CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 705	**Date: May 21, 2010**
	Change Request 6983

SUBJECT: Version D.0 Inbound National Council for Prescription Drug Programs (NCPDP) Medicare Secondary Payer (MSP) Claims Processing

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide direction to the ViPS Medicare System shared system maintainer on the calculating of several dollar amounts needed for processing NCPDP version D.0 MSP claims. This is a follow-up to CR 6845 being implemented in the October 2010 release which contains all necessary systems changes for NCPDP version D.0.

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-*Only One Per Row.*

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

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable.

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 705	Date: May 21, 2010	Change Request: 6983

SUBJECT: Version D.0 Inbound National Council for Prescription Drug Programs (NCPDP) Medicare Secondary Payer (MSP) Claims Processing

EFFECTIVE DATE: **October 1, 2010**

IMPLEMENTATION DATE: October 4, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the next version of the Health Insurance Portability and Accountability Act (HIPAA) transactions. The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 Version 5010, and the NCPDP Version D.0 as the next HIPAA transaction standards for covered entities to exchange HIPAA transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

Effective Date of the regulation:	March 17, 2009
Level I compliance by:	December 31, 2010
Level II Compliance by:	December 31, 2011
All covered entities have to be fully compliant on:	January 1, 2012

Level I compliance means "that a covered entity can demonstrate that it could create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards (ASC X12 4010A1 and NCPDP 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date until the January 1, 2012, compliance date to facilitate testing subject to trading partner agreement.

The purpose of this Change Request (CR) is to provide direction to the ViPS Medicare System shared system maintainer on the calculating of several dollar amounts needed for processing NCPDP version D.0 MSP claims. This is a follow-up to CR 6845 being implemented in the October 2010 release which contains all necessary systems changes for NCPDP version D.0.

B. Policy: Health Insurance Reform: Modifications to the HIPAA: Final Rules published in the Federal Register on January 16, 2009, by the Department of Health and Human Services at 45 CFR Part 162.

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	
6983.1	The shared system maintainer shall use the following to determine the needed amounts for claims processing.								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	
6983.1.1	The shared system maintainer shall consider the Submitted Amount as equal to Gross Amount Due (430-DU) on the NCPDP D.0 Billing claim								X		
6983.1.2	The shared system maintainer shall consider the Other Payer Amount Paid (431-DV) is used in conjunction with Other Payer Amount Paid Qualifier (342-HC) to determine the amount paid by the other payer.								X		
6983.1.3	The shared system maintainer shall consider Other Payer Patient Responsibility Amount (352-NQ) is used in conjunction with Other Payer Patient Responsibility Amount Qualifier (351-NP) to determine the financial obligation of the beneficiary from the other payer.								X		
6983.1.4	The shared system maintainer shall add the sum of the Other Payer Amount Paid (431-DV) and Other Payer Patient Responsibility Amount (352-NQ) to determine the allowed amount and the amount the provider is obligated to accept as payment in full (OTAF).								X		
6983.1.4.1	In calculation purposes, the only Other Payer-Patient Responsibility Amount Qualifier (351-NP) values that shall be considered in the determination of Other Payer Allowed and OTAF for MSPPAY purposes are '01' (Amount Applied to Periodic Deductible) and '07' (Amount of Coinsurance).								X		
6983.2	The shared system maintainer shall calculate the Other Payer Amount Paid as the sum of the 431-DV amounts (qualifiers applicable to the MSP benefit, e.g. 07 Drug Benefit)								X		
6983.2.1	In calculation purposes, the only Other Payer Amount Paid Qualifier (342-HC) values that shall be considered in the determination of Other Payer Amount Paid for MSPPAY purposes is '07' (Drug Benefit).								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	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

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

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

V. CONTACTS

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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*: Not Applicable

Section B: *For Medicare Administrative Contractors (MACs):*

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