CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 72	**Date: October 29, 2009**
	Change Request 6501

Subject: Claim Adjustment Reason Code (CARC) Update for Medicare Secondary Payer (MSP) Claims Processing

I. SUMMARY OF CHANGES: This CR instructs Contractors and SSMs how the new or updated adjustment shall be utilized when processing MSP claims.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *April 1, 2010
IMPLEMENTATION DATE: April 5, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-05	Transmittal: 72	Date: October 29, 2009	Change Request: 6501

SUBJECT: Claim Adjustment Reason Code (CARC) Update for Medicare Secondary Payer (MSP) Claims Processing

EFFECTIVE DATE: April 1, 2010

IMPLEMENTATION DATE: April 5, 2010

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instruct health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. CARCs are an integral part of processing electronic and hardcopy Medicare Secondary Payer (MSP) claims. CARC changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors and Shared System Maintainers (SSMs) are notified about these code changes through another change request; however, this CR instructs Contractors and SSMs how these new or updated adjustments shall be utilized when processing MSP claims.

B. Policy: All Medicare contractors and associated SSMs must utilize CAS segment adjustments on the 837 Institutional and Professional claims, including the paper remittance advice for hardcopy MSP claims, when adjudicating MSP claims. Shared System Maintainers and contractors must make the necessary changes on a regular basis as per this MSP CARC update change request.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6501.1	The Medicare contractors and shared system maintainers shall take into consideration CRs 6426, 6427 and 6453 when implementing this instruction.	X	X	X	X	X	X	X	X		
6501.2	The Medicare contractors and shared system maintainers shall update codes that have been modified, added or deleted that apply to MSP claims.	X	X	X	X	X	X	X	X		
6501.3	The shared system maintainers shall modify their systems to utilize the following claim adjustment reason code when processing MSP claims.						X	X	X	X	
6501.4	All Contractors and Shared Systems shall recognize CARC 230: No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6501.4.1	The Part A shared systems shall create and populate a new one byte MSP liability indicator field with a "Y" on the CWF HUIP, HUOP, HUHH, and HUHC claim transactions at the claim level when there is a CARC 230 on an incoming MSP claim.						X			X	
6501.4.2	The Part A shared systems shall populate a "space" in the new indicator field on all HUIP, HUOP, HUHH, and HUHC claim transactions when CARC 230 is not found on incoming MSP claims.						X				
6501.4.3	The Part B shared systems shall create and populate a new one byte MSP liability indicator field with a "Y" on the CWF HUBC and HUDC claim transactions at the line level when there is a CARC 230 on an incoming MSP claim.							X	X	X	
6501.4.4	The Part B shared systems shall populate a "space" in the new indicator field on all other HUBC and HUDC claim transactions when CARC 230 is not found on incoming MSP claims.							X	X		
6501.5	When CARC 230 appears on an MSP claim, the shared system shall send the claim to CWF and CWF shall verify if an open liability record is on CWF.						X	X	X		
6501.5.1	The shared system shall send an indicator to CWF telling CWF to verify whether the diagnosis codes on CWF match the diagnosis codes on the claim and determine whether Medicare shall pay or not make a payment on the claim.						X	X	X	X	NCH NGD MBD
6501.5.2	If there is an open MSP record on CWF and the diagnosis codes on CWF and on the claim match, CWF shall reject the record and Medicare contractors shall process the claim accordingly based on the promptly period rules.	X	X	X	X	X	X	X	X	X	
6501.5.2.1	If the claim is received during the promptly period and Medicare does not know whether the liability insurer will make payment during the promptly period Medicare shall reject/deny the claim.	X	X	X	X	X	X	X	X		
6501.5.2.2	If the claim is received outside the promptly period or Medicare knows the insurer will not make a payment during the promptly period Medicare shall pay conditionally.	X	X	X	X	X	X	X	X		
6501.5.2.3	Contractors shall follow the promptly period rules as found in IOM 100-05, Chapters 1 – 7.	X	X	X	X	X					
6501.5.3	The CWF shall issue an over-rideable MSP error code 68xx for non-GHP claims where an MSP claim does	X	X	X	X	X				X	

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	not match an MSP occurrence on CWF or the diagnosis codes on the claim does not match the diagnosis codes found in CWF.										
6501.5.3.1	The new error code will be placed in the override field on the detail of the claim.	X	X	X	X	X	X	X	X		
6501.5.4	The contractor shall send an ECRS request to the COBC to develop when the diagnosis codes on the claim and CWF do not match.	X	X	X	X	X					
6501.6	If the primary payer makes a payment on the claim, Medicare shall make a secondary payment if the service is covered and payable by Medicare.	X	X	X	X	X	X	X	X		
6501.6.1	The indicator shall not be sent to CWF if the non-ghp mad e a payment on the claim.	X	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	MSP claims received with CARC 230 should be developed and/or processed, as necessary, according to MSP Liability and no-Fault rules stated in the MSP provisions.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.