CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 81	**Date: July 29, 2011**
	Change Request 7483

SUBJECT: Requesting the Common Working File (CWF) to Cease Submitting First Claim Development (FCD) and Trauma Code Development (TCD) Alerts to the Coordination of Benefits Contractor (COBC)

I. SUMMARY OF CHANGES: This change request instructs CWF to remove FCD and TCD alerts from its system and cease submitting FCD and TCD alerts to the COBC.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

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
R	Chapter 5/20/20.1/Identification of Liability and No-Fault Situations
R	Chapter 6/10/General Information

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

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Effective Date: **January 1, 2012**

Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: The COBC develops for all Medicare Secondary Payer (MSP) situations. The COBC previously developed for FCs received by Medicare Contractors and for TCs found on No-Fault, Liability and Workers' Compensation claims. The COBC also develops for claims that Part A Medicare Contractors receive with Condition Code (CC) 08. Part A Providers continue to submit CC 08 on claims when Medicare beneficiaries do not provide MSP information at the time when services are rendered. When Medicare contractors receive MSP claims with CC 08 and this information is sent to CWF, CWF sends a CC08 alert to the COBC so the contractor can develop for potential MSP with the beneficiary.

Several years ago COBC was instructed to discontinue FC and TC development (FCD and TCD) since very few FCD and TCD requests were sent to the COBC. Although COBC has ceased such development practices CWF continues to send FCD and TCD alerts to COBC. CWF FCD and TCD alerts are no longer required. This change request instructs CWF to remove FCD and TCD alerts from its system and cease submitting FCD and TCD alerts to the COBC.

B. Policy: COBC continues to develop with beneficiaries to determine the appropriate primary payer to Medicare based on data received through the "I" record process and ECRS. CWF shall continue to send cc08 alerts to COBC in situations when the cc08 appears on MSP claims.

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	
7483.1	CWF shall update its hierarchy to remove FCD and TCD alerts.									X	
7483.2	CWF shall no longer send FCD and TCD alerts to the COBC.									X	
7483.3	CWF shall continue to send CC08 alerts to the COBC.									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:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7483.1	CMS shall delete references to COBC FCD and TCD CWF procedures from Chapter 5 and Chapter 6 of the MSP Manuals.

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

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.

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

20.1 - Identification of Liability and No-Fault Situations
(Rev. 81, Issued: 07-29-11, Effective: 01-01-12, Implementation: 01-03-12)

Medicare Contractors must be alert to identify liability and no-fault situations. However, contractors must use the indicators listed below to identify claims in which there is a possibility that payment can be made by a liability insurer:

- The contractor receives information from a physician, a provider, a supplier, a beneficiary, the contractor's internal operations (e.g., medical or utilization review) or those of the contractor's non-Medicare counterpart, another Medicare *Part A or Part B Contractor*, or any other source, indicating Medicare has been billed for services when there is a possibility of payment by a liability insurer;

- The health insurance claim shows that the services were related to an accident;

- The claim shows a complementary insurer as an insurance organization that does not issue health insurance;

- The contractor or the RO is asked to endorse a check from another insurer payable to Medicare and the beneficiary;

- The contractor receives or is informed of a request from an insurance company or from an attorney for copies of bills or medical records;

- There is indication that a liability insurer previously paid benefits related to the same injury or illness or that a claim for such benefits is pending. There is no need to investigate this lead, however, if contractor records show that the services were furnished after the date of a final liability insurance award or settlement for the same injury or illness, and the award or settlement does not make provisions for payments for future medical services;

- The *Medicare Part A Contractor* receives an ambulance claim indicating that trauma related services were involved; and

- The CWF HIMR screen shows that an auxiliary record has been established for a known liability situation.

In addition, *Medicare Part A Contractors* use the following indicators on the Form CMS-1450*/UB-04* to identify the possibility of payment by a liability insurer.

- Another insurer is shown as Payer on line A of FL 50 or a primary payer is identified in "Remarks" on the bill;
- Occurrence codes 01 through 03 or 24 are shown in FLs 32-35 or occurrence span code field in FL 36;
- Codes 1 or 2 are shown as the type of admission under FL 19;
- Code 14 is the value code shown under FLs 39-41;
- Condition codes 10, 28, 29, D7, and D8 are shown under FLs 24-30;
- Remarks are in FL 84.

For *Medicare Part B Contractors*, completion of block 10 on the Form CMS-1500 indicates another insurer may be involved. The *Medicare Part A or Part B Contractor* receiving a claim on which there is an indication of liability or no-fault coverage submits an MSP record to CWF using the service date of the claim as the effective date of MSP and a validity indicator of "*I*". This causes CWF to generate an investigation record to the COBC to ascertain the correct MSP period. The COBC develops the appropriate MSP dates with the insurer or beneficiary, or other party, as appropriate, and transmits a CWF maintenance transaction to reflect the proper MSP period.

Upon receipt of the CWF data, the *Medicare Part A or Part B Contractor* adjudicates the claim per Chapter 7, §50.4.

Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP) CWF Process

10 - General Information
(Rev. 81, Issued: 07-29-11, Effective: 01-01-12, Implementation: 01-03-12)

Medicare Part A and Part B Contractors obtain information pertinent to the identification of MSP for each beneficiary via the CWF, MSP auxiliary file. The auxiliary file is associated with the beneficiary's master record within CWF.

The Coordination of Benefits (COBC) contractor completes MSP updates on a daily basis upon receipt of notice that another payer is primary to Medicare (e.g., an explanation of benefits, a beneficiary questionnaire, a notice from a third party payer, etc.). Every claim for a given beneficiary is validated against the same MSP data housed in a CWF, MSP auxiliary file, thus

permitting uniform processing. Contractor claims data inconsistent with a CWF, MSP auxiliary file will cause rejects and/or error conditions. An MSP auxiliary record consistent with an identified MSP situation must be present before a payment is approved for an MSP claim. An MSP auxiliary record is established by an MSP maintenance transaction submitted to CWF. The claim must agree with the MSP auxiliary record that was established, or it will not process.

The COBC is the source for establishing new MSP records, with the exception of four situations described in §10.1, below. The COBC submits MSP maintenance transactions on the basis of information obtained outside the claims process. Examples include IEQ, IRS/SSA/CMS Data Match, voluntary MSP data match agreements, *Section 111 reporting*, attorney, beneficiary, provider information, and 411.25 Notices.