Medicare Secondary Payer (MSP) Manual
Chapter 5 – Contractor MSP Claims Prepayment Processing Requirements

Table of Contents
(Rev. 11997, 04-28-23)

Transmittals for Chapter 5

10 - Coordination with the MSP Contractor
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Initial Medicare Secondary Payer (MSP) Development Activities by the MSP Contractor

The MSP Contractor responsible for coordination of benefits (formerly known as the Benefits Coordination & Recovery Center or the Coordination of Benefits Contractor and hereafter termed the "MSP contractor") consolidates activities that support the collection, management, and reporting of all other health insurance coverage of Medicare beneficiaries, as well as all insurance coverage obligated to pay primary to Medicare. The MSP Contractor assumed responsibility for virtually all initial MSP development activities formerly performed by A/B MACs and DME MACs. The MSP Contractor is charged with ensuring the accuracy and timeliness of updates to the Common Working File (CWF) MSP auxiliary file. The MSP Contractor does not process claims, nor claims specific inquiries (telephone or written). The MSP Contractor is responsible for determining the existence or validity of MSP for Medicare beneficiaries. The MSP Contractor handles all MSP related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries. These inquiries (verbal and written) can come from any source, including but not limited to beneficiaries, attorneys/beneficiary representatives, employers, insurers, providers, suppliers and A/B MACs and DME MACs and the MSP contractor.

The MSP Contractor is primarily an information gathering entity. The MSP Contractor is dependent upon various sources to collect this information. With limited exceptions (e.g., claim clarification with provider to avoid returning the claim to the provider (RTP)), A/B MACs and DME MACs are no longer responsible for initiating MSP development and making MSP determinations. Following CMS' correspondence guidelines (found in Pub. 100-09 chapter 6); the A/B MACs and DME MACs shall forward all information that they receive that might have MSP implications to the MSP Contractor. This requirement includes filling out all fields in the Electronic Correspondence Referral System (ECRS) Web where the information is available. If the A/B MACs and DME MACs do not have the information, and it is not a required field, the A/B MACs and DME MACs shall leave the field blank. Only with this timely and accurate information can the MSP Contractor evaluate all relevant information to make the correct MSP determination and appropriately update CWF for proper claims adjudication. Once the MSP record has been established on CWF by the MSP Contractor, the MSP Contractor shall be responsible for all MSP activities related to the identification and recovery of MSP-related debts.

All A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs) shall contact their consortia representative for inquires related to specific workload activities. All A/B MACs and DME MACs shall provide the MSP Contractor, through CMS with a list of names, private phone numbers, and fax numbers of each A/B MAC and DME MAC primary and backup MSP contact on a quarterly basis as instructed in CMS TDL-140383 so the MSP Contractor may follow-up with the A/B MACs and DME MACs as needed.

10.1 - A/B MACs and DME MACs Contractor MSP Auxiliary File Update Responsibility

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The capability to update the CWF MSP auxiliary file is, essentially, a function of only the MSP Contractor. A/B MACs and DME MACs do not have the capability to delete any MSP auxiliary file records, including those they have been established. If they believe a record should be updated or deleted, they shall use the MSP Contractor ECRS Web (discussed in §10.2) to update the MSP record.

Below are some examples where the A/B MACs and DME MACs may need to create and send an ECRS request. They are:

1 - The A/B MACs and DME MACs receive a piece of correspondence from a beneficiary representative, beneficiary, third party payer, another insurer's explanation of benefits or other source, or phone call from the provider, that establishes, exclusive of any further required development or investigation that MSP no longer applies. A termination date is included in the correspondence or provided by phone. The A/B MACs and DME MACs shall submit an ECRS request to the MSP Contractor with the appropriate termination date identified within forty-five (45) calendar days of the mailroom date-stamped receipt/date of the correspondence, as applicable.

EXAMPLE

Scenario

Union Hospital is calling the A/B MAC (Part A) to report that the group health plan MSP period contained on the CWF for beneficiary X should be terminated.

A/B MAC (Part A) **Action**

The A/B MAC (Part A) shall check for a matching auxiliary record on CWF and initiate the CWF assistance request to the MSP Contractor to terminate the record.

2 - The A/B MACs and DME MACs **receive a GHP claim for secondary benefits and could, without further development (for example, the explanation of benefits from another insurer or third-party payer contains all necessary data), add an MSP occurrence and pay the secondary claim.**

The A/B MACs shall use a validity indicator of "I" to add any new MSP occurrences (only if no MSP record with the same MSP type already exists on CWF with an effective date within 45 days of the effective date of the incoming "I" record). An “I” record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF. Note, Dark Days, or some federal holidays, may impact the time frame for uploading an “I” record to CWF. The A/B MAC and DME MAC contractors shall retain suspense dates and be able to provide either screen prints or create upon request a report reflecting all status dates of claim suspensions. Note: Managing the MSP inventory of workload in such a way as to require all MSP related claims be processed within 10 calendar days from the date in which the claim suspends for MSP will ensure the CMS requirement for the creation

of “I” records is consistently met. The A/B MACs shall not submit a new record with a "Y" or any record with an "N" validity indicator. The DME MACs shall submit an MSP Inquiry, or Assistance Request if applicable, within ten (10) calendar days from the last day when the claim is suspended for MSP (internal system or CWF, whichever suspends first), for MSP, or within 45 calendar days of receipt of the claim. Invalid values are not allowed in the following critical fields for any ECRS entries: HICN, MBI, MSP Type, MSP Effective Date, Patient Relationship and Insurer Name.

3 - The A/B MAC **receives an NGHP claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development.**

The A/B MAC shall add the MSP occurrence using an "I" validity indicator. An “I” record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF. The A/B MAC and DME MAC contractors shall retain suspense dates and be able to provide either screen prints or create upon request a report reflecting all status dates of claim suspensions. Note: Managing the MSP inventory of workload in such a way as to require all MSP related claims be processed within 10 calendar days from the date in which the claim suspends will ensure the CMS requirement for the creation of “I” records is consistently met.

When creating an NGHP MSP “I” record, not all diagnosis codes apply to No-Fault and Liability situations. A list of invalid/prohibited diagnosis codes can be found within the Section 111 NGHP User Guide on CMS.gov, Chapter V, Appendices I and J, at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide

The A/B MAC transmits "I" records to CWF via the current HUSP transaction. The CWF treats the "I" validity indicator the same as a "Y" validity indicator when A/B MAC contractors process claims. "I" records shall only be submitted to CWF if no MSP record with the same MSP type already exists on CWF with an effective date within 45 calendar days of the effective date of the incoming "I" record. A/B MAC-created "I" records submitted to CWF that fail these edit criteria shall be rejected with an SP 20 error code.

There are circumstances when an incomplete MSP claim is received and an A/B MAC shall not submit an “I” record. When this occurs the A/B MAC shall submit an ECRS Inquiry with all pertinent information found on the claim. It would be the responsibility of the MSP Contractor to establish the correct effective date. All A/B MACs shall submit an MSP Inquiry within ten (10) calendar days from the last day when the claim is suspended for MSP (internal system or CWF, whichever suspends first), or within 45 calendar days of receipt of the claim. If the ECRS attempt fails, the A/B MACs are reminded to resubmit the ECRS request within 48 hours, or two (2) business days. Follow up with your MSP Contractor consortia representative if the ECRS attempt continues to fail. Note: DME MACs do not submit “I” records to CWF. DME MACs instead utilize the ECRS process when the DME MAC receives a claim for payment, and the claim contains sufficient information to create an MSP record without further development. The MSP Contractor shall receive a trigger from the CWF when an “I” record is transmitted and applied. The MSP Contractor develops and confirms all "I" maintenance transactions established by the A/B MAC contractors. The MSP Contractor will delete an “I” record if: It has not received a response to its development request within 45 days; or it has determined that there is no MSP based upon the development response.

An "I" record should never be established when the mandatory fields of information are not readily available to the A/B MAC and DME MAC on its claim or associated attachment (e.g., other payer's explanation of benefits (EOB) paid or remittance advice).

The following are to be used as default values when creating an "I" record:

(1) MSP Effective Date: Use the Part A entitlement date for GHP. For NGHP use the date of incident as the MSP effective date as identified in the occurrence code field as found on the claim.

(2) Patient Relationship: Use "01" if no indication of other insured member, and use "02" if another member is shown but uncertain of relationship.

(3) MSP Type: For GHP, use the current reason for entitlement: working aged (12), disability (43), or ESRD (13). For NGHP, if not identified, the default to be used is No-Fault (14).

In addition, a refund or returned check is no longer a justification for submission of an "I" record. Since an "I" record does not contain the source (name and address) of the entity that returned the funds, the MSP Contractor lacks the information necessary to develop to that source. Follow the examples below to determine which ECRS transaction to submit:

1. An MSP inquiry should be submitted when there is no existing or related GHP MSP record on the CWF and the incoming claim does not have enough information needed to create an "I" record. Note: A 'related' record means if an MSP record on CWF matches and has the same HICN/MBI, MSP type, MSP effective date, Insurance type, patient relationship code and, validity indicator. All A/B MACs shall submit an MSP Inquiry, or Assistance Request, within ten (10) calendar days from the last day when the claim is suspended for MSP (internal system or CWF, whichever suspends first), or within 45 calendar days of receipt of the claim.

2. The CWF assistance request should be submitted when the information on the CWF is incorrect or the MSP record has been deleted.

3. If the check or voluntary refund either opens or closes the MSP case or MSP issue. Under these circumstances, the A/B MAC or DME MAC shall submit an MSP inquiry to open or close the MSP record. The A/B MAC or DME MAC should refer to ECRS manual for more information regarding closed cases.

The check should be deposited to unapplied cash until MSP Contractor makes an MSP determination. Refer to Chapter 6, Section 20.2 for examples.

If the A/B MACs have the actual date that Medicare became secondary payer or the date of the accident or incident, it shall use that as the MSP effective date. If that information is not available, the A/B MACs shall use the Part A entitlement date as the MSP effective date. A/B MACs may add a termination date when creating an "I" record, if applicable. However, an A/B MAC cannot add a termination date to an already established "I" record in CWF. The following are mandatory fields for MSP records with a validity indicator of "Y" and "I":

- Medicare beneficiary identifier;

- MSP type;
- Validity indicator;
- MSP effective date;
- A/B MAC identification number;
- Insurer name;
- Patient relationship; and
- Insurance type.

Chapter 6, §40.8, contains the CWF MSP utilization error codes, descriptions, and resolution for the A/B MAC's use in correcting MSP utilization error codes.

10.2 - MSP Contractor Electronic Correspondence Referral System (ECRS)

(Rev. 11997; Issued: 04-28-23; Effective: 05-30-23; Implementation: 05-30-23)

The MSP Contractor (formerly known as the Coordination of Benefits Contractor (COBC)) assumes responsibility for virtually all activities related to establishing MSP periods of coverage at CWF that result from initial MSP development activities. Since the A/B MACs and DME MACs receive MSP information, the MACs must utilize the ECRS Web application to send MSP information to the MSP Contractor. The ECRS Web application allows A/B MAC and DME MAC MSP representatives and Regional Office MSP staff to complete the online forms and electronically transmit information to the MSP Contractor.

The ECRS is operational 24 hours a day, 7 days a week, except for maintenance. A/B MACs and DME MACs shall report connection problems or systems failures directly to the MSP Contractor EDI Hotline at 646-458-6740. If A/B MACs and DME MACs are unable to receive technical assistance from the MSP Contractor EDI Hotline, or the issue has not been resolved, please E-mail questions or issues should be forwarded to the MSP Contractor via Internet address at ECRSHELP@ehmedicare.com.

Attachment 1 - ECRS Web User Guide

To view Attachment 1, click here: Attachment 1, ECRS Web User Guide, User Guide

Attachment 2 – ECRS Web - Quick Reference Card

To view Attachment 2, click here: Attachment 2, ECRS Web User Guide Quick Reference Card

10.2.1 - ECRS Functional Description
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

In general, there are two ECRS submission processes: the MSP inquiry process and the CWF assistance request. The MSP inquiry process is used to transmit information to the MSP Contractor where no related MSP record exists on the CWF. The CWF assistance request is used to transmit information to the MSP Contractor to modify or delete existing MSP information currently residing on the CWF for any type of MSP situation. Assistance requests should be done only on "related" records (i.e., Note: A 'related' record means if an MSP record on CWF matches and has the same HICN/MBI, MSP type, MSP effective date, Insurance type, same patient relationship code and, validity indicator is for the same insurer, and has part of or all of the MSP time span reflected on the claim. A/B MACs and DME MACs shall refer to the ECRS Web User Guide-Attachment 1 for step-by-step instructions on how to submit MSP inquiry and CWF assistance request transactions to the MSP Contractor, and how to perform status inquiries on previously submitted transactions. When entering the type of MSP record in ECRS, A/B MACs and DME MACs shall enter the correct MSP information even if the provider submits an incorrect MSP information including the insurer information found on the claim. Note, if information on a claim is received which necessitates the A/B MAC or DME MAC to create or update an MSP record in CWF, and the "I" record process cannot be used, an accurate MSP Inquiry or Assistance transactions shall be sent to the MSP Contractor within 10 calendar days from the last day the claim is suspended/rejected for MSP (internal system or CWF, whichever suspends first), or within 45 calendar days of receipt of claim. Invalid values will not be allowed in the following critical fields for any ECRS entries: HICN, MBI, MSP Type, MSP Effective Date, Patient Relationship and Insurer Name.

Common Working File (CWF) Updates Allowed After "I" Record Development Period. However, A/B MACs shall not fax or email "I" record update requests to the MSP Contractor. Medicare A/B MACs shall only create an MSP Inquiry if the "I" record was deleted and they have confirmed other coverage.

MSP Claims that Match Deleted "I" Records

When A/B MACs receive claims with MSP payment information that conflicts with an already deleted "I" record created during the 45-day development period, they shall:

1. Remove the MSP payment information from the claim and pay the claim as primary; and
2. Apply Claim Adjustment Reason Code CO 45 or OA 23 with remittance advice remark Code MA 17 to the affected claims, or line items, as applicable.

Additionally, A/B MACs and DME MACs shall submit an MSP Inquiry request when an "I" record was deleted during the 45-day development period only if one of the MSP matching criteria on the claim (MBI, MSP effective date, MSP type, Patient Relationship, or Insurer Type) is different from the existing MSP matching criteria on the deleted "I" record and there is not a matching "Y" validity record. If you receive information where the insurer information truly differs from what is found on the deleted "I" record (for example, BCBS and BCBSCA would be considered the same while BCBSCS and Aetna are truly different entities),
submit an MSP Inquiry request.

Invalid and Prohibited Diagnosis Codes Submitted on NGHP "I" Records.

Not all diagnosis codes can be submitted on NGHP "I" record submissions. A list of invalid/prohibited diagnosis codes can be found within the Section 111 NGHP User Guide on CMS.gov at, Chapter V, Appendices I and J, at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide. If the A/B MAC submits an "I" record with an invalid/prohibited diagnosis code, systematic development will still occur. If a response is received within the 45-day development period, the system will attempt to post a "Y" validity record in CWF. The record will be systematically reviewed by BCRS utilizing the normal edit process, which includes a review of the diagnosis codes. The system will flag the record with an SP22 error to allow for manual correction by the MSP Contractor before allowing the record to be posted to CWF with a "Y" validity.

The below steps identify how the MSP Contractor handles the processing of the SP22 - Invalid Diagnosis Code for single and multiple diagnosis codes.

- Scenario 1: A single diagnosis code is present on the MSP file and it is invalid/prohibited - The MSP Contractor rejects the record in full. The NGHP MSP record must have one diagnosis code on the MSP record.
- Scenario 2: Multiple diagnosis codes are present on the MSP file, and the MSP Contractor locates invalid/prohibited code(s) - The MSP Contractors removes the invalid/prohibited code(s), but applies the MSP record to CWF (with at least one (1) diagnosis code being present).

Updating Section 111 Records

In the past A/B MACs and DME MACs have sent ECRS requests to the MSP Contractor requesting that GHP section 111 records be updated. The MSP Contractor has rejected most of these requests based on CMS hierarchy of Section 111 entities taking precedence in updating COB contractor number 11121 MSP records. However, CMS has clarified that the MSP Contractor shall accept A/B MACs and DME MACs ECRS requests to update Section 111 COB contractor number 11121 MSP records based on conditions below. A/B MACs and DME MACs shall continue to submit ECRS requests to the MSP Contractor for COB contractor numbers 11121 for the following circumstances:

- When the A/B MACs and DME MACs receive information indicating the group number or policy number of the primary payer has changed;
- When the A/B MACs and DME MACs learns of a retirement date for the beneficiary and a termination date must be added to the MSP record;
- When the A/B MACs and DME MACs receive information indicating the Insurance Type A, J, or K has changed or conflicts with what is on the CWF MSP Auxiliary file; or
- When the A/B MACs and DME MACs receive a primary payer EOB or remittance advice showing payment for a deleted or closed Section 111 GHP MSP record that should remain open.

For COB contractor number 11122 MSP records, the MSP Contractor will not accept an NGHP record update request for any type of MSP claim situation.

Note: For non-section 111 NGHP records the A/B MACs and DME MACs shall continue to submit ECRS requests to the MSP contractor for COB contractor numbers other than 11122, in order to make updates to the policy number, and add missing information. It is at the MSP Contractor's discretion whether to approve the Section 111 ECRS requests upon review. Approval or denial of such ECRS requests shall be sent to the A/B MACs and DME MACs by the MSP Contractor. Those A/B MACs and the DME MACs that have questions regarding denial of ECRS requests shall contact their MSP Contractor consortia representative.

ECRS Access:

- A/B MACs and DME MACs that require access to ECRS Web must register in the CMS Individuals Authorized Access to CMS EIDM system to request ECRS access, and have a A/B MAC or DME MAC contractor ID and access code. If a MAC representative has an EIDM ID and password and an A/B MAC or DME MAC contractor number and needs assistance obtaining a A/B MAC or DME MAC access code, please contact the MSP Contractor.
- To request an EIDM for access to ECRS WEB, A/B MACs and DME MACs should follow the directions provided in the latest ECRS Web User Guide; see section 10.2, Attachment 1, above, for a link to that Guide or reference section 5.1 of this chapter for the latest Guide update.)
- MAC representatives should log back on to ECRS to check on the status of their request, including final determination.

10.3 - Providing Written Documents to the MSP Contractor
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs and DME MACs do not routinely submit paper documentation to the MSP Contractor. However, if requested by the MSP Contractor, A/B MACs and DME MACs shall submit written supporting documentation to the MSP Contractor within five (5) business days of their receipt of the request. The MSP Contractor shall contact the A/B MAC and the DME MAC via phone for documentation requests. There are limited situations where the A/B MACs and DME MACs should mail, or fax, paper documents to the MSP Contractor. A/B MACs and DME MACs shall forward to the MSP Contractor, within forty-five (45) calendar days of their mailroom date-stamped receipt, any development form originally sent from the MSP Contractor that the A/B MACs and DME MACs inadvertently received. In those situations, where the A/B MACs and DME MACs is permitted to mail paper or fax documents to the MSP Contractor, please refer to the following link to identify the appropriate contact: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page. Note: A/B MACs shall not fax or email "I" record update requests to the MSP Contractor. A/B MACs and DME MACs shall only create an MSP Inquiry if the "I" record was deleted and they have confirmed other coverage.

10.4 - Contractor Record Retention
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs and DME MACs are responsible for retaining documentation that they do not forward to the MSP Contractor following current CMS document retention guidelines, including the assignment of a document control number for their use in subsequent retrieval. However, also see §10.7, which requires the A/B MACs and DME MACs receiving a liability, no-fault or workers' compensation inquiry to forward all associated documentation to the MSP Contractor

10.5 - Notification to A/B MACs and DME MACs of MSP Auxiliary File Updates
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs and DME MACs have the capability to log on to ECRS Web to generate an ECRS report with a list of their submissions and status of those submissions. A/B MACs and DME MACs can also search by the beneficiary's Medicare beneficiary identifier to see what Inquiries/Assistance Requests have been submitted by all A/B MACs and DME MACs.

A/B MACs and DME MACs shall be cognizant that the CM (i.e., completed) status in ECRS and the associated ECRS completion date is the same as the CWF maintenance date. A/B MACs and DME MACs shall use this date to timely resolve pending correspondence and other such workloads to be in compliance with the CMS 45 calendar day correspondence timeframe or other prescribed timeframes for designated MSP workloads. A/B MACs and DME MACs shall not send combined interim and final response letters. The A/B MACs and DME MACs shall follow the procedures cited in Pub. 100-05, Chapter 5 section 10.5 and Pub. 100-09, Chapter 6 when responding to MSP incoming inquiries. This means the A/B MACs and DME MACs shall send an interim response if the final correspondence response cannot be sent within 45 calendar days. A final response is also required when an ECRS response of CM (completed) is received from the MSP Contractor. If claims are impacted, the final response shall be either a claim adjustment or, if necessary, direction that the provider contact the A/B MAC or DME MAC directly regarding any claim adjustments resulting from an updated MSP record. Contact the MSP Contractor if an ECRS response has not been received within 45 calendar days.

10.6 - Referring Calls to the MSP Contractor
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Contractor Customer Service number is 855-798-2627 All questions on any of the activities listed in §10.7 shall appropriately go directly to the MSP Contractor. A/B MACs and DME MACs shall refer telephone calls on any of the activities listed in §10.7 to the MSP Contractor Customer Service number. Where the A/B MAC and DME MAC phone system has the capability, it shall transfer the caller to the MSP Contractor. If the A/B MAC and DME MAC does not have this capability, it shall transfer the call through a manual transfer process that does not require the caller to dial another number. If it has neither capability, it shall take the information from the caller and refer the issue to the MSP Contractor via ECRS within two (2) calendar days of receipt of phone call. Also, it shall provide the caller with the MSP Contractor's toll-free Customer Service number and direct the caller to place any follow-up calls to the MSP Contractor. The A/B MACs and DME MACs shall

always provide this number to the caller. The hearing and speech impaired shall be referred to TTY/TDD: 1-855-797-2627.

10.7 - Additional Activities Arranged by Non-GHP MSP Type
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MACs and DME MACs retain the responsibility of handling phone and written correspondence/inquiries related to existing no-fault insurance (automobile no-fault insurance of all types, including personal injury protection/med-pay), workers' compensation (WC), and liability cases, unless the phone call or written correspondence reveals information discrepant with that on CWF.

The MSP Contractor shall handle all calls and written correspondence where a beneficiary, third party payer, provider, or attorney is initially reporting the existence of a no-fault, WC, or liability case. The MSP Contractor shall develop all information necessary to establish an MSP occurrence. These auxiliary records shall appear on CWF.

After the MSP Contractor has established a new case (i.e., added a "Y" auxiliary record), all follow-up calls are the responsibility of the MSP Contractor.

A/B MACs and DME MACs are reminded that they may have overlapping MSP periods for liability, no-fault, workers' compensation, and/or group health plan insurance.

10.7.1 - No-Fault Development
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If Medicare is billed as primary payer, but there is an indication of possible coverage under no-fault insurance (including automobile no-fault insurance of all types, including personal injury protection) the A/B MACs and DME MACs shall advise the MSP Contractor through the ECRS. The MSP Contractor develops to determine whether there is coverage primary to Medicare through a form of no-fault insurance (including automobile no-fault insurance of all types, including personal injury protection). If there is coverage available, the MSP Contractor shall post an open "Y" auxiliary record on CWF.

If, upon further investigation, the MSP Contractor learns that the beneficiary is filing a liability insurance claim, the MSP Contractor shall create a new MSP record (with a +1-day difference in the Effective Date.) for the liability situation.

10.7.2 - Workers' Compensation (WC) Development
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Contractor develops to determine whether there is coverage primary to Medicare through WC insurance. The MSP Contractor determines the nature of the injury using the diagnosis code(s) submitted on the claim and through additional development, as necessary. The MSP auxiliary record added to CWF includes the diagnosis code(s) relating to that injury.

10.7.3 - Liability Development

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Contractor develops to determine if a liability (including automobile liability) insurance claim has been or will be filed. If, as a result of that development or receipt of self-reported information (for example, letter from beneficiary or attorney or other beneficiary representative, notification from provider), the beneficiary/representative indicates the intent to file a liability insurance claim, the beneficiary/representative is notified by the MSP Contractor of Medicare's potential recovery claim. If there is a settlement, judgment, or award, the MSP Contractor shall, where appropriate, send the attorney or other beneficiary representative a release agreement to be completed.

If the MSP Contractor's development indicates there is a possible payment under liability insurance, the A/B MAC or DME MAC shall make conditional payment.

10.8 - MSP Contractor Numbers

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Contractor accretes MSP records using designated COB contractor numbers. Different numbers have been assigned for each MSP Contractor activity for purposes of separately capturing savings attributable to each activity. See Chapter 6, §10.2, for a complete list of MSP Contractor COB numbers and corresponding Nonpayment/Payment Denial codes and CROWD, MDX, Special Project numbers.

When the A/B MACs submit an "I" record to CWF, it's A/B MAC contractor number is shown as the originating A/B MAC contractor. If the MSP Contractor converts the record to a "Y" with no change to the information, the originating A/B MAC contractor number remains on the record. If the record is changed to a "Y" and any of the data elements change, one of the MSP Contractor COB numbers shows as the originating contractor.

10.8.1 - No-Fault Development

(Rev. 39, Issued: 10-21-05; Effective Date: 10-01-05; Implementation Date: 11-19-05)

If Medicare is billed as primary payer, but there is an indication of possible coverage under no-fault insurance (including automobile no-fault insurance of all types, including personal injury protection) the contractor shall advise the COBC through the ECRS. The COBC develops to determine whether there is coverage primary to Medicare through a form of no-fault insurance (including automobile no-fault insurance of all types, including personal injury protection). If there is coverage available, the COBC shall post an open "Y" auxiliary record on CWF. Through its initial development with the insurer and/or attorney, the COBC may receive information that indicates that coverage through the no-fault insurance has been exhausted. In these cases, the COBC shall direct the insurer or attorney to forward information to the lead contractor to determine whether benefits have been exhausted.

Using the information supplied by the COBC, the contractor processes the claim to payment or denial.

If, after the COBC's initial development, the lead contractor later determines that benefits have been exhausted under this policy, it shall post the termination date following the instructions in §10.1. If the lead contractor receives information through recovery development efforts that serves to modify the information that is contained on CWF, it shall send a CWF Assistance Request via ECRS (See§10.2.1).

If, upon further investigation the COBC learns that the beneficiary is filing a liability insurance claim, the COBC shall create a new MSP record (with the same effective date as the no-fault) for the liability situation and notify the designated lead contractor to validate that benefits have been exhausted. The lead contractor shall make the determination to terminate the no-fault record. If the lead contractor receives this information, it shall post a termination date (if none is existing), and forward the liability information to the COBC via ECRS (See§10.2.1).

10.8.2 - Workers' Compensation (WC) Development

(Rev. 39, Issued: 10-21-05; Effective Date: 10-01-05; Implementation Date: 11-19-05)

The COBC develops to determine whether there is coverage primary to Medicare through WC insurance. The COBC determines the nature of the injury using the diagnosis code(s) submitted on the claim and through additional development, as necessary. The MSP auxiliary record added to CWF includes the diagnosis code(s) relating to that injury. If, after the COBC's initial development, the lead contractor later determines that benefits have been exhausted under WC, it shall post the termination date following the instructions in §10.1. If the lead contractor receives information through recovery development efforts that serves to modify the information that is contained on CWF, it sends a CWF Assistance Request to the COBC via ECRS (See§10.2.1).

10.8.3 - Liability Development

(Rev. 39, Issued: 10-21-05; Effective Date: 10-01-05; Implementation Date: 11-19-05)

The COBC develops to determine if a liability (including automobile liability) insurance claim has been or will be filed. If, as a result of that development or receipt of self-reported information (for example, letter from beneficiary or attorney or other beneficiary representative, notification from provider), the beneficiary/representative indicates the intent to file a liability insurance claim, the beneficiary/representative is notified by the COBC of Medicare's potential recovery claim, if there is a settlement, judgment, or award, the COBC shall, where appropriate, send the attorney or other beneficiary representative a release agreement to be completed and returned directly to the lead contractor. The lead contractor shall post a termination date if it is notified that a liability case has been resolved through a settlement, judgment or award and does not provide for future medical payments. If its recovery development efforts find additional information that serves to modify the information that is contained on CWF, it sends a CWF Assistance Request to the COBC via ECRS (See §10.2.1).

If the COBC's development indicates there is a possible payment under liability insurance, the contractor shall make conditional payment. The COBC shall designate a lead contractor to monitor the progress of the liability claim and coordinate Medicare recovery efforts (See Chapter 7, §50.5).

See §10.8.1 for instructions where a liability insurance claim follows a no-fault situation; the lead contractor is responsible for the same type of actions where a no-fault claim follows a liability claim.

20 - Sources That May Identify Other Insurance Coverage
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and DME MACs use the following guidelines to identify claims for otherwise covered services when there was a possibility that payment had been made or can be made by an insurer primary to Medicare.

- Information is received from a provider, physician, supplier, the beneficiary, A/B MAC and DME MAC operations (e.g., medical or utilization review), other non-Medicare counterparts, or any other source indicating Medicare has been billed for services when there is a possibility of payment by an insurer that is primary to Medicare;

- The health insurance claim form shows that the services were related to an accident (i.e., the diagnosis is due to trauma) or occupational illness (e.g., black lung disease) or were furnished while the beneficiary was covered by a GHP or an LGHP which is primary to Medicare;

- The CWF indicates a validity indicator value of “I” or "Y" showing the presence of MSP coverage;

- Information in an A/B MAC or DME MAC record- indicates a primary payer;

- There is an indication that the beneficiary previously received benefits or had a claim pending for insurance that is primary to Medicare. The A/B MAC or DME MAC assumes, in the absence of information to the contrary, that this coverage continues;

- Medicare has not made payment and the A/B MAC and the DME MAC is asked to endorse a check from another insurer payable to Medicare and some other entity. The A/B MAC or the DME MAC returns the check to the requester and advises that the insurer pay primary benefits to the full extent of the GHP's primary obligation. (The A/B MAC and the DME MAC follows the recovery instructions in Chapter 7, "MSP Recovery," and Chapter 3 of Pub. 100-6, the Medicare Financial Management Manual, if the check relates to services for which Medicare paid primary.) As necessary, it follows up with the provider, physician, supplier, beneficiary, and/or attorney to find out if the beneficiary receives payment from the GHP;

- Medicare receives or is informed of a request from an insurance company or attorney for copies of bills or medical records. Providers are instructed to notify the MSP Contractor promptly of such requests and to send a copy of the request. If the request is unavailable, providers are to provide full details of the request, including the name and Medicare beneficiary identifier of the patient, name and address of the insurance company and/or attorney, and date(s) of services for which Medicare has been billed or will be billed;

- Where a GHP's primary coverage is established because the individual forwards a copy of the GHP's explanation of benefits and the individual meets the conditions in Chapter 1, §10, the A/B MAC and the DME MAC processes the claim for secondary benefits;

- A claim is billed as Medicare primary and it is the first claim received for the beneficiary and there is no indication that previous MSP development has occurred; or

- The CWF MSP auxiliary detail screen contains a 1-byte Ongoing Responsibility for Medicals (ORM) indicator, where the value is "Y," which indicates that a Section 111 Medicare, Medicaid, and S-CHIP Extension Act (MMSEA) Responsible Reporting Entity (RRE) has accepted ongoing responsibility for a particular liability, no-fault, and workers' compensation incident. **NOTE:** Further details regarding ORM, the new 1-byte ORM indicator on CWF, and how to handle and process claims based on the value present within the CWF ORM field may be found in Section 2.4 below.

Other insurance that may be primary to Medicare is shown on the institutional claim as follows:

- A Value Code of 12, 13, 14, 15, 16, 41, 43, 44, or 47;

- An Occurrence Code of 01, 02, 03, 04, 05, 24, 25, or 33;

- A Condition Code of 02, 05, 06, 77, or D7;

- A diagnosis code is shown on the NGHP claim; or

- Another insurer is shown as the primary payer on line A of Payer Name.

Special Note for Incoming Hard Copy Part B Non-Facility Claims: Other insurance that may be primary to Medicare is shown on the Form CMS-1500 claim form when item 11 is completed. A primary insurer is identified in the "Remarks" portion of the bill.

With the installation of the Benefits Coordination & Recovery Center (MSP Contractor), the A/B MACs and DME MACs use ECRS to advise the MSP Contractor of the possibility of another insurer, and awaits MSP Contractor development before processing the claim.

20.1 - Identification of Liability and No-Fault Situations
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs and DME MACs shall use the indicators listed below to identify claims in which there is a possibility that payment can be made by a liability or no-fault insurer:

- The A/B MACs and DME MACs receive information from a physician, a provider, a supplier, a beneficiary, the A/B MACs and DME MACs internal operations (e.g., medical or utilization review) or those of the A/B MACs and DME MACs non-Medicare counterpart,

another A/B MAC or DME MAC, 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 A/B MAC, the DME MAC or the RO is asked to endorse a check from another insurer payable to Medicare and the beneficiary;

- The A/B MAC or the DME MAC 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 the A/B MAC or the DME MAC 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 A/B MAC receives an ambulance claim indicating that trauma related services were involved;

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

- A “Y” ORM indicator is present on the MSP auxiliary file for a liability, no-fault or workers’ Compensation record. (See Section 20.4 for more information.)

In addition, A/B MACs (Part A) and A/B MACs (Part HHH) use the following indicators on the institutional claim to identify the possibility of payment by a liability insurer.

- Another insurer is shown as Payer on line A of Payer Name or a primary payer is identified in "Remarks" on the bill;

- Occurrence Codes 01 through 03 or 24 are shown for Occurrence Span Code;

- Codes 1 or 2 are shown as the Type of Admission;

- Code 14 is the Value Code shown;
  - Condition Codes 10, 28, 29, D7, and D8 are shown; and

  - Remarks are shown.

For A/B MACs (Part B), completion of block 10 on the Form CMS-1500 indicates another insurer may be involved. The A/B MAC (Part B) receiving a claim on which there is an indication of liability or no-fault coverage submits an MSP record to CWF using the accident date as the effective date of

MSP and a validity indicator of "I." This causes CWF to generate an investigation record to the MSP Contractor to ascertain the correct MSP period. The MSP Contractor 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 A/B MAC (Part B) adjudicates the claim per Pub. 100-05, Chapter 3, Section 90.

20.2 - Identify Claims with Possible WC Coverage

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MACs and DME MACs must identify claims with possible WC coverage. If the provider submitting the claim provides information that clearly indicates the services will not be covered by WC, the A/B MACs or DME MAC pays the claim. Such indications may be:

- A denial letter from the WC carrier;
- A supplemental statement is included in “remarks” on the claim form;
- Form CMS-1450 claims contain an occurrence code 24 (insurance denied) and the date of denial is reported in FLs 28-32;
- For A/B MACs (Part B), completion of block 10 on the Form CMS-1500 indicates another insurer may be involved;
- The beneficiary previously received WC for the same condition;
- The Common Working File’s MSP auxiliary record contains a “Y” validity indicator and an MSP code (“E” or “H”) that indicates the beneficiary is entitled to Black Lung benefits; and
- A “Y” ORM indicator is present on the MSP auxiliary file for a liability, no-fault or Workers’ Compensation record. (See Section 20.4 for more information.)

Where it appears that the services may be compensatory by WC, the A/B MAC or DME MACs receiving a claim on which there is an indication of WC 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 MSP Contractor to ascertain the correct MSP period. The MSP Contractor 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 A/B MAC adjudicates the claim to a final disposition.

20.3 - Medicare Claims Where Veterans' Affairs (VA) Liability May Be Involved

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Under certain circumstances, the VA may authorize a veteran to receive care on a fee-for-service basis from a non-VA physician/supplier. Generally, this authorization is related to a specific condition. Medicare payment for all other services is appropriate. Since no payment may be made under Medicare for services authorized by the VA, A/B MACs and DME MACs must assure that Medicare funds are not used to supplement or duplicate VA benefits. See the Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, §50.1, for an explanation of Medicare policy in relation to VA authorized services.

20.3.1 - VA Payment Safeguards

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When the beneficiary is identified as possibly having VA entitlement, the A/B MAC and the DME MAC may contact the provider, physician/supplier to determine whether a claim has been, or will be, submitted to the VA for payment for the procedures listed. It does not contact the beneficiary or the VA. It uses only information from the provider, physician/supplier to determine whether VA liability is involved. It processes the claim according to the following rules:

- If a claim has not, and will not, be filed with the VA, the A/B MAC and the DME MAC processes the claim;

- If the provider, physician/supplier responds that the claim is being, or has been, sent to the VA, the A/B MAC and the DME MAC denies the claim; and

- If the claim was for multiple services and the physician/supplier states that the VA has assumed responsibility for some, the A/B MAC and the DME MAC denies those services the VA has responsibility for and processes the other Medicare covered services.

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, §50.1, for policy and procedures describing when Medicare may take into consideration VA claims paid for by the VA to: 1) credit the beneficiary Medicare deductible, and 2) to reimburse the beneficiary their VA copayment amounts charged for VA authorized services furnished by non-VA sources.

20.4 - Identification of On-Going Responsibility for Medicals (ORM) in Liability, No-Fault, and Workers' Compensation Situations

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Instructions to in regards to ORM for NGHP situations are identified in the below sub-sections.

20.4.1 - Background Regarding ORM for A/B MACs and DME MACs

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards, or other payments involving individuals who are or were Medicare beneficiaries to the Centers for Medicare & Medicaid Services (CMS). The applicable plan is the "Responsible Reporting Entity" (RRE) for this process.

The required reporting includes instances where the RRE has assumed ongoing responsibility for medicals (ORM) associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted, or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date to the MSP Contractor via an ECRS request, and this information is uploaded to Common Working File (CWF) by the MSP Contractor.

NOTE: A Section 111 ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

20.4.2 – Policy Regarding ORM

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made..." under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

Systems Changes Made and A/B MACs and DME MACs Contractor Operational Responsibilities

An ORM indicator field was added to CWF that will be populated with two values: "Y," which denotes that ORM responsibility assumed/exists, or a "space," which signifies that an RRE has not assumed ORM. Please note that where ORM is reported, the ORM indicator on associated MSP auxiliary records remains a "Y" even where the ORM is subsequently terminated. **Important:** A "Y"

ORM indicator value denotes that the ORM existed for a particular period of time (not necessarily that it currently exists).

All A/B MACs and DME MACs shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSP D (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. After comparing the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record, all A/B MACs and DME MACs shall deny claims where the 1-byte ORM indicator on the MSPD screen equals "Y" and the diagnosis code(s) match(es) (or match(es) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim (s) be reprocessed.

A/B MACs and DME MACs shall deny payment for claims with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the A/B MAC and the DME MAC receives information that the policy limit has been exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

A/B MACs and DME MACs may receive Congressionals or inquiries from providers physicians, other suppliers including beneficiaries, or authorized representatives, stating that Medicare claims were inappropriately denied because the services performed for an accident or injury are not related to the Liability, No-fault or Workers' Compensation MSP record found on CWF. Even though the diagnosis codes on the claim are within the family of diagnosis codes found on the MSP NGHP record there are situations where the claim services are not related to the accident or injury. If evidence/documentation is later received and it demonstrates that the services performed are unrelated to the MSP NGHP record, the A/B MAC and DME MAC may make payment on the claim.

NOTE: Unless otherwise mentioned, A/B MACs and DME MACs shall assume that normal MSP claims processing requirements (e.g., checking claim service dates against MSP auxiliary record effective and termination dates; matching diagnosis codes on the claim against those on CWF (including the family of diagnosis codes policy); and affording appeal rights on MSP claims) apply.

The A/B MACs, DME MACs and shared systems shall only apply the prompt payment rules for liability insurance and the prompt payment rules for no-fault insurance and workers' compensation if the ORM indicator on the MSPD screen equals a "space," which means ORM does not exist for this MSP record.

Special Circumstance for A/B **MACs and DME MACs**

While it may not occur frequently, there may be situations where an RRE will continue to assume ORM for a particular injury/illness and at the same time have a lump sum type settlement or other payment with respect to other alleged injuries/illnesses for the same date of accident/injury/loss.

Consequently, it is possible that CWF could have both an open ORM occurrence as well as an open Medicare Set-Aside (MSA) occurrence, just not for the same diagnosis code(s). Therefore, the A/B MACs shall determine which record on CWF is applicable in order to process the claim appropriately. For example, the A/B MAC may review the diagnosis codes on the claim and compare them to the diagnosis codes on the open ORM occurrence and the MSA occurrence, as well as any other open CWF occurrences that fall within the date perimeters being reviewed, to find the correct match for MSP claims processing purposes.

Residual Payments on Claims

Until future instructions are issued, A/B MACs and DME MACs shall follow existing procedures when they need to make a residual secondary payment in ORM situations (where an MSP D, E, or L records contain an ORM indicator of "Y," but the primary payer did not make complete payment on the claim). For example, they may need to request permission from their CMS Contracting Officer Representative (COR) to pay the claim outside of CWF. In situations where the ORM has been exhausted, A/B MACs and DME MACs shall send an ECRS request to the MSP Contractor identifying the date when benefits were exhausted.

20.4.3 - Operationalizing ORM for Liability, No-Fault and Workers' Compensation Situations

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MACs, DME MACs and shared system maintainers shall accept and process a revised MSP 03 trailer response from CWF that will now include the 1- byte ORM indicator with valid values.

The A/B MACs, DME MACs and shared systems shall accept and process the three (3) new overridable utilization error codes (68xx) when returned with an 08 trailer. These 3 new error codes will be for Liability (including self-insurance), No-Fault, and Workers' Compensation records on CWF. These error codes are:

6816 --"No-Fault record exists with a valid (Y) ORM indicator. A/B MAC and DME MAC payment is not allowed."

6817--"Workers' Compensation record exists with a valid (Y) ORM indicator. A/B MAC and DME MAC payment is not allowed. "

6818 - - "Liability record exists with a valid (Y) ORM indicator. A/B MAC and DME MAC payment is not allowed."

When determining whether to apply any of the above 3 new error codes, as applicable, CWF shall take the following steps by referencing the MSP auxiliary file:

(1) Validate that the ORM indicator on the open MSP ORM record on CWF equals "Y"; and

(2) Determine if the diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF.

If CWF determines that any of the 68xx error codes discussed in the previous paragraph above apply, it shall return them to the A/B MAC or DME MAC with disposition code equal to a UR. In addition, when CWF returns any of the 68xx edits to the A/B MACs and DME MACs, CWF shall also return a trailer 39 to the A/B MACs and DME MACs to make certain that, as applicable, they can determine to which service detail line the 68xx edit applies.

Additionally, CWF shall ensure that error code 68xx may be overridden by A/B MACs, DME MACs and shared systems as follows:

- Allow the 68xx to be entered in the claim header if applicable to the entire claims on which MSP NGHP diagnosis codes do not apply; or

- Allow for individual claim service lines on which MSP NGHP diagnosis codes do not apply to be overridden with an "N." (NOTE: In these cases, CWF shall not apply the line level override to the entire claim but only to the identified claim service detail lines.)

The A/B MACs, DME MACs and shared systems shall accept the three (3) new overridable utilization error codes (68xx) when returned via the 08 trailer.

When applying the 68xx editing logic to the applicable Liability, No-Fault, or Workers' Compensation record, CWF shall ensure that open NGHP MSP records with a "Y" ORM indicator are given precedence over another NGHP record, where all other variables except the ORM indicator match.

A/B MACs Claims Processing Instructions

When the A/B MACs (Part A), A/B MACs (Part HHH) and shared systems deny a claim, with an open ORM occurrence (with an indicator of "Y"), they shall create a "22" No Pay Code in the appropriate claim line and header of their HUIP, HUOP, HUHH, HUHC claim before sending it to CWF.

When the A/B MACs (Part B) and DME MACs and shared systems deny a claim, with an open ORM occurrence (with an indicator of "Y"), they shall create a "22" Payment Denial indicator in the HUBC and HUDC claim header transactions before sending them to CWF. In addition, they shall create a "22" in the claim detail pay process field before sending the claim to CWF.

Specified CARCs to Use in Denying Claims Due to ORM

The A/B MACs, DME MACs and shared systems shall include the existing Claim Adjustment Reason Codes (CARCs) 19, 20, and 21, as applicable, on the outbound 835 and the 837 crossover claims when denying claims due to ORM, together with CAS Group Code PR. These three (3) CARC codes are defines as follows:

CARC 19 -- "This is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier." [Associated Remittance Advice Remark Code (RARC) is N728.]

CARC 20 – "This injury/illness is covered by the liability carrier." [Associated RARC=N725.]

CARC 21 – "This injury/illness is the liability of the no-fault carrier." [Associated RARC=N727.]

In conjunction with the three (3) CARCs mentioned above, the A/B MACs, DME MACs and shared systems shall make certain that the three (3) new Remittance Advice Remark Codes (RARCs) for a D, E, or L records—namely, N725, N727, and N728, —are matched up and applied to the corresponding CARC codes for these same types of records, as appropriate.

These 3 new RARC codes shall be applied to the outbound 835 Electronic Admittance Advices (ERAs) and 837 crossover claims when denying claims due to an ORM indicator of "Y" on an open NGHP MSP record.

NOTE: Additionally**,** three (3) new Medicare Summary Notices (MSN) messages have been developed specifically for the three (3) types of NGHP MSP ORM types of records. These will be communicated elsewhere in the IOM.

Exceptions to Denial of Claims Policy Due to ORM

The A/B MACs, DME MACs and shared systems shall **not** allow or make Medicare payments on open ORM occurrences that contain an ORM indicator of "Y," unless the Claim Adjustment Reason Codes (CARCs) on the claim—specifically, CARCs 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 204, 242, 256, B1 (if a covered Medicare visit), and B14—permit Medicare to make a payment.

The A/B MACs, DME MACs and the shared systems shall make a payment, as appropriate, for those services related to diagnosis codes associated with the ORM MSP Auxiliary record when the claim's service date falls outside the termination date on the MSP auxiliary record or deleted.

Possible A/B MAC and DME **MAC Review of Suspended Claims**

A/B MACs and DME MACs shall still be required, on occasion and part of normal process/procedures, to make determinations on claims that are suspended for review with an associated ORM occurrence if:

(1) The ORM indicator on the CWF MSP record equals "Y"; and

(2) The diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the MSP ORM record on CWF.

Reopenings and Appeals for ORM Situations

In a reopening or separate claim appeal situation where the appellant or individual initiating the reopening is stating that ORM no longer applies due to benefits exhaustion, A/B MACs and DME

MACs shall continue to follow their current procedures for determining sufficiency of the information received as a basis for overturning or paying the claim at issue.

If an A/B MAC and DME MAC appeals or claims staff obtain an itemized schedule of payments from a third-party payer (ORM entity) that confirms exhaustion of available benefits as of a specified date, these individuals, together with internal MSP staff, shall take the following steps, as applicable:

- Appeals or claims staff shall contact your internal MSP personnel who regularly submit ECRS requests to the MSP Contractor to request that they alert the MSP Contractor that they have received documentation confirming exhaustion of benefits for a given MSP ORM occurrence.

- MSP staff shall initiate an ECRS Assistance Request using existing action codes that will alert the MSP Contractor that the benefits tied to a given MSP ORM occurrence have been exhausted.

(**NOTE:** A third party payer letter indicating benefits were exhausted without an accompanying itemized schedule of payments is not sufficient evidence for initiating an alert to the MSP Contractor via the ECRS process.)

Submitting ECRS Assistance Requests to the MSP Contractor For ORM-Related Matters

When submitting the ECRS Assistance Request to the MSP Contractor, the A/B MACs and DME MACs shall indicate this relates to an open MSP record with ORM indicator=Y and shall provide the following:

- The name of the third-party payer; and

- A request to apply a termination date of the record that equals the benefits exhaustion date, in accordance with the third-party payer's itemized schedule of payment notice.

From a claims processing scenario, should an A/B MAC and DME MAC obtain an incoming claim that contains PR*119 (benefits exhaustion) or any of the CARCs specified in CR 8821 they shall pay primary, in accordance with current procedures.

(**NOTE:** A/B MACs or DME MACs shall not initiate ECRS Assistance Requests to the MSP Contractor in these situations.)

20.5 - Medicare Residual Payments Due When On-going Responsibility for Medicals (ORM) Benefits Terminate, or Deplete, During a Beneficiary's Provider Facility Stay or Upon a Physician, or Supplier, Visit

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

There are situations where ORM benefits may terminate or deplete during a beneficiary's provider facility stay or upon a physician's visit and a residual Medicare secondary payment is due. Under these circumstances Medicare may make a residual Medicare secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the ORM benefit or responsibility for payment terminates mid-service. The A/B MACs, DME MACs and shared systems may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare. The A/B MAC or DME MAC sends an ECRS Assistance Request to the MSP Contractor to update the ORM record due to the ORM being terminated or when benefits are exhausted.

The A/B MACs, DME MACs and shared systems, shall receive, accept, and make a residual payment on electronic No-Fault insurance (CWF MSP Code D, Part A Value Code 14), Workers' Compensation, (CWF MSP Code E, Part A Value Code 15), or Liability insurance (including self-insurance) (CWF MSP Code L, Part A Value Code 47) ORM claims when the CAS segment shows one of the following CARCs and primary payer benefits are terminated, exhausted or the claim contains a partial or zero payment:

27 – Expenses occurred after coverage terminated.
35 – Lifetime benefit maximum has been reached.
119 – Benefit maximum for this time period, or occurrence, has been reached.
149 – Lifetime benefit maximum has been reached for this source/benefit category.

The A/B MACs, DME MACs and shared systems shall receive, accept, and make payment on MSP Type 14, 15 and 47 ORM paper (hard copy) claims when the claim includes an attached remittance advice/Explanation of Benefits that:

1) Shows the claim with a zero payment or was not paid in full by the primary payer and a residual payment is due;

2) Is a Medicare covered and reimbursable service; and

3) Contains a reason code for denial or similar verbiage if a reason code is not indicated:

- Expenses occurred after the coverage terminated;
- Lifetime benefit maximum has been reached;
- Benefit maximum for this time period, or occurrence, has been reached; or
- Lifetime benefit maximum has been reached for this source/benefit category.

NOTE: If a No-Fault insurance (CWF MSP Code D, Part A Value Code 14), Workers' Compensation, (CWF MSP Code E, Part A Value Code 15), or Liability insurance (including self-insurance) (CWF MSP Code L, Part A Value Code 47) electronic, or hard copy claim, is received and the claim contains a partial, or zero, payment from a primary insurer and the claim, or attached primary payer remittance advice/EOB, does not include a reason code for denial or similar verbiage if a reason code is not indicated, the A/B MAC, DME MAC and shared system shall deny the claim based on the CWF utilization 6815, 6816, 6817, and 6818 error code received.

In order for the residual payment to occur, CWF performs the following functions:

CWF HUIP, HUOP, HUHH, HUHC (HBIP, HBOP, HBHH, and HBHC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level. Valid values for the field = X or space.

CWF HUBC and HUDC (HBBC and HBDC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level and at the detail level. Valid values for the field = X or space.

NOTE: The shared systems must ensure that the A/B MACs and DME MACs are able to input an "X" at the claim header for those claims, and at the service line level, when applicable, that are sent to CWF for situations when the claim is not paid, or not paid in in full, by the primary payer.

CWF shall override the three new ORM utilization error codes (6816, 6817 and 6818) when the A/B MACs and DME MACs determine a residual payment should be made on the claim.

The A/B MACs and DME MACs make a residual payment by placing the "X" at the header for the Part A claims, or an 'X' at either the header or detail line for Part B Professional and DME MAC claims.

The A/B MACs, DME MACs and shared systems must send the primary payer's MSP amounts, found on the incoming ORM claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare.

The A/B MAC and DME MAC shall submit an ECRS Request to the MSP contractor to add a termination date to the CWF ORM record when ORM benefits are exhausted or terminated.

30 - Develop Claims for Medicare Secondary Benefits

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When Medicare is indicated as primary payer on a claim, assume, in the absence of evidence to the contrary, that the provider has correctly determined that there is no other primary coverage and process the claim accordingly. There are instances in which further development is necessary, as discussed in §30.2.

Under the COB contract, the MSP Contractor is responsible for developing whether there is a payer primary to Medicare. The A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs) supplies the MSP Contractor information via ECRS or by telephone or fax, depending on circumstances. The A/B MAC and DME MAC obtains the MSP data needed to process claims via CWF, which the MSP Contractor updates with the results of its investigations. There is some minimal provision for the A/B MAC and DME MAC to update the MSP auxiliary file on CWF with MSP information. See §10.1, above.

30.1 - Further Development Is Not Necessary

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Medicare providers are required by law to obtain other payer information and to certify that such development has occurred. Submission of the following types of information by a hospital is to be accepted without further inquiry.

- Claim containing an MSP value code and payment amount;
- Condition codes 05, 09, 10, 11, 26, 28, and 29 are shown on the bill;
- Occurrence codes 05, 06, 12, 20, 23, 24, 25, 18, 19, and dates are shown on the bill;
- Use of remarks field for further clarification;
- Claim denied because active MSP record, but claim not filed as MSP;
- MSP claim filed and information on claim matches MSP CWF record; and
- MSP record shows "not active," and claim was filed with Medicare as primary payer.

When a complete MSP claim information is submitted, do not attempt further development.

In relation to the reporting of occurrence codes 18 and 19, as referenced above, hospitals adhere to the following policy when precise retirement dates cannot be obtained during the intake process:

POLICY: When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, the provider reports the beneficiary's Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, the provider reports the beneficiary's Medicare entitlement date as his or her retirement date.

If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it is determined that it has been at least five years since the beneficiary retired, the provider enters the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, the provider reports the retirement date as January 4, 1997, in the format currently used.) As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

30.2 - Further Development Is Required

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MAC (Part A) submits an ECRS request to the MSP Contractor when the following billing situation occurs:

- Claim with primary insurer identification, no primary payer amounts, and nothing indicated in remarks field;
- Beneficiary has a black lung CWF record, bill is submitted with a black lung CWF record, and bill is submitted with a black lung diagnosis, but without the primary amount shown or without an Medicare Summary Notice (MSN), or without remarks, which denies the black lung claim;
- MSP claim filed with very low primary payment (investigate for possible keying error with provider to ensure accurate payment amount) (Note: A/B MACs and DME MACs A/B MACs and DME MACs must set the threshold that constitutes a very low primary payment amount. A/B MACs and DME MACs must evaluate this threshold amount on an annual basis);
- Diagnosis code, no MSP record, and claim does not show occurrence code 05 and date nor remarks;
- Retirement dates same as dates of service (i.e., improper use of occurrence codes 18 and 19);
- Occurrence codes 01-04 used, but not MSP claim. No occurrence code 24 or remarks; and
- No value code and zero dollars showing request for conditional payment.

30.3 - GHP May Be Primary to Medicare

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Where Medicare is indicated as primary payer on the Part A or Part B electronic or paper claim, the A/B MAC and DME MAC assumes, in the absence of evidence to the contrary, that there is no other primary coverage and processes the claim accordingly. If CWF indicates that Medicare is secondary, the A/B MAC notifies the MSP Contractor via ECRS to develop to determine if there is another payer primary to Medicare.

30.3.1 - Develop ESRD Claims Where Basis for Medicare Entitlement Changes

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Medicare is the secondary payer throughout the entire 30-month ESRD coordination period when a beneficiary is eligible for, or entitled to, Medicare on the basis of ESRD. If the beneficiary becomes disabled or aged before the coordination period ends, see Chapter 2, §20.1.3, of this manual. To assist A/B MACs and DME MACs in processing claims under these provisions, the MSP Contractor determines the coordination period based upon information it develops, and updates the CWF (See

Chapter 3). A/B MACs and DME MACs are encouraged to use the End-Stage Renal Disease Quality Reporting System (EQRS)to determine and enter the correct ESRD COB period. However, A/B MACs and DME MACs are permitted to show the actual or default effective date without an end date. If the A/B MACs and DME MACs enter the end date, it is held accountable for entering the correct COB period. Note: To begin the process of gaining access to EQRS, please have the requestor submit a ticket to the Quality Net Help Desk, information below. The staff there will be able to walk the user through the process, which begins with establishing a CMS EIDM account:

QualityNet Help Desk, CROWNWEB/ EQRS Systems, phone: (866) 288-8912, Fax (888) 329-7377, email: qnetsupport-esrd@hcqis.org

30.4 - Workers' Compensation Responses

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If the MSP Contractor investigation indicates that WC benefits should be paid for the services, the A/B MAC and the DME MAC denies benefits and notifies the claimant that Medicare benefits are not payable for services covered under WC. It advises the claimant to file a claim with WC, and, if a WC claim is filed and denied, the Medicare claim may be reopened. It further advises the claimant that if the reason for denial of WC benefits is due to the claimant's failure to timely file a claim, Medicare payment will not be made and the A/B MAC and the DME MAC documents the determination.

When Medicare benefits are denied because all or part of the services are reimbursable under the Black Lung (BL) program, by virtue of the diagnosis codes submitted, the A/B MAC and the DME MAC advises the claimant to submit a claim to:

U.S. Department of Labor OWCP/DCMWC
P.O. Box 8307
London, KY 40742-8307

The A/B MAC and the DME MAC advises the claimant that Medicare cannot pay for the services, because the Federal Black Lung program, administered by DOL, pays primary to Medicare. However, if DOL does not pay for all services, the claimant or provider of service should resubmit the claim to the A/B MAC and the DME MAC with a copy of DOL's explanation of its payment.

30.4.1 - Patient Receives Concurrent Services Which Are Not Work-Related

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Sometimes an individual receives services for a condition that is not work-related from the same provider or physician/supplier who is furnishing services for a work-related condition. The diagnosis may indicate a service for a preexisting condition or the provider or physician/supplier may submit a separate bill for services indicating that the service is for a non-work-related condition. Where it is clear that services for a non-work-related condition were rendered, the A/B MAC and the DME MAC

does not delay payment for such services even though payment for the work-related services is being denied or delayed pending development under the WC exclusion.

30.5 - No-Fault Responses
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Contractor conducts all no-fault investigations (See Chapter 3 and §10.8.1, above). If Medicare is billed as primary payer, but the MSP Contractor indicates there is coverage under no-fault insurance and the provider did not submit a satisfactory explanation to the development request concerning why Medicare is billed as primary, the A/B MAC and the DME MAC denies the claim.

30.5.1 - No-Fault Insurer Denies That It Is the Primary Payer
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Denial by an insurer on the basis that Medicare is the primary payer may be a forerunner of similar action on multiple claims. Advise the MSP Contractor of this circumstance via ECRS if the CARC shows a valid reason why the claim was denied; e.g., benefits were exhausted or other reasons as described in the IOM or CMS CRs such as CMS CRs 6426 and 6427 including subsequent CRs. The MSP Contractor is responsible for any needed follow-up action with the no-fault insurer. See sections 40.6 and 40.6.1 for reasons why the NGHP insurer may deny the claim and that Medicare may make a conditional payment.

30.5.2 - No-Fault Insurance Does Not Pay All Charges Because of a Deductible or Coinsurance Provision in Policy
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

In a number of States, no-fault insurers may reduce no-fault insurance benefits by deductible or coinsurance amounts, or may offer the option for such a reduction. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare-covered expenses that are not reimbursable under such a no-fault contract. Therefore, if a no-fault insurer has been billed and has made no payment
because of a deductible or coinsurance, or only a partial payment (e.g., the insurance deductible has been bridged), Medicare may pay but, before payment is made. The CARCs are utilized to determine why the claim was not paid by the no-fault insurer and whether a Medicare payment is warranted. For paper claims an NGHP EOB is utilized showing the status of the no-fault insurance deductible after taking into account the expenses for which Medicare is being billed.

EXAMPLE 1:

A beneficiary receives physician services covered by no-fault insurance. Total charges are $200. The no-fault insurer is billed but makes no payment because of a $1000 deductible in the policy. The provider on behalf of the beneficiary submits a paper claim for $200 to Medicare along with a copy of explanation of benefits from the no-fault insurer. Medicare can pay benefits on this claim.

EXAMPLE 2:

Beneficiary's operation is covered by no-fault insurance, which allows physician's full charges of $1640, but pays only $756 because it reduces payment by an $800 unmet deductible under the no-fault policy, as well as by $84 coinsurance. The physician bills Medicare for $884. If the physician did not submit a copy of the no-fault insurer's explanation of benefits, or the CARC does not identify the adjustment amounts, deny the claim if there is not enough information to process the MSP claim. The Medicare reasonable charge for the services is $1200. The beneficiary has not previously met the Medicare deductible for that year. Calculate the payment as noted below.

1. The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer.

   $1640 - $756 = $884

2. The amount that Medicare would pay if the services were not covered by a primary payer.

   $1200 reasonable charge - $233.00 deductible = $967 x 80% = $773.60

3. The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the primary payer’s allowable charge (without regard to any deductible or co-insurance imposed by the policy or plan) minus the amount actually paid by the primary payer.

   $1640 – 756 = $884

   Medicare pays the lowest of the 3 calculations. Medicare pays $773.60.

30.5.3 - State Law or Contract Provides That No-Fault Insurance Is Secondary to Other Insurance

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Even though State laws or insurance contracts specify that benefits paid under their provisions are secondary to any other source of payment or otherwise limits portions of their benefits to payments only when all other sources of health insurance are exhausted, Medicare does not make payment when benefits are otherwise available. For example, a state provides $2,000 in no-fault benefits for medical expenses and an additional $6,000 in no-fault benefits are available, but only after the claimant has exhausted all other health insurance. In such cases, the Medicare law has precedence over state laws and private contracts. Therefore, under these circumstances, Medicare makes secondary payments only after the total no-fault benefits are exhausted.

30.6 - Liability Claim Is Filed and There is Also Coverage Under Automobile or Non-Automobile Medical or No-Fault Insurance

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If injuries are covered under automobile medical or no-fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, a claim determination must first be made by the automobile medical or no-fault insurer before a claim for Medicare benefits can be paid. This determination should be made to prevent Medicare from paying primary. Medicare payments may be made to the extent that payment cannot be made under the automobile medical and no-fault insurance, subject to recovery if the individual later receives payment from a liability insurer. The MSP Contractor undertakes the necessary development and updates the CWF.

For example, an individual incurs $20,000 in hospital expenses due to an automobile accident. The individual receives $5,000 in no-fault insurance benefits toward hospital expenses and has a liability claim pending. Medicare will not pay benefits for the $5,000 in expenses paid for by the no-fault insurer, but will pay the remaining $15,000 for the entire hospital stay, if the liability insurer does not pay promptly, subject to recovery when the liability claim is paid.

40 - A/B MACs (Part A), A/B MACs (Part B), A/B MACs (Part HHH), and DME MACs Claims Processing Rules

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSP claims processing rules, policies and procedures are identified below and must be followed by the A/B MACs and DME MACs.

40.1 - Claim Indicates Medicare is the Primary Payer

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Where the claimant indicates Medicare is the primary payer, the A/B MACs (Part A), A/B MACs (Part B), and A/B MACs (Part HHH) (collectively referred to as A/B MACs) and the DME MACs assume, in the absence of evidence to the contrary, that the claimant has correctly determined that there is no primary GHP coverage and processes the claim. It pays primary Medicare benefits only if the services were not rendered during a coordination period, or if the GHP denies a claim because the beneficiary is not entitled to benefits under the plan, or benefits under the plan are exhausted for the particular services, or the services are not covered by the GHP, and the beneficiary is not appealing the GHP denial. The A/B MAC and the DME MAC does not pay primary benefits if there is reason to believe that the GHP covers the services. If the A/B MAC and the DME MAC pays primary Medicare benefits and later learns that the beneficiary is appealing the GHP denial, it treats the payment as a conditional primary payment. Any necessary recovery actions will later be initiated by CMS's Commercial Repayment Center.

If the A/B MACs (Part A) believes that a GHP may be the primary payer, it returns the bill to the provider requesting the provider to ascertain whether primary GHP benefits are payable, and if so, to bill for primary benefits. The A/B MAC (Part A) should instruct the provider that if a GHP has denied its claim for primary benefits, the provider must annotate the claim with the reason for the denial and enter occurrence code 24 and the date of denial. No attachment is needed.

If the A/B MACs (Part B) believes that a GHP may be the primary payer, the A/B MACs (Part B) will return the bill to the physician or other supplier requesting the provider to ascertain whether primary GHP benefits are payable, and if so, to bill for primary benefits. The A/B MACs (Part B)

shall instruct the physician or other supplier on the remittance advice that if a GHP has denied its claim for primary benefits, the provider must annotate the claim with the reason for the denial in the CARC segment. No attachment is needed.

When a claim is received from a member of a religious order who has taken a vow of poverty, whose order filed an election under §3121(r) of the IRC, and who does not have group health coverage from employment outside the order, the A/B MAC processes the claim as a primary Medicare claim.

A GHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on Medicare. The A/B MACs and DME MACs evaluate claims under existing guidelines to assure that Medicare covers the services, regardless of the GHP decision.

40.1.1 - Facts Indicate Reasonable Likelihood of Workers' Compensation Coverage (Other Than Federal Black Lung Benefits)

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If the submitted claim or the CWF response indicates WC (excluding Black Lung) is responsible based upon the diagnosis reported on the claim, the A/B MAC and DME MAC denies the claim.

The notice to the provider or physician/supplier and beneficiary should:

- State that the services are not covered under Medicare because the law prohibits payment for services which are reimbursable under a WC law or plan;
- Advise the beneficiary, provider or physician/supplier to submit a claim to the beneficiary's WC carrier (or employer if the employer is self-insured) and;
- Inform the provider or physician/supplier that if the WC carrier does not pay for all of the services, the provider or physician/supplier should resubmit the claim to Medicare for further consideration with a copy of any notification received from the WC carrier explaining why the services are not reimbursable under WC.

If it is not clear whether WC is responsible, the A/B MAC and DME MAC advises the MSP Contractor of possible WC involvement and adjudicates the claim based on the results of the MSP Contractor's development.

40.1.1.1 - The Beneficiary Is on the Black Lung Entitlement Rolls

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If an A/B MAC and DME MAC learns that the beneficiary may be entitled to receive medical benefits from the Department of Labor (DOL) under the Federal Black Lung Program, it advises the MSP Contractor of possible Federal Black Lung Program

involvement and adjudicates the claim based on the results of the MSP Contractor's development.

40.1.2 - Services by Outside Sources Not Covered
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Where Medicare is secondary payer for a person enrolled in an employer sponsored managed care health plan (e.g., Health Maintenance Organization (HMO)/Competitive Medicare Plan (CMP)), Medicare does not pay for services obtained from a source outside the employer-sponsored managed care health plan if:

- The same type of services could have been obtained as covered services through, or paid for by, the managed care employer health plan, or

- The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded under these circumstances even if the individual receives services outside of the managed care health plan's service area, e.g., while the individual is away from home.

At the time of admission, providers are to ask beneficiaries that are enrolled in GHPs whether the plan is a managed care health plan. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required to be sent to the A/B MACs (Part A) per Chapter 3, §40.1.)

NOTE: This restriction only affects Medicare beneficiaries enrolled in employer sponsored managed care health plans that either do not have a Medicare contract or have a Medicare cost contract. Beneficiaries in HMO/CMPs that have Medicare risk contracts are not affected because beneficiaries enrolled in a risk-basis HMO/CMP are locked into the plan in all instances except for emergency or urgently needed services.

40.1.2.1 - Exception
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If a beneficiary obtains services from a source outside the managed care GHP, and has not been notified in writing of this special rule, Medicare pays, provided the plan will not pay for legitimate reasons. In general, it is assumed that written notification has not been given in the absence of evidence to the contrary, e.g., the A/B MAC’s internal system indicates that the beneficiary is a working aged, ESRD, or disabled beneficiary who
belongs to a managed care GHP and that the beneficiary has been notified that Medicare will not pay. Where payment is made for services from a source outside the managed care health plan, the Medicare Benefits Notice (Form CMS-1533), or the MSN, where applicable, states the following:

> Our records show that you are a member of an employer sponsored managed care health plan. Since Medicare is secondary payer for you, services from sources outside your health plan are not covered. However, since you were not previously notified of this, we will pay this time. In

the future, payment will not be made for non-plan services that could have been obtained from or through the prepaid health plan (PHP).

A/B MACs and DME MACs may systematically keep this information in their system so the A/B MACs and DME MACs may alert the beneficiary of the one-time notification of going outside the managed care GHP network.

40.1.3 - Notice to Beneficiary
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MACs and DME MACs deny any bills received for Medicare payment from, or on behalf of a beneficiary enrolled in a managed care GHP who has previously been notified in writing. Advise that the reason for the denial is that Medicare's records show that the beneficiary is a member of a managed care health plan as follows:

> Our records show that you are a member of an employer- sponsored managed care health plan. Because Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from or through the managed care health plan are not payable. Medicare's records show that you were previously informed of this rule. Therefore, payment cannot be made for the non-plan services you received.

(There are standard Medicare Summary Messages (MSN) that convey this information.)

40.2 - Update CWF MSP Auxiliary File
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When an A/B MAC and DME MAC has identified a beneficiary under §40.1.2.1 and the A/B MAC and DME MAC has notified the beneficiary in writing that Medicare does not pay for services obtained outside of the plan or there is information that the beneficiary was previously notified, the A/B MAC and DME MAC must update its internal system to show that the beneficiary is a working aged, ESRD, or disabled beneficiary and belongs to a managed care GHP and that the beneficiary has been notified that Medicare will not pay. This is accomplished by entering the following information in remarks:

> "Working aged, ESRD, or disabled beneficiary belongs to a managed care GHP. Medicare will not pay."

40.2.1 - Action if Payment Has Been Made Under No-Fault Insurance
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If the A/B MAC and DME MAC is aware when processing a Medicare claim that payment has been made either to the provider, physician, or to the beneficiary under no-fault insurance, or there is an open ORM record on CWF, the A/B MAC and DME MAC denies the claim.

However, a Medicare secondary payment may be made if the no-fault insurer paid less than the full physician's charge **and** the physician is not obligated to accept the payment as payment in full if no ORM record on CWF or ORM benefits have been exhausted. If A/B MACs and DME MACs learn after Medicare benefits were paid that payment was also made by a no-fault insurer, the excess Medicare benefits are subject to recovery in accordance with the Pub. 100-05, Chapter 7, Section 20.8 states when a physician is liable for refunding the primary Medicare payments. The beneficiary is liable in all other situations as cited in Section 20.9.

40.3 – Processing Part B Claims Involving GHPs

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When it appears that a GHP should be primary payer, a claim for Medicare primary benefits may not be processed unless accompanied by an explanation of benefits, or found on the 837 claim, from the insurer indicating that the GHP has previously processed a claim for the services and denied primary benefits for reasons other than it makes payment after Medicare for services provided to the beneficiary.

If the claim is not accompanied by a GHP's explanation of benefits, or the appropriate primary payment information is not found on the 837 claim, the claim is denied

Unless the claimant submits a satisfactory explanation of why full or partial payment under primary insurance cannot be made, or in WC, liability, or no-fault claims, there is evidence that a decision will not be made promptly, the A/B MAC (Part B) denies the claim for primary Medicare benefits. Medicare is primary only if an insurer that is primary to Medicare cannot make payment. Examples of acceptable reasons why the GHP cannot pay are:

- A deductible applies, or
- The beneficiary is not entitled to benefits, or
- Benefits under the plan are exhausted for particular services, or
- The services are not covered under the plan.

However, the primary insurer **cannot** assert that the beneficiary is not entitled to **primary** benefits or the services are not covered for **primary** payment under the plan because the beneficiary has Medicare.

If the A/B MAC (Part B) pays primary benefits and later learns that the beneficiary is appealing the GHP's denial, it treats the payment as a conditional primary payment. When a primary Medicare claim is denied, the denial notice informs the claimant that, after the primary insurer has processed the claim for primary benefits, a claim for secondary Medicare benefits may be filed and that a copy of the GHP's explanation of benefits must be included.

40.3.1 - GHP Denies Payment for Primary Benefits

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Where a GHP has denied the claim because the plan provides only secondary coverage, the A/B MAC and the DME MAC denies the claim for Medicare primary benefits. If a provider bills a GHP and the plan refuses to pay primary benefits because it claims that its benefits are secondary to Medicare's, the A/B MAC and the DME MAC does not pay conditional benefits. Instead, it suspends the claim and sends an ECRS request to the MSP Contractor for development.

If the A/B MAC and DME MAC pays primary Medicare benefits and later learns that the beneficiary is appealing the GHP denial, it treats the payment as a conditional primary payment.

The A/B MAC (Part A) should instruct its provider that, if a GHP has denied its claim for primary benefits, the provider must annotate Item 84 "Remarks" of the Medicare claim form with the reason for the denial and enter occurrence code 24 and the date of denial in Items 32 to 35. The A/B MAC (Part A) annotates its records with the reason for the denial to avoid the need for any future recovery efforts.

The A/B MAC (Part B) and DME MAC processing a claim with similar GHP involvement would send the beneficiary a denial letter including similar information and state that if the GHP does not pay the full charge, then the beneficiary must submit a claim for secondary benefits including a copy of the GHP's explanation of benefits. If the physician, or supplier accepted assignment, the A/B MAC and DME MAC notifies the physician/supplier and the beneficiary that the beneficiary may not be charged more than the Medicare deductible and coinsurance amounts and charges for noncovered services. (Services that are or could have been paid for by the GHP are not considered "noncovered.")

Any denial notice must include appropriate appeals information. The A/B MAC and the DME MAC advises the beneficiary to consult with his or her employer and/or the state insurance commissioner or other official having jurisdiction (such as the U.S. Department of Labor) if he or she believes the GHP should have paid for the services. The A/B MAC and the DME MAC also advises the claimant of the private right of legal action to collect double damages. (See Chapter 2, §40.1.)

40.3.2 - GHP Does Not Pay Because of Deductible or Coinsurance Provision
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A GHP may reduce benefits by deductible and coinsurance amounts. If such provisions apply to all policyholders, Medicare pays secondary benefits with respect to Medicare covered expenses that are not reimbursable under the GHP contract. Therefore, if a GHP has been billed and has made no payment or only partial payment because of a deductible or coinsurance, Medicare may pay. Before paying such a claim, the A/B MAC and the DME MAC requires an explanation of benefits or payment, or adjustment information found on the 837 claim from the GHP showing the status of the deductible after taking into account the expenses for which Medicare is being billed.

40.3.3 - GHP Gives Medicare Beneficiary Choice of Using Preferred Provider
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If a Medicare beneficiary is given the choice by the GHP whether to choose a preferred provider or to obtain medical services from a non-preferred provider, the beneficiary may choose the non-preferred provider and Medicare makes secondary payments based on the amount paid by the GHP. However,

see Chapter 1 of Pub. 100-05 for rules governing employer-sponsored HMO/CMPs when Medicare cannot make primary payments.

40.4 - GHP Pays Primary
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The below subsections discuss the varying types of payments the primary GHP insurers pay on MSP claims. This includes when the GHP makes full payment, partial payment, when its in bankruptcy or liquidation.

40.4.1 - GHP Pays Charges in Full
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If the GHP pays the provider's, physician's, or supplier's charges in full, and the provider, physician, or supplier is obligated to accept, or the provider, physician, supplier voluntarily accepts, consider the GHP's payment amount as full payment. The A/B MAC and the DME MAC makes no Medicare payment. (Physicians and other suppliers that participate in BlueShield plans or HMO/PPO arrangements typically must accept the Blue Shield plan's or HMO/PPO arrangement's approved amount as payment in full.)

Any excess of the GHP's payment over the gross amount payable by Medicare is not subtracted from the provider's Medicare reimbursement. The provider submits a "no payment bill" in accordance with Chapter 3 – MSP Provider Billing Requirements, §40.1.

40.4.2 - GHP Pays Portion of Charges
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Medicare secondary payment can be made if the following conditions are met:

- A GHP pays an amount less than the physician's/supplier's charges for the services, and less than the gross amount payable by Medicare (as defined below),

and;

- the provider does not accept, and is not obligated to accept, the payment as payment in full.

"Payment in full" is an amount that the provider is obligated to accept (e.g., contractually) or voluntarily accepts as payment in full from the insurer (i.e., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation."

40.4.3 - GHP Pays Primary Benefits When Not Required
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Cases may come to the A/B MACs and DME MACs attention in which a GHP has mistakenly paid primary benefits for the services of a physician/supplier (e.g., the GHP of an employer of less than 20 employees has paid primary benefits). If the time limits for reopening identified in 100-09, MACs, Beneficiary, and Provider Communications Manual, Chapter 1, permit, and if requested by the provider, physician, other supplier or beneficiary, the A/B MAC and DME MAC reopens the Medicare secondary claim, and pays any additional amount due as primary benefits. The A/B MAC or DME MAC notifies the provider, physician or other supplier of any such Medicare payments. If the A/B MAC (Part B) and DME MAC receives a secondary claim on an assignment basis, it pays the additional amount to the physician/supplier. It instructs the provider, physician or other supplier to refund to the GHP or the beneficiary the amount that the GHP or the beneficiary has paid in excess of the applicable Medicare deductible and coinsurance and charges for noncovered services. If the A/B MAC (Part B) and DME MAC received the secondary claim on an unassigned basis, it pays the additional amount to the beneficiary and advises the beneficiary to make appropriate refund to the GHP. However, Medicare cannot require the beneficiary to make this refund even though the beneficiary may be legally obligated to repay the GHP.

When a GHP has mistakenly paid primary benefits for the services of a physician/supplier and no Medicare claim was submitted for those services, the provider, physician or other supplier has the responsibility to submit an assigned or unassigned Medicare claim, as appropriate. (The time limit for filing may be extended if failure to file timely resulted from error or misrepresentation by an employee, A/B MAC or DME MAC, or agent of the DHHS. For this purpose, the Social Security Administration is considered an agent of the DHHS.)

In such cases where a GHP has inappropriately paid primary benefits, A/B MACs instructs the provider to bill Medicare as primary payer and to refund to the GHP the amount it paid, except for an amount equivalent to the Medicare deductible and coinsurance amounts, and charges for noncovered services.

40.5 - Primary Payer Is Bankrupt or Insolvent

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When a GHP or NGHP primary payer fails to pay primary benefits in accordance with CMS' policy because it is bankrupt or insolvent, CMS does not make a conditional primary payment and does not make a Medicare secondary payment until after the conclusion of the bankruptcy or insolvency proceedings.

After the conclusion of the bankruptcy or insolvency proceedings, providers, physicians, or other suppliers may file Medicare secondary claims. CMS determines the amount of Medicare secondary payments, if any, after the conclusion of the bankruptcy or insolvency proceedings.

40.5.1 - Billing Beneficiaries During the Liquidation Process

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

During the liquidation process, participating providers, physicians, and other suppliers that have accepted assignment may not collect or seek to collect from the beneficiary or the beneficiary's estate, charges for Medicare covered services. Under the terms of the Medicare provider agreement and the

terms of the Medicare assignment, the providers, physicians, and other suppliers may bill the beneficiary (or the beneficiary's estate) only to establish a legal claim for future collection of charges and not for purposes of currently collecting charges from the beneficiary or the beneficiary's estate.

40.5.2 - When to Make a Medicare Secondary Payment

(Rev .11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

After the conclusion of the bankruptcy or insolvency proceedings, Medicare secondary payments may be made if the:

- Provider or physician/supplier has filed a claim with the receiver (i.e., the entity responsible for settling and/or paying the outstanding debts of the bankrupt or insolvent primary payer);

- Payment made on behalf of the bankrupt or insolvent entity responsible for paying primary benefits is less than the amount of the charge and less than the amount Medicare would have paid as the primary payer; and

- Provider, physician, or other supplier is not required to accept the payment as full discharge of the liability of the beneficiary (or estate) for the bill.

The receiver determines the payments that can be made on behalf of the bankrupt or insolvent entity. The providers, physicians, and other suppliers receive any available primary payment from the receiver and can then file Medicare claims to obtain any appropriate secondary payments. After the Medicare secondary claims have been processed, any remaining liability (e.g., deductibles, coinsurance, and payment for noncovered services) of the beneficiary (or of a deceased beneficiary's estate) can be pursued by the providers, physicians, and other suppliers. However, they may not pursue collection from the beneficiary if a receiver orders that the allocated fractional payment must be accepted as full discharge of the entire bill.

If circumstances dictate, CMS will advise A/B MACs and DME MACs by an official CMS instruction that it will coordinate the pursuit of the bankruptcy court's findings and communicate the results to them.

40.5.3 - Amount of Secondary Payment

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The amount of the Medicare secondary payment is computed and is based on the amount of the primary payer's liability, as determined by the receiver, and the terms of the payments made by the receiver on behalf of the primary payer.

If the receiver determines that the provider or physician/supplier may pursue collection of the portion of the charge not paid by the receiver, a Medicare secondary payment may be made. The Medicare secondary payment is computed based on the amount the receiver pays on behalf of the bankrupt or insolvent entity (i.e., the amount paid by the receiver constitutes the primary payment on which

Medicare bases its secondary payment). In effect, this means that the Medicare secondary payment makes up for the liability of the primary payer that was not satisfied because of lack of funds.

EXAMPLE: A participating physician furnishes a service for which the approved charges of the primary payer and Medicare are $100 and $90, respectively. The primary payer would normally pay 80 percent of $100, or $80, and Medicare would make a secondary payment of $100 minus $80, or $20. However, the primary payer is bankrupt and, after a long delay, its receiver pays the physician only $32. Medicare pays the physician $100 minus $32, or $68, which is $48 more than its normal liability (i.e., $68 minus $20).

If the receiver determines that the fractional payment must be accepted as full discharge of the amount the primary payer would have been obligated to pay were it not bankrupt or insolvent, the Medicare secondary payment amount would be the amount payable had the receiver paid the full primary payment (i.e., Medicare pays only $100 minus $80, or $20).

If the receiver determines that the provider and physician or other supplier is required to accept the fractional payment as full discharge of the entire bill, Medicare may not make a secondary payment. Thus, in the above example, the receiver might determine that the physician must accept the $32 it pays as payment. In the above example, the receiver might determine that the $32 it pays fully discharges the liability of the primary payer for the $80 the primary payer would have paid if it were solvent (i.e., in this situation, the full discharge of the physician's bill). In this case, Medicare makes no secondary payment.

40.5.4 - Time Limits for Filing Secondary Claims After Liquidation Process

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Participating providers and physicians and other suppliers that have accepted assignment should file claims with a receiver as soon as possible. The time limit for filing secondary claims once the liquidation process has been completed is the later of the following:

- The usual time limit specified in regulations for filing Medicare claims which is 1 year from the date of service or date of discharge for inpatient hospital facility claims; or

- The last day of the sixth month following the month of the written notice by the bankrupt or insolvent entity to the provider, physician, or other supplier of the amount of primary benefits payable.

When the A/B MAC and DME MAC denies a claim for Medicare conditional primary or secondary benefits in insolvency cases because the receiver has not completed the determination of final payment, notify the provider or physician/supplier of the possible 6-month extension on filing claims as described above.

40.6 - Conditional Primary Medicare Benefits

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Conditional primary Medicare benefits may be paid if;

- The beneficiary has appealed or is protesting the GHP denial of the claim for any reason other than that the GHP offers only secondary coverage of services covered by Medicare;

- The GHP denied the claim (that is, the claim made on behalf of the beneficiary) because the time limit for filing the claim with the GHP has expired (whether appealed or not);

- The provider, physician, or other supplier fails to file a proper claim because of mental or physical incapacity of the beneficiary;

- The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement of the workers' compensation carrier.

- GHP or NGHP benefits are exhausted and the one of the following CARCs are identified:

  27 – Expenses occurred after coverage terminated.
  35 – Lifetime benefit maximum has been reached.
  119– Benefit maximum for this time period, or occurrence, has been reached.
  149 – Lifetime benefit maximum has been reached for this source/benefit category.

- A/B MACs, DME MACs and shared systems shall make conditional payments for claims for specific items and service where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that no-fault insurance or workers' compensation is involved for that specific item or service, (2) there is/was no open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the physician, provider or other supplier sent the claim to the no-fault insurer or workers' compensation entity first, and (4) there is information on the claim that indicates that the no-fault insurer or workers' compensation entity did not pay the claim during the promptly period for any reason except when the workers' compensation carrier claims that its benefits are only secondary to Medicare.

- A/B MACs, DME MACs and shared systems shall make conditional payments for claims for specific items and services where the following conditions are met: (1) there is information on the claim or information on CWF that indicates that liability insurance (including self-insurance) is involved for that specific item or service, (2) there is/was no open GHP record on the MSP auxiliary file as of the date of service, (3) there is information on the claim that indicates that the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and (4) there is information on the claim that indicates that the liability insurer (including the self-insurer) did not make payment on the claim during the promptly period.

Before making a conditional primary payment in cases involving appealed or protested claims, the A/B MAC and DME MAC notifies the GHP, as well as the beneficiary, that the payment is conditioned upon reimbursement, by the insurer and the beneficiary, to the trust fund if it is

demonstrated that the GHP has or had responsibility to make primary payment. The A/B MAC and DME MAC reminds the GHP that it is obligated to reimburse Medicare if it should be later determined that it was the proper primary payer for the services. A responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured, or by other means.

40.6.1 - Conditional Medicare Payment

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

There is frequently a long delay between an injury and the decision by a State Workers' Compensation agency, no-fault insurance, or liability insurer (including self-insurance) in cases where compensability is contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might use their own funds for expenses that are eventually borne by either Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation situations or Medicare. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made if there is no other GHP that is primary to Medicare. Note: if there is a primary GHP and the physician, provider or other supplier did not send the claim to the GHP first Medicare will not pay conditionally on the Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation claim.

When such conditional Medicare payments are made, they are conditioned upon reimbursement, by the insurer and beneficiary, to the trust fund if it is demonstrated that the Liability insurance (including self-insurance), No Fault insurance or Workers' Compensation Carrier has or had a responsibility to make payment. A responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured, or by other means.

When making a conditional payment, the MSP Contractor notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve them of the obligation to refund the payments.) The MSP Contractor asks the insurer to notify them when the insurer is prepared to pay the claim, so that direct refund can be arranged. For Part A claims involving Liability insurance (including self-insurance), No Fault insurance, or Workers' Compensation situations, if there is no primary payer GHP to Medicare that will pay for services and the promptly period has expired, the A/B MAC (Part A) shall make a conditional payment. Providers of service may request Medicare conditional non-GHP payments by submitting a claim with the appropriate insurance Value Code (i.e., Value Code 14, 15 or 47) with zero reflected as the value amount.

Type of Insurance	CAS	Part A Value Code (2300 HI)	Value Amount (2300 HI)	Occurrence Code (2300 HI)	Condition Code (2300 HI)
No-Fault/Liability	2320 - valid information why NGHP or GHP did not make payment	14 or 47	$0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date 24 – Date Insurance Denied	
Workers' Compensation	2320 - valid information why NGHP or GHP did not make payment	15	$0	04-Accident/Tort Liability & Date 24 – Date Insurance Denied	02-Condition is Employment Related

A/B MACs (Part A) are required to look for the zero-value code paid amount and occurrence code in the 2300 HI when claims are received electronically in the ASC X12 837 institutional claim format. The appropriate Occurrence code **(**2300 HI), coupled with the zeroed paid amount and MSP value code **(**2300 HI), and the CAS segment (see previous CMS MSP change requests on processing MSP claims utilizing the CAS) may be used in billing situations in cases where the provider has attempted to bill a primary payer in non-GHP (i.e., Liability, No-Fault and Workers' Compensation) situations, but the primary payer is not expected to pay in the promptly period. A conditional payment by Medicare may be made. For hardcopy claims, the identity of the other payer is shown on line A of Payer Name, the identifying information about the insured is shown on line A of Insured's Name, Patient's Relationship to Insured, Insured's Unique Identifier, Insured's Group Name, Insured's Group Number, Treatment Authorization Code, DCN, Employer

Name (of the Insured) and the address of the insured is shown in Responsible Party Name and Address or in Remarks. Medicare claims processing A/B MACs process conditional payment bills following normal procedures.

In determining conditional payments for physician and other supplier electronic claims it is known that the ASC X12 837 professional claim format does not include Value Codes nor Condition Codes. To determine whether conditional payment should be granted for ASC X12 837 professional claims the following fields must be completed and defined as

follows: The physician/supplier must complete the 2320AMT02 = $0 if whole claim is a non-GHP claim and conditional payment is being requested for the whole claim, or 2430 SVD02 is completed for line level conditional payment requests if the claim contains other service line activity not related to the accident or injury. The CAS shall be taken into consideration when processing NGHP claims and determining if a conditional payment should be made. For the 2320 SBR05 it is acceptable to receive and include CP Medicare Conditionally Primary, AP for auto insurance policy or OT for other. The 2320 SBR09 may contain the claim filing indicator code of AM (automobile medical); LI (Liability), LM (Liability Medical) or WC (Workers' Compensation Health Claim). Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types. The 2300 DTP identifies the date of the accident with appropriate Value. The accident "related causes code" is found in 2300 CLM 11-1 through CLM 11-3.

NOTE: There is no occurrence code for ASC X12 837 professional format claims so the following conditional payment policy is being implemented. For Part B claims involving Liability insurance (including self-insurance), No Fault insurance, or Workers' Compensation situations, if there is no primary payer GHP to Medicare that will pay for services and the promptly period has expired, the A/B MAC (Part B) shall make a conditional payment for Medicare payable and covered services. A conditional payment may be made by Medicare where the physician or other supplier has attempted to bill a primary payer in non-GHP (i.e., Liability, No-Fault and Workers' Compensation) situations, but the NGHP insurer is not expected to pay in the promptly period. The A/B MACs (Part B) and shared systems shall take into consideration the CAS segment on the ASC X12 837 to also determine if conditional payment shall be made.

The graph below explains what the ASC X12 837 professional claim should look like when a physician/supplier is requesting MSP conditional payments:

Type of Insurance	**CAS**	**Insurance Type (2320 SBR05)**	**Claim Filing Indicator (2320 SBR09)**	**Paid Amount (2320 AMT or 2430 SVD02)**	**Insurance Type Code (2000B SBR05)**	**Date of**
No-Fault/ Liability	2320 or 2430 valid information on why GHP did	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AB, AP or OA

Type of Insurance	CAS	Insurance Type Code (2320 SBR05)	Claim Filing Indicator (2320	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2000B SBR05)	Date of Accident
	not make payment					
Workers' Compensation	2320 or 2430 valid information on why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

For the ASC X12 837 professional claims the insurance codes change and the acceptable information for Medicare conditional payment request is modified to look like the following:

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/Liability	2320 or 2430 – valid information on why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00		2300 DTP 01 through 03 (Qualifier 439, D8) and 2300 CLM 11-1 through 11-3 with value AA or OA

Workers' Compensation	2320 or 2430 – valid information on why NGHP or GHP did not make payment	15	WC	$0.00	02- Condition is Employment Related	2300 DTP 01 through 03 (Qualifier 439, D8) and 2300 CLM 11-1 through or 11-3 with value EM

40.6.2 - When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Neither primary nor conditional primary Medicare payments may be made where a GHP denies payment for particular services because:

- The services are not covered by the plan, and there is reason to believe the plan does cover the services;

- The plan offers only secondary coverage of services covered by Medicare. Conditional primary benefits may not be paid in this situation even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, the Medicare claims processing A/B MACs and DME MACs denied the claim for Medicare primary benefits and follows the instructions in §10.7;

- The plan limits its payments when the individual is entitled to Medicare;

- The services are covered under the GHP for younger employees and spouses but not for employees and spouses age 65 or over;

- The provider fails to file a proper claim for any reason other than the physical or mental incapacity of the beneficiary; or,

- When the employer plan fails to furnish information that is requested by CMS and that is necessary to determine whether the employer plan is primary to Medicare.

In addition to the bullet points stated above, Medicare primary or conditional primary Medicare benefits are not payable for the following reasons:

A) For no-fault insurance or workers' compensation situations, A/B MACs and DME MACs shall deny claims where the following conditions are met: (1)

the claim is a no-fault insurance or workers' compensation claim; (2) there is a GHP record on the MSP auxiliary file; (3) the claim was not sent to the GHP; (4) and the physician, provider, or supplier sent the claim to the no-fault or workers' compensation entity, but the no-fault or workers' compensation entity did not pay the claim; (5) there is an open ORM MSP record on CWF; or (6) the CARC explaining the reason for denial was not identified on the claim.

A/B MACs and DME MACs shall deny claims where the following conditions are met: (1) the claim is a no-fault insurance or workers' compensation claim; (2) there is a GHP record on the MSP auxiliary file; (3) the GHP denied the claim because the GHP asserted that the no-fault insurer or workers' compensation entity should pay first; (4) and the physician, provider, or supplier sent the claim to the no-fault insurer or workers' compensation entity, but the no-fault or workers' compensation entity did not pay the claim; (5) there is an open ORM MSP record on CWF; or (6) the CARC explaining the reason for denial was not identified on the claim.

For Liability insurance claims (including self-insurance), A/B MACs and DME MACs shall deny claims where the following conditions are met: (1) the claim is a liability claim; (2) there is a GHP record on the MSP auxiliary file; (3) the claim was not sent to the GHP; (4) and the physician, provider, or other supplier sent the claim to the liability insurer (including the self-insurer), but the liability insurer (including the self-insurer) did not pay the claim; 5) there is an open ORM MSP record on CWF; or (6) the CARC explaining the reason for denial was not identified on the claim.

A/B MACs and DME MACs shall deny claims where the following conditions are met: (1) the claim is a liability insurance (including self-insurance) claim; (2) there is a GHP record on the MSP auxiliary file; (3) the GHP denied the claim because the GHP asserted that liability insurer (including the self-insurer) should pay first; (4) and the physician, provider, or other supplier sent the claim to the liability insurer (including the self-insurer), but the liability insurer (including self-insurer) did not pay the claim; 5) there is an open ORM MSP record on CWF; or (6) the CARC explaining the reason for denial was not identified on the claim.

Note: Individuals are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim. However, beneficiaries are required to cooperate in the filing of no-fault and workers' compensation claims. If the beneficiary refuses to cooperate in filing of no-fault or workers' compensation claims, Medicare does not pay.

Conditional benefits are not payable if payment cannot be made under no-fault insurance because the provider or the beneficiary failed to file a proper claim. (See Chapter 1, §20, for definition.) Exception: When failure to file a proper claim is due to mental or physical incapacity of the beneficiary, and the provider could not have known that a no-fault claim was involved, this rule does not apply.

40.7 - A/B MACs (Part B) and DME MACs Processing Procedures for Medicare Secondary Claims
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Validity Edits

A/B MACs (Part B) and DME MACs are responsible for validating the data submitted on Medicare claims including MSP data.

A/B MACs (Part B) and DME MACs use the date of birth in CWF records to determine the month and year of birth. When the patient is the spouse of the worker, the A/B MAC (Part B) and the DME MAC obtains the date of birth of both the worker and the spouse. The A/B MAC (Part B) and DME MAC presumes that the day of birth is not the first of the month unless information on the claim form indicates that it is. A person is considered 65 or 70 for the month if he "attains" 65 or 70 any time during the month. For Medicare entitlement purposes, a person attains a particular age on the day before his or her birthday. Therefore, if a person's 65th birthday is on the first day of a month, Medicare is secondary payer beginning with the first day of the preceding month.

B. Verify Part A entitlement

For purposes of reviewing working aged claims, the A/B MAC (Part B) and DME MAC presumes that Part A entitlement exists for all Medicare beneficiaries between 65 and 69 except those who are uninsured.

C. Determine if Group Health Plan Coverage Exists

Chapter 1 contains a complete discussion of "employer" and "employer group health plan." The MSP Contractor is now responsible for developing whether Group Health Plan (GHP) coverage exists. If the A/B MAC (Part B) and DME MAC becomes aware that GHP is involved in a claim, for example, through receipt of a claim for secondary benefits with an EOB, or an electronic claim and this is not reflected in the CWF response for the claim, the A/B MAC then updates the CWF auxiliary file with an "I" indicator to add the new MSP occurrence (see §10.1, subsection 2). DME MACs submit an ECRS inquiry, DME MACs do not submit “I” records. For situations when a voluntary refund is received with GHP coverage identified and CWF record does not exist an ECRS Inquiry is sent to the MSP Contractor.

40.7.1 - Crediting the Part B Deductible
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Expenses paid by the GHP count toward the Medicare deductible. For claims where reasonable charge applies, the A/B MAC (Part B) and DME MAC credits the payment made under the insurer's plan toward the Medicare deductible up to the amount of the Medicare reasonable charge or fee amount for the service; i.e., if the primary plan paid

$75 on a procedure and the reasonable charge or fee amount for the procedure is $50, the A/B MAC (Part B) and DME MAC credits $50 toward the deductible.

The A/B MAC (Part B) and DME MAC processes all claims to CWF, including those to be denied because the claim has not been submitted to the primary payer, if the Medicare deductible is unmet. If the beneficiary has GHP, and it is not reflected in the CWF response, the A/B MAC (Part B) either updates the MSP auxiliary file with an "I" indicator if it is sure of the MSP involvement (see §10.1 subsection 2), or if further development is required, advises the MSP Contractor via ECRS, and pends the claim awaiting the MSP Contractor results via CWF (See §10.2.1, above). DME MACs do not create "I" records. In these situations, the DME MAC submits an ECRS Inquiry to the MSP Contractor.

40.7.2 - Medicare Payment Calculation Methodology

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The below subsections describe the processes and procedures to calculate Medicare's secondary payment. Differing scenarios and examples are cited below.

40.7.3 - Medicare Secondary Payment Calculation Methodology for Services Reimbursed on Reasonable Charge or Other Basis Under Part B

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When a proper claim has been filed (i.e., a claim that is filed in a timely manner and meets all other filing requirements of the GHP), the amount of secondary benefits payable is the lowest of the:

- Actual charge by the physician/supplier (or the amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the GHP;

- Amount Medicare would pay if services were not covered by a GHP. (In determining this amount, the payment limitations are found in IOM 100-02, Medicare Benefit Policy Manual, Chapter 6, §70, for non-inpatient psychiatric services apply; and the payment limitations in 100-02, Medicare Benefit Policy Manual, Chapter 15, for physical therapy services that apply.); or

- Higher of the Medicare fee schedule or other amount that would be payable under Medicare (without regard to any Medicare deductible and/or coinsurance amounts) or the GHP's allowable charge (without regard to any copayment imposed by the policy or plan) minus the amount actually paid by the GHP.

NOTE: In general, WC medical benefits constitute a service benefit (i.e., the payment constitutes full discharge of the patient's liability for services). In such cases, physicians/suppliers are obligated to accept the WC payment as payment in full and no secondary Medicare benefits are payable. However, if WC pays for Medicare covered services and, under the WC plan, the physician/supplier is not obligated to accept the payment as payment in full, Medicare secondary benefits may be payable.

To calculate the amount of Medicare secondary benefits payable on a given claim, it is generally necessary to have the following information not otherwise required in processing Medicare claims:

- The amount paid by the GHP;
- The amount the provider is obligated to accept as payment in full (OTAF) if the OTAF is lower than the submitted charges; and
- The GHP's allowable charge.

This information can generally be derived from the GHP's explanation of benefits. In the event that the GHP's allowable charge cannot readily be determined from its explanation of benefits, the A/B MAC (Part B) assumes, in the absence of evidence to the contrary, that the actual charge is the GHP's allowable charge.

In the following examples, all physicians/suppliers have accepted assignment.

EXAMPLE 1

An individual received treatment from a physician who charged $175. The individual's Part B deductible had been met. As a primary payer, an employer allowed $150 of the charge and paid 80 percent of this amount or $120. The fee schedule amount for this treatment is $125. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $175 - $120 = $55.

B. The Medicare payment is determined in the usual manner: .80 x $125 = $100.

C. Employer plan's allowable charge of $150 (which is higher than Medicare's fee schedule amount of $125) minus the employer plan's payment of $120 equals $30.

D. Medicare pays $30 (lowest of amounts in steps A, B, or C).

EXAMPLE 2

An individual received treatment from a physician who charged $150. The individual's Part B deductible had been met. As a primary payer, an employer plan allowed a fee schedule payment of $100. The Medicare fee schedule amount for the treatment is $110. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $150 - $100 = $50.

B. The Medicare payment is determined in the usual manner: .80 x $110 = $88.

C. Medicare's fee schedule amount of $110 (which is higher than the employer plan's allowable charge of $100) minus the employer plan's payment of $100 equals $10.

D. Medicare pays $10 (lowest of amounts in steps A, B, or C).

EXAMPLE 3

An individual received treatment from a physician who charged $300. The individual's unmet Part B deductible was $233. As primary payer, an employer plan allowed $225 and paid 80 percent of this amount or $180. The Medicare fee schedule amount for his treatment is $250. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $300 - $180 = $120.

B. The Medicare payment is determined in the usual manner: $250 - $233 = $17 x .80 = $13.60.

C. Medicare's allowable charge of $250 (which is higher than employer's plan allowable amount of $225) minus the employer plan's payment of $180 equals $70.

D. Medicare pays $13.60 (lowest of amounts in steps A, B, or C).

The beneficiary's Medicare deductible is credited with $233, which is the amount that would have been credited to the deductible based on the fee schedule amount of $250 if Medicare had been primary payer. (See Chapter 1, §40.)

The beneficiary can be charged $56.40 (the $250 fee schedule amount minus the sum of the $180 primary payment plus the $13.60 Medicare payment). (See Chapter 3, §10.2.1.)

EXAMPLE 4:

An individual received treatment from a physician who charged $250. The individual's unmet Part B deductible was $50 to accommodate the remaining deductible amounts for the calendar year. As primary payer, an automobile insurer allowed the $250 charge in full. The insurer deducted $100 from the $250 physician charge to meet its own deductible and paid 80 percent of the remaining $150, or $120. The Medicare fee schedule amount for this treatment is $200. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $250 - $120 = $130.

B. The Medicare payment is determined in the usual manner: $200 - $50 = $150 x .80 = $120.

C. GHP's allowable charge of $250 (which is higher than Medicare's fee schedule amount of $200) minus its payment of $120 equals $130.

D. Medicare pays $120 (lowest of amounts in steps A, B, or C).

The beneficiary's Medicare deductible is credited with $50, the amount that would have been credited to the deductible based on the fee schedule amount of $200 payable if Medicare had been primary payer.

All of the beneficiary deductible except $50 had been previously met. (See Chapter 1, §40.)

The physician cannot bill the beneficiary because the sum total of the primary payment ($120) and the Medicare payment ($120) exceeds the fee schedule amount ($200).

EXAMPLE 5:

An individual received treatment from a physician who charged $600. The individual paid the physician $50 and the physician also filed a claim with a GHP. The individual's unmet Medicare deductible was $233. The GHP's allowable charge was $450 and, as a primary payer, it paid the physician $400. The claim showed the total charge and other amounts paid by the GHP and the individual. The Medicare fee schedule amount for the treatment is $500. The Medicare secondary payment is calculated as follows:

A. Actual charge by the physician minus the third party payment: $600 - $400 = $200.

B. The Medicare payment is determined in the usual manner: $500 - $233 = $267 x .80 = $213.60

C. Medicare's fee schedule amount of $500 (which is higher than the EGHP's allowable charge of $450) minus the GHP's payment of $400equals $100.

D. Medicare pays $100 (lowest of amounts in steps A, B, or C).

Since the physician collected $50 from the individual, the $100 Medicare payment is split: $50 goes to the individual and $50 goes to the physician. The beneficiary's Medicare deductible is credited with $233, the amount that would have been credited to the deductible based on the fee schedule amount of $500 if Medicare had been primary payer. (See Chapter 1, §40.)

The physician cannot bill the beneficiary because the sum total of the primary payment ($400) and the Medicare payment ($100) equals the fee schedule amount ($500). (See Chapter 3, §10.2.1.)

EXAMPLE 6:

An individual received treatment from a physician who charged $175. The individual's Part B deductible had been met. As a primary payer, an employer plan allows $160 but has a preferred physician arrangement under which the physician agrees to accept 90 percent of the plan's allowable amount as payment in full (i.e., $144 ($160 x .90)). The plan also has a $50 deductible for physician services, which yet has not been satisfied in any part. Thus, the plan pays $94 ($144 preferred physician rate minus $50 deductible). The fee schedule amount for this treatment is $150. The Medicare secondary payment is calculated as follows:

A. The amount the physician is obligated to accept as payment in full minus the third party payment: $144 - $94 = $50.

B. The Medicare payment is determined in the usual manner: $150 x .80 = $120.

C. Employer plan's allowable charge of $160 (which is higher than Medicare's fee schedule amount of $150) minus the employer plan's payment of $94 equals $66.

D. Medicare pays $50 (lowest of amounts in steps A, B, or C).

EXAMPLE 7:

Mr. Jones belongs to an employer-sponsored HMO that is primary to Medicare. He had 2 visits with a doctor for which he paid a $10 co-payment per visit. He has not met his Medicare deductible. He wishes Medicare to make secondary payments to reimburse him for these co-payments. Mr. Jones submits a paper claim to his A/B MAC (Part B) for reimbursement.

The Medicare allowable amount for each of Mr. Jones visits was $32 giving a total of $64 for the 2 visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

A. Determine the Medicare payment in the usual manner: .80 x $64 ($32 per visit x 2 visits) = $51.20.

B. The co-payments for the 2 visits total $20.

C. If the deductible had been met, the lowest of steps 1 or 2 would be payable. Since it was not met, the amount credited toward the deductible is:

- The Medicare allowable amount for the covered services if they had been furnished on a fee-for-service basis ($32 x 2 = $64).

- To this amount, add the total co-payments for those covered services: $64 + ($10 x 2) = $84.

Mr. Jones is credited with $84 toward his deductible. Since Mr. Jones has not met the Medicare deductible, no MSP amount is payable.

40.7.3.1 - Medicare Secondary Payment Part B Claims Determination for Services Received on ASC X12 837 Professional Electronic Claims

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Medicare's secondary payment is based on provider charges, or the amount the physician or other supplier is obligated to accept as payment in full (OTAF), whichever is lower; the primary payers allowed amount for Part B services; what Medicare would have paid as the primary payer; and the primary payer(s) payment. MSP policy also dictates what the shared systems and A/B MACs (Part B) and DME MACs must take into consideration in processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the Claims Adjustment (CAS) segments on the ASC X12 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the remittance advice and report these adjustments on the ASC X12 837 professional claim format when sending the claim to Medicare for secondary payment. The physician and other supplier also identify its charges and the other payer payment amounts which are found in other loops and segments in the ASC X12 837 professional claim transaction. ASC X12 837 claim transaction examples are cited below.

Example 1: A Medicare beneficiary visits her physician for an exam where the provider charges $1,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is primary to Medicare. The beneficiary's deductible had already been met. The physician is a participating physician under the primary payer group health plan. The contract amount, a.k.a. obligated to accept as payment in full amount, is the same as Medicare's fee schedule amount of $800. The primary payer also

allowed $800. The primary payer ultimately pays $720 for the services. The service amounts are broken down:

Medicare Fee Schedule Procedure	$800
Submitted Charges	$1,000
Payer 1 Allowed Amount	$800
Payer 1 Contracted Agreement (OTAF)	$800
Payer 1 Patient Co-Insurance @ 10%	$ 80
Payer 1 Payment Amount	$720

Medicare payment is calculated as follows:

1) The contractual agreement amount (since this amount is lower than the charges) minus the third party payment: $800 - $720 = $80

2) Determine the Medicare payment in the usual manner: $800 - $160 = $640

3) The allowable charge minus the primary payer payment: $800 - $720 = $80

4)Medicare Pays $ 80 (lowest of amounts in steps 1, 2, or 3) Primary Payer

Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*1000*720*80*12*07256000236520**1~
CAS*CO*45*200~
CAS*PR*2*80~

Physician Abbreviated Secondary Claim to Medicare:

SBR*P*18*ABCGROUP******CI
CAS*CO*45*200~
CAS*PR*2*80~
AMT*D*720~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 1000-200=800
OTAF amount equals submitted charge minus CO group code adjustments – 1000-200=800

Medicare Abbreviated 835 to Physician

CLP*200725638901*2*1000*80**MB*0725600110236520**1~
CAS*OA*23*920~

Example 2: The same patient receives the same service from the physician. However, in this case the physician fails to follow plan procedures and is assessed a $50 penalty under the contract for not following plan procedures.

Medicare Fee schedule	$800
Submitted Charges	$1000
Payer 1 Contracted Agreement (OTAF)	$800
Payer 1 CO Plan Procedures not followed	$50
Payer 1 Patient Co insurance @ 10%	$75
Payer 1 Payment Amount	$675

Medicare's Payment is calculated in the usual manner:

1. The contractual agreement amount (since this amount is lower than the charges) minus the third party payment: $800 - $725 = $75

2. Determine the Medicare payment in the usual manner: $800 - $160 = $640

3. The Medicare's allowable charge minus the primary payer payment: $800 - $725 = $75

4. Medicare pays $75 (lowest of amounts in steps 1, 2, or 3)

Due to the physician not following the primary health plan procedures Medicare uses the payment amount that the primary payer would have paid if the primary payer claim was filed properly.

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*1000*675*75*12*07256000236520**1~
CAS*CO*45*200**95*50~
CAS*PR*2*75~

Physician Abbreviated Secondary Claim to Medicare
SBR*P*18*ABCGROUP******CI
CAS*CO*45*200**95*50~
CAS*PR*2*75~
AMT*D*675~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – 1000-200 - 50=750
OTAF amount equals submitted charge minus CO group code adjustments – 1000-200=800

Medicare Abbreviated 835 to Physician

CLP*200725638901*2*1000*75**MB*0725600110236520**1~
CAS*OA*23*925~

Note: One of the problems of looking at adjustments other than patient responsibility is how accurately payers code 835's. In the above example the $50 adjustment could just as easily have been reported out as OA - Other Adjustment with the same Claim Adjustment Reason Code. That would necessitate examining not only group codes, but individual Claim Adjustment Reason Codes and possibly Remarks Codes in the Medicare edit logic.

Example 3: A patient receives services from a participating Medicare physician who is not a participating provider in the Primary Payer's network. The patient in this case is responsible for up to the provider's charges, but as a Medicare participating physician, the physician accepts the Medicare fee (Allowed Amount) as payment in full and thus cannot accept payment in excess of the Medicare Allowed Amount, a.k.a. Medicare fee schedule. Medicare would indicate a $200 contractual obligation in its 835 remittance statement to the physician.

Medicare Fee schedule	$800
Submitted Charges	$1000
Payer 1 Fee Schedule	$700
Payer 1 Patient Co-insurance @ 10%	$70
Payer 1 Payment Amount	$630

Note that the charges and the OTAF are the same due to physician not participating in the primary payer's network. For this reason, no CO appears on the inbound 837 to Medicare.

Medicare's Payment is calculated in the usual manner:

1. The charges/OTAF minus the third party payment: $1000 - $630 = $370

2. Determine the Medicare payment in the usual manner: $800 - $160 = $640
3. The Medicare's allowable charge minus the primary payer payment: $800 - $630 = $170
4. Medicare pays $170 (lowest of amounts in steps 1, 2, or 3)

Shared System MSP calculation:

Primary payer allowed amount equals submitted charge minus CARC 45 adjustments – 1000-300=700
OTAF amount equals submitted charge minus CO group code adjustments – 1000-0=1000

Primary Payer Abbreviated 835 containing amounts for MSP calculation

CLP*200725638901*1*1000*630*370*12*07256000236520**1~
CAS*PR*45*300**2*70~

Physician Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI
CAS*PR*45*300**2*70~
AMT*D*630~

Medicare Abbreviated 835 to Physician

CLP*200725638901*2*1000*170**MB*0725600110236520**1~
CAS*CO*45*200~
CAS*OA*23*630~

40.7.3.2 - Medicare Secondary Payment Part A Claims Determination for Services Received on ASC X12 837 Institutional Electronic or Hardcopy Claims Format

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Medicare's secondary payment for A/B MAC (Part A) MSP claims is based on:

1) Medicare covered charges, or the amount the provider is obligated to accept as payment in full (OTAF), whichever is lower (in the case where there are multiple prior payers to Medicare the lowest OTAF is used unless the Medicare covered charges are lower);

2) what Medicare would have paid as the primary payer; and

3) the primary payer(s) payment.

MSP policy also dictates what the shared systems and A/B MACs (Part A) must take into consideration in processing MSP claims. This includes adjustments made by the primary payer(s), which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer(s) are reported in the Claims Adjustment (CAS) segments on the 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the primary payer(s) remittance advice and report

these adjustments on the 837 when sending the claim to Medicare for secondary payment. 837 claims transaction examples are cited below.

Example 1: A Medicare beneficiary visits a hospital that charges $10,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is primary to Medicare. The beneficiary's Medicare deductible had already been met. The provider participates under the primary payer's employer group health plan. The contract amount (the OTAF amount) is the same as Medicare's fee schedule amount of $8,000. The primary payer (Payer 1) ultimately pays $7,200 for the services. The service amounts are broken down:

Medicare Fee schedule Procedure $8,000

Charges $10,000

Payer 1 Allowed Amount $8,000 (not sent to MSPPAY)

Payer 1 Contractual Amount (OTAF) $8,000

Payer 1 Patient Co-Insurance @ 10% $800

Payer 1 Payment Amount $7,200

The Value Code(s) 44 OTAF amount is found in the HI segment (BE qualifier) on the 837 Institutional Claim (837-I) and this amount is sent to MSPPAY. If the OTAF is not found in the HI segment (BE qualifier), but there is a group code CO (Contractual Obligation) in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY. In the case where there are multiple prior payers to Medicare, perform the calculation (the charge minus the CO amount) for each prior payer contractual amount and send the lowest calculated contractual amount as the OTAF amount to MSPPAY, if the OTAF amount is lower than the charges.

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*10000*7200*800*12*07256000236520**1~

CAS*CO*45*2000~

CAS*PR*2*800~

Provider Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI
CAS*CO*45*2000~

CAS*PR*2*800~

AMT*D*7200~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC CO 45 adjustments – $10,000 - $2,000 = $8,000.

(**NOTE:** The allowed amount is shown here and is used for purposes of balancing the remittance advice.)

Since the HI segment (BE qualifier) did not contain OTAF, the CO adjusted amount in the CAS is used to determine the OTAF. OTAF amount equals charges minus CO group code adjustments – $10,000 - $2,000 = $8,000

Medicare Abbreviated 835 to Provider

CLP*200725638901*2*10000*800**MB*0725600110236520**1~

CAS*OA*23*9200~

Example 2: A Medicare beneficiary visits a hospital that charges $10,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is prior to Medicare. The beneficiary's spouse is also working with employer group plan insurance that is prior to Medicare. The beneficiary's Medicare deductible had already been met. The provider participates under both prior payers' employer group health plans. The contract amount (the OTAF amount) for one of the prior payers, is the same as Medicare's fee schedule amount of $8,000. You must combine both prior payers' payment amounts and send the total payment amount to MSPPAY. The prior payers ultimately pay $7,200 for the services. The service amounts are broken down:

Medicare Fee schedule Procedure $8,000

Charges $10,000

Payer 1 Allowed Amount $9,000 (not sent to MSPPAY)

Payer 1 Contractual Amount (OTAF) $9,000

Payer 1 Patient Co-Insurance @ 30% $3,000
Payer 1 Payment Amount $6,000

Payer 2 Allowed Amount $8,000 (not sent to MSPPAY)

Payer 2 Contractual Amount (OTAF) $8,000

Payer 2 Patient Co-Insurance @ 10% $800

Payer 2 Payment Amount $1,200

The Value Code(s) 44 OTAF amount is found in the HI segment (BE qualifier) on the 837-I and this amount is sent to MSPPAY. If the OTAF is not found in the HI segment (BE qualifier), but there is a group code CO in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY. In the case where there are multiple prior payers to Medicare, perform the calculation (the charge minus the CO amount) for each prior payer and send the lowest calculated contractual amount as the OTAF amount to MSPPAY if lower than the charges. The Medicare covered charges or the OTAF amounts are never combined.

Medicare payment is calculated as follows:

1) The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8,000 - $0 = $8,000

2) The gross amount payable by Medicare minus the primary payments: $8,000 - $7,200 = $800

3) The lowest obligated to accept payment in full minus the primary payment: $8,000 - $7,200 = $800

4) The obligated to accept payment in full minus the Medicare deductible: $8,000 – $0 = $8,000

5) Pay $800 (lowest of amounts in steps 1, 2, 3, or 4)

First Prior Payer's Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*10000*6000*3000*12*07256000236520**1~

CAS*CO*45*1000~

CAS*PR*2*3000~

Second Prior Payer's Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*10000*7200*800*12*07256000236520**1~
CAS*CO*45*2000~

CAS*PR*2*800~

Provider Abbreviated Secondary Claim to Medicare

SBR*P*19*CBAGROUP******CI~

CAS*CO*45*1000~

CAS*PR*2*3000~

AMT*D*6000~

SBR*S*18*ABCGROUP******CI~

CAS*CO*45*2000~

CAS*PR*2*800~

AMT*D*7200~

Shared System MSP calculation:

Allowed amount equals submitted charge minus highest CARC 45 adjustments – $10,000 - $2,000 = $8,000.

(NOTE: The allowed amount is shown here and is used for purposes of balancing the remittance advice.)

Since the HI segment (BE qualifier) did not contain OTAF, the CO adjusted amount in the CAS is used to determine the OTAF. The lowest OTAF amount from all the prior payers equals charges minus CO group code adjustments – $10,000-$2,000=$8,000
Medicare Abbreviated 835 to Provider

CLP*200725638901*2*10000*800**MB*0725600110236520**1~

CAS*OA*23*9200~

Example 3: The patient receives the same service from the provider. However, in this case the provider fails to follow plan procedures and is assessed a $500 penalty under the contract for not following plan procedures. Medicare bases its payment on the amount the primary payer would have paid if the provider followed plan procedures.
Medicare Fee schedule $8,000
Charges $10,000

Payer 1 Contractual Amount (OTAF) $8,000

Payer 1 CO Plan Procedures not followed $500

Payer 1 Patient Responsibility @ 10% $750

Payer 1 Payment Amount $6,750

The Value Code(s) 44 OTAF amount is found in the HI segment (BE qualifier) on the 837-I and this amount is sent to MSPPAY. If the OTAF is not found in the HI segment (BE qualifier), but there is a group code CO in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY. In the case where there are multiple prior payers to Medicare, perform the calculation (the charge minus the CO amount) for each prior payer and send the lowest calculated contractual amount as the OTAF amount to MSPPAY if lower than the charges. The Medicare covered charges or the OTAF amounts are never combined.

Medicare's Payment is calculated in the usual manner:

1) The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8,000 - $0 = $8,000

2) The gross amount payable by Medicare minus the primary payment: $8,000 - $7,250 = $750

3) The obligated to accept payment in full minus the primary payment: $8,000 - $7,250 = $750

4) The obligated to accept payment in full minus the Medicare deductible: $8,000 – 0 = $8,000

5) Pay $750 (lowest of amounts in steps 1, 2, 3, or 4)

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*10000*6750*750*12*07256000236520**1~

CAS*CO*45*2000**95*500~

CAS*PR*2*750~

Physician Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI

CAS*CO*45*2000**95*500~

CAS*PR*2*750~

AMT*D*6750~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – $10,000 - $2,000 - $500 = $7500

OTAF amount equals submitted charge minus CO group code adjustments – $10,000 - $2,000 = $8,000

Medicare Abbreviated 835 to Provider

CLP*200725638901*2*10000*750**MB*0725600110236520**1~

CAS*OA*23*9250~

40.7.3.3 - Version 5010 Balancing for Incoming ASC X12 837 MSP Claims Where MSP Amounts Appear at the Claim Level and Not at the Service Detail Line

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

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. A/B MACs (Part B) may refer to the 5010 ASC X12

837professional claim 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 considered in balance by version 837 balancing rules, however, the sum of the line level primary paid amounts does not equal the claim level primary paid amount.

40.7.4 - Effect of Medicare Limiting Charge on Medicare Secondary Payments

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Under §1848(g)(1)(A) of the Social Security Act (the Act,) a nonparticipating physician/supplier who does not take assignment on a claim may not charge more than the Medicare limiting charge and no person is liable for payment of any amounts in excess of the limiting charge. Effective January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians (See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," for further explanation of limiting charge.) Therefore, a nonparticipating physician/ supplier who does not take assignment must reduce their actual charge to the GHP, or to the beneficiary, to reflect the Medicare limiting charge. The rules above for calculating Medicare secondary benefits apply whether or not the limiting charge applies. However, when the limiting charge is less than the actual charge, the limiting charge will be considered to be the actual charge as well as the plan's allowable charge in applying those rules. This is because CMS cannot recognize an illegal charge as a basis for calculating Medicare benefits.

EXAMPLE: A physician erroneously billed $200 for a procedure. The GHP allowed $175 and paid $150 (which was more than it was obligated to pay under the Medicare limited charge law). The Medicare allowed amount for the nonparticipating physician is $125 (95 percent of the fee schedule amount for participating physicians in accordance with the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §30.3.12.3). The limiting charge is $143.75 (115 percent of $125). The secondary payment should be determined as follows:

A. The actual charge by the physician (the limiting charge) minus the GHP's payment: $143.75 - $150 = 0.

B. The Medicare payment is determined in the usual manner: .80 x $125 = $100.

C. Employer plan allowable charge (the limiting charge) minus the third party payments: $143.75 - $150 = $0

Medicare pays $0 (lowest of the amounts in A, B, or C).

40.7.4.1 - GHP Does Not Pay for Certain Services

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

When a GHP pays for certain services furnished to an individual but does not pay for other services or when the benefits available under the policy or plan have been exhausted, Medicare may pay primary benefits for the services not reimbursed by the GHP, provided they are otherwise covered.

EXAMPLE 1:

A physician charges $600 for services related to an on-the-job injury. The physician also charges $400 for the services of an independent physical therapist in his or her office, which were for treatment of a preexisting condition unrelated to the job injury. The fee schedule amount for the physician's services is $400 and the fee schedule for the therapist's services is $300. The beneficiary does not have GHP coverage. The beneficiary previously met the Medicare Part B deductible. Workers Compensation paid a fee schedule amount of $375 for the work-related injury, which the physician was required to accept as payment in full for services, but WC did not pay for physical therapy related to the preexisting condition. Since the WC payment is payment in full for the physician's services, no secondary Medicare benefits are payable for these services. However, Medicare may pay for the covered physical therapy services (provided by an independent physical therapist) not covered by WC. Medicare pays primary benefits of $240 (80 percent of the fee schedule amount of $300) for the independent therapist's services.

EXAMPLE 2:

A beneficiary is injured in an automobile accident. The beneficiary is covered by no-fault insurance that has a $2,500 benefit limit. Over a 12-month course of treatment, a physician charges $1,400 for services and $1,800 for the services of an independent physical therapist in his or her office. The physician bills all charges to the no-fault insurer. The A/B MAC (Part B) determines that the fee schedule amount for the physician's services is $1,050 and $1,350 for the therapist's services. The beneficiary previously met the Part B deductible. The no-fault insurer paid the physician's charges in full and $1,100 of the

therapist's charges for a total of $2,500. Since the physician received full payment for the services, no secondary Medicare benefits are payable for these services.

However, Medicare may pay secondary benefits for the therapist's services because the no-fault insurance benefits are exhausted. The Medicare secondary payment amount is calculated as follows:

A. Actual charge of $1,800 minus the third-party payment of $1,100 = $700.

B. The Medicare payment is determined in the usual manner: .80 x $1,350 = $1,080.

C. No-fault insurer's allowable charge of $1,800 (which is higher than Medicare's fee schedule amount of $1,350) minus the $1,100 paid by the insurer equals $700.

D. Medicare pays $700 (lowest of amounts in steps A, B, or C).

The physician cannot bill the beneficiary because the sum total of the primary payment ($1,100) and the Medicare secondary payment ($700) exceeds the fee schedule amount ($1,350). (See Chapter 3, §10.2.1.)

40.7.4.2 - Third Party Payment Includes Both Medicare Covered and Noncovered Services

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

To determine the amount of GHP payment for covered services when a bill includes both Medicare covered and noncovered services and it cannot be determined from the GHP's explanation of benefits how much of its payment is for Medicare covered services, the A/B MAC and DME MAC submits the MSP claim to the MSPPAY module which allocates the third-party payment proportionately to the Medicare covered and noncovered services. To do this, it determines the ratio of the charges for covered services to the total charges and multiplies the third-party allowable charge and payment by that ratio. The results are, respectively, the third-party allowable charge and the amount of the third-party payment considered to be for Medicare covered services. The MSPPAY module computes the Medicare secondary payment amount.

40.7.5 - Effect of Failure to File Proper Claim

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

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 A/B MAC (Part B) or the DME MAC 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 A/B MAC (Part B) or the DME MAC recovers this amount, plus any applicable interest, from the party determined to be liable for the overpayment in accordance with the Medicare Pub. 100-06, Financial Management Manual, Chapter 3, §200.

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 claim rules and in the above example, appear in the CAS segment on ASC X12 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 Value Codes by the provider. For example, if the employed beneficiary is working aged over 65 a VC 12 would be used in Value Codes. 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 Value Codes 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 A/B MAC and DME MAC 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.

40.7.6 - Medicare Secondary Payment for Managed Care Organizations' (MCO) Copayments

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Most managed care organizations (MCOs) (e.g., HMOs, CMPs, health care prepayment plans (HCPPs)) charge copayment amounts for which Medicare Part B secondary payment may be made once the individual has met the Part B deductible. The deductible can be met either by covered services obtained outside the MCO or by covered services obtained through the MCO. The amounts credited to the deductible for MCO services are the Medicare allowable amounts that would have been allowed for the services if they had been furnished on a fee-for-service basis plus any copayments charged for the services. Once the deductible is met, the Medicare secondary payment is the amount Medicare would pay if the services were not covered by a GHP (the MCO) or the copayment amount, whichever is less. The MCO must file a claim showing all the usual claims information except the amount of the charges and the amount paid since payment is made on a capitation basis.

If the MCO does not submit the claim, the A/B MAC (Part B) or DME MAC advises the MCO in writing that, under §1848(g)(4) of the Act, a claim must be submitted. Willful

failure to comply within one year of the date of the service will subject the provider to a civil monetary penalty of up to $2,000 under §1842(p)(3) of the Act.

The A/B MAC Part B or DME MAC asks the beneficiary to submit the copayment receipts together with a signed statement explaining that the beneficiary is a member of an employer-sponsored MCO that is primary to Medicare and is requesting that Medicare pay secondary benefits for the MCO's copayment charges. This will serve as a substitute for the GHP's explanation of benefits notice.

The Medicare secondary payment would be the lesser of the:

- Amount Medicare would pay on the basis of the Medicare allowable amount if Medicare were primary, or
- MCO's copayment.

The below examples are for paper claims submitted by beneficiaries who want to be reimbursed by Medicare for copayments made to the physicians, providers or other suppliers. Most claims of these types are submitted electronically by healthcare professionals and are processed through the MSPPAY module. Providers, physicians and other suppliers shall not accept co-payments from Medicare beneficiaries when there is a primary payer to Medicare. The copayment expected should be sent as claim by the provider, physician or other supplier to Medicare for payment. A Medicare remittance advice will be returned stating whether there is a remaining beneficiary responsibility. All A/B MACs and DME MACs shall re-educate providers, physicians and other suppliers reminding them of this policy as necessary.

EXAMPLE 1:

Mr. Jones is enrolled in a non-Medicare HMO, which is his primary payer. His Part B deductible has been met. He required the services of a specialist and the HMO referred him to Dr. Smith who does not accept assignment. The doctor charged him a copayment of $25 for each visit. After eight visits, Mr. Jones contacted the A/B MAC (Part B) requesting secondary benefits.

The A/B MAC (Part B) should request Mr. Jones submit his copayment receipts with a dated statement that he is requesting secondary benefits from Medicare for the copayments he paid to the physician. This statement will then serve as Mr. Jones claim. Then the A/B MAC (Part B) requests the HMO to submit Form CMS-1500 showing the usual claims information, except for the charges and the amount paid.

The Medicare allowable amount for the nonparticipating physician was $55. The Medicare secondary payment is calculated as follows:

A. The Medicare payment is determined in the usual manner: .80 x $440 ($55 per visit x 8 visits) = $352.

B. The copayment for the 8 visits total $200 ($25 x 8).

C. Medicare pays $200, the total copayment, since that amount is lower than the amount Medicare would pay as primary payer.

EXAMPLE 2:

Mr. Smith belongs to an employer sponsored HMO that is primary to Medicare. He had two visits with a doctor for which he paid a $10 copayment per visit. He has not met his Medicare deductible. He wishes Medicare to make secondary payments to reimburse him for these copayments.

The Medicare allowable amount for each of Mr. Smith's visits was $32 giving a total of $64 for the two visits. To determine whether a Medicare secondary payment can be made, the following calculation is used:

A. The Medicare payment is determined in the usual manner: .80 x $64 ($32 per visit x 2 visits) = $51.20.

B. The copayments for the 2 visits total $20.

C. If the deductible had been met, the lowest of steps A or B would be payable. Since it was not met, the amount credited toward the deductible is:

- The Medicare allowable amount for the covered services if they had been furnished on a fee-for-service basis ($32 x 2 = $64).

- To this amount, the total copayments are added for those covered services: $64 + ($10 x 2) = $84.

Mr. Smith is credited with $84 toward his deductible. Since Mr. Smith has not met the Medicare deductible, no MSP amount is payable.

40.7.7 - MSP Situations Under CAP

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Providers who elect into the CAP voluntarily agree to obtain CAP drugs for Medicare beneficiaries exclusively through an approved CAP vendor. In situations where participating CAP providers obtain a drug from the CAP vendor for a beneficiary who is incorrectly determined to have Medicare as their primary insurer, but the provider and the CAP vendor must first bill the appropriate primary insurer for the drug and the administration service.

Upon receipt of the primary insurer's payment, MSP claims should then be submitted by the physician to their A/B MAC (Part B) for the administration service and by the

approved CAP vendor to the CAP designated A/B MAC (Part B) for the drug. Providers are required to submit MSP claims even if they believe there is no outstanding balance due. Such claims must adhere to CAP guidelines and include the drug HCPCS code, the prescription number provided by the approved CAP vendor and an appropriate CAP no-pay modifier. Approved CAP vendor claims must also adhere to CAP requirements and include the assigned prescription number.

All participating CAP providers to submit MSP claims for drug administration services where the drug was obtained from the approved CAP vendor. Failure to submit an MSP claim for the drug administration prevents the processing of the vendor's MSP claim by the CAP designated A/B MAC (Part B).

Drugs Obtained Outside of the CAP for Beneficiaries with Medicare

In certain rare situations, participating CAP providers may mistakenly obtain drugs for Medicare beneficiaries outside of the CAP vendor because they had determined that the beneficiary had another insurer that was primary to Medicare. In order to make an appropriate payment for drugs administered under these unusual circumstances, we are allowing temporary use of the J3 modifier to bypass CAP edits and pay the participating CAP provider at the current ASP rate.

40.8 - A/B MAC (Part A) Processing Procedures for Medicare Secondary Claims

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If a primary payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare (as defined below) in the absence of a primary payment, and the provider does not accept and is not obligated to accept the primary payment as payment in full, Medicare secondary benefits may be paid. In this situation, and where the employer plan paid an amount that equals or exceeds the amount that Medicare would have paid in the absence of a primary payment, the instructions below describe processing claims from providers on cost reimbursement, and providers on prospective payment.

If payment by the primary payer for Medicare covered services (as determined by the formula below) equals or exceeds the provider's full charges for those services or the Medicare gross payment amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the primary payment as payment in full for the services, and it receives this amount, no payment is due from Medicare and no inpatient utilization is charged to the beneficiary.

The provider submits a bill according to the procedures described in the Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, "Inpatient Hospital Billing," for no-payment bills.

40.8.1 - Medicare Secondary Payment Calculation Methodology When Proper Claim Has Been Filed

(Rev . 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Definition of the Gross Amount Payable by Medicare

The gross amount payable by Medicare is the amount prior to deductions for the Medicare deductible and/or coinsurance amounts. It consists of:

- The current Medicare interim payment amount (see §40.8.2) for providers paid on a reasonable cost basis;

- The Medicare payment for hospitals paid on a prospective payment basis; or

- The fee schedule amounts.

If a provider furnishes services that are payable under more than one payment method (e.g., fee schedule amounts), Medicare determines the combined amount for the services as its gross amount payable without regard to the effect of the Medicare deductible, coinsurance, or payment by the third-party payer.

For PPS providers, the Medicare payment rate is the amount Medicare would pay under PPS. It consists of the total prospective payment amount for the discharge and interim payments for those items that are paid retroactively. It is determined without regard to any deductible or coinsurance. The amount is computed in the same manner for PIP and non-PIP hospitals and is the sum of:

- The total prospective payment amount, as determined by PRICER, including payment for the DRG and any outlier payments, adjustments for hospitals serving a disproportionate share of low income patients, indirect medical education, or other payments. Since the basic prospective payment is payable if a beneficiary has at least one covered day in the stay, payable days may exceed covered days if there are non-outlier days before entitlement or after benefits are exhausted, and

- Payment for direct graduate medical education activities (42 CFR 413.86).

40.8.2 - Rule to Determine the Amount of Secondary Benefits

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The amount of secondary benefits payable to providers is the lowest of the following:

- The gross amount payable by Medicare (see definition for PPS providers and non-PPS providers above) minus the applicable deductible and/or coinsurance amount; or,

- The gross amount payable by Medicare minus the amount paid by the primary payer for Medicare covered services; or,

- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full), minus the amount paid by the primary payer for Medicare covered services; or

- The provider's charges (or an amount less than the charges that the provider is obligated to accept in full), minus the applicable Medicare deductible and/or coinsurance amounts.

NOTE: When the primary payer pays less than actual charges (e.g., under the terms of a preferred provider agreement) and less than the amount the provider is obligated to accept as payment in full (e.g., because of imposition of a primary payer's deductible and/or copayment, but not because of failure to file a proper claim), Medicare uses the amount the provider is obligated to accept as payment in full in its payment calculation. In such cases, the provider reports in value code 44 the amount it is obligated to accept as payment in full. Medicare considers this amount to be the provider's charges. Absent a lower amount that the provider is obligated to accept as payment in full, the amount of the provider's actual charges is used.

The provider uses condition code 77 to indicate it has accepted or is obligated/required due to a contractual arrangement or law to accept payment as payment in full. Therefore, no Medicare secondary payment nor any beneficiary payment is due.

The beneficiary has no liability for Medicare covered services if the primary payment is greater than the applicable Medicare deductible and coinsurance amounts. Otherwise, the beneficiary's liability is limited to the applicable Medicare deductible and coinsurance amounts less the primary payment.

40.8.3 - Application of the MSP Formula

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The Medicare payment amount is calculated by applying the following formulas:

A. Prospective Payment

Medicare pays the lesser of the gross amount payable by Medicare, minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or

- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 43, or 47, as appropriate, items 39-41).

O R

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, Items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or

- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 43, or 47, as appropriate, items 39-41).

B. Percentage of Charge

Medicare pays the lesser of total charges (sum of covered and noncovered), identified by revenue code 001, less any Medicare noncovered charges times the percentage of charges used for the Medicare rate, minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or

- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 43, or 47, as appropriate, items 39-41).

O R

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, Items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or

- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

C. Periodic Interim Payments (PIP)

Medicare pays the lesser of the per diem or per visit rate based on the provider's current PIP amount times the number of covered days (visits) minus the larger of:

- Total Deductions (the sum of deductible and coinsurance amounts); or

- The amount paid by primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

O R

The provider's charges, revenue code 001 in item 47 (or the amount the provider is obligated to accept as payment in full when the primary payer pays a lesser amount, value code 44, items 39 - 41) minus the larger of:

- Total Deductions (the sum of deductibles and coinsurance); or

- The amount paid by the primary payer for Medicare covered services (dollar amount entered as a value code amount associated with the value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47, as appropriate, items 39-41).

The A/B MAC (Part A) uses the above formulas in calculating Medicare liability for prior year claims processed in the current year.
The A/B MAC (Part A) informs them of the applicable per diem (per visit) or percentage rates and of any changes.

The MSPPAY module provided by CMS calculates this payment. For documentation, refer to specifications distributed with the most recent module release.

EXAMPLE 1:

A hospital furnished seven days of inpatient hospital care to a Medicare beneficiary. The hospital's charges for Medicare covered services totaled $25,000. The primary payer paid $20,500 for Medicare covered services. No part of the Medicare inpatient hospital deductible of $1,556 had been met. The Medicare gross payment amount without regard to the deductible is $22,000 As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible) minus the primary payer's payment: $22,000 - $20,500 = $1,500;

- The Medicare gross payment amount (without regard to deductible) minus the Medicare inpatient deductible: $22,000 - $1,556 = $20,444;

- The hospital's charges minus the primary payer's payment: $25,000 - $20,500 = $4,500; or

- The hospital's charges minus the Medicare inpatient deductible: $25,000 - $1,556 = $23,444.

Medicare pays $1,500. The combined payment made by the primary payer and Medicare on behalf of the beneficiary is $22,000. The beneficiary has no liability for Medicare covered services since the primary payer's payment satisfied the $1,556 inpatient Medicare deductible.

EXAMPLE 2:

A hospital furnished one day of inpatient hospital care to a Medicare beneficiary. The hospital's charges for Medicare covered services totaled $3,000. The primary payer paid $2,000 for Medicare covered services. No part of the Medicare inpatient hospital deductible of $1,556 had been met. The Medicare gross payment amount without regard to the deductible is $2,500. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible) minus the primary payer's payment: $2,500 - $2,000 = $500;

- The Medicare gross payment amount (without regard to deductible) minus the Medicare inpatient deductible: $2,500 - $1,556 = $944;

- The hospital's charges minus the primary payer's payment: $3,000 - $2,000 = $1,000; or

- The hospital's charges minus the Medicare inpatient deductible: $3,000 - $1,556 = $1,444.

Medicare pays $500. The combined payment made by the primary payer and Medicare on behalf of the beneficiary is $2,500. The beneficiary has no liability for Medicare covered services since the primary payer's payment satisfied the $1,556 inpatient Medicare deductible.

EXAMPLE 3:

A hospital furnished five days of inpatient care to a Medicare beneficiary. No part of the Medicare inpatient deductible of $1,556 had been met. The hospital's charges for Medicare covered services were $15,000 and the Medicare gross payment amount (without regard to the deductible) was $14,000. The provider agreed to accept $13,000 as payment in full. The primary payer paid $12,500 due to a deductible requirement under its plan. The amount the provider is obligated to accept as payment in full (OTAF) $13,000 is considered by Medicare to be the hospital's charges in this situation. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible) minus the primary payer's payment: $14,000 - $12,500 = $1,500;

- The Medicare gross payment amount (without regard to deductible) minus the Medicare inpatient deductible: $14,000 - $1,556 = $12,444;

- The OTAF amount minus the primary payer's payment: $13,000 - $12,500 = $500; or

- The OTAF amount minus the Medicare inpatient deductible: $13,000 - $1,556 = $11,444.

Medicare pays $500. The combined payment made by the primary payer and Medicare on behalf of the beneficiary is $13,000. The beneficiary has no liability for Medicare covered services since the primary payer's payment satisfied the $1,556 inpatient deductible.

EXAMPLE 4:

A hospital furnished 2 days of inpatient hospital care to a Medicare. The hospital's charges were $5,000. The deductible had been met and there is no coinsurance. The primary payer paid $3,400 for Medicare covered services. The Medicare gross payment amount without regard to deductible and coinsurance is $4,600. As secondary payer, Medicare pays the lowest of:

- The Medicare gross payment amount (without regard to deductible or coinsurance) minus the primary payer's payment: $4,600 - $3,400 = $1,200;

- The Medicare gross payment amount (without regard to deductible or coinsurance) minus the applicable coinsurance: $4,600 - $0 = $4,600; = $3,822

- The hospital's charges minus the primary payer's payment: $5,000 - $3,400 = $1,600; or

- The hospital's charges minus the applicable coinsurance: $5,000 - $0 = $5,000.

Medicare pays $1,200.

EXAMPLE 5: HHA Per Visit Method

A beneficiary received 5 skilled nursing visits for which the HHA's current Medicare per visit payment amount at $156 per visit was $780 (the gross payment amount). The HHA's charges were $800. The primary payer paid $600 for Medicare covered services. As secondary payer, Medicare pays the lower of:

- The current Medicare gross payment amount minus the amount paid by the primary payer for Medicare covered services: $780 - $600 = $180.; or

- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $800 - $600 = $200.

Medicare pays $180 as secondary payer.

EXAMPLE 6: HHA Percentage of Billed Charges Method

A beneficiary received 5 skilled nursing visits for which the HHA charged $156 per visit for a total charge of $780.The per visit payment was 90 percent ($780 X 90 percent), which equaled $702 (the gross Medicare payment amount). The primary payer paid $600 for Medicare covered services. As secondary payer, Medicare pays the lower of:

- The current Medicare gross payment amount minus the amount paid by the primary payer for Medicare covered services: $702 - $600 = $102; or
- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $780 - $600 = $180.

Medicare pays $102 as the secondary payer.

EXAMPLE 7: HHA Billing for DME

A beneficiary not under a plan of treatment purchased an item of DME for which the HHA charged $3,500. No part of the $233 Part B deductible had been met. The Medicare final payment without regard to the deductible and coinsurance for this item of DME was $3,300 (the lower of the $3,500 charges or the $3,300 fee schedule amount). The primary payer paid $3,000 for Medicare covered services. As secondary payer, Medicare pays the lower of:

- The Medicare gross payment amount (without regard to the deductible or coinsurance) minus the amount paid by the primary payer for Medicare covered services: $3,300 - $3,000 = $300;

- The Medicare gross payment amount (without regard to deductible or coinsurance) minus any applicable Medicare deductible and/or coinsurance amounts: $3,300 - $233 - *$613.40 = $2,453.60;

- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $3,500 - $3,000 = $500; or

- The HHA's charges minus any applicable Medicare deductible and/or coinsurance amounts: $3,500 - $233 - *$613.40 = $2,653.60.

*The coinsurance is calculated as follows:

$3,300 fee schedule amount - $233 deductible = $3,067 x 20% = $613.40 coinsurance.

Medicare pays $300. The HHA may not charge the beneficiary since the deductible and coinsurance were met by the primary payer's payment. (For the Provider Statistical and Reimbursement Report (PS&R,) the A/B MAC (Part A) records $233 deductible, $613.40 coinsurance and $2,260 primary payer's payment.)

EXAMPLE 8: HHA Accepted Amount Less Than Charges

Same facts as in Example 7 except the HHA agreed to accept $3,200 from the primary payer and the primary payer paid $3,100 due to the deductible requirement under its plan. The amount the HHA is obligated to accept as payment in full ($3,200) is considered by Medicare to be the HHA's charges in this situation. As secondary payer, Medicare pays the lower of:

- The Medicare gross payment amount (without regard to the deductible or coinsurance) minus the amount paid by the primary payer for Medicare covered services: $3,300 - $3,100 = $200;
- The Medicare gross payment amount (without regard to the deductible or coinsurance) minus any applicable Medicare deductible and/or coinsurance amounts: $3,300 - $233 - $613.40* = $2,453.60;

- The HHA's charges minus the amount paid by the primary payer for Medicare covered services: $3,200 - $3,100 = $100; or

- The HHA's charges minus any applicable Medicare deductible and/or coinsurance amounts: $3,200 - $233 - $613.40* = $2353.60.

*See Example 7 for coinsurance calculation.

Medicare pays $100. The beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment. (For the PS&R, the A/B MAC (Part A) records $100 deductible, $640 coinsurance and $2,360 primary payer payment.)

40.8.4 – Provider Interim Payment (PIP) Reduction

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

For providers on PIP (see Pub. 100-04, Chapter 3, section 150.18, Provider Interim Payment), the A/B MAC (Part A) reduces the PIP amount for prospective payments or interim payments (for non-PPS providers) to reflect any excess of the primary payment amount over the applicable deductible and coinsurance amount. Where Medicare is determined not to have any liability, the A/B MAC (Part A) reduces the PIP amount to reflect that no interim payment is due. Where Medicare is determined to be secondarily liable, the A/B MAC (Part A) reduces the PIP amount to reflect any excess of the primary payment over the applicable deductible and coinsurance. Any reduction in PIP payments is accomplished by offsetting against the next payment or by taking estimated reductions into account in establishing the PIP payment level. All adjustments resulting from primary payment amounts are reflected only in the PIP payment level.

NOTE: No reduction is made to the PIP amount with regard to conditional payments since in these situations' payment is made, although conditionally, as if Medicare were fully liable for the stay.

If the applicable Medicare deductible and coinsurance or the primary payment amount exceeds the total prospective payment amount, the A/B MAC (Part A) subtracts the excess from prospective payments due the hospital for other discharges. It does not adjust biweekly payments for direct graduate medical education activities and for items that are paid on a reasonable cost basis as a result of primary payment amounts. Biweekly payment is the method by which these amounts are paid on an interim basis for both PPS-PIP and PPS non-PIP hospitals. (See PRM Part I, §2405.2 and 2405.3.) A primary payment amount in excess of the total prospective payment amount for a particular discharge need not be, identified to, and subtracted from, the biweekly payments because the hospitals cost report provides for subtraction of total primary payments from the aggregate of all Medicare payments otherwise due.

40.8.5 - MSP Part B Claims (Outpatient and Other Part B Services, Home Health Part B and Ancillary Services When Part A Benefits are Exhausted)

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

These provisions apply to outpatient and other Part B services, Home Health Part B and ancillary services for individuals who have exhausted their Part A benefits.

If payment by the primary payer for Medicare covered services (as determined by the formula above) equals or exceeds the provider's charges for those services or the current Medicare gross payment amount (without regard to the deductible or coinsurance) or the provider accepts, or is obligated to accept, the primary payer's payment as payment in full and it receives at least this amount and the provider knows the individual has already met the outpatient deductible, no bill is submitted. However, a bill is submitted where the deductible may not yet be met. Although Medicare can make no payment, the expenses can be applied to the beneficiary's deductible. The provider completes the bill according to the instructions in the Medicare Claims Processing Manual. In addition, the provider determines the charges as usual, including those covered by the primary payer's payment.

The charges shown in total charges are treated as noncovered for payment purposes. When the primary payer amount satisfies the claim in full, the A/B MAC (Part A) does not record the deductible, coinsurance, or charges on the PS&R.

EXAMPLE 1: Primary Payer's Payment Is Less Than Unmet Deductible

A Medicare beneficiary incurred $300 of covered charges for outpatient services. No part of the beneficiary's $233 Part B deductible had been met. The primary payer paid $200 for Medicare covered services. The current Medicare gross payment (without regard to the deductible or coinsurance) for these services is $250. As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $250 - $200 = $50;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $250 - $233 = $17;

- The provider's charges minus the primary payer's payment: $300 - $200 = $100; or
- The provider's charges minus the applicable Medicare deductible and coinsurance: $300 - $233 = $67.

*The coinsurance is calculated as follows:

300 charges - $233 deductible = $67 x 20% = $13.40

Medicare pays $17. The beneficiary's liability is $46.40 ($33.00 for the deductible and $13.40 for the coinsurance.

The beneficiary's $233 deductible is satisfied$200 by the primary payer's payment and $33.00 by the beneficiary.

(For the PS&R, the A/B MAC (Part A) records $233 deductible and $13.40 coinsurance.)

EXAMPLE 2: Primary Payer's Payment Is More Than Unmet Deductible

Same facts as in Example 1 except the primary payer's payment for Medicare covered services is $250:

As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $250 - $250 = $0;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $250 - $233 - $13.40 = $3.60;

- The provider's charges minus the primary payer's payment: $300 - $250 = $50; or

- The provider's charges minus the applicable Medicare deductible and coinsurance: $300 - $233 - $13.40 = $53.60.

(*See Example 1 for coinsurance calculation.)
Medicare pays $0. The provider may not charge the beneficiary since the deductible and coinsurance were met by the primary payer's payment. (For the PS&R, the A/B MAC (Part

A) records $233 deductible, $13.40 coinsurance, and $3.60 primary payment which totals to the primary payer's payment of $250.

EXAMPLE 3: Primary Payer's Payment Equals Unmet Deductible

Same facts as in Example 1 except the primary payer's payment for Medicare covered services is $233:

As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $250 - $233 = $17;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $250 - $233 - $13.40* = $3.60;

- The provider's charges minus the primary payer's payment: $300 - $233 = $67; or

- The provider's charges minus the applicable Medicare deductible and coinsurance: $300 - $233 - $13.40 = $53.60

(*See Example 1 for coinsurance calculation.)

Medicare pays $3.60. The provider may bill the beneficiary $13.40 for coinsurance. The $233 Medicare deductible is satisfied by the primary payer's payment. For the PS&R, the Part A/B MAC (Part A) records $233 Medicare deductible and $13.40 coinsurance.

EXAMPLE 4: Deductible Met Prior To Primary Payer's Payment

Same facts as in Example 1, except the deductible has been met.

As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $250 - $200 = $50;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare coinsurance: $250 - $60* = $190; $

- The provider's charges minus the primary payer's payment: $300 - $200 = $100; or

- The provider's charges minus the applicable Medicare coinsurance: $300 - $60* = $240.

*The coinsurance is calculated as follows:

$300 charges x 20% = $60 coinsurance.

Medicare pays $90. The hospital may not charge the beneficiary since the coinsurance is paid by the primary payer's payment. (For the PS&R, the A/B MAC (Part A) records $60 coinsurance and $140 primary payer payment which totals the $200 primary payer payment.)

EXAMPLE 5: Amount Provider Accepted Less Than Charges

A Medicare beneficiary incurred $450 covered charges for outpatient services, and the current Medicare gross payment amount (without regard to the deductible and coinsurance) was $400. The primary payer paid $300 due to a deductible requirement under its plan. The amount the provider is obligated to accept as payment in full ($350) is considered by Medicare to be the provider's charges in this situation. As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $400 - $300 = $100;

- The current Medicare gross payment amount (without regard to deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $400 - $233 - $43.40* = $123.60;

- The OTAF amounts minus the primary payer's payment: $350 - $300 = $50; or

- The OTAF amounts minus the applicable deductible and coinsurance: $350 - $233 = $117 - $43.40 = $73.60.

*The coinsurance is calculated as follows:
$450 charges - $233 = $217 x 20% = $43.40 coinsurance.

Medicare pays $50. The provider may not charge the beneficiary since the beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment. (For the PS&R report, the A/B MAC (Part A) records $233, deductible, $43.40 coinsurance and $23.60 primary payment which equals the $300 primary payment.

EXAMPLE 6: ESRD Services

An ESRD beneficiary received eight dialysis treatments for which a facility charged $500 $160 per treatment for a total of $4,000. No part of the beneficiary's $233 Part B deductible had been met. The primary payer paid $2,000 for Medicare covered services. The Medicare payment per dialysis treatment at this facility is $257 or $2,056 for 8 treatments. There is no OTAF identified on the claim. As secondary payer, Medicare pays the lowest of:

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the primary payer's payment: $2,056 - $2,000 = $56;

- The current Medicare gross payment amount (without regard to the deductible or coinsurance) minus the applicable Medicare deductible and coinsurance: $2,056 - $233 - $364.60* = $1,458.40;

- The provider's charges minus the primary payer's payment: $4,000 - $2,000 = $2,000; or
- The provider's charges minus the applicable deductible and coinsurance: $4,000 - $233 - $364.60* = $3,402.40.

*The coinsurance is calculated as follows:

$2,056 Medicare payment - $233 Medicare deductible = $1,823 x 20% = $364.60 coinsurance.

Medicare pays $56. The provider may not charge the beneficiary since the beneficiary's Medicare deductible and coinsurance were satisfied by the primary payer's payment. (For the PS&R, the A/B MAC (Part A) records $233 Medicare deductible, $354.60 coinsurance, and $1,412.40 primary payment which totals the $2,000 primary payment.

EXAMPLE 7: ESRD PPS Bundled Payment for Services

An individual received 6 dialysis treatments over a one-month period for which an independent facility charged $500 per treatment. The facility bills on a monthly basis. The ESRD PPS payment rate for these services is $257.90 per treatment. The beneficiary's $233 Part B deductible was previously met. The primary payer paid $200 per visit for a total of $1,200 paid for the 6 Medicare covered services. No OTAF is identified on the claim. As secondary payer, Medicare pays the lowest of:

- The ESRD PPS Bundled Rate (without regard to the deductible or coinsurance) minus the primary payer's payment: $1,547.40 - $1,200 = $347.40;

- The ESRD PPS Bundled Rate for the separately billable services (without regard to the deductible or coinsurance) minus the applicable coinsurance: $1,547.40 - $309.48* = $1,237.92;

- The provider's charges minus the primary payer's payment: $3,000 - $1,200 = $1,800; or

- The provider's charges minus the applicable Medicare coinsurance: $3,000 - $309.48* = $2,690.52.

*The coinsurance is calculated as follows:

$1,547.40 (ESRD PPS Payment) x 20% = $309.48 coinsurance.

Medicare pays $347.40. The facility may not charge the beneficiary since the coinsurance was met by the primary payer's payment. (For the PS&R, the A/B MAC (Part A) records $309.48 coinsurance and $890.52 primary payment which totals the $1,200 primary payment.)

40.8.6 - MSP Outpatient Claims Involving Lab Charges Paid by Fee Schedule

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The following procedures describe how to prorate primary payments for MSP outpatient claims that include charges for clinical diagnostic lab services (paid on the basis of 100 percent of a fee schedule) and charges for non-lab services (subject to the regular deductible and coinsurance requirement) when a primary payer pays in part for the services, without designating how much of its payment is for each type of service.

40.8.6.1 - Prorating Primary Payments

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MAC (Part A) prorates the undesignated primary payer's payment for Medicare covered services by applying a ratio of this payment between lab and non-lab charges on the bill to determine what portion of the primary payer's payment is attributable to the non-lab charges. Note, the ratio and payment can be done by sending the claim to the MSPPAY module for payment calculation.

NOTE: This ratio is based upon Medicare billed charges and not Medicare's payment under the fee schedule.

40.8.6.2 - Calculation of Deductible and Coinsurance

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The A/B MAC (Part A) calculates deductible and coinsurance in the usual manner after applying the primary payer's payment allocated for non-lab services. See examples below for calculation of coinsurance.

EXAMPLE 1: Deductible Previously Met

Outpatient services were furnished to a Medicare beneficiary for whom the provider billed $100 for lab services and $200 for emergency room services. The lab fee schedule amount for the $100 lab services is $70. The beneficiary's Part B deductible was previously met. The primary payer paid $150 for Medicare covered services without designating what portion of its payment was for each type of service. Since the ratio of lab charges to non-lab charges is $100/$200, the A/B MAC (Part A) divides the primary payer's payment of $150 into two amounts based upon the same ratio: $100/$200 = $50/$100. It applies $50 of the primary payer's payment to the $70 lab fee schedule amount and the remaining $100 to the $200 in non-lab charges (emergency room services). It calculates the coinsurance in the usual manner based upon the $200 non-lab charges. It does not charge coinsurance since the primary payment of $100 allocated to non-lab charges is greater than the $40 coinsurance on the $200 in non-lab charges. (For the PS&R, the A/B MAC (Part A) records $40 coinsurance and $60 primary payment.)

EXAMPLE 2: Deductible Not Met

Outpatient services were furnished to a Medicare beneficiary for whom the provider billed $100 for lab services and $200 for emergency room services. The lab fee schedule amount for the $100 lab services is $70. Only $158.00 of the beneficiary's Part B deductible had been met previously leaving the remaining $75.00 to be met. The primary payer paid $150 for Medicare covered services without designating what portion of its payment was for each type of service. Since the ratio of lab charges to non-lab charges is $100/$200, the A/B MAC (Part A) divides the primary payer's payment of $150 into two amounts based upon the same ratio: $100/$200 = $50/$100. It applies $50 of the primary payer's payment to the $70 lab fee schedule amount and the remaining $100 to the $200 in non-lab charges (emergency room services). It calculates the deductible and coinsurance in the usual manner based upon the $200 non-lab charges. It does not charge any deductible or coinsurance since the primary payment of $100 allocated to non-lab charges is equal to the $25 coinsurance and $75 remaining deductible on the $200 in non-lab charges. (For the PS&R, the A/B MAC (Part A) records $75 deductible and $25 coinsurance.)

40.8.7 - Calculating Medicare Secondary Payments When Proper Claim Has Not Been Filed With Third Party Payer

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A "proper claim" means one that is filed timely and meets all other filing requirements specified by the third party payer (e.g., mandatory second opinion, prior notification before seeking treatment).

When a provider, or a beneficiary who is not physically or mentally incapacitated, receives no third party payment, or 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 third party payer had paid on the basis of a proper claim. The A/B MAC (Part A) calculates this amount with the rules in §30.5.1, except that the phrase "the amount the third party would have paid for Medicare covered services if a proper claim

had been filed with the third party" is substituted for the phrase "amount payable by the third party for Medicare covered services."

The provider must inform CMS that the third party payer has made no payment, or a reduced payment, and the amount that the third party payer would have been paid if a proper claim had been filed. If the A/B MAC (Part A) makes a greater secondary payment because the provider fails to provide such notice, and it is later discovered that the third party made no payment, or paid a reduced amount, because of failure to file a proper claim, the difference between the Medicare payment and the amount Medicare should have paid, on the basis of a proper claim for third party payment, is an overpayment. The A/B MAC (Part A) recovers this amount in accordance with the instructions in Pub 100-05, Chapter 7.

However, when failure to file a proper claim is attributable to the physical or mental incapacity of the beneficiary, the A/B MAC (Part A) 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.

EXAMPLE: A beneficiary receives services for which a hospital's charges are $10,000. The primary payer would pay $9,900 on a properly filed claim. However, the primary payer requires that the beneficiary submit a second opinion regarding the medical need for a hospital admission as a condition for filing a proper claim. Since the beneficiary failed to do so, the primary payer reduced its payment by 50 percent; i.e., the plan paid $4,950. Medicare determines its secondary payment, in this case, as if the primary payer had paid on the basis of a proper claim. The Medicare gross payment amount (total prospective payment amount without regard to deductible and coinsurance amount) is $10,000. The secondary payment is calculated as follows:

A. The Medicare gross payment amount minus the applicable Medicare deductible amount:

$10,000 - $676 = $9,324.

B. The Medicare gross payment amount minus the amount the primary payer would have paid on the basis of a proper claim:

$10,000 - $9,900 = $100.

C. The hospital's charges (or an amount the hospital is obligated to accept as payment in full), minus the amount the primary payer would have paid on the basis of a proper claim:

$10,000 = $9,900 = $100.

D. The hospital's charges (or an amount the hospital is obligated to accept as payment in full), minus the applicable Medicare deductible and/or coinsurance amounts:

$10,000 - $676 = $9,324.

E. Medicare pays $100 (lowest of amounts in steps 1, 2, 3, or 4).

The beneficiary can be billed $4,950 by the hospital (the amount of the primary payer reduction).

40.8.8 - Determining Patient Utilization Days, Deductible, and Coinsurance Amounts

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Where a primary payer pays an amount for Medicare covered services that is equal to or less than the deductible and coinsurance that would apply if Medicare was the primary payer, Medicare charges full utilization. Therefore, it calculates coinsurance in the usual manner.

Where a primary payer pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare were the primary payer, Medicare charges utilization only to the extent that it paid for the services.

The MSP payment modules calculate days to be charged to the beneficiary's utilization. The A/B MAC (Part A) reports the result in the in the appropriate field of the CWF record as described in CWF documentation. The procedures below describe how utilization and coinsurance are charged.

If payment by the primary payer for Medicare covered services is less than the provider's charges for those services and the current Medicare payment amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the primary payer payment as payment in full, the A/B MAC (Part A) follows the procedures below to determine utilization and coinsurance applicable.

Where the stay involves coinsurance days, the A/B MAC (Part A) determines utilization chargeable to the beneficiary. It completes coinsurance value codes and amounts accordingly. No adjustment to covered days is made based on this determination. The provider completes covered days in the usual manner.

The A/B MAC (Part A) charges utilization as follows:

- It determines the Medicare secondary payment amount in accordance with §§30.5.1 or 30.5.2 above;

- It divides this amount by the amount that Medicare would have paid as primary payer. This is the Medicare interim payment for the stay reduced by the deductible and coinsurance for non-PPS providers or the Medicare payment rate reduced by deductible and coinsurance for PPS providers; and

- It multiplies this percentage by the number of covered days in the stay or for PPS providers, the number of payable days in the stay.

The A/B MAC (Part A) does not charge a partial day resulting from this calculation as a full day if it is less than a half of a day. It charges a full day if it is a half day or more. For PPS providers, where the number of payable days in the stay exceeds the number of days for which benefits are available (e.g., benefits are exhausted during the nonoutlier portion of the stay), the number of utilization days charged may not exceed the actual days available. If regular benefit days are exhausted during the basic portion of the stay and lifetime days are used for the outlier portion of the stay, the A/B MAC (Part A) separately computes the chargeable days for each portion of the stay.

The A/B MAC (Part A) charges coinsurance days as follows:

- If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed; or

- If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, A/B MACs (Part A) must perform the same calculation to verify that coinsurance Value Codes and Amounts are completed correctly. The A/B MAC (Part A) advises the provider of any discrepancies.

EXAMPLE 1: Deductible Involved - PPS (no outlier involved) or Non-PPS Hospital

An individual was hospitalized 15 days for which total charges were $5,000. The primary payer paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $764 had been met. The Medicare gross payment amount (without regard to the deductible or coinsurance) for the services absent the primary payer's payment would have been $3,600. The Medicare secondary payment is $1,200 ($3,600 - $2,400). Medicare would have paid $2,836 as primary payer ($3,600 - $764). The A/B MAC (Part A) calculates the beneficiary's utilization as follows: $1,200 divided by $2,836 = .423 x 15 days = 6.34 or 6 days, when rounded.

EXAMPLE 2: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

An individual was hospitalized for 20 days (all of which are lifetime reserve days) for which total charges were $20,000. The primary payer paid $13,000 for Medicare

covered services. The applicable coinsurance amount was $ 7,640. The current Medicare interim payment amount (without regard to the deductible or coinsurance) for the services, absent the primary payer's payment, would have been $17,000. The Medicare secondary payment amount is $4,000 (the Medicare gross payment amount of $17,000 minus the primary payer's payment of $13,000). Medicare would have paid $9,360 as primary payer ($17,000 - $7,640). The A/B MAC (Part A) calculates the beneficiary's utilization as follows: $4,000 divided by $ $9,360 = .427 x 20 days = 8.5 or 9 days when rounded. If the primary payer's payment in this example had been $7,640 or less, full utilization would have been charged. The beneficiary would have been charged with 20 days utilization.

EXAMPLE 3: Primary Payer Pays for Specified Number of Days - PPS (no outlier involved) or Non-PPS Hospital

The A/B MAC (Part A) uses this formula even when the primary payer pays for only a specified number of days of a stay because of a payment limitation under the plan based upon the number of benefit days available. For example, a provider furnished 20 days of inpatient care. The primary payer paid all of the charges for the first 10 days. These charges were $4,500. No part of the Medicare inpatient deductible of $764 had been met. The current Medicare gross payment amount (without regard to the deductible or coinsurance) that Medicare would have paid for the 20-day stay, absent primary payer coverage, was $7,000. The Medicare secondary payment is $2,500 ($7,000 - $4,500). Medicare would have paid $ 6,236 as primary payer ($7,000 - $764). The A/B MAC (Part A) calculates the utilization charged to the beneficiary as follows: $2,500 divided by $6,236 = .400 X 20 days = 8.01 days or 8, days when rounded.

EXAMPLE 4: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

A beneficiary has 17 full days available at admission. The inpatient stay was 20 days. The provider bills 20 days in Covered Days (form locator 7 of the Form CMS-1450) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed.

Absent any other insurer's payment, three days are billed in form locator 9 (Coinsurance Days) with Value Code 9 or 11 and Value Amount in form locator 39 (Coinsurance Value Code and Amount) and 20 days are in the "Cost Report Days" field of the CWF record.

EXAMPLE 5: Coinsurance Involved - PPS (no outlier involved) or Non-PPS Hospital

A beneficiary has 30 coinsurance days available at admission. The hospital stay was 20 days. The provider bills 20 days in Covered Days (form locator 7) as if there were no other payer involved. After performing the calculation to determine utilization

chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed.

Absent any other insurer's payment, 20 days are billed in form locator 9 (Coinsurance Days) with Value Code 9 or 11 and the Value Amount in form locator 39 (Coinsurance Value Code and Amount).

The A/B MAC (Part A) enters 10 days in the "Coinsurance Days" field and the "Cost Report Days" field of the CWF Record.

Absent any other insurer's payment, 20 days are billed in form locator 9 (Coinsurance Days) with Value Code 9 or 11 and the Value Amount in form locator 39 (Coinsurance Value Code and Amount).

In this case, the A/B MAC (Part A) enters 20 days in the "Coinsurance Days" field and the "Cost Report Days" field of the CWF record.

EXAMPLE 6: PPS Hospital

A beneficiary enters the hospital with two lifetime reserve days (LTR) remaining and elects to use them. The beneficiary is discharged after 15 days before the outlier threshold is reached. The Medicare payment rate is $5,000. The primary payer amount for Medicare covered services is $3,000. The applicable coinsurance amount is $764 (2 LTR days at $382 a day). Medicare would have paid $4,236 as primary payer ($5,000 - $764).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Utilization days potentially chargeable equal:

$2,000 divided by $4,236 X 15 days = 7 days

In this case, charge only the actual days of coverage in the stay, or two days, for utilization and cost reporting purposes.

EXAMPLE 7: PPS Hospital - Stay

A beneficiary enters the hospital with two regular coinsurance days remaining and is discharged after 15 days. The primary payer amount for Medicare covered services (i.e., the entire stay) was $3,000. The Medicare payment rate is $5,000. The applicable coinsurance amount is $396 (2 coinsurance days at $198 a day). Medicare would have paid $4,604 as primary payer ($5,000 - $396).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Regular benefit days chargeable =

$2,000 divided by $4,604 X 10 days in basic portion of stay = 7 days

Charge the beneficiary two coinsurance days, since only two days were available.

Lifetime reserve days chargeable =

$2,000 divided by $2,708 X 5 days in outlier portion of stay = 3.6 rounded to 4 days.

Charge the beneficiary for lifetime reserve days and determine coinsurance on this basis.

40.8.9 - Benefits Exhausted Situations When Medicare Is Secondary Payer for Reasonable Cost Providers

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

If Medicare has secondary liability for an inpatient stay, services that would otherwise not be covered because the beneficiary had exhausted benefits may be covered after the impact of the primary payment on utilization is determined. Since the primary payment extends the covered portion of the beneficiary's stay, it affects Medicare covered charges in situations where benefits are exhausted. At the same time, the ratio of Medicare covered charges to total charges determines the portion of the primary payment that is allocated to Medicare covered services. The A/B MAC (Part A) considers the primary payment's effect upon Medicare covered services before allocating the primary payment.

To determine Medicare covered charges in benefits exhausted situations in other than a PPS hospital, the A/B MAC (Part A) proceeds as in the example below, in which Medicare benefits were exhausted after the seventh hospital day. For PPS hospitals, see §40.8.8.

EXAMPLE:

Total Charges	$5,000
Medicare Covered Charges (without regard to benefits exhausted)	$4,500
Medicare Covered Charges for Day 1-7	$3,000
Primary Payment (unallocated)	$3,000
Remaining Benefit Days	3
Covered Medicare Days (without regard to benefits exhausted)	10
Current Medicare Payment Rate	$ 480

Step 1. The A/B MAC (Part A) determines what the current Medicare payment would be if benefits were not exhausted (and no primary payments were involved).

EXAMPLE:

$480 X 10 days = $4,800

Step 2. The A/B MAC (Part A) determines the amount of the primary payment that would apply to Medicare services if benefits were not exhausted.

- If the primary payer's allocation can be determined, the A/B MAC (Part A) uses

it.

EXAMPLE:

The primary payer's explanation of benefits indicates that the $3,000 primary payment was for the first 5 days of the stay. Medicare, in the absence of a primary payer would have paid $3,000 for 7 days. Since the primary payer paid for 5 of the 10 days of the stay, Medicare has responsibility for the 5 remaining days. Medicare would have covered $3,000 for 7 days. It covers 5/7 of $3,000, or $2,143 for the 5 days for which it is responsible.

- If the primary payer's allocation cannot be determined, the A/B MAC (Part A) applies a ratio of Medicare covered charges (without regard to benefits exhausted) to total charges for the stay to the total primary payment to determine the portion that would be attributable to Medicare.

EXAMPLE:

$4,500 / $5,000 X $3,000 = $2,700

Step 3. The A/B MAC (Part A) determines the Medicare secondary payment that would be made in the absence of benefits exhausted (without regard to deductible or coinsurance) by subtracting Step 2 from Step 1.

EXAMPLE:

$4,800 - $2,700 = $2,100

Step 4: The A/B MAC (Part A) determines the benefit days that would be chargeable absent benefits exhausted by applying a ratio of Step 3 to Step 1 to the number of Medicare covered days without regard to benefits exhausted.

EXAMPLE:

$2,100 / $4,800 X 10 = 4.375

Step 5: The A/B MAC (Part A) determines the number of days for which benefits are actually available.

EXAMPLE: 3 days

Step 6: If the number of days in Step 5 is greater than the number of days in Step 4, the primary payment extends Medicare coverage over the entire stay. The case no longer involves benefits exhaustion. All otherwise covered days and charges are reported as covered for statistical and payment purposes. The amount in Step 3 is the Medicare secondary payment (without regard to the deductible or coinsurance) and the number of days determined in Step 4 are charged to the beneficiary's utilization record.

Step 7: If the number of days in Step 5 is less than the number of days in Step 4, the beneficiary does not have sufficient benefit days available to cover the entire stay. The A/B MAC (Part A) proceeds as follows:

- It charges the days in Step 5 to the beneficiary's utilization record.

EXAMPLE: 3 days

- It multiplies the number of Medicare covered days without regard to benefits exhausted by the ratio of the number of days in Step 5 to the number of days in Step 4 to determine the days recorded as covered for statistical purposes.

EXAMPLE:

3 / 4.375 X 10 = 6.86 = 7 days

Charges for days 1-7 are shown as covered on the bill. Charges for days 8-10 are reported as noncovered.

- The A/B MAC (Part A) re-determines the allocation of the primary payer's payment for covered services based upon the revised Medicare covered charges.

EXAMPLE:

$3,000 / $5,000 X $3,000 = $1,800

- The A/B MAC (Part A) determines Medicare current interim payment for days recorded as covered for statistical purposes.

EXAMPLE:

$480 X 7 days = $3,360

- The A/B MAC (Part A) determines Medicare's secondary payment.

EXAMPLE:

$3,360 - $1,800 = $1,560

40.8.10 - Deductible and/or Coinsurance Rates Spanning Two Calendar Years

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Where Medicare is secondarily liable because another payer primary to Medicare has made payment on an inpatient claim and the stay spans two calendar years, the provider bills the deductible and/or coinsurance rate applicable to the year in which Medicare utilization is charged. Medicare utilization (calculated in accordance with the above instruction) is charged beginning with the first day of the stay. This rule applies even though the primary payer paid for only a specified number of days of a stay, e.g., the primary payer's plan covers the first 20 days of a 30-day stay.

Where Medicare utilization involves coinsurance days spanning two calendar years, the provider bills coinsurance for each coinsurance day in accordance with the applicable coinsurance rate for the year in which the day was used. The provider uses value codes 09 and 11, form locators 39 through 41, to show specific coinsurance amounts. See CWF documentation for reporting coinsurance days on the CWF record.

EXAMPLE l:

A beneficiary is in a new benefit period and was admitted to the hospital on December 15, 2021, and discharged on January 14, 2022. An insurer primary to Medicare paid the first 20 days of the stay. The provider bills the $1,484.00 deductible (the applicable deductible for the first year in which Medicare utilization is charged).

EXAMPLE 2:

A beneficiary was admitted to the hospital on December 15, 2021, and discharged on January 14, 2022. Only coinsurance days were available. An insurer primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 15 thru December 24). The provider bills 10 days coinsurance at the 2021 rate ($371 x 10 = $3,710). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are used.

EXAMPLE 3:

A beneficiary was admitted to the hospital on December 25, 2021, and discharged on January 24, 2021. Only coinsurance days were available. An insurer primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 25, 2021

thru January 3, 2022). The provider bills 7 days coinsurance at the 2021 rate ($371 x 7 = $2,597) and 3 days coinsurance at the 2022, rate ($389 x 3 = $1,167). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are used. The data is reported on the Form CMS-1450 as follows:

- Value Code 09, Medicare Coinsurance Amount in First Calendar Year = $2,597;

- Value Code 11, Medicare Coinsurance Amount in Second Calendar Year = $1,167;

- Form Locator 9, Coinsurance Days =10

40.8.11 - Submit Data to CWF When Full Payment Made by Primary Payer

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Rules concerning submitting data to CWF if the Medicare payment amount is zero are as follows:

- If the MSP payment module determines that the Medicare payment amount is zero, A/B MACs and DME MACs do NOT complete the nonpayment code;

- The "Utilization Days" field of the CWF record contains the days the MSP payment module determines to be charged to the beneficiary's utilization record. If the Medicare payment amount is zero, this figure must also be zero;

- The "Cost Report Days" field of the CWF record contain zero days;

- The "Value Code" field in the value data portion of the CWF record contains the appropriate value code to identify the primary payer. (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 25, §70 and 75, Field Locators 39-41, for appropriate value codes.);

- The "Value Amount" field in the value data portion of the CWF record contains the amount Medicare would have paid in the absence of the primary payer's payment. (The A/B MAC (Part A) does **NOT** record this amount on the PS&R.);

- The A/B MAC (Part A) does not record days or charges on the PS&R; and,

- The A/B MAC (Part A) submits the bill to CMS in accordance with CWF documentation.

The CMS uses data reported in the blood deductible and inpatient deductible items to update deductibles. (This data is not used for the PS&R.)

40.8.12 - Submit Data to CWF When Partial Payment Made by Primary Payer

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs (Part A) submit data concerning the patient's utilization days, deductible, coinsurance amounts and MSP payment amounts to CWF. Utilization days used and deductible and coinsurance amounts satisfied are determined in the MSP payment modules after calculation of the Medicare payment amount.

The "Utilization Days" field of the CWF Record contains the days to be charged to the beneficiary's Medicare utilization record as determined above.

The "Value Code" fields of the CWF Record identify the coinsurance and amount charged the beneficiary as well as an MSP type of primary payer and the primary payer amount.

Value code 44 and the amount are entered on the CWF Record in the appropriate fields (see CWF Documentation). Value code 44 indicates the amount the provider is obligated to accept as payment in full from the primary payer and this amount is greater than the amount paid by the primary payer for Medicare covered services entered by the provider in the identifying primary payer value code.

For the PS&R, the A/B MAC (Part A) records the primary payment amount minus any deductible or coinsurance amounts.

50 - MSP Pay Modules to Calculate Medicare Secondary Payment Amount

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Payment Modules are used to calculate the Medicare secondary payment amount. The calculation is based on information from the claim, payment calculation amounts and the primary insurer's explanation of benefits data for hardcopy claims.

The A/B MACs (Part A), A/B MACs (Part B), and A/B MACs (Part HHH) (collectively referred to as A/B MACs) and the DME MACs, through the shared systems, send the appropriate data which includes submitted charges, the other payer allowed amount (Part B claims only), the other payer paid amount, the obligated to accept in full (OTAF) amount, and Medicare’s fee schedule amount to the MSP payment modules, identified below, to calculate the secondary payment amount.

50.1 - Medicare Secondary Payer (MSP) Payment Modules (MSPPAY) for Carriers Medicare Secondary Payer (MSP) Payment Modules (MSPPAY) for A/B MACs (Part B) and DME MACs

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Introduction

The Part B MSPPAY modules are standardized software A/B MACs (Part B) and DME MACs must use to calculate the secondary payment amount. This ensures consistent MSP payment calculations. The calculations performed by these modules are in accordance with 42 CFR 411.33. Updates to these modules including technical documentation are furnished by CMS, as required.

50.1.1 - Payment Calculation Processes for MSP Claims

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

For a valid Medicare secondary payer Part B claim, the Part B MSPPAY module performs the following payment calculation processes:

- Apportions the primary payer's paid amount, the other payer's allowed amount and obligated to accept as payment in full (if applicable), based on the ratio computed by the total amount billed for each service divided by the total billed amount, if line item information is not supplied by the primary payer.

- Computes the Medicare secondary payment amount for assigned and unassigned claims by line; and

Computes Medicare secondary savings.

50.1.2 - MSPPAY "Driver" Module

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSPPAY makes the determination based on the service "thru-date" on the claim to call one of the following MSP sub-modules to process the payment calculations. All MSP claims are calculated based on the MSP regulations effective November 13, 1989.

A. MSPPAYB

Calculates payment for Medicare Part B claims. It accepts the limiting charge and the 115 percent limit on fee schedule amounts for nonparticipating physicians for Medicare Part B claims and calculates payment for Medicare Part B claims by line service.

B. MSPPAYBL

Accepts data from MSPPAY, if the claim is at the aggregate level, and apportions the primary payer's allowed amount for each service and how much the primary payer paid for each service based on the ratio computed by the amount billed for each service divided by the total billed amount. It calls MSPPAYB to calculate the claim by line.

The MSPPAY receives claim data from the A/B MACs (Part B) system and does the following:

A. Performs validity edits on the sending field THRU-DATE:

- Century value must be "19" or "20."
- Year value must be "00" thru "99."
- Month value must be "01" thru "12."
- Day value must be "01" thru "31."

B. Performs validity edits on the sending field RECORD-ID:

- HMBC = Part B claim; or,
- HMBL = Part B claim by line;

C. Calls the appropriate MSP payment sub-modules:

- MSPPAYB for claim service THRU-DATE with RECORD-ID of HMBC; or,
- MSPPAYBL for claim service THRU-DATE with RECORD-ID HMBL

D. Returns appropriate status codes along with the Medicare secondary payment computation and savings data to the A/B MACs (Part B) system. See §50.1.3 for an explanation of return codes.

Once MSPPAY passes information to the A/B MACs **(**Part B) claims processing system, it can be retrieved in any format desired, e.g., savings reports, management tools, and MSN generation. The reports can be tailored to the A/B MACs **(**Part B) specific needs.

50.1.3 - Return Codes

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

One of the following codes is returned to the A/B MAC (Part B) system, which indicates the results from processing secondary payment computation and savings.

These codes are also referenced in the technical documentation released with the MSPPAY modules.

Return Code	Description
3010	Claim is fully paid
3020	Claim is partially paid
3030	Line of service denied
3500	Invalid MSP value code
3510	Invalid number of other payers
3520	Non-numeric MSP amount
3530	MSP amount equals zeros
3540	Invalid record identification
3545	Non-numeric Gramm-Rudmann-Hollings percent
3560	Non-numeric blood deductible
3570	Non-numeric cash deductible
3700	Non-numeric total coinsurance amount
3730	Non-numeric Medicare primary payment
3780	Non-numeric provider payment amount
3790	Non-numeric patient payment amount
3800	Invalid assignment indicator
3805	Invalid par indicator
3810	Non-numeric other payer allowed amount
3820	Non-numeric charges not subject to deductible and coinsurance
3830	Non-numeric charges subject to deductible

Return Code	Description
3840	Non-numeric psychiatric charges
3880	Invalid "thru-date" of claim
3890	Non-numeric Medicare reasonable charge/fee schedule
3910	Non-numeric obligated to accept
3920	Non-numeric total actual charges
3930	Non-numeric limited fee
3940	Non-numeric limited charge
3950	Limited fee equal zeros
3960	Limited charge equal zeros

50.1.4 - Executing and Testing MSPPAY Software

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs (Part B) and DME MACs receive the MSP software through their standard system along with the Medicare Secondary Payment Technical Manual documenting, and describing the execution of the MSPPAY Module(s). The input data elements and output data elements required are referenced in these manuals. The Medicare Integrated Systems Testing (MIST) contractor is responsible for testing and verifying the accuracy of the MSPPAY software when updates are implemented. A/B MACs (Part B) and DME MACs also test the MSPPAY software independently and review the results.

50.1.5 - Carrier MSPPAY Processing Requirements

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The following processing requirements apply:

- Process all MSP physician/supplier claims through the MSPPAY software to determine MSP payment amount, at the line level, where applicable, deductible, coinsurance, and savings;
- Claims processed by MSPPAY must be in ready-to-pay status, e.g., the amount that Medicare would have paid as the primary payer, the type of MSP situation, the amount of the primary insurer's payment, information regarding outstanding deductible and coinsurance must be available to MSPPAY; and
- All data elements required by MSPPAY must be passed to it. Section 50.1.7.A lists these data elements. The Medicare Secondary Payment Technical Manual also contains additional information about them.

- The shared systems must accept MSP claims for services at the line level including incoming charges, the OTAF amount, the other payer allowed and paid amounts for incoming MSP claims at the line level.

- Forward the service line level amounts to the MSPPAY Module for payment calculation.

- Receive the MSP payment at the line level when the completed calculations are returned to the system from the MSPPAY module.

50.1.6 - Error Resolution

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs (Part B) and DME MACs are responsible for resolving error conditions reflected as return codes. These return codes are identified in §50.1.3 above and in the Medicare Secondary Payment Technical Manual. It is easier to resolve error conditions by turning on the test switch provided in the software and printing the displays.

After reviewing the displays, the A/B MACs (Part B) and DME MACs should forward any unresolved error conditions and displays to the CMS MSP Coordinator in the MAC's region. The A/B MAC (Part B) and DME MAC includes any additional documentation that may assist in resolving the error.

50.1.7 - Payment Calculation for Physician/Supplier Claims (MSPPAYB Module)

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSPPAYB module performs the necessary payment calculation for physician/supplier claims.

A. Data Elements to send to MSPPAYB

MSPPAY must send the following data elements to MSPPAYB:

NO.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software display sending and returning data. Used to identify payment problems.	"T" = display send/return data Space = do not display data.
2	THRU DATE	Ending service date of the period included on the claim (CCYYMMDD)	Supplied by A/B MAC (Part B) system from the claim.
		THRU DATE CC	Value = "19" or "20"

NO.	Field Name	Definition/Use	Source/Value
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
3	RECORD ID	Identifies the claim type.	Part B = "HMBC"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by A/B MAC (Part B) system from the claim
5	DOC CNTL NUM	Assigned document control number.	Assigned and supplied by A/B MAC (Part B) system.
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by A/B MAC (Part B) system. Values: Y = Fully Paid Space = Not Fully Paid
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by A/B MAC (Part B) system Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data	Supplied by A/B MAC (Part B) system. May occur up to 10 times.
	MSP CODE	Code(s) identifying the other payer: 12 = EGHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers" Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Based on information obtained from the claim or from third party-payer information submitted with the claim, i.e., explanation of benefits.
	MSP AMOUNT	Amount(s) paid by the other payer.	Third party payer explanation of benefits
9	TOTAL ACTUAL CHARGES	Total charges billed by the physician/supplier.	Total Charges billed on the professional claim.
10	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer.	Third party payer explanation of benefits

NO.	Field Name	Definition/Use	Source/Value
11	OTHER PAYER ALLOWED AMT.	Covered charges allowed by the third party payer.	Third party payer explanation of benefits
12	MEDICARE REASONABLE CHG & FEE SCHEDULE	The Medicare reimbursement amount excluding applicable deductible and coinsurance.	Computed and supplied by A/B MAC (Part B) system.
13	FILLER		Nine Value Spaces
14	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare.	Zero for Medicare Part B
15	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Supplied by A/B MAC (Part B) system.
16	FILLER		Sixty-eight value spaces
17	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by A/B MAC (Part B) system.
18	FILLER		Six value spaces
19	Assignment Indicator	An indicator that identifies if the claim is assigned or unassigned.	From the claim.
20	FILLER		Twenty-eight value spaces
21	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by A/B MAC (Part B) system.
22	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by A/B MAC (Part B) system.
23	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by A/B MAC (Part B) system.
24	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by A/B MAC (Part B) system.
25	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Compute and supplied by A/B MAC (Part B) system.
26	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by A/B MAC (Part B) system.

NO.	Field Name	Definition/Use	Source/Value
27	PSYCH CHARGES	Allowed psychiatric charges.	Computed and supplied by A/B MAC (Part B) system.
28	PAR INDICATOR		Supplied by A/B MAC (Part B) system "P" = Par Provider "N" = No-Par Provider
29	LIMITED FEE NON-PAR		Computed and supplied by A/B MAC (Part B) system
30	LIMITED CHARGES UNASSIGNED		Computed and supplied by A/B MAC (Part B) system
31	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred seventy nine value spaces.
32	RESERVED FOR USER	Space reserved for user as necessary.	One hundred ninety value spaces.

B. MSPPAYB Returning Data Elements

MSPPAYB will return the following data elements to MSPPAY. Refer to section A above for field definitions not reflected below.

NO.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.

No	Field Name	Definition/Use
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to CWF.
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF
4	FILLER	Seventy-seven value spaces
5	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the CWF.
6	FILLER	Nine value spaces
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
8	PROVIDER PAYMENT AMT	

No	Field Name	Definition/Use
9	PATIENT PAYMENT AMT	
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
13	FILLER	Three value spaces
14	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
15	GROSS MEDICARE PAYMENT	The amount Medicare pays as primary excluding deductibles and coinsurance.
16	FILLER	Nine value spaces.
17	SAVINGS MSP GHP	Amount saved by Medicare when an GHP has made a payment for a working aged beneficiary (MSP Code 12).
18	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
19	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
20	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
21	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
22	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).
23	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
24	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).
25	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
26	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment.

No	Field Name	Definition/Use
		Includes all MSP codes 12 - 16, 41 - 43, and 47.
27	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41, and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
28	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, and 42. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
29	MSP COMPUTATION 1	The result of: the total actual charge by the physician/supplier, or the limiting charge (if the claim is unassigned), or an amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer for covered services.
30	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
31	MSP COMPUTATION 3	The result of the higher of the primary payer's allowed or the Medicare allowed minus the amount paid by the primary payer. The Medicare allowed and the primary payer's allowed are determined without regard to the Medicare or primary plan's deductible or coinsurance, respectively.
32	FILLER	Nine value spaces
33	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)
34	RESERVED FOR USER	Space Reserved for User as Necessary. (153 value spaces)

50.1.8 - Payment Calculation for Physician/Supplier Claims (MSPPAYBL)

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The sub-module performs the necessary payment calculation, on a by-line basis, for physician/supplier claims with service "thru-dates" on or after April 1, 1998.

A. MSPPAYBL Sending Data Elements.

MSPPAY must send the following data to MSPPAYBL:

No.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software display sending and returning data. Used to identify payment problems.	"T" = display send/return data; Space = do not display data
2	FILLER		8 value spaces
3	RECORD ID		Identification of Part B type claim being processed = "HMBL"
4	CLMNO	Health Insurance Claim Number	Supplied by the A/B MAC (Part B) system.
5	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the A/B MAC (Part B) system
6	FILLER		1 value space
7	APPORTION SWITCH	Determine whether to apportion the Other Payer's Allowed Amount and Payment Amount	Supplied by the A/B MAC (Part B) system "N" = do not apportion Space = do apportion
8	TOTAL ACTUAL CHARGES		Supplied by the A/B MAC (Part B) system
9	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare	Supplied by the A/B MAC (Part B) system. Valid value '01' thru '10'

NOTE: THE FOLLOWING FIELDS WILL OCCUR 13 TIMES

No.	Field Name	Definition/Use	Source/Value
10	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data. MSP Code - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal disease) 14 = AUTO (Automobile/No-Fault) 15 = Work (Worker's Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = Liab (Liability)	Based on information obtained from the claim, third party information submitted with the claim, i.e., explanation of benefits or appropriate electronic data elements. Supplied by the A/B MAC (Part B) system. May occur up to 10 times.
	MSP AMOUNT	Amount(s) paid by the other payer.	
11	OTHER PAYER ALLOWED AMT	Covered charges allowed by the third party payer.	Third Party Payer explanation of benefits
12	NUMBER OF LINES	Number of lines to compute MSP amounts.	Supplied by the A/B MAC (Part B) system
13	RESERVED FOR CMS	Space reserved for future enhancements.	124 value spaces
14	RESERVED FOR USER	Space reserved for user as necessary.	100 value spaces
15	LINE NUMBER	Line of service number.	Supplied by the A/B MAC (Part B) system. Values "01" thru "13"
16	DENIED INDICATOR	Indicator that reflects whether Medicare or the other A/B MAC (Part B) denied the line of service.	Supplied by the A/B MAC (Part B) system "D" = Line of service denied by the other A/B MAC (Part B) and/or Medicare. Space = Line of service accepted for payment by the other A/B MAC (Part B) and/or Medicare.
17	FILLER		One value space
18	THRU DATE	Ending service date of the period included on the claim (CCYYMMDD) THRU DATE CC THRU DATE YY THRU DATE MM	Supplied by the A/B MAC (Part B) system from Field 24 of the Form CMS-1500 Value = "19" or "20" Value = "00" thru "99" Value = "01" thru "12"

No.	Field Name	Definition/Use	Source/Value
		THRU DATE DD	Value = "01" thru "31"
19	RECORD ID	Identifies the claim type.	Part B = "HMBL"
20	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the A/B MAC (Part B) system from Field 1a of the Form CMS-1500
21	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the A/B MAC (Part B) system
22	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the A/B MAC (Part B) system "Y" = Fully paid by other payer Space = Not fully paid by other payer
23	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare	Supplied by the A/B MAC (Part B) system Valid value "01" thru "10"
24	THIRD PARTY PAYER TABLE	MSP code(s) and MSP amount comprise third party data.	Based on information obtained from the claim. Third party information submitted with the claim, i.e., explanation of benefits or appropriate electronic data elements.
25	MSP CODE	Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal disease) 14 = AUTO (Automobile/No-Fault) 15 = Work (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Supplied by the A/B MAC (Part B) system. May occur up to 10 times
26	MSP AMOUNT	Amount(s) paid by the other payer.	Third party payer explanation of benefits
27	TOTAL ACTUAL CHARGES	Total charges billed by the physician/supplier.	Form CMS-1500, Field 28
28	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full when this amount is less than the charges but higher than the	Third party payer explanation of benefits

No.	Field Name	Definition/Use	Source/Value
		payment received from the primary payer.	
29	OTHER PAYER ALLOWED AMT	Covered charges allowed by the third party payer.	Third party payer explanation of benefits
30	MEDICARE REASONABLE CHG &FEE SCHEDULE	The Medicare reimbursement amount excluding applicable deductible and coinsurance.	Computed and supplied by the A/B MAC (Part B) system.
31	FILLER		Nine value spaces
32	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare.	Zero for Medicare Part B
33	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Supplied by the A/B MAC (Part B) system.
34	FILLER		Sixty-eight value spaces
35	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the A/B MAC (Part B) system.
36	FILLER		Six value spaces
37	ASSIGNMENT INDICATOR	An indicator that identifies if the claim is assigned or unassigned.	From the claim "A" = Assigned claim "B" = Non-assigned claim
38	FILLER		Twenty eight value spaces
39	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the A/B MAC (Part B) system.
40	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the A/B MAC (Part B) system.
41	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the A/B MAC (Part B) system.
42	G-R-H PERCENT (GRAMM-RUDMANN - HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the A/B MAC (Part B) system.

No.	Field Name	Definition/Use	Source/Value
43	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the A/B MAC (Part B) system.
44	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the A/B MAC (Part B) system.
45	PSYCH CHARGES	Allowed psychiatric charges.	Computed and supplied by the A/B MAC (Part B) system.
46	PAR INDICATOR	Indicator reflecting whether the provider participates in the Medicare program.	Supplied by the A/B MAC (Part B) system. "P" = Par Provider "N" = Non-Par Provider
47	LIMITED FEE NON-PAR	The fee amount paid to a nonparticipating provider.	Computed and supplied by the A/B MAC (Part B) system.
48	LIMITED CHARGES UNASSIGNED	The charge for each service on unassigned claims.	Computed and supplied by the A/B MAC (Part B) system if LC on the claim exceeds more than 115% of Medicare fee schedule amount.
49	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred seventy nine value spaces.
50	RESERVED FOR USER	Space reserved for user as necessary.	One hundred ninety value spaces.

B. MSPPAYBL Returning Data Elements.

MSPPAYBL will return the following data to MSPPAY:

No	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.
2	HEADER OR LINE ERROR	Reflects if an error was detected at the claim header or line when computing MSP by line.	Determined by MSPPAYBL: "H" = Header Error "L" = Line Error

No	Field Name	Definition/Use	Source/Value
3	LINE NUMBER OF ERROR	Reflects the line of service an error was detected.	
4	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).	
5	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF	
6	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File.	
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.	
8	PROVIDER PAYMENT AMT	Medicare's secondary payment computed by the MSP software.	
9	PATIENT PAYMENT AMT	Medicare's secondary payment computed by the MSP software.	
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
13	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
14	SAVINGS MSP GHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
15	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	
16	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
17	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
18	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	

No	Field Name	Definition/Use	Source/Value
19	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
20	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
21	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
22	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
23	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	
24	RESERVED FOR CMS	Space reserved for future enhancements. (123 value spaces)	
25	RESERVED FOR USER	Space reserved for user as necessary. (118 value spaces)	

NOTE: THE FOLLOWING FIELDS WILL OCCUR 13 TIMES

26	LINE NUMBER	Line of service number
27	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.

NOTE: The Source/Value is determined by MSPPAYB Valid values "3000" thru "3999" (See §40.1.3 above; also refer to the technical and user documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.

No	Field Name	Definition
28	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the CWF
29	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the CWF.
30	FILLER	(77 value spaces)
31	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the CWF.
32	FILLER	(9 value spaces)
33	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
34	PROVIDER PAYMENT AMT	Reimbursement paid to the provider.
35	PATIENT PAYMENT AMT	Reimbursement paid to the patient.

No	Field Name	Definition/Use	Source/Value
36	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
37	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
38	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
39	FILLER	(3 value spaces)	
40	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
41	GROSS MEDICARE PAYMENT	The amount Medicare pays as primary excluding deductibles and coinsurance.	
42	FILLER	(36 value spaces)	
43	SAVINGS MSP GHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
44	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	
45	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
46	SAVINGS MSP WORK	Amount saved by Medicare when Workers' compensation payment has been made (MSP Code 15).	
47	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
48	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
49	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
50	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
51	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
52	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	
53	FILLER	Eighteen value spaces	
54	MSP COMPUTATION 1	The result of the total actual charge by the physician/supplier, or the limiting charge (if the claim is unassigned), or an amount the physician/supplier is obligated to accept as payment in full, if that is less than the charges, minus the amount paid by the primary payer for covered services.	

No	Field Name	Definition/Use	Source/Value
55	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.	
56	MSP COMPUTATION 3	The result of the higher of the primary payer's allowed or the Medicare allowed minus the amount paid by the primary payer. The Medicare allowed and the primary payer's allowed are determined without regard to the Medicare or primary plan's deductible or coinsurance, respectively.	
57	FILLER	Nine value spaces	
58	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)	
59	RESERVED FOR USER	Space reserved for user as necessary. (153 value spaces)	

50.2 - Medicare Secondary Payer (MSP) Payment Modules (MSPPAY) for Part A MACs

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Introduction

The Part A MSPPAY modules are standardized software A/B MACs (Part A) must use to calculate MSP bill payment. This ensures consistent MSP payment calculations. The calculations performed by these modules are in accordance with regulations 42 CFR 411.33. (See Chapter 1, §10.8 and this chapter, §30.3.1, and §30.5. Updates to these modules including technical documentation are furnished by CMS, as required.

50.2.1 - Payment Calculation Processes for MSP Claims

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The following payment calculation processes are performed for a complete Medicare secondary payer bill.

- Apportions the primary payer's paid amount and obligated to accept as payment in full (if applicable), for outpatient services, based on the ratio computed by the Total Medicare Covered Charges for each service line divided by the Total Medicare Covered Charges;

- Computes the Medicare secondary payment amount, applicable deductible, and coinsurance amounts;
- Reduces benefit utilization (if applicable); and

- Computes Medicare secondary savings.

MSPPAY is the "driver" module in the above processes.

50.2.2 - MSPPAY "Driver" Module
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSPPAY, the "Driver Module," makes the determination based on the service "thru-date" on the bill to call one of the following MSP sub-modules to process the payment calculations:

A. MSPPAYAI

MSPPAYAI calculates payment for inpatient, skilled nursing facility (SNF), and religious nonmedical health care (RNHC) bill types.

B. MSPPAYOL

MSPPAYOL calculates payment at the service line level for outpatient bill types. (See §50.2.8). Accepts data from MSPPAY and apportions the primary payer's paid amount and obligated to accept as payment in full (if applicable) based on the ratio computed by the Total Medicare Covered Charges for each service line divided by the Total Medicare Covered Charges. It calls MSPPAYAO to calculate the claim by line.

C. MSPPAYAO

MSPPAYAO calculates payment for outpatient, home health agency (HHA), and hospice bill types MSPPAY receives bill data from the A/B MACs (Part A) and A/B MACs (HHH) system and performs the following processes:

A. Performs validity edits on the sending field "THRU-DATE"

- Century value must be "19" or "20"
- Year value must be "00" thru "99."
  - Month value must be "01" thru "12."
  - Day value must be "01" thru "31."

B. Performs validity edits on the sending field RECORD-ID

- HMIP = Inpatient/SNF/CSS bills
- HMOL = Outpatient claims by line
- HMOP = Outpatient bills
- HMHH = Home health bills
- HMHC = Hospice claim

C. Calls the appropriate MSP payment sub-modules

- MSPPAYAI for bill service with RECORD-ID of HMIP; and
- MSPPAYAO for bill service with RECORD-ID of HMOP, HMHH, or HMHC
- MSPPAYOL for claim service with RECORD-ID of HMOL

D. Returns appropriate status codes along with the MSP computation and savings data to the A/B MACs (Part A) system

See §50.2.3 below for an explanation of return codes.

Once MSPPAY passes back information to the A/B MACs (Part A) and A/B MACs (HHH) claims processing system, the data can be retrieved in any format desired, e.g., savings reports, management tools, and MSN generation. The reports can be tailored to the A/B MACs (Part A) specific needs.

50.2.3 - Return Codes

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

One of the following return codes indicates the results from processing secondary payment computation and savings. These codes are also referenced in the technical documentation released with the MSPPAY modules.

Return Code	Description
3010	Claim is fully paid
3020	Claim is partially paid
3030	Line of service denied
3500	Invalid MSP value code
3510	Invalid number of other payers
3520	Non-numeric MSP amount
3530	MSP amount equals zeros
3540	Invalid record identification
3545	Non-numeric Gramm-Rudmann-Hollings percent
3550	Non-numeric total covered charges
3560	Non-numeric blood deductible
3570	Non-numeric cash deductible
3700	Non-numeric total coinsurance amount
3730	Non-numeric Medicare primary payment
3780	Non-numeric provider payment amount
3790	Non-numeric patient payment amount
3820	Non-numeric charges not subject to deductible and coinsurance
3830	Non-numeric charges subject to deductible
3850	Invalid from date of claim
3880	Invalid "thru-date" of claim

3900	Non-numeric Medicare payment amount
3910	Non-numeric obligated to accept
3580	Non-numeric regular coinsurance days 1st year
3590	Non-numeric regular coinsurance rate 1st year
3600	Non-numeric regular coinsurance amount 1st year
3610	Non-numeric regular coinsurance days 2nd year
3620	Non-numeric regular coinsurance rate 2nd year
3630	Non-numeric regular coinsurance amount 2nd year
3640	Non-numeric life-time reserve days 1st year
3650	Non-numeric life-time reserve rate 1st year
3660	Non-numeric life-time reserve amount 1st year
3670	Non-numeric life-time reserve days 2nd year
3680	Non-numeric life-time reserve rate 2nd year
3690	Non-numeric life-time reserve amount 2nd year
3710	Non-numeric full days
3720	Non-numeric covered days
3740	Invalid PPS indicator
3750	Non-numeric DRG amount
3760	Non-numeric direct graduate medical education
3770	Non-numeric pass thru per diem amount
3920	Non-numeric regular coinsurance days 3rd year
3930	Non-numeric regular coinsurance rate 3rd year
3940	Non-numeric regular coinsurance amount 3rd year
3950	Non-numeric regular coinsurance days 4th year
3960	Non-numeric regular coinsurance rate 4th year

3965	Non-numeric regular coinsurance amount 4th year
3985	Non-numeric regular coinsurance days 5th year
3990	Non-numeric regular coinsurance rate 5th year
4000	Non-numeric regular coinsurance amount 5th year
4010	Non-numeric regular coinsurance days 6th year
4020	Non-numeric regular coinsurance rate 6th year
4030	Non-numeric regular coinsurance amount 6th year
4040	Non-numeric life-time reserve days 3rd year
4050	Non-numeric life-time reserve rate 3rd year
4060	Non-numeric life-time reserve amount 3rd year
4070	Non-numeric life-time reserve days 4th year
4080	Non-numeric life-time reserve rate 4th year
4090	Non-numeric life-time reserve amount 4th year
4100	Non-numeric life-time reserve days 5th year
4110	Non-numeric life-time reserve rate 5th year
4120	Non-numeric life-time reserve amount 5th year
4130	Non-numeric life-time reserve days 6th year
4140	Non-numeric life-time reserve rate 6th year
4150	Non-numeric life-time reserve amount 6th year
4160	Non-numeric regular coinsurance days 7th year
4170	Non-numeric regular coinsurance rate 7th year
4180	Non-numeric regular coinsurance amount 7th year
4190	Non-numeric regular coinsurance days 8th year
4200	Non-numeric regular coinsurance rate 8th year
4210	Non-numeric regular coinsurance amount 8th year
4220	Non-numeric regular coinsurance days 9th year
4230	Non-numeric regular coinsurance rate 9th year
4240	Non-numeric regular coinsurance amount 9th year
4250	Non-numeric regular coinsurance days 10th year
4260	Non-numeric regular coinsurance rate 10th year
4270	Non-numeric regular coinsurance amount 10th year
4280	Non-numeric regular coinsurance days 11th year
4290	Non-numeric regular coinsurance rate 11th year
4300	Non-numeric regular coinsurance amount 11th year
4310	Non-numeric regular coinsurance days 12th year
4320	Non-numeric regular coinsurance rate 12th year
4330	Non-numeric regular coinsurance amount 12th year
4340	Non-numeric regular coinsurance days 13th year
4350	Non-numeric regular coinsurance rate 13th year
4360	Non-numeric regular coinsurance amount 13th year
4370	Non-numeric regular coinsurance days 14th year
4380	Non-numeric regular coinsurance rate 14th year
4390	Non-numeric regular coinsurance amount 14th year
4400	Non-numeric regular coinsurance days 15th year
4410	Non-numeric regular coinsurance rate 15th year
4420	Non-numeric regular coinsurance amount 15th year

4430	Non-numeric life-time reserve days 7th year
4440	Non-numeric life-time reserve rate 7th year
4450	Non-numeric life-time reserve amount 7th year
4460	Non-numeric life-time reserve days 8th year
4470	Non-numeric life-time reserve rate 8th year
4480	Non-numeric life-time reserve amount 8th year
4490	Non-numeric life-time reserve days 9th year
4500	Non-numeric life-time reserve rate 9th year
4510	Non-numeric life-time reserve amount 9th year
4520	Non-numeric life-time reserve days 10th year
4530	Non-numeric life-time reserve rate 10th year
4540	Non-numeric life-time reserve amount 10th year
4550	Non-numeric life-time reserve days 11th year
4560	Non-numeric life-time reserve rate 11th year
4570	Non-numeric life-time reserve amount 11th year
4580	Non-numeric life-time reserve days 12th year
4590	Non-numeric life-time reserve rate 12th year
4600	Non-numeric life-time reserve amount 12th year
4610	Non-numeric life-time reserve days 13th year
4620	Non-numeric life-time reserve rate 13th year
4630	Non-numeric life-time reserve amount 13th year
4640	Non-numeric life-time reserve days 14th year
4650	Non-numeric life-time reserve rate 14th year
4660	Non-numeric life-time reserve amount 14th year
4670	Non-numeric life-time reserve days 15th year
4680	Non-numeric life-time reserve rate 15th year
4690	Non-numeric life-time reserve amount 15th year

50.2.4 - Installation

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs (Part A) and A/B MACs (HHH) utilize the MSP software through its shared system. A/B MACs (Part A) and A/B MACs (HHH) also receive a copy of the Medicare Secondary Payment technical manuals documenting and describing installation and execution of the MSPPAY module(s). The input data elements and output data elements required are referenced in these manuals. The Medicare Integrated Systems Testing (MIST) contractor is responsible for testing and verifying the accuracy of the MSPPAY software when updates are implemented. A/B MACs (Part A) and A/B MACs (HHH) also test the MSPPAY software independently and review the results .

50.2.5 - Part A Processing Requirements

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The following processing requirements apply:

- The A/B MACs (Part A) and A/B MACs (HHH) processes all MSP inpatient hospital, SNF, HHA bills through the MSPPAY software to determine MSP payment amount, deductible, coinsurance, and savings.

- The A/B MACs (Part A) and A/B MACs (HHH) processes all MSP outpatient bills through the MSPPAY software, at the line level, to determine MSP payment amount, deductible, coinsurance, and savings.

- Bills processed by MSPPAY must be in ready-to-pay status, e.g., the amount that Medicare would have paid as the primary payer, the type of MSP situation, the amount of the primary insurer's payment, information regarding outstanding deductible and coinsurance must be available to MSPPAY; and

- All data elements required by MSPPAY must be passed to it. Sections 50.2.7.A and 50.2.8.A list these data elements. The Medicare Secondary Payment Technical manuals also contain additional information about them.

50.2.6 - Error Resolution
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs (Part A) and A/B MACs (HHH) are responsible for resolving error conditions reflected as return codes. These return codes are identified in **§50.2.3** above and in the Medicare Secondary Payment Technical manuals. It is easier to resolve error conditions by turning on the test switch provided in the software and printing the displays.

After reviewing the displays, if the A/B MAC (Part A) and A/B MAC (HHH) is still unable to resolve an error condition, it forwards these displays to its shared system's representative. It includes any additional documentation that may assist in resolving the error.

50.2.7 - Payment Calculation for Inpatient Bills (MSPPAYAI Module)
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSPPAYAI performs the necessary payment calculation for inpatient, skilled nursing facility (SNF), and Religious Nonmedical Health Care (RNHC) bills.

A. Data Elements to send to MSPPAYAI

MSPPAY must send the following data elements to MSPPAYAI

No.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software to display sending and returning data. Use to identify payment errors.	"T" = display send/return data; Space = do not display data.

No.	Field Name	Definition/Use	Source/Value
2	THRU DATE	Ending service date of the period included on the bill (CCYYMMDD)	Supplied by the A/B MAC (Part A) system from the claim
		THRU DATE CC	Value = "19" thru "20"
		THRU DATE YY	Value = "00" thru "99"
		THRU DATE MM	Value = "01" thru "12"
		THRU DATE DD	Value = "01" thru "31"
3	RECORD ID	Identifies the bill type.	Inpatient (including SNF/CSS) bills = "HMIP"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the A/B MAC (Part A) system from the claim
5	DOC CNTL NUM	Assigned document control number	Assigned and supplied by the A/B MAC (Part A) system
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the A/B MAC (Part A) system. Can be identified by an "O" frequency indicator in Type of Bill. Also identified by Condition Code "77". Value Y = Fully Paid Space = Not Fully Paid
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by the A/B MAC (Part A) system. Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE	MSP code and MSP amount comprise primary payer data.	Supplied by the A/B MAC (Part A) system. Values = "01" thru "10"

No.	Field Name	Definition/Use	Source/Value
	MSP CODE	Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability)	Value Codes 12-16 and 41-47 from the claim
	MSP AMOUNT	Amount(s) paid by the other payer.	Value Amounts from the claim
9	TOTAL COVERED CHARGES	Total charges covered by Medicare	Total Covered Charges from the claim
10	OBLIGATED TO ACCEPT	The amount a provider agrees to accept as payment in full when this amount is less than the charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" or CAS group code CO amount, appears on the bill. It is reported in addition to the MSP Code(s) and MSP amounts(s) and the total covered charges on the bill.	Value Code "44" or CAS group code CO amount, from the claim
11	FILLER		Eighteen value spaces.
12	MED PAYMENT AMOUNT	Medicare payment without regard to deductibles and coinsurance.	Computed and supplied by the A/B MAC (Part A) system.
13	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare	Value Code 06 from the claim

No.	Field Name	Definition/Use	Source/Value
14	CASH DEDUCTION	Dollar amount of cash deductible charged by Medicare.	Value Code 07 from the claim
15	REG COIN DAYS 1ST YR	Medicare coinsurance days charged in the year of admission.	Computed and supplied by the A/B MAC (Part A) system
16	REG COIN RATE 1ST YR.	The Medicare coinsurance rate charged in the year of admission.	Computed and supplied by the A/B MAC (Part A) system.
17	REG COIN AMT 1ST YR	The Medicare coinsurance amount charged in the year of admission.	Value Code 09 from the claim
18	REG COIN DAYS 2ND YR	Medicare coinsurance days charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the A/B MAC (Part A) system.
19	REG COIN RATE 2ND YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the A/B MAC (Part A) system.
20	REG COIN AMT 2ND YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.	Value Code 11 from the claim
21	REG COIN DAYS 3RD YR	Medicare coinsurance days charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the A/B MAC (Part A) system.
22	REG COIN RATE 3RD YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the A/B MAC (Part A) system.
23	REG COIN AMT 3^{RD} YR	The Medicare coinsurance amount charged in the year	Value Code 11 from the claim

No.	Field Name	Definition/Use	Source/Value
		of discharge where the bill spans three calendar years.	
24	REG COIN DAYS 4TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the A/B MAC (Part A) system.
25	REG COIN RATE 4th YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the A/B MAC (Part A) system.
26	REG COIN AMT 4TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans four calendar years.	Value Code 11 from the claim
27	REG COIN DAYS 5TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the Computed and supplied by the A/B MAC (Part A) system.
28	REG COIN RATE 5TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the A/B MAC (Part A) system.
29	REG COIN AMT 5TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans five calendar years.	Value Code 11 from the claim
30	REG COIN DAYS 6TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the A/B MAC (Part A) system.
31	REG COIN RATE 6TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the A/B MAC (Part A) system.
32	REG COIN AMT 6TH YR	The Medicare coinsurance amount charged in the year	Value Code 11 from the claim

No.	Field Name	Definition/Use	Source/Value
		of discharge where the bill spans six calendar years.	
33	REG COIN DAYS 7TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans seven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
34	REG COIN RATE 7TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans seven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
35	REG COIN AMT 7TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans seven calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
36	REG COIN DAYS 8TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans eight calendar years.	Computed and supplied by the A/B MAC (Part A) system.
37	REG COIN RATE 8TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans eight calendar years.	Computed and supplied by the A/B MAC (Part A) system.
38	REG COIN AMT 8TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans eight calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
39	REG COIN DAYS 9TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans nine calendar years.	Computed and supplied by the A/B MAC (Part A) system.
40	REG COIN RATE 9TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans nine calendar years .	Computed and supplied by the A/B MAC (Part A) system.
41	REG COIN AMT 9TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans nine calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11

No.	Field Name	Definition/Use	Source/Value
42	REG COIN DAYS 10TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans ten calendar years.	Computed and supplied by the A/B MAC (Part A) system.
43	REG COIN RATE 10TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans ten calendar years.	Computed and supplied by the A/B MAC (Part A) system.
44	REG COIN AMT 10TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans ten calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
45	REG COIN DAYS 11TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans eleven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
46	REG COIN RATE 11TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans eleven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
47	REG COIN AMT 11TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans eleven calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
48	REG COIN DAYS 12TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans twelve calendar years.	Computed and supplied by the A/B MAC (Part A) system.
49	REG COIN RATE 12TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans twelve calendar years.	Computed and supplied by the A/B MAC (Part A) system.

No.	Field Name	Definition/Use	Source/Value
50	REG COIN AMT 12TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans twelve calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
51	REG COIN DAYS 13TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans thirteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
52	REG COIN RATE 13TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans thirteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
53	REG COIN AMT 13TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans thirteen calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
54	REG COIN DAYS 14TH YR	Medicare coinsurance days charged in the year of discharge where the bill spans fourteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
55	REG COIN RATE 14TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans fourteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
56	REG COIN AMT 14TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans fourteen calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
57	REG COIN DAYS 15TH YR	Medicare coinsurance days charged in the year of	Computed and supplied by the A/B MAC (Part A) system.

No.	Field Name	Definition/Use	Source/Value
		discharge where the bill spans fifteen calendar years.	
58	REG COIN RATE 15TH YR	The Medicare coinsurance rate charged in the year of discharge where the bill spans fifteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
59	REG COIN AMT 15TH YR	The Medicare coinsurance amount charged in the year of discharge where the bill spans fifteen calendar years.	Form CMS-1450 (UB-92), form Locators 39-41, Value Code 11
60	LTR COIN DAYS 1ST YR	Medicare lifetime reserve days charged in the year of admission.	Computed and supplied by the A/B MAC (Part A) system.
61	LTR COIN RATE 1ST YR	The Medicare lifetime reserve rate charged in the year of admission.	Computed and supplied by the A/B MAC (A) system.
62	LTR COIN AMT 1ST YR	The Medicare lifetime reserve amount charged in the year admission.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 08
63	LTR COIN DAYS 2ND YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the A/B MAC (Part A) system.
64	LTR COIN RATE 2ND YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans two calendar years.	Computed and supplied by the A/B MAC (Part A) system.
65	LTR COIN AMT 2ND YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11

No.	Field Name	Definition/Use	Source/Value
66	LTR COIN DAYS 3RD YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the A/B MAC (Part A) system.
67	LTR COIN RATE 3RD YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans three calendar years.	Computed and supplied by the A/B MAC (Part A) system.
68	LTR COIN AMT 3RD YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans three calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
69	LTR COIN DAYS 4TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the A/B MAC (Part A) system.
70	LTR COIN RATE 4TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans four calendar years.	Computed and supplied by the A/B MAC (Part A) system.
71	LTR COIN AMT 4TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans four calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
72	LTR COIN DAYS 5TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the A/B MAC (Part A) system.
73	LTR COIN RATE 5TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans five calendar years.	Computed and supplied by the A/B MAC (Part A) system.

No.	Field Name	Definition/Use	Source/Value
74	LTR COIN AMT 5TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans five calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
75	LTR COIN DAYS 6TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the A/B MAC (Part A) system.
76	LTR COIN RATE 6TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans six calendar years.	Computed and supplied by the A/B MAC (Part A) system.
77	LTR COIN AMT 6TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans six calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
78	LTR COIN DAYS 7TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans seven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
79	LTR COIN RATE 7TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans seven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
80	LTR COIN AMT 7TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans seven calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
81	LTR COIN DAYS 8TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans eight calendar years .	Computed and supplied by the A/B MAC (Part A) system.

No.	Field Name	Definition/Use	Source/Value
82	LTR COIN RATE 8TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans eight calendar years.	Computed and supplied by the A/B MAC (Part A) system.
83	LTR COIN AMT 8TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans eight calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
84	LTR COIN DAYS 9TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans nine calendar years.	Computed and supplied by the A/B MAC (Part A) system.
85	LTR COIN RATE 9TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans nine calendar years.	Computed and supplied by the A/B MAC (Part A) system.
86	LTR COIN AMT 9TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans nine calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
87	LTR COIN DAYS 10TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans ten calendar years.	Computed and supplied by the A/B MAC (Part A) system.
88	LTR COIN RATE 10TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans ten calendar years.	Computed and supplied by the A/B MAC (Part A) system.
89	LTR COIN AMT 10TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans ten calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11

No.	Field Name	Definition/Use	Source/Value
90	LTR COIN DAYS 11TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans eleven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
91	LTR COIN RATE 11TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans eleven calendar years.	Computed and supplied by the A/B MAC (Part A) system.
92	LTR COIN AMT 11TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans eleven calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
93	LTR COIN DAYS 12TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans twelve calendar years.	Computed and supplied by the A/B MAC (Part A) system.
94	LTR COIN RATE 12TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans twelve calendar years.	Computed and supplied by the A/B MAC (Part A) system.
95	LTR COIN AMT 12TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans twelve calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
96	LTR COIN DAYS 13TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans thirteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
97	LTR COIN RATE 13TH YR	The Medicare lifetime reserve rate charged in the	Computed and supplied by the A/B MAC (Part A) system.

No.	Field Name	Definition/Use	Source/Value
		year of discharge where the bill spans thirteen calendar years.	
98	LTR COIN AMT 13TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans thirteen calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
99	LTR COIN DAYS 14TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans fourteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
100	LTR COIN RATE 14TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans fourteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
101	LTR COIN AMT 14TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans fourteen calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11
102	LTR COIN DAYS 15TH YR	Medicare lifetime reserve days charged in the year of discharge where the bill spans fifteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
103	LTR COIN RATE 15TH YR	The Medicare lifetime reserve rate charged in the year of discharge where the bill spans fifteen calendar years.	Computed and supplied by the A/B MAC (Part A) system.
104	LTR COIN AMT 15TH YR	The Medicare lifetime reserve amount charged in the year of discharge where the bill spans fifteen calendar years.	Form CMS-1450 (UB-92) form locators 39-41, Value Code 11

No.	Field Name	Definition/Use	Source/Value
105	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the A/B MAC (Part A) system.
106	FULL DAYS	The inpatient Medicare days occurring in the first 60 days in a single spell of illness.	Computed and supplied by the A/B MAC (Part A) system.
107	COVERED DAYS	The number of Medicare covered days.	Form CMS-1450 (UB-92) form locator 7
108	FILLER		One value space
109	PPS IND	An indicator that identifies a prospective payment provider.	Supplied by Part A system: X = PPS S = CSS (non-PPS), Spaces = non-PPS
110	DRG AMOUNT	Total prospective payment amount including any outlier payment, as determined by Pricer.	Computed by Pricer and supplied by the A/B MAC (Part A) system
111	DIRECT GRADUATE MEDICAL EDUCATION	Estimated adjustment for the direct graduate medical education activities (See 42 CFR 413.86.)	Computed and supplied by the A/B MAC (Part A) system.
112	PASS THRU PER DIEM	Payment amount for those items that are reimbursed on a reasonable cost basis.	Computed and supplied by the A/B MAC (Part A) system.
113	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the A/B MAC (Part A) system.
114	PROVIDER PAYMENT AMOUNT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the A/B MAC (Part A) system.
115	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the A/B MAC (Part A) system.
116	G-R-H PERCENT (GRAMM-	The applicable percent reduction required by the	Supplied by the A/B MAC (Part A) system.

No.	Field Name	Definition/Use	Source/Value
	RUDMANN-HOLLINGS)	Gramm-Rudmann-Hollings Act.	
117	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the A/B MAC (Part A) system.
118	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the A/B MAC (Part A) system.
119	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred ninety eight value spaces.
120	RESERVED FOR USER	Space reserved for user as necessary.	One-hundred ninety value Spaces

B. Data Elements returned from MSPPAYAI

MSPPAYAI will return the following data elements to MSPPAY. Refer to §50.2.7 for field definitions not reflected below.

NO.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAI. Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical documentation released with the software.

Unless specified otherwise, MSPPAY is the source of all the following fields, possibly modified by MSPPAYAI.

NO.	Field Name	Definition/Use
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the Common Working File (CWF).
4	REG COIN DAYS 1ST YR	
5	REG COIN RATE 1ST YR	

6. REG COIN RATE 1ST YR

7 REG COIN DAYS 2ND YR
8 REG COIN RATE 2ND YR
9 REG COIN AMT 2ND YR
10 REG COIN DAYS 3RD YR
11 REG COIN RATE 3RD YR
12 REG COIN AMT 3RD YR
13 REG COIN DAYS 4TH YR
14 REG COIN RATE 4TH YR
15 REG COIN AMT 4TH YR
16 REG COIN DAYS 5TH YR
17 REG COIN RATE 5TH YR
18 REG COIN AMT 5TH YR
19 REG COIN DAYS 6TH YR
20 REG COIN RATE 6TH YR
21 REG COIN AMT 6TH YR
22 REG COIN DAYS 7TH YR
23 REG COIN RATE 7TH YR
24 REG COIN AMT 7TH YR
25 REG COIN DAYS 8TH YR
26 REG COIN RATE 8TH YR
27 REG COIN AMT 8TH YR
28 REG COIN DAYS 9TH YR
29 REG COIN RATE 9TH YR
30 REG COIN AMT 9TH YR
31 REG COIN DAYS 10TH YR
32 REG COIN RATE 10TH YR
33 REG COIN AMT 10TH YR
34 REG COIN DAYS 11TH YR
35 REG COIN RATE 11TH YR
36 REG COIN AMT 11TH YR
37 REG COIN DAYS 12TH YR
38 REG COIN RATE 12TH YR
39 REG COIN AMT 12TH YR
40 REG COIN DAYS 13TH YR
41 REG COIN RATE 13TH YR
42 REG COIN AMT 13TH YR
43 REG COIN DAYS 14TH YR
44 REG COIN RATE 14TH YR
45 REG COIN AMT 14TH YR
46 REG COIN DAYS 15TH YR
47 REG COIN RATE 15TH YR
48 REG COIN AMT 15TH YR
49 LTR COIN DAYS 1ST YR
50 LTR COIN RATE 1ST YR

51 LTR COIN AMT 1ST YR
52 LTR COIN DAYS 2ND YR

53 LTR COIN RATE 2ND YR
54 LTR COIN AMT 2ND YR
55 LTR COIN DAYS 3RD YR
56 LTR COIN RATE 3RD YR
57 LTR COIN AMT 3RD YR

58 LTR COIN DAYS 4TH YR
59 LTR COIN RATE 4TH YR
60 LTR COIN AMT 4TH YR
61 LTR COIN DAYS 5TH YR
62 LTR COIN RATE 5TH YR
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65 LTR COIN RATE 6TH YR
66 LTR COIN AMT 6TH YR
67 LTR COIN DAYS 7TH YR
68 LTR COIN RATE 7TH YR
69 LTR COIN AMT 7TH YR
70 LTR COIN DAYS 8TH YR
71 LTR COIN RATE 8TH YR
72 LTR COIN AMT 8TH YR
73 LTR COIN DAYS 9TH YR
74 LTR COIN RATE 9TH YR
75 LTR COIN AMT 9TH YR
76 LTR COIN DAYS 10TH YR
77 LTR COIN RATE 10TH YR
78 LTR COIN AMT 10TH YR
79 LTR COIN DAYS 11TH YR
80 LTR COIN RATE 11TH YR
81 LTR COIN AMT 11TH YR
82 LTR COIN DAYS 12TH YR
83 LTR COIN RATE 12TH YR
84 LTR COIN AMT 12TH YR
85 LTR COIN DAYS 13TH YR
86 LTR COIN RATE 13TH YR
87 LTR COIN AMT 13TH YR
88 LTR COIN DAYS 14TH YR
89 LTR COIN RATE 14TH YR
90 LTR COIN AMT 14TH YR
91 LTR COIN DAYS 15TH YR
92 LTR COIN RATE 15TH YR
93 LTR COIN AMT 15TH YR

94	PART A REG COIN DAYS	The total Medicare coinsurance days chargeable to the beneficiary.
95	PART A LTR COIN DAYS	The total Medicare lifetime reserve days chargeable to the beneficiary.
96	PARTA COIN DAYS	The total Medicare coinsurance and lifetime reserve days chargeable to the beneficiary.
97	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File (CWF).
98	FULL DAYS	The number of inpatient Medicare days occurring in the first 60 days in a single spell of illness.
99	UTILIZED DAYS	Days of care that are chargeable to Medicare
100	COST REPORT DAYS	Days credited to the provider's PS&R as Medicare days.
101	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.
102	PROVIDER PAYMENT AMT	
103	PATIENT PAYMENT AMT	
104	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.
105	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.
106	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.
107	MSP COVERED DAYS	The number of days covered by the primary payer.
108	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.
109	GROSS MEDICARE PAYMENT	The amount Medicare pays excluding deductibles and coinsurance. (For PPS claims, direct graduate medical education and pass-thru amounts are included.)
110	MSP NON-EGHP PYMT SDC	The amount paid by a non-EGHP to be reflected on the PS&R. The primary payer amount designated to lab charges reimbursed at 100%is not reflected in this figure. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)

111	MSP PYMT SDC	The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT" reflects the total primary payer amount. The primary payer amount designed to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)
112	FILLER	Nine Value spaces.
113	PPS CREDIT AMOUNT	The excess of the MSP amount over the DRG amount.
114	SAVINGS MSP EGHP	Amount saved by Medicare when an EGHP has made a payment for a working aged beneficiary (MSP Code 12).
115	SAVINGS MSP ESRD	Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).
116	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).
117	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).
118	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).
119	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).
120	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).
121	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).

122	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).
123	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer and a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.
124	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41, and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
125	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, 42, and 43. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.)
126	MSP COMPUTATION 1	The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.
127	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.
128	MSP COMPUTATION 3	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount paid by the primary payer.
129	MSP COMPUTATION 4	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts.
130	RESERVED FOR CMS	Space reserved for future enhancements. (200 Value Spaces)
131	RESERVED FOR USER	Space reserved for user as necessary. (153 Value Spaces)

50.2.8 - Payment Calculation for Outpatient Claims (MSPPAYOL)
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSPPAYOL performs the necessary payment calculation, on a line-by-line basis, for outpatient claims.

A. MSPPAYOL Sending Data Elements

MSPPAY must send the following data elements to MSPPAYOL:

No.	Field Name/Definition/Use	Source/Value
	(H) = Claim Header	
1.	TEST SWITCH (H) Indicator to turn on function within the MSP software to display sending and returning data. Used to identify payment problems.	"T" = display send/return data space = do not display data
2.	FILLER	Value spaces
3.	RECORD ID (H) Identifies the bill type	Part A Outpatient by line - "HMOL"
4.	CLMNO (H) Health Insurance Claim Number	Supplied by the A/B MAC (Part A) system from the claim.
5.	DOC CNTL NUM (H) Assigned document control number	Assigned and supplied by the A/B MAC (Part A) system
6.	FILLER	Value space
7.	APPORTION SWITCH (H)	Supplied by the A/B MAC (Part A) system to determine whether to apportion the Other Payer's Payment Amount and Obligated To Accept (if applicable): "N" = Do not apportion Space = do apportion
8.	TOTAL COVERED CHARGES (H)	Supplied by the A/B MAC (Part A) system
9.	NUM OTHER PAYERS (H) The number of other payers who are primary to Medicare	Supplied by the A/B MAC (Part A) system Valid value "01" thru "10"

No.	Field Name/Definition/Use	Source/Value
10.	THIRD PARTY PAYER TABLE (H) MSP CODE (H) - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) MSP AMOUNT (H) - Amounts paid by the other payer	Supplied by the A/B MAC (Part A) system May occur up to 10 times. Value Codes 12-16 and 41-47 from the claim.
11.	OBLIGATED TO ACCEPT Amount the provider agrees to accept as payment in full when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44" or CAS group code CO amount, appears on the bill. It is reported in addition to the MSP code(s), MSP amount(s), and the total covered charges on the bill.	
12.	NUMBER OF LINES (H) - of lines to compute MSP amounts	Supplied by the A/B MAC (Part A) system
13.	RESERVED FOR CMS (H)	76 value spaces
14.	RESERVED FOR USER (H)	75 value spaces
	(L) CLAIM LINE **NOTE:** THE FOLLOWING FIELDS WILL OCCUR 450 TIMES	
15.	LINE NUMBER (L) Line of service number.	Supplied by the A/B MAC (Part A) system Values "01" thru "450"

No.	Field Name/Definition/Use	Source/Value
16.	BYPASS INDICATOR (L)	Supplied by the A/B MAC (Part A) system "B" = Line of service to be bypassed by the software. Space = Line of service not bypassed by the software.
17.	DENIED INDICATOR (L)	Supplied by the A/B MAC (Part A) system "D" = Line of service denied by the Other Payer. Space = Line of service accepted for payment by the Other Payer.
18.	THRU DATE (L) THRU DATE CC (L) THRU DATE YY (L) THRU DATE MM (L) THRU DATE DD (L)	Supplied by the A/B MAC (Part A) system Value = "19" or "20" Value = "00" thru "99" Value = "01" thru "12" Value = "01" thru "31"
19.	FULLY PAID CLAIM IND (L) Indicator that reflects line is fully paid by the third party payer	Supplied by the A/B MAC (Part A) system "Y" = Fully Paid by Other Payer Space = Not Fully Paid by Other Payer
20.	NUM OF OTHER PAYERS (L) The number of other payers who are primary to Medicare.	Supplied by the A/B MAC (Part A) system Value "01" thru "10"
21.	THIRD PARTY PAYER TABLE (L)	Supplied by the A/B MAC (Part A) system May occur up to 10 times.
	MSP CODE (L) - Code(s) identifying the other payer: 12 = GHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) MSP AMOUNT (L) - Amounts paid by the other payer	Institutional claim Value Codes 12-16 and 41-47.
22.	TOTAL COVERED CHARGES (L)	Supplied by the A/B MAC (Part A) system

No.	Field Name/Definition/Use	Source/Value
	Total charges covered by Medicare. Code(s), MSP amount(s), and the total covered charges on the bill.	
23.	OBLIGATED TO ACCEPT (L) Amount the provider agrees to accept as payment in full when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44," or group code CO amount, appears on the bill. It is reported in addition to the MSP code(s), MSP amount(s), and the total covered charges on the bill.	Claim Value Code "44", or CAS group code CO amount, from the claim Apportioned by MSPPAY Software
24.	MED PAYMENT AMOUNT (L) Medicare payment without regard to deductibles and coinsurance	Supplied by the A/B MAC (Part A) system
25.	BLOOD DEDUCTION (L) Dollar amount of blood deductible charged by Medicare.	Claim Value Code 06.
26.	CASH DEDUCTION (L) Dollar amount of deductible charged by Medicare.	Claim Value Code 07.
27.	TOTAL COIN AMT (L) The Total Coinsurance amount chargeable to the beneficiary	Computed and Supplied by the A/B MAC (Part A) system.
28.	MED PRIMARY PAYMENT (L) The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the A/B MAC (Part A) system
29.	PROVIDER PAYMENT AMT (L) The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the A/B MAC (Part A) system
30.	PATIENT PAYMENT AMT (L) The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the A/B MAC (Part A) system
31.	G-R-H PERCENT (L) (GRAMM-RUDMANN-HOLLINGS) The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the A/B MAC (Part A) system
32.	CHARGES NSDC (L)	Computed and supplied by the A/B MAC (Part A) system

No.	Field Name/Definition/Use	Source/Value
	CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE) - Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	
33.	CHARGES SD (L) (CHARGES SUBJECT TO DEDUCTIBLE) Charge amount subject to the deductible.	Computed and supplied by the A/B MAC (Part A) system
34.	PPS IND (L) - An indicator that identifies a prospective payment computation	"P" = PPS Spaces = Non-PPS

B. MSPPAYOL Returning Data Elements

MSPPAYOL will return the following data elements to MSPPAY.

No.	Field Name/Definition/Use	Source/Value
	(H) CLAIM HEADER	
1.	RETURN CODE (H) Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYOL Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical and user documentation released with the software.)
2.	HEADER OR LINE ERROR (H) Reflects if an error was detected at the claim header or line when computing MSP by line.	Determined by MSPPAYOL "H" = Header Error "L" = Line Error
3.	LINE NUMBER OF ERROR (H) Reflects the line of service an error was detected.	
4.	BLOOD DEDUCTION TO CWF (H) Amount of blood deductible to report to the Common Working File (CWF).	
5.	CASH DEDUCTION TO CWF (H) Dollar amount of deductible to report to the CWF.	
6.	TOTAL COIN AMT TO CWF (H) - The total coinsurance amount to report to the CWF.	

No.	Field Name/Definition/Use	Source/Value
7.	MED SECONDARY PAYMENT (H) Medicare's secondary payment computed by the MSP software.	
8.	PROVIDER PAYMENT AMT (H) -	
9.	PATIENT PAYMENT AMT (H)	
10.	BLOOD DEDUCTION TO CHG (H) The amount of blood deductible the beneficiary may be charged by the provider.	
11.	CASH DEDUCTION TO CHG (H) - The dollar amount of deductible the beneficiary may be charged by the provider	
12.	TOTAL COIN AMT TO CHG (H) - The total coinsurance amount chargeable to the beneficiary	
13.	G-R-H SAVINGS REDUCTION (H) - (Gramm-Rudmann-Hollings) The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
14.	GROSS MEDICARE PAYMENT (H) The amount Medicare pays excluding deductibles and coinsurance.	
15.	MSP PYMT SDC (H) The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT" reflects the total primary payer amount. The primary payer amount designed to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
16.	PSR AMOUNT (H) The primary payer amount used in the Provider Statistical Report System.	

No.	Field Name/Definition/Use	Source/Value
17.	SAVINGS MSP GHP - Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
18.	SAVINGS MSP ESRD - Amount saved by Medicare when a GHP has made a payment for an ESRD beneficiary (MSP Code 13).	
19.	SAVINGS MSP AUTO - Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
20.	SAVINGS MSP WORK -Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	
21.	SAVINGS MSP FEDS - Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
22.	SAVINGS MSP BL - Amount saved by Medicare when Black Lung payment has been made by the Department of Labor. (MSP Code 41).	
23.	SAVINGS MSP VA - Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
24.	SAVINGS MSP DSAB - Amount saved by Medicare when a LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
25.	SAVINGS MSP LIAB - Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
26.	SAVINGS TOTAL - Total savings to the Medicare program when Medicare is the secondary payer and a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47. (L) CLAIM LINE	

No.	Field Name/Definition/Use	Source/Value
	NOTE: THE FOLLOWING FIELDS WILL OCCUR 450 TIMES	
27.	LINE NUMBER - Line of service number.	
28.	RETURN CODE - Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAO. Valid values "3000" thru "3999" See §50.2.3 above; also refer to the technical and user documentation released with the software.) Unless otherwise specified MSPPAY is the source of all the following, possibly modified by MSPPAY.
29.	BLOOD DEDUCTION TO CWF - Amount of blood deductible to report to the CWF	
30.	CASH DEDUCTION TO CWF - Dollar amount of deductible to report to the CWF.	
31.	TOTAL COIN AMT TO CWF - The total coinsurance amount to report to the CWF.	
32.	MED SECONDARY PAYMENT - Medicare's secondary payment computed by the MSP software.	
33.	PROVIDER PAYMENT AMT - Reimbursement paid to the provider.	
34.	PATIENT PAYMENT AMT - reimbursement paid to the patient.	
35.	BLOOD DEDUCTION TO CHG - The amount of blood deductible the beneficiary may be charged by the provider.	
36.	CASH DEDUCTION TO CHG - The dollar amount of deductible the beneficiary may be charged by the provider.	
37.	TOTAL COIN AMT TO CHG - The total coinsurance amount chargeable to the beneficiary.	
38.	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION - The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
39.	GROSS MEDICARE PAYMENT - The amount Medicare pays as primary	

No.	Field Name/Definition/Use	Source/Value
	excluding deductibles and coinsurance.	
40.	SAVINGS MSP GHP - Amount saved by Medicare when an GHP has made a payment for a working aged beneficiary (MSP Code 12).	
41.	SAVINGS MSP ESRD - Amount saved by Medicare when an EGHP has made a payment for an ESRD beneficiary (MSP Code 13).	
42.	SAVINGS MSP AUTO - Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
43.	SAVINGS MSP WORK - Amount saved by Medicare when Workers' compensation payment has been made (MSP Code 15).	
44.	SAVINGS MSP FEDS - Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
45.	SAVINGS MSP BL - Amount saved by Medicare when Black Lung payment has been made by the Department of Labor (MSP Code 41).	
46.	SAVINGS MSP VA - Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code 42).	
47.	SAVINGS MSP DSAB - Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
48.	SAVINGS MSP LIAB - Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
49.	SAVINGS TOTAL - Total savings to the Medicare program when Medicare is the secondary payer a primary payer(s) has made some payment. Includes all MSP codes 12 - 16, 41 - 43, and 47.	

No.	Field Name/Definition/Use	Source/Value
50.	MSP COMPUTATION 1 - The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.	
51.	MSP COMPUTATION 2 - The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts.	
52.	MSP COMPUTATION 3 - The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount paid by the primary payer.	
53.	MSP COMPUTATION 4 - The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts.	

50.2.8.1 – MSPPAY Update to Apportion Prospective Payment System (PPS) Outlier Amounts to All Service Lines with Potential Outlier Involvement

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSPPAYOL (1) accepts OPPS and HHPPS MSP claims at the Ambulatory Payment Classification (APC), Home Health Resource Groups (HHRG) and line levels, and (2) apportions OPPS and HHPPS outlier amounts, when greater than zero, to all service lines that are PRICER-related and potential outlier service lines, that is, all service lines sent to the PRICER and returned with a reimbursement. When MSP claims are received, A/B MAC (Part A) and A/B MAC (HHH) must send the claim outlier amount received from the prospective payment PRICER systems to the MSPPAY software. The shared system must set an indicator of "O" for any APC or HHRG amount that includes a PRICER reimbursement. The indicator will enable MSPPAYOL to determine which service amounts the outlier should apply. MSPPAYOL takes into consideration the outlier amount, if available, and then apportion the outlier amount to the PRICER-related service lines before calculating Medicare's secondary payment. The subsequent service line level calculation will account for the apportioned outlier amount resulting in a single payment amount for each PRICER-related service line. MSPPAY will return the calculated MSP payment amounts to the standard system along with an informational field reporting the apportioned outlier used to calculate payment for that line item service or group of services. The modifications to MSPPAYOL will allow for the service lines on the provider Remittance Advice (RA) to balance, but the informational apportioned outlier amount will not be shown on the RA. The modifications will also result in the line level MSP payment amounts being correctly reported on the PS&R Report. If providers request Medicare adjust or reprocess HHPPS and OPPS MSP claims originally processed prior to July 1, 2003, intermediaries must send these claims to MSPPAYOL.

A. MSPPAYPS

The CMS is making two modifications to MSPPAYPS as follows:

1 - MSPPAYPS is being modified to return provider and beneficiary line level reimbursement amounts to the standard system.

2 - Although MSPPAYPS is no longer used to process OPPS and HHPPS MSP claims, CMS will retain the sub-module for circumstances where Medicare is required to process MSP claims under MSPPAYPS resulting from a court order, litigation or change to federal regulations. The shared system retains a field where an indicator can be set that tells the standard system to redirect these types of claims to MSPPAYPS instead of the MSPPAYOL sub-module.

50.2.9 - Payment Calculation for Outpatient Bills (MSPPAYAO Module)

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSPPAYO performs the necessary payment calculation for outpatient, home health, and hospice bills with service.

A. MSPPAYAO Sending Data Elements

MSPPAY, or MSPPAYOL, when the claim is calculated to the line level, must send the following data elements to MSPPAYAO:

NO.	Field Name	Definition/Use	Source/Value
1	TEST SWITCH	Indicator to turn on function within the MSP software to display sending and returning data. Used to identify payment problems.	T = display send/return data; Space = do no display data.
2	THRU DATE	Ending service date of the period included on the bill (CCYYMMDD) THRU DATE CC THRU DATE YY THRU DATE MM THRU DATE DD	Supplied by the A/B MAC (Part A) system from the From-Through dates of the claim Value = "19" thru "20" Value = "00" thru "99" Value = "01" thru "12" Value = "01" thru "31"
3	RECORD ID	Identifies the bill type.	Outpatient = "HMOP" Home health = "HMHH" Hospice = "HMHC"
4	CLMNO	Health Insurance Claim Number (HICN)	Supplied by the A/B MAC (Part A) system from the claim.
5	DOC CNTL NUM	Assigned document control number.	Assigned and supplied by the A/B MAC (Part A) system.

NO.	Field Name	Definition/Use	Source/Value
6	FULLY PAID CLAIM IND	Indicator that reflects claim is fully paid by the third party payer.	Supplied by the A/B MAC (Part A) system. Can be identified by a "0" frequency indicator in Type of Bill, or Condition Code "77" on the claim. MSPPAYO Values: Y = Fully paid by other payer. Space = Not fully paid by other payer.
7	NUM OF OTHER PAYERS	The number of other payers who are primary to Medicare.	Supplied by the A/B MAC (Part A) system. Values = "01" thru "10"
8	THIRD PARTY PAYER TABLE MSP AMOUNT	MSP code(s) and MSP amount comprise third party data. MSP CODE - Code(s) identifying the other payer: 12 = EGHP (Working Aged) 13 = ESRD (End Stage Renal Disease) 14 = AUTO (Automobile/No-Fault) 15 = WORK (Workers' Compensation) 16 = FEDS (Federal) 41 = BL (Black Lung) 42 = VA (Veterans) 43 = DSAB (Disability) 47 = LIAB (Liability) Amount(s) paid by the other payer.	Supplied by the A/B MAC (Part A) system from claim Value Codes 12-16 and 41-47. May occur up to 10 times. .

NO.	Field Name	Definition/Use	Source/Value
9	TOTAL COVERED CHARGES	Total charges covered by Medicare. Code(s), MSP amount(s), and the total covered charges on the bill.	Claim Value Code Amounts
10	OBLIGATED TO ACCEPT	Amount the provider agrees to accept as payment in full, when this amount is less than charges but higher than the payment received from the primary payer. This field only needs to be completed when a value code "44," or CAS group code CO amount, appears on the bill. It is reported in addition to the MSP amount(s), and the total covered charges on the bill.	
11	FILLER		Eighteen value spaces
12	MED PAYMENT AMOUNT	Medicare payment without regard to deductibles and coinsurance.	Computed and supplied by the A/B MAC (Part A) system.
13	BLOOD DEDUCTION	Dollar amount of blood deductible charged by Medicare	Claim Value Code 06 Amount
14	CASH DEDUCTION	Dollar amount of deductible charged by Medicare.	Claim Value Code 07 Amount
15	FILLER		Sixty-eight value spaces
16	TOTAL COIN AMT	The total coinsurance amount chargeable to the beneficiary.	Computed and supplied by the A/B MAC (Part A) system.
17	FILLER		Six value spaces
18	FILLER		Twenty-nine value spaces
19	MED PRIMARY PAYMENT	The Medicare reimbursement amount less applicable deductible and coinsurance.	Computed and supplied by the A/B MAC (Part A) system.
20	PROVIDER PAYMENT AMT	The Medicare reimbursement amount to be paid to the provider.	Computed and supplied by the A/B MAC (Part A) system.
21	PATIENT PAYMENT AMT	The Medicare reimbursement amount to be paid to the patient.	Computed and supplied by the A/B MAC (Part A) system.
22	G-R-H PERCENT (GRAMM-RUDMANN-HOLLINGS)	The applicable percent reduction required by the Gramm-Rudmann-Hollings Act.	Supplied by the A/B MAC (Part A) system.

NO.	Field Name	Definition/Use	Source/Value
23	CHARGES NSDC (CHARGES NOT SUBJECT TO DEDUCTIBLE AND COINSURANCE)	Charge amount not subject to deductible and coinsurance, i.e., reimbursed at 100%.	Computed and supplied by the A/B MAC (Part A) system.
24	CHARGES SD (CHARGES SUBJECT TO DEDUCTIBLE)	Charge amount subject to the deductible.	Computed and supplied by the A/B MAC (Part A) system.
25	FILLER		Nine value spaces.
26	RESERVED FOR CMS	Space reserved for future enhancements.	One hundred ninety-eight value spaces.
27	RESERVED FOR USER	Space reserved for user as necessary.	One-hundred ninety value spaces.
28	PPS IND	An indicator that identifies a prospective payment computation	"P" = PPS Spaces = Non-PPS

B. MSPPAYAO Returning Data Elements

MSPPAYAO will return the following data elements to MSPPAYOL when the claim is calculated to the line level for outpatient claims. Refer to §50.2.7.B for field definitions not reflected below.

No.	Field Name	Definition/Use	Source/Value
1	RETURN CODE	Numeric code indicating the results from processing the secondary payment computation and savings. Identifies a fully or partially paid bill as well as invalid sending data.	Determined by MSPPAYAO. Valid values "3000" thru "3999" (See §50.2.3 above; also refer to the technical and user documentation released with the software.)
2	BLOOD DEDUCTION TO CWF	Amount of blood deductible to report to the Common Working File (CWF).	Unless otherwise specified, MSPPAY is the source of all the following, possibly modified by MSPPAYAI.
3	CASH DEDUCTION TO CWF	Dollar amount of deductible to report to the Common Working File (CWF)	
4	FILLER		Seventy-seven value spaces.
5	TOTAL COIN AMT TO CWF	The total coinsurance amount to report to the Common Working File	

No.	Field Name	Definition/Use	Source/Value
6	FILLER		Nine Value Spaces
7	MED SECONDARY PAYMENT	Medicare's secondary payment computed by the MSP software.	
8	PROVIDER PAYMENT AMT		
9	PATIENT PAYMENT AMT		
10	BLOOD DEDUCTION TO CHG	The amount of blood deductible the beneficiary may be charged by the provider.	
11	CASH DEDUCTION TO CHG	The dollar amount of deductible the beneficiary may be charged by the provider.	
12	TOTAL COIN AMT TO CHG	The total coinsurance amount chargeable to the beneficiary.	
13	FILLER	Three value spaces.	
14	G-R-H (GRAMM-RUDMANN-HOLLINGS) SAVINGS REDUCTION	(Gramm-Rudmann-Hollings) The amount of the MSP savings reduced for Gramm-Rudmann-Hollings.	
15	GROSS MEDICARE PAYMENT (H)	The amount Medicare pays excluding deductibles and coinsurance.	
16	NON-EGHP PYMT SDC	The amount paid by a non-EGHP to be reflected on the PS&R. The primary payer amount designated to lab charges reimbursed by 100% is not reflected in this figure. (This field is only returned for claims with services "thru-dates" prior to 11/13/89)	

No.	Field Name	Definition/Use	Source/Value
17	MSP PYMT SDC	The amount excluding "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, AND MSP TOTAL COINSURANCE AMOUNT" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount when added to the "MSP CASH DEDUCTIBLE, MSP BLOOD DEDUCTIBLE, and the MSP TOTAL COINSURANCE AMOUNT," reflects the total primary payer amount. The primary payer amount designated to lab charges reimbursed at 100% is not reflected in this figure. (This Field is only returned for claims with service "thru-dates" prior to 11/13/89.)	
18	PS&R AMOUNT	The primary payer amount used in the Provider Statistical Report System.	
19	FILLER	Nine value spaces.	
20	SAVINGS MSP EGHP	Amount saved by Medicare when a GHP has made a payment for a working aged beneficiary (MSP Code 12).	
21	SAVINGS MSP ESRD	Amount saved by Medicare when a GHP has made a payment for an ESRD beneficiary (MSP Code 13).	
22	SAVINGS MSP AUTO	Amount saved by Medicare when another insurer has made payment in an automobile/no-fault situation (MSP Code 14).	
23	SAVINGS MSP WORK	Amount saved by Medicare when workers' compensation payment has been made (MSP Code 15).	

No.	Field Name	Definition/Use	Source/Value
24	SAVINGS MSP FEDS	Amount saved by Medicare when PHS or other Federal agency made payment (MSP Code 16).	
25	SAVINGS MSP BL	Amount saved by Medicare when Black Lung payment has been dame by the Department of Labor (MSP Code 41).	
26	SAVINGS MSP VA	Amount saved by Medicare when payment has been made by the Department of Veteran's Affairs (MSP Code42).	
27	SAVINGS MSP DSAB	Amount saved by Medicare when an LGHP has made a payment for a disabled beneficiary (MSP Code 43).	
28	SAVINGS MSP LIAB	Amount saved by Medicare when payment has been made by a liability insurer (MSP Code 47).	
29	SAVINGS TOTAL	Total savings to the Medicare program when Medicare is the secondary payer and a primary payers(s) has made some payment. Includes all MSP codes 12-16, 41- 43 and 47.	
30	SAVINGS NON-EGHP	Total savings to the Medicare program for all non-EGHP payments for a Medicare beneficiary. Includes MSP codes 14, 15, 16, 41 and 47. (This field is only returned for claims with service "thru-dates" prior to 11/13/89.	
31	SAVINGS EGHP	Total savings to the Medicare program for all EGHP payments for a Medicare beneficiary. Includes MSP codes 12, 13, and 42. (This field is only returned for claims with	

No.	Field Name	Definition/Use	Source/Value
		service "thru-dates" prior to 11/13/89.)	
32	MSP COMPUTATION 1	The result of the gross amount payable by Medicare minus the amount paid by the primary payer for covered services.	
33	MSP COMPUTATION 2	The result of the gross amount payable by Medicare minus applicable deductible and coinsurance amounts	
34	MSP COMPUTATION 3	The result of the provider charges (or an amount the provider is obligated to accept as payment in full if that is less than the charges), minus the amount paid by the primary payer	
35	MSP COMPUTATION 4	The result of the provider charges (or an amount the provider is obligated to accept as payment in full, if that is less than the charges), minus applicable deductible and coinsurance amounts	
36	RESERVED FOR CMS	Space reserved for future enhancements. (200 value spaces)	
37	RESERVED FOR USER	Space reserved for user as needed. (153 value spaces)	

50.3 – Multiple Primary Payer Amounts For a Single Service

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. A/B MACs (Part A) Instructions

Sometimes more than one primary payer makes payment on a Medicare Part A electronic claim and Medicare may still make a secondary payment on the claim. Shared system changes were e made, as necessary, so the A/B MACs (Part A) can:

1) Identify electronic incoming MSP claims with multiple primary payers;

2) Send each claim level MSP value code, other than Value Code 44, paid amount found on the primary payer's MSP claim through the shared system so MSPPAY can calculate Medicare's secondary payment; and

3) Identify the lowest obligated to accept as payment in full (OTAF) amount, which is identified by Value Code 44 or CAS group code CO amount if VC 44 is not on the claim, and send that amount to MSPPAY (**NOTE:** MSPPAY will use Medicare covered charges if covered charges are lower than the OTAF amount).

B. Multiple Primary Payers

Providers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the ASC X12 837 institutional implementation guide, regarding the submission of Medicare beneficiary claims when there are multiple primary payers. Providers must follow the "provider to payer to provider" methodology of submitting MSP claims. When multiple payer claim information is attached to the inbound ASC X12 837, the shared systems identifies these types of claims and shall do the following:

1) Primary Payer Paid Amounts: Identify Primary Payer information from loop 2300, qualifier HIXX-1=BE. The value codes found in HIXX-2 and the value code monetary amounts found in HIXX-5 must be combined and sent to MSPPAY by the shared system.

2) OTAF: Take the lowest Value Code 44 (the OTAF) amount, which must be greater than zero, found in loop 2300 segment HI, and send that amount to MSPPAY. **NOTE**: A value of "Y," in loop 2320, segment OI03, indicates there is an OTAF amount in loop 2300 segment HI. Use CAS group code CO if VC 44 does not appear on the electronic claim.

C. Part A Hardcopy MSP Claims

When an A/B MAC (Part A) and A/B MAC (HHH) receives a hardcopy MSP claim, they take the Value Code paid Amounts, from Form CMS-1450 and send these amounts to MSPPAY. If more than one Value Code 44 is received on the claim, these Value Codes must be keyed and sent to the shared system. The shared system must take the lowest Value Code 44 amount found on the claim and send it to MSPPAY.

D. Claim Example

Below is an example of a Part A MSP claim sent to an A/B MAC (Part A). All services are Medicare covered services. The following OTAF and other Payer Paid Amounts are sent to MSPPAY at the claim level. The other Payer Paid Amounts (below) may be calculated and sent by line for non-OPPS CELIP claims

Payer 1	Submitted Covered Charges	OTAF	Other Payer Paid Amount

Total	**$150.00**	**$80.00**	**$70.00**

Payer 2	**Submitted Covered Charges**	**OTAF**	**Other Payer Paid Amount**
Total	**$150.00**	**$50.00**	**$40.00**

A/B MACs (Part A) send the following other payer amounts to MSPPAY based on the instructions cited above.

OTAF:	**$50.00 (lowest OTAF)**
Other Payer Paid Amount:	**$110.00 (combined total other payer paid amounts)**

50.4 – Processing Medicare Secondary Payer (MSP) Fully Paid Claims for Outpatient and Home Health Claims

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. MSP Fully Paid Claims

Medicare does not make a secondary payment when MSP claims are fully paid by the primary payer. The Part A shared system sends the fully paid claim payment information to the Medicare Secondary Payer Payment (MSPPAY) module for purposes of determining and crediting beneficiary deductible and coinsurance. The payment data sent to MSPPAY includes the condition code (cc) 77 if present on the claim. When the cc77 is on the incoming claim, the shared system sets the fully paid indicator in MSPPAY at the claim level and to each of the service lines so MSPPAY does not assign a secondary payment. The shared system also sets the fully paid indicator for MSP claims that are fully paid at the claim level and set the fully paid indicator on all service lines covered by Medicare including those claims that do not contain the cc77.

B. Determining MSP Fully Paid Claims

The Part A shared system shall identify Outpatient and Home Health MSP fully paid claims when cc77 does not appear on the hardcopy or electronic claim form. FISS shall identify the MSP claim as fully paid if at least one of the requirements below is met:

1) The shared system shall compare the primary payer(s) payment amount to the total covered charge or the obligated to accept as payment in full amount (OTAF) (VC 44) if the OTAF is less than the total covered charge. If the primary payer payment amount is equal to, or greater than, the total covered charges, or the OTAF amount, the shared system shall determine this claim as fully paid and shall set the fully paid indicator for all lines of service in MSPPAYOL.

2) The shared system shall compare the primary payer(s) payment amount to the gross Medicare payable by Medicare. If the primary payer payment amount is equal to, or greater than, the gross amount payable by Medicare, the shared system shall

determine this claim as fully paid and shall set the fully paid indicator for all lines of service in MSPPAYOL.

MSPPAY shall return a zero amount to the shared system on MSP claims that are fully paid. The shared system and A/B MAC (Part A) and A/B MAC (HHH), as necessary, shall put the zero Medicare reimbursement amount on the outbound remittance advice and Medicare Summary Notice.

60 - MSP Reports
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The identification and calculation of MSP Savings is identified in the below subsections.

60.1 - Monthly Part A Report (Form CMS-1563) and Monthly Part B Report (Form CMS-1564) on Medicare Secondary Payer Savings
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Each month the MSP Contractor, A/B MACs (Part A), A/B MACs (Part B), and A/B MACs (Part HHH) (collectively referred to as A/B MACs) and the DME MACs must electronically transmit to CMS central office a monthly Part A report (Form CMS-1563) and a monthly Part B report (Form CMS-1564) on Medicare Secondary Payer Savings. To submit forms K and L, the A/B MACs and DME MACs must connect to the CMS Data Center (CDC). (See §60.1.3.3.) Hard-copy reports are not required. A/B MACs and DME MACs transmit a separate report for each office assigned a separate A/B MAC and DME MAC contractor number.

60.1.1 - Overview of Report
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Purpose and Scope

The Monthly Part A Report and Monthly Part B Report on Medicare Secondary Payer Savings supplies CMS with current data on MSP savings and MSP pending workloads.

B. Due Date

Form CMS-1563 or Form CMS-1564 is due in CO as soon as possible after the end of the month being reported, but not later than the15th of the following month. Non-receipt of the report by the 15th will result in a telephone contact to the respective A/B MAC and DME MAC to obtain required information.

C. Form Heading

Each A/B MAC and DME MAC, and MSP Contractor, enters its name, assigned number, and the State in which the provider is located. In the space labeled "Reporting Period", it enters the numeric designation for month and year for which the report is being prepared, e.g., it shows “01/22” for January 2022.

60.1.2 - Savings Calculations
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A/B MACs, DME MACs, and the MSP Contractor, shall report savings on the Forms CMS-1563 and CMS-1564 only for the actual amount (principal dollars only) of savings realized, plus Medicare's share of the procurement costs. Under no circumstances shall the MSP Contractor, A/B MACs and DME MACs claim more savings than Medicare actually paid in benefits. The MSP Contractor, A/B MACs and DME MACs shall not claim interest dollars recovered as savings. Interest collected goes to the General Revenue Fund and is not returned to the Medicare Trust Funds.

A/B MACs and DME MACs shall report cost-avoided savings through their shared systems. However, A/B MACs and DME MACs shall not update the claims history in connection with post pay recoveries received except when the re-establishment of exhaustible benefits is required. This rule applies to GHPs as well as non-GHPs

The MSP contractor and A/B MACs and DME MACs for non-GHP cases shall report savings attributable to the recoveries (regardless of who the processing contractor is) associated with a liability, no fault or workers compensation case recovery. A/B MACs and DME MACs shall not update the shared systems paid claims history (via claims adjustments) with the recovery amounts, unless there is a need to re-establish exhaustible benefits. The MSP contractor, A/B MACs and DME MACs pursuing recovery of GHP debts or DPPs, shall, upon case closure, report savings associated with the GHP recoveries in the appropriate categories.

A/B MACs and DME MACs shall re-establish exhaustible benefits for post pay recoveries associated with GHP **and** non-GHP cases if the restoration of benefits will be beneficial to the beneficiary. The A/B MACs and DME MACs shall take the necessary actions to restore exhaustible benefits and claim the savings with respect to the claims associated with the exhaustible benefits. If the A/B MACs and DME MACs determines that restoration of benefits is not beneficial, the A/B MACs and DME MACs shall still report savings on the claims referred to them. The recovery MSP contractor, or A/B MAC and DME MAC, shall not report the savings associated with the claims referred for possible restoration of benefits.

Exception to reporting manual savings: A/B MACs and DME MACs having responsibility for a provider, physician, or other supplier DPP recovery shall recover and update their paid claims history files (via a claims adjustment) with information regarding the collection and subsequent MSP savings.

When notified by CMS, the MSP contractor, A/B MACs and DME MACs shall report additional savings manually, as requested by CMS.

A/B MACs and DME MACs and the MSP Contractor utilize the HIGLAS system to determine MSP Savings. These reports detail all debts that have been closed and collected on for MSP Contractor, A/B MAC and DME MAC. These reports will be inclusive of the original demand amount, Medicare's procurement costs where applicable (that is, the pro rata share of the procurement costs associated with the actual amount recovered), collected amounts (principal

and interest), etc. The MSP Contractors, A/B MACs and DME MACs must use these reports to enter the savings figures recovered via HIGLAS, as applicable, into the CROWD/MDX system.

A. Savings Priority

A/B MACs and DME MACs shall report MSP savings in the following order: (1) exhaustible Part A benefits, (2) exhaustible Part B benefits, (3) the remaining (non-exhaustible) Part A benefits, and (4) the remaining (non-exhaustible) Part B benefits. In each separate type of benefit listed above, savings are applied to the highest dollar claim first.

Exhaustible Benefits are benefits where their restoration would affect payment for a subsequent claim of the same type. Some examples of exhaustible benefits include: hospital inpatient lifetime reserve days (60 days), inpatient skilled nursing facility care, and inpatient lifetime reserve psychiatric days (190 days).

Additionally, claims adjustments for exhaustible benefits are not necessary if it is clear that their restoration could have no beneficial effect for the beneficiary; for example, if the issue is lifetime reserve days where the beneficiary is deceased and did not exhaust his lifetime reserve days without taking into account such restoration.

B. Reporting Dollar Values

The MSP contractor, A/B MACs and DME MACs shall round **all** dollar values to the nearest whole dollar.

C. Checking Reports/Report Equations

- Line 7 must equal the sum of lines 1 + 3 + 5 for all columns;
- Line 8 must equal the sum of lines 2 + 4 + 6 for all columns;
- Line 13 must equal the sum of lines 9 + 11 for all columns;
- Line 14 must equal the sum of lines 10 + 12 for all columns;
- Line 15 equals line 1 for all columns;
- Line 16 equals line 2 for all columns;
- Line 17 equals the sum of lines 3 + 9 for all columns;
- Line 18 equals the sum of lines 4 + 10 for all columns;
- Line 19 equals the sum of lines 5 + 11 for all columns;

- Line 20 equals the sum of lines 6 + 12 for all columns;
- Line 21 equals the sum of lines 15 + 17 + 19 for all columns;
- Line 22 equals the sum of lines 16 + 18 + 20 for all columns.

60.1.3 - Recording Savings

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The A/B MACs and DME MACs control all claims from which MSP savings are extracted and verifies all amounts recorded on the Forms CMS-1563 or CMS-1564 when requested. All prepay and post pay MSP Savings must be uploaded in the CROWD/MDX system.

A. MSP Savings File

The A/B MACs and DME MACs retain specific key identifying information on each claim counted as savings on the Forms CMS-1563 or CMS-1564. At a minimum, it records the beneficiary's name, Medicare beneficiary identifier, type and dates of service, claim control number, billed charges and savings amounts reported.

B. Savings Data from Non-Medicare Sources

If savings are recorded from data obtained from the A/B MACs and DME MACs "corporate side" records or any other "outside" source, the A/B MACs and DME MACs extract the same claims specific information noted above, i.e., verifies that Medicare covered services are involved and that it is able to calculate "what Medicare would have paid." In addition, A/B MACs and DME MACs must compare this data with the data contained in the MSP savings file to ensure that savings have not previously been recorded for the same claims. If savings have not previously been taken for the claim, the A/B MACs and DME MACs count them as savings on the Forms CMS-1563 or CMS-1564 and enters them into the A/B MACs and DME MACs MSP savings file.

C. Total Savings for Special Projects

The MSP Contractor, A/B MACs and DME MACs shall total each respective Special Project Savings and place these totals under their respective special project columns in the Special Project Savings Total in the CROWD Savings Report. A/B MACs and DME MACs and the designated shared system shall apply the correct MSP cost avoided indicator that pertains to the incoming claim, including subsequent adjustments, and apply the savings to the originating

contractor under the appropriate special project and MSP type in CROWD. Note, for savings reporting purposes the term contractor is identified to mean the MSP Contractor or A/B MAC and DME MAC number unless specified. The A/B MACs and DME MACs and designated shared systems shall apply the appropriate MSP indicator that pertains to each service line on the incoming claim. This includes applying the MSP savings to the originating contractor of the MSP record under the appropriate special project and MSP type in CROWD at the line level for cost avoided claims, full and partial recoveries, and total savings for prepay and post pay MSP. If there are different MSP lines on the same claim, the service lines shall be counted under each MSP type, by the originating contractor, for each service line in CROWD. For example, there are three MSP occurrences on CWF. Occurrence 1 is an open working aged record created by contractor 11101. Occurrence 2 is an open Workers' Compensation Set Aside (WCMSA) record created by contractor 11119. Occurrence 3 is a closed workers' compensation record. A claim is received for two services: one service is for a routine checkup and the second service is for the workers' compensation injury for which the beneficiary has a WCMSA. MSP savings related to the routine physical would be applied to originating contractor 11101, special project 6010, under the working aged column in the savings report. Savings related to the WCMSA would be applied to originating contractor 11119, special project 7019, under the workers' compensation column in the savings report.

60.1.3.1 - Source of Savings

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP Contractor, A/B MAC and DME MAC reports data by total and by source as shown below:

Total Column

All MSP savings regardless of source
Workers' compensation (WC) column (including black lung (BL)) (codes 15 & 41)

The MSP Contractor, A/B MACs and DME MACs include data related to all MSP savings resulting from medical benefits provided by the WC Plans of the 50 States, the District of Columbia, Guam and Puerto Rico. In addition, it includes Federal WC provided under the Federal Employee's Compensation Act, the U. S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal BL Program). It keeps separate records for each distinct category (WC and BL). The MSP contractor identifies recovery savings under Post Pay Recoveries for the columns identified below.

NOTE: VA savings are now counted under the column titled "VA/Other Federal."

Working Aged **Column (code 12)**

The A/B MACs and DME MACs include data related to all MSP savings resulting from benefits payable under a GHP for beneficiaries aged 65 and older that are covered by reason of their own employment or the employment of a spouse of any age. Under section 1862(b) of Title XVIII of

the Social Security Act, Medicare is the secondary payer for individuals age 65 or over who are covered under a GHP by virtue of current employment status of the individual or the individual's spouse. The individual, or spouse, who is covered under the GHP must be employed by an employer that has 20 or more employees. Section 1862(b)(1)(A)(ii) of the Social Security Act permits small employer GHPs an exclusion from the MSP provisions, if the employer employs less than 20 employees and the employer makes the exclusion.

End Stage Renal Disease (ESRD) Column (code 13)

The A/B MACs and DME MACs include data related to all MSP savings resulting from benefits payable under a GHP for individuals who are entitled to Medicare benefits on the basis of ESRD during a period of up to 30 months. The period during which Medicare pays secondary benefits is defined in Chapter 2, §20.2.

Auto Medical/No-Fault Column (code 14)

The A/B MACs and DME MACs include data related to all MSP savings resulting from:

Automobile Medical/ No-Fault Insurance – Include data related to all MSP savings resulting from insurance coverage (including a self-insured plan) that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes, but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage."

NOTE: Auto medical/ no-fault is captured under this column. auto liability is captured under the Liability column.

Disabled Column (code 43)

The A/B MACs and DME MACs include data related to all MSP savings resulting from situations where Medicare is the secondary payer for disabled beneficiaries under age 65 (except ESRD beneficiaries) who elect to be covered by a large group health plan (LGHP) based on their current employment or a family member's current employment. An LGHP is any health plan that covers employees of at least one employer who normally employs 100 or more employees.

Liability Column (code 47)

The A/B MACs and DME MACs include data related to all MSP savings resulting from liability insurance --Insurance (including a self-insured plan) that provides payment based on legal liability for injury, illness, or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. (**Note:** Where the beneficiary receives medical payment under his or her own homeowners' insurance, it should be reported under auto medical/ no fault).

The MSP contractor, A/B MACs and DME MACs shall report the savings for Federal Tort Claim Act (FTCA) cases in the Liability column. The FTCA shall be reported under code 47. FTCA cases arise when a person is injured on Federal property, in or by a Federal vehicle, via medical malpractice at a Veterans Administration (VA) hospital or at any government sponsored hospital setting and Medicare pays conditionally. In an FTCA case, the other Federal agency has the responsibility to refund Medicare as any other third party payer refunds Medicare. FTCA cases are classified as a self-insured entity. These recoveries are liability recoveries. The responsibility of a recovery for FTCA cases shall be to identify Medicare's recovery claim amount and to coordinate/facilitate communications with other the MSP contractor, A/B MACs and DME MACs, as required by the Centers for Medicare & Medicaid Services (CMS) central office. For FTCA cases, the MSP contractor shall be the lead contractor for liability and no-fault cases. These recoveries will continue to be under the specific direction of CMS staff as necessary.

Veterans Administration (VA)/Other Federal Column (codes 42 & 16)

The A/B MACs and DME MACs include data related to all MSP savings resulting from situations where the VA pays for fee-for-service medical care received by Medicare beneficiaries. "Other Federal" means another Federal program is primary to Medicare. The A/B MACs and DME MACs include data related to all MSP savings resulting from situations where another Federal program pays for fee-for-service medical care received by Medicare beneficiaries.
NOTE: Workers' compensation cases are reported under the column titled "Workers' Compensation column."

60.1.3.2 - Type of Savings
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The MSP contractor, A/B MACs and DME MACs include data by type of savings as shown below. There are two categories of savings on the savings reports, one for pre-payment savings and one for post-payment savings. There are three types of savings shown on the reports: (1) cost avoided savings, (2) full recovery savings, and (3) partial recovery savings.

60.1.3.2.1 – Pre-payment Savings – Cost Avoided (Unpaid MSP Claims)
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Cost Avoidance Savings

Cost avoided (unpaid MSP claims) savings, reported in lines 1 and 2, are those that the A/B MAC and DME MAC has returned without payment because there is strong evidence that another insurer is the primary payer and there is no indication that payment has been requested from that payer. Cost avoided savings are always classified as pre-payment savings. The information indicating MSP involvement may be contained in the A/B MACs and DME MACs files, on the CWF Auxiliary file, or on the claim itself. In addition, any information obtained

from a non-Medicare source and used as the basis for claiming cost avoidance savings must meet the criteria in §60.1.3.B.

Information considered adequate for claiming cost avoidance savings includes statements on the claim noting "automobile accident," "collision," or the name of the automobile insurer. Another example would be previous information obtained that shows that GHP coverage exits. The A/B MAC and DME MAC does not count claims it develops as "possible" MSP situations based on routine edits as cost avoidance savings unless there is previous information that another payer has primary responsibility. For example, "trauma code" edits are not, by themselves, considered strong evidence that Medicare is the secondary payer.

Line	Description	Instruction
Line 1	Cost Avoid (# of claims)	The number of cost avoided claims from which savings is recorded on the report.
Line 2	Cost Avoid ($)	The dollar value of the potential Medicare payments calculated for the claims on Line 1 that will be saved if the primary payer makes a payment that relieves Medicare of all payment liability.

The amount of cost avoided is **what Medicare would have paid**. **The** A/B MAC and DME MAC must not count total charges as cost avoided savings.

For A/B MACs (Part A) the cost avoided amount is the "Medicare payment rate" or the "current Medicare interim reimbursement amount" less any coinsurance amount applicable. It reduces Part B services subject to coinsurance for the coinsurance amount or uses a "coinsurance reduction factor" of 19 percent to calculate coinsurance charges for all Part B services. It may assume that the deductible has been met.

A/B MACs (Part B) reduce the cost avoided amount based upon reasonable charge and coinsurance calculations:

- **Reasonable Charge Reductions -** The reasonable charge amount may be calculated through the actual reasonable charge methodology or through a "reasonable charge reduction factor" which is the percentage derived from the most current Forms CMS-1565A by dividing line 3 (Total Amount of reduction) by Line 1 (Total Covered Charges for All Claims). (See the Medicare Financial Management Manual, Chapter 6, §240.2.)

- **Coinsurance -** The A/B MACs reduce line items subject to the Part B coinsurance by that amount or apply a "coinsurance reduction factor" of 19 percent to all charges.

B. Tracking/Adjusting Cost Avoidance Savings

Cost avoidance savings may not duplicate savings reported as full or partial recoveries and may not be shown where Medicare ultimately makes primary payment. To prevent duplicate counting, the A/B MACs and DME MACs suspends all claims returned unpaid. It sets up a control on the claim when it is returned for development. It maintains this control for 75 days, unless further information is received before that time which allows processing the claim. If no further information on the claim is received, the claim may be denied after 75 days. A/B MACs and DME MACs are required to continue tracking the claim, but retain the key identifying information on the claim, as described in §60.1.3.A.

The CMS prefers cost avoidance savings only after 75 days have elapsed. However, A/B MACs and DME MACs do have the option of counting the savings when the claim is initially suspended or at any time during the suspension period. If the latter alternative is selected, the A/B MACs and DME MACs adjust cost avoidance savings if the claim is resubmitted during the suspension period with information showing it is not a legitimate cost avoidance.

NOTE: The A/B MAC (Part B) may not return a non-assigned claim to a beneficiary, but must control it as described above when the claim is being developed for MSP involvement and counted as cost avoidance savings. The following situations require special consideration if cost avoidance savings are counted before the 75 day suspense period has ended:

- A claim returned (and counted as cost avoided) is paid in part by another payer and the provider resubmits it for secondary payment.

- A claim returned (and counted as cost avoided) is denied by the other payer and the provider resubmits it for primary payment.

- A claim returned (and counted as cost avoided) is paid in full by the other payer and the provider submits a no-payment bill. The A/B MAC and DME MAC shows "pre-payment full recovery" savings and not cost avoidance.

In these situations, the A/B MAC and DME MAC adjusts the cost avoidance savings figures by deducting or "backing out" the applicable amounts. It makes the adjustments in the reporting month in which a final determination is rendered. The following chart outlines the correct reporting of savings in each situation.

ADJUSTMENTS TO REPORTED MSP COST AVOIDANCE SAVINGS

CLAIMS PROCESSING ACTIONS	**MSP SAVINGS REPORTED**		
	Cost Avoidance	**Pre-payment Partial Recoveries**	**Pre-payment Full Recoveries**
I. Pre-payment Partial Recovery Adjustment – A/B MAC (Part A)			
• MSP situation indicated. The A/B MAC (Part A) calculated the Medicare payment to be $1200 if Medicare was primary payer. Claim is returned to submitter.	$1,200		
• Provider resubmits the claim to the A/B MAC (Part A) showing $900 paid by the other insurer. Medicare secondary payment of $300 is made.	$(1,200)*	$900	
II. Pre-payment Partial Recovery Adjustment – A/B MAC (Part B)			
• MSP situation indicated. A/B MAC (Part B)	$50		

CLAIMS PROCESSING ACTIONS	MSP SAVINGS REPORTED		
	Cost Avoidance	**Pre-payment Partial Recoveries**	**Pre-payment Full Recoveries**
if Medicare was primary payer. Claim is returned to submitter.			
• Claim is resubmitted to the A/B MAC (Part B) showing $30 paid by the other insurer. Medicare secondary payment of $20 is made.	$(50) *	$30	
III. "Other Payer Denial" Adjustment – A/B MAC (Part A)			
• MSP situation indicated; Medicare "primary" payment by the A/B MAC (Part A) is, $2,000. Claim is returned to providers.	$2,000		
• Other payer denies claim. Medicare found to be primary and Medicare payment of $2,000 is made.	$ (2,000) *		
IV. "Other Payer Denial" Adjustment – A/B MAC (**Part B)**			
• MSP situation indicated; Medicare's "primary" payment by the A/B MAC (Part B) is calculated to be $75. Claim is returned to submitter.	$75		
• Other payer denies claim; Medicare found to be primary and Medicare payment of $75 is made.	$ (75)*		
V. Full Recovery Adjustment - A/B MAC (**Part A)**			
• MSP situation indicated - Medicare "primary" payment, $900. Claim is returned to provider.	$ 900		

CLAIMS PROCESSING ACTIONS	MSP SAVINGS REPORTED		
	Cost Avoidance	**Pre-payment Partial Recoveries**	**Pre-payment Full Recoveries**
• Provider submits a "no-payment" bill showing full payment by the other payer.	$ (900) *		$ 900
VI. Full Recovery Adjustment – A/B MAC (**Part B)**			
• MSP situation indicated: Medicare's "primary" payment calculated to be $80. Claim is returned to submitter.	$ 80		
• Submitter or other source informs the A/B MAC (Part B) that full payment was made by the other payer.	$ (80) *		$ 80

*Amounts "backed out" of cost avoidance savings figures.

60.1.3.2.2 – Pre-payment Savings – Full Recoveries

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Pre-payment full recoveries occur when a primary payer makes full payment up to the Medicare allowed amount before Medicare makes any payment, relieving Medicare of all payment liability.

Line	Description	Instruction
Line 3	Full Recovery (# of claims)	Report the number of full recoveries made during the month.
Line 4	Full Recovery ($)	Report the dollar value of full recoveries made during the month.

Part A Pre-payment Full Recoveries

Part A pre-payment full recoveries is defined by the type of bill submitted. If a claim submitted to a A/B MAC (Part A) has a bill type code with a third digit of 0,1,2,3,4 or 5, the A/B MAC (Part A) shall classify this claim as pre-payment savings.

A/B MAC (Part A) Example

A hospital identifies a GHP as the primary payer, submits its charge to that insurer, and the GHP pays the hospital's full cost. The A/B MAC (Part A) subsequently receives a "no pay" bill. It determines what Medicare would have paid if the GHP had not made payment and records that total as a pre-payment full recovery savings.

Part B Pre-payment Full Recoveries

Part B pre-payment full recoveries include those claims that are processed as MSP-involved and occur when the standard system determines that another insurer's paid amount exceeds Medicare's allowed amount.

A/B MAC (Part B) Example
A physician identifies a GHP as the primary payer, submits the bill to that insurer, and the GHP pays the charges in full. The beneficiary informs the A/B MAC (Part B) of this and submits a copy of the GHP explanation of benefits. The A/B MAC (Part B) determines what would have been paid if the GHP had not made payment and records that total as full recovery savings.

60.1.3.2.3 – Pre-payment Savings – Partial Recoveries
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Pre-payment partial recoveries occur when Medicare makes a secondary payment and the savings are calculated as the difference between the Medicare allowed amount if primary and the amount Medicare paid as secondary.

A/B MAC (Part A) Example:

A hospital identifies a GHP as the primary payer, submits its charge to that insurer, and the GHP makes primary payment, but it does not cover the full cost. The A/B MAC (Part A) calculates the difference between what Medicare would have paid, if primary, and the amount Medicare paid as secondary. This amount is recorded as a prepayment partial recovery.

A/B MAC (Part B) Example:

A physician identifies a GHP as the primary payer, submits the bill to that insurer, and the GHP makes primary payment, but it does not cover the full cost. The beneficiary informs the A/B MAC (Part B) of this and submits a copy of the GHP explanation of benefits. The A/B MAC (Part B) calculates the difference between what Medicare would have paid, if primary, and the amount Medicare paid as secondary. This amount is recorded as a prepayment partial recovery.

Line	Description	Instruction
Line 5	Partial Recovery (# of claims)	Report the number of pre-payment partial recoveries made during the month.
Line 6	Partial Recovery ($)	Report the dollar value of pre-payment partial recoveries made during the month.

A/B MAC (Part A) pre-payment partial recoveries are defined by the type of bill submitted. If a claim submitted to a A/B MAC (Part A) has a bill type code with a third digit of 0,1,2,3,4 or 5, the A/B MAC (Part A) shall classify this claim as pre-payment savings.

A/B MAC (Part B) pre-payment partial recovery savings occur when the other insurer's payment is less than the Medicare allowed amount, causing a Medicare secondary payment. The A/B MAC (Part B) shall calculate these savings by determining the difference between the Medicare allowed amount if primary and the amount Medicare paid as secondary.

Line 7 is the sum of lines 1, 3 and 5. It represents total pre-payment savings (# of claims). Line 8 is the sum of lines 2, 4 and 6. It represents total pre-payment savings ($). Lines 7 and 8 are automatically calculated.

60.1.3.2.4 – Post-payment Savings – Full Recoveries

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Post-payment full recoveries are recorded when Medicare recovers the full amount demanded minus any adjustments. Part A and Part B savings are sometimes recorded manually without a claim's adjustment.

Line	Description	Instruction
Line 9	Full Recovery (# of claims)	Report the number of post-payment full recoveries made during the month.
Line 10	Full Recovery ($)	Report the dollar value of post-payment full recoveries made during the month.

Part A post-payment full recoveries are recorded by the type of bill submitted. If a claim adjustment has a bill type code with a third digit of 7, 8, or F - P, the adjustment is classified as post-payment savings.

Part B post-payment full recovery savings are recorded when a claims adjustment is taken to completely adjust off Medicare's payment.

NOTE: Part A savings are always taken first before Part B savings.

NOTE: The amount of savings taken/recorded for group health plan's (GHP) is equal to the amount of principal recovered. The amount of savings taken/recorded for liability, no-fault, and WC is always equal to the actual amount of repayment of principal received plus, where applicable, the amount of pro-rata reduction for attorney fees and costs associated with the actual recovery amount. Remember that interest shall not be counted as savings.

MSP Savings may be recorded only after receipt of payment. MSP Contractor, A/B MACs and DME MACs count recovery savings in the month they are received. Please note that full recoveries pursuant to an extended repayment plan (i.e., formal installment/repayment request) are an exception and are not counted until all monies have been received.

NOTE: For GHP debt, full recoveries are counted on a claim-by-claim basis. Count the full recovery of each individual claim in a GHP debt as a full recovery. For liability/no-fault/WC debt, full recoveries are counted on a debt-by-debt basis. Do not count a recovery as a full recovery unless the full principal for the entire debt is recovered.

Part B post-payment full recoveries savings occur when the adjustment is taken to completely adjust off Medicare's primary payment, since the claim should have been fully paid by the primary insurer.

60.1.3.2.5 – Post-payment Savings – Partial Recoveries
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Post-payment partial recoveries are those savings realized when a primary payer makes a payment which covers only a part of Medicare's payment for the services at issue. This includes situations where Medicare compromises its recovery claim or waives recovery of part of its claim. Part A and Part B recovery savings are sometimes recorded manually without a claim's adjustment.

Line	Description	Instruction
Line 11	Partial Recovery (# of claims)	Report the number of post-payment partial recoveries made during the month.
Line 12	Partial Recovery ($)	Report the dollar value of post-payment partial recoveries made during the month.

Part A post-payment partial recoveries are recorded by the type of bill submitted. If a claims adjustment has a bill type code with a third digit of 7, 8, or F - P, the adjustment is classified as a post-payment savings.

Part B post-payment partial recovery savings are recorded when a claims adjustment is done for less than Medicare's original payment. The amount adjusted is classified as a post-payment savings.

NOTE: Part A savings are always taken first before Part B savings.

NOTE: The amount of savings taken/recorded for group health plan's is equal to the amount of principal recovered. The amount of savings taken/recorded for liability, no-fault, and WC is always equal to the actual amount of repayment of principal received plus, where applicable, the amount of pro-rata reduction for attorney fees and costs associated with the actual recovery amount. Remember that interest shall not be counted as savings.

Savings may be recorded only after receipt of payment. MSP Contractor, A/B MAC and DME MAC count recovery savings in the month they are received. Please note that partial recoveries pursuant to an extended repayment plan (i.e., formal installment/repayment request) are an exception and are not counted until all monies have been received.

NOTE: For GHP debt, full recoveries are counted on a claim-by-claim basis. Count the full recovery of each individual claim in a GHP debt as a full recovery. For liability/no-fault/WC debt, full recoveries are counted on a debt-by-debt basis. Do not count a recovery as a full recovery unless the full principal for the entire debt is recovered.

60.1.3.2.6 – Total Post-payment Savings

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

In this part of the report, lines 13 and 14 are automatically calculated to reflect the total number of claims (debts) and the total dollar value of MSP full and partial recoveries realized during the month.

Line	Description	Instruction
Line 13	Total Post-pay Savings (# of claims)	The system will automatically report the total post-payment savings (number) realized during the month. [Line 13 is the sum of lines 9 and 11.]
Line 14	Total Post-pay Savings ($ - dollars)	The system will automatically report the total post-payment savings (dollar value) realized during the month. [Line 14 is the sum of lines 10 and 12.]

60.1.3.3 - Electronic Submission

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

To submit forms K and L, the MSP Contractor, A/B MAC and DME MAC must connect to the CMS Data Center (CDC). The preferred method is to use the IBM Host On-Demand software that is issued to every registered CDC user. While the A/B MACs and DME MACs can connect to the CDC using software of their own choosing, CMS will not provide support for any problems or issues that arise from the employment of this software.

60.1.3.3.1 - Data Entry of the Forms CMS-1563 and CMS-1564
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

MSP savings data entry on the CROWD system can be accomplished via two methods, keying or uploading. For data entry instructions, please reference the "CROWD User Guide." Upload instructions are also available on the CDC ... just click on the "Tips and Hints" icon on the Microsoft Internet Explorer screen the first screen that is displayed when Host On-Demand is initiated.

60.1.3.3.2 – System Calculations for Forms CMS-1563 and CMS-1564
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The following system calculations are performed on the Forms CMS-1563 and CMS 1564;

- A valid 5-digit MSP Contractor or A/B MACs (Part A) number is required on the Form CMS-1563 or;
- A valid 5-digit MSP Contractor or A/B MACs (Part B) number is required on the Form CMS-1564; and;
- The default value for areas not keyed is zero;
- Appropriate reporting period (MMYYYY) is required;
- Enter the 2-position alpha State code;
- Line 7 must equal the sum of lines 1 + 3 + 5 for all columns;
- Line 8 must equal the sum of lines 2 + 4 + 6 for all columns;
- Line 13 must equal the sum of lines 9 + 11 for all columns;
- Line 14 must equal the sum of lines 10 + 12 for all columns;
- Line 15 equals line 1 for all columns;
- Line 16 equals line 2 for all columns;
- Line 17 equals the sum of lines 3 + 9 for all columns;
- Line 18 equals the sum of lines 4 + 10 for all columns;
- Line 19 equals the sum of lines 5 + 11 for all columns;
- Line 20 equals the sum of lines 6 + 12 for all claims;

- Line 21 equals the sum of lines 15 + 17 + 19 for all columns;
- Line 22 equals the sum of lines 16 + 18 + 20 for all columns.

60.1.3.4 - Exhibit 1: Medicare Secondary Payer (MSP) Savings Report
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

NATIONAL TOTAL SPEC PROJ: GROUP HEALTH PLAN RECOVERY (7039)

DESCRIPTIO	LINE NUMBER	TOTAL	WORKER S' COMP (including BL) (codes 15 & 41)	WORKING AGED (code 12)	ESRD (code 13)	AUTO MEDICAL / NO FAULT (code14)	DISABLED (code 43)	Liability (including FTCA) (code 47)	VA/OTHE R FEDERAL (codes 42 & 16)
Prepay Savings:									
Cost Avoid (# of claims)	1	0	0	0	0	0	0	0	0
Cost Avoid ($)	2	0	0	0	0	0	0	0	0
Full Recovery (# of claims)	3	0	0	0	0	0	0	0	0
Full Recovery ($)	4	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	5	0	0	0	0	0	0	0	0
Partial Recovery ($)	6	0	0	0	0	0	0	0	0
Total Prepay Savings(# of claims):	7	0	0	0	0	0	0	0	0
Total Prepay Savings($):	8	0	0	0	0	0	0	0	0

Postpay Savings:			0						
Full Recovery (# of claims)	9	0	0	0	0	0	0	0	0
Full Recovery ($)	10	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	11	0	0	0	0	0	0	0	0
Partial Recovery ($)	12	0	0	0	0	0	0	0	0
Total Postpay Savings(# of claims):	13	0	0	0	0	0	0	0	0
Total Postpay Savings($):	14	0	0	0	0	0	0	0	0
Total Cost Avoid Savings(# of claims)	15	0	0	0	0	0	0	0	0
Total Cost Avoid Savings ($)	16	0	0	0	0	0	0	0	0
Total Full Recovery Savings(# of claims)	17	0	0	0	0	0	0	0	0
Total Full Recovery Savings($)	18	0	0	0	0	0	0	0	0
Total Partial Recovery Savings(# of claims)	19	0	0	0	0	0	0	0	0
Total Partial Recovery Savings($)	20	0	0	0	0	0	0	0	0

Total Savings (# of claims):	21	0	0	0	0	0	0	0	0
Total Savings ($):	22	0	0	0	0	0	0	0	0

NATIONAL TOTAL SPECIAL PROJ: NON-GROUP HEALTH PLAN NON-ORM (7041)

DESCRIPTION	LINE NUMBER	TOTAL	WORKER S' COMP (including BL) (codes 15 & 41)	WORKING AGED (code 12)	ESRD (code 13)	AUTO MEDICAL / NO FAULT (code14)	DISABLED (code 43)	Liability (including FTCA) (code 47)	VA/OTHER FEDERAL (codes 42 & 16)
Prepay Savings:									
Cost Avoid (# of claims)	1	0	0	0	0	0	0	0	0
Cost Avoid ($)	2	0	0	0	0	0	0	0	0
Full Recovery (# of claims)	3	0	0	0	0	0	0	0	0
Full Recovery ($)	4	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	5	0	0	0	0	0	0	0	0
Partial Recovery ($)	6	0	0	0	0	0	0	0	0

Total Prepay Savings(# of claims):	7	0	0	0	0	0	0	0	0
Total Prepay Savings($):	8	0	0	0	0	0	0	0	0
Postpay Savings:									
Full Recovery (# of claims)	9	0	0	0	0	0	0	0	0
Full Recovery ($)	10	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	11	0	0	0	0	0	0	0	0
Partial Recovery ($)	12	0	0	0	0	0	0	0	0
Total Postpay Savings(# of claims):	13	0	0	0	0	0	0	0	0
Total Postpay Savings($):	14	0	0	0	0	0	0	0	0
Total Cost Avoid Savings(# of claims)	15	0	0	0	0	0	0	0	0
Total Cost Avoid Savings ($)	16	0	0	0	0	0	0	0	0
Total Full Recovery Savings(# of claims)	17	0	0	0	0	0	0	0	0
Total Full Recovery Savings($)	18	0	0	0	0	0	0	0	0
Total Partial Recovery Savings(# of claims)	19	0	0	0	0	0	0	0	0
Total Partial Recovery Savings($)	20	0	0	0	0	0	0	0	0

Total Savings (# of claims):	21	0	0	0	0	0	0	0	0
Total Savings ($):	22	0	0	0	0	0	0	0	0

NATIONAL TOTAL

SPECIAL PROJ: NON-GROUP HEALTH PLAN ORM RECOVERY (7042)

DESCRIPTION	**LINE NUMBER**	**TOTAL**	**WORKER S' COMP (including BL) (codes 15 & 41)**	**WORKING AGED (code 12)**	**ESRD (code 13)**	**AUTO MEDICAL / NO FAULT (code14)**	**DISABLED (code 43)**	**Liability (including FTCA) (code 47)**	**VA/OTHE R FEDERAL (codes 42 & 16)**
Prepay Savings:									
Cost Avoid (# of claims)	1	0	0	0	0	0	0	0	0
Cost Avoid ($)	2	0	0	0	0	0	0	0	0

Full Recovery (# of claims)	3	0	0	0	0	0	0	0	0
Full Recovery ($)	4	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	5	0	0	0	0	0	0	0	0
Partial Recovery ($)	6	0	0	0	0	0	0	0	0
Total Prepay Savings(# of claims):	7	0	0	0	0	0	0	0	0
Total Prepay Savings($):	8	0	0	0	0	0	0	0	0
Postpay Savings:									
Full Recovery (# of claims)	9	0	0	0	0	0	0	0	0
Full Recovery ($)	10	0	0	0	0	0	0	0	0
Partial Recovery (# of claims)	11	0	0	0	0	0	0	0	0
Partial Recovery ($)	12	0	0	0	0	0	0	0	0
Total Postpay Savings(# of claims):	13	0	0	0	0	0	0	0	0
Total Postpay Savings($):	14	0	0	0	0	0	0	0	0
Total Cost Avoid Savings(# of claims)	15	0	0	0	0	0	0	0	0
Total Cost Avoid Savings ($)	16	0	0	0	0	0	0	0	0

Total Full Recovery Savings(# of claims)	17	0	0	0	0	0	0	0	0
Total Full Recovery Savings($)	18	0	0	0	0	0	0	0	0
Total Partial Recovery Savings(# of claims)	19	0	0	0	0	0	0	0	0
Total Partial Recovery Savings($)	20	0	0	0	0	0	0	0	0
Total Savings (# of claims):	21	0	0	0	0	0	0	0	0
Total Savings ($):	22	0	0	0	0	0	0	0	0

60.1.3.5 - Exhibit 2: CWF Source Codes and Corresponding CROWD Special Project Numbers

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

CWF Source Codes	MSP/COB Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
B, D, T, U, V, or W	77777 = IRS/SSA/HCFA Data Match (I, II, III, IV, V, or VI)	Y	1000
O	99999 = Initial Enrollment Questionnaire (IEQ)	T	2000
P	55555 = HMO Rate Cell Adjustment	U	3000
	33333 = Litigation Settlement	V	4000
Q	88888 = Voluntary Agreements	Q	5000
0	11100 = COB Contractor	00	6000
1	11101 = Initial Enrollment Questionnaire (IEQ)	T	6010
2	11102 = IRS/SSA/CMS Data Match	Y	6020
3	11103 = HMO Rate Cell	U	6030
4	11104 = Litigation Settlement	V	6040
5	11105 = Employer Voluntary Reporting	Q	6050
6	11106 = Insurer Voluntary Reporting	K	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080

9	11109 = Secondary Claims Investigation	G	6090

CWF Source Codes	MSP/COB Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
10	11110 = Self Reports	H	7000
11	11111 = 411.25	J	7010
12	11112 = Blue Cross – Blue Shield Voluntary Agreements	12	7012
13	11113 = Office of Personnel Management (OPM) Data Match	13	7013
14	11114 = State Workers' Compensation (WC) Data Match	14	7014
15	11115 = WC Insurer Voluntary Data Sharing Agreements (WC VDSA)	15	7015
16	11116 = Liability Insurer Voluntary Data Sharing Agreements (LIAB VDSA)	16	7016
17	11117 = Voluntary Data Sharing Agreements (No Fault VDSA)	17	7017
18	11118 = Pharmacy Benefit Manager Data	18	7018
19	11119 = Workers' Compensation Medicare Set-Aside Arrangement	19	7019
20	11120 = To be determined	20	7020
21	11121 = MIR Group Health Plan	21	7021
22	11122 = MIR non-Group Health Plan	22	7022
""	""	""	""

CWF Source Codes	MSP/COB Contractor Numbers	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
25	11125=Recovery Audit Contractor-California	25	7025
26	11126=Recovery Audit Contractor-Florida	26	7026
27	11127=To be Determined	27	7027
39	11139 = Group Health Plan Recovery	39	7039
41	11141 = Non-Group Health Plan Non-ORM Recovery	41	7041
42	11142 = Non-Group Health Plan ORM Recovery	42	7042
43	11143 = MSP Contractor/Medicare Part C/Medicare Advantage	43	7043
44	11144 = Liability Medicare Set Aside Arrangement	44	7044
45	11145 = No-Fault Medicare Set Aside Arrangement	45	7045
99	11199 = To be determined	99	7099

70 - Hospital Review Protocol for Medicare Secondary Payer

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Federal law mandates that Medicare is the secondary payer for:

- Claims involving Medicare beneficiaries age 65 or older who are insured by GHP coverage based upon their own current employment with an employer that has 20 or more employees, or that of their spouses of any age, or the beneficiary is covered by a multiple employer, or multi-employer, group health plan by virtue of their, or a spouse's, current employment status and the GHP covers at least one employer with 20 or more employees;

- Claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage that was already secondary to Medicare at the time ESRD occurred;

- Claims involving liability or no-fault insurance;

- Claims involving government programs, e.g., WC, services approved and paid for by the Department of Veterans Affairs (DVA), or BL benefits; and

- Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans of employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon their own current employment status or the current employment status of a family member.

The following sections provide a methodology for reviewing hospitals' MSP policies and practices to ensure that hospital procedures comply with the law. The A/B MACs (Part A) shall review hospital admission and bill processing procedures.

70.1 - Reviewing Hospital Files
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

In order to conduct an effective review, the A/B MACs (Part A) shall obtain complete files from the hospital on all beneficiaries represented in the bills selected for review. (See §70.2 concerning sample selections.) For the purposes of this review, a complete file must contain:

- A copy of the completed UB-92 (Form CMS-1450) or its facsimile;

- A copy of the admission questions and responses (the beneficiary's signature is not required; see §70.3.B) and/or the X12 270/271 transaction and any notations made to the transaction resulting from the admissions process. If the hospital uses an online query process, including the X12 270/271 transaction, no hardcopy form needs to appear in the file. Screen prints may be used instead (see §70.1.2.B); and

- Beneficiary's MSN form for all secondary claims.

70.1.1 - Frequency of Reviews and Hospital Selection Criteria
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

Each year the A/B MACs (Part A) shall conduct a review of 10 percent of the hospitals (or a maximum of 20, whichever is the lesser of the two) in each state for which it has Medicare claims processing responsibility. Hospitals to consider for review include those which:

- Fail to develop MSP claims properly;
- Fail to submit MSP fully paid claims (no pay bills including claims containing condition code 77);
- Claims containing condition code 77; and
- Do not submit auto accident cases (even if they have shock trauma units specializing in emergency admissions).

The A/B MACs (Part A) shall refrain from repeatedly selecting the same hospital for review each year. A hospital reviewed within the last 12 months is not to be reviewed the following year if there are hospitals that were not reviewed during the preceding 12 months, unless serious deficiencies are identified. The objective of hospital reviews is to review all hospitals in the A/B MAC (Part A) geographic area. The review period generally lasts a maximum of two days.

Multiple A/B MACs (Part A) having a presence in one state shall communicate with each other to ensure that duplicate reviews do not occur and that, as a combined total, the multiple A/B MACs (Part A) do not review more hospital providers than would have been reviewed if only one A/B MAC (Part A) processed claims for all hospital providers in that state.

A/B MACs (Part A) shall complete all hospital reviews and submit the final hospital review report to the provider within 6 months from the start of the audit.

70.1.2 - Methodology for Review of Admission and Bill Processing Procedures

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Entrance Interview

The A/B MAC (Part A) shall conduct an entrance interview with the admissions staff (including
inpatient, outpatient, and emergency) to determine whether the hospital established:

1. Policies identifying other payers primary to Medicare; and

2. A system in which such policies are carried out in practice.

A/B MACs (Part A) shall use the checklist found in §70.5.3, Exhibit 3 to conduct the entrance interview. During the interview, the A/B MACs (Part A) shall request a descriptive walk-through of the admissions process. It is not necessary to observe an actual admission of a beneficiary.

B. Review of Hospital Admission Questions and Responses

The A/B MAC (Part A) shall review copies of the hospital's inpatient, outpatient, and emergency room (ER) hospital admission questions and/ or the X12 270/271 transaction and existing responses and notations. If the hospital uses an online admission query process, the A/B MAC (Part A) shall review the system screen prints. If the hospital has both hard copy questions and online questions and responses, the reviewer may exercise discretion in deciding whether to review hard copy questions or online responses (or both, if desired). The reviewer shall compare the hospital's admissions questions to the model admission questions found in the Medicare Secondary Payer Manual, Chapter 3, § 20.2.1) to ensure that the appropriate questions are being asked to identify other payers that may be primary to Medicare.

Analysis of the admission questions and responses, including the X12 270/271 transaction and existing notations or system screen prints utilized from the provider online screening process, for purposes of insuring that it matches the information billed should be undertaken during the review of billing procedures. (See §70.3.B for instructions.)

70.2 - Selection of Bill Sample

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The sample period shall be determined by selecting the sample from two months of the hospital's processed claims history. The reviewer (i.e., A/B MAC (Part A)) shall notify the hospital in advance of the month's claims to be reviewed. For example, notice would be given on 11/30/xx that a random sample would be selected from the provider's October and November processed claims history. The reviewer is not required to perform the review during the same month as the month of bills selected. The reviewer shall make an effort to conduct the review within three months after the sample period.

The reviewer shall provide the listing of claims selected for the review within 15 days of the date of initial notice. The provider should compile the data requested and return it to the reviewer within 30 days. (For example, notice is given 11/30/xx. The sample selection is completed by 12/15/xx. Data is given back to the reviewer by 01/15/xx. The reviewer should be able to schedule an onsite review by 02/01/xx.)

The bill universe shall consist of Medicare inpatient, outpatient, and subunit claims for which a primary or secondary Medicare payment was made. The reviewer shall select the sample using the following criteria:

- At least 2/3 of the sample should consist of inpatient bills. The remaining 1/3 is to be outpatient bills. The split is to be determined at the reviewer's discretion;

- The sample must contain a minimum of 20 bills and a maximum of 60 bills;

- The reviewer shall include Medicare no-pay bills in the sample in order to examine the ratio of no-pay bills submitted by the hospital to those actually billed;

- The sample is to include a mixture of bill types from the hospital's bill universe. Accordingly, if the hospital does not submit ESRD bills, then the reviewer is not required to review that particular bill type; and

- Both Medicare primary and secondary bills are to be included in the sample.

Claims for reference laboratory services shall not be included in the sample of claims that are audited during MSP hospital reviews. Reference laboratory services, as defined in section 943 of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, "are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation."

70.3 - Methodology for Review of Hospital Billing Data
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Entrance Interview

The reviewer shall conduct an entrance interview with the billing staff to determine whether the hospital established:

1. Policies concerning billing other payers primary to Medicare; and

2. A system in which such policies are carried out in practice.

Both these areas are to be examined in one interview. The reviewer shall use the checklist found in §70.5.4, Exhibit 4 to conduct the entrance interview. During the interview, the reviewer shall request a walk-through of the billing process.

B. Comparing Completed Admission Questions and Responses with Bills

The reviewer shall request completed inpatient, outpatient, and ER admission questions and responses (or the X12 270/271 transaction and existing notations or screen prints for hospitals using online admission query systems) for each Medicare beneficiary included in the bill sample. (See §70.2 concerning selection of sample.) It is not necessary that the beneficiary sign the completed admission questions and responses.

The form may be kept as paper, optical image, microfilm, or microfiche. If the hospital uses online admission screens, it is not necessary to obtain a copy of an admission form or screen print as long as the hospital has documented procedures for collecting and reporting other primary payer information. The reviewer may request screen prints, if necessary. Hospitals with online query systems are encouraged to retain affirmative and negative responses to the admission questions and responses for 10 years after the date of service. Should a hospital choose not to retain this information for up to 10 years, it does so at its own risk.

The reviewer shall analyze the admission questions and responses, the X12 270/271 transaction and existing notations, or online admission query procedures, for Medicare beneficiaries to determine whether the information provided on the admission questions and the responses match the bill. The reviewer shall check to see whether each response to the admission questions is reflected on the bill. For example, the reviewer shall check to ensure that the primary payer reflected on the admission questions and responses is shown as primary on the bill, including the name and address of the insurer(s) reflect correctly on the bill, etc. Reviewers should check this admissions information at the same time the bill review is conducted.

70.3.1 - Review of Form CMS-1450

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The reviewer shall obtain all Form CMS-1450s, also known as the UB-04, for each case included in the sample. The reviewer shall separate the bills according to bill type. The reviewer shall determine the amount billed to Medicare for each case. The reviewer shall review Form CMS-1450 for the following MSP data to determine if the billed amount is accurate and to conduct the comparison process using the admissions questions and responses described at §70.5.3, Exhibit 3. Item numbers reflect Form CMS-1450 field locators.

70.3.1.1 - General Review Requirements

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The reviewer shall review the following items, which are not specific to a particular bill type.

A. Condition Codes: FLs 24 thru 30

The following condition codes must be completed where applicable:

- 08 - Beneficiary would not provide information concerning other insurance coverage;
- 09 - Neither patient nor spouse employed;
- 10 - Patient and/or spouse is employed, but no GHP;
- 11- Disabled beneficiary but no Large Group Health Plan (LGHP);
- 28 - Patient and/or spouse's GHP is secondary to Medicare; or
- 29- Disabled beneficiary and/or family member’s LGHP is secondary to Medicare.

B. Occurrence Codes and Dates: FLs 32 thru 36

The following occurrence codes must be completed where applicable:

- 18 - Date of retirement (patient/beneficiary);
- 19 - Date of retirement (spouse);
- 24 - Date insurance denied; or,
- 25 - Date benefits terminated by primary payer (date on which coverage, including Workers' Compensation benefits or no-fault coverage, is no longer available to patient)

In relation to the reporting of occurrence codes 18 and 19, referenced above, hospitals are now instructed that when precise retirement dates cannot be obtained during the intake process, they should follow this policy:

When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, report his or her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his or her retirement date.

If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it has been at least five years since the beneficiary retired, enter the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2022, the provider reports the retirement date as January 4, 2017. As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

C. Value Codes and Amounts: FLs 39 thru 41

Value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services. Where the hospital is requesting conditional payment, zeros should be entered beside the appropriate value code in this item.

D. Payer Identification: FL 50A

Payer identification should be completed to show the identity of the other payer primary to Medicare. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A.

E. Payer Identification: FLs 50B, C

Payer identification should be completed to show when Medicare is the secondary or tertiary payer.

F. Insured's Name: FL 58A

The insured's name should be completed to show the name of the individual in whose name the insurance is carried. This information is of particular importance when Medicare is not the primary payer.

G. Patient's Name: FL 58B

In FL 58B, the hospital should have entered the patient's name as shown on the HI card or other Medicare notice or as annotated in the hospital's system.

H. Patient's Relationship to the Insured: FL 59

This item indicates whether the individual may have coverage based on the current employment status of a spouse or other family member.

I. Certification/SSN/Medicare beneficiary identifier: FLs 60A, B, C

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the hospital should have entered the patient's Medicare beneficiary identifier. If the hospital is reporting any other insurance coverage higher in priority than Medicare (e.g., employer coverage for the patient or the spouse or during the first 30 months of ESRD entitlement), the involved claim number for that coverage should be shown on the appropriate line.

70.3.1.2 - Working Aged Bills

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Value Codes and Amounts: FLs 39 thru 41

The following Working Aged value code and amount fields should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

- 12 - Working aged/beneficiary/spouse with group health plan coverage

70.3.1.3 - Accident Bills

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Occurrence Codes and Dates: FLs 39 thru 34

The following accident related occurrence codes should be completed to show the type and date of the accident:

- 01 - Auto accident;
- 02 - Auto accident with no-fault insurance;
- 03 - Accident involving civil court process;
- 04 - Employment related accident;
- 05 - Other accident

B. Value Codes and Amounts: FLs 39 thru 41

The following NGHP value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services:

- 14 - Automobile, or other no-fault insurance;
- 47 - Any liability insurance;

When occurrence codes 01 thru 04 and 24 are entered, they must be accompanied by the entry of the appropriate value code in FLs 39-41 (shown here) if there is another payer involved.

70.3.1.4 - Workers' Compensation Bills

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Condition Codes: FLs 24 thru 30

Condition codes should be completed with condition code 02 if the condition is employment related.

B. Value Codes and Amounts: FLs 39 thru 41

The following WC value code and amount should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.
15 - Workers' compensation

70.3.1.5 - ESRD Bills
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Value Codes and Amounts: FLs 39 thru 41

The following ESRD value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

13 - ESRD beneficiary in 30-month period with group health plan coverage

70.3.1.6 - Bills for Federal Government Programs
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Value Codes and Amounts: FLs 39 thru 41

The following two value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services:

- 16 - PHS, other Federal agency; and,
- 41 - Black lung.

70.3.1.7 - Disability Bills
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

A. Value Codes and Amounts: FLs 39 thru 41

The following disability value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

43 - Disabled beneficiary with large group health plan coverage

70.3.2 - Use of Systems Files for Review
(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The reviewer shall use the processing A/B MAC (Part A) paid history files, MSP files, and any other relevant data to assist in evaluating hospital procedures used in processing claims included in the sample. The purpose of a review is to determine whether the hospital has filed any improper claims. This can be accomplished by reviewing certain files before the on-site review, and other files after the review, subject to the reviewer judgment concerning the most effective use of a particular file.

The following areas should be reviewed against the A/B MACs (Part A) MSP files:

- Claims denied to determine whether a hospital is using information from the admission questions or from the HETS 270/271 properly;

- Claims paid to determine if proper amounts are being billed;

- No-pay bills. The reviewer shall check the A/B MACs (Part A) claims files to determine if the hospital is submitting no-pay bills;

- Adjustments to determine whether an automatic adjustment was needed. The reviewer may exercise discretion in determining what documentation is needed to justify the adjustment made; and

- MSP claim denials to determine whether a claim reflects changes in the beneficiary's current employment status.

In cases where the reviewer ascertains that an improper claim has been filed, the reviewer shall document these instances on the assessment form. (See §70.5.1, Exhibit 1.)

70.3.3 - Review of Hospitals with Online Admissions Query or Use of the X12 270/271 Transaction

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

While hospitals that solicit admission data through an online process are not required to retain hard copies of admission questions and responses, they must utilize a specific set of admission questions that seek the appropriate MSP information. The hospital must demonstrate that responses to admission questions asked are retained, and match the information shown on the bill. The reviewer shall use the same review requirements described in §70.3. Although not required, the use of screen prints of admission questions and responses will likely facilitate easier review, particularly for the bill comparison process described at §70.2. The reviewer shall notify the hospital in advance of any screen prints that are needed. If the provider uses the X12 270/271 transaction which contains existing notations obtained from the admission's interview copies of transactions must be used as part of your review following the steps outlined in this section.

70.4 - Assessment of Hospital Review

(Rev. 11550; Issued: 08-12-22; Effective: 10-13-22; Implementation:10-13-22)

The reviewer shall complete the assessment form (§70.5.1, Exhibit 1) for each hospital reviewed. The reviewer shall include selection criteria for the hospital, findings, and suggested recommendations, if appropriate. The reviewer shall include any discrepancies between the hospital's MSP policies and practices, as well as any hospital innovations that have been/are being devised to determine primary plan resources. The reviewer shall

note any discrepancies between the hospital's MSP policies and those required by law. The reviewer shall complete the Survey of Bills Reviewed, provided as an attachment to the assessment form. (See §70.5, Exhibit 2.) The reviewer shall indicate whether any follow-up action is needed in the appropriate column. If no follow-up action is needed, the reviewer shall enter "none." If action is needed, the reviewer shall briefly describe action required and time frame within which follow-up will commence. It is not necessary to estimate when action will be completed. The A/B MAC (Part A) shall send a copy of the assessment form, with its attachment, to the MSP Coordinator at the RO representing their MAC jurisdiction and to the ART system within 30 days of the date the review is completed.

The A/B MAC (Part A) shall send the hospital a copy of the assessment form as well. It shall follow-up every 30 days until appropriate corrective action is taken. It shall report continued problems after three months to the RO MSP Coordinator. The A/B MAC (Part A) may contact the RO MSP Coordinator representing its jurisdiction after 90 days if the hospital has not implemented any of its action plans. The RO shall follow-up with the provider as necessary to discuss when the action plans will be implemented.

70.5 - Exhibits

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Exhibit 1 - Assessment of Medicare Secondary Payer Hospital Review

Exhibit 2 - Survey of Bills Reviewed

Exhibit 3 - Entrance Interview Checklist: Admissions Questionnaire and Procedures

Exhibit 4 - Entrance Interview Checklist: Billing Procedures

70.5.1 - Exhibit 1: Assessment of Medicare Secondary Payer Hospital Review

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Contractor Name and No.: _____

ASSESSMENT OF MEDICARE SECONDARY PAYER HOSPITAL REVIEW

1 Name of hospital reviewed

2 Number of cases reviewed

3 Period of review (month/year)

4 Selection criteria used to determine why hospital selected for review. (See §70.1.1)

5 Describe findings in accordance with review protocol standards found at §70.3 and §70.4.

6 Recommendations

cc: CMS Regional Office, MSP Coordinator

Hospital Reviewed

Attachment: Survey of bills reviewed.

70.5.2 - Exhibit 2: Survey of Bills Reviewed
(Rev. 125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Name of Beneficiary	Mbi	Bill Type	Follow-Up Action Needed (Action Date)

70.5.3 - Exhibit 3: Entrance Interview Checklist
(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

Admissions Questionnaire and Procedures

A - Admissions Procedures

1 When is other payer information solicited? (During billing or during admission?)

2 Describe the process followed to solicit MSP information.

3 Do admissions staff receive training on soliciting MSP information? If so, describe the training. Do you think the staff understands the admissions questions well enough to solicit information and/or explain to beneficiaries?

4 Is MSP information obtained primarily from the patient, Medicare Common Working File, or in some other way?

B – Questionnaire

1 Are the admissions questionnaire data solicited through an online query (i.e. are the admissions questions asked and responses retained online) or through the X12 270/271 transaction?

2 Do you re-administer the questionnaire each time the patient is admitted? (It should be administered once per admission.)

3 Do you require the beneficiary's signature on the questionnaire? (No signature is required, and the hospital should be informed, if necessary.)

4 Are there written hospital policies, instructions or procedures concerning soliciting primary plan information? (Request copies for review.)

5 How long are admission questionnaires, or copies of the X12 270/271 transaction, retained, either online, in files, or both? (Requirements are found at §70.3.)

70.5.4 - Exhibit 4: Entrance Interview Checklist: Billing Procedures

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

1 Does the hospital bill for all bill types?

2 Are all claims electronically billed?

3 Is the information pertaining to a payer primary to Medicare contained on the admission questionnaire, the X12 270/271 transaction, or in an online database, available in its entirety to the billing department? (The billing department must be made aware of a payer primary to Medicare, e.g., working aged, ESRD, liability insurance.)

4 Do circumstances arise where the billing department obtains information directly from the patient? How is it obtained? Is the regular admissions form used to obtain the information in these situations?

5 Where there is the possibility of payment by a Federal government grant program, how does the hospital bill Medicare? (Determine whether the hospital bills both the grant program and Medicare, or only Medicare.)

6 How does the hospital bill the Department of Labor where the services are covered by the Federal Black Lung (BL) program? (The hospital should bill the black lung program first.)

7 Does the hospital have the ability to track workers' compensation (WC) cases on succeeding visits to the hospital or the outpatient department? Describe the tracking mechanism. How does the hospital bill for the succeeding visits? (Many times individuals may have to return to the hospital for additional medical services as a result of a WC occurrence.)

8 Does the hospital bill more than one primary insurer simultaneously? (Providers are prohibited from billing more than one insurer for primary payment. Reviewer should request a credit balance report for this aspect of the review.)

9 Where the patient is in the ESRD coordination period and an employer has paid in part, or should pay for the services, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

10 What is the hospital's policy on submission of no-pay bills?

11 Where a GHP or LGHP is the primary payer because the beneficiary is either working aged or disabled, or is involved in a no-fault or liability case, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R11997MSP	04/28/2023	Electronic Correspondence Referral System (ECRS) Updates to the Hierarchy Business Rules For Part D Drug Records and Added Alert Notifications Closed Request Inquiries Block, Completed ECRS Request and Inquiry Page, New Action Code Options and Clarified Zip File Usage	05/30/23	13175
	02/09/2023	Online Electronic Correspondence Referral System (ECRS) Added Edits Checking for Medicare Entitlement and Part D Enrollment For Specific Group Health Plan (GHP) Types and Batch Edits. Effective April, 2023, Hierarchy Rules Will Be Applied to Primary and Supplemental Part D Records	03/09/2023	13078
R11788MSP	01/19/2023	Electronic Correspondence Referral System (ECRS) Updates to the Check Amount Screens, Removal of the Insurer Phone Number, Batch Processing Error Code Updates, Removal and Relocation of Excluded ICD-10 Diagnosis Codes and Clarification of Action Code II	02/21/2023	12995
R11754MSP	12/21/2022	Electronic Correspondence Referral System (ECRS) Restoration of Patient Relationship Code 18, Update to Medicare Secondary Payer (MSP) Inquiry Transactions for Deceased Beneficiaries, and Clarification of Existing ECRS User Guide Policy Based on the Medicare Administrative Contractors Feedback	01/23/2023	12916
R11550MSP	08/12/2022	Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5	10/13/2022	12765
R11247MSP	01/28/2022	Electronic Correspondence Referral System (ECRS) Updates to the Medicare Secondary Payer (MSP) Development	02/28/2022	12608

Rev #	Issue Date	Subject	Impl Date	CR#
		Letter and Additional Operational Updates		
R11069MSP	10/21/2021	ECRS Updates to the Prescription Drug Assistance Request (PDAR) Fields; Medicare Secondary Payer Future Date Fields; Electronic File Transfer Naming Convention; Updated ICD-10 Diagnosis Codes for No-Fault Plan Insurance Type D and the Addition of Reason Code 94	11/22/2021	12484
R10401MSP	10/28/2020	Electronic Correspondence Referral System (ECRS) User Guide Updates	11/24/2020	12010
R125MSP	03/22/2019	Update to Publication (Pub.) 100-05 to Provide Language-Only Changes for the New Medicare Card Project	04/22/2019	11193
R123MSP	08/17/2018	Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual	11/20/2018	10863
R124MSP	08/31/2018	Updates to Chapters 5 and 6 of Publication 100-05 to Further Clarify Medicare Secondary Payer (MSP) Processes that Include Electronic Correspondence Referral System (ECRS) Requests Submissions and Timely Submission of MSP I Records, General Inquiries and Hospital Reviews	10/01/2018	10855
R116MSP	11/24/2015	Instructions on Using the Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A CMS-1450 Paper Claims, Direct Data Entry (DDE), and 837 Institutional Claims Transactions	10/05/2015	8486
R114MSP	09/18/2015	Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures	07/06/2015	8984

Rev #	Issue Date	Subject	Impl Date	CR#
		Regarding Ongoing Responsibility for Medicals (ORM)		
R113MSP	08/06/2015	Instructions for the Shared Systems and Medicare Administrative Contractors (MACs) to follow when a Medicare Residual Payment must be Paid on Workers' Compensation Medicare Set-aside Arrangement (WCMSA) or for Ongoing Responsibility of Medicals (ORM) Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Claims	01/04/2016	9009
112MSP	06/04/2015	Inpatient Hospital Claims and Medicare Secondary Payer (MSP) Claims with Medicare Coinsurance Days and/or Medicare Lifetime Reserve Days Occurring in the Seventh to Fifteenth Years	04/06/2015	8932
R11MSP	05/08/2015	Instructions on Using the Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A CMS-1450 Paper Claims, Direct Data Entry (DDE), and 837 Institutional Claims Transactions – Rescinded and replaced by Transmittal 116	10/05/2015	8486
R110MSP	03/06/2015	Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM) – Rescinded and replaced by Transmittal 114	07/06/2015	8984
R108MSP	11/07/2014	Inpatient Hospital Claims and Medicare Secondary Payer (MSP) Claims with Medicare Coinsurance Days and/or Medicare Lifetime Reserve Days Occurring in the Seventh to Fifteenth Years – Rescinded and replaced by Transmittal 112	04/06/2015	8932
R107MSP	10/24/2014	Update to Pub. 100-05, Chapters 05 and 06 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	11/28/2014	8947

Rev #	Issue Date	Subject	Impl Date	CR#
R100MSP	03/26/2014	The Medicare Contractors and the Shared Systems Shall Send the Correct Cost Avoided Indicator and Special Project Type to the Common Working File (CWF) so the Correct Savings is applied both to the Medicare Secondary Payer (MSP) Savings Report and the Originating Contractor	04/07/2014	8495
R99MSP	02/14/2014	Apply Front-End Edits to Electronic Correspondence Referral System (ECRS) Files Submitted Via ECRS Web and PDR Assistance Request Action Code BN	03/17/2014	8563
R98MSP	11/22/2013	The Medicare Contractors and the Shared Systems Shall Send the Correct Cost Avoided Indicator and Special Project Type to the Common Working File (CWF) so the Correct Savings is applied both to the Medicare Secondary Payer (MSP) Savings Report and the Originating Contractor – Rescinded and replaced by Transmittal 100	04/07/2014	8495
R97MSP	09/27/2013	Prevent Electronic Correspondence Referral System (ECRS) Inquiries from Being Submitted with Insurance Types Other than A, J, K, R, S, or Blank Spaces	10/01/2013	8302
R96MSP	08/30/2013	ECRS Batch file Layout Changes for ICD-10 Codes	01/06/2014	8300
R94MSP	06/28/2013	Update the Medicare Secondary Payer Manuals to Indicate Unsolicited Refund Documentation is No Longer a Justification for Submission of an “I” Record	07/30/2013	8253
R90MSP	02/02/2013	Inpatient Hospital Claims and Medicare Secondary Payer (MSP) Claims with Medicare Coinsurance Days and/or Medicare Lifetime Reserve Days Occurring in the Third or More Calendar Years	07/01/2013	8130
R89MSP	08/30/2012	Expanding the Coordination of Benefits (COB) Contractor Numbers to Include	01/07/2013	7906

Rev #	Issue Date	Subject	Impl Date	CR#
		11139 and 11142 for the Common Working File (CWF)		
R88MSP	08/17/2012	Expanding the Coordination of Benefits (COB) Contractor Numbers to Include 11139 and 11142 for the Common Working File (CWF)	01/07/2013	7906
R87MSP	08/03/2012	Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims	10/01/2012	7355
R86MSP	05/25/2012	Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims	01/07/2013	7355
R85MSP	05/03/2012	Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation Medicare Secondary Payer (MSP) Claims – Rescinded and replaced by Transmittal 86	10/01/2012	7355
R84MSP	03/30/2012	Electronic Correspondence Referral System (ECRS) Web Enhancements Phase I	04/02/2012	7614
R83MSP	02/03/2012	Electronic Correspondence Referral System (ECRS) Web Enhancements Phase I	04/02/2012	7614
R82MSP	08/05/2011	Updates to the Electronic Correspondence Referral System (ECRS) Web User Guide v2.0 and Chapter 5	09/05/2011	7463
R81MSP	07/29/2011	Requesting the Common Working File (CWF) to Cease Submitting First Claim Development (FCD) and Trauma Code Development (TCD) Alerts to the	01/03/2012	7483

Rev #	Issue Date	Subject	Impl Date	CR#
		Coordination of Benefits Contractor (COBC)		
R80MSP	03/18/2011	Updating the Medicare Secondary Payer (MSP) Part B Savings Report to Include Additional Saving Information and Additional Special Project Numbers	07/05/2011	7265
R79MSP	02/18/2011	Updates to the Electronic Correspondence Referral System (ECRS) Web User Guide v1.0 and Quick Reference Card v1.0	03/01/2011	7309
R78MSP	01/28/2011	Updates to the Electronic Correspondence Referral System (ECRS) Web User Guide v1.0 and Quick Reference Card v1.0 – Rescinded and replaced by Transmittal 79	03/01/2011	7309
R76MSP	11/19/2010	Common Working File (CWF) Medicare Secondary Payer (MSP) Coordination of Benefits Contractor (COBC) Number Update and Implementation of MSP Group Health Plan (GHP) COBC Hierarchy Rules as related to Mandatory Insurer Reporting	04/04/2011	7216
R75MSP	10/29/2010	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	04/04/2011	7027
R73MSP	02/05/2010	Instructions on How to Process Negative Claim Adjustment Reason Code (CARC) Adjustment Amounts When Certain CARCs Appear on Medicare Secondary Payer Claims	07/06/2010	6736
R70MSP	06/26/2009	Instructions on Utilizing 837 Institutional CAS Segments for Medicare Secondary Payer (MSP) Part A Claims	04/06/2009, 07/06/2009, and 10/05/2009	6426

Rev #	Issue Date	Subject	Impl Date	CR#
R69MSP	05/15/2009	Update to the Electronic Correspondence Referral System (ECRS) User Guide v10.0 and Quick Reference Card v10.0	07/06/2009	6479
R67MSP	03/27/2009	Instructions for Utilizing 837 Professional Claim Adjustment (CAS) Segments for Medicare Secondary Payer (MSP) Part B Claims	04/06/2009 and 07/06/2009	6426
R66MSP	03/27/2009	Instructions on Utilizing 837 Institutional CAS Segments for Medicare Secondary Payer (MSP) Part A Claims - Rescinded and replaced by Transmittal 70	04/06/2009 and 07/06/2009	6426
R63MSP	12/19/2008	Instructions on Utilizing 837 Institutional CAS Segments for Medicare Secondary Payer (MSP) Part A Claims – Rescinded and replaced by Transmittal 66	04/06/2009 and 07/06/2009	6275
R62MSP	12/12/2008	Instructions for Utilizing 837 Professional Claim Adjustment (CAS) Segments for Medicare Secondary Payer (MSP) Part B Claims – Rescinded and replaced by Transmittal 67	04/06/2009 and 07/06/2009	6211
R60MSP	09/19/2008	Expanding the Mandatory Insurer Reporting (MIR) Coordination of Benefits (COB) Contractor Numbers for the Common Working File (CWF)	01/05/2009	6182
R57MSP	10/27/2006	Instructions for the Coordination of Medicare Secondary Payer (MSP) Claims for the Competitive Acquisition Program (CAP)	01/02/2007	5332
R56MSP	10/13/2006	Updating the Medicare Secondary Payer (MSP) Manual for Consistency on Instructing Part A Contactors on Handling MSP Claims with Condition Code (cc) 08	04/02/2007	5266
R55MSP	07/21/2006	Update the Fiscal Intermediary Shared System (FISS) on Processing Medicare	01/02/2007	4355

Rev #	Issue Date	Subject	Impl Date	CR#
		Secondary Payer (MSP) Fully Paid Claims When Condition Code 77 is Not Present on Outpatient and Home Health Claims		
R50MSP	05/12/2006	Clarification of Exhaustible Benefits and HIGLAS' Role Within Transmittal 20	06/12/2006	4190
R46MSP	12/21/2005	Updates to the Electronic Correspondence Referral System (ECRS) User Guide v9.0 and Quick Reference Card v9.0	01/03/2006	4162
R44MSP	11/10/2005	Updates to the Electronic Correspondence Referral System (ECRS) User Guide v9.0 and Quick Reference Card v9.0-Replaced by Revision 46MSP	12/27/2005	4162
R39MSP	10/21/2005	Request to Change Lead Contractor	11/19/2005	4088
R38MSP	10/14/2005	Hospital Audit Workload Updates	01/14/2006	4056
R27MSP	03/25/2005	Updates to the Electronic Correspondence Referral System (ECRS) User Guide v8.0 and Quick Reference Card v8.0	04/25/2005	3787
R25MSP	02/25/2005	Changes Included in the Medicare Modernization Act (MMA)	04/25/2005	3219
R20MSP	10/29/2004	Medicare Secondary Payer (MSP) Savings Report Redesign	04/06/2005	3181
R14MSP	04/09/2004	Allocation of Initial Claims Entry Activities Where Claim is Paid Secondary to Medicare	N/A	2074
R13MSP	03/19/2004	Updates to the Electronic Correspondence Referral System (ECRS) User Guide v7.0 and Quick Reference Card v7.0	04/19/2004	3174
R11MSP	02/27/2004	Hospital Reference Lab Services	03/29/2004	3064
R05MSP	12/22/2003	ECRS	02/13/2004	3026

Rev #	Issue Date	Subject	Impl Date	CR#
R04MSP	12/19/2003	ECRS-Replaced by Revision 5MSP	01/20/2004	3026
R01MSP	10/01/2003	Initial Issuance of Manual	N/A	N/A

Back to top of Chapter