



Provider Inquiry Assistance

Instructions for Utilizing 837 Professional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part B Claims (This Change Request (CR) rescinds and fully replaces CR6211) – JA6427

Related CR Release Date: March 27, 2009

Date Job Aid Revised: April 6, 2009

Effective Date: July 1, 2009

Implementation Date: July 6, 2009

Key Words MM6427, CR6427, R67MSP, CAS, Professional, Secondary, MSP

Contractors Affected

- Medicare Carriers
- Durable Medical Equipment Medicare Administrative Contractors (DME MACs)
- Part A/B MACs

Provider Types Affected Physicians, providers, and suppliers submitting claims to Medicare Carriers, DME MACs, and/or A/B MACs for services provided to Medicare beneficiaries



- CR6427 informs Medicare contractors about the changes necessary to derive MSP payment calculations from incoming 837 4010-A1 claims transactions.
 - CR6427 is limited to providers billing Part B contractors as noted above.
-

Provider Needs to Know...

- MLN Matters article 6427 reminds providers to include the CAS segment related group codes, claim adjustment reason codes, and associated adjustment amounts on their MSP 837 claims they send to their Medicare contractor.
- Medicare contractors need these adjustments to properly process MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer (e.g., an explanation why the claim's billed amount was not fully paid).
- The instructions detailed by CR6427 are necessary to ensure:
 - Medicare complies with Health Insurance Portability and Accountability Act (HIPAA) transaction and code set requirements,
 - Physician and suppliers code for the CAS segments claims to reflect any adjustments made by primary payers; and
 - MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.
- Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If the provider is obligated to accept, or voluntarily accepts, an amount as payment in full from the primary payer, they must use the group code Contractual Obligation to identify their contractual adjustment amount. This amount is also known as the obligated to accept as payment in full amount (OTAF). Details of the MSP provisions may be found in the *Medicare Secondary Payer Manual* and in 42 Code of Federal Regulations 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.

Background

- HIPAA requires that Medicare and all other health insurance payers in the United States comply with the Electronic Data Interchange standards for health care as established by the Secretary of Health and Human Services.
- The X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available at <http://www.wpc-edi.com> on the Internet.

Operational Impact

N/A

**Reference
Materials**

The related MLN Matters article can be found at
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6427pdf> on the CMS
website.

The official instruction (CR6427) issued regarding this change may be found at
<http://www.cms.hhs.gov/Transmittals/downloads/R67MSP.pdf> on the CMS website.
