CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 67	**Date: March 27, 2009**
	Change Request 6427

Transmittal 62, Change Request 6211, dated December 12, 2008, is rescinded and replaced with Transmittal 67, dated March 27, 2009. The Purpose of the change request is to alert the Medicare contractors and shared systems to changes necessary to derive MSP payment calculations from incoming 837 4010-A1 claims transactions.

Subject: Instructions For Utilizing 837 Professional Claim Adjustment (CAS) Segments for Medicare Secondary Payer (MSP) Part B Claims. (This CR rescinds and fully replaces CR 6211)

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to alert the Medicare contractors and shared systems to the changes necessary to derive MSP payment calculations from incoming 837 4010-A1 claims transactions.

New / Revised Material
Effective Date: April 1, 2009 (Analysis & Design)
July 1, 2009 (Code and Implementation)
October 1, 2009 (CWF code and implementation)

Implementation Date: April 6, 2009 (Analysis & Design)
July 6, 2009 (Code and Implementation)
October 5, 2009 (CWF code and implementation)

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	5/40.7/40.7.3.1/Medicare Secondary Payment Part B Claims Determination for Services Received on 837 Professional Electronic Claims

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-05	Transmittal: 67	Date: March 27, 2009	Change Request: 6427

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SUBJECT: Instructions For Utilizing 837 Professional Claim Adjustment (CAS) Segments for Medicare Secondary Payer (MSP) Part B Claims.

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I. GENERAL INFORMATION

A. Background: The purpose of this change request (CR) is to alert the Medicare contractors and shared systems to the changes necessary to derive MSP payment calculations from incoming 837 4010-A1 claims transactions. The CR is limited to Part B contractors and Durable Medical Equipment Medicare Administrative Contractors (DMACs) and their associated systems. A future instruction that addresses these same requirements for Part A contractors and their shared system will be forthcoming. (**NOTE:** Contractors and the shared systems will follow most of the same MSP claims processing instructions as outlined in this CR when version 837 5010 goes live. Any other substantial changes resulting from transitioning to 5010 will be identified in another change request). The changes herein addressed are necessary to ensure Medicare's compliance with the Health Insurance Portability Act (HIPAA) transaction and code set requirements and to ensure that MSP claims are properly calculated by the Medicare contractors and their associated shared systems using payment information derived from the incoming 837 professional claim. 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 payer's 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 when 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 CAS segments on the 835 electronic remittance advice (ERA) or paper remittance. The provider must take the CAS segment adjustments, as found on the 835, and report these adjustments on the 837, unchanged, when sending the claim to Medicare for secondary payment. The Part B contractors must use CAS segment adjustment amounts in determining MSP payment on MSP claims using instructions discussed below.

B. Policy: All Part B contractors and DMACs and associated shared systems must utilize CAS segment adjustments on the 837 when adjudicating MSP claims.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6427.1	The Medicare contractors and shared systems shall continue to recognize and use all CAS segment adjustment amounts applicable for MSP claims.	X	X		X			X	X		
6427.2	The shared systems shall differentiate from those MSP claims payment amounts that should be sent or not sent to MSPPAY based upon the CAS segment reason codes, as stated in business requirements 6427.6, 6427.7, 6427.8, 6427.9 and 6427.10 below.							X	X		
6427.3	The shared systems shall utilize CAS segment information that is attributable to the primary payer by adding or subtracting the adjustment amounts, as appropriate, from the primary payer's payment amount segment (loop 2320AMT and the 2430 line level) prior to sending payment amounts to MSPPAY.							X	X		
6427.4	The shared systems shall utilize CAS segment information that is attributable to the primary payer in determining the primary payer's allowed amount by subtracting the CARC 45 adjustment amounts, as appropriate, from the physician's or supplier's charges prior to sending payment amounts to MSPPAY if not otherwise received in the 2320 AMT B6 or the 2400AMT AAE.							X	X		
6427.4.1	The Part B shared systems shall send the adjusted payment amounts, based on the CAS segment adjustment calculations, to MSPPAY for MSP payment calculation.							X	X		
6427.4.2	When services are reported at the line level and primary payment amounts are reflected at the claim level, the shared systems shall send the line level amounts and claim level payment amounts to MSPPAY for apportionment to each given service line.							X	X		
6427.5	If claim adjustment reason code (CARC) "1" "2" "3" or "66" appears in the CAS segments and the claim contains both a primary payer and Medicare covered service and the primary payer payment is equal to zero	X	X		X			X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	on all lines of service, Medicare shall make a primary payment. (NOTE: This process is accomplished in the MSPPAY module.										
6427.6	The shared systems shall add the following claim CARC amounts to the primary payer payment amount for that service as found in the 2430 SVD02 (or the 2320/AMT02 when 2320/SBR01 = P and 2320/AMT01 = D, if one of the listed CARCs is submitted in the 2320 loop or the claim is submitted at the claim level) and send this amount as the paid amount to MSPPAY: 15, 17, 29, 58, 61, 95, 112, 117, 125, 130, 150, 163, 164, 179, 181, 182, 197, 210, 223, B4, B5, B7, B8, B10, B16.							X	X		
6427.6.1	The Medicare contractors and shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.	X	X		X			X	X		
6427.6.2	The share system shall send the adjusted payment amount as the "paid amount" on the claim to CWF. (**NOTE:** The adjusted payment amount is the incoming payment amount or the apportioned incoming payment amount) plus the CARC adjustment.							X	X		
6427.6.3	The contractors shall store the adjusted payment amount.	X	X		X			X	X		
6427.7	The Medicare contractors and shared systems shall deny and not make a Medicare payment for a given service when the following CARCs are found on an MSP claim and the primary payer did not make a payment: 4, 10, 11, 13, 14, 16, 19, 20, 21, 34, 39, 54, 101, 110, 111, 114, 115, 128, 129, 133, 136, 140, 146, 155, 158, 165, 174, 175, 176, 177, 180, 188, 189, 201, 206, 207, 208, 225, A1, B15, B18, B23.	X	X		X			X	X		
6427.7.1	Medicare shall make a secondary payment if the primary payer made a payment greater than zero for the service line and the service is a Medicare covered service.	X	X		X			X	X		
6427.7.2	The Medicare contractors and shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount	X	X		X			X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	adjusted.										
6427.7.3	The shared systems shall create and populate a new Worker's Compensation indicator field with a Y on the CWF HUBC and HUDC claim transactions at the line level when there is a CARC 19, 20 or 21 on an incoming MSP claim.							X	X	X	
6427.7.4	The contractor shared systems shall populate a "space" on all other HUBC and HUDC claim transactions when CARC 19, 20, 21 are not found on incoming MSP claims.							X	X		
6427.7.5	When CWF receives the new Worker's Compensation indicator, it shall search for an MSP occurrence for Worker's Compensation indicator field to determine if the diagnosis codes on the claim are related to the diagnosis codes on the MSP auxiliary file occurrence for worker's compensation.									X	NCH NGD MBD
6427.7.6	If CWF does not find an non-GHP MSP occurrence for Worker's Compensation, liability or no fault, or the diagnosis codes on the claim does not match the diagnosis codes, or the codes within the same category, found on the MSP auxiliary file, the CWF system shall reject the claim to the contractor's claim system.									X	
6427.7.6.1	The CWF shall issue an over-rideable MSP error code 68xx for non-GHP claims where an MSP claim does not match an MSP occurrence on CWF or the diagnosis codes on the claim are not related to the diagnosis codes found in CWF.									X	
6427.7.6.2	Upon receipt of the rejected claim, the affected contractor shall send an ECRS inquiry request to the COBC, including the worker's compensation, liability or no-fault information as found on the claim.	X	X		X			X	X		
6427.8	The contractors and their shared systems shall make a primary payment for a given service if the following CARCs are found on the claim and if the service is covered by Medicare and the primary payer did not make a payment: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 204, B1 (if a Medicare covered visit), B14, W1. Note: for W1 Medicare shall pay conditionally when the "E" Workers' Comp record is open on CWF if payment will not be made within the promptly period.	X	X		X			X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6427.8.1	Medicare shall make a secondary payment if the primary payer made a payment greater than zero for the service line and the service is a Medicare covered service.	X	X		X			X	X		
6427.8.2	The shared systems shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.	X	X		X			X	X		
6427.8.3	In relation to CARC W1, Medicare shall not make a primary payment if there is an open WCSA on the MSP auxiliary file.	X	X		X			X	X		
6427.8.4	In relation to 6427.8.3, if the Medicare contractors, or shared systems, determine that the WCSA auxiliary record is closed, the Medicare contractor, or shared system, shall make a primary payment.	X	X		X			X	X		
6427.8.5	The shared systems shall send the M or N override code to CWF when the CAS segment includes the CARC codes in requirement 6427.8, thereby ensuring that the contractors are able to make a primary payment.								X	X	
6427.9	The shared systems shall suspend claims so that contractors may review claims to determine whether they shall make a Medicare payment, taking into consideration applicable MSP and claims processing rules and procedures, when the following CARCs appear on the service line: 5, 6, 7, 8, 9, 12, 18, 23, 24, 33, 38, 40, 97, 107, 109, 116, 138, 148, 171, 172, 178, 183, 185, 191, 193, 224, A7, B11, B12, B13.	X	X		X			X	X		
6427.9.1	The contractors shall apply the appropriate MSP and claims processing rules to determine whether Medicare shall make a primary payment, a secondary payment or deny/reject the claim for the CARCs in requirement 6427.9.	X	X		X						
6427.10	The Medicare contractors shall 1) make a secondary payment for a given service, or group of services, and 2) utilize the primary payer's payment amount when the following CARC adjustments appear an incoming MSP claim and the service is covered and payable by Medicare: 44, 45, 59, 90, 91, 94, 100, 102, 103, 106, 118, 131, 147, 151, 152, 153, 154, 160, 156, 157, 159, 173, 190, 192, 194, 198, 202, 203, B9, B20, B22.	X	X		X			X	X		
6427.10.1	The shared systems shall use the CARC OA23 on the							X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.										
6427.11	The shared systems shall determine the obligated to accept as payment in full (OTAF) amount by subtracting the contractual obligation amount (CO) group code amount from the submitted charges.							X	X		
6427.11.1	The shared system shall send the OTAF amount and the submitted charges (as found in loop 2300 in the CLM02 segment at the claim level; or as found in loop 2400 in the SV102 segment for service line amounts) to the MSPPAY module for MSP payment calculation.							X	X		
6427.11.2	With the implementation of this change request, the shared systems shall 1) ignore the amount found within the CN1 segment**;** however 2) create the CN1 amount for inclusion on the outbound 837 COB flat file.							X	X		
6427.12	For 40101A1 MSP claims processing, the shared system shall continue to utilize the primary payer allowed amounts (as found in loop 2320 in AMT02, with a B6 qualifier for claim level; or as found in loop 2400 in AMT02 for service line amounts) and primary payer payment amounts (as found in loop 2320 in the AMT02 segment, qualified by "D," at the claim level; or as found in loop 2430 in the SVD02 segment for service line amounts) and send these amounts to MSPPAY.							X	X		
6427.12.1	The Part B shared system shall continue to send line level MSP amounts to the MSPPAY module when service line amounts appear on the claim.							X			
6427.13	If the primary payer's allowed amount is not available in the 2320 AMT02 or in the 2400 AMT02, the shared systems shall identify the primary payer's allowed amount in the CAS segments, which shall be identified as the CARC 45 adjustments.							X	X		
6427.13.1	The shared systems shall 1) determine the allowed amount by taking the submitted charges minus the CARC 45 adjustments; and 2) send the resulting amount as the "allowed amount" to MSPPAY.							X	X		
6427.14	If the allowed amount in the primary payer 2300							X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	AMT02 or 2400 AMT02 loop is equal to $0, and there is no CARC 45 adjustment amounts indicated, the shared systems shall send the submitted charges as the "allowed amount" to MSPPAY.										
6427.15	CARC 223: Contractors or shared systems shall add or subtract this adjustment from the payment amount depending on whether the CARC amount contains a negative or positive sign.	X	X		X			X	X		
6427.16	CARC 225: Contractors or shared systems shall deny and return this claim to the physician or other supplier when CARC 225 appears on the claim.	X	X		X			X	X		
6427.17	The Medicare contractors and their affiliated shared systems shall apply appropriate remarks codes to the physician's and other supplier's remittance advice and to the beneficiary Medicare Summary Notice (MSN).	X	X		X			X	X		
6427.18	The shared systems shall continue to take into consideration the business requirements identified in CRs 2007 and 3407 when determining Medicare's secondary payment and for purposes of balancing the Medicare remittance advice.							X	X		
6427.19	CMS shall issue and the Medicare contractors and shared systems shall implement any future instructions for those CARCs that are added, modified, or deactivated when such CARCs impact MSP claims.	X	X		X			X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6427.20	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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	X		X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6427.16	Contractors and shared systems should refer to CRs 2007 and 3407 for MSP calculation and ERA balancing purposes.

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, Richard.Mazur2@cms.hhs.gov, (410) 786-1418

Post-Implementation Contact(s): Richard Mazur, Richard.Mazur2@cms.hhs.gov, (410) 786-1418

VI. FUNDING

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

Medicare Secondary Payer (MSP) Manual

Chapter 5 - Contractor Prepayment Processing Requirements

(Rev. 67, 03-27-09)

40.7.3.1 - Medicare Secondary Payment Part B Claims Determination for Services Received in the 837 Professional Electronic Claims Format

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

(Rev. 67, Issued: 03-27-09, Effective: 04-01-09 Design and Analysis/07-01-09Code and Impl./10-01-09 CWF Code and Impl., Implementation: 04-06-09 Design and Analysis/07-06-09 Code and Impl./10-05-09 CWF Code and Impl.)

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), which ever 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 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the remittance advice and report these adjustments on the 837 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 837 transaction. 837 claims 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*C4*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*C4*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*
   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*C4*630~*

Medicare Abbreviated 835 to Physician

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