CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 75	**Date: October 29, 2010**
	Change Request 7027

SUBJECT: Process 5010 Professional Medicare Secondary Payer (MSP) and Paper Claims Where Claim Adjustment Reason Code (CARC) Amounts Appear at the Claim Level and Not at the Detail Line

I. SUMMARY OF CHANGES: This CR instructs the Part B shared systems to use the claim level amounts to determine Medicare's secondary payment. This involves determining the MSP amounts utilizing the CAS adjustments, as instructed in previous MSP and MSP CARC change requests, and then send these amounts, along with the claim detail information, to MSPPAY so MSPPAY can apportion the MSP amounts to the detail.

EFFECTIVE DATE: *April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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	5/40/40.7.3.3/Version 5010 Balancing for Incoming MSP Claims Where MSP Amounts Appear at the Claim Level and Not at the Service Detail Line

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: 75	Date: October 29, 2010	Change Request: 7027

SUBJECT: Process 5010 Professional Medicare Secondary Payer (MSP) and Paper Claims Where Claim Adjustment Reason Code (CARC) Amounts Appear at the Claim Level and Not at the Detail Line

Effective Date: April 1, 2011
Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: The Part B shared systems have expressed concerns regarding the 5010 professional claims transactions for situations where the primary payer may identify the CARCs at the line level, but may also include additional CARCs and adjustments at the header level. Although receiving such MSP claims is a rare occurrence it is possible that these types of claims may be sent on 5010 claim transactions or on hardcopy claims.

The current Medicare Secondary Payer Payment Module (MSPPAY) calculates MSP claims payment for MSP claims received at the header level or at the detail level. Currently, when there is MSP information at the header level that is not identified at the detail the share system turns on the apportioning switch in MSPPAY to apportion the MSP claims to the detail lines. In situations where the claim level OTAF, primary payer allowed amount and/or primary payer paid amounts are not equal to the sum of the corresponding detail amounts, but the claim balances, this CR instructs the Part B shared systems to use the claim level amounts to determine Medicare's secondary payment. This involves determining the MSP amounts utilizing the CAS adjustments, as instructed in previous MSP and MSP CARC change requests, and then send these amounts, along with the claim detail information, to MSPPAY so MSPPAY can apportion the MSP amounts to the detail.

B. Policy: The MSP apportioning policy must be followed by the Medicare Contractors and shared systems and applies to both 837 5010 professional claims and hardcopy MSP claims that includes an attachment to the incoming claim form. Once all header level CARC adjustments, or similar CARC type adjustments on hardcopy MSP claims, and MSP claims payment amounts are determined by the shared systems, the shared systems must turn on the apportioning switch in MSPPAY and send the header amounts, along with the detail amounts, to MSPPAY for secondary payment calculation.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
7027.1	Medicare contractors and shared systems shall not return claims to the physician or supplier where, under 5010, an MSP claim is received containing claim level CARC adjustments when detail MSP payment information has been submitted in the 2430 loop and the claim balances.	X	X		X			X	X		
7027.2	The Contractors and shared systems shall also apply the below requirements to paper MSP claims.	X	X		X			X	X		
7027.3	The shared systems shall not overlay claim level MSP payment information with the sum of the line level MSP payment information when a claim level payment adjustment is submitted.							X	X		
7027.4	The Contractors and Part B shared systems shall use the header level adjustments and then send the MSP amounts, along with the claim detail information, to MSPPAY to apportion the MSP amounts to the detail in situations where the claim level OTAF, primary payer allowed amount, and/or primary payer paid amounts are not equal to the sum of the corresponding detail amounts, but the claim still balances.	X	X		X			X	X		
7027.5	The shared system shall turn on the apportionment switch in MSPPAY so claims are apportioned to the detail level.							X	X		
7027.6	DME contractors and VMS shall make sure that MSP Claims balancing continues to be performed in pre-pass editing by CEDI for DMEPOS claims.		X						X		CEDI

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

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 (FIs), Regional Home Health Intermediaries (RHHIs)*:

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

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(Rev. 75, 10-29-10)

40.7.3.3 - Version 5010 Balancing for Incoming MSP Claims Where MSP Amounts Appear at the Claim Level and Not at the Service Detail Line.

(Rev. 75, Issued: 10-29-10, Effective: 04-01-11, Implementation: 04-04-11)

There may be situations where the primary payer may identify the CARCs at the line level, but may also include additional CARCs and adjustments at the header level. Although receiving such MSP claims is a rare occurrence it is possible that these types of claims may be sent on 5010 claim transactions or on hardcopy claims.

The current Medicare Secondary Payer Payment Module (MSPPAY) calculates MSP claims payment for MSP claims received at the header level or at the detail level. Currently, when there is MSP information at the header level that is not identified at the detail the share system turns on the apportioning switch in MSPPAY to apportion the MSP claims to the detail lines. In situations where the claim level OTAF, primary payer allowed amount and/or primary payer paid amounts are not equal to the sum of the corresponding detail amounts, but the claim balances, this manual section instructs the Part B shared systems to use the claim level amounts to determine Medicare's secondary payment. This involves determining the MSP amounts utilizing the CAS adjustments as instructed in previous MSP and MSP CARC change requests, and then send these amounts, along with the claim detail information, to MSPPAY so MSPPAY can apportion the MSP amounts to the detail. Contractors may refer to the 5010 837P Implementation Guide – Front matter, Balancing section, specifically 1.4.4.1 for additional reference as needed.

To summarize this balancing, the claim level primary paid amount must equal the sum of the line level primary paid amounts less any claim level reductions.

	Submitted *Charges*	***Submitted*** *Primary Payment*	***Submitted*** *CARCs*
Claim Level	*$200*	*$170*	*CO-xx $30*
Line 1	*$100*	*$100*	
Line 2	*$100*	*$100*	

The above claim is consider in balance by version 5010 balancing rules, however, the sum of the line level primary paid amounts does not equal the claim level primary paid amount.