CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 94	**Date: June 28, 2013**
	Change Request 8253

SUBJECT: Update the Medicare Secondary Payer Manuals to Indicate Unsolicited Refund Documentation is No Longer a Justification for Submission of an "I" record.

I. SUMMARY OF CHANGES: On July 31, 2002, the Centers for Medicare and Medicaid Services (CMS) issued Transmittal AB-02-107, instructing Medicare Contractors on when they are permitted to submit "I" records to the Common Working File (CWF). It was noted in the transmittal that the receipt of an unsolicited check is no longer a justification for submission of an "I" record. Although the transmittal was issued as an instruction to the Medicare contractors, Internet Only Manual (IOM) Pub.100-05, Chapter 5, §10.1 was not updated with this instruction. The purpose of this CR is to update the cited IOM section to 1) indicate receipt of an unsolicited check is no longer a justification for submission of an "I" record; and 2) require that Medicare contractors follow the Electronic Correspondence Referral System (ECRS) process to submit unsolicited check information to the Coordination of Benefits Contractor (COBC).

This CR also updates IOM Pub.100-05, Chapter 4, §10.3 to include clarification on what contractors must do for MSP claims that require further clarification from providers to properly process MSP claims. Pub.100, Chapter 6, § 20.2 has been updated to include the most current Medicare terminology.

EFFECTIVE DATE: July 30, 2013
IMPLEMENTATION DATE: July 30, 2013

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/10.3/Contractors Claim Referrals to the COBC
R	5/10.1/Contractors MSP Auxiliary File Update Responsibility
	6/Table of Contents
R	6/20.2/Medicare Secondary Payer (MSP) Maintenance Transaction Record/Medicare Contractor MSP Auxiliary File Update Responsibility

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 94	Date: June 28, 2013	Change Request: 8253

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EFFECTIVE DATE: July 30, 2013
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I. GENERAL INFORMATION

A. Background: On July 31, 2002, the Centers for Medicare and Medicaid Services (CMS) issued Transmittal AB-02-107, instructing Medicare Contractors on when they are permitted to submit "I" records to the Common Working File (CWF). It was noted in the transmittal that the receipt of an unsolicited check is no longer a justification for submission of an "I" record. Although the transmittal was issued as an instruction to the Medicare contractors, Internet Only Manual (IOM) Pub.100-05, Chapter 5, §10.1 was not updated with this instruction. The purpose of this CR is to update the cited IOM section to 1) indicate receipt of an unsolicited check is no longer a justification for submission of an "I" record; and 2) require that Medicare contractors follow the Electronic Correspondence Referral System (ECRS) process to submit unsolicited check information to the Coordination of Benefits Contractor (COBC).

This CR also updates IOM Pub.100-05, Chapter 4, §10.3 to include clarification on what contractors must do for MSP claims that require further clarification from providers to properly process MSP claims. Pub.100, Chapter 6, § 20.2 has been updated to include the most current Medicare terminology.

B. Policy: Contractors shall not consider the receipt of an unsolicited check as justification for the submission of an "I" record. CMS maintains this position because an unsolicited check often does not contain the source, including name and address of the entity that returned the funds. Therefore, COBC lacks the information necessary to contact that source through the "I" record process.

Additionally, contractors shall adhere to the following criteria in determining which ECRS transaction to use: 1) Submit an MSP Inquiry when there is no existing, or related, MSP record on the CWF; 2) Submit a CWF MSP Assistance Request to apply a termination date to an existing MSP record, and 3) Submit a CWF Assistance Request when the information on CWF is incorrect, or the MSP record has been terminated erroneously or deleted.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8253.1	Medicare Contractors shall not send an "I" record to CWF based on information found on an unsolicited refund.	X	X		X	X	X	X					
8253.2	Medicare contractors shall submit an ECRS request to the COBC when information found on	X	X		X	X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	an unsolicited check requires additional information and development.												
8253.3	Medicare contractors shall follow the examples below to determine which ECRS transaction to use: 1. Submit an MSP Inquiry when there is no existing, or related, MSP record on the CWF; 2. Submit a CWF Assistance Request to apply a termination date to an existing MSP record; or 3. Submit a CWF Assistance Request when information on the CWF is incorrect, or the MSP record has been terminated erroneously or deleted.	X	X		X	X	X	X					
8253.4	Medicare contractors shall take note of and properly apply the updated Medicare terminology found in Chapter 6, section 20.2.	X	X		X	X	X	X					
8253.5	Medicare contractors shall follow the claims processing procedures for Other Claims (other than clean) as outlined in Pub.100-04, chapter 1, § 80.3and in the Pub100-05, chapter 4, §10.3 in determining whether a MSP claim is unprocessable and then following up with providers as deemed necessary.	X	X		X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, 410-786-1418 or Richard.Mazur2@cms.hhs.gov , Erica Watkins, 410-786-2805 or Erica.Wtkins@cms.hhs.gov

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

VI. FUNDING

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

No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Secondary Payer (MSP) Manual

Chapter 4 - Coordination of Benefits Contractor (COBC) Requirements

10.3 - Contractors Claim Referrals to the COBC

(Rev.94, Issued: 06-28-13, Effective Date: 07-30-13, Implementation Date: 07-30-13)

Contractors retain the responsibility to process claims for Medicare payment. The COBC is not responsible for processing any claims, nor will it handle any mistaken payment recoveries or claims specific inquiries (telephone or written).

Contractors should instruct providers not to forward claims or copies of claims to the COBC. All claims related activity (e.g., processing, adjustments) remains the contractor's jurisdiction (including claims submitted with value codes, primary payer information, EOB's, copies of checks). If claims are received that do not contain enough information to create an MSP record with an "I" validation indicator, contractors shall follow current claims processing guidelines and send the information through Electronic Correspondence Referral System (ECRS) (see Chapter 5, §10) as an MSP inquiry. They should send this information within one business day of processing the claim.

The COBC will return any claims received to the submitter indicating that claims should be sent to its *Medicare* contractor only for claims processing and payment.

In cases of claims clarification where the contractor would normally contact (telephone) the provider to complete the processing of a claim in order to avoid suspending or RTP'ing the claim back to the provider, it may continue this practice. However, if it finds that the clarification provided by the provider is still questionable or is in direct opposition to CWF, it must follow current claims processing guidelines and send the information through ECRS as an MSP inquiry (see Chapter 5, §10). It must send this information within one business day of processing the claim.

The following are examples of fields, or information missing, on an MSP claim and/or on CWF that may require clarification from a provider for Contractors to properly process MSP claims. The below list is not inclusive since there could be other reasons why a MSP claim cannot be processed without further clarification from the provider (NOTE: Contractors must continue to follow the claims processing procedures for Other Claims (other than clean) as outline in 100-04/1/80.3 to determine if a claim is unprocessable):

- Health Insurance Claim Number;
- MSP type;
- Validity indicator;
- MSP effective date;
- Contractor identification number;

- Insurer name;
- Patient relationship;
- Insurance type; and
- Incomplete MSP data elements found on the claim.

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

10.1 - Contractors MSP Auxiliary File Update Responsibility
(Rev.94, Issued: 06-28-13, Effective Date: 07-30-13, Implementation Date: 07-30-13)

The capability to update the CWF MSP auxiliary file is, essentially, a function of only the COBC. Contractors do not have the capability to delete any MSP auxiliary file records, including those they have established. If they believe a record should be changed or deleted, they shall use the COBC ECRS Web (discussed in §10.2).
Contractors retain the responsibility of adding termination dates to MSP auxiliary records already established on CWF with a "Y" validity indicator, where there is no discrepancy in the validity of the information contained on CWF. Contractors do not have the capability to alter an existing termination date. There are only three instances in which the contractor shall retain the capability to update CWF. They are:

1 - The contractor receives a phone call or correspondence from a beneficiary representative, beneficiary, third party payer, provider, another insurer's explanation of benefits or other source that establishes, exclusive of any further required development or investigation that MSP no longer applies.

Examples of such contacts include a telephone call from a beneficiary to report retirement or cessation of group health insurance. The contractor shall post a termination date to the MSP auxiliary record using a "Y" validity indicator. While Contractors should update CWF as soon as possible so that proper payments can be made; contractors shall update CWF within the lesser of:

- Ten (10) calendar days from completion of the evaluation (i.e. comparing the incoming information with the existing CWF MSP record and determining that there are no discrepancies between the incoming data and the existing CWF MSP record allowing for a termination date to be posted), but no later than

- Forty-five (45) calendar days of the mailroom date-stamped receipt/date of phone call, as applicable

EXAMPLE 1

Scenario

Mr. Doe is calling to report that his employer group health coverage has ended.

Contractor Action

The contractor shall check for a matching auxiliary record on CWF and terminate the record if no conflicting data are present. If the contractor cannot add a termination date, the contractor shall submit a CWF assistance request (See §10.2 Attachment 1). The contractor shall not transfer the call to the COBC.

EXAMPLE 2

Scenario

Mrs. X is calling to report that she has retired.

Contractor Action

The contractor shall check for a matching auxiliary record on CWF and terminate the record if no conflicting data are present. If the contractor cannot add a termination date or if the date on CWF needs to be altered, the contractor shall submit a CWF assistance request (See §10.2 Attachment 1). The contractor shall not transfer the call to the COBC.

EXAMPLE 3

Scenario

Union Hospital is calling to report that the group health plan MSP period contained on the CWF for beneficiary X should be terminated.

Contractor Action

The contractor shall check for matching auxiliary record on CWF and terminate if no conflict in evidence is presented. If the contractor cannot add a termination date or if the date on CWF needs to be altered, the contractor shall submit a CWF assistance request (See §10.2 Attachment 1). The contractor shall not transfer the call to the COBC.

2 - The contractor receives a 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 contractor 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 one hundred (100) days of the effective date of the incoming "I" record). The contractor shall update CWF within ten (10) calendar days from completion of the evaluation. It shall not submit a new record with a "Y" or any record with an "N" validity indicator.

3 - The contractor receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development.

The contractor shall add the MSP occurrence using an "I" validity indicator. The contractor shall update CWF within ten (10) calendar days from completion of the evaluation.

The contractor 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 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 one hundred (100) calendar days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria shall be rejected with an SP 20 error code.

The COBC shall receive a trigger from the CWF when an “I” record is transmitted and applied. The COBC develops and confirms all "I" maintenance transactions established by the contractor. If the COBC has not received information to the contrary within one hundred (100) calendar days, the “I” validity indicator will be converted to a "Y". If the COBC develops and determines there is no MSP, the COBC will delete the "I" record.

An "I" record should never be established when the mandatory fields of information are not readily available to the contractor on its claim or associated attachment (e.g., other payer’s explanation of benefits (EOB) paid).

In addition, effective January 1, 2003, 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, COBC 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 MSP record on the CWF.
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 will open and close the case/MSP issue, the Medicare Contractors should submit an MSP inquiry. They should refer to ECRS manual for more information regarding closed cases.

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

If the contractor has 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 contractor shall use the Part A entitlement date as the MSP effective date. Contractors shall add termination dates when an “I” record is initially established, where applicable. A contractor shall not add a termination date to an already established "I" record.

The following are mandatory fields for MSP records with a validity indicator of "Y" and "I":

- Health Insurance Claim Number;
- MSP type;
- Validity indicator;
- MSP effective date;
- Contractor 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 contractor’s use in correcting MSP utilization error codes.

Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP) CWF Process
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(Rev. 94, Issued: 06-28-13)

20.2 - Medicare Secondary Payer (MSP) Maintenance Transaction Record/*Medicare Contractor* MSP Auxiliary File Update Responsibility
(Rev.94, Issued: 06-28-13, Effective Date: 07-30-13, Implementation Date: 07-30-13)

Effective January 1, 2001, the capability to update the CWF Medicare Secondary Payer (MSP) auxiliary file is essentially a function of only the Coordination of Benefits Contractor (COBC). *Medicare Contractors* will not have the capability to delete any MSP auxiliary file records, including those that a specific *Medicare Contractor* has established. If it is believed that a record should be changed or deleted, *Medicare Contractors* use the COB Contractor Electronic Correspondence Referral System (discussed in the Medicare Secondary Payer (MSP) Manual, Chapters 4 and 5, CWF Assistance Request option, to notify the COB Contractor. *Medicare Contractors* process claims in accordance with existing claims processing guidelines.

There are only two instances in which *Medicare Contractors* will retain the capability to update CWF. They are:

A. A claim is received for secondary benefits and the contractor could, without further development (for example, the EOB from another insurer or third party payer contains all necessary data), add an MSP occurrence and pay the secondary claim. *Medicare Contractors* must use a new validity indicator of "I" to add any new MSP occurrences, and update CWF within 10 calendar days from completion of the evaluation *Medicare Contractors* cannot submit a new record with a "Y" or any record with an "N" validity indicator.

B. A claim is received for conditional payment, and the claim contains sufficient information to create an "I" record without further development. *Medicare Contractors* add the MSP occurrence using an "I" validity indicator. They must update CWF within 10 calendar days from completion of the evaluation.

Medicare Contractors will transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. Receipt of an "I" validity indicator will result in a CWF trigger to the COB Contractor. The COB Contractor will develop and confirm all "I" maintenance transactions established by *Medicare Contractors*. If the COB Contractor has not received information to the contrary within 100 calendar days, the COB Contractor will automatically convert the "I" validity indicator to a "Y." If the COB Contractor develops and determines there is no MSP, the COB Contractor will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to a *Medicare Contractors* on a claim attachment. If they have the actual date that Medicare became secondary payer, they use that as the MSP effective date. If that information is not available, they use the Part A entitlement date as the MSP effective date. *Medicare Contractors* may include a termination date when they initially establish an "I" record. They may not add a termination date to an already established "I" record.

Effective January 1, 2003, CWF accepts an "I" record only if no MSP record (validity indicator of either "I" or "Y;" open, closed or deleted status) with the same MSP type already exists on CWF with an effective date within 100 days of the effective date of the incoming "I" record. "I" records submitted to CWF that fail these edit criteria will reject with an SP 20 error code. The resolution for these cases is to transfer **all** available information to the COBC via the Electronic Correspondence Referral System (ECRS) CWF assistance request screen. It will be the responsibility of the COBC to reconcile the discrepancy and make any necessary modifications to the CWF auxiliary file record.

In addition, effective January 1, 2003, 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, COBC 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 MSP record on the CWF.
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 will open and close the case/MSP issue, the *Medicare Contractors* should submit an MSP inquiry. They should refer to *the* ECRS manual for more information regarding closed cases. The check should be deposited to unapplied cash until COBC makes an MSP determination.