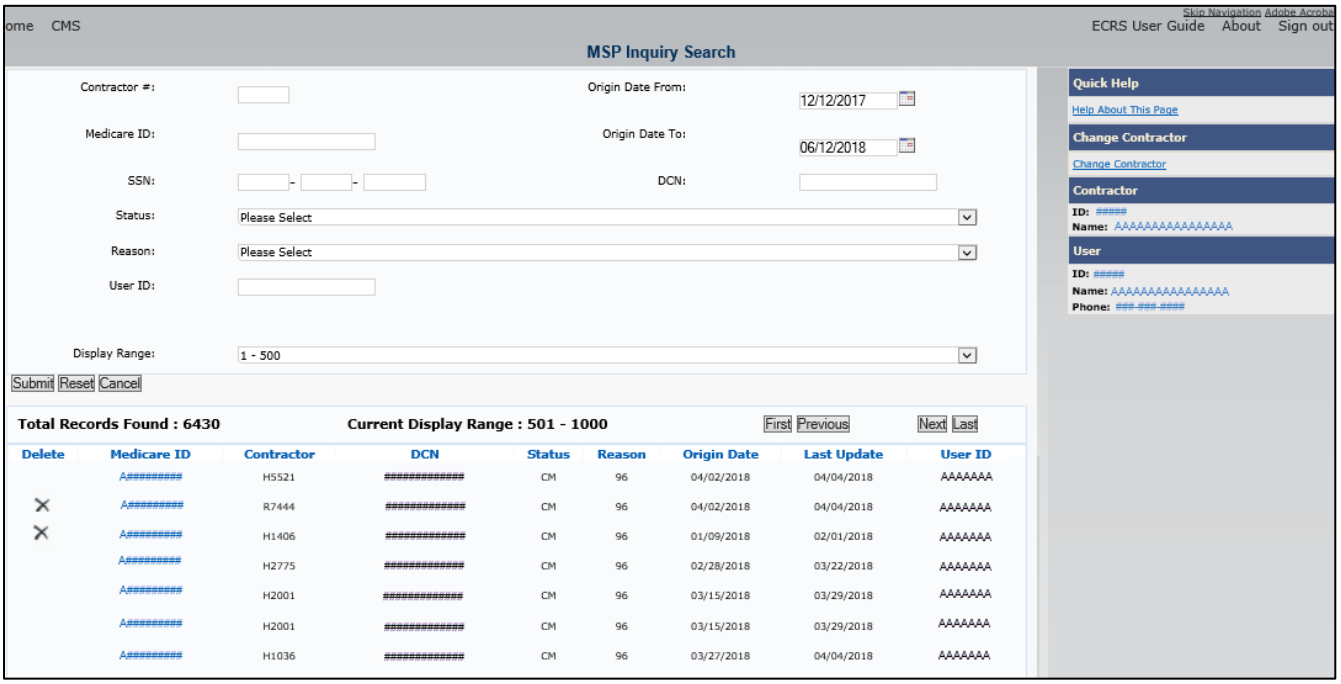

Table 4-7: MSP Inquiry Search Listing

Field	Description
DISPLAY RANGE	Select a range to filter the display of records in the search results by a defined range. Note: This field is only visible if a search has been completed. The range in the DISPLAY RANGE field defaults to 1-500.
Total Records Found	Total number of records found.
Current Display Range	Defined display range for the records found. Note: This field defaults to 1-500.
Delete	Click the delete [**X**] link to mark a transaction for deletion.
MEDICARE ID	Medicare ID (*Mbi*) for the MSP Inquiry transaction. (*Protected field*). Click the link to view the *Summary* page.
CONTRACTOR	Contractor number. (*protected field*)

Field	Description
DCN	Document Control Number assigned to the MSP Inquiry transaction by the Medicare contractor. (*protected field*)
STATUS	Status of the MSP Inquiry transaction. (*protected field*)
REASON	Reason for the MSP Inquiry transaction. (*protected field*)
ORIGIN DATE	Originating date in MMDDCCYY format. (*protected field*)
LAST UPDATE	Date the MSP Inquiry transaction was last changed in MMDDCCYY format. (*protected field*)
USER ID	User ID of the operator who entered the MSP Inquiry transaction. (*protected field*)
Export options	Click the link to export search results. Note: You may export all results returned, up to 500 records at a time, based on the records currently displayed.

5.1.1 Retrieving Beneficiary Information

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Beneficiary Information is automatically retrieved when Medicare ID (*Mbi*) and other required data is entered and saved on the first page of the Prescription Drug Assistance Request (Action Requested). The information is displayed on the right side bar, and carried forward on the Prescription Drug Assistance Request transaction.

5.2.1 Navigation Links

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Several basic navigation links are displayed on every *Main Menu* page. See Section 2.6.4 for descriptions of the Heading Bar links and the Right Side Bar links and fields.

Type/select data in all of *the required fields* on the *Action Requested* page, and click **Continue**. *Required fields* are noted with a red asterisk (*) and are as follows:

DCN
MEDICARE ID
ACTIVITY CODE
ACTION
SOURCE
RECORD TYPE
PATIENT RELATIONSHIP
PERSON CODE
ORIGINATING CONTRACTOR
EFFECTIVE DATE

Note: If beneficiary information is not found for the Medicare ID you have entered, you will not be able to continue the Prescription Drug Assistance Request.

3. After all relevant fields have been entered, click **Continue** to go to the Prescription Drug Assistance Request Informant Information page, or select a page link from the left side bar.
4. To exit the *Prescription Drug Assistance Request Detail* pages, click **Home** to return to the Main Menu or **Sign Out** to exit the application.

Figure 5-4: Prescription Drug Assistance Action Requested

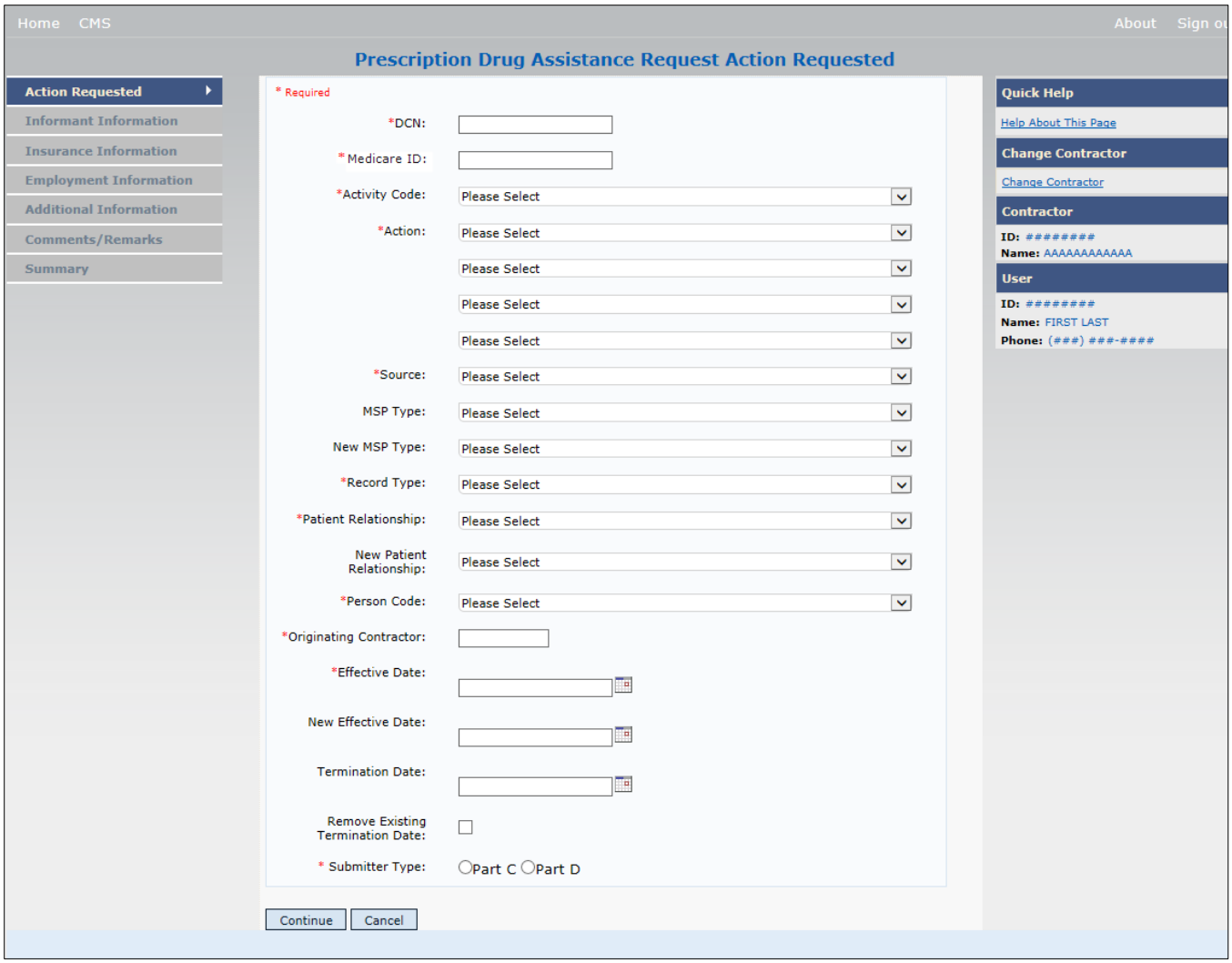
Home CMS
About Sign ou
Prescription Drug Assistance Request Action Requested
Action Requested
Informant Information
Insurance Information
Employment Information
Additional Information
Comments/Remarks
Summary
* Required
*DCN:
* Medicare ID:
*Activity Code:
*Action:
Please Select
*Source:
MSP Type:
New MSP Type:
*Record Type:
*Patient Relationship:
New Patient Relationship:
*Person Code:
*Originating Contractor:
*Effective Date:
New Effective Date:
Termination Date:
Remove Existing Termination Date:
* Submitter Type:
Part C
Part D
Continue
Cancel
Quick Help
Help About This Page
Change Contractor
Change Contractor
Contractor
ID: ########
Name: AAAAAAAAAAA
User
ID: ########
Name: FIRST LAST
Phone: (###) ###-####

Table 5-8: Prescription Drug Assistance Request Action Requested

Field	Description
DCN	Document Control Number assigned by the contractor to correspondence and/or paperwork associated with transaction (*required field*) The system auto-generates the DCN, but it can be changed by the user.
MEDICARE ID	Medicare ID (*Mbi*) of the beneficiary (*required field*). Enter the ID without dashes, spaces, or other special characters.
ACTIVITY CODE	Activity of contractor (*required field*). Valid values are: C Claims (Pre-Payment) D Debt Collection/Referral G Group Health Plan I General Inquiries N Liability, No-Fault, Workers' Compensation, and Federal Tort Claim Act
ACTION	Two-character code defining action to take on Prescription Drug record (*required field*). Valid values are: AP Add Policy Number/Group Number BN Develop for RX BIN CT Change Termination Date CX Change RX Values (BIN, Group, PCN) DO Delete Occurrence EA Change Employer Address ED Change Effective Date EI Change Employer Info GR Develop for Group Number II Change Insurer Information IT Change Insurance Type MT Change MSP Type PC Update RX Person Code PN Develop for/add PCN PR Change Patient Relationship TD Add Termination Date II Change Insurer Information **Notes:** Action Code II cannot be used with Action Code DO. The following Actions can be combined together, but not with any other Actions: BN Develop for RX BIN GR Develop for Group Number PN Develop for/add PCN Prescription Drug Assistance Request with the following Actions will be automatically processed, given they have no reject errors: AP Add Policy Number/Group Number CX Change RX Values (BIN, Group, PCN) DO Delete Occurrence II Change Insurer Information TD Add Termination Date The BIN field is not required when the action code is "BN."

Field	Description
SOURCE	Four-character code identifying the source of the Prescription Drug Assistance Request information (*required field*). Valid values are: CHEK = Unsolicited check LTTR = Letter PHON = Phone call SCLM = Claim submitted to Medicare contractor for secondary payment SRVY = Survey
MSP TYPE	One-character code identifying type of MSP coverage. Description of code displays next to value. Valid values are: A Working Aged B ESRD C Conditional Payment D Automobile Insurance, No Fault E Workers' Compensation F Federal (Public) G Disabled H Black Lung L Liability W Workers' Compensation Medicare Set Aside *Required field* when ACTION is MT.
NEW MSP TYPE	One-character code identifying type of new MSP coverage. Description of code displays next to value. *Required field* when ACTION is MT.
RECORD TYPE	Prescription Coverage Record Type (*required field*). Valid values are: PRI Primary SUP Supplemental **Note**: RECORD TYPE must be PRI when ACTION is MT.

Field	Description
PATIENT RELATIONSHIP	Patient relationship between policyholder and beneficiary (*required field*). Description of code displays next to value. Valid values are: 01 Patient is policy holder 02 Spouse 03 Natural child, insured has financial responsibility 04 Natural child, insured does not have financial responsibility 05 Stepchild 06 Foster child 07 Ward of the Court 08 Employee 09 Unknown 10 Handicapped dependent 11 Organ donor 12 Cadaver donor 13 Grandchild 14 Niece/nephew 15 Injured plaintiff 16 Sponsored dependent 17 Minor dependent of a minor dependent 18 Parent 19 Grandparent dependent 20 Domestic partner (Effective April, 2004.) For the following MSP Types, the patient relationship codes listed to the right are the only valid values that can be used: MSP Type Patient Relationship --- A 01, 02 B 01, 02, 03, 04, 05, 18, 20 G 01, 02, 03, 04, 05, 18, 20
NEW PATIENT RELATIONSHIP	New patient relationship between policyholder and beneficiary. Description of code displays next to value *Required field* when ACTION is PR.
PERSON CODE	Plan-specific Person Code. Values are: 001 Self 002 Spouse 003 Other *Required field* when: RECORD TYPE is Supplemental ACTION is PC
ORIGINATING CONTRACTOR	Contractor number of the contractor that created the original Prescription Drug record at MBD (*required field*).
EFFECTIVE DATE	Effective date of drug coverage in MMDDCCYY format (*required field*.)
NEW EFFECTIVE DATE	New effective date of drug coverage in MMDDCCYY format. *Required field* when ACTION is ED.
TERMINATION DATE	Termination date of drug coverage in MMDDCCYY format. *Required field* when ACTION is TD or CT.
REMOVE EXISTING TERMINATION DATE checkbox	Check to remove an existing termination date.

Field	Description
CONTINUE	Command button. Click to go to the *Informant Information* page. **Note**: All *required field*s must be populated before clicking **Continue**.
CANCEL	Command button. Click to return to the Main Menu.

5.9.1 View Transactions

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

1. Type search criteria in the appropriate fields and click **Submit**.

   To create a list of all Prescription Drug Assistance Requests for a specific Medicare ID, enter the Medicare ID in the search criteria and leave the CONTRACTOR NUMBER field blank.

   When searching by Origin Date, User ID, Status, and/or Reason, you must also enter a DCN, Medicare ID, SSN, or Contractor Number.

   The system displays a list of Prescription Drug Assistance Requests (Figure 5-9*)*. There are up to 500 items per page; scroll through the records or use the **First**, **Previous**, **Next**, and **Last** navigation at the top of the list to view other transactions on other pages.

2. Change or delete search criteria to initiate a new search.

Figure 5-5: Prescription Drug Assistance Requests Search Listing

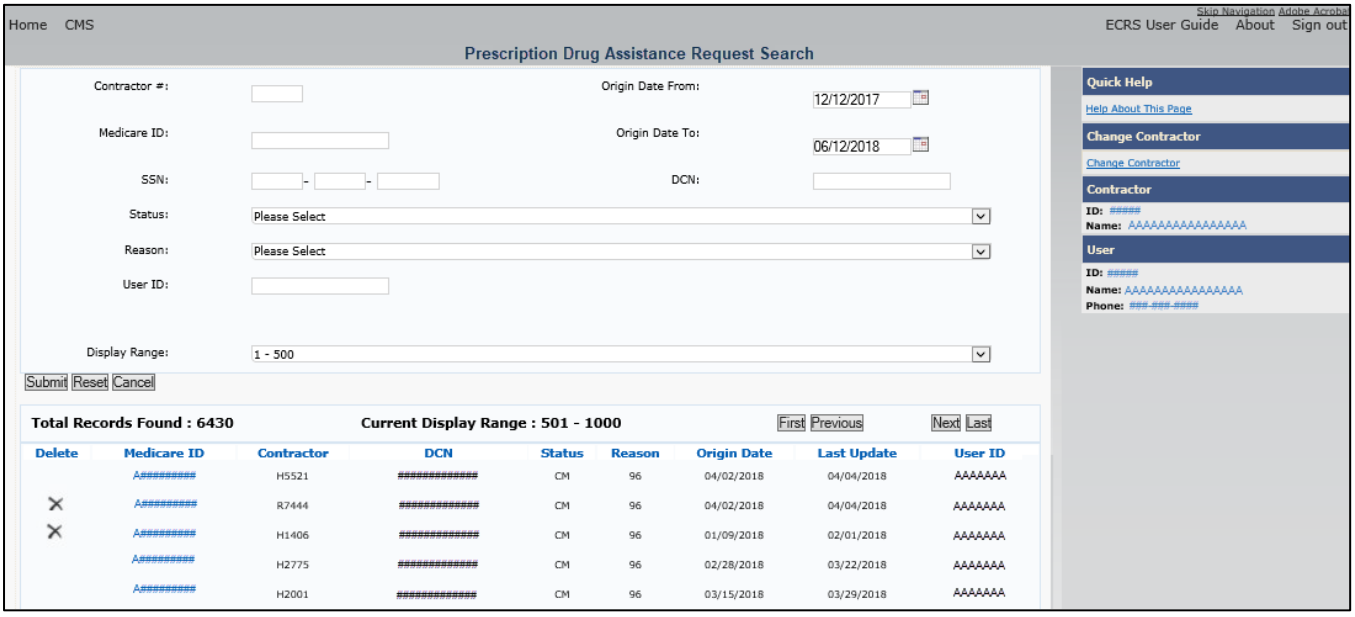

Table 5-9: Prescription Drug Assistance Requests Search Listing

Field	Description
DISPLAY RANGE	Select a range to filter the display of records in the search results by a defined range. Note: This field is only visible if a search has been completed. The range in the DISPLAY RANGE field defaults to 1-500.
Total Records Found	Total number of records found.

Field	Description
Current Display Range	Defined display range for the records found. Note: This field defaults to 1-500.
Delete	Click the delete [**X**] icon to mark a transaction for deletion
MEDICARE ID	Medicare ID (*Mbi*) for the Prescription Drug Assistance Request transaction. (*Protected field*). Click the Medicare ID link to view the *Summary* page.
CONTRACTOR	Contractor number. (*protected field*)
DCN	Document Control Number assigned to the Prescription Drug Assistance Request transaction by Medicare contractor. (*protected field*)
STATUS	Status of the Prescription Drug Assistance Request transaction. (*protected field*)
REASON	Two-character code explaining why the Prescription Drug Assistance Request is in a particular status. (See Appendix E for the complete list of codes.) (*protected field*)
ORIGIN DATE	Originating date in MM-DD-CCYY format. (*protected field*)
LAST UPDATE	Date Prescription Drug Assistance Request transaction was last changed in MMDDCCYY format. (*protected field*)
USER ID	User ID of operator who entered the Prescription Drug Assistance Request transaction. (*protected field*)
Export options	Click the link to export search results. Note: You may export all results returned, up to 500 records at a time, based on the records currently displayed.

Chapter 6: Prescription Drug Inquiry Transactions

6.1.1 Retrieving Beneficiary Information

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Beneficiary Information is automatically retrieved when the Medicare ID (*Mbi*) and other required data is entered on the first page of the *Prescription Drug Inquiry* (Initial Information) and you click **Continue**. The information is displayed on the right side bar, and is carried forward on the Prescription Drug Inquiry transaction.

6.2.1 Navigation Links

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Several basic navigation links are displayed on every *Main Menu* page. See Section 2.6.5 for descriptions of the Heading Bar links and the Right Side Bar links and fields.

1. Enter data in all fields and click **Continue** to go to the Additional Information page, or select a page link from the left side bar.

   Note: If Beneficiary Information is not found for the Medicare ID (*Mbi*) you have entered, you will receive a warning message but will still be able to continue with the Prescription Drug Inquiry.

2. To exit the Prescription Drug Inquiry Detail pages, click **Home** to return to the Main Menu or **Sign Out** to exit the application.

Table 6-10: Prescription Drug Inquiry Initial Information

Field	Description
DCN	Document Control Number assigned by the contractor to correspondence and/or paperwork associated with the transaction. *Required field*. The system auto-generates the DCN, but it can be changed by the user.
MEDICARE ID	Medicare ID (*Mbi*) of the beneficiary. Enter the ID without dashes, spaces, or other special characters. *Required field*.
ACTIVITY CODE	Activity of contractor. *Required field*. Valid values are: C Claims (Pre-Payment) D Debt Collection/Referral G Group Health Plan I General Inquiries N Liability, No Fault, Workers' Compensation, and Federal Tort Claim Act
SOURCE	Four-character code identifying source of the Prescription Drug Inquiry information. *Required field.* Valid values are: CHEK = Unsolicited check LTTR = Letter PHON = Phone call SCLM = Claim submitted to Medicare contractor for secondary payment SRVY = Survey
MSP TYPE	One-character code identifying type of MSP coverage. *Required field*. Valid values are: A Working Aged B ESRD C Conditional Payment D Automobile Insurance, No Fault E Workers' Compensation F Federal (Public) G Disabled H Black Lung L Liability
PATIENT RELATIONSHIP	Patient relationship between the policyholder and the beneficiary. Valid values are: 01 POLICY HOLDER 02 SPOUSE 03 CHILD 04 OTHER
SEND TO MDB	Indicates whether to send the Prescription Drug inquiry to MBD. *Required field.* Valid values are: YES Send to MBD (default) NO Do not send to MBD
CONTINUE	Command button. Click to go to the *Additional Information* page. *Required field*s must be entered before clicking **Continue**.
CANCEL	Command button. Click to return to the Main Menu.

6.6.1 Tracking Prescription Drug Inquiries

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

When Prescription Drug information is entered in conjunction with an MSP inquiry, no additional tracking of status and reason is performed on the Prescription Drug information. Status and Reason codes are tracked on the MSP inquiry only.

When Prescription Drug information is entered as a stand-alone inquiry, the following status/reason code combinations are used to track the inquiry:

NW01 Not yet read by COB

DE01 Deleted by Medicare Contractor

CM15 Update Sent to MBD

CM53 Duplicate ECRS Request

CM60 Invalid Medicare ID

CM92 Change of Venue not allowed after 90 days

Note: CM92 refers to a request to change the lead contractor more than 90 days after the initial assignment; this request will be rejected.

Figure 6-6: Prescription Drug Inquiry Search

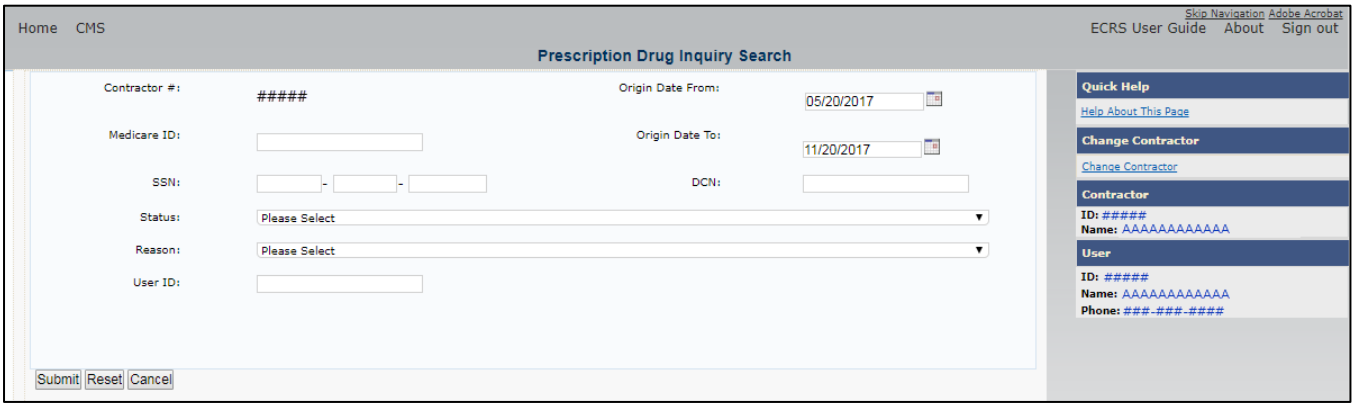

Table 6-11: Prescription Drug Inquiry Search Criteria

Field	Description
CONTRACTOR	If you are a Medicare contractor, this field will be pre-filled with the Contractor Number entered during Contractor Sign In. *(protected field)* If you are a Regional Office or CMS user, this field will be prefilled with the CMS ID/RO Number entered during Contractor Sign In. **Note**: This field is updateable with any Medicare Contractor Number, but only the CMS ID/RO Number entered during Contractor Sign-In can be used.
MEDICARE ID	Enter a Medicare ID (*Mbi*). **Note:** If searching by Medicare ID, do not enter an SSN or DCN.
SSN	Enter a Social Security Number. **Note:** If searching by SSN, do not enter a Medicare ID or DCN.
STATUS	Enter a Status code. To view all in-process Prescription Drug Inquiry transactions, select IP in the STATUS field.
REASON	Select a Reason code. (See Appendix E for the complete list of codes.)
USER ID	Enter a User ID.
ORIGIN DATE FROM	Enter a starting date for the date range, if applicable. **Note:** MMDDCCYY format.
ORIGIN DATE TO	Enter an ending date for the date range. **Note:** The dates in the ORIGIN DATE FROM and TO fields default to the date 31 calendar days prior to the current date and the current date but can be changed to any calendar day range, as long as it is not more than 6 months.
DCN	Enter a Document Control Number. **Note:** If searching by DCN, do not enter a Medicare ID or SSN.
SUBMIT	Click **Submit** to display search results.
RESET	Click **Reset** to clear search results.
CANCEL	Click **Cancel** to return to the Main Menu.

6.6.2 View Transactions

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

1. Type search criteria in the appropriate fields and click **Submit**.

   To create a list of all Prescription Drug Inquiries for a specific Medicare ID, enter the Medicare ID in the search criteria and leave the CONTRACTOR NUMBER field blank.

   When searching by Origin Date, User ID, Status, and/or Reason, you must also enter a DCN, Medicare ID, SSN or Contractor Number.

   The system displays a list of Prescription Drug Inquiries (Figure 6-6). There are up to 500 items per page; scroll through the records or use the **First**, **Previous**, **Next**, and **Last** navigation at the top of the list to view other transactions on other pages.

2. Change or delete search criteria to initiate a new search.

Figure 6-7: Prescription Drug Inquiry Search Listing

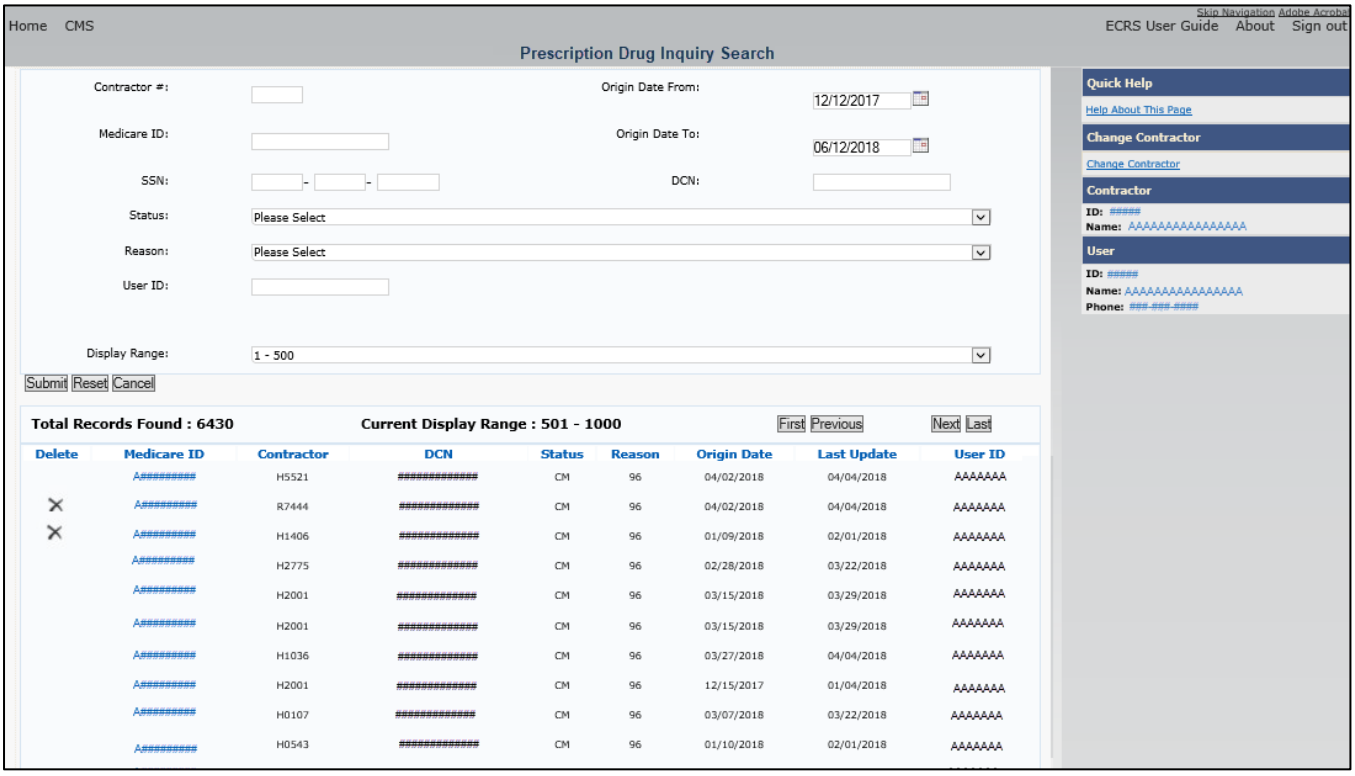

Table 6-12: Prescription Drug Inquiry Search Listing

Field	Description
DISPLAY RANGE	Select a range to filter the display of records in the search results by a defined range. Note: This field is only visible if a search has been completed. The range in the DISPLAY RANGE field defaults to 1-500.
Total Records Found	Total number of records found.
Current Display Range	Defined display range for the records found. Note: This field defaults to 1-500.
DELETE	Click the delete [**X**] link to mark a transaction for deletion
MEDICARE ID	Medicare ID (*Mbi*) for Prescription Drug Inquiry transaction *(protected field)*. Click the **Medicare ID** link to view the Summary page
CONTRACTOR	Contractor number. *(protected field)*
DCN	Document Control Number assigned to the Prescription Drug Inquiry transaction by the Medicare contractor. *(protected field)*

Field	Description
STATUS	Status of the Prescription Drug Inquiry transaction. (*protected field*)
REASON	Two-character code explaining why the Prescription Drug Inquiry is in a particular status. (See Appendix E for the complete list of codes.) *(protected field)*
ORIGIN DATE	Originating date in MM-DD-CCYY format. *(protected field)*
LAST UPDATE	Date the Prescription Drug Inquiry transaction was last changed in MMDDCCYY format. *(protected field)*
USER ID	User ID of the operator who entered the Prescription Drug Inquiry transaction. *(protected field)*
Export options	Click the link to export search results. Note: You may export all results returned, up to 500 records at a time, based on the records currently displayed.

Chapter 7: Reports

7.4 QASP Report

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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 *Quality Assurance Surveillance Plan (QASP)* report provides CMS and RO users with statistics on the number of ECRS Inquiries and Assistance Requests that contractor sites submitted during a date range you specify. The report is sorted by contractor number.

Note: Search results are limited to 3000 transactions, sorted by the most recent Origination Date. If more than 3000 transactions are returned, revise your search criteria.

Follow the steps below to review ECRS Inquiry and Assistance Request statistics for selected contractor sites.

From the Main Menu, click the **Quality Assurance Surveillance Plan (QASP) Report** link in the Reports section. The system displays the QASP Report page.

Enter the desired criteria in the search fields and click **Submit.**

The system re-displays the *QASP Report* page, with report details displayed at the bottom of the page (Figure 7-6).

3. Export the report to a file by clicking the **Export Data** link.
4. Change the search criteria and click **Submit** to re-create the report using the revised criteria. Click **Reset** to clear all search criteria.
5. To exit the QASP Report page, click the **Home** link in the upper navigation bar. This returns you to the Main Menu.

Figure 7-8: QASP Report

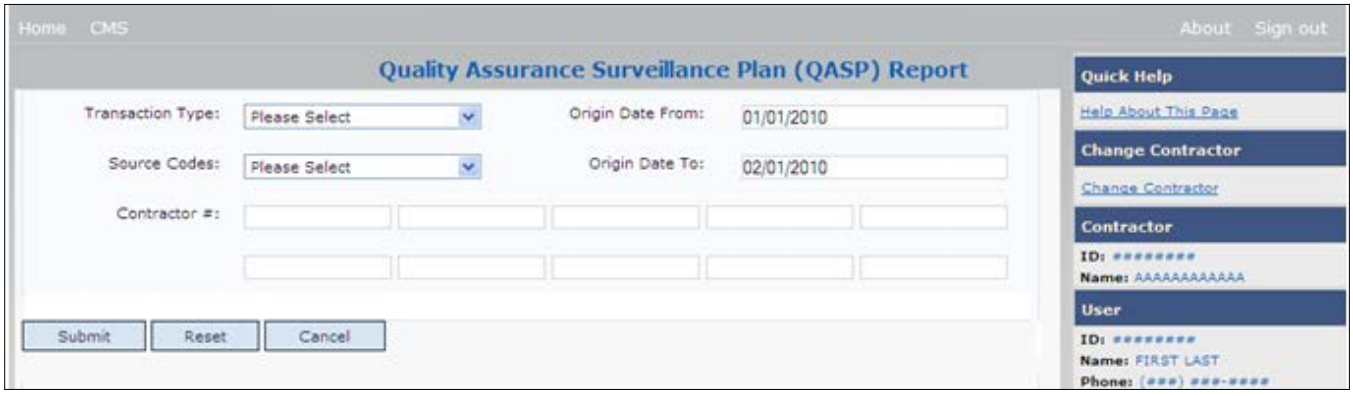

Table 7-13: QASP Report Selection Criteria

Field	Description

Field	Description
TRANSACTION TYPE	Select a transaction type. Options are: M MSP Inquiry R CWF Assistance Request P Prescription Drug Inquiries D Prescription Drug Assistance Requests To search for all transaction types, leave this field blank.
SOURCE CODES	Select a source. Options are: CHEK LTTR SCLM SRVY To search for all SOURCEs, leave this field blank.
ORIGIN DATE FROM	Enter a start date for the reporting period. Defaults to the first day of the previous month.
ORIGIN DATE TO	Enter an end date for the reporting period. Defaults to the last day of the previous month. The origination date range cannot be greater than 6 months.
CONTRACTOR #	Enter a contractor number to display CMS workload statistics for. Leave the field blank to display results for all contractors. Enter at least one, but no more than 10, contractor numbers.
EXPORT DATA	Link. Click to launch the File Save dialog box.
SUBMIT	Command button. Click to create the report using the selected criteria.
RESET	Command button. Click to clear search criteria and results.
CANCEL	Command button. Click to return to the Main Menu.

Figure 7-9: QASP Report Listing

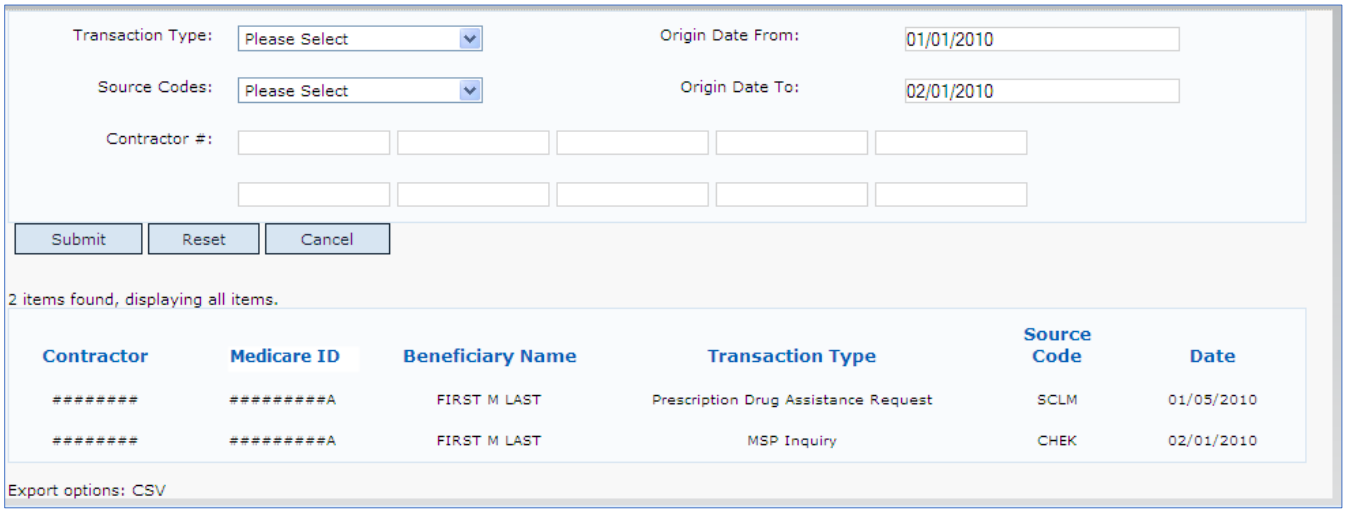

Table 7-14: QASP Report Listing

Field	Description
CONTRACTOR	Unique five-digit contractor numbers assigned to Medicare contractors by CMS. Used to identify Medicare contractors.
MEDICARE ID	Medicare ID (*Mbi*) of the beneficiary associated with the record or transaction.
BENEFICIARY NAME	Name of the beneficiary associated with the record or transaction.

TRANSACTION TYPE	Type of record or transaction.
SOURCE CODE	Source of the record or transaction.
DATE	Origination date of the record or transaction.

Appendix G File Layouts

G.3 CWF Assistance Request Detail Record

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

This record layout **must be used** for **all** CWF Assistance Request file submissions as of 1/1/2014.

Table G-1: CWF Assistance Request Detail Record Layout

Data Field	Length	Type	Displacement	Description
Transaction type	4	Alpha	1 – 4	Set to 'ECRS' **Required**
Contractor Number	5	Alpha-Numeric	5-9	Medicare Contractor (MACs, MA/PD Plans) Number. **Required**
DCN	15	Text	10-24	Document Control Number; assigned by the Medicare Contractor. Required. Each record shall have a unique DCN.
Tran Type Code	1	Alpha	25	Transaction Type Indicator Set to 'R' for CWF Assistance Requests **Required**
Trans Seq No	3	Numeric	26-28	Sequence Number assigned by COB. Internal use only. Populate with spaces.
Update Operator ID	8	Alpha-Numeric	29-36	ID of user making update. Not required
Contractor Name	25	Text	37-61	Contractor name Not required
Contractor Phone	10	Numeric	62-71	Contractor Phone Number Not required
Tran Stat Cd	2	Alpha	72-73	Status Code Set to 'NW' for New
Tran Reason Cd	2	Numeric	74-75	Reason Set to '01' for New

Data Field	Length	Type	Displacement	Description
Trans Action Code 1	2	Alpha	76-77	Action Code. Valid values are: AI = Change Attorney Information AP = Add Policy and/or Group Number AR = Add CWF remark codes CA = CMS Grouping Code CD = Date of Injury/Date of Loss Changes CP = Incorrect ESRD Coordination Period CT = Change termination date DA = Develop to the attorney DD = Develop for the diagnosis code DE = Develop to employer or for employer info DI = Develop to insurer or for insurer info DO = Mark occurrence for deletion DR = Investigate/redevelop closed or deleted record DT = Develop for termination date DX = Change diagnosis codes EA = Change employer address ED = Change effective date EF = Develop for the effective date EI = Change employer information ES = Employer size below minimum (20 for working aged, 100 for disability) ID = Investigate/possible duplicate for deletion II = Change insurer information IT = Change insurer type LR = Add duplicate liability record MT = Change MSP type MX = SSN/MEDICARE ID mismatch NR = Create duplicate no-fault record PH = Add PHP date PR = Change patient relationship TD = Add Termination Date. VP = Beneficiary has taken a vow of poverty WN = Notify BCRC of Updates to WCMSA Cases **Required.** Enter up to four Actions unless the CWF assistance request is DE, DI, DO, DR, ID, or VP. You cannot combine these six Actions with any other action codes.
Trans Action Code 2	2	Alpha-Numeric	78-79	Action Code 2 Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Trans Action Code 3	2	Alpha-Numeric	80-81	Action Code 3 Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Trans Action Code 4	2	Alpha-Numeric	82-83	Action Code 4 Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Activity Code	1	Alpha	84	Activity of Contractor. Valid values are: C = Claims (Prepayment) – 22001 N = Liability, No-Fault, WC, and FTCA - 42002 G = Group Health Plan – 42003 I = General Inquiry – 42004 D = Debt Collection – 42021 **Required**
Develop to	1	Alpha	85	Development source code indicating where development letter was sent. Not required. Populate with spaces if not available.
RSP	1	Alpha	86	Development response indicator. Not required. Populate with spaces if not available.
Trans Source Cd	4	Alpha	87-90	Four-character code identifying source of CWF assistance request information. Valid values are: CHEK = Unsolicited check LTTR = Letter PHON= Phone call SCLM = Claim submitted to Medicare contractor for secondary payment SRVY = Survey CLAM = Claim **Required**
Medicare ID	12	Alpha-Numeric	91-102	Medicare *b*eneficiary *i*dentifier (M*bi*) of beneficiary. Enter without dashes, spaces, or other special characters. **Required** if SSN is not entered.
Beneficiary's Social Security Number	9	Numeric	103-111	Beneficiary's Social Security Number **Required** if Medicare ID not entered.
Beneficiary's Date of Birth	8	Date	112-119	Beneficiary's Date of Birth in CCYYMMDD format Not required. Populate with zeros if not available.
Beneficiary's Sex Code	1	Numeric	120	Sex of beneficiary Valid values are: U = Unknown M = Male F = Female Not required. Populate with spaces if not available.
Beneficiary's First Name	15	Text	121-135	First name of beneficiary. **Required**
Beneficiary's Initial	1	Alpha	136	Middle initial of beneficiary
Beneficiary's Last Name	24	Text	137-160	Last name of beneficiary. **Required**

Data Field	Length	Type	Displacement	Description
Patient Relationship	2	Numeric	161-162	Patient relationship between policyholder and beneficiary Valid values are: 01 = Patient is policy holder 02 = Spouse 03 = Natural child, insured has financial responsibility 04 = Natural child, insured does not have financial responsibility 05 = Stepchild 06 = Foster child 07 = Ward of the Court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 12 = Cadaver donor 13 = Grandchild 14= Niece/nephew 15= Injured plaintiff 16= Sponsored dependent 17= Minor dependent of a minor dependent 18= Parent 19= Grandparent dependent 20= Domestic partner (Effective April, 2004.) **Required** **Note:** For the following MSP TYPEs below, the PATIENT RELATIONSHIP codes listed to the right are the only valid values that can be used. MSP TYPE PATIENT RELATIONSHIP --- A 01, 02 B 01, 02, 03, 04, 05, 18, 20 G 01, 02, 03, 04, 05, 18, 20
MSP Type	1	Alpha	163	One-character code identifying type of MSP coverage Valid values are: A = Working Aged B = ESRD C = Conditional Payment D = Automobile Insurance E = Workers' Compensation F = Federal (Public) G = Disabled H = Black Lung L = Liability W =Workers' Compensation Set-Aside **Required**
MSP Effective Date	8	Date	164-171	Effective date of MSP coverage in CCYYMMDD format. **Required**

Data Field	Length	Type	Displacement	Description
MSP Term Date	8	Date	172-179	Termination date of MSP coverage in CCYYMMDD format. Type one or more zeroes in this field to remove an existing termination date. Type 9 eight times in this field if you have conflicting dates for the termination date. Not required. Populate with zeros if not available.
AUX Row Number	3	Numeric	180-182	AUX record number of MSP record at CWF. **Required**. Populate with zeros if not available.
MSP Accretion Date	8	Date	183-190	Accretion date of MSP coverage in CCYYMMDD format. Not required. Populate with zeros if not available.
Originating Contractor	5	Alpha-Numeric	191-195	Contractor number of contractor that created original MSP occurrence at CWF **Required**
Filler	6	Alpha	196-201	Populate with spaces.
Beneficiary's Address 1	32	Text	202-233	First line of beneficiary's street address. Not required. Populate with spaces if not available.
Beneficiary's Address 2	32	Text	234-265	Second line of beneficiary's street address. Not required. Populate with spaces if not available.
Beneficiary's City	15	Text	266-280	Beneficiary's city Not required. Populate with spaces if not available.
Beneficiary's State	2	Alpha	281-282	Beneficiary's state Not required. Populate with spaces if not available.
Beneficiary's Zip Code	9	Numeric	283-291	Beneficiary's zip code Not required. Populate with spaces if not available.
Beneficiary's Phone	10	Numeric	292-301	Beneficiary's telephone number Not required. Populate with zeros if not available.
Check Date	8	Numeric	302-309	Date of check received in CCYYMMDD format. Required if value in SOURCE field = CHEK. You cannot future-date this field. Populate with zeros if SOURCE field not equal to CHEK.
Check Amount	15	Alpha	310-324	Amount of check received in $999,999,999.99 format. Required if value in SOURCE field = CHEK. Populate with zeros if SOURCE field not equal to CHEK.
Check Number	15	Alpha	325-339	Number of check received. Required if value in SOURCE field = CHEK. Populate with zeros if SOURCE field not equal to CHEK.
Informant's First Name	15	Text	340-354	Name of person informing contractor of change in MSP coverage. Required when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON.
Informant's Middle Initial	1	Alpha	355	Informants middle initial. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Informant's Last Name	24	Text	356-379	Last name of person informing contractor of change in MSP coverage. Required when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON.
Informant's Phone	10	Numeric	380-389	Informant's telephone number Not required. Populate with zeros if not available.
Informant's Address 1	32	Text	390-421	Informant's street address 1 **Required** when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON.
Informant's Address 2	32	Text	422-453	Name of person informing contractor of change in MSP coverage. Not required
Informant's City	15	Text	454-468	Informant's city. **Required** when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON
Informant's State	2	Alpha	469-470	Informant's state **Required** when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON.
Informant's Zip Code	9	Numeric	471-479	Informant's zip code Required when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON.
Informant's Relationship Code	1	Alpha	480	Relationship of informant to beneficiary. Valid values are: A = Attorney representing beneficiary B = Beneficiary C = Child D = Defendant's attorney E = Employer F = Father I = Insurer M = Mother N = Non-relative O = Other relative P = Provider R = Beneficiary representative other than attorney S = Spouse U = Unknown Required when SOURCE is CHEK, LTTR or PHON. Populate with spaces if Source field not equal to CHEK, LTTR or PHON.
Employer's Name	32	Text	481-512	Name of employer providing group health insurance under which beneficiary is covered Not required. Populate with spaces if not available.
Employer EIN	18	Text	513-530	Employer's Identification Number Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Employer's Address 1	32	Text	531-562	Employer's Street Address 1 Not required. Populate with spaces if not available.
Employer's Address 2	32	Text	563-594	Employer's Street Address 2 Not required. Populate with spaces if not available.
Employer's Phone	10	Numeric	595-604	Employer's Telephone Number Not required. Populate with spaces if not available.
Employer's City	15	Text	605-619	Employer's City Not required. Populate with spaces if not available.
Employer's State	2	Alpha	620-621	Employer's State Not required. Populate with spaces if not available.
Employer's ZIP Code	9	Numeric	622-630	Employer's Zip Code Not required. Populate with spaces if not available.
Employee No	12	Text	631-642	Employee Number of Policy Holder Not required. Populate with spaces if not available.
Insurer's name	32	Text	643-674	Name of insurance carrier for MSP coverage Required for II ACTION. Populate with spaces if ACTION not equal to II.
Insurer Type	1	Alpha	675	Type of Insurance A = Insurance or Indemnity (Other Types) B = Group Health Organization (GHO) C = Preferred Provider Organization D = TPA/ASO E = Stop Loss TPA F = Self-insured/Self-Administered (Self-Insured) G = Collectively-bargained Health and Welfare Fund H = Multiple Employer Health Plan with 100 or more employees. I = Multiple Employer Health Plan with 20 or more employees. J = Hospitalization only plan covering inpatient hospital K = Medical Service only plan covering non-inpatient medical M = Medicare Supplement Plan U = Unknown Not required. Populate with A if not available.
Insurer's Address 1	32	Text	676-707	Insurer's street address 1 Not required. Populate with spaces if not available.
Insurer's Address 2	32	Text	708-739	Insurer's street address 2 Not required. Populate with spaces if not available.
Insurer's City	15	Text	740-754	Insurer's city Not required. Populate with spaces if not available.
Insurer's State	2	Alpha	755-756	Insurer's state Not required. Populate with spaces if not available.
Insurer's ZIP Code	9	Numeric	757-765	Insurer's zip code Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Insurer's Phone	10	Numeric	766-775	Insurer's telephone number Not required. Populate with zeros if not available.
Insurer Group Number	20	Text	776-795	Group number of insurance coverage. Not required. Populate with spaces if not available.
Insurer Policy Number	17	Text	796-812	Policy number of insurance coverage. Not required. Populate with spaces if not available.
Subscriber First Name	15	Text	813-827	First name of individual covered by this insurance. Not required. Populate with spaces if not available.
Subscriber Initial	1	Alpha	828	Middle initial of individual covered by this insurance. Not required. Populate with spaces if not available.
Subscriber Last Name	24	Text	829-852	Last name of individual covered by this insurance. Not required. Populate with spaces if not available.
PHP Date	8	Date	853-860	Pre-paid Health Plan date in CCYYMMDD format. Not required. Populate with zeros if not available.
Remarks Code 1	2	Alpha-Numeric	861-862	Two-character CWF remark code explaining reason for transaction. See Appendix F for a list of remark codes. Not required. Populate with spaces if not available.
Remarks Code 2	2	Alpha-Numeric	863-864	Two-character CWF remark code explaining reason for transaction. See Appendix F for a list of remark codes. Not required. Populate with spaces if not available.
Remarks Code 3	2	Alpha-Numeric	865-866	Two-character CWF remark code explaining reason for transaction. See Appendix F for a list of remark codes. Not required. Populate with spaces if not available.
Filler	25	Filler	867-891	Filler
Submitter Type	1	Alpha	892	Part C/D Submitter Indicator Valid Values 'C' = Part C Contractor 'D' = Part D Contractor If not valid value, drop file with error code HE06.
Filler	7	Filler	893-899	Filler
Trans Comment	180	Text	900-1079	Comments—Used by Submitter
Filler	8	Filler	1080-1087	Filler

Data Field	Length	Type	Displacement	Description
New Patient Relationship	2	Numeric	1088-1089	Patient relationship between policyholder and beneficiary Valid values are: 01 Patient is policy holder 02 Spouse 03 Natural child, insured has financial responsibility 04 Natural child, insured does not have financial responsibility 05 Stepchild 06 Foster child 07 Ward of the Court 08 Employee 09 Unknown 10 Handicapped dependent 11 Organ donor 12 Cadaver donor 13 Grandchild 14 Niece/nephew 15 Injured plaintiff 16 Sponsored dependent 17 Minor dependent of a minor dependent 18 Parent 19 Grandparent dependent 20 Domestic partner (Effective April, 2004.) **Required** when Action is PR. **Note:** For the following MSP Types below, the patient relationship codes listed to the right are the only valid values that can be used. MSP TYPE PATIENT RELATIONSHIP --- A 01, 02 B 01, 02, 03, 04, 05, 18, 20 G 01, 02, 03, 04, 05, 18, 20
New MSP Type	1	Alpha	1090	One-character code identifying type of MSP coverage Valid values are: A = Working Aged B = ESRD C = Conditional Payment D = Automobile Insurance E = Workers' Compensation F = Federal (Public) G = Disabled H = Black Lung L = Liability **Required** when Action is MT.
New MSP Effective Date	8	Date	1091-1098	Effective date of MSP coverage in CCYYMMDD format. **Required** when Action is ED.

Data Field	Length	Type	Displacement	Description
New Insurer Type	1	Alpha	1099	Type of Insurance A = Insurance or Indemnity (Other Types) B = Group Health Organization (GHO) C = Preferred Provider Organization D = TPA/ASO E = Stop Loss TPA F = Self-insured/Self-Administered (Self-Insured) G = Collectively-bargained Health and Welfare Fund H = Multiple Employer Health Plan with 100 or more employees. I = Multiple Employer Health Plan with 20 or more employees. J = Hospitalization only plan covering inpatient hospital K = Medical Service only plan covering non-inpatient medical M = Medicare Supplement Plan U = Unknown **Required** when Action is IT
Diagnosis Code 1 ICD Indicator	1	Numeric	1100	One-digit diagnosis code indicator to identify whether the submitted Diagnosis Code 1 is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1A and the record will be dropped. **Required if Diagnosis Code 1 is submitted**.
Diagnosis Code 1	7	Text	1101 – 1107	ICD-9-CM Diagnosis Code or ICD-10-CM diagnosis code that applies to this MSP occurrence. Required if Action code is CA or CL. **Required if Diagnosis Code 1 ICD Indicator is submitted.** If Diagnosis Code 1 ICD Indicator = 0, Diagnosis Code 1 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 1 ICD Indicator = 9, Diagnosis Code 1 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. * Refer to Appendix B for complete set of *required field*s for various source codes. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE69 and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 2 ICD Indicator	1	Numeric	1108	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1B and the record will be dropped. **Required if Diagnosis Code 2 is submitted.**
Diagnosis Code 2	7	Text	1109 -1115	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 2 ICD Indicator is submitted.** If Diagnosis Code 2 ICD Indicator = 0, Diagnosis Code 2 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 2 ICD Indicator = 9, Diagnosis Code 2 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE70 and the record will be dropped.
Diagnosis Code 3 ICD Indicator	1	Numeric	1116	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1C and the record will be dropped. **Required if Diagnosis Code 3 is submitted.**
Diagnosis Code 3	7	Text	1117 – 1123	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 3 ICD Indicator is submitted.** If Diagnosis Code 3 ICD Indicator = 0, Diagnosis Code 3 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 3 ICD Indicator = 9, Diagnosis Code 3 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE71 and the record will be dropped. Not required.
Diagnosis Code 4 ICD Indicator	1	Numeric	1124	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1D and the record will be dropped. **Required if Diagnosis Code 4 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 4	7	Text	1125 - 1131	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 4 ICD Indicator is submitted.** If Diagnosis Code 4 ICD Indicator = 0, Diagnosis Code 4 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 4 ICD Indicator = 9, Diagnosis Code 4 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE72 and the record will be dropped.
Diagnosis Code 5 ICD Indicator	1	Numeric	1132	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1E and the record will be dropped. **Required if Diagnosis Code 5 is submitted.**
Diagnosis Code 5	7	Text	1133 - 1139	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 5 ICD Indicator is submitted**. If Diagnosis Code 5 ICD Indicator = 0, Diagnosis Code 5 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 5 ICD Indicator = 9, Diagnosis Code 5 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE73 and the record will be dropped.
Diagnosis Code 6 ICD Indicator	1	Numeric	1140	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1F and the record will be dropped. **Required if Diagnosis Code 6 is submitted.**

Data Field	Length	Type	Displacement	Description
Diagnosis Code 6	7	Text	1141 – 1147	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 6 ICD Indicator is submitted.** If Diagnosis Code 6 ICD Indicator = 0, Diagnosis Code 6 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 6 ICD Indicator = 9, Diagnosis Code 6 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1G and the record will be dropped.
Diagnosis Code 7 ICD Indicator	1	Numeric	1148	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1H and the record will be dropped. **Required if Diagnosis Code 7 is submitted**.
Diagnosis Code 7	7	Text	1149 – 1155	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 7 ICD Indicator is submitted**. If Diagnosis Code 7 ICD Indicator = 0, Diagnosis Code 7 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 7 ICD Indicator = 9, Diagnosis Code 7 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1I and the record will be dropped.
Diagnosis Code 8 ICD Indicator	1	Numeric	1156	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM If an invalid code is entered, the user will see error code PE1J and the record will be dropped. **Required if Diagnosis Code 8 is submitted.**

Data Field	Length	Type	Displacement	Description
Diagnosis Code 8	7	Text	1157 – 1163	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 8 ICD Indicator is submitted**. If Diagnosis Code 8 ICD Indicator = 0, Diagnosis Code 8 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 8 ICD Indicator = 9, Diagnosis Code 8 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1K and the record will be dropped.
Diagnosis Code 9 ICD Indicator	1	Numeric	1164	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1L and the record will be dropped. **Required if Diagnosis Code 9 is submitted**.
Diagnosis Code 9	7	Text	1165 – 1171	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 9 ICD Indicator is submitted.** If Diagnosis Code 9 ICD Indicator = 0, Diagnosis Code 9 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 9 ICD Indicator = 9, Diagnosis Code 9 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1M and the record will be dropped.
Diagnosis Code 10 ICD Indicator	1	Numeric	1172	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1N and the record will be dropped. **Required if Diagnosis Code 10 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 10	7	Text	1173 – 1179	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 10 ICD Indicator is submitted**. If Diagnosis Code 10 ICD Indicator = 0, Diagnosis Code 10 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 10 ICD Indicator = 9, Diagnosis Code 10 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1O and the record will be dropped.
Diagnosis Code 11 ICD Indicator	1	Numeric	1180	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1P and the record will be dropped. **Required if Diagnosis Code 11 is submitted.**
Diagnosis Code11	7	Text	1181 – 1187	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 11 ICD Indicator is submitted**. If Diagnosis Code 11 ICD Indicator = 0, Diagnosis Code 11 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 11 ICD Indicator = 9, Diagnosis Code 11 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1Q and the record will be dropped.
Diagnosis Code 12 ICD Indicator	1	Numeric	1188	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1R and the record will be dropped. **Required if Diagnosis Code 12 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 12	7	Text	1189 – 1195	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 12 ICD Indicator is submitted.** If Diagnosis Code 12 ICD Indicator = 0, Diagnosis Code 12 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 12 ICD Indicator = 9, Diagnosis Code 12 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1S and the record will be dropped.
Diagnosis Code 13 ICD Indicator	1	Numeric	1196	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1T and the record will be dropped. **Required if Diagnosis Code 13 is submitted**.
Diagnosis Code 13	7	Text	1197 – 1203	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 13 ICD Indicator is submitted.** If Diagnosis Code 13 ICD Indicator = 0, Diagnosis Code 13 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 13 ICD Indicator = 9, Diagnosis Code 13 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1U and the record will be dropped.
Diagnosis Code 14 ICD Indicator	1	Numeric	1204	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1V and the record will be dropped. **Required if Diagnosis Code 14 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 14	7	Text	1205 – 1211	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 14 ICD Indicator is submitted.** If Diagnosis Code 14 ICD Indicator = 0, Diagnosis Code 14 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 14 ICD Indicator = 9, Diagnosis Code 14 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1W and the record will be dropped.
Diagnosis Code 15 ICD Indicator	1	Numeric	1212	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1X and the record will be dropped. **Required if Diagnosis Code 15 is submitted**.
Diagnosis Code 15	7	Text	1213 – 1219	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 15 ICD Indicator is submitted.** If Diagnosis Code 15 ICD Indicator = 0, Diagnosis Code 15 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 15 ICD Indicator = 9, Diagnosis Code 15 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1Y and the record will be dropped.
Diagnosis Code 16 ICD Indicator	1	Numeric	1220	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1Z and the record will be dropped. **Required if Diagnosis Code 16 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 16	7	Text	1221 – 1227	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 16 ICD Indicator is submitted**. If Diagnosis Code 16 ICD Indicator = 0, Diagnosis Code 16 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 16 ICD Indicator = 9, Diagnosis Code 16 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2A and the record will be dropped.
Diagnosis Code 17 ICD Indicator	1	Numeric	1228	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2B and the record will be dropped. **Required if Diagnosis Code 17 is submitted**.
Diagnosis Code 17	7	Text	1229 – 1235	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 17 ICD Indicator is submitted.** If Diagnosis Code 17 ICD Indicator = 0, Diagnosis Code 17 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 17 ICD Indicator = 9, Diagnosis Code 17 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2C and the record will be dropped.
Diagnosis Code 18 ICD Indicator	1	Numeric	1236	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2D and the record will be dropped. **Required if Diagnosis Code 18 is submitted.**

Data Field	Length	Type	Displacement	Description
Diagnosis Code 18	7	Text	1237 – 1243	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 18 ICD Indicator is submitted.** If Diagnosis Code 18 ICD Indicator = 0, Diagnosis Code 18 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 18 ICD Indicator = 9, Diagnosis Code 18 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2E and the record will be dropped.
Diagnosis Code 19 ICD Indicator	1	Numeric	1244	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2F and the record will be dropped. **Required if Diagnosis Code 19 is submitted**.
Diagnosis Code 19	7	Text	1245 – 1251	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 19 ICD Indicator is submitted.** If Diagnosis Code 19 ICD Indicator = 0, Diagnosis Code 19 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 19 ICD Indicator = 9, Diagnosis Code 19 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2G and the record will be dropped.
Diagnosis Code 20 ICD Indicator	1	Numeric	1252	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2H and the record will be dropped. **Required if Diagnosis Code 20 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 20	7	Text	1253 – 1259	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 20 ICD Indicator is submitted**. If Diagnosis Code 20 ICD Indicator = 0, Diagnosis Code 20 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 20 ICD Indicator = 9, Diagnosis Code 20 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2I and the record will be dropped.
Filler	8	Filler	1260 – 1267	Filler

Prescription Drug Assistance Request Detail Record

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Table G-2: Prescription Drug Assistance Request Detail Record Layout

Data Field	Length	Type	Displacement	Description
Transaction type	4	Alpha	1-4	Set to 'ECRS'
Contractor Number	5	Alpha-Numeric	5-9	Part C/D Plan Contractor Number **Required**
DCN	15	Alpha-Numeric	10-24	Document Control Number: assigned by the Part C/D plan. **Required**. Each record shall have a unique DCN.
Trans Type Code	1	Alpha	25	Transaction Type Indicator Set to 'D' for Prescription Drug Assistance Requests **Required**
Trans Seq. No	3	Numeric	26-28	Sequence Number assigned by the COB. Internal use only. Populate with spaces.
Update Operator ID	8	Alpha-Numeric	29-36	ID of user making update. Not required
Contractor Name	25	Alpha-Numeric	37-61	Contractor name Not required
Contractor Phone	10	Numeric	62-71	Contractor phone number Not required
Trans Status Code	2	Alpha	72-73	Transaction Status Code: Set to 'NW' for New
Trans Reason Code	2	Numeric	74-75	Transaction Reason Code: Set to '01' for New

Data Field	Length	Type	Displacement	Description
Action Code 1	2	Alpha	76-77	Two-character code defining action to take on Prescription Drug record (*required field*). Valid values are: AP = Add Policy and/or Group Number BN = Develop for RX BIN CT = Change termination date CX = Change RX Values (BIN, Group, PCN) DO = Mark occurrence for deletion EA = Change employer address ED = Change effective date EI = Change employer information GR = Develop for Group Number IT = Change insurer type MT = Change MSP type PC = Update RX Person Code PN = Develop for/add PCN PR = Change patient relationship TD = Add Termination Date II Change Insurer Information **Notes:** Action Code II cannot be used with Action Code DO. *The following action codes can be combined together, but not with any other action codes:* BN = Develop for RX BIN GR = Develop for Group Number PN = Develop for/add PCN *Prescription Drug Assistance Request with the following action codes will be automatically processed, given they have no reject errors:* AP Add Policy Number/Group Number CX Change RX Values (BIN, Group, PCN) DO Delete Occurrence TD Add Termination Date
Action Code 2	2	Alpha	78-79	Transaction Action Code 2: Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Action Code 3	2	Alpha	80-81	Transaction Action Code 3: Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Action Code 4	2	Alpha	82-83	Transaction Action Code 4: Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Activity Code	1	Alpha	84	Activity of Contractor: Valid values are: C = Claims (Prepayment) – 22001 N = Liability, No-Fault, WC, and FTCA - 42002 G = Group Health Plan – 42003 I = General Inquiry – 42004 D = Debt Collection – 42021 **Required**
Trans Source Code	4	Alpha	85-88	Four-character code identifying source of RX DRUG assistance request information Valid values are: CHEK = Unsolicited check LTTR = Letter PHON = Phone call SCLM = Claim submitted to Medicare contractor for secondary payment SRVY = Survey CLAM =Claim **Required**
Medicare ID	12	Alpha-Numeric	89-100	Medicare *b*eneficiary *i*dentifier (M*bi*) of beneficiary. Enter without dashes, spaces, or other special characters.
Beneficiary Date of Birth	8	Date	101-108	Beneficiary's Date of Birth in CCYYMMDD format Not Required. Populate with zeros if not available.
Beneficiary Sex Code	1	Alpha	109	Sex of Beneficiary: Valid values are: U = Unknown M = Male F = Female Not required. Populate with spaces if not available.
Beneficiary First Name	15	Text	110-124	First Name of beneficiary **Required**
Beneficiary Middle Initial	1	Text	125	Middle Initial of beneficiary
Beneficiary Last Name	24	Text	126-149	Last Name of beneficiary **Required**
Beneficiary Address Line 1	32	Text	150-181	First line of beneficiary's street address.
Beneficiary Address Line 2	32	Text	182-213	Second line of beneficiary's street address
Beneficiary City	15	Text	214-228	Beneficiary's city
Beneficiary State	2	Alpha	229-230	Beneficiary's state
Beneficiary Zip code	9	Numeric	231-239	Beneficiary's zip code
Beneficiary Phone	10	Numeric	240-249	Beneficiary's telephone number

Data Field	Length	Type	Displacement	Description
Patient Relationship	2	Numeric	250-251	Patient relationship between policyholder and beneficiary Required when Record Type is Primary Valid values are: 01 Patient is policy holder 02 Spouse 03 Natural child, insured has financial responsibility 04 Natural child, insured does not have financial responsibility 05 Stepchild 06 Foster child 07 Ward of the Court 08 Employee 09 Unknown 10 Handicapped dependent 11 Organ donor 12 Cadaver donor 13 Grandchild 14 Niece/nephew 15 Injured plaintiff 16 Sponsored dependent 17 Minor dependent of a minor dependent 18 Parent 19 Grandparent dependent 20 Domestic partner (Effective April, 2004.) For the following MSP Types, the patient relationship codes listed to the right are the only valid values that can be used: MSP TYPE PATIENT RELATIONSHIP --- A 01, 02 B 01, 02, 03, 04, 05, 18, 20 G 01, 02, 03, 04, 05, 18, 20
New Patient Relationship	2	Numeric	252-253	New patient relationship between policyholder and beneficiary. Description of code displays next to value **Required** when ACTION is PR
Person Code	3	Numeric	254-256	Plan-specific Person Code. Values are: 001 Self 002 Spouse 003 Other **Required** when: RECORD TYPE is Supplemental ACTION is PC

Data Field	Length	Type	Displacement	Description
MSP Type	1	Alpha	257	One-character code identifying type of MSP coverage. Valid values are: A = Working Aged B = ESRD C = Conditional Payment D = Automobile Insurance E = Workers' Compensation F = Federal (Public) G = Disabled H = Black Lung L = Liability W =Workers' Compensation Set-Aside **Required** when Action is MT.
New MSP Type	1	Alpha	258	One-character code identifying new type of MSP coverage. **Required** when Action is MT.
Record Type	3	Alpha-Numeric	259-261	Drug Record Type PRI Primary SUP Supplemental **Required**
Drug Coverage Effective Date	8	Date	262-269	Effective date of Drug coverage in CCYYMMDD format.
New Drug Coverage Effective Date	8	Date	270-277	New Effective date of Drug coverage in CCYYMMDD format
Term Date	8	Date	278-285	Termination date of Drug coverage in CCYYMMDD format.
Originating Contractor	5	Alpha-Numeric	286-290	Contractor number of contractor that created original Drug occurrence
Informant First Name	15	Text	291-305	Name of person informing contractor of change in Drug coverage. **Required** when SOURCE is CHEK or LTTR. Populate with spaces if Source field not equal to CHEK or LTTR.
Informant Middle Initial	1	Text	306	Informants middle initial.
Informant Last Name	24	Text	307-330	Last name of person informing contractor of change in Drug coverage. **Required** when SOURCE is CHEK or LTTR. Populate with spaces if Source field not equal to CHEK or LTTR.
Informant Address	32	Text	331-362	Informant's street address **Required** when SOURCE is CHEK or LTTR. Populate with spaces if Source field not equal to CHEK or LTTR.
Informant City	15	Text	363-377	Informant's city **Required** when SOURCE is CHEK or LTTR. Populate with spaces if SOURCE field not equal to CHEK or LTTR.

Data Field	Length	Type	Displacement	Description
Informant State	2	Text	378-379	Informant's state **Required** when SOURCE is CHEK or LTTR. Populate with spaces if SOURCE field not equal to CHEK or LTTR.
Informant Zip code	9	Numeric	380-388	Informant's zip code **Required** when SOURCE is CHEK or LTTR. Populate with spaces if SOURCE field not equal to CHEK or LTTR.
Informant Phone	10	Numeric	389-398	Informant's telephone number Not Required. Populate with spaces if not available.
Informant's Relationship Code	1	Alpha	399	Relationship of informant to beneficiary. Valid values are: A = Attorney representing beneficiary B = Beneficiary C = Child D = Defendant's attorney E = Employer F = Father I = Insurer M = Mother N = Non-relative O = Other relative P = Provider R = Beneficiary representative other than attorney S = Spouse U =Unknown **Required** when SOURCE is CHEK or LTTR. Populate with spaces if SOURCE field not equal to CHEK or LTTR.
Employers Name	32	Text	400-431	Name of employer providing group health insurance under which beneficiary is covered Not required. Populate with spaces if not available.
Employers Address 1	32	Text	432-463	Employer's Street Address 1 Not required. Populate with spaces if not available.
Employers Address 2	32	Text	464-495	Employer's Street Address 2 Not required. Populate with spaces if not available.
Employers City	15	Text	496-510	Employer's City Not required. Populate with spaces if not available.
Employers State	2	Alpha	511-512	Employer's State Not required. Populate with spaces if not available.
Employers Zip code	9	Numeric	513-521	Employer's Zip code Not required. Populate with spaces if not available.
Employers Phone	10	Numeric	522-531	Employer's Phone Number Not required. Populate with spaces if not available.
Employers EIN	18	Text	532-549	Employer's Identification Number Not required. Populate with spaces if not available.
Employee Number	12	Text	550-561	Employee Number of Policy Holder Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Supplemental Type	1	Alpha-Numeric	562	Prescription Drug policy type. Valid values are: L Supplemental M Medigap N Non-qualified State Program O Other P PAP R Charity T Federal Government Programs 1 Medicaid 2 Tricare 3 Major Medical
RX Drug Coverage Type	1	Alpha-Numeric	563	Prescription Drug Coverage Type Prescription Drug Coverage Type of Insurance. Valid Values are: U Drug Network V Drug Non-network Z Health account (such as a flexible spending account provided by other party to pay prescription drug costs or premiums) **Required**
Insurance Company Name	32	Text	564-595	Name of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. Action Code II cannot be used with Action Code DO.
Insurance Company Address 1	32	Text	596-627	Address 1 of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered.
Insurance Company Address 2	32	Text	628-659	Address 2 of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered.
Insurance Company City	15	Text	660-674	City of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered.
Insurance Company State	2	Alpha	675-676	State of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered.
Insurance Company Zip code	9	Numeric	677-685	Zip code of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered.

Data Field	Length	Type	Displacement	Description
Insurer Type	1	Alpha	686	Type of Insurance A Insurance or Indemnity (Other Types) B Group Health Organization (GHO) C Preferred Provider Organization D TPA/ASO E Stop Loss TPA F Self-insured/Self-Administered (Self-Insured) G Collectively-bargained Health and Welfare Fund H Multiple Employer Health Plan with 100 or more employees. I Multiple Employer Health Plan with 20 or more employees. J Hospitalization only plan covering inpatient hospital K Medical Service only plan covering non-inpatient medical M Medicare Supplement Plan U Unknown **Required** when ACTION is IT
New Insurer Type	1	Alpha	687	New Type of Insurance **Required** when ACTION is IT
Policy Number	17	Text	688-704	Prescription Drug Policy Number
RX BIN	6	Text	705-710	Prescription Drug BIN Number
RX PCN	10	Text	711-720	Prescription Drug PCN Number
RX Group	15	Text	721-735	Prescription Drug Group Number
RX ID	20	Text	736-755	Prescription Drug ID Number
RX Phone	10	Numeric	756-765	Prescription Drug Phone Number
Check Amount	15	Alpha-Numeric	766-780	Amount of check received in $999,999,999.99 format. **Required** if value in SOURCE field = CHEK Populate with zeros if Source field not equal to CHEK.
Check Date	8	Date	781-788	Date of check received in CCYYMMDD format **Required** if value in SOURCE field = CHEK Populate with zeros if Source field not equal to CHEK.
Check Number	15	Alpha-Numeric	789-803	Number of check received. **Required** if value in SOURCE field = CHEK Populate with zeros if Source field not equal to CHEK.
Remark Code 1	2	Alpha-Numeric	804-805	Two-character PDR remark code explaining reason for transaction. Not Required
Remark Code 2	2	Alpha-Numeric	806-807	Two-character PDR remark code explaining reason for transaction. Not Required

Data Field	Length	Type	Displacement	Description
Remark Code 3	2	Alpha-Numeric	808-809	Two-character PDR remark code explaining reason for transaction. Not Required
Comment ID	8	Alpha-Numeric	810-817	ID of operator entering trans comments—Used by Submitter
Trans Comment	180	Text	818-997	Comments—Used by Submitter
Filler	270	Filler	998 -1267	Unused Field – fill with spaces

MSP Inquiry Detail Record

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

This record layout **must be used** for **all** MSP Inquiry file submissions as of 1/1/2014.

Table G-3: MSP Inquiry Detail Record Layout

Data Field	Length	Type	Displacement	Description
Transaction type	4	Alpha	1 – 4	Type of Record Set to 'ECRS' **Required**
Contractor Number	5	Alpha-Numeric	5-9	Medicare Contractor (MACs, MA/PD Plans) Number. **Required**
DCN	15	Text	10-24	Document Control Number; assigned by the Medicare Contractor. Required. Each record shall have a unique DCN.
Tran Type Code	1	Alpha	25	Transaction Type Indicator Set to 'I' for MSP Inquiry **Required**
Trans Seq No	3	Numeric	26-28	Sequence Number assigned by the COB. Internal use only. Populate with spaces.
Update Operator ID	8	Alpha-Numeric	29-36	ID of user making update. Not required
Contractor Name	25	Text	37-61	Contractor name Not required
Contractor Phone	10	Numeric	62-71	Contractor Phone Number Not required
Tran Stat Cd	2	Alpha	72-73	Status Code Set to 'NW' for New
Tran Reason Cd	2	Numeric	74-75	Reason Set to '01' for New

Data Field	Length	Type	Displacement	Description
Trans Action Code 1	2	Alpha	76-77	Action Code 1 Valid values are: CA CMS Grouping Code CL Closed or Settled Case DE Develop to employer or for employer info DI Develop to insurer or for insurer info Not required. Populate with spaces if not available.
Trans Action Code 2	2	Alpha-Numeric	78-79	Action Code 2 Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Trans Action Code 3	2	Alpha-Numeric	80-81	Action Code 3 Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Trans Action Code 4	2	Alpha-Numeric	82-83	Action Code 4 Valid values same as Trans Action Code 1. Not required. Populate with spaces if not available.
Activity Code	1	Alpha	84	Activity of Contractor. Valid values are: C = Claims (Prepayment) – 22001 N = Liability, No-Fault, WC, and FTCA - 42002 G = Group Health Plan – 42003 I = General Inquiry – 42004 D = Debt Collection – 42021 **Required**
First Development	1	Alpha	85	Development source code indicating where initial development letter was sent. Valid values are: A = Attorney B = Beneficiary E = Employer I = Insurer P = Provider R = Beneficiary Representative (other than attorney) Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Second Development	1	Alpha	86	Development source code indicating where subsequent development letter was sent. Valid values are: A Attorney B Beneficiary E Employer I Insurer P Provider R Beneficiary Representative (other than attorney) Not required. Populate with spaces if not available.
RSP	1	Alpha	87	Development response indicator. Valid values are: A Attorney B Beneficiary E Employer I Insurer P Provider R Beneficiary Representative Not required. Populate with spaces if not available.
Trans Source Cd	4	Alpha	88-91	Four-character code identifying source of MSP inquiry information. Valid values are: CHEK = Unsolicited check LTTR = Letter PHON = Phone call SCLM = Claim submitted to Medicare contractor for secondary payment SRVY = Survey CLAM = Claim **Required**
Medicare ID	12	Alpha-Numeric	92-103	Medicare *b*eneficiary *i*dentifier (M*bi*). Enter without dashes, spaces, or other special characters. **Required** if SSN is not entered.
Beneficiary's Social Security Number	9	Numeric	104-112	Beneficiary's Social Security Number **Required** if Medicare ID not entered.
Beneficiary's Date of Birth	8	Date	113-120	Beneficiary's Date of Birth in CCYYMMDD format Required
Beneficiary's Sex Code	1	Alpha	121	Sex of beneficiary Valid values are: U = Unknown M = Male F = Female **Required**. Default to U if unavailable.

Data Field	Length	Type	Displacement	Description
Beneficiary's First Name	15	Text	122-136	Beneficiary's First Name **Required**
Beneficiary's Initial	1	Alpha	137	Beneficiary's Middle Initial Not required
Beneficiary's Last Name	24	Text	138-161	Beneficiary's Last Name **Required**
Patient Relationship	2	Numeric	162-163	Patient Relationship between policyholder and patient. Valid values are: 01 = Patient is policy holder 02 = Spouse 03 = Natural child, insured has financial responsibility 04 = Natural child, insured does not have financial responsibility 05 = Stepchild 06 = Foster child 07 = Ward of the Court 08 = Employee 09 = Unknown 10 = Handicapped dependent 11 = Organ donor 12 = Cadaver donor 13 = Grandchild 14 = Niece/nephew 15 = Injured plaintiff 16 = Sponsored dependent 17 = Minor dependent of a minor dependent 18 = Parent 19 = Grandparent dependent 20 = Domestic partner (Effective April, 2004.) Not required. Populate with zeros if not available **Note:** For the following MSP Types below, the patient relationship codes listed to the right are the only valid values that can be used. MSP Type Patient Relationship --- A 01, 02 B 01, 02, 03, 04, 05, 18, 20 G 01, 02, 03, 04, 05, 18, 20

Data Field	Length	Type	Displacement	Description
MSP Type	1	Alpha	164	One-character code identifying type of MSP coverage. Valid values are: A Working Aged B ESRD C Conditional Payment D Automobile Insurance E Workers' Compensation F Federal (Public) G Disabled H Black Lung L Liability **Required**
MSP Effective Date	8	Date	165-172	Effective date of MSP coverage in CCYYMMDD format, cannot equal termination date. Not required. Populate with zeros if not available.
MSP Term Date	8	Date	173-180	Termination date of MSP coverage in CCYYMMDD format, cannot equal Effective Date. Not required. Populate with zeros if not available.
Send CWF	1	Alpha	181	Indicates whether to send MSP inquiry to CWF. Valid values are: Y Send to CWF (default unless ACTION(s) field = DE or DI or INFMT REL field = D, in which case default is N and this is a *protected field*) N Do not send to CWF For EGHP MSP Types: In addition to the minimum HUSP fields, the EMPLR NAME, STREET, CITY, ST, and ZIP fields are required or the system will set this switch to N and develop the record.

Data Field	Length	Type	Displacement	Description
CMS Grouping Code	2	Alpha	182-183	CMS Grouping Code 01 = Gel Implants (Trailblazers, 00400) 02 = Gel Implants (Alabama, 00010) 03 = Bone screw recoveries 04 = Diet drug recoveries 05 = Sulzer Inter-op Acetabular shells for hip implant recoveries 06 = Sulzer orthopedic and defective knee replacement recoveries 07 = Baycol litigation use beneficiary state logic for lead assignment 08 = Dexatrim (90000) 09 = Rhode Island receivership recoveries (00180) 10 = Propulsid (00010) 11 = Asbestos Exposure 12 = Garretson Asbestos Cases 13 = Fleet Phosphate 14 = Accutane 15 = Garretson - Traysol 16 = Zelnorm 17 = Total Body Supplement TBS 18 = Hormone Replacement Therapy – HRT 19 = Keugl Mesh Not required. Populate with spaces if not available.
Beneficiary's Address 1	32	Text	184-215	Beneficiary's Address 1 Not required. Populate with spaces if not available.
Beneficiary's Address 2	32	Text	216-247	Beneficiary's Address 2 Not required. Populate with spaces if not available
Beneficiary's City	15	Text	248-262	Beneficiary's City Not required. Populate with spaces if not available.
Beneficiary's State	2	Alpha	263-264	Beneficiary's State Not required. Populate with spaces if not available.
Beneficiary's Zip Code	9	Numeric	265-273	Beneficiary's Zip Code Not required. Populate with spaces if not available
Beneficiary's Phone	10	Numeric	274-283	No edits other than data type edits. If not valid, drop the record with edit code 'PE20'.
Check Date	8	Numeric	284-291	Date of check in CCYYMMDD format. **Required** if Source is CHEK

Data Field	Length	Type	Displacement	Description
Check Amount	15	Alpha	292-306	Amount of check in $999,999,999.99 format. **Required** if Source is CHEK
Check Number	15	Alpha	307-321	Check Number **Required** if Source is CHEK
Informant's First Name	15	Text	322-336	Informant's First Name Required if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Informant's Middle Initial	1	Alpha	337	Informant's Middle Initial Not required. Populate with spaces if not available.
Informant's Last Name	24	Text	338-361	Informant's Last Name Required if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Informant's Phone	10	Numeric	362-371	Informant's Phone Number Not required. Populate with zeros if not available.
Informant's Address 1	32	Text	372-403	Informant's Address 1 Required if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Informant's Address 2	32	Text	404-435	Informant's Address 2 Not required. Populate with spaces if not available.
Informant's City	15	Text	436-450	Informant's City **Required** if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.

Data Field	Length	Type	Displacement	Description
Informant's State	2	Alpha	451-452	Informant's State **Required** if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Informant's Zip Code	9	Numeric	453-461	Informant's Zip **Required** if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Informant's Relationship Code	1	Alpha	462	Relationship of informant to beneficiary. Valid values are: A Attorney representing beneficiary B Beneficiary C Child D Defendant's attorney E Employer F Father I Insurer M Mother N Non-relative O Other relative P Provider R Beneficiary representative other than attorney S Spouse U Unknown **Required** if Source is CHEK, LTTR, or PHON. Not required if SOURCE is SCLM. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Employer's Name	32	Text	463-494	Name of employer providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer EIN	18	Text	495-512	Employer's EIN providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Employer's Address 1	32	Text	513-544	Employer's Address 1 providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's Address 2	32	Text	545-576	Employer's Address 2 providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's Phone	10	Numeric	577-586	Employer's City providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's City	15	Text	587-601	Employer's State providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's State	2	Alpha	602-603	Employer's Zip Code providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's ZIP Code	9	Numeric	604-612	Employer's Address 1 providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employee No	12	Text	613-624	Policyholder's Employee Number Not required. Populate with spaces if not available.
Insurer's name	32	Text	625-656	Name of insurance carrier for MSP coverage. Required if Action is DI. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.

Data Field	Length	Type	Displacement	Description
Insurer Type	1	Alpha	657	Type of Insurance Valid values are: A = Insurance or Indemnity (Other Types) .J = Hospitalization only plan covering inpatient hospital K = Medical Service only plan covering non-inpatient medical R = GHP Health Reimbursement Arrangement S = GHP Health Savings Account **Required** if Action is DI. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Insurer's Address 1	32	Text	658-689	Address 1 of insurance carrier for MSP coverage. **Required** if Action is DI. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Insurer's Address 2	32	Text	690-721	Address 2 of insurance carrier for MSP coverage. Not required.
Insurer's City	15	Text	722-736	City insurance carrier for MSP coverage. Required if Action is DI. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Insurer's State	2	Alpha	737-738	State of insurance carrier for MSP coverage. **Required** if Action is DI. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Insurer's ZIP Code	9	Numeric	739-747	Zip Code of insurance carrier for MSP coverage. **Required** if Action is DI. Populate with spaces if not available. * Refer to Appendix B for complete set of *required field*s for various source codes.
Insurer's Phone	10	Numeric	748-757	Insurer's Phone Number Not required. Populate with zeros if not available.
Insurer Group Number	20	Text	758-777	Group number of insurance coverage. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Insurer Policy Number	17	Text	778-794	Policy number of insurance coverage. Not required. Populate with spaces if not available.
Subscriber First Name	15	Text	795-809	First Name of individual covered by this insurance. Not required. Populate with spaces if not available.
Subscriber Initial	1	Alpha	810	Middle initial of individual covered by this insurance. Not required. Populate with spaces if not available
Subscriber Last Name	24	Text	811-834	Last Name of individual covered by this insurance. Not required. Populate with spaces if not available
Subscriber Social Security Number	9	Numeric	835-843	Social Security Number of the policy holder/subscriber **Required**
Filler	25	Filler	844-868	Filler
Illness/Injury Date	8	Date	869-876	Date illness or injury occurred for workers' compensation, automobile, or liability coverage (in CCYYMMDD format) Not required. Populate with zeros if not available.
Illness/Injury Description	64	Text	877-940	Description of illness or injury for workers' compensation, automobile, or liability coverage. Not required. Populate with zeros if not available.
Representative Name	32	Text	941-972	Name of individual representing a beneficiary's medical affairs or estate. Representation may be applicable in a workers' compensation, automobile, or liability insurance case. Type name in first name/middle initial/last name format. Not required. Populate with spaces when not available.
Representative Address 1	32	Text	973-1004	Representative's Street address 1. Not required. Populate with spaces when not available.
Representative Address 2	32	Text	1005-1036	Representative's Street address 2. Not required. Populate with spaces when not available.
Representative City	15	Text	1037-1051	Representative's City Not required. Populate with spaces when not available.
Representative State	2	Alpha	1052-1053	Representative's Street address 2. Not required. Populate with spaces when not available.

Data Field	Length	Type	Displacement	Description
Representative Zip	9	Numeric	1054-1062	Representative's Zip Code. Not required. Populate with spaces when not available.
Representative Type	1	Alpha	1063	Type of relationship between beneficiary and his or her representative. Valid values are: A = Attorney R = Representative not acting as an attorney Not required. Populate with spaces if not available.
Dialysis Train Date	8	Date	1064-1071	Date beneficiary received self-dialysis training (in CCYYMMDD format) Not required. Populate with zeros if not available.
Black Lung Indicator	1	Alpha	1072	One-character code indicating whether beneficiary receives benefits under the Black Lung Program. Valid values are: Y = Yes N = No Not required. Populate with spaces if not available.
Black Lung Effective Date	8	Date	1073-1080	Date beneficiary began receiving benefits under the Black Lung Program in CCYYMMDD format. Not required. Populate with zeros if not available.
Diagnosis Code 1 ICD Indicator	1	Numeric	1081	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1A and the record will be dropped. **Required if Diagnosis Code 1 is submitted**.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 1	7	Text	1082 – 1088	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. Required if Action code is CA or CL. **Required if Diagnosis Code 1 ICD Indicator is submitted**. If Diagnosis Code 1 ICD Indicator = 0, Diagnosis Code 1 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 1 ICD Indicator = 9, Diagnosis Code 1 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. * Refer to Appendix B for complete set of *required field*s for various source codes. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE69 and the record will be dropped.
Diagnosis Code 2 ICD Indicator	1	Numeric	1089	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1B and the record will be dropped. **Required if Diagnosis Code 2 is submitted**.
Diagnosis Code 2	7	Text	1090 -1096	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 2 ICD Indicator is submitted.** If Diagnosis Code 2 ICD Indicator = 0, Diagnosis Code 2 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 2 ICD Indicator = 9, Diagnosis Code 2 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE70 and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 3 ICD Indicator	1	Numeric	1097	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1C and the record will be dropped. **Required if Diagnosis Code 3 is submitted**.
Diagnosis Code 3	7	Text	1098 – 1104	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 3 ICD Indicator is submitted.** If Diagnosis Code 3 ICD Indicator = 0, Diagnosis Code 3 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 3 ICD Indicator = 9, Diagnosis Code 3 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE71 and the record will be dropped.
Diagnosis Code 4 ICD Indicator	1	Numeric	1105	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1D and the record will be dropped. **Required if Diagnosis Code 4 is submitted.**
Diagnosis Code 4	7	Text	1106 – 1112	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 4 ICD Indicator is submitted.** If Diagnosis Code 4 ICD Indicator = 0, Diagnosis Code 4 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 4 ICD Indicator = 9, Diagnosis Code 4 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE72 and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 5 ICD Indicator	1	Numeric	1113	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1E and the record will be dropped. **Required if Diagnosis Code 5 is submitted**.
Diagnosis Code 5	7	Text	1114 - 1120	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 5 ICD Indicator is submitted.** If Diagnosis Code 5 ICD Indicator = 0, Diagnosis Code 5 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 5 ICD Indicator = 9, Diagnosis Code 5 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE73 and the record will be dropped.
Diagnosis Code 6 ICD Indicator	1	Numeric	1121	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1F and the record will be dropped. **Required if Diagnosis Code 6 is submitted.**
Diagnosis Code 6	7	Text	1122 – 1128	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 6 ICD Indicator is submitted**. If Diagnosis Code 6 ICD Indicator = 0, Diagnosis Code 6 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 6 ICD Indicator = 9, Diagnosis Code 6 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1G and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 7 ICD Indicator	1	Numeric	1129	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1H and the record will be dropped. **Required if Diagnosis Code 7 is submitted**.
Diagnosis Code 7	7	Text	1130 – 1136	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 7 ICD Indicator is submitted**. If Diagnosis Code 7 ICD Indicator = 0, Diagnosis Code 7 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 7 ICD Indicator = 9, Diagnosis Code 7 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1I and the record will be dropped.
Diagnosis Code 8 ICD Indicator	1	Numeric	1137	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1J and the record will be dropped. **Required if Diagnosis Code 8 is submitted**.
Diagnosis Code 8	7	Text	1138 – 1144	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 8 ICD Indicator is submitted.** If Diagnosis Code 8 ICD Indicator = 0, Diagnosis Code 8 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 8 ICD Indicator = 9, Diagnosis Code 8 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1K and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 9 ICD Indicator	1	Numeric	1145	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1L and the record will be dropped. **Required if Diagnosis Code 9 is submitted.**
Diagnosis Code 9	7	Text	1146 – 1152	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 9 ICD Indicator is submitted**. If Diagnosis Code 9 ICD Indicator = 0, Diagnosis Code 9 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 9 ICD Indicator = 9, Diagnosis Code 9 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1M and the record will be dropped.
Diagnosis Code 10 ICD Indicator	1	Numeric	1153	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1N and the record will be dropped. **Required if Diagnosis Code 10 is submitted**.
Diagnosis Code 10	7	Text	1154 – 1160	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 10 ICD Indicator is submitted.** If Diagnosis Code 10 ICD Indicator = 0, Diagnosis Code 10 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 10 ICD Indicator = 9, Diagnosis Code 10 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1O and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 11 ICD Indicator	1	Numeric	1161	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1P and the record will be dropped. **Required if Diagnosis Code 11 is submitted**.
Diagnosis Code11	7	Text	1162 – 1168	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 11 ICD Indicator is submitted.** If Diagnosis Code 11 ICD Indicator = 0, Diagnosis Code 11 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 11 ICD Indicator = 9, Diagnosis Code 11 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1Q and the record will be dropped.
Diagnosis Code 12 ICD Indicator	1	Numeric	1169	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1R and the record will be dropped. **Required if Diagnosis Code 12 is submitted.**
Diagnosis Code 12	7	Text	1170 – 1176	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 12 ICD Indicator is submitted.** If Diagnosis Code 12 ICD Indicator = 0, Diagnosis Code 12 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 12 ICD Indicator = 9, Diagnosis Code 12 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1S and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 13 ICD Indicator	1	Numeric	1177	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1T and the record will be dropped. **Required if Diagnosis Code 13 is submitted.**
Diagnosis Code 13	7	Text	1178 – 1184	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 13 ICD Indicator is submitted.** If Diagnosis Code 13 ICD Indicator = 0, Diagnosis Code 13 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 13 ICD Indicator = 9, Diagnosis Code 13 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1U and the record will be dropped.
Diagnosis Code 14 ICD Indicator	1	Numeric	1185	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1V and the record will be dropped. **Required if Diagnosis Code 14 is submitted**.
Diagnosis Code 14	7	Text	1186 – 1292	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 14 ICD Indicator is submitted.** If Diagnosis Code 14 ICD Indicator = 0, Diagnosis Code 14 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 14 ICD Indicator = 9, Diagnosis Code 14 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1W and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 15 ICD Indicator	1	Numeric	1193	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1X and the record will be dropped. **Required if Diagnosis Code 15 is submitted.**
Diagnosis Code 15	7	Text	1194 – 1200	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 15 ICD Indicator is submitted.** If Diagnosis Code 15 ICD Indicator = 0, Diagnosis Code 15 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 15 ICD Indicator = 9, Diagnosis Code 15 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE1Y and the record will be dropped.
Diagnosis Code 16 ICD Indicator	1	Numeric	1201	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE1Z and the record will be dropped. **Required if Diagnosis Code 16 is submitted**.
Diagnosis Code 16	7	Text	1202 – 1208	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 16 ICD Indicator is submitted.** If Diagnosis Code 16 ICD Indicator = 0, Diagnosis Code 16 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 16 ICD Indicator = 9, Diagnosis Code 16 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2A and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 17 ICD Indicator	1	Numeric	1209	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2B and the record will be dropped. **Required if Diagnosis Code 17 is submitted.**
Diagnosis Code 17	7	Text	1210 – 1216	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 17 ICD Indicator is submitted.** If Diagnosis Code 17 ICD Indicator = 0, Diagnosis Code 17 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 17 ICD Indicator = 9, Diagnosis Code 17 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2C and the record will be dropped.
Diagnosis Code 18 ICD Indicator	1	Numeric	1217	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2D and the record will be dropped. **Required if Diagnosis Code 18 is submitted**.
Diagnosis Code 18	7	Text	1218 – 1224	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 18 ICD Indicator is submitted.** If Diagnosis Code 18 ICD Indicator = 0, Diagnosis Code 18 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 18 ICD Indicator = 9, Diagnosis Code 18 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2E and the record will be dropped.

Data Field	Length	Type	Displacement	Description
Diagnosis Code 19 ICD Indicator	1	Numeric	1225	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2F and the record will be dropped. **Required if Diagnosis Code 19 is submitted.**
Diagnosis Code 19	7	Text	1226 – 1232	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 19 ICD Indicator is submitted**. If Diagnosis Code 19 ICD Indicator = 0, Diagnosis Code 19 must contain a valid ICD-10-CM diagnosis code. If Diagnosis Code 19 ICD Indicator = 9, Diagnosis Code 19 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2G and the record will be dropped.
Diagnosis Code 20 ICD Indicator	1	Numeric	1233	One-digit diagnosis code indicator to identify whether the diagnosis code received is in ICD-9-CM or ICD-10-CM format. 0 = ICD-10-CM format 9 = ICD-9-CM format If an invalid code is entered, the user will see error code PE2H and the record will be dropped. **Required if Diagnosis Code 20 is submitted.**
Diagnosis Code 20	7	Text	1234 – 1240	ICD-9-CM or ICD-10-CM diagnosis code that applies to this MSP occurrence. **Required if Diagnosis Code 20 ICD Indicator is submitted.** If Diagnosis Code 20 ICD Indicator = 0, Diagnosis Code 20 must contain a valid ICD-20-CM diagnosis code. If Diagnosis Code 20 ICD Indicator = 9, Diagnosis Code 20 must contain a valid ICD-9-CM diagnosis code. Populate with spaces if not applicable. NGHP MSP types will require a valid diagnosis code to be entered. If an invalid code is entered, the user will see error code PE2I and the record will be dropped.
Filler	17	Filler	1241- 1267	Unused Field – fill with spaces

Prescription Drug Inquiry Detail Record

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Table G-4: Prescription Drug Inquiry Detail Record Layout

Data Field	Length	Type	Displacement	Description
Transaction Type	4	Alpha	1 – 4	Type of Record Set to 'ECRS' **Required**
Contractor Number	5	Alpha-Numeric	5-9	Part D Plan Contractor number **Required**
DCN	15	Text	10-24	Document Control Number; assigned by the Part D Plan. **Required**. Each record shall have a unique DCN.
Tran Type Code	1	Alpha	25	Transaction Type Indicator Set to 'P' for Prescription Drug Inquiry **Required**
Trans Seq No	3	Numeric	26-28	Sequence Number assigned by the COB. Internal use only. Populate with spaces.
Tran Stat Cd	2	Alpha	29-30	Status Code Set to 'NW' for New
Tran Reason Cd	2	Numeric	31-32	Reason Set to '01' for New
Trans Source Cd	4	Alpha	33-36	Source of Record Valid Values are: CHEK= Check LTTR = Letter PHON= Phone SCLM= Secondary Claim CLAM= Claim SRVY = Survey **Required**
Update Operator ID	8	Alpha-Numeric	37-44	ID of user making update. Not required
Contractor Name	25	Text	45-69	Contractor name Not required
Contractor Phone	10	Numeric	70-79	Contractor Phone Number Not required
Medicare ID	12	Alpha-Numeric	80-91	Medicare *b*eneficiary *i*dentifier (M*bi*). **Required** if SSN is not entered.
Beneficiary's Social Security Number	9	Numeric	92-100	Beneficiary's Social Security Number **Required** if Medicare ID not entered.

Data Field	Length	Type	Displacement	Description
Beneficiary's Date of Birth	8	Date	101-108	Beneficiary's Date of Birth in CCYYMMDD format **Required**
Beneficiary's Sex Code	1	Alpha	109	Sex of beneficiary Valid values are: U = Unknown M = Male F = Female Default to 'U' if not available **Required**
Beneficiary's First Name	15	Text	110-124	Beneficiary's First Name **Required**
Beneficiary's Initial	1	Alpha	125	Beneficiary's Middle Initial Not required
Beneficiary's Last Name	24	Text	126-149	Beneficiary's Last Name **Required**
Patient Relationship	2	Character	150-151	Patient Relationship between policy holder and patient. Valid values are: 1 Patient is Policy Holder 2 Spouse 3 Child 4 Other **Required**
Check Date	8	Numeric	152-159	Date of check in CCYYMMDD format. **Required** if Source is CHEK
Check Amount	15	Alpha	160-174	Amount of check in $999,999,999.99 format. **Required** if Source is CHEK
Check Number	15	Alpha	175-189	Check Number **Required** if Source is CHEK
Beneficiary's Address 1	32	Text	190-221	Beneficiary's Address 1 Not required. Populate with spaces if not available.
Beneficiary's Address 2	32	Text	222-253	Beneficiary's Address 2 Not required. Populate with spaces if not available
Beneficiary's City	15	Text	254-268	Beneficiary's City Not required. Populate with spaces if not available.
Beneficiary's State	2	Alpha	269-270	Beneficiary's State Not required. Populate with spaces if not available.
Beneficiary's Zip Code	9	Numeric	271-279	Beneficiary's Zip Code Not required. Populate with spaces if not available
Beneficiary's Phone	10	Numeric	280-289	Beneficiary's Phone Not required. Populate with zeros if not available

Data Field	Length	Type	Displacement	Description
Informant's First Name	15	Text	290-304	Informant's First Name **Required**
Informant's Middle Initial	1	Alpha	305	Informant's Middle Initial Not required. Populate with spaces if not available.
Informant's Last Name	24	Text	306-329	Informant's Last Name **Required**
Informant's Relationship Code	1	Alpha	330	Relationship of informant to beneficiary. Valid values are: A = Attorney representing beneficiary B = Beneficiary C = Child D = Defendant's attorney E = Employer F = Father I = Insurer M = Mother N = Non-relative O = Other relative P = Provider R = Beneficiary representative other than attorney S = Spouse U = Unknown **Required**
Informant's Address 1	32	Text	331-362	Informant's Address 1 **Required**
Informant's Address 2	32	Text	363-394	Informant's Address 2 Not required. Populate with spaces if not available.
Informant's City	15	Text	395-409	Informant's City **Required**
Informant's State	2	Alpha	410-411	Informant's State **Required**
Informant's Zip Code	9	Numeric	412-420	Informant's Zip **Required**
Informant's Phone	10	Numeric	421-430	Informant's Phone Number Not required. Populate with zeros if not available.
Employer's Name	32	Text	431-462	Name of employer providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Employer's Address 1	32	Text	463-494	Employer's Address 1 providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's Address 2	32	Text	495-526	Employer's Address 2 providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's City	15	Text	527-541	Employer's City providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's State	2	Alpha	542-543	Employer's State providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's ZIP Code	9	Numeric	544-552	Employer's Zip Code providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer's Phone	10	Numeric	553-562	Employer's Phone Number providing group health insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Employer EIN	18	Text	563-580	Employer's Identification Number (EIN) providing group health insurance under which the beneficiary is covered. Not required. Populate with spaces if not available.
Employee No	12	Text	581-592	Policyholder's Employee Number Not required. Populate with spaces if not available.
Person Code	3	Numeric	593-595	Person Code. Plan specific (Relationship assigned plan administrator at the plan level) Valid values are: 001 = Self 002 = Spouse 003 = Other **Required** only for Supplemental Drug Coverage records. If not Supplemental Drug Coverage record, populate with spaces.

Data Field	Length	Type	Displacement	Description
Sup Type	1	Alpha-Numeric	596	Supplemental Drug Type Valid values are: L = Supplemental M = Medigap N = Non-qualified SPAP O = Other P = PAP R = Charity T = Federal Government Programs 3 = Major Medical **Required** if Record Type = 'SUP'. Otherwise not required, populate with spaces.
MSP Type	1	Alpha-Numeric	597	Medicare Secondary Payer Type Valid values are: A Working Aged B ESRD C Conditional payment D Automobile Insurance - No-fault E Workers' Compensation F Federal (public) G Disabled H Black Lung W Workers' Compensation Set-Aside **Required** if Record Type of Primary 'PRI' is selected. Populate with spaces if not available.
Type	1	Alpha-Numeric	598	Prescription Drug Coverage Type Valid values are: U = Drug network V = Drug non-network Z = Health account (such as a flexible spending account provided by other party to pay prescription drug costs or premiums) Not required. Populate with spaces if not available.
Rec Type	3	Alpha-Numeric	599-601	Prescription Drug Coverage Type of Insurance Valid values are: PRI = Primary SUP = Supplemental Not required. If Sup Type is populated and this field is blank, SUP will be assumed. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Insurer's name	32	Text	602-633	Name of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. If Insurer's Name contains any of the following values it is an error: NO NONE N/A HCFA ATTORNEY UNK MIS CMS NA UNKNOWN If Insurer's name contains only one of the following values it is an error: BC BS BX BCBX Medicare BLUE CROSS COB **Required**
Insurer's Address 1	32	Text	634-665	Address 1 of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Insurer's Address 2	32	Text	666-697	Address 2 of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Insurer's City	15	Text	698-712	City of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Insurer's State	2	Alpha	713-714	State of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. Not required. Populate with spaces if not available.
Insurer's ZIP Code	9	Numeric	715-723	Zip Code of insurer providing Supplemental Prescription Drug Insurance under which beneficiary is covered. Not required. Populate with spaces if not available.

Data Field	Length	Type	Displacement	Description
Drug Coverage Effective Date	8	Date	724-731	Effective Date of Supplemental Prescription Drug Coverage. **Required**
Term Date	8	Date	732-739	Termination Date of Supplemental Prescription Drug Coverage. Not Required. Populate with zeros if not available.
Policy Number	17	Text	740-756	Prescription Drug Policy Number Not required. Populate with spaces if not available.
RX BIN	6	Text	757-762	Prescription Drug BIN Number **Required** if TYPE = "U" Must be six numeric digits.
RX PCN	10	Text	763-772	Prescription Drug PCN Number **Required** if TYPE = "U" Populate with spaces if not available.
RX Group	15	Text	773-787	Prescription Drug Group Number **Required** if TYPE = "U" Populate with spaces if not available.
RX ID	20	Text	788-807	Prescription Drug ID Number **Required** if TYPE = "U" Populate with spaces if not available.
RX Phone	18	Text plus '(' and ')'	808-825	Prescription Drug Phone Number Not required. Populate with spaces if not available.
Filler	442	Filler	826-1267	Unused Field – fill with spaces

Appendix K Acronyms

Table K-5: Acronyms

Term/Acronym	Definition
BCRC	Benefits Coordination & Recovery Center
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CWF	Common Working File
DCN	Document Control Number
ECRS	Electronic Correspondence Referral System
EIDM	CMS Enterprise Identity Management
EIN	Employer Identification Number
GHI	Group Health Incorporated
HICN	Health Insurance Claim Number
HIMR	Health Insurance Master Record
HUSP	Health Utilization Secondary Payer
IVR	Interactive Voice Response
MBD	Medicare Beneficiary Database
Mbi	*Medicare beneficiary identifier*
MFA	Multi-Factor Authentication
MSP	Medicare Secondary Payer
RIDP	Remote Identity Proofing
RO	Regional Office
SSN	Social Security Number

1.1.1 Electronic Correspondence Referral System for the Web (ECRS Web) Quick Reference Card

1.1.2 CWF Assistance Request Codes

Enter CWF assistance requests for existing MSP records

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Table 15: Required Fields on CWF Assistance Request Detail Pages

Field	Description
DCN	Document Control Number
MEDICARE ID	Beneficiary's Health Insurance Claim Number (HICN) or *Medicare beneficiary identifier (Mbi)*
ACTIVITY CODE	Activity code
ACTION(S)	Action codes
SOURCE	Source of request information
IMPORT HIMR MSP DATA	Select to import HIMR data for the existing MSP record
MSP TYPE	Type of MSP coverage
PATIENT RELATIONSHIP	Patient relationship
AUXILIARY RECORD #	Record number of MSP auxiliary occurrence at CWF Note: Part D contractors must enter "001" when the Auxiliary record number is unknown.

Field	Description
ORIGINATING CONTRACTOR	Contract number of contractor that created original MSP occurrence at CWF
EFFECTIVE DATE	Effective date of MSP coverage
TERMINATION DATE	Date MSP coverage ended
FIRST NAME	Informant's first name
LAST NAME	Informant's last name
ADDRESS	Informant's address
CITY	Informant's city
STATE	Informant's state
ZIP	Informant's zip code
RELATIONSHIP	Informant's relationship to the beneficiary
INSURANCE COMPANY NAME	Insurance company name
INSURANCE TYPE	Type of insurance coverage
POLICY NUMBER	Insurance policy number (not required if group number is entered)
GROUP NUMBER	Insurance policy group number (not required if policy number is entered)
EMPLOYER NAME	Name of the beneficiary's employer
ADDRESS	Employer's address
CITY	Employer's city
STATE	Employer's state
ZIP	Employer's zip code
CHECK NUMBER	Check number
CHECK DATE	Date on the check
CHECK AMOUNT	Amount of the check
PRE-PAID HEALTH PLAN DATE	Pre-paid Health Plan date
SOCIAL SECURITY NUMBER	Beneficiary's social security number
DIAGNOSIS CODES	Diagnosis codes Required when ACTION is DX.
ICD Indicator	Type of diagnosis code. Select "ICD-9" or "ICD-10". Required if corresponding Diagnosis Code is submitted.
REMARKS	Remarks

1.1.3 MSP Inquiry Codes

Note: Action codes are not required for MSP inquiries.

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

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Table 16: Required Fields on MSP Inquiry Detail Pages

Field	Description
DCN	Document Control Number
MEDICARE ID	Beneficiary's Health Insurance Claim Number (HICN) or *Medicare beneficiary identifier (Mbi)*
ACTIVITY CODE	Activity code
SOURCE	Source of request information
PATIENT RELATIONSHIP	Patient's relationship Note: required when action code is blank and MSP type is F.
EFFECTIVE DATE	Effective date of MSP coverage
TERMINATION DATE	Date MSP coverage ended
CMS GROUPING CODE	CMS grouping code
FIRST NAME	Informant's first name
LAST NAME	Informant's last name
ADDRESS	Informant's address
CITY	Informant's city
STATE	Informant's state
ZIP	Informant's zip code
RELATIONSHIP	Informant's relationship to the beneficiary
INSURANCE COMPANY NAME	Name of beneficiary's insurer
ADDRESS LINE 1	First line of insurer's address Note: required when Insurance Company Name is entered.
CITY	Insurer's city Note: required when Insurance Company Name is entered.

Field	Description
STATE	Insurer's state Note: required when Insurance Company Name is entered.
ZIP	Insurer's zip code Note: required when Insurance Company Name is entered.
INSURANCE TYPE	Type of insurance
EMPLOYER NAME	Name of beneficiary's employer Note: required when MSP Type is F and Send to CWF is Yes.
ADDRESS	Employer's address Note: required when MSP Type is F and Send to CWF is Yes.
CITY	Employer's city Note: required when MSP Type is F and Send to CWF is Yes.
STATE	Employer's state Note: required when MSP Type is F and Send to CWF is Yes.
ZIP	Employer's zip code Note: required when MSP Type is F and Send to CWF is Yes.
CHECK NUMBER	Check number
CHECK AMOUNT	Amount on the check
CHECK DATE	Date on the check
DIAGNOSIS CODES	Diagnosis codes Note: If the MSP Type is A, B, or G, the system will prevent the entry of diagnosis codes.
ICD Indicator	Type of diagnosis code. Select "ICD-9" or "ICD-10". Required if corresponding Diagnosis Code is submitted
BIN	BIN Note: required when Coverage Type is U.
PCN	PCN Note: required when Coverage Type is U.
GROUP	Group number Note: required when Coverage Type is U.

Field	Description
ID	ID number Note: required when Coverage Type is U.
SUPPLEMENTAL TYPE	Type of supplemental insurance Note: must be L when Record Type is Supplemental.
PERSON CODE	Person code Note: required when Record Type is Supplemental and Supplemental type is L.

1.1.4 Prescription Drug Inquiry Codes

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Table 17: Required Fields on Prescription Drug Inquiry Detail Pages

Field	Description
DCN	Document Control Number
MEDICARE ID	Beneficiary's Health Insurance Claim Number (HICN) or *Medicare beneficiary identifier (Mbi)*
ACTIVITY CODE	Activity code
SOURCE	Source of request information
MSP TYPE	MSP type Note: Leave MSP Type blank when Record Type is Supplemental
PATIENT RELATIONSHIP	Patient's relationship Note: required when action code is blank and MSP type is F.
SEND TO MBD	Select Yes to send inquiry to MBD
SUBMTTER TYPE	Submitter type
CHECK NUMBER	Check number
CHECK DATE	Date on the check
CHECK AMOUNT	Amount on the check
INFORMANT FIRST NAME	Informant's first name
INFORMANT LAST NAME	Informant's last name
INFORMANT ADDRESS	Informant's address
INFORMANT CITY	Informant's city
INFORMANT STATE	Informant's state
INFORMANT ZIP	Informant's zip code
INFORMANT RELATIONSHIP	Informant's relationship to the beneficiary

Field	Description
INSURANCE COMPANY NAME	Name of the insurance carrier for drug coverage.
EFFECTIVE DATE	Effective date of prescription coverage
TERMINATION DATE	Date prescription coverage ends Note: automatically populated when Coverage Type is U.
BIN	BIN Note: required when Coverage Type is U.
PCN	PCN Note: required when Coverage Type is U.
GROUP	Group number Note: required when Coverage Type is U.
ID	ID number Note: required when Coverage Type is U.
PERSON CODE	Person code Note: required when Record Type is Supplemental, or when Record Type is blank and Supplemental type is L.

Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP) CWF Process

20.1.2 - MSP Change Transaction
(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

An MSP change transaction occurs when the key fields on the incoming maintenance transaction match those on an existing MSP auxiliary occurrence.

A match occurs when the following items are the same:

Medicare beneficiary identifier;

MSP type;

MSP effective date;

Insurance type; and

Patient relationship

When these items match, the balance of the record is overlaid.

No change transactions will be permitted to records established, except for the addition of a termination date, by any contractor other than the COBC.

30.3 - MSP Auxiliary File Errors

(Rev.125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. 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.

Maintenance transactions to the MSP Auxiliary file reject invalid data with errors identified by a value of "SP" in the disposition field on the Reply Record. A trailer of "08" containing up to four error codes will always follow. Listed below are the possible MSP Maintenance Transaction error codes with a general description.

Error Code	Definition	Valid Values
SP11	Invalid MSP transaction record type	"HUSP," "HISP," or "HBSP"
SP12	Invalid *Medicare beneficiary identifier*	Valid *Medicare beneficiary identifier*
SP13	Invalid Beneficiary Surname	Valid Surname
SP14	Invalid Beneficiary First Name Initial	Valid Initial
SP15	Invalid Beneficiary Date of Birth	Valid Date of Birth
SP16	Invalid Beneficiary Sex Code	0=Unknown, 1=Male, 2=Female
SP17	Invalid Contractor Number	CMS Assigned Contractor Number
SP18	Invalid Document Control Number	Valid Document Control Number
SP19	Invalid Maintenance Transaction Type	0=Add/Change MSP Data transaction, 1=Delete MSP Data Transaction
SP20	Invalid Validity Indicator	Y= Beneficiary has MSP Coverage, I= Entered by intermediary/ carrier - Medicare Secondary-COB investigate, N -No MSP coverage
SP21	Invalid MSP Code	A=Working Aged B=ESRD C= Conditional Payment D= No Fault E= Workers' Compensation F= Federal G= Disabled H= Black Lung

Error Code	Definition	Valid Values
		I= Veteran's Administration L= Liability
SP22	Invalid Diagnosis Code 1-5	Valid Diagnosis Code
SP23	Invalid Remarks Code 1-3	See the Valid Remarks Codes Below
SP24	Invalid Insurer Type	See definitions of Insurer Type codes below
SP25	Invalid Insurer Name An SP25 error is returned when the MSP Insurer Name is equal to one of the following: Supplement Supplemental Insurer Miscellaneous CMS Attorney Unknown None N/A Un Misc NA NO BC BX BS BCBX Blue Cross Blue Shield Medicare	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; : Insurer Name must be present if Validity Indicator = Y
SP26	Invalid Insurer Address 1 and/or Address 2	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP27	Invalid Insurer City	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP28	Invalid Insurer State	Must match U.S. Postal Service state abbreviation table.
SP29	Invalid Insurer Zip Code	If present, 1st 5 digits must be numeric. If foreign country "FC" state code, the nine positions may be spaces.

Error Code	Definition	Valid Values
SP30	Invalid Policy Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP31	Invalid MSP Effective Date (Mandatory)	Non-blank, non-zero, numeric, number of days must correspond with the particular month. MSP Effective Date must be less than or equal to the current date.
SP32	Invalid MSP Termination Date	Must be numeric; may be all zeroes if not used; if used, date must correspond with the particular month.
SP33	Invalid Patient Relationship	The following codes are valid for all MSP Auxiliary occurrences regardless of accretion date: 01 = Self; Beneficiary is the policy holder or subscriber for the other GHP insurance reflected by the MSP occurrence **–or-** Beneficiary is the injured party on the Workers Compensation, No-Fault, or Liability claim 02 =Spouse or Common Law Spouse 03 = Child 04 = Other Family Member 20 = Life Partner or Domestic Partner The following codes are only valid on MSP Auxiliary occurrences with accretion dates **PRIOR TO 4/4/2011**: 05 = Step Child 06 = Foster Child 07 = Ward of the Court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ donor 12 = Cadaver Donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff

Error Code	Definition	Valid Values
		16 = Sponsored Dependent 17 = Minor Dependent of a Minor Dependent 18 = Parent 19 = Grandparent 20 = Life Partner or Domestic Partner
SP34	Invalid subscriber First Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP35	Invalid Subscriber Last Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP36	Invalid Employee ID Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP37	Invalid Source Code	Spaces, A through W, 0 – 19, 21, 22, 25, 26, 39, 41, 42, 43. See §10.2 for definitions of valid CWF Source Codes.
SP38	Invalid Employee Information Data Code	Spaces if not used, alphabetic values P, S, M, F. See §30.3.4 for definition of each code.
SP39	Invalid Employer Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP40	Invalid Employer Address	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP41	Invalid Employer City	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP42	Invalid Employer State	Must match U.S. Postal Service state abbreviations.
SP43	Invalid Employer ZIP Code	If present, 1st 5 digits must be numeric. If foreign country 'FC' is entered as the state code, and the nine positions may be spaces.
SP44	Invalid Insurance Group Number	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP45	Invalid Insurance Group Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP46	Invalid Pre-paid Health Plan Date	Numeric; number of days must correspond with the particular month.
SP47	Beneficiary MSP indicator not on for delete transaction.	Occurs when the code indicating the existence of

Error Code	Definition	Valid Values
		MSP auxiliary record is not equal to "1" and the MSP maintenance transaction type is equal to ‘1.’
SP48	MSP auxiliary record not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP49	MSP auxiliary occurrence not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP50	Invalid function for update or delete. Contractor number unauthorized	See MSP Auxiliary Record add/update and delete function procedures above
SP51	MSP Auxiliary record has 17 occurrences and none can be replaced	
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B and G when the Validity Indicator is "Y"	Accretion Dates prior to 4/4/2011: Patient Relationship must be 01 or 02 for MSP Code A (Working Aged). Patient Relationship must be 01, 02, 03, 04, 05, 18 or 20 for MSP Codes B (ESRD) and G (Disabled). Accretion Dates 4/4/2011 and subsequent: Patient Relationship must be 01 or 02 for MSP Code A (Working Aged). Patient Relationship must be 01, 02, 03, 04, or 20 for MSP Codes B (ESRD) and G (Disabled).
SP53	The maintenance transaction was for Working Aged EGHP and there is either a ESRD EGHP or Disability EGHP entry on file that has a termination date after the Effective date on the incoming transaction or is not terminated, and the contract number on the maintenance transaction is not equal to "11102", "11104", 11105", "11106", "33333", "66666", "77777", "88888", or "99999".	
SP54	MSP Code A, B or G has an Effective date that is in conflict with the calculated age 65 date of the Bene.	For MSP Code A, the Effective date must not be less than the date at age 65. For MSP Code G, the Effective date must not be greater than the date at age 65.
SP55	MSP Effective date is less than the earliest Bene Part A or Part B Entitlement Date.	
SP56	MSP Prepaid Health Plan Date must be = to or greater than MSP Effective date or less	

Error Code	Definition	Valid Values
	than MSP Term. date.	
SP57	Termination Date Greater than 6 months prior to date added for Contractor numbers other than 11100 – 11119, 11121, 11122, 11126, 11139, 11141, 11142, 11143, 33333, 55555, 77777, 88888, and 99999.	
SP58	Invalid Insurer type, MSP code, and validity indicator combination.	If MSP code is equal to "A" or "B" or "G" and validity indicator is equal to "I" or "Y" then insurer type must not be equal to spaces.
SP59	Invalid Insurer type, and validity indicator combination	If validity indicator is equal to "N" then insurer type must be equal to spaces.
SP60	Other Insurer type for same period on file (Non "J" or "K") Insurer type on incoming maintenance record is equal to "J" or "K" and Insurer type on matching aux record is not equal to "J" or "K".	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP61	Other Insurer type for same period on file ("J" or "K") Insurer type on incoming maintenance record is not equal to "J" or "K" and Insurer type on matching aux record is equal to "J" or "K".	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP62	Incoming term date is less than MSP Effective date.	
SP66	MSP Effective date is greater than the Effective date on matching occurrence on auxiliary file	
SP67	Incoming term date is less than posted term date for Provident	
SP72	Invalid Transaction attempted	A HUSP add transaction is received from a FI or Carrier (non-COBC) with a validity indicator other than "I."
SP73	Invalid Term Date/Delete Transaction	A MAC attempts to change a Term Date on a MSP Auxiliary record with a "I" or "Y" Validity Indicator that is already terminated, or trying to add Term Date to "N" record.
SP74	Invalid cannot update "I" record.	A MAC submits a HUSP transaction to update/change an "I" record or to add an "I" record and a match MSP Auxiliary occurrence exists with a "I" validity indicator.
SP75	Invalid transaction, no Medicare Part A benefits	A HUSP transaction to add a record with a Validity Indicator equal to "I" (from an FI/carrier) or "Y" (from BCRC) with an MSP Type equal to "A," "B," "C," or "G" and the effective

Error Code	Definition	Valid Values
		date of the transaction is not within a current or prior Medicare Part A entitlement period, or the transaction is greater than the termination date of a Medicare entitlement period.
SP76	MSP Type is equal to W (Workers' Compensation Medicare Set-Aside) and there is an open MSP Type E (Workers' Compensation) record.	
SP79	A MAC attempts to create/enter a value in the ORM field on the incoming I HUSP record (makes sure that a MAC cannot update or overlay an ORM value in the ORM field).	Valid Values for the 1-byte ORM indicator on the CWF MSP Detail screen (MSPD) are: Y (Yes) or a space. A "Y" ORM indicator value denotes that the ORM existed for a period of time, not necessarily that it currently exists. An ORM indicator of a "space" implies that an RRE has not assumed ORM.
SP80	A MAC attempted to create/enter an ORM indicator on an MSP record other than a D, E, and L.	The 1- byte ORM indicator (valid values = Y or a space) shall only be received on HUSP transactions with MSP Codes "D, E, and L."
SP81	A contractor, other than the following contractor numbers of 11100, 11110, 11122, 11141, and 11142, attempts to update, remove or set the existing ORM record indicator of a "Y" to a "space."	To ensure that no other entity than the following contractor numbers (11100, 11110, 11122, 11142, and 11142) can modify an existing record's ORM indicator to equal a "space," if originally it was a "Y."

40.6 - Online Inquiry to MSP Data

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The MSP data may be viewed online in CWF via the HIMR access. The user enters the transaction HIMR, which displays the HIMR Main Menu, and enters the MSPA selection. (A complete record layout and field descriptions can be found in the CWF Systems Documentation at http://cms.csc.com/cwf/, Record Name: MSP Auxiliary File and MSP Audit History File.)

A user can view a selected CWF, MSP auxiliary record by following the steps outlined below:

A. Enter the *Medicare beneficiary identifier* and MSP record type.

If the data entered is invalid, an error message is displayed with the field in error highlighted. If the data entries are valid, a search is done of the beneficiary master file for an MSP indicator. The search of the master file will show one of the following:

- The MSP indicator on the beneficiary file is not set. In this case the message "MSP not indicated" is displayed;
- No record is found. In this case, a message "MSP auxiliary file not found" is displayed; or
- MSP **is** indicated. In this case, the MSP auxiliary file is read and the screen will display an MSP Record.

A successful reading of the MSP file, as noted in the third bullet above, will display an MSP occurrence summary screen that includes:

- Summary selection number;
- MSP code;
- MSP code description;
- Validity indicator;
- Delete indicator;
- Effective date; and
- Termination date, if applicable.

B. Enter the summary selection number on the MSP occurrence summary screen.

This results in a display of the MSP occurrence detail screen for the selected MSP occurrence. The MSP occurrence detail screen is a full display of the information on the MSP auxiliary file for the particular MSP occurrence.