CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3635	**Date: October 28, 2016**
	Change Request 9818

SUBJECT: Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42

I. SUMMARY OF CHANGES: This CR is to correct a misinterpretation of the changes made with CR 8198 - Updating the Shared Systems and Common Working File (CWF) to no Longer Create Veteran Affairs (VA) “I” records in the Medicare Secondary Payer (MSP) Auxiliary File, Transmittal 1213, Issued May 3, 2013. We are clarifying how Medicare contractors shall process inpatient claims for services in a Non-VA facility that were not authorized by the VA.

EFFECTIVE DATE: October 1, 2013
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	3/100/100.9/Requirements for Processing Non Veterans Administration (VA) Authorized Inpatient Claims

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3635	Date: October 28, 2016	Change Request: 9818

SUBJECT: Instructions to Process Services Not Authorized by the Veterans Administration (VA) in a Non-VA Facility Reported With Value Code (VC) 42

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I. GENERAL INFORMATION

A. Background: To support language found in §1862(a) (3) of the Social Security Act (the Act): Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity, Technical Direction Letter #12002 instructed Medicare Administrative Contractors (MACs) to stop using all VA coding within the Medicare shared systems and HIGLAS, indicating VA as an MSP situation and to stop faxing ECRS requests for VA related issues to the Coordination of Benefits Contractor (COBC). CR 8198 also instructed MACs, the Common Working File (CWF), and the shared system maintainers to discontinue creating VA MSP records. In addition, the COBC also disabled the creation of VA Medicare Secondary Payer (MSP) records in CWF when they received a request via the Electronic Correspondence Referral System (ECRS) to create a VA record in the MSP Auxiliary file. VA paid claims, therefore, represent a Medicare program exclusion rather than an indication of MSP.

MLN Matters Special Edition Article (SE) 1517 was issued to provide clarification and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services. CMS was recently notified of a scenario where a hospital cannot follow the instructions in SE 1517 to split the claim to bill Medicare for only the non VA authorized services as instructed in SE 1517.

Currently hospitals submit no pay inpatient claims paid by the VA to Medicare for the purpose of crediting the Part A deductible and coinsurance amounts.

B. Policy: There is no new policy. CMS is using the MSPPAY module as a tool to process non–authorized services for VA entitled beneficiaries in a non-VA facilities when the VA has made a partial payment for VA authorized services. Medicare requires condition code (CC) '26' - VA eligible patient chooses to receive services in a Medicare certified facility and value code (VC) '42' - That portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. The A/B MACs (A) shall continue to send VA claims payment information to the MSPPAY module when a VA beneficiary has services performed at a Medicare facility and the VA has made partial payment on the claim.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility			
		A/B MAC	DME	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9818.1	Medicare contractors shall accept value code '42' on inpatient claims with type of bill codes 11X, 18X, 21X, 41X and 51X.	X				X				
9818.2	Medicare contractors shall not require a CWF MSP record (alpha code 'I') for value code '42' for Medicare to make payment for covered Medicare charges not covered by the VA.	X				X				
9818.3	Medicare contractors shall use the MSP PAY module to calculate the Medicare payment for an inpatient claim when condition code '26' and value code '42' are present on a claim.					X				
9818.3.1	Medicare contractors shall return the claim to the provider if CC '26' is present without VC '42' or vice versa.	X				X				
9818.3.2	Medicare contractor shall accept and allow for claims payment information, with a VC 42, to process through MSPPAY when an MSP VA record of “I” is not found in the MSP auxiliary record.					X				
9818.3.3	Medicare contractor shall NOT capture or report MSP Savings for VC 42 claims when these claims are processed through the MSPPAY module. NOTE: MSPPAY usually sends MSP savings information to FISS after calculating Medicare’s Secondary payment. FISS shall ignore the savings information sent back from MSPPAY.					X				
9818.4	Medicare contractors shall utilize the current CARC, Group and MSN messages listed below, when a primary payer has made a partial payment and Medicare is making a secondary payment. • MSN message 29.25 • Group CO • CARC 45	X				X				
9818.5	Medicare contractors shall override timely filling edits upon receipt of a claim with value code '42', condition code '26'.	X				X				
9818.6	Medicare contractors shall accept VC 42 with primary payment amount and the group and CARC codes for amounts not paid by the primary payer found on the incoming claim.	X				X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9818.7	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov (Inpatient Hospital Contact) , Yvonne Young, yvonne.young@cms.hhs.gov (VA Contact) , Rick Mazur, richard.mazur@cms.hhs.gov (MSP Contact)

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 3 – Inpatient Hospital Billing

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(Rev. 3635, 10-16)

100.9 – Requirements for Processing Non Veterans Administration (VA) Authorized Inpatient Claims

(Rev.3635, Issued: 10/28/16; Effective: 10-01-13; Implementation: 04-03-17)

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program.

When a VA- eligible beneficiary chooses to receive services in a Medicare Certified Facility for which the VA has not authorized, the facility shall use Condition Code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare Certified provider instead of a VA facility and value code 42 with the amount of the VA payment for the authorized days.