CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 73	**Date: February 5, 2010**
	Change Request 6736

SUBJECT: Instructions on How to Process Negative Claim Adjustment Reason Code (CARC) Adjustment Amounts when Certain CARCs Appear on Medicare Secondary Payer Claims

I. SUMMARY OF CHANGES: This CR instructs the shared systems and contractors not to add a CAS CARC adjustment to the paid amount if the same CARC and adjustment amount appears as a negative adjustment in the CAS on an incoming MSP claim.

New / Revised Material
Effective Date: July 1, 2010
Implementation Date: July 6, 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
R	5/40.7.5 - Effect of Failure to File Proper Claim

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: 73	Date: February 5, 2010	Change Request: 6736

SUBJECT: Instructions on How to Process Negative Claim Adjustment Reason Code (CARC) Adjustment Amounts when Certain CARCs Appear on Medicare Secondary Payer Claims.

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background: Change requests (CRs) 6426 and 6427 instruct the Medicare contractors and shared systems to take into consideration the CARCs and the applicable adjustment amounts when processing MSP claims. Business requirements (BRs) 6426.6 and 6427.6 instruct shared systems to add certain CARC adjustment amounts to the paid amounts when these CARCs are received on a claim. There have been rare circumstances where the CARCs found in BR 6426.6 and 6427.6 on incoming MSP claims include a negative adjustment amount and the shared systems add the same adjustment amount to the claim based on instructions found in CR 6426 and 6427. This CR provides instructions to the shared systems not to add the CARCs in BR 6426.6 and 6427.6 when the adjustment amounts on incoming MSP claims are negative.

B. Policy: Medicare contractors and shared systems must utilize CAS segment CARCs when processing MSP claims. Medicare contractors and shared systems must take into consideration the proper claim rules, as found in Pub. 100-05/Chapter 5/ 40.7.5 entitled Effect of Failure to File Proper Claim, when processing MSP claims. The CARCs found in BR 6426.6 and 6427.6 identify potential situations when claims are not properly filed with the primary payer. BR 6426.6 currently reads: "The shared systems shall add the following claim CARC amounts to the primary payer payment amount if one of the listed CARCs is submitted on a claim: 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." BR 6427.6 states: 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.

Use"Shall" to denote a mandatory requirement

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	
6736.1	The shared systems shall stop adding the CARC adjustment found in 6426.6 or 6427.6 when the same						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	
	CARC and corresponding adjustment is found in the CAS as a negative adjustment on an incoming MSP claim.										
6736.2	In the absence of a negative CAS adjustment amount the shared systems shall continue to add the CARC amounts found in BR 6426. 6 and 6427.6 on the incoming MSP claim.						X	X	X		
6736.3	Part A, Part B and DME MAC shared systems shall create a program to find these MSP claims and work with their respective contractors to automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive CAS CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as negative adjustment as identified in BR 6426.6 and BR 6427.6..	X	X	X	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	
6736.4	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	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:

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

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),* include the following statement:

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.

40.7.5 - Effect of Failure to File Proper Claim

(Rev. 73; Issued: 02-05-10; Effective Date: 07-01-10; Implementation Date: 07-06-10)

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 carrier 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 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 a Part 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 Form Locator (FL) 39-41 by the provider. For example, if the employed beneficiary is working aged over 65 a VC 12 would be used in FL 39-41. 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 Form locator 39-41 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.