CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 74	**Date: April 28, 2010**
	Change Request 6768

SUBJECT: New Medicare Secondary Payer Insurer Type Codes

I. SUMMARY OF CHANGES: This Change Request updates the CWF to accept new insurer codes for Health Reimbursement Account and Health Savings Account information.

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
R	5/6/30.3.2/Valid Insurance Type Codes

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. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 74	Date: April 28, 2010	Change Request: 6768

SUBJECT: New Medicare Secondary Payer Insurer Type Codes

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background:

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111) adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Implementation dates are January 1, 2009, for GHP arrangement information and July 1, 2009, for information concerning liability insurance, no-fault insurance and workers' compensation. The new provisions for GHP arrangements found at 42 U.S.C. 1395y(b)(7) add reporting rules that do not eliminate any existing statutory provisions or regulations, include penalties for noncompliance, contain provisions for the Secretary to share information on Part A entitlement and enrollment under Part B, include who must report, include what must be reported with the data elements determined by the Secretary, and specify that reporting must be done in a form and manner, including frequency, specified by the Secretary. GHP reporting will be done on a quarterly basis in an electronic format.

B. Policy:

Two elements that are required to be reported under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111) are Health Reimbursement Arrangements (HRAs) and are Health Savings Accounts (HSAs). The CMS considers a HRA to be a GHP product for MSP purposes and therefore must be reported under Section 111. A HSA is typically associated with a high deductible GHP product, but the CMS will not consider HSAs to be reportable under Section 111 as long as Medicare beneficiaries may not make a current year contribution to an HSA or did not make a contribution during the time he/she was a Medicare beneficiary. Legislation has been proposed that would allow Medicare beneficiaries to contribute to HSAs. If such proposal were enacted, a HSA would qualify as a GHP and therefore would need to be reported under Section 111.

Medicare as Secondary Payer Insurer Type codes are specific codes that indicate the source of a beneficiary's primary insurance. (i.e. - "A" = Insurance or Indemnity; "J" = Hospitalization Only Plan.) Currently, the Common Working File (CWF) does not have a Medicare as Secondary Payer Insurer Type code to identify a HRA or HSA. In order to properly identify Medicare Secondary Payer (MSP) occurrences and coordinate benefits, the insurer type of "R" for HRA and "S" for HSA will need to be added to CWF. The new insurer type codes "R" and "S" are to be handled in the same manner in which current Medicare as Secondary Insurer Type codes are processed.

II. BUSINESS REQUIREMENTS TABLE

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	
6768.1	CWF shall create two (2) new Medicare as secondary payer insurer type codes to identify HRAs and HSAs.									X	
6768.2	CWF shall identify these two (2) codes as follows: R shall indicate a HRA and S shall indicate a HSA.									X	
6768.3	CWF shall recognize and upload the insurer type R and S on incoming HUSP transactions.									X	COBC
6768.4	The appropriate SP error codes shall be updated to add the new insurer type codes.	X	X	X	X	X	X	X	X	X	
6768.5	The Medicare contractors and shared systems shall recognize and process MSP claims with insurer type R and S.	X	X	X	X	X	X	X	X		
6768.6	The Medicare contractors and shared systems shall receive and send updated MSP information for beneficiaries when the insurer type is "R" or "S."	X	X	X	X	X	X	X	X		
6768.7	The Medicare contractors and shared systems shall treat insurer types "R" or "S" like insurer type "A" and make a secondary payment for both Medicare Part A and Part B covered services.	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	
	None.										

IV. SUPPORTING INFORMATION

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

V. CONTACTS

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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.

30.3.2 - Valid Insurance Type Codes

(Rev.74, Issued: 04-28-10, Effective: 10-01-10, Implementation: 10-04-10)

Insurer Type Code	Definition
A	Insurance or Indemnity
B	GHO
C	Preferred Provider Organization (PPO)
D	Third Party Administrator arrangement under an Administrative Service Only (ASO) contract without stop loss from any entity.
E	Third Party Administrator arrangement with stop loss insurance issued from any entity.
F	Self-Insured/Self-Administered.
G	Collectively-Bargained Health and Welfare Fund.
H	Multiple Employer Health Plan with at least one employer who has more than 100 full and/or part-time employees.
I	Multiple Employer Health Plan with at least one employer who has more than 20 full and/or part-time employees.
J	Hospitalization Only Plan - A plan that covers only Inpatient hospital services.
K	Medical Services Only Plan - A plan that covers only noninpatient medical services.
M	Medicare Supplemental Plan, Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan.
R	*Health Reimbursement Arrangement (HRA)*
S	*Health Savings Account (HSA)*