CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 107	**Date: October 24, 2014**
	Change Request 8947

SUBJECT: Update to Pub. 100-05, Chapters 05 and 06 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This Change Request contains language-only changes for updating ICD-10 language in Pub 100-05, Chapters 05 and 06. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. 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: ASC X12: January 1, 2012; ICD-10: Upon Implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: November 28, 2014
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	05/ TOC
R	05/20/ Sources That May Identify Other Insurance Coverage
R	05/20.1/ Identification of Liability and No-Fault Situations
R	05/40.6.1/ Conditional Medicare Payment
R	05/40.7.3.1/ Medicare Secondary Payment Part B Claims Determination for Services Received on ASC X12 837 Professional Electronic Claims
R	05/40.7.3.2/ Medicare Secondary Payment Part A Claims Determination for Services Received on ASC X12 837 Institutional Electronic or Hard Copy Claim Formats

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	05/40.7.3.3/ Version 5010 Balancing for Incoming MSP Claims Where MSP Amounts Appear at the Claim Level and Not at the Service Level Detail Line
R	05/40.7.5/ Effect of Failure to File a Proper Claim
R	05/40.8.8/ Determining Patient Utilization Days, Deductible, and Coinsurance Amounts
R	05/50.1.7/ Payment Calculation for Physician/Supplier Claims (MSPPAYB Module)
R	05/50.1.8/ Payment Calculation for Physician/Supplier Claims (MSPPAYBL)
R	05/50.2.7 Payment Calculation for Inpatient Bills (MSPPAYAI Module)
R	05/50.2.8/ Payment Calculation for Outpatient Claims (MSPPAYOL)
R	05/50.2.9/ Payment Calculation for Outpatient Bills (MSPPAYAO Module)
R	05/50.3/ Multiple Primary Payer Amounts For a Single Service
R	06/Table of Contents
R	06/40.10/ Processing of Medicare Secondary Payer Claims Related or Unrelated to an Accident or Injury for Non-GHP Claims with ICD-9-CM Diagnosis Codes 500-508 and 800-999 or Related ICD-10-CM Diagnosis Codes
R	06/40.10.1/ Definition of ICD-9-CM Diagnosis Category Codes and Examples
R	06/40.10.2/ Certain Diagnosis Codes Not Allowed on No-Fault Medicare Secondary Payer (MSP) Records
R	06/50.3/ MSP “W” Record and Accompanying Processes
R	06/70/Converting Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Codes to Common Working File (CWF) Medicare Secondary Payer (MSP) Patient Relationship Codes

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 obliged 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: 107	Date: October 24, 2014	Change Request: 8947

SUBJECT: Update to Pub. 100-05, Chapters 05 and 06 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

EFFECTIVE DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: November 28, 2014

I. GENERAL INFORMATION

A. Background: This Change Request contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-05, Chapters 05 and 06. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. 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.

B. Policy: This Change Request contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-05, Chapters 05 and 06. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. 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	
8947.1	A/B MACs (A, B, and HHH), RRB SMAC, and DME MACs shall be aware of the updated language for ICD-10 and ASC X12 in Pub. 100-05, Chapters 05 and 06.	X	X	X	X					RRB-SMAC

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Rick Mazur, 410-786-1418

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

VI. FUNDING

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

ATTACHMENTS: 0

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

Table of Contents
(Rev. 107, 10-24-14)

20 - Sources That May Identify Other Insurance Coverage

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

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 contractor'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 HICN 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.

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

- A *V*alue *C*ode of 12, 13, 14, 15, 16, 41, 42, 43, 44, or 47;

- An *O*ccurrence *Code* of 01, 02, 03, 04, 05, 24, 25, or 33;

- A *Condition C*ode 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 COBC, the *MAC* uses ECRS to advise the COBC of the possibility of another insurer, and awaits COBC development before processing the claim.

20.1 - Identification of Liability and No-Fault Situations

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

Medicare Contractors must be alert to identify liability and no-fault situations. However, contractors must use the indicators listed below to identify claims in which there is a possibility that payment can be made by a liability insurer:

- The contractor receives information from a physician, a provider, a supplier, a beneficiary, the contractor's internal operations (e.g., medical or utilization review) or those of the contractor's non-Medicare counterpart, another *MAC* , or any other source, indicating Medicare has been billed for services when there is a possibility of payment by a liability insurer;

- The health insurance claim shows that the services were related to an accident;

- The claim shows a complementary insurer as an insurance organization that does not issue health insurance;

- The contractor or the RO is asked to endorse a check from another insurer payable to Medicare and the beneficiary;

- The contractor receives or is informed of a request from an insurance company or from an attorney for copies of bills or medical records;

- There is indication that a liability insurer previously paid benefits related to the same injury or illness or that a claim for such benefits is pending. There is no need to investigate this lead, however, if contractor records show that the services were furnished after the date of a final liability insurance award or settlement for the same injury or illness, and the award or settlement does not make provisions for payments for future medical services;

- The *A/B MAC (A)* receives an ambulance claim indicating that trauma related services were involved; and

- The CWF HIMR screen shows that an auxiliary record has been established for a known liability situation.

In addition, *A/B MACs (A)* use the following indicators on the *institutional claim* to identify the possibility of payment by a liability insurer.

- Another insurer is shown as Payer on line A of *Payer Name* or a primary payer is identified in "Remarks" on the bill;

- Occurrence *C*odes 01 through 03 or 24 are shown or *an Occurrence S*pan *C*ode;

- Codes 1 or 2 are shown as the *T*ype of *A*dmission;

- Code 14 is the *V*alue *C*ode shown;

- Condition *C*odes 10, 28, 29, D7, and D8 are shown;

- Remarks are shown.

For *A/B MACs (B)*, completion of block 10 on the Form CMS-1500 indicates another insurer may be involved. The *MAC* receiving a claim on which there is an indication of liability or no-fault coverage submits an MSP record to CWF using the service date of the claim as the effective date of MSP and a validity indicator of "I". This causes CWF to generate an investigation record to the COBC to ascertain the correct MSP period. The COBC develops the appropriate MSP dates with the insurer or beneficiary, or other party, as appropriate, and transmits a CWF maintenance transaction to reflect the proper MSP period.

Upon receipt of the CWF data, the *MAC* adjudicates the claim per Chapter 7, §50.4.

40.6.1 - Conditional Medicare Payment

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

There is frequently a long delay between an injury and the decision by a State Workers' Compensation agency, no-fault insurance, or liability insurer (including self-insurance) in cases where compensability is contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might use their own funds for expenses that are eventually borne by either Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations or Medicare. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made if there is no other GHP that is primary to Medicare. Note: if there is a primary GHP and the physician, provider or other supplier did not send the claim to the GHP first Medicare will not pay conditionally on the Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation claim.

When such conditional Medicare payments are made, they are conditioned upon reimbursement, by the insurer and beneficiary, to the trust fund if it is demonstrated that the Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation Carrier has or had a responsibility to make payment. A responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured, or by other means.

When making conditional notify the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.) It asks the insurer to notify it when the insurer is prepared to pay the claim, so that direct refund can be arranged.

For Part A Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations, if there is no primary payer GHP to Medicare that will pay for

services and the promptly period has expired then the *MAC* shall make a conditional payment. Providers of service may request Medicare conditional non-GHP payments *by submitting a claim with the* appropriate insurance *V*alue *C*ode (i.e., *V*alue *C*ode 14, 15 or 47) and zero as the value amount.

Type of Insurance	**CAS**	**Part A Value Code (2300 HI)**	**Value Amount (2300 HI)**	**Occurrence Code (2300 HI)**	**Condition Code (2300 HI)**
No-Fault/Liability	2320 - valid information why NGHP or GHP did not make payment	14 or 47	$0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date 24 – Date Insurance Denied	
Workers' Compensation	2320 - valid information why NGHP or GHP did not make payment	15	$0	04-Accident/Tort Liability & Date 24 – Date Insurance Denied	02-Condition is Employment Related

A/B MACs (A) are required to look for the zero value code paid amount and occurrence code in the 2300 HI when claims are received electronically in the *ASC X12 837 institutional claim* format. The appropriate Occurrence code **(**2300 HI), coupled with the zeroed paid amount and MSP value code **(**2300 HI), and the CAS segment (see previous CMS MSP change requests on processing MSP claims utilizing the CAS) may be used in billing situations in cases where the provider has attempted to bill a primary payer in non-GHP (i.e., Liability, No-Fault and Workers' Compensation) situations, but the primary payer is not expected to pay in the promptly period. A conditional payment by Medicare may be made. For hardcopy claims, the identity of the other payer is shown on line A of Payer Name, the identifying information about the insured is shown on line A of *Insured's Name, Patient's Relationship to Insured, Insured's Unique Identifier, Insured's Group Name, Insured's Group Number, Treatment Authorization Code, DCN, Employer Name (of the Insured)* and the address of the insured is shown in *Responsible Party Name and Address* or *in* Remarks. Medicare claims processing contractors process conditional payment bills following normal procedures.

In determining conditional payments for physician and other *s*upplier electronic claims it is known that the ASC X12 837 professional claim *format* does not include Value Codes nor Condition Codes. To determine whether conditional payment should be granted for *ASC X12 837 professional* claims the following fields must be completed and defined as follows: The physician/supplier must complete the 2320AMT02 = $0 if whole claim is a non-GHP claim and conditional payment is being requested for the whole claim, or 2430 SVD02 is completed for line level conditional payment requests if the claim contains other service line activity not related to the accident or injury. The CAS shall be taken into consideration when processing NGHP claims and determining if a conditional payment should be made. For the 2320 SBR05 it is acceptable to receive and include CP Medicare Conditionally Primary, AP for auto insurance policy or OT for other. The 2320 SBR09 may contain the claim filing indicator code of AM (automobile medical); LI (Liability), LM (Liability Medical) or WC (Workers' Compensation Health Claim). Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types. The 2300 DTP identifies the date of the accident with appropriate Value. The accident "related causes code" is found in 2300 CLM 11-1 through CLM 11-3.

NOTE: There is no occurrence code for *ASC X12 837 professional format* claims so the following conditional payment policy is being implemented. For Part B Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations, if there is no primary payer GHP to Medicare that will pay for services and the promptly period has expired then the *MAC* shall make a conditional payment for Medicare payable and covered services. A conditional payment may be made by Medicare where the physician or other supplier has attempted to bill a primary payer in non-GHP (i.e., Liability, No-Fault and Workers' Compensation) situations, but the NGHP insurer is not expected to pay in the promptly period. The *MACs* and shared systems shall take into consideration the CAS segment on the *ASC X12* 837 to also determine if conditional payment shall be made.

The graph below explains what the MSP 4010 *p*rofessional claim should look like when a physician/supplier is requesting conditional payments:

Type of Insurance	**CAS**	**Insurance Type Code (2320 SBR05)**	**Claim Filing Indicator (2320 SBR09)**	**Paid Amount (2320 AMT or 2430 SVD02)**	**Insurance Type Code (2000B SBR05)**	**Date of Accident**
No-Fault/ Liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AB, AP or OA

Type of Insurance	CAS	Insurance Type Code (2320 SBR05)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2000B SBR05)	Date of Accident
Workers' Compensation	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

For 5010 *p*rofessional claims the insurance codes change and the acceptable information for Medicare conditional payment request is modified to look like the following:

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/Liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00		2300 DTP 01 through 03 *(Qualifier 439, D8)* and 2300 CLM 11-1 through 11-3 with value AA or OA
Workers' Compensation	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02- Condition is Employment Related	2300 DTP 01 through 03 *(Qualifier 439, D8)*and 2300 CLM 11-1 through or 11-3 with value EM

40.7.3.1 - Medicare Secondary Payment Part B Claims Determination for Services Received on *ASC X12* 837 Professional Electronic Claims

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

Medicare's secondary payment is based on provider charges, or the amount the physician or other supplier is obligated to accept as payment in full (OTAF), whichever is lower; the primary payers allowed amount for Part B services; what Medicare would have paid as the primary payer; and the primary payer(s) payment. MSP policy also dictates what the shared systems and contractors must take into consideration in processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the Claims Adjustment (CAS) segments on the *ASC X12* 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the remittance advice and report these adjustments on the *ASC X12* 837 *professional claim format* when sending the claim to Medicare for secondary payment. The physician and other supplier also identify its charges and the other payer payment amounts which are found in other loops and segments in the *ASC X12* 837 *professional claim* transaction. *ASC X12* 837 claim transaction examples are cited below.

Example 1: A Medicare beneficiary visits her physician for an exam where the provider charges $1,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is primary to Medicare. The beneficiary's deductible had already been met. The physician is a participating physician under the primary payer group health plan. The contract amount, a.k.a. obligated to accept as payment in full amount, is the same as Medicare's fee schedule amount of $800. The primary payer also allowed $800. The primary payer ultimately pays $720 for the services. The service amounts are broken down:

Medicare Fee Schedule Procedure	$800
Submitted Charges	$1,000
Payer 1 Allowed Amount	$800
Payer 1 Contracted Agreement (OTAF)	$800
Payer 1 Patient Co-Insurance @ 10%	$ 80
Payer 1 Payment Amount	$720

Medicare payment is calculated as follows:

1) The contractual agreement amount (since this amount is lower than the charges) minus the third party payment: $800 - $720 = $80

2) Determine the Medicare payment in the usual manner: $800 - $160 = $640

3) The allowable charge minus the primary payer payment: $800 - $720 = $80

4) Medicare Pays $ 80 (lowest of amounts in steps 1, 2, or 3)

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

CLP*200725638901*1*1000*720*80*12*07256000236520**1~

CAS*CO*45*200~
CAS*PR*2*80~

Physician Abbreviated Secondary Claim to Medicare:

SBR*P*18*ABCGROUP******CI
CAS*CO*45*200~
CAS*PR*2*80~
AMT**D**720~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 1000-200=800
OTAF amount equals submitted charge minus CO group code adjustments – 1000-200=800

Medicare Abbreviated 835 to Physician

CLP*200725638901*2*1000*80**MB*0725600110236520**1~
CAS*OA*23*920~

Example 2: The same patient receives the same service from the physician. However, in this case the physician fails to follow plan procedures and is assessed a $50 penalty under the contract for not following plan procedures.

Medicare Fee schedule	$800
Submitted Charges	$1000
Payer 1 Contracted Agreement (OTAF)	$800
Payer 1 CO Plan Procedures not followed	$50
Payer 1 Patient Co-insurance @ 10%	$75
Payer 1 Payment Amount	$675

Medicare's Payment is calculated in the usual manner:

1. The contractual agreement amount (since this amount is lower than the charges) minus the third party payment: $800 - $725 = $75

2. Determine the Medicare payment in the usual manner: $800 - $160 = $640

3. The Medicare's allowable charge minus the primary payer payment: $800 - $725 = $75

4. Medicare pays $75 (lowest of amounts in steps 1, 2, or 3)

Due to the physician not following the primary health plan procedures Medicare uses the payment amount that the primary payer would have paid if the primary payer claim was filed properly.

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

CLP*200725638901*1*1000*675*75*12*07256000236520**1~
CAS*CO*45*200**95*50~
CAS*PR*2*75~

Physician Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI
CAS*CO*45*200**95*50~
CAS*PR*2*75~
AMT**D**675~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 1000-200 - 50=750
OTAF amount equals submitted charge minus CO group code adjustments – 1000-200=800

Medicare Abbreviated 835 to Physician

CLP*200725638901*2*1000*75**MB*0725600110236520**1~
CAS*OA*23*925~

Note: One of the problems of looking at adjustments other than patient responsibility is how accurately payers code 835's. In the above example the $50 adjustment could just as easily have been reported out as OA - Other Adjustment with the same Claim Adjustment Reason Code. That would necessitate examining not only group codes, but individual Claim Adjustment Reason Codes and possibly Remarks Codes in the Medicare edit logic.

Example 3: A patient receives services from a participating Medicare physician who is not a participating provider in the Primary Payer's network. The patient in this case is responsible for up to the provider's charges, but as a Medicare participating physician, the physician accepts the Medicare fee (Allowed Amount) as payment in full and thus cannot accept payment in excess of the Medicare Allowed Amount, a.k.a. Medicare fee

schedule. Medicare would indicate a $200 contractual obligation in its 835 remittance statement to the physician.

Medicare Fee schedule	$800
Submitted Charges	$1000
Payer 1 Fee Schedule	$700
Payer 1 Patient Co-insurance @ 10%	$70
Payer 1 Payment Amount	$630

Note that the charges and the OTAF are the same due to physician not participating in the primary payer's network. For this reason no CO appears on the inbound 837 to Medicare.

Medicare's Payment is calculated in the usual manner:

1. The charges/OTAF minus the third party payment: $1000 - $630 = $370

2. Determine the Medicare payment in the usual manner: $800 - $160 = $640
3. The Medicare's allowable charge minus the primary payer payment: $800 - $630 = $170
4. Medicare pays $170 (lowest of amounts in steps 1, 2, or 3)

Shared System MSP calculation:

Primary payer allowed amount equals submitted charge minus CARC 45 adjustments – 1000-300=700
OTAF amount equals submitted charge minus CO group code adjustments – 1000-0=1000

Primary Payer Abbreviated 835 containing amounts for MSP calculation

CLP*200725638901*1*1000*630*370*12*07256000236520**1~
CAS*PR*45*300**2*70~

Physician Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI
CAS*PR*45*300**2*70~
AMT**D**630~

Medicare Abbreviated 835 to Physician

CLP*200725638901*2*1000*170**MB*0725600110236520**1~
CAS*CO*45*200~
CAS*OA*23*630~

40.7.3.2 - Medicare Secondary Payment Part A Claims Determination for Services Received on *ASC X12* 837 Institutional Electronic or Hardcopy Claim Format*s*

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

Medicare's secondary payment for Part A MSP claims is based on Medicare covered charges, or the amount the physician or other supplier is obligated to accept as payment in full (OTAF), which ever is lower; what Medicare would have paid as the primary payer; and the primary payer(s) payment. MSP policy also dictates what the shared systems and contractors must take into consideration in processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the Claims Adjustment (CAS) segments on the *ASC X12* 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the primary payer remittance advice and report these adjustments on the *ASC X12* 837 when sending the claim to Medicare for secondary payment. *ASC X12* 837 claim transaction*s* examples are cited below.

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

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

The VC 44 OTAF amount is found in the *H*I segment on the *ASC X12* 837 *institutional claim* and this amount is sent to MSPPAY. If the OTAF is not found in the *H*I segment, but there is a group code CO in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY.

Medicare payment is calculated as follows:

1) The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8000- 0= $8000
2) The gross amount payable by Medicare minus the primary payment: $8000- $7200 = $800

3) The obligated to accept payment in full minus the primary payment: $8000 - $7200 = $800
4) The obligated to accept payment in full minus the Medicare deductible: $8000 – 0 = $8000
5) Pay $800 (lowest of amounts in steps 1, 2, 3, or 4)

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

CLP*200725638901*1*10000*7200*800*12*07256000236520**1~
CAS*CO*45*2000~
CAS*PR*2*800~

Provider Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI
CAS*CO*45*2000~
CAS*PR*2*800~
AMT*D*7200~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 10000-2000=8000.

(NOTE: Although the primary payer allowed amount is not used to determine Medicare's secondary payment it is shown here because it will appear on incoming *ASC X12* 837 *institutional claim format* in the CAS. The allowed amount is shown here and is used for purposes of balancing the remittance advice.)

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

Medicare Abbreviated 835 to Provider

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

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

Medicare Fee schedule	$8000
Charges	$10000
Payer 1 Contracted Agreement (OTAF)	$8000

Payer 1 CO Plan Procedures not followed	$500
Payer 1 Patient Responsibility @ 10%	$750
Payer 1 Payment Amount	$6750

Medicare's Payment is calculated in the usual manner:

1) The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8000- 0= $8000

2) The gross amount payable by Medicare minus the primary payment: $8000- $7250 = $750

3) The obligated to accept payment in full minus the primary payment: $8000 - $7250 = $750

4) The obligated to accept payment in full minus the Medicare deductible: $8000 – 0 = $8000

5) Pay $750 (lowest of amounts in steps 1, 2, 3, or 4)

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

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

Physician Abbreviated Secondary Claim to Medicare

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

Shared System MSP calculation:

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

Medicare Abbreviated 835 to Provider

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

40.7.3.3 - Version 5010 Balancing for Incoming MSP Claims Where MSP Amounts Appear at the Claim Level and Not at the Service Level Detail Line

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

There may be situations where the primary payer may identify the CARCs at the line level, but may also include additional CARCs and adjustments at the header level. Although receiving such MSP claims is a rare occurrence it is possible that these types of claims may be sent on 5010 claim transactions or on hardcopy claims.

The current Medicare Secondary Payer Payment Module (MSPPAY) calculates MSP claims payment for MSP claims received at the header level or at the detail level. Currently, when there is MSP information at the header level that is not identified at the detail the share system turns on the apportioning switch in MSPPAY to apportion the MSP claims to the detail lines. In situations where the claim level OTAF, primary payer allowed amount and/or primary payer paid amounts are not equal to the sum of the corresponding detail amounts, but the claim balances, this manual section instructs the Part B shared systems to use the claim level amounts to determine Medicare's secondary payment. This involves determining the MSP amounts utilizing the CAS adjustments as instructed in previous MSP and MSP CARC change requests, and then send these amounts, along with the claim detail information, to MSPPAY so MSPPAY can apportion the MSP amounts to the detail. Contractors may refer to the 5010 *ASC X12* 837*professional claim i*mplementation *g*uide - Front matter, Balancing section, specifically 1.4.4.1 for additional reference as needed.

To summarize this balancing, the claim level primary paid amount must equal the sum of the line level primary paid amounts less any claim level reductions.

	Submitted Charges	**Submitted** Primary Payment	**Submitted** CARCs
Claim Level	$200	$170	CO-xx $30
Line 1	$100	$100	
Line 2	$100	$100	

The above claim is consider in balance by version 5010 balancing rules, however, the sum of the line level primary paid amounts does not equal the claim level primary paid amount.

40.7.5 - Effect of Failure to File Proper Claim

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

The term "proper claim" means one that is filed in a timely manner and meets all other filing requirements specified by the GHP (e.g., mandatory second opinion, prior notification before seeking treatment).

When a provider, physician, supplier, or beneficiary (who is not physically or mentally incapacitated) receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment is the amount that Medicare would have paid if the GHP had paid on the basis of a proper claim.

The provider, physician, supplier, or beneficiary must inform CMS that a reduced payment was made and the amount that the GHP would have paid if a proper claim had been filed. If the *A/B MAC (B)* makes a greater secondary payment because the physician, supplier, or beneficiary fails to provide such notice and later discovers that the third party payment was a reduced amount because of failure to file a proper claim, the difference between the Medicare payment and the amount that Medicare should have paid on the basis of a proper claim for third party payment is an overpayment. The contractor recovers this amount, plus any applicable interest, from the party determined to be liable for the overpayment in accordance with the Medicare Financial Management Manual, Chapter 3, §§200 and 210.

EXAMPLE: A beneficiary receives services for which the physician's charges are $1,000. The primary payer's allowed charge is also $1,000, of which it would pay 80 percent or $800. However, the primary payer requires that the beneficiary receive a second opinion regarding the medical need for this service as a condition for filing a proper claim. Since the beneficiary failed to do so, the primary payer rejected the claim and refused to pay the beneficiary for the service. Medicare determines its secondary payment, in this case, as if the primary payer had paid on the basis of a proper claim. The Medicare fee schedule amount for this service is $800. The secondary payment is calculated as follows:

A. Actual charge by the physician minus what the GHP would have paid on the basis of a proper claim: $1,000 - $800 = $200.

B. The Medicare payment is determined in the usual manner: .80 x $800 = $640.

C. The primary payer's allowable charge of $1,000 (which is higher than Medicare's fee schedule amount of $800) minus the $800 the primary payer would have paid on the basis of a proper claim equals $200.

D. Medicare pays $200 (lowest of amounts in steps A, B, or C).

The beneficiary can be billed $800 by the physician (the amount of the third party payment reduction).

The adjustments, related to the proper claims rules and in the above example, appear in the CAS segment on *ASC X12* 837 MSP claims. The CAS claim adjustment reason code should appear as follows:

Billed:	$1000
CARC: PR1	$ 200
CARC: OA61	$800
Primary Pays:	$0

Medicare then takes the $800 penalty adjustment from the CAS for not getting a second opinion and adds this adjustment to the primary payer amount of zero. The $800 payment is sent to MSPPAY.

Another example would be if an *A/B MAC (A)* provider submitted the MSP claim on paper to seek payment for the hospital stay, the payment amount, what the primary payer would have paid if a claim was properly filed, would be placed in *Value Codes* by the provider. For example, if the employed beneficiary is working aged over 65 a VC 12 would be used in *Value Codes*. However the beneficiary did not get a second opinion as required by the primary insurance so a $500.00 penalization applies. So if the primary payer paid $6750.00 on the claim, but it would have paid $7250.00 if the claim was properly filed, then $7250.00 is placed in *Value Codes* with VC12. The manual explains this under 100-04/25/75.3. The beneficiary is held liable for the $500 penalty amount.

When failure to file a proper claim is due to the physical or mental incapacity of the beneficiary, the contractor considers the primary claim to have been properly filed and pays secondary benefits without regard to any third party benefit reduction attributable to failure to file a proper claim.

40.8.8 - Determining Patient Utilization Days, Deductible, and Coinsurance Amounts

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

Where a primary payer pays an amount for Medicare covered services that is equal to or less than the deductible and coinsurance that would apply if Medicare was the primary payer, Medicare charges full utilization. Therefore, it calculates coinsurance in the usual manner.

Where a primary payer pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare were the primary payer, Medicare charges utilization only to the extent that it paid for the services.

The MSP payment modules calculate days to be charged to the beneficiary's utilization. The *A/B MAC (A)* reports the result in the in the appropriate field of the CWF record as

described in CWF documentation. The procedures below describe how utilization and coinsurance are charged.

If payment by the primary payer for Medicare covered services is less than the provider's charges for those services and the current Medicare interim payment amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the primary payer payment as payment in full, the *A/B MAC (A)* follows the procedures below to determine utilization and coinsurance applicable.

Where the stay involves coinsurance days, the *A/B MAC (A)* determines utilization chargeable to the beneficiary. It completes coinsurance value codes and amounts accordingly. No adjustment to covered days is made based on this determination. The provider completes *covered days* in the usual manner.

The *A/B MAC (A)* charges utilization as follows:

- It determines the Medicare secondary payment amount in accordance with §§30.5.1 or 30.5.2 above;

- It divides this amount by the amount that Medicare would have paid as primary payer. This is the Medicare interim payment for the stay reduced by the deductible and coinsurance for non-PPS providers or the Medicare payment rate reduced by deductible and coinsurance for PPS providers; and

- It multiplies this percentage by the number of covered days in the stay or for PPS providers, the number of payable days in the stay.

The *A/B MAC (A)* does not charge a partial day resulting from this calculation as a full day if it is less than a half of a day. It charges a full day if it is a half day or more.

For PPS providers, where the number of payable days in the stay exceeds the number of days for which benefits are available (e.g., benefits are exhausted during the nonoutlier portion of the stay), the number of utilization days charged may not exceed the actual days available. If regular benefit days are exhausted during the basic portion of the stay and lifetime days are used for the outlier portion of the stay, the *A/B MAC (A)* separately computes the chargeable days for each portion of the stay.

The *A/B MAC (A)* charges coinsurance days as follows:

- If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed; or

- If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, *A/B MACs (A)* must perform the same calculation to verify that coinsurance *V*alue *C*odes and *A*mounts are completed correctly. The *A/B MAC (A)* advises the provider of any discrepancies.

EXAMPLE 1: Deductible Involved - PPS (no outlier involved) or Non-PPS Hospital

In 1998, an individual was hospitalized 15 days for which total charges were $5,000. The primary payer paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $764 had been met. The Medicare gross payment amount (without regard to the deductible or coinsurance) for the services absent the primary payer's payment would have been $3,600. The Medicare secondary payment is $1,200 ($3,600 - $2,400). Medicare would have paid $2,836 as primary payer ($3,600 - $764). The *A/B MAC (A)* calculates the beneficiary's utilization as follows: $1,200 divided by $2,836 = .423 x 15 days = 6.34 or 6 days, when rounded.

EXAMPLE 2: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

In 1998, an individual was hospitalized for 20 days (all of which are lifetime reserve days) for which total charges were $20,000. The primary payer paid $13,000 for Medicare covered services. The applicable coinsurance amount was $ 7,640. The current Medicare interim payment amount (without regard to the deductible or coinsurance) for the services, absent the primary payer's payment, would have been $17,000. The Medicare secondary payment amount is $4,000 (the Medicare gross payment amount of $17,000 minus the primary payer's payment of $13,000). Medicare would have paid $9,360 as primary payer ($17,000 - $7,640). The *A/B MAC (A)* calculates the beneficiary's utilization as follows: $4,000 divided by $ $9,360 = .427 x 20 days = 8.5 or 9 days when rounded. If the primary payer's payment in this example had been $7,640 or less, full utilization would have been charged. The beneficiary would have been charged with 20 days utilization.

EXAMPLE 3: Primary Payer Pays for Specified Number of Days - PPS (no outlier involved) or Non-PPS Hospital

The *A/B MAC (A)* uses this formula even when the primary payer pays for only a specified number of days of a stay because of a payment limitation under the plan based upon the number of benefit days available. For example, in 1998, a provider furnished 20 days of inpatient care. The primary payer paid all of the charges for the first 10 days. These charges were $4,500. No part of the Medicare inpatient deductible of $764 had been met. The current Medicare gross payment amount (without regard to the deductible or coinsurance) that Medicare would have paid for the 20-day stay, absent primary payer coverage, was $7,000. The Medicare secondary payment is $2,500 ($7,000 - $4,500). Medicare would have paid $ 6,236 as primary payer ($7,000 - $764). The *A/B MAC (A)* calculates the utilization charged to the beneficiary as follows: $2,500 divided by $6,236 = .400 X 20 days = 8.01 days or 8, days when rounded.

EXAMPLE 4: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

A beneficiary has 17 full days available at admission. The inpatient stay was 20 days. The provider bills 20 days in *C*overed *D*ays (form locator 7 of the *Form CMS-1450*) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed.

Absent any other insurer's payment, three days are billed in form locator 9 (*C*oinsurance *D*ays) with *V*alue *C*ode 9 or 11 and *V*alue *A*mount in *form locator* 39 (*C*oinsurance *V*alue *C*ode and *A*mount) and 20 days are in the "Cost Report Days" field of the CWF record.

EXAMPLE 5: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

A beneficiary has 30 coinsurance days available at admission. The hospital stay was 20 days. The provider bills 20 days in *C*overed *D*ays (form locator 7) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed.

Absent any other insurer's payment, 20 days are billed in form locator 9 (*C*oinsurance *D*ays) with *V*alue *C*ode 9 or 11 and the *V*alue *A*mount in form locator 39 (*C*oinsurance *V*alue *C*ode and *A*mount).

The *A/B MAC (A)* enters 10 days in the "Coinsurance Days" field and the "Cost Report Days" field of the CWF Record.

Absent any other insurer's payment, 20 days are billed in form locator 9 (*C*oinsurance *D*ays) with *V*alue *C*ode 9 or 11 and the *V*alue *A*mount in form locator 39 (*C*oinsurance *V*alue *C*ode and *A*mount).

In this case, the *A/B MAC (A)* enters 20 days in the "Coinsurance Days" field and the "Cost Report Days" field of the CWF record.

EXAMPLE 6: PPS Hospital

A beneficiary enters the hospital with two lifetime reserve days (LTR) remaining and elects to use them. The beneficiary is discharged after 15 days before the outlier threshold is reached. The Medicare payment rate is $5,000. The primary payer amount for Medicare covered services is $3,000. The applicable coinsurance amount is $764 (2 LTR days at $382 a day). Medicare would have paid $4,236 as primary payer ($5,000 - $764).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Utilization days potentially chargeable equal:

$2,000 divided by $4,236 X 15 days = 7 days

In this case, charge only the actual days of coverage in the stay, or two days, for utilization and cost reporting purposes.

EXAMPLE 7: PPS Hospital - CY 2001 Stay

A beneficiary enters the hospital with two regular coinsurance days remaining and is discharged after 15 days. The primary payer amount for Medicare covered services (i.e., the entire stay) was $3,000. The Medicare payment rate is $5,000. The applicable coinsurance amount is $396 (2 coinsurance days at $198 a day). Medicare would have paid $4,604 as primary payer ($5,000 - $396).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Regular benefit days chargeable =

$2,000 divided by $4,604 X 10 days in basic portion of stay = 7 days

Charge the beneficiary two coinsurance days, since only two days were available.

Lifetime reserve days chargeable =

$2,000 divided by $2,708 X 5 days in outlier portion of stay = 3.6 rounded to 4 days.

Charge the beneficiary for lifetime reserve days and determine coinsurance on this basis.

50.1.7 - Payment Calculation for Physician/Supplier Claims (MSPPAYB Module)

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

The MSPPAYB module performs the necessary payment calculation for physician/supplier claims with service "thru-dates" on or after November 13, 1989.

A. Data Elements to send to MSPPAYB

MSPPAY must send the following data elements to MSPPAYB:

NO.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function	"T" = display send/return data

NO.	Field Name	Definition/Use	Source/Value
		within the MSP software display sending and returning data. Used to identify payment problems.	Space = do not display data.
2	THRU DATE	Ending service date of the period included on the claim (CCYYMMDD)	Supplied by *A/B MAC (B)* system from *the claim.*
		THRU DATE CC	Value = "19" or "20"
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
3	RECORD ID	Identifies the claim type.	Part B = "HMBC"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by *A/B MAC (B)* system from *the claim*
5	DOC CNTL NUM	Assigned document control number.	Assigned and supplied by *A/B MAC (B)* system.
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by *A/B MAC (B)* system. Values: Y = Fully Paid Space = Not Fully Paid
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by *A/B MAC (B)* system Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data	Supplied by *A/B MAC (B)* system. May occur up to 10 times.
	MSP CODE	Code(s) identifying the other payer: 12 = EGHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers" Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Based on information obtained from the *claim or from* third party-payer information submitted with the claim, i.e., explanation of benefits.
	MSP AMOUNT	Amount(s) paid by the other payer.	Third party payer explanation of benefits
9	TOTAL ACTUAL CHARGES	Total charges billed by the physician/supplier.	*Total Charges billed on the professional claim.*

NO.	Field Name	Definition/Use	Source/Value
10	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer.	Third party payer explanation of benefits
11	OTHER PAYER ALLOWED AMT.	Covered charges allowed by the third party payer.	Third party payer explanation of benefits
12	MEDICARE REASONABLE CHG & FEE SCHEDULE	The Medicare reimbursement amount excluding applicable deductible and coinsurance.	Computed and supplied by *A/B MAC (B)* system.
13	FILLER		Nine Value Spaces
14	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare.	Zero for Medicare Part B
15	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Supplied by *A/B MAC (B)* system.
16	FILLER		Sixty-eight value spaces
17	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by *A/B MAC (B)* system.
18	FILLER		Six value spaces
19	Assignment Indicator	An indicator that identifies if the claim is assigned or unassigned.	*From the claim.*
20	FILLER		Twenty-eight value spaces
21	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by *A/B MAC (B)* system.
22	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by *A/B MAC (B)* system.
23	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by *A/B MAC (B)* system.
24	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by *A/B MAC (B)* system.
25	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Compute and supplied by *A/B MAC (B)* system.

NO.	Field Name	Definition/Use	Source/Value
	AND COINSURANCE)		
26	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by *A/B MAC (B)* system.
27	PSYCH CHARGES	Allowed psychiatric charges reduced by the psychiatric percent (62.5% of 80%) but unreduced by coinsurance and deductible (if applicable).	Computed and supplied by *A/B MAC (B)* system.
28	PAR INDICATOR		Supplied by *A/B MAC (B)* system "P" = Par Provider "N" = No-Par Provider
29	LIMITED FEE NON-PAR		Computed and supplied by *A/B MAC (B)* system
30	LIMITED CHARGES UNASSIGNED		Computed and supplied by *A/B MAC (B)* system
31	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred seventy nine value spaces.
32	RESERVED FOR USER	Space reserved for user as necessary.	One hundred ninety value spaces.

B. MSPPAYB Returning Data Elements

MSPPAYB will return the following data elements to MSPPAY. Refer to section A above for field definitions not reflected below.

No.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.

No	Field Name	Definition/Use
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to CWF.
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF

No	Field Name	Definition/Use
4	FILLER	Seventy seven value spaces
5	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the CWF.
6	FILLER	Nine value spaces
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
8	PROVIDER PAYMENT AMT	
9	PATIENT PAYMENT AMT	
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
13	FILLER	Three value spaces
14	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
15	GROSS MEDICARE PAYMENT	The amount Medicare pays as primary excluding deductibles and coinsurance.
16	FILLER	Nine value spaces.
17	SAVINGS MSP GHP	Amount saved by Medicare when an GHP has made a payment for a working aged beneficiary (MSP Code 12).
18	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
19	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
20	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
21	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
22	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).
23	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
24	SAVINGS MSP DSAB	Amount saved by Medicare when an

No	Field Name	Definition/Use
		LGHP has made a payment for a disabled beneficiary (MSP Code 43).
25	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
26	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.
27	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41, and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
28	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, and 42. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
29	MSP COMPUTATION 1	The result of: the total actual charge by the physician/supplier, or the limiting charge (if the claim is unassigned), or an amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer for covered services.
30	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
31	MSP COMPUTATION 3	The result of the higher of the primary payer's allowed or the Medicare allowed minus the amount paid by the primary payer. The Medicare allowed and the primary payer's allowed are determined without regard to the Medicare or primary plan's deductible or coinsurance, respectively.
32	FILLER	Nine value spaces
33	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)
34	RESERVED FOR USER	Space Reserved for User as Necessary. (153 value spaces)

50.1.8 - Payment Calculation for Physician/Supplier Claims (MSPPAYBL)

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

The sub-module performs the necessary payment calculation, on a by line basis, for physician/supplier claims with service "thru-dates" on or after April 1, 1998.

A. MSPPAYBL Sending Data Elements.

MSPPAY must send the following data to MSPPAYBL:

No.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software display sending and returning data. Used to identify payment problems.	"T" = display send/return data; Space = do not display data
2	FILLER		8 value spaces
3	RECORD ID		Identification of Part B type claim being processed = "HMBL"
4	CLMNO	Health Insurance Claim Number	Supplied by the *A/B MAC (B)* system.
5	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the *A/B MAC (B)* system
6	FILLER		1 value space
7	APPORTION SWITCH	Determine whether to apportion the Other Payer's Allowed Amount and Payment Amount	Supplied by the *A/B MAC (B)* system "N" = do not apportion Space = do apportion
8	TOTAL ACTUAL CHARGES		Supplied by the *A/B MAC (B)* system
9	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare	Supplied by the *A/B MAC (B)* system. Valid value '01' thru '10'

NOTE: THE FOLLOWING FIELDS WILL OCCUR 13 TIMES

No.	Field Name	Definition/Use	Source/Value

No.	Field Name	Definition/Use	Source/Value
10	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data. MSP Code - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal disease) 14 = AUTO (Automobile/No-Fault) 15 = Work (Worker's Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = Liab (Liability)	Based on information obtained from the *claim*, third party information submitted with the claim, i.e., explanation of benefits or appropriate electronic data elements. Supplied by the *A/B MAC (B)* system. May occur up to 10 times.
	MSP AMOUNT	Amount(s) paid by the other payer.	
11	OTHER PAYER ALLOWED AMT	Covered charges allowed by the third party payer.	Third Party Payer explanation of benefits
12	NUMBER OF LINES	Number of lines to compute MSP amounts.	Supplied by the *A/B MAC (B)* system
13	RESERVED FOR CMS	Space reserved for future enhancements.	124 value spaces
14	RESERVED FOR USER	Space reserved for user as necessary.	100 value spaces
15	LINE NUMBER	Line of service number.	Supplied by the *A/B MAC (B)* system. Values "01" thru "13"
16	DENIED INDICATOR	Indicator that reflects whether Medicare or the other *A/B MAC (B)* denied the line of service.	Supplied by the *A/B MAC (B)* system "D" = Line of service denied by the other *A/B MAC (B)* and/or Medicare. Space = Line of service accepted for payment by the other *A/B MAC (B)* and/or Medicare.
17	FILLER		One value space
18	THRU DATE	Ending service date of the period included on the claim (CCYYMMDD) THRU DATE CC THRU DATE YY THRU DATE MM	Supplied by the *A/B MAC (B)* system from Field 24 of the Form CMS-1500 Value = "19" or "20" Value = "00" thru "99" Value = "01" thru "12"

No.	Field Name	Definition/Use	Source/Value
		THRU DATE DD	Value = "01" thru "31"
19	RECORD ID	Identifies the claim type.	Part B = "HMBL"
20	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the *A/B MAC (B)* system from Field 1a of the Form CMS-1500
21	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the *A/B MAC (B)* system
22	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the *A/B MAC (B)* system "Y" = Fully paid by other payer Space = Not fully paid by other payer
23	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare	Supplied by the *A/B MAC (B)* system Valid value "01" thru "10"
24	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data.	Based on information obtained from the *claim*. Third party information submitted with the claim, i.e., explanation of benefits or appropriate electronic data elements.
25	MSP CODE	Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal disease) 14 = AUTO (Automobile/No-Fault) 15 = Work (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Supplied by the *A/B MAC (B)* system. May occur up to 10 times
26	MSP AMOUNT	Amount(s) paid by the other payer.	Third party payer explanation of benefits
27	TOTAL ACTUAL CHARGES	Total charges billed by the physician/supplier.	Form CMS-1500, Field 28
28	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full when this amount is less than the charges but higher than the	Third party payer explanation of benefits

No.	Field Name	Definition/Use	Source/Value
		payment received from the primary payer.	
29	OTHER PAYER ALLOWED AMT	Covered charges allowed by the third party payer.	Third party payer explanation of benefits
30	MEDICARE REASONABLE CHG &FEE SCHEDULE	The Medicare reimbursement amount excluding applicable deductible and coinsurance.	Computed and supplied by the *A/B MAC (B)* system.
31	FILLER		Nine value spaces
32	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare.	Zero for Medicare Part B
33	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Supplied by the *A/B MAC (B)* system.
34	FILLER		Sixty-eight value spaces
35	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the *A/B MAC (B)* system.
36	FILLER		Six value spaces
37	ASSIGNMENT INDICATOR	An indicator that identifies if the claim is assigned or unassigned.	*From the claim* "A" = Assigned claim "B" = Non-assigned claim
38	FILLER		Twenty eight value spaces
39	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the *A/B MAC (B)* system.
40	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the *A/B MAC (B)* system.
41	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the *A/B MAC (B)* system.
42	G-R-H PERCENT (GRAMM-RUDMANN - HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the *A/B MAC (B)* system.
43	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the *A/B MAC (B)* system.
44	CHARGES SD	Charge amount subject to	Computed and supplied by the

No.	Field Name	Definition/Use	Source/Value
	(CHARGES SUBJECT TO DEDUCTIBLE)	the deductible.	*A/B MAC (B)* system.
45	PSYCH CHARGES	Allowed psychiatric charges reduced by the psychiatric percent (62.5% of 80%) but unreduced by coinsurance and deductible (if applicable).	Computed and supplied by the *A/B MAC (B)* system.
46	PAR INDICATOR	Indicator reflecting whether the provider participates in the Medicare program.	Supplied by the *A/B MAC (B)* system. "P" = Par Provider "N" = Non-Par Provider
47	LIMITED FEE NON-PAR	The fee amount paid to a nonparticipating provider.	Computed and supplied by the *A/B MAC (B)* system.
48	LIMITED CHARGES UNASSIGNED	The charge for each service on unassigned claims.	Computed and supplied by the *A/B MAC (B)* system if LC on *the claim* exceeds more than 115% of Medicare fee schedule amount.
49	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred seventy nine value spaces.
50	RESERVED FOR USER	Space reserved for user as necessary.	One hundred ninety value spaces.

B. MSPPAYBL Returning Data Elements.

MSPPAYBL will return the following data to MSPPAY:

No	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.
2	HEADER OR LINE ERROR	Reflects if an error was detected at the claim header or line when computing MSP by line.	Determined by MSPPAYBL: "H" = Header Error "L" = Line Error
3	LINE NUMBER OF ERROR	Reflects the line of service an error was detected.	

No	Field Name	Definition/Use	Source/Value
4	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).	
5	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF	
6	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File.	
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.	
8	PROVIDER PAYMENT AMT		
9	PATIENT PAYMENT AMT		
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
13	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
14	SAVINGS MSP GHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
15	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	
16	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
17	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
18	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
19	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
20	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	

No	Field Name	Definition/Use	Source/Value
21	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
22	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
23	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	
24	RESERVED FOR CMS	Space reserved for future enhancements. (123 value spaces)	
25	RESERVED FOR USER	Space reserved for user as necessary. (118 value spaces)	

NOTE: THE FOLLOWING FIELDS WILL OCCUR 13 TIMES

26	LINE NUMBER	Line of service number
27	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.

NOTE: The Source/Value is determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical and user documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.

No	Field Name	Definition
28	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the CWF
29	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF.
30	FILLER	(77 value spaces)
31	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the CWF.
32	FILLER	(9 value spaces)
33	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
34	PROVIDER PAYMENT AMT	Reimbursement paid to the provider.
35	PATIENT PAYMENT AMT	Reimbursement paid to the patient.

No	Field Name	Definition/Use	Source/Value
36	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
37	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
38	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
39	FILLER	(3 value spaces)	
40	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
41	GROSS MEDICARE PAYMENT	The amount Medicare pays as primary excluding deductibles and coinsurance.	
42	FILLER	(36 value spaces)	
43	SAVINGS MSP GHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
44	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	
45	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
46	SAVINGS MSP WORK	Amount saved by Medicare when Workers' compensation payment has been made (MSP Code 15).	
47	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
48	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
49	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
50	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
51	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
52	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	
53	FILLER	Eighteen value spaces	
54	MSP COMPUTATION 1	The result of the total actual charge by the physician/supplier, or the limiting charge (if the claim is unassigned), or an amount the physician/supplier is obligated to accept as payment in full, if that is less than the charges, minus the amount paid by the	

No	Field Name	Definition/Use	Source/Value
		primary payer for covered services.	
55	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.	
56	MSP COMPUTATION 3	The result of the higher of the primary payer's allowed or the Medicare allowed minus the amount paid by the primary payer. The Medicare allowed and the primary payer's allowed are determined without regard to the Medicare or primary plan's deductible or coinsurance, respectively.	
57	FILLER	Nine value spaces	
58	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)	
59	RESERVED FOR USER	Space reserved for user as necessary. (153 value spaces)	

50.2.7 - Payment Calculation for Inpatient Bills (MSPPAYAI Module)

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

MSPPAYAI performs the necessary payment calculation for inpatient, skilled nursing facility (SNF), and Religious Nonmedical Health Care (RNHC) bills with service dates on or after November 13, 1989.

A. Data Elements to send to MSPPAYAI

MSPPAY must send the following data elements to MSPPAYAI

No.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software to display sending and returning data. Use to identify payment errors.	"T" = display send/return data; Space = do not display data.
2	THRU DATE	Ending service date of the period included on the bill (CCYYMMDD)	Supplied by the *A/B MAC (A)* system from *the claim*
		THRU DATE CC THRU DATE YY THRU DATE MM THRU DATE DD	Value = "19" thru "20" Value = "00" thru "99" Value = "01" thru "12" Value = "01" thru "31"
3	RECORD ID	Identifies the bill type.	Inpatient (including SNF/CSS) bills =

No.	Field Name	Definition/Use	Source/Value
			"HMIP"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the *A/B MAC (A)* system from *the claim*
5	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the *A/B MAC (A)* system
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the *A/B MAC (A)* system. Can be identified by an "O" frequency indicator in *Type of Bill*. Also identified by *C*ondition *C*ode "77". Value Y = Fully Paid Space = Not Fully Paid
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by the *A/B MAC (A)* system. Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE	MSP code and MSP amount comprise primary payer data.	Supplied by the *A/B MAC (A)* system. May occur up to 10 times.
	MSP CODE	Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	*V*alue *C*odes 12-16 and 41-47 *from the claim*
	MSP AMOUNT	Amount(s) paid by the other payer.	Value *A*mounts *from the claim*
9	TOTAL COVERED CHARGES	Total charges covered by Medicare	*Total Covered Charges from the claim*

No.	Field Name	Definition/Use	Source/Value
10	OBLIGATED TO ACCEPT	The amount a provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" *or CAS group code CO amount,* appears on the bill. It is reported in addition to the MSP Code(s) and MSP amounts(s) and the total covered charges on the bill.	Value Code "44" *or CAS group code CO amount,from the claim*
11	FILLER		Eighteen value spaces.
12	MED PAYMENT AMOUNT	Medicare payment without regard to deductibles and coinsurance.	Computed and supplied by the *A/B MAC (A)* system.
13	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare	Value Code 06 *from the claim*
14	CASH DEDUCTION	Dollar amount of cash deductible charged by Medicare.	Value Code 07 *from the claim*
15	REG COIN DAYS 1ST YR	Medicare coinsurance days charged in the year of admission.	Computed and supplied by the *A/B MAC (A)* system
16	REG COIN RATE 1ST YR.	The Medicare coinsurance rate charged in the year of admission.	Computed and supplied by the *A/B MAC (A)* system.
17	REG COIN AMT 1ST YR	The Medicare coinsurance amount charged in the year of admission.	Value Code 09 *from the clai*m
18	REG COIN DAYS 2ND YR	Medicare coinsurance days charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the *A/B MAC (A)* system.
19	REG COIN RATE 2ND YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans	Computed and supplied by the *A/B MAC (A)* system.

No.	Field Name	Definition/Use	Source/Value
		two calendar years.	
20	REG COIN AMT 2ND YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.	Value Code 11 *from the claim*
21	REG COIN DAYS 3RD YR	Medicare coinsurance days charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the *A/B MAC (A)* system.
22	REG COIN RATE 3RD YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the *A/B MAC (A)* system.
23	REG COIN AMT 3RD YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans three calendar years.	Value Code 11 *from the claim*
24	REG COIN DAYS 4TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the *A/B MAC (A)* system.
25	REG COIN RATE 4th YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the *A/B MAC (A)* system.
26	REG COIN AMT 4TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans four calendar years.	Value Code 11 *from the claim*
27	REG COIN DAYS 5TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the *A/B MAC (A)* system.
28	REG COIN RATE 5TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the *A/B MAC (A)* system.
29	REG COIN AMT 5TH YR	The Medicare coinsurance amount charged in the year of	Value Code 11 *from the claim*

No.	Field Name	Definition/Use	Source/Value
		discharge where the bill spans five calendar years.	
30	REG COIN DAYS 6TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the *A/B MAC (A)* system.
31	REG COIN RATE 6TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the *A/B MAC (A)* system.
32	REG COIN AMT 6TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans six calendar years.	Value Code 11 *from the claim*
33	LTR COIN DAYS 1ST YR	Medicare lifetime reserve days charged in the year of admission.	Computed and supplied by the *A/B MAC (A)* system.
34	LTR COIN RATE 1ST YR	The Medicare lifetime reserve rate charged in the year of admission.	Computed and supplied by the *A/B MAC (A)* system.
35	LTR COIN AMT 1ST YR	The Medicare lifetime reserve amount charged in the year admission.	Value Code 08 *from the claim*
36	LTR COIN DAYS 2ND YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the *A/B MAC (A)* system.
37	LTR COIN RATE 2ND YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the *A/B MAC (A)* system.
38	LTR COIN AMT 2ND YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.	Value Code 11 *from the claim*
39	LTR COIN DAYS 3RD YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans	Computed and supplied by the *A/B MAC (A)* system.

No.	Field Name	Definition/Use	Source/Value
		three calendar years.	
40	LTR COIN RATE 3RD YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the *A/B MAC (A)* system.
41	LTR COIN AMT 3RD YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans three calendar years.	Value Code 11 *from the claim*
42	LTR COIN DAYS 4TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the *A/B MAC (A)* system.
43	LTR COIN RATE 4TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the *A/B MAC (A)* system.
44	LTR COIN AMT 4TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans four calendar years.	Value Code 11 *from the claim*
45	LTR COIN DAYS 5TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the *A/B MAC (A)* system.
46	LTR COIN RATE 5TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the *A/B MAC (A)* system.
47	LTR COIN AMT 5TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans five calendar years.	Value Code 11 *from the claim*
48	LTR COIN DAYS 6TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the *A/B MAC (A)* system.

No.	Field Name	Definition/Use	Source/Value
49	LTR COIN RATE 6TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the *A/B MAC (A)* system.
50	LTR COIN AMT 6TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans six calendar years.	Value Code 11 *from the claim*
51	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the *A/B MAC (A)* system.
52	FULL DAYS	The inpatient Medicare days occurring in the first 60 days in a single spell of illness.	Computed and supplied by the *A/B MAC (A)* system.
53	COVERED DAYS	The number of Medicare covered days.	*From the claim*
54	FILLER		One value space
55	PPS IND	An indicator that identifies a prospective payment provider.	Supplied by *the A/B MAC (A)* system: X = PPS S = CSS (non-PPS), Spaces = non-PPS
56	DRG AMOUNT	Total prospective payment amount including any outlier payment, as determined by Pricer.	Computed by Pricer and supplied by the *A/B MAC (A)* system
57	DIRECT GRADUATE MEDICAL EDUCATION	Estimated adjustment for the direct graduate medical education activities (See 42 CFR 413.86.)	Computed and supplied by the *A/B MAC (A)* system.
58	PASS THRU PER DIEM	Payment amount for those items that are reimbursed on a reasonable cost basis.	Computed and supplied by the *A/B MAC (A)* system.
59	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the *A/B MAC (A)* system.
60	PROVIDER PAYMENT AMOUNT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the *A/B MAC (A)* system.

No.	Field Name	Definition/Use	Source/Value
61	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the *A/B MAC (A)* system.
62	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the *A/B MAC (A)* system.
63	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the *A/B MAC (A)* system.
64	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the *A/B MAC (A)* system.
65	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred ninety eight value spaces.
66	RESERVED FOR USER	Space reserved for user as necessary.	One-hundred ninety value Spaces

B. Data Elements returned from MSPPAYAI

MSPPAYAI will return the following data elements to MSPPAY. Refer to §50.2.7 for field definitions not reflected below.

NO.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAI. Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical documentation released with the software.

Unless specified otherwise, MSPPAY is the source of all the following fields, possibly modified by MSPPAYAI.

NO.	Field Name	Definition/Use
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to

NO.	Field Name	Definition/Use
		the Common Working File (CWF).
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the Common Working File (CWF).
4	REG COIN DAYS 1ST YR	
5	REG COIN RATE 1ST YR	
6	REG COIN AMT 1ST YR	
7	REG COIN DAYS 2ND YR	
8	REG COIN RATE 2ND YR	
9	REG COIN AMT 2ND YR	
10	REG COIN DAYS 3RD YR	
11	REG COIN RATE 3RD YR	
12	REG COIN AMT 3RD YR	
13	REG COIN DAYS 4TH YR	
14	REG COIN RATE 4TH YR	
15	REG COIN AMT 4TH YR	
16	REG COIN DAYS 5TH YR	
17	REG COIN RATE 5TH YR	
18	REG COIN AMT 5TH YR	
19	REG COIN DAYS 6TH YR	
20	REG COIN RATE 6TH YR	
21	REG COIN AMT 6TH YR	
22	LTR COIN DAYS 1ST YR	
23	LTR COIN RATE 1ST YR	
24	LTR COIN AMT 1ST YR	
25	LTR COIN DAYS 2ND YR	
26	LTR COIN RATE 2ND YR	
27	LTR COIN AMT 2ND YR	
28	LTR COIN DAYS 3RD YR	
29	LTR COIN RATE 3RD YR	
30	LTR COIN AMT 3RD YR	

NO.	Field Name	Definition/Use
31	LTR COIN DAYS 4TH YR	
32	LTR COIN RATE 4TH YR	
33	LTR COIN AMT 4TH YR	
34	LTR COIN DAYS 5TH YR	
35	LTR COIN RATE 5TH YR	
36	LTR COIN AMT 5TH YR	
37	LTR COIN DAYS 6TH YR	
38	LTR COIN RATE 6TH YR	
30	LTR COIN AMT 6TH YR	
31	PART A REG COIN DAYS	The total Medicare coinsurance days chargeable to the beneficiary.
32	PART A LTR COIN DAYS	The total Medicare lifetime reserve days chargeable to the beneficiary.
33	PARTA COIN DAYS	The total Medicare coinsurance and lifetime reserve days chargeable to the beneficiary.
34	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File (CWF).
35	FULL DAYS	The number of inpatient Medicare days occurring in the first 60 days in a single spell of illness.
36	UTILIZED DAYS	Days of care that are chargeable to Medicare
37	COST REPORT DAYS	Days credited to the provider's PS&R as Medicare days.
38	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
39	PROVIDER PAYMENT AMT	
40	PATIENT PAYMENT AMT	
41	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.

NO.	Field Name	Definition/Use
42	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
43	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
44	MSP COVERED DAYS	The number of days covered by the primary payer.
45	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
46	GROSS MEDICARE PAYMENT	The amount Medicare pays excluding deductibles and coinsurance. (For PPS claims, direct graduate medical education and pass-thru amounts are included.)
47	MSP NON-EGHP PYMT SDC	The amount paid by a non-EGHP to be reflected on the PS&R. The primary payer amount designated to lab charges reimbursed at 100%is not reflected in this figure. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
48	MSP PYMT SDC	The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT" reflects the total primary payer amount. The primary payer amount designed to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)
49	FILLER	Nine Value spaces.
50	PPS CREDIT AMOUNT	The excess of the MSP amount over the DRG amount.

NO.	Field Name	Definition/Use
51	SAVINGS MSP EGHP	Amount saved by Medicare when an EGHP has made a payment for a working aged beneficiary (MSP Code 12).
52	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
53	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
54	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
55	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
56	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).
57	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
58	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).
59	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
60	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer and a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.

NO.	Field Name	Definition/Use
61	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41, and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
62	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, 42, and 43. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
63	MSP COMPUTATION 1	The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.
64	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
65	MSP COMPUTATION 3	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount paid by the primary payer.
66	MSP COMPUTATION 4	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts.
67	RESERVED FOR CMS	Space reserved for future enhancements. (200 Value Spaces)
68	RESERVED FOR USER	Space reserved for user as necessary. (153 Value Spaces)

50.2.8 - Payment Calculation for Outpatient Claims (MSPPAYOL)

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

MSPPAYOL performs the necessary payment calculation, on a line-by-line basis, for outpatient claims with service "thru-dates" on or after November 13, 1989.

A. MSPPAYOL Sending Data Elements

MSPPAY must send the following data elements to MSPPAYOL:

No.	Field Name/Definition/Use	Source/Value
	(H) = Claim Header	
1.	TEST SWITCH (H) Indicator to turn on function within the MSP software to display sending and returning data. Used to identify payment problems.	"T" = display send/return data space = do not display data
2.	FILLER	Value spaces
3.	RECORD ID (H) Identifies the bill type	Part A Outpatient by line - "HMOL"
4.	CLMNO (H) Health Insurance Claim Number	Supplied by the *A/B MAC (A)* system *from the claim.*
5.	DOC CNTL NUM (H) Assigned document control number	Assigned and supplied by the *A/B MAC (A)* system
6.	FILLER	Value space
7.	APPORTION SWITCH (H)	Supplied by the *A/B MAC (A)* system to determine whether to apportion the Other Payer's Payment Amount and Obligated To Accept (if applicable): "N" = Do not apportion Space = do apportion
8.	TOTAL COVERED CHARGES (H)	Supplied by the *A/B MAC (A)* system
9.	NUM OTHER PAYERS (H) The number of other payers who are primary to Medicare	Supplied by the *A/B MAC (A)* system Valid value "01" thru "10"

No.	Field Name/Definition/Use	Source/Value
10.	THIRD PARTY PAYER TABLE (H) MSP CODE (H) - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) MSP AMOUNT (H) - Amounts paid by the other payer	Supplied by the *A/B MAC (A)* system May occur up to 10 times. *Value Codes* 12-16 and 41-47 *from the claim.*
11.	OBLIGATED TO ACCEPT Amount the provider agrees to accept as payment in full when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" *or CAS group code CO amount,* appears on the bill. It is reported in addition to the MSP code(s), MSP amount(s), and the total covered charges on the bill.	
12.	NUMBER OF LINES (H) - of lines to compute MSP amounts	Supplied by the *A/B MAC (A)* system
13.	RESERVED FOR CMS (H)	76 value spaces
14.	RESERVED FOR USER (H)	75 value spaces
	(L) CLAIM LINE **NOTE:** THE FOLLOWING FIELDS WILL OCCUR 450 TIMES	
15.	LINE NUMBER (L) Line of service number.	Supplied by the *A/B MAC (A)* system Values "01" thru "450"

No.	Field Name/Definition/Use	Source/Value
16.	BYPASS INDICATOR (L)	Supplied by the *A/B MAC (A)* system "B" = Line of service to be bypassed by the software. Space = Line of service not bypassed by the software.
17.	DENIED INDICATOR (L)	Supplied by the *A/B MAC (A)* system "D" = Line of service denied by the Other Payer. Space = Line of service accepted for payment by the Other Payer.
18.	THRU DATE (L) THRU DATE CC (L) THRU DATE YY (L) THRU DATE MM (L) THRU DATE DD (L)	Supplied by the *A/B MAC (A)* system Value = "19" or "20" Value = "00" thru "99" Value = "01" thru "12" Value = "01" thru "31"
19.	FULLY PAID CLAIM IND (L) Indicator that reflects line is fully paid by the third party payer	Supplied by the *A/B MAC (A)* system "Y" = Fully Paid by Other Payer Space = Not Fully Paid by Other Payer
20.	NUM OF OTHER PAYERS (L) The number of other payers who are primary to Medicare.	Supplied by the *A/B MAC (A)* system Value "01" thru "10"
21.	THIRD PARTY PAYER TABLE (L)	Supplied by the *A/B MAC (A)* system May occur up to 10 times.
	MSP CODE (L) - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) MSP AMOUNT (L) - Amounts paid by the other payer	*Institutional claim Value Codes 12-16 and 41-47.*
22.	TOTAL COVERED CHARGES (L)	Supplied by the *A/B MAC (A)* system

No.	Field Name/Definition/Use	Source/Value
	Total charges covered by Medicare. Code(s), MSP amount(s), and the total covered charges on the bill.	
23.	OBLIGATED TO ACCEPT (L) Amount the provider agrees to accept as payment in full when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44," *or group code CO amount,* appears on the bill. It is reported in addition to the MSP code(s), MSP amount(s), and the total covered charges on the bill.	*Claim* Value Code "44", *or CAS group code CO amount, from the claim* Apportioned by MSPPAY Software
24.	MED PAYMENT AMOUNT (L) Medicare payment without regard to deductibles and coinsurance	Supplied by the *A/B MAC (A)* system
25.	BLOOD DEDUCTION (L) Dollar amount of blood deductible charged by Medicare.	*Claim* Value Code 06.
26.	CASH DEDUCTION (L) Dollar amount of deductible charged by Medicare.	*Claim* Value *C*ode 07.
27.	TOTAL COIN AMT (L) The Total Coinsurance amount chargeable to the beneficiary	Computed and Supplied by the *A/B MAC (A)* system.
28.	MED PRIMARY PAYMENT (L) The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the *A/B MAC (A)* system
29.	PROVIDER PAYMENT AMT (L) The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the *A/B MAC (A)* system
30.	PATIENT PAYMENT AMT (L) The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the *A/B MAC (A)* system
31.	G-R-H PERCENT (L) (GRAMM-RUDMANN-HOLLINGS) The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the *A/B MAC (A)* system
32.	CHARGES NSDC (L) CHARGES NOT SUBJECT TO	Computed and supplied by the *A/B MAC (A)* system

No.	Field Name/Definition/Use	Source/Value
	DEDUCTIBLE AND COINSURANCE) - Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	
33.	CHARGES SD (L) (CHARGES SUBJECT TO DEDUCTIBLE) Charge amount subject to the deductible.	Computed and supplied by the *A/B MAC (A)* system
34.	PPS IND (L) - An indicator that identifies a prospective payment computation	"P" = PPS Spaces = Non-PPS

B.
MSPPAYOL Returning Data Elements

MSPPAYOL will return the following data elements to MSPPAY.

No.	Field Name/Definition/Use	Source/Value
	(H) CLAIM HEADER	
1.	RETURN CODE (H) Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYOL Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical and user documentation released with the software.)
2.	HEADER OR LINE ERROR (H) Reflects if an error was detected at the claim header or line when computing MSP by line.	Determined by MSPPAYOL "H" = Header Error "L" = Line Error
3.	LINE NUMBER OF ERROR (H) Reflects the line of service an error was detected.	
4.	BLOOD DEDUCTION TO CWF (H) Amount of blood deductible to report to the Common Working File (CWF).	
5.	CASH DEDUCTION TO CWF (H) Dollar amount of deductible to report to the CWF.	
6.	TOTAL COIN AMT TO CWF (H) - The total coinsurance amount to report to the CWF.	

No.	Field Name/Definition/Use	Source/Value
7.	MED SECONDARY PAYMENT (H) Medicare's secondary payment computed by the MSP software.	
8.	PROVIDER PAYMENT AMT (H) -	
9.	PATIENT PAYMENT AMT (H)	
10.	BLOOD DEDUCTION TO CHG (H) The amount of blood deductible the beneficiary may be charged by the provider.	
11.	CASH DEDUCTION TO CHG (H) - The dollar amount of deductible the beneficiary may be charged by the provider	
12.	TOTAL COIN AMT TO CHG (H) - The total coinsurance amount chargeable to the beneficiary	
13.	G-R-H SAVINGS REDUCTION (H) - (Gramm-Rudmann-Hollings) The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
14.	GROSS MEDICARE PAYMENT (H) The amount Medicare pays excluding deductibles and coinsurance.	
15.	MSP PYMT SDC (H) The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT" reflects the total primary payer amount. The primary payer amount designed to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
16.	PSR AMOUNT (H) The primary payer amount used in the Provider Statistical Report System.	
17.	SAVINGS MSP GHP - Amount saved	

No.	Field Name/Definition/Use	Source/Value
	by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
18.	SAVINGS MSP ESRD - Amount saved by Medicare when a GHP has made a payment for an ESRD beneficiary (MSP Code 13).	
19.	SAVINGS MSP AUTO - Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
20.	SAVINGS MSP WORK -Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
21.	SAVINGS MSP FEDS - Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
22.	SAVINGS MSP BL - Amount saved by Medicare when Black Lung payment has been made by the Department of Labor. (MSP Code 41).	
23.	SAVINGS MSP VA - Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
24.	SAVINGS MSP DSAB - Amount saved by Medicare when a LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
25.	SAVINGS MSP LIAB - Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
26.	SAVINGS TOTAL - Total savings to the Medicare program when Medicare is the secondary payer and a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	
	(L) CLAIM LINE	
	NOTE: THE FOLLOWING FIELDS WILL OCCUR 450 TIMES	

No.	Field Name/Definition/Use	Source/Value
27.	LINE NUMBER - Line of service number.	
28.	RETURN CODE - Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAO. Valid values "3000" thru "3999" See §50.2.3 above; also refer to the technical and user documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.
29.	BLOOD DEDUCTION TO CWF - Amount of blood deductible to report to the CWF	
30.	CASH DEDUCTION TO CWF - Dollar amount of deductible to report to the CWF.	
31.	TOTAL COIN AMT TO CWF - The total coinsurance amount to report to the CWF.	
32.	MED SECONDARY PAYMENT - Medicare's secondary payment computed by the MSP software.	
33.	PROVIDER PAYMENT AMT - Reimbursement paid to the provider.	
34.	PATIENT PAYMENT AMT - reimbursement paid to the patient.	
35.	BLOOD DEDUCTION TO CHG - The amount of blood deductible the beneficiary may be charged by the provider.	
36.	CASH DEDUCTION TO CHG - The dollar amount of deductible the beneficiary may be charged by the provider.	
37.	TOTAL COIN AMT TO CHG - The total coinsurance amount chargeable to the beneficiary.	
38.	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION - The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
39.	GROSS MEDICARE PAYMENT - The amount Medicare pays as primary excluding deductibles and	

No.	Field Name/Definition/Use	Source/Value
	coinsurance.	
40.	SAVINGS MSP GHP - Amount saved by Medicare when an GHP has made a payment for a working aged beneficiary (MSP Code 12).	
41.	SAVINGS MSP ESRD - Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	
42.	SAVINGS MSP AUTO - Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
43.	SAVINGS MSP WORK - Amount saved by Medicare when Workers' compensation payment has been made (MSP Code 15).	
44.	SAVINGS MSP FEDS - Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
45.	SAVINGS MSP BL - Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
46.	SAVINGS MSP VA - Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
47.	SAVINGS MSP DSAB - Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
48.	SAVINGS MSP LIAB - Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
49.	SAVINGS TOTAL - Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	

No.	Field Name/Definition/Use	Source/Value
50.	MSP COMPUTATION 1 - The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.	
51.	MSP COMPUTATION 2 - The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.	
52.	MSP COMPUTATION 3 - The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount paid by the primary payer.	
53.	MSP COMPUTATION 4 - The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts.	

50.2.9 - Payment Calculation for Outpatient Bills (MSPPAYAO Module)

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

MSPPAYO performs the necessary payment calculation for outpatient, home health, and hospice bills with service "thru-dates" on or after November 13, 1989.

A. MSPPAYAO Sending Data Elements

MSPPAY, or MSPPAYOL, when the claim is calculated to the line level, must send the following data elements to MSPPAYAO:

NO.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software to display sending and returning data. Used to identify payment problems.	T = display send/return data; Space = do no display data.
2	THRU DATE	Ending service date of the period included on the bill (CCYYMMDD) THRU DATE CC	Supplied by the *A/B MAC (A)* system from *the From-Through dates of the claim* Value = "19" thru "20"

NO.	Field Name	Definition/Use	Source/Value
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
3	RECORD ID	Identifies the bill type.	Outpatient = "HMOP" Home health = "HMHH" Hospice = "HMHC"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the *A/B MAC (A)* system from *the claim.*
5	DOC CNTL NUM	Assigned document control number.	Assigned and supplied by the *A/B MAC (A)* system.
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the *A/B MAC (A)* system. Can be identified by a "0" frequency indicator in *Type of Bill, or C*ondition *C*ode "77" *on the claim*. *MSPPAYO* Values: Y = Fully paid by other payer. Space = Not fully paid by other payer.
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by the *A/B MAC (A)* system. Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE MSP AMOUNT	MSP code(s) and MSP amount comprise third party data. MSP CODE - Code(s) identifying the other payer: 12 = EGHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) Amount(s) paid by the other payer.	Supplied by the *A/B MAC (A)* system *from claim Value Codes 12-16 and 41-47*. May occur up to 10 times. .

NO.	Field Name	Definition/Use	Source/Value
9	TOTAL COVERED CHARGES	Total charges covered by Medicare. Code(s), MSP amount(s), and the total covered charges on the bill.	*Claim Value Code Amounts*
10	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full, when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44," *or CAS group code CO amount,* appears on the bill. It is reported in addition to the MSP amount(s), and the total covered charges on the bill.	
11	FILLER		Eighteen value spaces
12	MED PAYMENT AMOUNT	Medicare payment without regard to deductibles and coinsurance.	Computed and supplied by the *A/B MAC (A)* system.
13	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare	*Claim* Value Code 06 *Amount*
14	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	*Claim Value Code 07 Amount*
15	FILLER		Sixty-eight value spaces
16	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the *A/B MAC (A)* system.
17	FILLER		Six value spaces
18	FILLER		Twenty-nine value spaces
19	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the *A/B MAC (A)* system.
20	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the *A/B MAC (A)* system.
21	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the *A/B MAC (A)* system.
22	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the *A/B MAC (A)* system.

NO.	Field Name	Definition/Use	Source/Value
23	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the *A/B MAC (A)* system.
24	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the *A/B MAC (A)* system.
25	FILLER		Nine value spaces.
26	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred ninety-eight value spaces.
27	RESERVED FOR USER	Space reserved for user as necessary.	One-hundred ninety value spaces.
28	PPS IND	An indicator that identifies a prospective payment computation	"P" = PPS Spaces = Non-PPS

B. MSPPAYAO Returning Data Elements

MSPPAYAO will return the following data elements to MSPPAYOL when the claim is calculated to the line level for outpatient claims. Refer to §50.2.7.B for field definitions not reflected below.

No.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAO. Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical and user documentation released with the software.)
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).	Unless otherwise specified, MSPPAY is the source of all the following, possibly modified by MSPPAYAI.
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the Common Working File (CWF)	
4	FILLER		Seventy-seven value spaces.
5	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File	

No.	Field Name	Definition/Use	Source/Value
6	FILLER		Nine Value Spaces
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.	
8	PROVIDER PAYMENT AMT		
9	PATIENT PAYMENT AMT		
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
13	FILLER	Three value spaces.	
14	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	(Gramm-Rudmann-Hollings) The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
15	GROSS MEDICARE PAYMENT (H)	The amount Medicare pays excluding deductibles and coinsurance.	
16	NON-EGHP PYMT SDC	The amount paid by a non-EGHP to be reflected on the PS&R. The primary payer amount designated to lab charges reimbursed by 100% is not reflected in this figure. (This field is only returned for claims with services "thru-dates" prior to 11/13/89)	

No.	Field Name	Definition/Use	Source/Value
17	MSP PYMT SDC	The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT," reflects the total primary payer amount. The primary payer amount designated to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
18	PS&R AMOUNT	The primary payer amount used in the Provider Statistical Report System.	
19	FILLER	Nine value spaces.	
20	SAVINGS MSP EGHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
21	SAVINGS MSP ESRD	Amount saved by Medicare when a GHP has made a payment for an ESRD beneficiary (MSP Code 13).	
22	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
23	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
24	SAVINGS MSP	Amount saved by Medicare	

No.	Field Name	Definition/Use	Source/Value
	FEDS	when PHS or other Federal agency made payment (MSP Code 16).	
25	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been dame by the Department of Labor (MSP Code 41).	
26	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code42).	
27	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
28	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
29	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer and a primary payers(s) has made some payment. Includes all MSP codes 12-16, 41- 43 and 47.	
30	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41 and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.	
31	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, and 42. (This field is only returned for claims with service "thru-dates" prior to	

No.	Field Name	Definition/Use	Source/Value
		11/13/89.)	
32	MSP COMPUTATION 1	The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.	
33	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts	
34	MSP COMPUTATION 3	The result of the provider charges (or an amount the provider is obligated to accept as payment in full if that is less than the charges), minus the amount paid by the primary payer	
35	MSP COMPUTATION 4	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts	
36	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)	
37	RESERVED FOR USER	Space reserved for user as needed. (153 value spaces)	

50.3 – Multiple Primary Payer Amounts For a Single Service

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

A. ***A/B MAC (A)*** **Instructions**

Sometimes more than one primary payer makes payment on a Medicare Part A electronic claim and Medicare may still make a secondary payment on the claim. Shared system changes must be made, as necessary, so contractors can:

1) Identify electronic incoming MSP claims with multiple primary payers;

2) Send each claim level MSP value code, other than Value Code 44, paid amount found on the primary payer's MSP claim through the shared system so MSPPAY can calculate Medicare's secondary payment; and

3) Identify the lowest obligated to accept as payment in full (OTAF) amount, which is identified by Value Code 44 *or CAS group code CO amount if VC 44 is not on the claim,* and send that amount to MSPPAY (**NOTE:** MSPPAY will use Medicare covered charges if covered charges are lower than the OTAF amount).

B. Multiple Primary Payers

Providers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the *ASC X12* 837 *institutional implementation guide,* version 4010*/5010 as applicable*, regarding the submission of Medicare beneficiary claims when there are multiple primary payers. Providers must follow model 1 in Section 1.4.2.1, which discusses the "provider to payer to provider" methodology of submitting claims. When multiple payer claim information is attached to the inbound *ASC X12* 837, your shared system must be able to identify these types of claims and do the following:

1) Primary Payer Paid Amounts: Identify Primary Payer information from loop 2300, qualifier HIXX-1=BE. The value codes found in HIXX-2 and the value code monetary amounts found in HIXX-5 must be sent to MSPPAY by the shared system.

2) OTAF: Take the lowest Value Code 44 (the OTAF) amount, which must be greater than zero, found in loop 2300 segment HI, and send that amount to MSPPAY. **NOTE**: A value of "Y," in loop 2320, segment OI03, indicates there is an OTAF amount in loop 2300 segment HI. *Use CAS group code CO if VC 44 does not appear on the electronic claim.*

C. Part A Hardcopy MSP Claims

When an *A/B MAC (A)* receives a hardcopy MSP claim, they take the Value Code paid *A*mounts, *from Form CMS-*1450 and send these amounts to MSPPAY. If more than one Value Code 44 is received on the claim, these *V*alue *C*odes must be keyed and sent to the shared system. The shared system must take the lowest Value Code 44 amount found on the claim and send it to MSPPAY.

D. Claim Example

Below is an example of a Part A MSP claim sent to an *A/B MAC (A)*. All services are Medicare covered services. The following OTAF and other Payer Paid Amounts are sent to MSPPAY at the claim level. The other Payer Paid Amounts (below) may be calculated and sent by line for non-OPPS CELIP claims

Payer 1	Submitted Covered Charges	OTAF	Other Payer Paid Amount
Total	**$150.00**	**$80.00**	**$70.00**

Payer 2	Submitted Covered Charges	OTAF	Other Payer Paid Amount
Total	**$150.00**	**$50.00**	**$40.00**

Contractors send the following other payer amounts to MSPPAY based on the instructions cited above.

OTAF:	**$50.00 (lowest OTAF)**
Other Payer Paid Amount:	**$110.00 (combined total other payer paid amounts)**

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

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(Rev.107, Issued: 10-24-14)

40.10 - Processing of Medicare Secondary Payer Claims Related or Unrelated to an Accident or Injury for Non-GHP Claims with *ICD-9-CM* Diagnosis Codes 500-508 and 800-999 *or Related ICD-10-CM Diagnosis Codes*

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

Medicare contractors receive Liability, No-Fault (NF), and Workers' Compensation (WC), as well as Black Lung (BL), Medicare Secondary Payer (MSP) claims with ICD-9 diagnosis (DX) codes resulting from an accident, illness, or injury. DX codes are placed on the beneficiary MSP auxiliary file for purposes of processing non group health plan (non-GHP) MSP claims correctly. An MSP Liability, NF, or WC record with associated DX code(s) tells CWF to process the claim as secondary, or conditionally, if a conditional payment code is associated to the MSP file telling the contractor to make a conditional payment. The COB Contractor (COBC) also determines what DX codes should be placed on the beneficiary MSP file when diagnosis information is received through COB development process.

Effective July 1, 2011, CMS *automated* the ICD-9 DX code matching process for DX Code categories 500-508 and 800-999 only and establish*ed* a process where CWF determines whether the DX codes housed on the MSP auxiliary record are related to the ICD-9 DX codes on the incoming claim without unnecessarily prompting denial of claims or requiring the contractor to determine relatedness. The best way to assist in this process is to associate each DX code with the category of codes with which that DX code is affiliated. Contractors shall continue to follow current MSP policy and development procedures for all other DX codes received that do not fall within 500-508 and 800-999 DX categories as identified in this instruction. Contractors may use an ICD-9 code list as deemed necessary when DX code research is warranted for beneficiary claims and other MSP purposes.

NOTE: The*se instructions apply* to the current ICD-9 DX category codes 500-508 and 800-999 MSP procedures and not ICD-10 MSP procedures. An ICD-10 MSP processes and procedures instruction shall be issued *when available* after the MSP ICD-10 workgroup meets to discuss all pertinent MSP ICD-10 issues and the latest ICD-10 codes are published.

40.10.1 - Definition of *ICD-9-CM* Diagnosis Category Codes and Examples

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Contractors, and their associated systems, shall assume that category codes in the ranges identified below are related. Likewise, category codes in the range 800.x through the 804.xx shall be deemed related. However, CWF shall assume that category codes 804 and 805, which relate to separate classification of fractures, are not related to each other.

Below are the ICD-9 DX Codes for category ranges that include Black Lung Code (500), Lung Diseases (501-508) and Injury and Poisoning Codes (800-999).

ICD-9 Clinical Modification (CM) contains sections of related codes which are grouped by injuries to specific body parts or systems. These sections are shown within the ICD-9-CM code book preceding each section. Listed below are the general categories of these sections along with the specific code range within each section. Assume that codes within each section are related except as noted below.

Coal Workers' Pneumoconiosis (500) – Only one code is used to identify Black Lung for MSP purposes.

Pneumoconiosis and other lung diseases due to external agents (501 - 508) - codes 501.00 - 508.00. Contractors shall assume each DX code within this category is related.

Fractures (800-829) Fracture of skull (800-804) - code range = 800.00 - 804.99. Contractors shall assume each DX code within this category is related.

Fracture of neck and trunk (805-809) - code range = 805.00 - 809.18. Contractors shall assume each DX code within this category is related.

Fracture of upper limb (810-819) - code range = 810.00 - 819.13. Contractors shall assume each DX code within this category is related.

Fracture of lower limb (820-829) - code range = 820.00 - 829.1. Contractors shall assume each DX code within this category is related.

Dislocations (830-839)

Contractors shall assume each code within the 3-digit code category for dislocations is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 830 (830.0 - 830.1) shall be assumed to be related; however, codes within category 831 (831.0 - 831.9) shall assume to be unrelated to the 830 category DX codes.

Sprains and strains of joints and adjacent muscles (840-848)

Contractors shall assume each code within the 3-digit code category for sprains and strains is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 840 (840.0 - 840.9) shall assume to be related; however, codes within category 841 (841.0 - 841.9) shall assume to be unrelated to the 840 category DX codes.

Intracranial injury, excluding those with skull fracture (850-854) (codes 850.0 – 854.19)

Contractors shall assume each code with the 3-digit code category for intracranial injuries is related. For instance, all codes within category 850 (850.0 - 850.9) shall assume to be related; however, codes within category 854 (854.0 - 854.1) shall assume to be unrelated to the 850 category DX codes.

Injury codes from 860 -869 (codes 860.0– 869.1)

Contractors shall assume each code within the 3-digit code category for injuries is related.

Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 861 (861.0 - 861.32) shall assume to be related; however, codes within category 862 (862.0 – 862.9) shall assume to be unrelated to the 861 category DX codes.

Open wound of head, neck and trunk (870-879)

Contractors shall assume each code within the 3-digit code category for open wounds is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 870 (870.0 - 870.9) shall assume to be related; however, codes within category 876 (876.0 - 876.1) shall assume to be unrelated to the 870 category DX codes

Open wound of upper limb (880-887), codes 880.00 - 887.7

Contractors shall assume DX codes within this category range are related.

Open wound of lower limb (890-897), codes 890.0 - 897.7

Contractors shall assume DX codes within this category range are related.

Injury to blood vessels (900-904), codes 900.00 - 904. 9

Contractors shall assume DX codes within this category range are related.

Late effects of injuries, poisonings, toxic effects, and other external causes (905 - 909), codes 905.0 - 909.9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 905 (905.0 – 905.9) shall assume to be related; however, codes within category 908 (908.0 - 908.9) shall assume to be unrelated to the 905 category DX codes.

Superficial injury (910 - 919), codes 910.0 - 919.9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 910 (910.0 - 910.9) shall assume to be related; however, codes within category 916 (916.0 - 916.9) shall assume to be unrelated to the 910 category DX codes.

Contusion with intact skin surface (920 - 924), codes 920 - 924.9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 921 (921.0 - 921.9) shall assume to be related; however, codes within category 924 (924.00 - 924.9) shall assume to be unrelated to the 921 category DX codes.

Crushing injury (925 – 929), codes 925.1 - 929.9

Contractors shall assume DX codes within this category range are related.

Effects of foreign body entering through orifice (930-939), codes 930.0 - 939. 9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 930 (930.0 - 930.9) shall assume to be related; however, codes within category 934 (934.0 - 934.9) shall assume to be unrelated to the 930 category DX codes.

Burns (940-949), codes 940.0 – 949.5

Contractors shall assume DX codes within this category range are related.

Injury to nerves and spinal cord (950- 957), codes 950.0 - 957.9

Contractors shall assume DX codes within this category range are related.

Certain traumatic complications and unspecified injuries (958 - 959), codes 958.0 - 959.9

Contractors shall assume DX codes within this category range are related.

Poisoning by drugs, medicinal and biological substances (960-979)

Contractors shall assume each code within the 3-digit code category for poisoning by drugs medicinal and biological substances is related. Contractors shall assume codes outside of the 3-digit category are not related. For instance, all codes within category 960 (960.0 - 960.9) shall assume to be related; however, codes within category 961 (961.0 - 961.9) shall assume to be unrelated to the 960 category codes.

Toxic effects of substances chiefly non-medicinal as to source (980 - 989)

Contractors shall assume each code within the 3-digit code category for toxic effects of substances chiefly non-medicinal as to source is related. Codes outside of the three digit category are not related. For instance, all codes within category 980 (980.0 - 980.9) shall be assumed to be related; however, codes within category 982 (982.0 - 982.8) shall be assumed to be unrelated to the 980 category codes.

Other and unspecified effects of external causes (990-995), codes 990.0 - 995.94

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 991 (991.0 - 991.9) shall assume to be related; however, codes within category 992 (992.0 - 992.9) shall assume to be unrelated to the 991 category DX codes.

Complications of surgical and medical care NEC (996-999)

Contractor shall assume each code with the 3-digit category is related unto itself. For instance, codes 996.0, 996.1, 996.2, 996.3, 996.4, 996.5, 996.6, 996.7, 996.8, 996.9 are not related to each other; however, 996.40 and 996.41, which are within its' own category, are related to each other. (Note: A fifth digit may be included in these series of DX codes that fall within these categories to reflect highest level of specificity).

To further explain, codes 997.0, 997.1, 997.2, 997.3, 997.4, 997.5, 997.6 997.7, 997.9 are not related to each other; however, codes 997.60 and 997.62, which are within its' own category, are related to each other.

Codes 998.0, 998.1, 998.2, 998.3, 998.4, 998.5, 998.6, 998.7, 998.8, and 998.9 are not related to each other; however, codes 998.30 and 998.31 which are within its' own category, are related to each other.

Codes 999.0, 999.1, 999.2, 999.3, 999.4, 999.5, 999.6, 999.7, 999.8, 999.9 are not related to each other; however, codes 999.31 and 999.39 which are within its' own category, are related to each other.

Examples:

Fractures are currently identified in the 800-829 DX code range. Codes within the 800 - 804 category (Fracture of Skull) are not related to codes within the 805 - 809 category (Fracture of the Neck and Trunk). For instance, if a beneficiary CWF MSP auxiliary record contains a DX code 800.2, but an 806.1 DX code is received on an incoming claim, CWF and the contractor shall not assume that the 806.1 DX code is related to the 800.2 DX code on the MSP record. Development actions by the contractor are required in this situation. Following are a few more specific examples:

Example 1: A beneficiary has several injuries due to an automobile accident. The beneficiary previously acquired fractures to the base of the skull (801), multiple fractures involving skull or face with other bones (806), and a fracture of pelvis (808). The incoming claim shows DX codes 801.6, 801.8, 801.9, 806.1, 806.71, 806.79, 808.49 and 808.53 (Note: A fifth digit may be included in these series of DX codes that fall within these categories to reflect highest level of specificity.). The CWF MSP auxiliary record currently reflects DX codes 801.8, 806.71 and 808.49. The DX codes found on the MSP auxiliary record therefore fall within the 801, 806, and 808 category codes. The DX codes on the claim include additional codes that also fall within the 801, 806, and 808 categories of codes. The CWF will interpret this to mean that claim DX codes 801.6, 801.9, 806.1, 806.79, and 808.53 falls within the same category of codes as 801, 806, and 808 and therefore are related to the injury noted on the MSP auxiliary record. The contractor shall process the claim appropriately without further development or manual intervention even though the DX codes on the claim do not exactly match the codes on CWF. The DX codes on the claim do not need to be forwarded and placed on the CWF MSP auxiliary file because the related codes already exist on CWF.

Example 2: The same beneficiary from Example 1 has another accident a few months later. This time, the beneficiary fell at the local grocery store. The beneficiary goes to the hospital where it is determined he has a fractured ankle and phalange. The DX codes provided on the claim are 824.1, 824.7 and 826.1. The contractor receives the claim and determines this accident is not related to a current accident/injury noted on

the existing MSP auxiliary record. The contractor therefore 1) establishes an "I" record at CWF, since there is enough information on the claim to create an "I" record, and 2) ensures that the DX codes on the claim are also uploaded to CWF. Any subsequent future claims received with additional DX codes that fall within the 824 and 826 DX code categories shall be processed appropriately as codes related to the accident or injury and based on the non-GHP processing rules.

Example 3: The COBC received information indicating a beneficiary was involved in an accident at her workplace. The COBC mails a development letter to the beneficiary requesting additional information on the accident. The beneficiary responds stating she suffered from a concussion and lost consciousness for no more than one hour. Through development COBC determines that the DX code is 850.12 for the incident and creates a CWF MSP auxiliary record in which this code is reflected. The beneficiary later sees her specialist, who includes DX codes 850.2 and 850.9 on the claims submitted to Medicare. These DX codes that appear on the specialist's incoming claims, following creation of the original MSP record, shall assume to be related to the accident and processed by the Medicare contractor accordingly. The DX codes on the claim do not need to be forwarded and placed on the CWF MSP auxiliary file because the related codes already exist on CWF.

Example 4: A Medicare beneficiary is also entitled to BL benefits. A 500 DX code is on the beneficiary BL MSP auxiliary file record. A contractor receives a claim containing accident services including a DX 506.4 which is not related to the BL DX code 500 as found on CWF. A new MSP record may need to be uploaded for a new accident and injury record. The contractor processes the new MSP information and claim accordingly based on the COBC development and non-GHP MSP claims processing rules.

40.10.2 – Certain Diagnosis Codes *N*ot Allowed on No-Fault Medicare Secondary Payer (MSP) Records

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

There are certain diagnosis codes that systems must not apply to MSP Type 14, CWF MSP Type D No-Fault records. In order for these MSP claims not to deny and process correctly, the CWF must only allow those diagnosis codes related to the accident or injury. Although CWF does not have the capability of knowing which codes should apply to No-Fault MSP records, CMS has provided the below diagnosis codes that are currently the greatest offenders and are not related to a No-Fault auto accident or injury. Although this list is not inclusive it will assist in processing thousands of claims systematically and lessen chances of inappropriate MSP claim denials as they pertain to No-Fault MSP records. CMS is only applying this policy to No-fault records. CWF shall continue to allow the below diagnosis codes on Liability and Workers' Compensation MSP records. It is also noted that the FISS system, which currently systematically processes MSP "I" records for *A/B MACs (A)*, shall also update their system to not allow the below diagnosis codes from applying to No-Fault MSP records. All Medicare contractors and shared systems shall not apply the below diagnosis codes to No-Fault MSP "I" records, No-Fault MSP Inquiries, No-Fault CWF assistance requests and No-Fault MSP HUSP transactions.

The following *ICD-9* diagnosis codes shall not be applied to No-Fault MSP records:

ICD-9 **Diagnosis Code**	**Definition**
244.0 - 244.9	Hypothyroidism
250.00 - 250.93	Diabetes
272.0 - 272.9	Disorders of Lipoid Metabolism
285.0 - 285.9	Other and Unspecified Anemia
300.00 - 300.9	Anxiety States
305.1	Tobacco Use Disorder
401.9	Hypertension - unspecified

ICD-9 **Diagnosis Code**	**Definition**
403.00 - 403.91	Kidney Disease
414.00 - 414.9	Other forms of Chronic Ischemic Heart Disease.
427.31 - 427.32	Atrial Fibrillation/Flutter
486	Pneumonia, Organism Unspecified
530.81 - 530.89	Disorder of Esophagus
584.5 - 584.9	Acute Renal Failure - unspecific and non-trauma
585.1 - 585.9	Chronic Kidney Disease
599.0 - 599.9	Disorders of Urethra and Urinary Tract
784.0	Headache
799.9	Unknown

NOTE: *The preceding guidance applies to the current ICD-9 MSP procedures and not ICD-10 MSP procedures. An ICD-10 MSP processes and procedures instruction shall be issued when available.*

50.3 - MSP "W' Record and Accompanying Processes

Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

I. Common Working File Requirements (CWF)

Effective July 1, 2009, the Common Working File (CWF) shall accept a new Medicare Secondary Payer (MSP) code "W" for Workers' Compensation Medicare Set-Aside Arrangements (WCMSA) for use on the HUSP records for application on the HUSP Auxiliary File. The CWF shall indicate the description name for a MSP code "W" record as "WC Medicare Set-Aside.

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

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

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

WCMSA
P.O. Box 33847
Detroit, MI 48232

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

The CWF maintainer shall create a new error code (6815). The message for this new error code (6815) shall read "WC Set-Aside exists. Medicare contractor payment not allowed". CWF shall activate this error under the following conditions:

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

The CWF shall ensure that error code 6815 may be overridden by Medicare contractors with a code N or M, for claim lines or claims on which workers' compensation set-aside diagnosis do not apply. CWF shall accept t the new error code (6815) as returned on the 08 trailer.

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

II. Shared Systems and Medicare Contractors

Effective July 1, 2009, contractor shared systems shall accept a new MSP Code "W" to identify a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) for use on HUSP records for application on the HUSP Auxiliary file. The Medicare shared systems shall accept the description name of 'WC Medicare Set-Aside' for MSP code "W" records.

The shared system shall accept a new contractor number "11119" on incoming MSP 'W' HUSP records for application on the MSP Auxiliary file.

The shared systems shall accept contractor number 11119 and MSP code " W" and source code "19" on the returned 03 CWF trailer.

The contractor shared systems shall accept "19" in the source code field on the HUS, HUSC, and HUST transactions for contractor 11119. The shared systems shall accept a "Y" validity indicator, as well as, MSP code W for HUSC transactions created by contractor 11119.

The contractor shared systems shall accept and process HUSC and HUST transactions when an add, change, or delete transaction is received for contractor 11119 or from contractor 11119.

The CROWD report shall be updated to reflect special project number '7019' as Workers' Compensation Set-Aside Arrangements.

Shared systems shall accept "19" in the header Payment Indicator field and in the detail Payment Process Indicator field for Contractor 11119.

Medicare contractors and their systems shall continue to accept claims with value code 15 for *A/B MACs (A)* and Insurance Code (15) for *A/B MACs (B)* and DME MAC*s* against an open "W" MSP Auxiliary file.

The shared systems shall accept new error code (6815) as returned with the 08 trailer. Following receipt of the utilization error code 6815, the Medicare contractors systems shall deny all claims (including conditional payment claims) related to the diagnosis codes on the CWF MSP code "W", when there is no termination date entered for the "W" code.

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

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

- Populate a "W" in the MSP code field and

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

Upon denying the claim *A/B MACs (A)* and the FISS system shall:

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

For MSP verification purposes, and prior to overriding claims on which the contractor received error code 6815, the contractor shall:

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

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

A/B MACs (B)/DME MACs shall override the payable lines with override code N.

The *A/B MACs (A)* shall override the payable claims with override code N. If a claim is to be allowed, a 'N' shall be placed on the "001" Total revenue charge line of the claim.

The contractor shared systems shall allow an override of new error code 6815 with the code N.

The Comprehensive Error Rate Testing (CERT) contractor shall accept the MSP code W" in the claim resolution field.

The shared systems shall bypass the MSPPAY module if there is an open MSP code "W".

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

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

The shared systems shall include Reason Code 201, Group Code "PR", Remark Code MA01, when denying claims based on a 'W' MSP auxiliary record on outbound *ASC X12* 837 claims.

The shared systems shall utilize Group Code "PR"; Remark Code MA01, Reason Code 201, when denying claims based on a "W" MSP auxiliary record for *ASC X12* 835 ERA and SPR messages.

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

III. The Medicare Contractors:

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

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

The Medicare contractors shall include Reason Code 201, Group Code "PR", Remark Code MA01, when denying claims based on a 'W' MSP auxiliary record on outbound *ASC X12* 837 claims.

The Medicare contractors shall utilize Group Code “PR”; Remark Code MA01, Reason Code 201, when denying claims based on a “W” MSP auxiliary record for *ASC X12* 835 ERA and SPR messages.

The Medicare Contractors and shared systems shall afford appeal rights for denied MSP code “W” claims.

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

The CROWD report shall be updated to reflect special project number “7019” as Workers’ Compensation Medicare Set-Aside Arrangements.

70 - Converting Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Codes to Common Working File (CWF) Medicare Secondary Payer (MSP) Patient Relationship Codes

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD – 10: Upon Implementation of ICD -10, Implementation: ICD – 10: Upon Implementation of ICD – 10; ASC X12: 11-28-14)

CMS has realized that its Common Working File (CWF) HUSP transaction does not allow for the correct association of HIPAA individual relationship codes, as found in the HIPAA 837 (4010*/5010*) *i*nstitutional and *p*rofessional *c*laims *i*mplementation *g*uides, with corresponding MSP Type Codes, such as working aged (A), end-stage renal disease (B), and disability (G). Therefore, effective July 6, 2004, all *A/B MACs (A)* that receive incoming electronic HIPAA, DDE, or hard copy claims that are in the HIPAA *ASC X12 837* format shall convert the incoming individual relationship codes to their equivalent CWF patient relationship codes. Until further notice, *A/B MACs (A)* shall continue to operate under the working assumption that all providers will be including HIPAA individual relationship codes on incoming claims.

Before CMS’ systems changes are effectuated, *A/B MACs (A)* may receive SP edits (i.e., SP-33 and SP-52) that indicate that an invalid patient relationship code was applied. *A/B MACs (A)* are to resolve those edits by manually converting the HIPAA individual relationship code to the CWF patient relationship code, as specified in the conversion chart below. If the *A/B MAC (A)* receives MSP edits and can determine that the HIPAA individual relationship code rather than the CWF patient relationship code was submitted on the incoming claim, it shall manually work the MSP edits incurred by converting the HIPAA individual relationship code to the appropriate CWF patient relationship code.

Until Part A shared system changes are effectuated to convert HIPAA individual relationship codes to CWF patient relationship codes, *A/B MACs (A)* may move claims with a systems age of 30 days or older that have suspended for resolution of patient relationship code, including SP-33 or SP-52 edits, to condition code 15 (CC-15).

The *A/B MAC (A)* contractor system shall utilize the conversion charts, found below, to cross-walk incoming HIPAA individual relationship codes to the CWF patient relationship code values.

For MSP Occurrences with accretion dates PRIOR to 4/4/2011:

HIPAA Individual Relationship Codes	Convert To CWF Patient Relationship Codes	Valid Values
18	01	Patient is Insured
01	02	Spouse
19	03	Natural Child, Insured has financial responsibility
43	04	Natural Child, insured does not have financial responsibility
17	05	Step Child
10	06	Foster Child

HIPAA Individual Relationship Codes	Convert To CWF Patient Relationship Codes	Valid Values
15	07	Ward of the Court
20	08	Employee
21	09	Unknown
22	10	Handicapped Dependent
39	11	Organ donor
40	12	Cadaver donor
05	13	Grandchild
07	14	Niece/Nephew
41	15	Injured Plaintiff
23	16	Sponsored Dependent
24	17	Minor Dependent of a Minor Dependent
32,33	18	Parent
04	19	Grandparent
53	20	Life Partner
29	N/A	Significant Other
30	N/A	?
31	N/A	?
36	N/A	?
G8	N/A	?
Other HIPAA Individual Relationship Codes	N/A	?

For MSP Occurrences with accretion dates 4/4/2011 AND SUBSEQUENT:

HIPAA Individual Relationship Codes	Convert To CWF Patient Relationship Codes	Description
18	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
01	02	Spouse
19	03	Child
43	03	Child
17	03	Child
10	03	Child
15	04	Other
20	04	Other
21	04	Other
22	04	Other
39	04	Other
40	04	Other
05	04	Other
07	04	Other
41	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
23	04	Other

HIPAA Individual Relationship Codes	Convert To CWF Patient Relationship Codes	Description
24	04	Other
32,33	04	Other
04	04	Other
53	20	Life Partner
29	N/A	Significant Other
30	N/A	?
31	N/A	?
36	N/A	?
G8	N/A	?
Other HIPAA Individual Relationship Codes	N/A	?

A/B MACs (A shall allow for the storing of CWF patient relationship codes in their internal MSP control files, since these files should be populated with information sent back to the *A/B MACs (A)*' systems via the automated HUSC transaction.