CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 687	Date: April 29, 2010
	Change Request 6795

SUBJECT: Additional Medicare Secondary Payer (MSP) Claims Processing Instructions for the Common Working File, Medicare Part B, and Durable Medical Equipment (DME) Shared Systems Regarding Medicare Secondary Payer Claims that Contain a Claim Adjustment Reason Code (CARC) 19, 20 or 21

I. SUMMARY OF CHANGES: This change request instructs CWF to compare the DX code from each line to what is in the MSP auxiliary records and what action contractors and shared systems must take if DX codes on the claim do not match the DX codes found in the beneficiary MSP Auxiliary record. This change request replaces instructions found only in BR 6427.7.3 through 6427.7.6.2.of CR 6427.

EFFECTIVE DATE: *October 1, 2010 IMPLEMENTATION DATE: October 4, 2010

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-

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE	
N/A		

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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. ATTACHMENT:

One-Time Notification

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

Attachment – One-Time Notification

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Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: MSP claims may contain diagnosis codes that may or may not match diagnosis codes on the beneficiary's MSP auxiliary record in CWF. There may be multiple lines of services on the claim containing diagnosis codes that may or may not be related to the accident or injury established in CWF. These types of MSP services may be identified in the CAS segment of the 837 MSP claim. Although the diagnosis codes found on the claim may or may not be related to the diagnosis codes in the beneficiary MSP record, CWF cannot determine which diagnosis codes found on the MSP claim at the line level match the codes in the MSP auxiliary record since CWF does not receive these codes nor make this determination at the line level. CWF currently verifies these codes only at the claim level. Diagnosis codes found on MSP claims should be identified at the line level by the shared system and sent to CWF for verification at the line level. CWF must determine whether the codes on the detail line claim match the codes in CWF by checking each line item diagnosis code it receives from the shared system.

This change request instructs CWF to compare the DX code from each line to what is in the MSP auxiliary records and what action contractors and shared systems must take if DX codes on the claim do not match the DX codes found in the beneficiary MSP Auxiliary record. This change request replaces instructions found only in BR 6427.7.3 through 6427.7.6.2.of CR 6427.

B. Policy: Medicare contractors shall make appropriate payments for MSP claims involving liability, no fault or workers compensation claims where diagnosis codes are found at the line level and CWF must verify if these line level diagnosis codes are found in the MSP auxiliary record.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
•		A	D	F	С	R	-	Sha	red-		Other
		/	M	I	A	Н		Syst	tem		
		В	Е		R	Н	M	aint	aine	ers	
					R	I	F	M	V	С	
		M	M		I		I	C	M	W	
		A	A		Е		S	S	S	F	
		C	C		R		S				
6795.1	The shared system shall populate the Worker's							X	X		
	Compensation Indicator field at the line level with a 'Y'										
	on an incoming HUBC or HUDC claim transactions to										
	CWF when there is a CARC '19', '20' or '21'.										

Number	Requirement Responsibility										
	A D F C R S										Other
		/	M	I	A			Sys			
		В	Е		R	Η	M	aint		rs	
		, ,			R	I	F	M		C	
		M			I		I	C	M		
		A C	A C		E R		S	S	S	F	
6795.2	CWF shall continue to set MSP edits in the hierarchy in				1		ט			X	
	which they are currently received (i.e., 6801, 6802 etc).										
6795.3	CWF shall create a new error code '6817' that will									X	
	reject at the line level of the HUBC or HUDC claim.										
6795.4	When CWF receives the 'Y' in the Worker's									X	
	Compensation Indicator field on the HUBC or HUDC										
	record, it shall search the MSP Auxiliary File for an										
	occurrence that contains a MSP Code 'D', 'E' or 'L'.										
6795.4.1	If an occurrence for 'D', 'E' or 'L' is not found, CWF									X	
	shall reject the HUBC or HUDC claim with the new										
	'6817' error code.										
6795.5	If CWF finds an occurrence for 'D', 'E', or 'L' on the									X	
	MSP Auxiliary file, CWF shall interrogate the line level										
	diagnosis on the incoming HUBC or HUDC claim to										
	determine if the line level diagnosis matches any of the										
	25 diagnosis codes found on the 'D', 'E' or 'L' occurrence. If one of the diagnosis codes match, the										
	claim will continue processing.										
6795.5.1	CWF shall accept the line level diagnosis submitted on							X	X		
0773.3.1	the claims from the Shared System.							71	21		
6795.5.2	If none of the diagnosis codes match, CWF shall reject									X	
	the HUBC or HUDC claim with the new '6817' error										
	code.										
6795.5.3	Upon receipt of the rejected claim, the affected	X	X		X			X	X		
	contractor shall send an ECRS inquiry request to the										
	COBC which includes all pertinent workers'										
	compensation, liability, or no-fault information found										
	on the claim.										
6795.6	CWF shall return the '03' Trailer with data from the									X	
	MSP Auxiliary File for the new '6817' error code.										
6795.7	CWF shall return Trailer '39' with data from the detail									X	
	line of the HUBC or HUDC claim that caused the reject										
6 7 0.5.0	for the new '6817' error code.									**	
6795.8	CWF shall return up to 13 detail lines of data in Trailer									X	
(705.0	'39' for the new '6817' error code.									*7	
6795.9	CWF shall add error code '6817' to the CWF Edit									X	
6705 10	Override table as a line level override edit.									V	
6795.10	CWF shall allow error code '6817' to be overridden in									X	
	the line level of the incoming HUBC or HUDC claim.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		Α	D	F	C	R	-	Shai	red-		Other
		/	M	I	A	Н		Syst	tem		
		В	Е		R	Н	M	aint	aine	ers	
					R	I	F	M	V	С	
		M	M		I		I	C	M	W	
		A	A		Е		S	S	S	F	
		C	C		R		S				
	N/A										

IV. SUPPORTING INFORMATION

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

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

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

V. CONTACTS

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

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

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