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

Table of Contents
(Rev. 125, 03-22-19)

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

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

The Coordination of Benefits (COBC) contractor completes MSP updates on a daily basis upon receipt of notice that another payer is primary to Medicare (e.g., an explanation of benefits, a beneficiary questionnaire, a notice from a third party payer, etc.). Every claim for a given beneficiary is validated against the same MSP data housed in a CWF, MSP auxiliary file, thus permitting uniform processing. Contractor claims data inconsistent with a CWF, MSP auxiliary file will cause rejects and/or error conditions. An MSP auxiliary record consistent with an identified MSP situation must be present before a payment is approved for an MSP claim. An MSP auxiliary record is established by an MSP maintenance transaction submitted to CWF. The claim must agree with the MSP auxiliary record that was established, or it will not process.

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

10.1 - Overview of CWF MSP Processing
(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

The CWF, MSP auxiliary file is updated with maintenance transactions from the BCRC, except for the following situations:

1. If the contractor receives a phone call or correspondence from an attorney/other beneficiary representative, beneficiary, third party payer, provider, another insurer’s Explanation of Benefits (EOB) or other source that establishes, exclusive of any further required development or investigation, that MSP no longer applies, it must add termination dates to MSP auxiliary records already established by the BCRC on CWF with a "Y" validity indicator where there is no discrepancy in the validity of the information contained on CWF. (See §20.1.4)

2. If the contractor receives a claim for secondary benefits and 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, it submits 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 100 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. It cannot submit a new record with a "Y" or any record with an "N" validity indicator.

3. If the contractor receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development, it must add the MSP occurrence using an "I" validity indicator (only if no MSP record 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). 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.

It shall 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. "I" records should only be submitted to CWF if no MSP record 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 be rejected with an SP 20 error code. Receipt of an "I" validity indicator will result in a CWF trigger to the BCRC. The BCRC will develop and confirm all "I" maintenance transactions established by the contractor. If the BCRC has not received information to the contrary within 100 calendar days, the BCRC will automatically convert the "I" validity indicator to a "Y". If the BCRC develops and determines there is no MSP, the BCRC 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 attachment or unsolicited refund documentation. If the contractor has the actual date that Medicare became secondary payer, it shall use that as the MSP effective date. If that information is not available, it shall use the Part A entitlement date as the MSP effective date. It may include a termination date when it initially establishes an "I" record. It may not add a termination date to an already established "I" record.

Prior to April 1, 2002, the contractors post MSP records to CWF where beneficiaries were entitled to Part B benefits, but not entitled to Part A benefits. An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF edits to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. If a contractor submits an Electronic Correspondence Referral System (ECRS) transaction to the BCRC to add a GHP MSP record where there is no Part A entitlement, reason code of 61 will be returned. Contractors should not submit an ECRS request to BCRC to establish a GHP MSP record when there is no Part A entitlement. Contractors that attempt to establish an "I" record will receive a CWF error.

The CWF will continue to allow the posting of MSP records where there is no Part A entitlement when non-employer GHP situations exists, such as automobile, liability, and workers' compensation. Where a non-employer GHP situation exists, contractors should continue to submit ECRS transactions and establish "I" records, as necessary. Note, in the past MACs have sent ECRS requests to the BCRC requesting that section 111 records be updated. The BCRC has rejected most of these requests based on CMS hierarchy of Section 111 entities taking precedence on updating contractor number 11121 and

11122 MSP records. However, CMS has clarified that the BCRC shall accept MACs ECRS requests to update contractor number 11121 and 11122 MSP records based on conditions below. MACs shall continue to submit ECRS requests to the BCRC for COB contractor numbers 11121 and 11122 for the following circumstances:

- When the MAC receives information indicating the Group number or policy number of the primary payer has changed,
- When the MAC learns of a retirement date for the beneficiary and a termination date must be added to the MSP record,
- When the MAC receives information indicating the Insurance Type A, J or K has changed or conflicts with what is on the CWF MSP Auxiliary file, or
- When a MAC receives a primary payer EOB or remittance advice showing payment for a deleted or closed Section 111 GHP MSP record that should remain open. Note, the BCRC will not accept an NGHP record update request for this type of MSP claim situation.

Please note it is to the discretion of the BCRC to approve these Section 111 ECRS requests upon review. Approval or denial of such ECRS requests shall be sent to the MACs by the BCRC.

MSP Auxiliary maintenance transactions, for the four situations listed above, and claims for payment approval may be submitted to CWF in the same file. The CWF processes the MSP maintenance transactions before processing claims. This procedural flow is to assure processing for claim validation against the most current MSP data. If the MSP claim is accepted, the CWF host will return all MSP data on a beneficiary's auxiliary file to the submitting contractor via an "03" trailer. If the claim is rejected, the host will return only those MSP records that fall within the dates of service on the claim. A maximum of 17 MSP auxiliary records may be stored in CWF for each beneficiary. The validity indicator field of each CWF, MSP auxiliary record indicates confirmation that:

- Another insurer is responsible for payment ("Y" in the field); or
- Medicare is the primary payer ("N" in the field, IEQ record).

Medicare contractors may access the MSP auxiliary file through the online CWF file display utility Health Insurance Master Record (HIMR).

Medicare contractors cannot delete MSP auxiliary records. They send such requests to the BCRC via the Electronic Correspondence Referral System (ECRS). (See Chapter 5, §§10.)

10.2 - Definition of MSP/CWF Terms

(Rev. 89, Issued: 08-30-12; Effective Date: 01-01-13; Implementation Date: 01-07-13)

Following is a list of terms and their definitions used in MSP/CWF processing.

MSP Auxiliary File - Up to 17 beneficiary MSP occurrences/records on the CWF database.

MSP Auxiliary Record - Record of beneficiary MSP information. One MSP record/occurrence within the beneficiary's MSP auxiliary file.

Occurrence - One MSP occurrence/record within the beneficiary's MSP auxiliary file.

MSP Effective Date - Effective date of MSP coverage.

MSP Termination Date - Termination date of MSP coverage.

Validity Indicator

- Y - Beneficiary has MSP coverage (there is a primary insurer for this period of time).
- N - No MSP coverage
- I - See §10.1.

MSP Types - Reason for other coverage entitlement.

- A = Working Aged
- B = End stage renal disease (ESRD)
- D = Automobile/Liability No-Fault
- E = Workers' Compensation (WC)
- F = Federal, Public Health
- G = Disabled
- H = Black Lung (BL)
- I = Veterans Affairs (VA)
- L=Liability
- W=Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA)

NOTE: VA and other Federal payments are exclusions rather than MSP non-payments.

Cost Avoided Claim - A claim returned without payment because CWF indicators indicate another insurer is primary to Medicare. (See Chapter 5, §60 for complete description.)

Transaction Type - Identifies type of maintenance record.

- 0 = Transaction type to add or change MSP data
- 1 = Transaction type to delete MSP data

Override Code - Code used to bypass CWF, MSP edit to allow primary Medicare payment. (See §40.4 for a detailed explanation.)

COB MSP Contractor Numbers

CWF Source Codes	MSP Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
	33333 = Litigation Settlement	V	4000
P	55555 = HMO Rate Cell Adjustment	U	3000
B,D,T,U,V, or W	77777 = IRS/SSA/HCFA Data Match (I, II, III, IV, V, or VI)	Y	1000
Q	88888 = Voluntary Data Sharing Agreements	Q	5000
O	99999 = Initial Enrollment Questionnaire	T	2000

COB Contractor Numbers prior to January 1, 2001

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
0	11100 = COB Contractor		6000
1	11101 = Initial Enrollment Questionnaire	K	6010
2	11102 = IRS/SSA/CMS Data Match	E	6020
3	11103 = HMO Rate Cell	F	6030
4	11104 = Litigation Settlement	G	6040
5	11105 = Employer Voluntary Reporting	H	6050
6	11106 = Insurer Voluntary Reporting	H	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
9	11109 = Secondary Claims Investigation	G	6090
X	11110 = Self Reports	H	7000
Y	11111 = 411.25	J	7010

NOTE: Effective January 1, 2001, the following COB Contractor numbers and nonpayment/payment denial codes will be used.

COB Contractor Numbers Effective January 1, 2001

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
0	11100 = COB Contractor	00 Effective 4/1/2020	6000
1	11101 = Initial Enrollment Questionnaire	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
10 - Effective 4/1/2002	11110 = Self Reports	H	7000
11 - Effective 4/1/2002	11111 = 411.25	J	7010

11101, 11102, 11103, 11104, and 11105 use the same non-payment denial codes as their previous contractor numbers (i.e., 33333, 55555, 77777, 88888, 99999). Savings from the old and new numbers, if applicable will be reported together (e.g., 11101 and 99999, etc). There must be a conversion of the MSP savings to the new non-payment/payment denial codes as of January 1, 2001.

Additional COB Contractor Numbers Effective April 1, 2002

Effective April 1, 2002, CWF is expanding the source code field and the nonpayment/ payment denial code field from 1-position fields to 2-position fields.

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
12	11112 = Blue Cross-Blue Shield Voluntary Data Sharing 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
23	11123 = To be determined	23	7023
24	11124 = To be determined	24	7024
25	11125 = Recovery Audit Contractor-California	25	7025
26	11126 = Recovery Audit Contractor-Florida	26	7026
27	11127 = To be determined	27	7027

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
“”	“”	“”	“”
39	11139 = GHP Recovery	39	7039
41	11141 =NGHP Non-ORM	41	7041
42	11142 = NGHP ORM Recovery	42	7042
43	11143 = COBC/Medicare Part C/Medicare Advantage	43	7043
44	11144 = To be determined	44	7044
“”	“”	“”	“”
99	11199 = To be determined	99	7099

20 - MSP Maintenance Transaction Record Processing

(Rev. 1, 10-01-03)
B3-4307.2, A3-3696.2, AB-00-107

The COBC shall submit an MSP maintenance transaction to establish an MSP auxiliary record within 10 calendar days of receipt of notice that another payer is primary to Medicare. The CWF applies extensive editing to the maintenance transaction. If an MSP maintenance transaction does not meet all edit criteria, error codes specific to the failed edit(s) will be returned via the CWF, MSP Maintenance Transaction Response. A complete record layout and field descriptions are contained in CWF Systems Documentation, Record Name: CWF, MSP Maintenance Transaction Response. For Out-of-Service Area transactions, the CWF OSA Maintenance Transaction Response is used. Its complete record layout and field descriptions are contained in CWF Systems Documentation, Record Name: CWF, MSP Maintenance Transaction Response. The consistency edit error codes and edit definitions are contained in CWF Systems Documentation Record Name: MSP Maintenance Transaction Error Codes. MSP transactions that pass all edits are applied to the CWF, MSP auxiliary file.

20.1 - Types of MSP Maintenance Transactions

(Rev. 1, 10-01-03)
B3-4307.2.A, A3-3696.2.A

The three types of maintenance transactions are add, change, and delete.

The COBC shall use MSP maintenance transaction type "O" (zero) for an add or a change transaction.

- The transaction is an add when no matching MSP occurrence - NO MATCHING MSP auxiliary record - is found for the beneficiary;

- The transaction is a change when a matching MSP occurrence is found.

After a successful MSP maintenance transaction processes through CWF, before and after images of the MSP auxiliary file occurrence are written to the MSP Audit File.

20.1.1 - MSP Add Transaction

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

The two situations in which the "add" maintenance transaction is used are:

- There is no MSP auxiliary file record for a beneficiary. In this case, the "add" transaction creates an MSP auxiliary record containing the new MSP transaction and sets the MSP indicator on the beneficiary's master record; or

- There is an MSP auxiliary file record but no matching occurrence for the beneficiary. In this case, the "add" transaction adds the maintenance transaction as a new occurrence.

The following fields are mandatory for a validity indicator of "Y" or "I" (Another insurer is responsible for payment):

- Medicare beneficiary identifier;

- MSP type (MSP code);

- Validity indicator;

- MSP effective date;

- Contractor identification number;

- Insurer name (CWF will allow a space in the second position provided the third position contains a valid character other than a space.);

- Patient relationship; and

- Insurance type.

A "Y" or "I" record CANNOT be established without the insurer name. Note, if the Insurance Company Name is blank, or contains one of the abbreviated values that should not be used as found in the ECRS manual, then it is considered an error.

NOTE: Although the insurer address cannot be MANDATORY, it should be provided whenever possible.

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

(1) MSP Effective Date: Use the Part A entitlement date.

(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).

20.1.2 - MSP Change Transaction

(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.

An MSP change transaction occurs when the key fields on the incoming maintenance transaction match those on an existing MSP auxiliary occurrence.

A match occurs when the following items are the same:

Medicare beneficiary identifier;
MSP type;
MSP effective date;
Insurance type; and
Patient relationship

When these items match, the balance of the record is overlaid.

No change transactions will be permitted to records established, except for the addition of a termination date, by any contractor other than the COBC.

20.1.3 - MSP Delete Transaction

(Rev. 89, Issued: 08-30-12; Effective Date: 01-01-13; Implementation Date: 01-07-13)

The MSP maintenance type "1" is used to delete an MSP auxiliary occurrence. This transaction checks the beneficiary's master record for an MSP indicator. The COBC is responsible for submitting this transaction. Medicare contractors advise the COBC, via the ECRS, of the need to process an MSP maintenance type 1 transaction (delete).

Only certain COBC contractor numbers may delete MSP occurrences originated or last updated by certain other COBC contractor numbers. No contractor number may update or delete a MSP occurrence originated or last updated by contractor number 11100 except contractor number 11100. Please see the table below for the exact criteria for deletion of

MSP occurrences last updated by COBC contractor numbers. A match shall occur in order to delete the MSP occurrence originated or last updated by one COBC contractor number with a delete transaction submitted under a certain COBC contractor number. For example, COBC contractor numbers 11100, 11110, 11141 and 11140 are the only contractor numbers that may delete a MSP occurrence originated or last updated by 11110. The COBC will remain the sole contractor that may delete COBC contractor numbers. The COBC shall maintain the necessary logic to control updating and deleting MSP occurrences based on COB contractor numbers. Medicare contractors shall follow the current restrictions regarding deletion of MSP records.

Originating or Last Updating Contractor Number	Contractor Number That Can Update/Delete
11100	11100
11110	11100, 11110, 11139, 11141, 11140, 11142
11141	11100, 11110, 11139, 11141, 11140, 11142
11140	11100, 11110, 11139, 11141, 11140, 11142
11121	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11143	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11139	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11142	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11105	11100, 11110, 11141, 11140, 11121, 11143, 11105, 11102, 11139, 11142
11102	11100, 11110, 11141, 11140, 11121, 11143, 11105, 11102, 11139, 11142
All others	Any

The COBC shall allow MIR (MMSEA Section 111) GHP responsible reporting entities (RREs) to override this update/delete hierarchy reflected in the table above under certain circumstances. MIR GHP RREs must submit an override code to the COBC after receiving an error on an attempted update/delete. The COBC will then apply the update/delete using contractor number 11121. This override capability shall not apply to MSP occurrences originated or last updated by 11100.

The COBC shall apply the same hierarchy rules represented in the table above to transactions that have the effect of adding back or reopening matching MSP occurrences previously deleted.

20.1.4 - MSP Termination Date Transaction
(Rev. 1, 10-01-03)

Intermediaries and carriers add 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. They handle phone calls and written

inquiries relating to simple terminations of existing MSP occurrences. Simple terminations are defined as terminations that can be made to a MSP auxiliary record without further development or investigation. They shall not transfer these calls or written inquiries to the COBC. In determining whether a call is to be handled by them or the COBC, the intermediary or carrier establishes the basis of the call. The following are examples when **not** to transfer a termination request to the COBC for further action.

EXAMPLE 1:

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

Intermediary/Carrier action: The intermediary/carrier checks for matching auxiliary record on CWF and terminates, if no conflicting data are presented. The intermediary/carrier does not transfer the call to the COBC.

EXAMPLE 2:

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

Intermediary/Carrier action: The intermediary/carrier checks for matching auxiliary record on CWF and terminates if no conflicting data are presented. The intermediary/carrier does not transfer the call to the COBC.

EXAMPLE 3:

Scenario: The intermediary/carrier receives written correspondence that benefits are exhausted for an automobile case.

Intermediary/Carrier Action: The intermediary/carrier checks for matching auxiliary record on CWF. The lead contractor terminates in accordance with existing guidelines (e.g., accounting of monies spent). The non-lead contractor refers the case to the lead contractor based on pre-COB guidelines as outlined in the fiscal year (FY) 2001 MSP post pay Budget and Performance Requirements (BPRs). It does not forward the correspondence to the COBC.

EXAMPLE 4

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

Intermediary/Carrier action: The intermediary/carrier checks for matching auxiliary record on CWF and terminates if no conflict in evidence is presented. It does not transfer the call to the COBC.

COBC Role

The COBC adds termination dates to records not covered in A, above. In addition, the COBC updates MSP occurrences as a result of a request from an intermediary or carrier, or as a result of COB development and investigation. The following are examples of when to transfer a termination request to the COBC for further action.

EXAMPLE 1:

Scenario: The termination date is greater than six months prior to the date of accretion (i.e., SP 57 error code) for all COBC numbers (e.g., 11100-11111, 33333, 77777, 88888, or 99999). (All COBC numbers follow the old data match 6-month termination rule.)

Intermediary/Carrier action: The intermediary/carrier sends a CWF assistance request to the COBC.

COBC action: The COBC checks for matching record on CWF and terminates. In cases where discrepant information exists, the COBC will investigate to determine the proper course of action.

EXAMPLE 2:

Scenario: The intermediary/carrier receives information with regard to termination that is discrepant with the information contained on CWF.

Intermediary/Carrier action: The intermediary/carrier forwards to the COBC for investigation via ECRS.

COBC action: The COBC checks for matching record on CWF, investigates, and terminates if appropriate.

20.2 - Medicare Secondary Payer (MSP) Maintenance Transaction Record/Medicare Contractor MSP Auxiliary File Update Responsibility

(Rev. 124, Issued: 08-31-18, Effective: 10-01-18, Implementation: 10-01-18)

Effective January 1, 2001, the capability to update the CWF Medicare Secondary Payer (MSP) auxiliary file is essentially a function of only the BCRC. 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 <u>two</u> 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 validity indicator of "I" to add new MSP occurrences and update CWF. 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. 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. 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.

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 BCRC via the Electronic Correspondence Referral System (ECRS) CWF assistance request screen. It will be the responsibility of the BCRC 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, BCRC 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. A “related” record means if an MSP record on CWF has the same relationship code, is for the same insurer, and has part or all of the MSP time span reflected on 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 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 BCRC makes an MSP determination.

30 - CWF, MSP Auxiliary File
(Rev. 1, 10-01-03)

A maximum number of 17 MSP auxiliary records may be stored in CWF for each beneficiary. The COBC is responsible for deletion of a record when the maximum storage is exceeded using the following priority:

- Oldest "deleted" (flagged for deletion) occurrence;
- Oldest "confirmed no" occurrence;
- Oldest termination date; or
- Oldest maintenance date for the MSP type to be added.

30.1 - Integrity of MSP Data
(Rev. 1, 10-01-03)

The CWF MSP data base integrity is totally dependent upon COBC input, supported by input by FIs and carriers to the COBC. The COBC is responsible for submitting to CWF MSP information it believes to be of the highest quality. It shall investigate information thoroughly before making changes to an existing CWF MSP auxiliary record.

Intermediaries and carriers shall update their internal MSP control file with the information received via the CWF "03" trailer response. If more current information is available that conflicts with that received from CWF, the contractor is responsible for advising the COBC, via ECRS, of the need to correct the CWF, MSP auxiliary record.

30.1.1 - Maintenance and Clean-Up of MSP Auxiliary files in CWF
(Rev. 1, 10-01-03)

1998 MSP BPRs for MSP

As a result of MSP litigation settlement agreements CMS negotiated, records were added to the MSP Auxiliary file under contractor number 33333 (litigation settlement). Under the settlement agreements, CMS was to receive records for only those Medicare beneficiaries for which Medicare was secondary payer per a settlement agreement However, some data provided to CMS contain records for Medicare beneficiaries covered under a retirement group health plan or supplemental plan. These records were added to the CWF, MSP Auxiliary File. As these erroneous records are identified, beneficiaries, providers and the primary health plan have been notifying contractors that the records need to be corrected to again reflect Medicare as primary. All MSP Auxiliary File records, including these litigation records, need to be corrected and complete to maintain the integrity of the MSP Auxiliary File. As they become aware of an erroneous record, intermediaries and carriers are to advise the COBC via ECRS.

30.1.2 - MSP Effective Date Change Procedure
(Rev. 1, 10-01-03)

When the COBC becomes aware that an MSP effective date is incorrect, it shall perform the following functions:

- Delete the auxiliary record containing the incorrect MSP effective date using an MSP delete transaction; and

- Submit a CWF, MSP maintenance transaction with the correct MSP effective date to establish a new auxiliary record.

NOTE: When the beneficiary is entitled to both Parts A and B, the COBC shall use the Part A entitlement date, if the insurance effective date is prior to entitlement to Medicare.

30.1.3 - CWF/MSP Transaction Request for Contractor Assistance
(Rev. 1, 10-01-03)

Instances occur when the intermediary or carrier determines that the MSP effective date is not correct. When this happens, the contractor shall advise the COB, via ECRS, of the need to change the MSP effective date and shall provide the COBC with documentation to substantiate the change.

30.2 - MSP Termination Date Procedure
(Rev. 1, 10-01-03)

A. Future Termination Dates

The CWF allows future termination dates up to six months for all MSP types, except ESRD. For ESRD, CWF uses the following criteria:

- MSP effective date prior to February 1, 1990, allows for termination date up to 12 months after the effective date;

- MSP effective date February 1, 1990, through February 29, 1996, allows for termination date up to 18 months after the effective date; or

- MSP effective date March 1, 1996, and later allows for termination date up to 30 months after the effective date.

B. Add Termination Dates

A termination date can only be added (not changed) to MSP auxiliary records established by contractor number "77777" or by contractor numbers "11101-11106."

C. Termination for "Y" Validity Indicator

A CWF MSP auxiliary record with a "Y" validity indicator establishes Medicare as the secondary payer. When posting a termination date to this record the "Y" validity indicator should not be changed. The record indicates a valid MSP occurrence and all future claims submitted will edit against the time frame posted. The contractor shall advise the COBC via ECRS when MSP no longer applies, and the COBC shall enter the termination date.

30.3 - MSP Auxiliary File Errors

(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.

Maintenance transactions to the MSP Auxiliary file reject invalid data with errors identified by a value of "SP" in the disposition field on the Reply Record. A trailer of "08" containing up to four error codes will always follow. Listed below are the possible MSP Maintenance Transaction error codes with a general description.

Error Code	Definition	Valid Values
SP11	Invalid MSP transaction record type	"HUSP," "HISP," or "HBSP"
SP12	Invalid *Medicare beneficiary identifier*	Valid *Medicare beneficiary identifier*
SP13	Invalid Beneficiary Surname	Valid Surname
SP14	Invalid Beneficiary First Name Initial	Valid Initial
SP15	Invalid Beneficiary Date of Birth	Valid Date of Birth
SP16	Invalid Beneficiary Sex Code	0=Unknown, 1=Male, 2=Female

Error Code	Definition	Valid Values
SP17	Invalid Contractor Number	CMS Assigned Contractor Number
SP18	Invalid Document Control Number	Valid Document Control Number
SP19	Invalid Maintenance Transaction Type	0=Add/Change MSP Data transaction, 1=Delete MSP Data Transaction
SP20	Invalid Validity Indicator	Y= Beneficiary has MSP Coverage, I= Entered by intermediary/ carrier - Medicare Secondary-COB investigate, N -No MSP coverage
SP21	Invalid MSP Code	A=Working Aged B=ESRD C= Conditional Payment D= No Fault E= Workers' Compensation F= Federal G= Disabled H= Black Lung I= Veteran's Administration L= Liability
SP22	Invalid Diagnosis Code 1-5	Valid Diagnosis Code
SP23	Invalid Remarks Code 1-3	See the Valid Remarks Codes Below
SP24	Invalid Insurer Type	See definitions of Insurer Type codes below

Error Code	Definition	Valid Values
SP25	Invalid Insurer Name An SP25 error is returned when the MSP Insurer Name is equal to one of the following: Supplement Supplemental Insurer Miscellaneous CMS Attorney Unknown None N/A Un Misc NA NO BC BX BS BCBX Blue Cross Blue Shield Medicare	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; : Insurer Name must be present if Validity Indicator = Y
SP26	Invalid Insurer Address 1 and/or Address 2	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP27	Invalid Insurer City	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP28	Invalid Insurer State	Must match U.S. Postal Service state abbreviation table.
SP29	Invalid Insurer Zip Code	If present, 1st 5 digits must be numeric. If foreign country "FC" state code, the nine positions may be spaces.

Error Code	Definition	Valid Values
SP30	Invalid Policy Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP31	Invalid MSP Effective Date (Mandatory)	Non-blank, non-zero, numeric, number of days must correspond with the particular month. MSP Effective Date must be less than or equal to the current date.
SP32	Invalid MSP Termination Date	Must be numeric; may be all zeroes if not used; if used, date must correspond with the particular month.
SP33	Invalid Patient Relationship	The following codes are valid for all MSP Auxiliary occurrences regardless of accretion date: 01 = Self; Beneficiary is the policy holder or subscriber for the other GHP insurance reflected by the MSP occurrence **–or-** Beneficiary is the injured party on the Workers Compensation, No-Fault, or Liability claim 02 =Spouse or Common Law Spouse 03 = Child 04 = Other Family Member 20 = Life Partner or Domestic Partner The following codes are only valid on MSP Auxiliary occurrences with accretion dates **PRIOR TO 4/4/2011**: 05 = Step Child 06 = Foster Child 07 = Ward of the Court

Error Code	Definition	Valid Values
		08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ donor 12 = Cadaver Donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored Dependent 17 = Minor Dependent of a Minor Dependent 18 = Parent 19 = Grandparent 20 = Life Partner or Domestic Partner
SP34	Invalid subscriber First Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP35	Invalid Subscriber Last Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP36	Invalid Employee ID Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP37	Invalid Source Code	Spaces, A through W, 0 – 19, 21, 22, 25, 26, 39, 41, 42, 43. See §10.2 for definitions of valid CWF Source Codes.
SP38	Invalid Employee Information Data Code	Spaces if not used, alphabetic values P, S, M, F. See §30.3.4 for definition of each code.
SP39	Invalid Employer Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP40	Invalid Employer Address	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP41	Invalid Employer City	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP42	Invalid Employer State	Must match U.S. Postal Service state abbreviations.

Error Code	Definition	Valid Values
SP43	Invalid Employer ZIP Code	If present, 1st 5 digits must be numeric. If foreign country 'FC' is entered as the state code, and the nine positions may be spaces.
SP44	Invalid Insurance Group Number	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP45	Invalid Insurance Group Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP46	Invalid Pre-paid Health Plan Date	Numeric; number of days must correspond with the particular month.
SP47	Beneficiary MSP indicator not on for delete transaction.	Occurs when the code indicating the existence of MSP auxiliary record is not equal to "1" and the MSP maintenance transaction type is equal to '1.'
SP48	MSP auxiliary record not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP49	MSP auxiliary occurrence not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP50	Invalid function for update or delete. Contractor number unauthorized	See MSP Auxiliary Record add/update and delete function procedures above
SP51	MSP Auxiliary record has 17 occurrences and none can be replaced	
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B and G when the Validity Indicator is "Y"	Accretion Dates prior to 4/4/2011: Patient Relationship must be 01 or 02 for MSP Code A (Working Aged). Patient Relationship must be 01, 02, 03, 04, 05, 18 or 20 for MSP Codes B (ESRD) and G (Disabled). Accretion Dates 4/4/2011 and subsequent:

Error Code	Definition	Valid Values
		Patient Relationship must be 01 or 02 for MSP Code A (Working Aged). Patient Relationship must be 01, 02, 03, 04, or 20 for MSP Codes B (ESRD) and G (Disabled).
SP53	The maintenance transaction was for Working Aged EGHP and there is either a ESRD EGHP or Disability EGHP entry on file that has a termination date after the Effective date on the incoming transaction or is not terminated, and the contract number on the maintenance transaction is not equal to "11102", "11104", 11105", "11106", "33333", "66666", "77777", "88888", or "99999".	
SP54	MSP Code A, B or G has an Effective date that is in conflict with the calculated age 65 date of the Bene.	For MSP Code A, the Effective date must not be less than the date at age 65. For MSP Code G, the Effective date must not be greater than the date at age 65.
SP55	MSP Effective date is less than the earliest Bene Part A or Part B Entitlement Date.	
SP56	MSP Prepaid Health Plan Date must be = to or greater than MSP Effective date or less than MSP Term. date.	
SP57	Termination Date Greater than 6 months prior to date added for Contractor numbers other than 11100 – 11119, 11121, 11122, 11126, 11139, 11141, 11142, 11143, 33333, 55555, 77777, 88888, and 99999.	
SP58	Invalid Insurer type, MSP code, and validity indicator combination.	If MSP code is equal to "A" or "B" or "G" and validity indicator is equal to "I" or "Y" then insurer type must not be equal to spaces.
SP59	Invalid Insurer type, and validity indicator combination	If validity indicator is equal to "N" then insurer type must be equal to spaces.
SP60	Other Insurer type for same period on file (Non "J" or "K") Insurer type on incoming	Edit applies only to MSP codes:

Error Code	Definition	Valid Values
	maintenance record is equal to "J" or "K" and Insurer type on matching aux record is not equal to "J" or "K".	A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP61	Other Insurer type for same period on file ("J" or "K") Insurer type on incoming maintenance record is not equal to "J" or "K" and Insurer type on matching aux record is equal to "J" or "K".	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP62	Incoming term date is less than MSP Effective date.	
SP66	MSP Effective date is greater than the Effective date on matching occurrence on auxiliary file	
SP67	Incoming term date is less than posted term date for Provident	
SP72	Invalid Transaction attempted	A HUSP add transaction is received from a FI or Carrier (non-COBC) with a validity indicator other than "I."
SP73	Invalid Term Date/Delete Transaction	A MAC attempts to change a Term Date on a MSP Auxiliary record with a "I" or "Y" Validity Indicator that is already terminated, or trying to add Term Date to "N" record.
SP74	Invalid cannot update "I" record.	A MAC submits a HUSP transaction to update/change an "I" record or to add an "I" record and a match MSP Auxiliary occurrence exists with a "I" validity indicator.
SP75	Invalid transaction, no Medicare Part A benefits	A HUSP transaction to add a record with a Validity Indicator equal to "I" (from an FI/carrier) or "Y" (from BCRC) with an MSP Type equal to "A," "B," "C," or "G" and the effective date of the transaction is not within a current or prior Medicare Part A entitlement period, or the transaction is greater than the

Error Code	Definition	Valid Values
		termination date of a Medicare entitlement period.
SP76	MSP Type is equal to W (Workers' Compensation Medicare Set-Aside) and there is an open MSP Type E (Workers' Compensation) record.	
SP79	A MAC attempts to create/enter a value in the ORM field on the incoming I HUSP record (makes sure that a MAC cannot update or overlay an ORM value in the ORM field).	Valid Values for the 1-byte ORM indicator on the CWF MSP Detail screen (MSPD) are: Y (Yes) or a space. A "Y" ORM indicator value denotes that the ORM existed for a period of time, not necessarily that it currently exists. An ORM indicator of a "space" implies that an RRE has not assumed ORM.
SP80	A MAC attempted to create/enter an ORM indicator on an MSP record other than a D, E, and L.	The 1- byte ORM indicator (valid values = Y or a space) shall only be received on HUSP transactions with MSP Codes "D, E, and L."
SP81	A contractor, other than the following contractor numbers of 11100, 11110, 11122, 11141, and 11142, attempts to update, remove or set the existing ORM record indicator of a "Y" to a "space."	To ensure that no other entity than the following contractor numbers (11100, 11110, 11122, 11142, and 11142) can modify an existing record's ORM indicator to equal a "space," if originally it was a "Y."

30.3.1 - Valid Remarks Codes
(Rev. 1, 10-01-03)

Remark Code	Definition
01	Beneficiary retired as of termination date.
02	Beneficiary's employer has less than 20 employees.
03	Beneficiary's employer has less than 100 employees

Remark Code	Definition
04	Beneficiary is dually entitled to Medicare, based on ESRD and Age or ESRD and disability
05	Beneficiary is not married.
06	The Beneficiary is covered under the group health plan of a family member whose employer has less than 100 employees.
07	Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan that has elected the working aged exception.
08	Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan that has not elected the working aged exception.
09	Beneficiary is self-employed.
10	A family member of the Beneficiary is self-employed.
20	Spouse retired as of termination date.
21	Spouse's employer has less than 20 employees.
22	Spouse's employer has less than 100 employees.
23	Spouse's employer has less than 100 employees but is in a qualifying multiple or multi-employer plan.
24	Spouse's employer has less than 20 employees and is multiple or multi-employer plan that has elected the working aged exception.
25	Spouse's employer has less than 20 employees and is multiple or multi-employer plan that has not elected the working aged exception.
26	Beneficiary's spouse is self-employed
30	Exhausted benefits under the plan
31	Preexisting condition exclusions exist
32	Conditional payment criteria met
33	Multiple primary payers, Medicare is tertiary payer
34	Information has been collected indicating that there is not a parallel plan that covers medical services

Remark Code	Definition
35	Information has been collected indicating that there is not a parallel plan that covers hospital services
36	Denial sent by EGHP, claims paid meeting conditional payment criteria.
37	Beneficiary deceased.
38	Employer certification on file.
39	Health plan is in bankruptcy or insolvency proceedings.
40	The termination date is the Beneficiary's retirement date.
41	The termination date is the spouse's retirement date.
42	Potential non-compliance case, Beneficiary enrolled is supplemental plan.
43	GHP coverage is a legitimate supplemental plan.
44	Termination date equals transplant date
50	Employment related accident
51	Claim denied by workers comp
52	Contested denial
53	Workers compensation settlement funds exhausted
54	Auto accident - no coverage
55	Not payable by black lung
56	Other accident - no liability
57	Slipped and fell at home
58	Lawsuit filed - decision pending
59	Lawsuit filed - settlement received
60	Medical malpractice lawsuit filed
61	Product liability lawsuit filed
62	Request for waiver filed

Remark Code	Definition
70	Data match correction sheet sent
71	Data match record updated
72	Vow of Poverty correction

30.3.2 - Valid Insurance Type Codes

(Rev. 76, Issued: 11-19-10; Effective Date: 04-01-11; Implementation Date: 04-04-11)

Insurer Type Code	Definition
A	GHP Hospital and Medical Coverage **-or-** Other Non-GHP
B	GHO
C	Preferred Provider Organization (PPO)
D	Third Party Administrator arrangement under an Administrative Service Only (ASO) contract without stop loss from any entity.
E	Third Party Administrator arrangement with stop loss insurance issued from any entity.
F	Self-Insured/Self-Administered.
G	Collectively-Bargained Health and Welfare Fund.
H	Multiple Employer Health Plan with at least one employer who has more than 100 full and/or part-time employees.
I	Multiple Employer Health Plan with at least one employer who has more than 20 full and/or part-time employees.
J	GHP Hospitalization Only Plan - A plan that covers only Inpatient hospital services.
K	GHP Medical Services Only Plan - A plan that covers only non-inpatient medical services.
M	Medicare Supplemental Plan, Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan.
R	GHP Health Reimbursement Arrangement

S	GHP Health Savings Account
SPACES	Unknown

NOTE: For MSP occurrences with accretion dates of 4/4/2011 and subsequent, the only valid Insurer Type Codes are A, J, K, R, S, and spaces.

30.3.3 - Other Effective Date and Termination Date Coverage Edits
(Rev. 1, 10-01-03)

If MSP Code:	**Effective Date Must Be Greater Than**
A - Working Aged	January 1, 1983 (830101)
A - Working Aged	Calculated Date beneficiary turned 65 (first day of month).
B - ESRD	October 1,1981
D - No Fault	December 1, 1980
E - Workers' Compensation	July 1, 1966
F - Federal/Public Health	July 1, 1966
H - Black Lung	July 1, 1973
I - Veterans' Administration	July 1, 1966
G - Disabled (43)	January 1, 1987
G - Disabled	Prior to the first day of the month the Beneficiary turns 65.
L - Liability	December 1, 1980

Other Termination date coverage edits are:

- If contractor number is that of the IRS/SSA/CMS data match project ("77777"), the term date may be equal to or greater than the effective date,
- Cannot be greater than the current date plus six months, except for MSP code = B, and
- Cannot be greater than the first day the beneficiary turned 65 if the MSP code is B or G.

30.3.4 - Employee Information Data Code
(Rev. 1, 10-01-03)

Employee Information Data Code	Valid Values
P	Patient
S	Spouse
M	Mother
F	Father

30.4 - Automatic Notice of Change to MSP Auxiliary File
(Rev. 8, 2-6-04)

The Common Working File (CWF) sends MSP transactions to all contractors of record when an MSP auxiliary record is created or changed for any beneficiary. The CWF sends this electronic transaction, known as a HUSC transaction, daily to the appropriate contractors' standard system. All contractors shall update their internal MSP files with HUSC transactions automatically. After the internal MSP files have been updated automatically, the contractor's MSP staff shall follow their current instructions regarding MSP recovery activities. This includes (1) initiating claims history searches within existing post-pay guidelines using HUSC transaction information and (2) initiating recovery actions on potential mistaken payments when appropriate.

Alerts are sent to Medicare contractors when an update is made to an MSP record. Medicare contractors shall continue to receive Unsolicited Response (UR) alerts. Although, COBC is not required to receive UR alerts for updates that were made to COBC contractor numbers (e.g., 111XX contractor numbers) as COBC receives a disposition that informs COBC that the transaction was accepted. Processing UR alerts initiated by COBC adds duplication to COBC's database and requires excess processing. The CWF is no longer required to transmit UR alerts to COBC for updates that were made to contractor number 111XX.

40 - MSP Claim Processing
(Rev. 1, 10-01-03)

The CWF performs consistency edit checks on claims submitted to it. Refer to CWF Systems Documentation for the complete record layout and field descriptions. Record names are:

- CWF Part B Claim Record, and
- CWF Inpatient/SNF Bill Record.

The MSP claims failing the consistency edits receive a reject with the appropriate disposition code, reject code, and MSP trailer data. Refer to CWF Systems Documentation, Record Name: CWF, MSP Basic Reply Trailer Data for the complete record layout and field descriptions. Claims passing the consistency edit process are reviewed for utilization compliance. Claims rejected by the utilization review process are rejected with the appropriate disposition code, reject code and MSP trailer data.

40.1 - CWF, MSP Claim Validation
(Rev. 1, 10-01-03)

There are four conditions that may occur when a contractor validates claims against the CWF, MSP auxiliary file:

- MSP is indicated on the claim and there is matching data on the CWF, MSP auxiliary record. The claim is accepted and all CWF, MSP auxiliary occurrences are returned,

- MSP is indicated on the claim and there is no matching data on an MSP auxiliary record. The claim is rejected and all CWF, MSP occurrences that apply are returned. Section 40.8 describes the CWF, MSP Utilization Error Codes, and the appropriate resolution for those codes,

- MSP is not indicated on the claim and the MSP auxiliary file has an occurrence that indicates there is MSP involvement for the time period affected. The claim is rejected and all occurrences that apply are returned, and

- MSP is not indicated on the claim and there are no matching occurrences on the CWF, MSP auxiliary file that indicate MSP involvement. The claim is accepted for payment.

NOTE: An occurrence applies if the claim service dates are equal to, or greater than, the effective date of the occurrence and less than, or equal to, the termination date of that occurrence, if there is a termination date.

40.2 - CWF Claim Matching Criteria Against MSP Records
(Rev. 1, 10-01-03)

The matching criteria between the claim and the MSP auxiliary occurrence is as follows:

- MSP types are equal;

- MSP auxiliary record validity indicator equals "Y";

- Overlapping dates of service on the claim (claim service dates after MSP effective date and before MSP termination date, if present); and

- No MSP override code used when submitting the claim.

40.3 - Conditional Payment
(Rev. 1, 10-01-03)

To make a conditional payment, FIs and carriers indicate conditional payment on the CWF, Part B Claim by placing a "C" in the "MSP code" field (field 97 of the CWF Part B Claim record.). Intermediaries indicate conditional payment on the CWF Inpatient/SNF Bill by placing zeros (0) in the **"value amount" field (position 77b)** along with the appropriate "value code". An MSP auxiliary record for the beneficiary with a "Y" validity indicator must be present. The CWF will reject the claim with error code 6805 when a claim for conditional payment is submitted and there is no matching MSP auxiliary record present.

40.4 - Override Codes
(Rev. 1, 10-01-03)

The CWF will accept MSP override codes. FIs and carriers must place the appropriate override code in the "MSP code" field (field 97) of the CWF Part B Claim record. Intermediaries must place the appropriate override code in the CWF (Inpatient/SNF Bill or Outpatient/Home Health/Hospice), "Special Action Code/Override Code, field 90". Override codes must be used only as described below.

The CWF employs the following matching criteria for override codes "M" and "N":

- Dates of service on the claim fall within the effective and termination dates on auxiliary record; and

- Validity indicator is equal to "Y".

The correct use of override codes is as follows:

A. Override code "M" is used where EGHP, LGHP and ESRD services are involved and the service provided is either:

- Not a covered service under the primary payer's plan;

- Not a covered diagnosis under the primary payer's plan; or

- Benefits have been exhausted under the primary payer's plan.

B. Override code "N" is used where non-EGHP (auto medical, no-fault, liability, Black Lung, Veterans Affairs and workers' compensation) services are involved and the service is either:

- Not a covered service under the primary payer's plan;

- Not a covered diagnosis under the primary payer's plan; or
- Benefits have been exhausted under the primary payer's plan.

Contractors receive error code 6806 when the MSP override code equals "M" or "N" and no MSP record is found with overlapping dates of service. The "Y" and "Z" override codes valid prior to the conversion of MSP data into CWF on December 10, 1990, are obsolete.

40.5 - MSP Cost Avoided Claims
(Rev. 1, 10-01-03)

Contractors shall follow the instructions cited in Chapter 5, §§50, for counting savings on MSP cost avoided claims.

They shall submit ALL MSP cost avoided claims to CWF.

Payment/Denial codes are used to identify the reason a claim was denied. Specific codes for MSP are listed and defined in §10.2 **under the MSP/COB/Contractor Number chart in that section.** Carriers submit the appropriate code to CWF in the "HUBC" claim record in field 63 "Payment/Denial Code" for line item denials. They complete the appropriate code for full claim denials in the "HUBC" claim record, field 16 "Payment/Denial". Intermediaries submit the appropriate code in the HUIP CWF record field 58 "Nonpayment" code for inpatient hospital and SNF claim denials. They submit the appropriate code in field 59 "No Pay Code" of the CWF record for the specific type of claim identified in the chart below.

PAYMENT/DENIAL CODE FIELDS IN CWF CLAIM RECORD

Contractor	Type of Claim	CWF Record	Field
Carrier	Full Claim Denial	HUBC	16 Payment/Denial
Carrier	Full Line Item Denial	HUBC	63 Payment/Denial Code
Intermediary	Inpatient hospital and inpatient SNF Denial	HUIP	58 Nonpayment Code
Intermediary	Outpatient	HUOP	59 No Pay Code
RHHI	Home Health	HUHH	59 No Pay Code
RHHI	Hospice	HUHC	59 No Pay Code

Contractor number 88888 identifies Voluntary Data Sharing Agreements with other insurers. The denial indicator of "Q" for cost avoided claims is to be used for claims that match against the 88888 contractor auxiliary record. If the denial indicator is incorrect, the CWF software will correct the denial indicator based on the matching MSP auxiliary record and send the correct value back to the contractor on the response record header.

- It is not necessary for an MSP auxiliary record to be present in order to post MSP cost avoided savings. If one is present, the FI or carrier uses the "X" or "Y" override code as appropriate.

40.6 - Online Inquiry to MSP Data

(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.

The MSP data may be viewed online in CWF via the HIMR access. The user enters the transaction HIMR, which displays the HIMR Main Menu, and enters the MSPA selection. (A complete record layout and field descriptions can be found in the CWF Systems Documentation at http://cms.csc.com/cwf/, Record Name: MSP Auxiliary File and MSP Audit History File.)

A user can view a selected CWF, MSP auxiliary record by following the steps outlined below:

A. Enter the *Medicare beneficiary identifier* and MSP record type.

If the data entered is invalid, an error message is displayed with the field in error highlighted. If the data entries are valid, a search is done of the beneficiary master file for an MSP indicator. The search of the master file will show one of the following:

- The MSP indicator on the beneficiary file is not set. In this case the message "MSP not indicated" is displayed;

- No record is found. In this case, a message "MSP auxiliary file not found" is displayed; or

- MSP **is** indicated. In this case, the MSP auxiliary file is read and the screen will display an MSP Record.

A successful reading of the MSP file, as noted in the third bullet above, will display an MSP occurrence summary screen that includes:

- Summary selection number;
- MSP code;
- MSP code description;
- Validity indicator;
- Delete indicator;
- Effective date; and
- Termination date, if applicable.

B. Enter the summary selection number on the MSP occurrence summary screen.

This results in a display of the MSP occurrence detail screen for the selected MSP occurrence. The MSP occurrence detail screen is a full display of the information on the MSP auxiliary file for the particular MSP occurrence.

40.7 - MSP Purge Process
(Rev. 1, 10-01-03)

The CWF process includes an MSP purge process. The CMS will determine when the purge process will be employed. The criteria for deletion of MSP data from the MSP auxiliary file will be a predetermined number of years from the following dates:

- Date of death;
- Termination date and last maintenance date; or
- Last maintenance date and delete indicator equal to "D".

The MSP purge criteria will be parameter driven. All occurrences of MSP data for a beneficiary will be copied to the MSP history audit file, and the MSP indicator on the beneficiary file will be disengaged (turned off) if no other occurrences are present on the file.

A Summary report, by originating contractor identification number, will contain the total number of MSP records affected by the purge and the total of each type of MSP occurrence deleted from the MSP auxiliary file.

40.8 - MSP Utilization Edits and Resolution for Claims Submitted to CWF

(Rev. 114, Issued: 09-18-15, Effective: 07-01-15 Implementation: 07-06-15, Design and Pre-Coding (CWF, FISS, and VMS); 10-05-15-Full implementation (CWF, FISS, MCS, and VMS)

Error codes 6801 - 6806 do not apply to first claim development.

Error Code	Error Description	Resolution
6801	MSP indicated on claim - no MSP auxiliary record exists on CWF data base.	Prepare an "I" MSP maintenance transaction and resubmit claim to CWF. See §10.1 for criteria to submit "I". If "I" criteria is not met, submit an MSP inquiry via ECRS.
6802	MSP indicated on claim - no match on MSP auxiliary file.	(1) Analyze CWF auxiliary file. (2) Create a new "I" MSP auxiliary record, or if "I" record criteria is not met, submit an MSP inquiry or CWF assistance request via ECRS; and (3) Resubmit claim.

NOTE: Match criteria: MSP types are equal, validity indicator equals "Y," dates of service are within MSP period and NO override code is indicated on claim.

6803	MSP auxiliary record exists - no MSP indicated on claim but dates of service match.	(1) Deny claim. Advise beneficiary/provider: "Resubmit claim with other payer's Explanation of Benefits for possible secondary payment. If other insurance has terminated, resubmit with documentation showing termination dates of other insurance." If you have documentation showing termination of the insurance coverage indicated in the CWF, MSP occurrence, process as follows: (2) Post a termination date; or (3) Resubmit claim as MSP. If the termination date is incorrect, submit a CWF assistance request via ECRS.

Error Code	Error Description	Resolution
6805	MSP conditional payment claim and matching MSP record with "Y" validity indicator not found.	(1) Create an "I" MSP Auxiliary Record when it fits the criteria for adding an "I" record. (2) Submit MSP inquiry or CWF assistance request via ECRS. (3) Resubmit claim.
6806	MSP override code equals "M" or "N" and no MSP record found with overlapping dates of service.	If record was deleted in error, request CWF assistance request. Do not recreate record with "I" validity indicator.
6810	Part A claim was processed and only a Part B (Insurer type = "K") matching record was found.	
6811	Part B claim was processed and only a Part A (Insurer type = "J") matching record was found.	
6815	WC Medicare Set-Aside exists. Medicare contractor payment not allowed.	
6816	No-Fault over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6817	Workers' Compensation over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6818	Liability over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	

See discussion in §40.4 above for proper use of override codes.

40.9 - CWF MSP Reject for A Beneficiary Entitled to Medicare Part B Only and A GHP

(Rev. 1, 10-01-03)

An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF will edit to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. Currently, if a contractor submits an Electronic Correspondence Referral System (ECRS) transaction to the coordination of benefits (COB) contractor to add a GHP MSP record where there is no Part A entitlement, the contractor will receive a reason code of 61. The COB contractor's system cannot delete these types of records once the records are posted to CWF by a contractor. Beginning April 2002 CWF will create a utility to retroactively delete all MSP GHP records where there is no Part A entitlement.

Contractors should not submit an ECRS request to COB to establish a GHP MSP record when there is no Part A entitlement. Contractors that attempt to establish an "I" record will receive a CWF error.

The CWF will continue to allow the posting of MSP records where there is no Part A entitlement when non-employer GHP situations exists, such as automobile, liability, and workers' compensation. Where a non-employer GHP situation exists, the contractor should continue to submit ECRS transactions and establish "I" records, as necessary.

40.10 –Processing of Medicare Secondary Payer Claims Related or Unrelated to an Accident or Injury for Non-GHP Claims with ICD-9-CM Diagnosis Codes 500-508 and 800-999 or Related ICD-10-CM Diagnosis Codes

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD–10: Upon Implementation of ICD-10, Implementation: ICD–10: Upon Implementation of ICD–10; ASC X12: 11-28-14)

Medicare contractors receive Liability, No-Fault (NF), and Workers' Compensation (WC), as well as Black Lung (BL), Medicare Secondary Payer (MSP) claims with ICD-9 diagnosis (DX) codes resulting from an accident, illness, or injury. DX codes are placed on the beneficiary MSP auxiliary file for purposes of processing non group health plan (non-GHP) MSP claims correctly. An MSP Liability, NF, or WC record with associated DX code(s) tells CWF to process the claim as secondary, or conditionally, if a conditional payment code is associated to the MSP file telling the contractor to make a conditional payment. The COB Contractor (COBC) also determines what DX codes should be placed on the beneficiary MSP file when diagnosis information is received through COB development process.

Effective July 1, 2011, CMS automated the ICD-9 DX code matching process for DX Code categories 500-508 and 800-999 only and established a process where CWF determines whether the DX codes housed on the MSP auxiliary record are related to the ICD-9 DX codes on the incoming claim without unnecessarily prompting denial of claims or requiring the contractor to determine relatedness. The best way to assist in this process is to associate each DX code with the category of codes with which that DX code

is affiliated. Contractors shall continue to follow current MSP policy and development procedures for all other DX codes received that do not fall within 500-508 and 800-999 DX categories as identified in this instruction. Contractors may use an ICD-9 code list as deemed necessary when DX code research is warranted for beneficiary claims and other MSP purposes.

NOTE: These instructions apply to the current ICD-9 DX category codes 500-508 and 800-999 MSP procedures and not ICD-10 MSP procedures. An ICD-10 MSP processes and procedures instruction shall be issued when available after the MSP ICD-10 workgroup meets to discuss all pertinent MSP ICD-10 issues and the latest ICD-10 codes are published.

40.10.1 - Definition of ICD-9-CM Diagnosis Category Codes and Examples

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD–10: Upon Implementation of ICD-10, Implementation: ICD–10: Upon Implementation of ICD–10; ASC X12: 11-28-14)

Contractors, and their associated systems, shall assume that category codes in the ranges identified below are related. Likewise, category codes in the range 800.x through the 804.xx shall be deemed related. However, CWF shall assume that category codes 804 and 805, which relate to separate classification of fractures, are not related to each other.

Below are the ICD-9 DX Codes for category ranges that include Black Lung Code (500), Lung Diseases (501-508) and Injury and Poisoning Codes (800-999).

ICD-9 Clinical Modification (CM) contains sections of related codes which are grouped by injuries to specific body parts or systems. These sections are shown within the ICD-9-CM code book preceding each section. Listed below are the general categories of these sections along with the specific code range within each section. Assume that codes within each section are related except as noted below.

Coal Workers' Pneumoconiosis (500) – Only one code is used to identify Black Lung for MSP purposes.

Pneumoconiosis and other lung diseases due to external agents (501 - 508) - codes 501.00 - 508.00. Contractors shall assume each DX code within this category is related.

Fractures (800-829) Fracture of skull (800-804) - code range = 800.00 - 804.99. Contractors shall assume each DX code within this category is related.

Fracture of neck and trunk (805-809) - code range = 805.00 - 809.18. Contractors shall assume each DX code within this category is related.

Fracture of upper limb (810-819) - code range = 810.00 - 819.13. Contractors shall assume each DX code within this category is related.

Fracture of lower limb (820-829) - code range = 820.00 - 829.1. Contractors shall assume each DX code within this category is related.

Dislocations (830-839)

Contractors shall assume each code within the 3-digit code category for dislocations is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 830 (830.0 - 830.1) shall be assumed to be related; however, codes within category 831 (831.0 - 831.9) shall assume to be unrelated to the 830 category DX codes.

Sprains and strains of joints and adjacent muscles (840-848)

Contractors shall assume each code within the 3-digit code category for sprains and strains is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 840 (840.0 - 840.9) shall assume to be related; however, codes within category 841 (841.0 - 841.9) shall assume to be unrelated to the 840 category DX codes.

Intracranial injury, excluding those with skull fracture (850-854) (codes 850.0 – 854.19)

Contractors shall assume each code with the 3-digit code category for intracranial injuries is related. For instance, all codes within category 850 (850.0 - 850.9) shall assume to be related; however, codes within category 854 (854.0 - 854.1) shall assume to be unrelated to the 850 category DX codes.

Injury codes from 860 -869 (codes 860.0– 869.1)

Contractors shall assume each code within the 3-digit code category for injuries is related.

Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 861 (861.0 - 861.32) shall assume to be related; however, codes within category 862 (862.0 – 862.9) shall assume to be unrelated to the 861 category DX codes.

Open wound of head, neck and trunk (870-879)

Contractors shall assume each code within the 3-digit code category for open wounds is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 870 (870.0 - 870.9) shall assume to be related; however, codes within category 876 (876.0 - 876.1) shall assume to be unrelated to the 870 category DX codes

Open wound of upper limb (880-887), codes 880.00 - 887.7

Contractors shall assume DX codes within this category range are related.

Open wound of lower limb (890-897), codes 890.0 - 897.7

Contractors shall assume DX codes within this category range are related.

Injury to blood vessels (900-904), codes 900.00 - 904. 9

Contractors shall assume DX codes within this category range are related.

Late effects of injuries, poisonings, toxic effects, and other external causes (905 - 909), codes 905.0 - 909.9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 905 (905.0 – 905.9) shall assume to be related; however, codes within category 908 (908.0 - 908.9) shall assume to be unrelated to the 905 category DX codes.

Superficial injury (910 - 919), codes 910.0 - 919.9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 910 (910.0 - 910.9) shall assume to be related; however, codes within category 916 (916.0 - 916.9) shall assume to be unrelated to the 910 category DX codes.

Contusion with intact skin surface (920 - 924), codes 920 - 924.9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 921 (921.0 - 921.9) shall assume to be related; however, codes within category 924 (924.00 - 924.9) shall assume to be unrelated to the 921 category DX codes.

Crushing injury (925 – 929), codes 925.1 - 929.9

Contractors shall assume DX codes within this category range are related.

Effects of foreign body entering through orifice (930-939), codes 930.0 - 939. 9

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 930 (930.0 - 930.9) shall assume to be related;

however, codes within category 934 (934.0 - 934.9) shall assume to be unrelated to the 930 category DX codes.

Burns (940-949), codes 940.0 – 949.5

Contractors shall assume DX codes within this category range are related.

Injury to nerves and spinal cord (950- 957), codes 950.0 - 957.9

Contractors shall assume DX codes within this category range are related.

Certain traumatic complications and unspecified injuries (958 - 959), codes 958.0 - 959.9

Contractors shall assume DX codes within this category range are related.

Poisoning by drugs, medicinal and biological substances (960-979)

Contractors shall assume each code within the 3-digit code category for poisoning by drugs medicinal and biological substances is related. Contractors shall assume codes outside of the 3-digit category are not related. For instance, all codes within category 960 (960.0 - 960.9) shall assume to be related; however, codes within category 961 (961.0 - 961.9) shall assume to be unrelated to the 960 category codes.

Toxic effects of substances chiefly non-medicinal as to source (980 - 989)

Contractors shall assume each code within the 3-digit code category for toxic effects of substances chiefly non-medicinal as to source is related. Codes outside of the three digit category are not related. For instance, all codes within category 980 (980.0 - 980.9) shall be assumed to be related; however, codes within category 982 (982.0 - 982.8) shall be assumed to be unrelated to the 980 category codes.

Other and unspecified effects of external causes (990-995), codes 990.0 - 995.94

Contractors shall assume each code within the 3-digit code category is related. Contractors shall assume that codes outside of the 3-digit category are not related. For instance, all codes within category 991 (991.0 - 991.9) shall assume to be related; however, codes within category 992 (992.0 - 992.9) shall assume to be unrelated to the 991 category DX codes.

Complications of surgical and medical care NEC (996-999)

Contractor shall assume each code with the 3-digit category is related unto itself. For instance, codes 996.0, 996.1, 996.2, 996.3, 996.4, 996.5, 996.6, 996.7, 996.8, 996.9 are not related to each other; however, 996.40 and 996.41, which are within its' own

category, are related to each other. (Note: A fifth digit may be included in these series of DX codes that fall within these categories to reflect highest level of specificity).

To further explain, codes 997.0, 997.1, 997.2, 997.3, 997.4, 997.5, 997.6 997.7, 997.9 are not related to each other; however, codes 997.60 and 997.62, which are within its' own category, are related to each other.

Codes 998.0, 998.1, 998.2, 998.3, 998.4, 998.5, 998.6, 998.7, 998.8, and 998.9 are not related to each other; however, codes 998.30 and 998.31 which are within its' own category, are related to each other.

Codes 999.0, 999.1, 999.2, 999.3, 999.4, 999.5, 999.6, 999.7, 999.8, 999.9 are not related to each other; however, codes 999.31 and 999.39 which are within its' own category, are related to each other.

Examples:

Fractures are currently identified in the 800-829 DX code range. Codes within the 800 - 804 category (Fracture of Skull) are not related to codes within the 805 - 809 category (Fracture of the Neck and Trunk). For instance, if a beneficiary CWF MSP auxiliary record contains a DX code 800.2, but an 806.1 DX code is received on an incoming claim, CWF and the contractor shall not assume that the 806.1 DX code is related to the 800.2 DX code on the MSP record. Development actions by the contractor are required in this situation. Following are a few more specific examples:

Example 1: A beneficiary has several injuries due to an automobile accident. The beneficiary previously acquired fractures to the base of the skull (801), multiple fractures involving skull or face with other bones (806), and a fracture of pelvis (808). The incoming claim shows DX codes 801.6, 801.8, 801.9, 806.1, 806.71, 806.79, 808.49 and 808.53 (Note: A fifth digit may be included in these series of DX codes that fall within these categories to reflect highest level of specificity.). The CWF MSP auxiliary record currently reflects DX codes 801.8, 806.71 and 808.49. The DX codes found on the MSP auxiliary record therefore fall within the 801, 806, and 808 category codes. The DX codes on the claim include additional codes that also fall within the 801, 806, and 808 categories of codes. The CWF will interpret this to mean that claim DX codes 801.6, 801.9, 806.1, 806.79, and 808.53 falls within the same category of codes as 801, 806, and 808 and therefore are related to the injury noted on the MSP auxiliary record. The contractor shall process the claim appropriately without further development or manual intervention even though the DX codes on the claim do not exactly match the codes on CWF. The DX codes on the claim do not need to be forwarded and placed on the CWF MSP auxiliary file because the related codes already exist on CWF.

Example 2: The same beneficiary from Example 1 has another accident a few months later. This time, the beneficiary fell at the local grocery store. The beneficiary goes to the hospital where it is determined he has a fractured ankle and phalange. The DX codes provided on the claim are 824.1, 824.7 and 826.1. The contractor receives the claim and

determines this accident is not related to a current accident/injury noted on the existing MSP auxiliary record. The contractor therefore 1) establishes an "I" record at CWF, since there is enough information on the claim to create an "I" record, and 2) ensures that the DX codes on the claim are also uploaded to CWF. Any subsequent future claims received with additional DX codes that fall within the 824 and 826 DX code categories shall be processed appropriately as codes related to the accident or injury and based on the non-GHP processing rules.

Example 3: The COBC received information indicating a beneficiary was involved in an accident at her workplace. The COBC mails a development letter to the beneficiary requesting additional information on the accident. The beneficiary responds stating she suffered from a concussion and lost consciousness for no more than one hour. Through development COBC determines that the DX code is 850.12 for the incident and creates a CWF MSP auxiliary record in which this code is reflected. The beneficiary later sees her specialist, who includes DX codes 850.2 and 850.9 on the claims submitted to Medicare. These DX codes that appear on the specialist's incoming claims, following creation of the original MSP record, shall assume to be related to the accident and processed by the Medicare contractor accordingly. The DX codes on the claim do not need to be forwarded and placed on the CWF MSP auxiliary file because the related codes already exist on CWF.

Example 4: A Medicare beneficiary is also entitled to BL benefits. A 500 DX code is on the beneficiary BL MSP auxiliary file record. A contractor receives a claim containing accident services including a DX 506.4 which is not related to the BL DX code 500 as found on CWF. A new MSP record may need to be uploaded for a new accident and injury record. The contractor processes the new MSP information and claim accordingly based on the COBC development and non-GHP MSP claims processing rules.

40.10.2 – Certain Diagnosis Codes Not Allowed on No-Fault Medicare Secondary Payer (MSP) Records

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD–10: Upon Implementation of ICD-10, Implementation: ICD– 0: Upon Implementation of ICD–10; ASC X12: 11-28-14)

There are certain diagnosis codes that systems must not apply to MSP Type 14, CWF MSP Type D No-Fault records. In order for these MSP claims not to deny and process correctly, the CWF must only allow those diagnosis codes related to the accident or injury. Although CWF does not have the capability of knowing which codes should apply to No-Fault MSP records, CMS has provided the below diagnosis codes that are currently the greatest offenders and are not related to a No-Fault auto accident or injury. Although this list is not inclusive it will assist in processing thousands of claims systematically and lessen chances of inappropriate MSP claim denials as they pertain to No-Fault MSP records. CMS is only applying this policy to No-fault records. CWF shall continue to allow the below diagnosis codes on Liability and Workers' Compensation MSP records. It is also noted that the FISS system, which currently systematically

processes MSP "I" records for A/B MACs (A), shall also update their system to not allow the below diagnosis codes from applying to No-Fault MSP records. All Medicare contractors and shared systems shall not apply the below diagnosis codes to No-Fault MSP "I" records, No-Fault MSP Inquiries, No-Fault CWF assistance requests and No-Fault MSP HUSP transactions.

The following ICD-9 diagnosis codes shall not be applied to No-Fault MSP records:

ICD-9 Diagnosis Code	Definition
244.0 - 244.9	Hypothyroidism
250.00 - 250.93	Diabetes
272.0 - 272.9	Disorders of Lipoid Metabolism
285.0 - 285.9	Other and Unspecified Anemia
300.00 - 300.9	Anxiety States
305.1	Tobacco Use Disorder
401.9	Hypertension - unspecified
403.00 - 403.91	Kidney Disease
414.00 - 414.9	Other forms of Chronic Ischemic Heart Disease.
427.31 - 427.32	Atrial Fibrillation/Flutter
486	Pneumonia, Organism Unspecified
530.81 - 530.89	Disorder of Esophagus
584.5 - 584.9	Acute Renal Failure - unspecific and non-trauma
585.1 - 585.9	Chronic Kidney Disease
599.0 - 599.9	Disorders of Urethra and Urinary Tract
784.0	Headache
799.9	Unknown

NOTE: The preceding guidance applies to the current ICD-9 MSP procedures and not ICD-10 MSP procedures. An ICD-10 MSP processes and procedures instruction shall be issued when available.

40.10.3 – Implementation of the International Classification of Diseases, Tenth Revision (ICD-10) Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims

(Rev. 121, Issued: 06-01-18, Effective: 10-01-18, Implementation: 10-01-18)

In accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Secretary of the Department of Health and Human Services adopts

standard medical data code sets for use in standard transactions. According to the ICD-10 final rule, published in the Federal Register on January 16, 2009, the Secretary adopted the ICD-10-CM and ICD-10- PCS code sets for use in appropriate HIPAA standard transactions, including those for submitting health care claims electronically. Entities covered under HIPAA, which includes Medicare and its providers submitting claims electronically, are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date.

CWF shall implement ICD 10 updates for its tables effective with future October releases and the annual file updates that are announced annually via Recurring Update Notifications.

50 - Special CWF Processes
(Rev. 1, 10-01-03)

50.1 - Extension of MSP-ESRD Coordination Period
(Rev. 1, 10-01-03)

Section 4631(b) of the Balanced Budget Act (BBA) of 1997 permanently extends the coordination period to 30 months for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who have not completed an 18-month coordination period by July 31, 1997, will have a 30-month coordination period under the new law. The Common Working File (CWF) will deny claims for primary payment that are submitted for applicable individuals during the 30-month coordination period. This provision does not apply to individuals who would reach the 18-month point on or before July 31, 1997. These individuals would continue to have an 18-month coordination period.

A one-time utility program was executed in CWF to extend the ESRD coordination period for applicable individuals (those records with a Medicare Secondary Payer (MSP) code of "B" and a coordination period termination date of August 1997, or later) to 30 months. This was done by adding 12 months to all coordination periods with a termination date on or after August 1997. All applicable records were changed by September 1, 1997. Any open records (those which do not have a termination date) remained open until they closed using the existing mechanisms, but following the time guidelines outlined above. That is, any ESRD, MSP termination dates, which were added to CWF where the coordination period ended in August 1997 or later, now reflect the new 30-month period. Claims erroneously submitted for primary payment are rejected with CWF Utilization Error Code 6803.

50.2 - Sending of HUSC Files From CWF to Recovery Management and Account Systems (ReMAS)
(Rev. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

A. Background of ReMas

Recovery Management and Account Systems (ReMAS) is a system that will identify mistaken Medicare primary payments in the case where Medicare should have paid secondary. In some instances, other insurance is available to pay for furnished services and Medicare payment is secondary to the payment obligation of the other insurance. Medicare does not generally make a primary payment if it should be the secondary payer, and it is aware that the insurance obligated to pay before Medicare is available. If Medicare makes a mistaken primary payment in such a situation, Medicare pursues recovery of the mistaken primary payment from an appropriate party. ReMAS will identify these mistaken payments so that recovery can be initiated from the party that should have paid primary. ReMAS replaces several contractor systems, as well as CMS systems in order to integrate the identification of mistaken MSP overpayments into a centralized database. ReMAS depends on an interface with CWF to receive notification of beneficiaries that had insurance coverage primary to Medicare. A separate, future instruction will explain how and when Medicare Contractors will use ReMAS.

B. Purpose, Frequency and File Description of CWF Interface with ReMAS

In order for ReMAS to receive notice of MSP situations, it will receive HUSC records from each CWF host on a daily basis. All CWF hosts will transmit HUSC records to ReMAS for every HUSP record that is accepted in CWF. The CWF will send these records to ReMAS using contractor number 11200. All files from each CWF host are sent to the CMS Data Center through the CMS mainframe telecommunication information system (MTIS) process, to a specific data set name that will be provided.

C. Data Feeds

Initial Data Feed: ReMAS will provide an Initial Data Feed Date to CWF. CWF will send any MSP occurrence (MSP Type Values "A"= Working aged; "B"= ESRD; "D"= Automobile Insurance, No-Fault; "E"= Workers' Compensation; "G"= Disabled; "L"= Liability; “W”=Workers’ Compensation Medicare Set-Aside Arrangement that was added to CWF since the Initial Data Feed Date.

Ongoing Data Feeds: CWF will send any valid new MSP occurrence (MSP Type A, B, D, E, G, L, or W). CWF will send any updates to any valid MSP occurrence (MSP Type A, B, D, E, G, L, or W). CWF will send any deletes of any valid MSP occurrences (MSP Type A, B, D, E, G, L, or W).

50.3 - MSP “W’ Record and Accompanying Processes

(Rev. 113, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

I. Common Working File Requirements (CWF)

Effective July 1, 2009, the Common Working File (CWF) shall accept a new Medicare Secondary Payer (MSP) code "W" for Workers' Compensation Medicare Set-Aside Arrangements (WCMSA) for use on the HUSP records for application on the HUSP Auxiliary File. The CWF shall indicate the description name for a MSP code "W" record as "WC Medicare Set-Aside.

The CWF shall accept a new contractor number 11119 on incoming MSP "W" HUSP records for application on the MSP Auxiliary file. The CWF shall accept a "19" in the source code field on both the HUSP, HUSC and HUST transactions for contractor 11119. The CWF shall accept the "Y" validity indicator for HUSP and HUSC transactions created by contractor 11119. The CWF shall return a "19" in the Source Code field of the '03' response trailer.

The CWF shall allow contractors 11100, 11101, 11102, 11103, 11104, 11105, 11106, 11107, 11108, 11109, 11110, 11111, 11112, 11113, 11114, 11115, 11116, 11117, 11118, 11119, 11122, 11125, 11126, 11139, 11140,11141, 11142, 11143, 33333, 55555, 77777, 88888, 99999, to update, delete, change records originated or updated by contractor 11119.

CWF will create and send a HUSC transaction to the contractor's shared systems that have processed claims for each beneficiary when an add or change transaction is received for contractor 11119 or from contractor 11119. The CWF shall use the following address for contractor number 11119:

WCMSA Proposal/Final Settlement
P.O. Box 138899
Oklahoma City, OK 73113-8899

The CWF shall apply the same MSP consistency edits for Workers' Compensation (WC) code "E" to MSP code "W".

The CWF maintainer shall create a new error code (6815). The message for this new error code (6815) shall read "WC Set-Aside exists. Medicare contractor payment not allowed". CWF shall activate this error under the following conditions:

- A MSP code "W" record is present.
- The record contains a diagnosis code related to the MSP code "W" occurrence.

The CWF shall ensure that error code 6815 may be overridden by **MACS (A/B) and MACs (DME)** with a code N or M, for claim lines or claims on which workers' compensation set-aside diagnosis do not apply. CWF shall accept the new error code (6815) as returned on the 08 trailer.

The CWF will create a new HUSP transaction error code, SP76, to set when an incoming HUSP transaction with MSP Code "W" is submitted and the beneficiary MSP Auxiliary

file contains an open MSP occurrence with MSP code “E” with the same effective date and diagnosis code(s).

II. Shared Systems and MACs (A/B) and MACS (DME)

Effective July 1, 2009, contractor shared systems shall accept a new MSP Code “W” to identify a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) for use on HUSP records for application on the HUSP Auxiliary file. The Medicare shared systems shall accept the description name of ‘WC Medicare Set-Aside’ for MSP code “W” records.

The shared system shall accept a new contractor number “11119” on incoming MSP ‘W’ HUSP records for application on the MSP Auxiliary file.

The shared systems shall accept contractor number 11119 and MSP code ” W” and source code “19” on the returned 03 CWF trailer.

The contractor shared systems shall accept “19” in the source code field on the HUSP, HUSC, and HUST transactions for contractor 11119. The shared systems shall accept a “Y” validity indicator, as well as, MSP code W for HUSC transactions created by contractor 11119.

The contractor shared systems shall accept and process HUSC and HUST transactions when an add, change or delete transaction is received for contractor 11119 or from contractor 11119.

The CROWD report shall be updated to reflect special project number ‘7019’ as Workers’ Compensation Set-Aside Arrangements.

Shared systems shall accept “19” in the header Payment Indicator field and in the detail Payment Process Indicator field for Contractor 11119.

The MACS (A/B) and MACS (DME) and their systems shall continue to accept claims with value code 15 for Part A and Insurance Code (15) for Part B and DME MAC against an open “W” MSP Auxiliary file.

The shared systems shall accept new error code (6815) as returned with the 08 trailer. Following receipt of the utilization error code 6815, the Medicare contractors systems shall deny all claims (including conditional payment claims) related to the diagnosis codes on the CWF MSP code “W”, when there is no termination date entered for the “W” code.

Upon denying the claim, all contractor shared systems shall create a “19” Payment Denial Indicator in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, HUDC claims.

Upon denying the claim the MACs (B) and MACS (DME), MCS and VMS shall…

- Populate a “W” in the MSP code field and

- Create a ‘19’ in the HUBC and HUDC claim header transaction and a ‘19’ in the claim detail process.

Upon denying the claim MACs (A) and the FISS system shall…

- Populate a 15 in the value code field, in addition to the requirements referenced above.

For MSP verification purposes, and prior to overriding claims on which the contractor received error code 6815, the contractor shall:

- check CWF to confirm that the date of service of the claim is after the termination date of the MSP “W” record.

- and confirm the diagnosis code on the claim is related to the diagnosis codes on the MSP W record.

MACs (B) and MACs (DME) shall override the payable lines with override code N.

The MACs (A) shall override the payable claims with override code N. If a claim is to be allowed, an ‘N’ shall be placed on the “001” Total revenue charge line of the claim.

The contractor shared systems shall allow an override of new error code 6815 with the code N.

The Comprehensive Error Rate Testing (CERT) contractor shall accept the MSP code ”W” in the claim resolution field.

The shared systems shall bypass the MSPPAY module if there is an open MSP code “W”.

The shared systems shall not make payment for those services related to diagnosis codes associated with the “W” Auxiliary record when the claims date of service is on or after the effective date and before or on the termination date of the record.

The shared systems shall make payment for those services related to the diagnosis codes associated with the “W” auxiliary record when a terminate date is entered and the claims date for service is after the termination date.

The shared systems shall include Reason Code 201, Group Code “PR”, Remark Code N722 and “Alert” Remark Code MA01, when denying claims based on a ‘W’ MSP auxiliary record on outbound 837 claims.

The shared systems shall utilize Group Code “PR”; Remark Code N722 and “Alert” Remark Code MA01, Reason Code 201, when denying claims based on a “W” MSP auxiliary record for 835 ERA and SPR messages.

The shared system shall afford appeal rights for denied MSP code “W” claims.

III. The MACS (A/B) and MACs (DME):

- Shall not make payment for those services related to diagnosis codes associated with an open “W” auxiliary record (not termed).

- Shall make payment for those services related to diagnosis codes associated with a termed auxiliary “W” record when the claims date of service is after the termination date.

The **MACS (A/B) and MACs (DME)**shall include Reason Code 201, Group Code “PR”, Remark Code N722 and “Alert” Remark Code MA01, when denying claims based on a ‘W’ MSP auxiliary record on outbound 837 claims.

The **MACS (A/B) and MACs (DME)** shall utilize Group Code “PR”; Remark Code N722 and “Alert” Remark Code MA01, Reason Code 201, when denying claims based on a “W” MSP auxiliary record for 835 ERA and SPR messages.

The **MACS (A/B) and MACs (DME)** and share systems shall afford appeal rights for denied MSP code “W” claims.

Those systems responsible for the 270/271 transaction shall ensure that documentation concerning the EB value and qualifier WC is updated.

The CROWD report shall be updated to reflect special project number “7019” as Workers’ Compensation Medicare Set-Aside Arrangements.

IV. Medicare Residual Payment When WCMSA benefits terminate, or deplete, during a beneficiary’s provider facility stay or upon a physician’s visit.

There are situations where WCMSA 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 secondary payment. The term “residual payment” is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The A/B MACs (A/B), 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 MACs (A/B), MACs (DME), and shared systems, shall receive, accept, and make a residual payment on MSP Type 15 (MSP Code E) WCMSA electronic 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 MACs (A/B), MACs (DME), and shared systems shall receive, accept, and make payment on MSP Type 15, WCMSA paper (hard copy) claims when the claim includes an attached remittance advice (RA)/Explanation of Benefits (EOB) 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 an MSP Type 15, WCMSA electronic, or hard copy claim, is received and there is a corresponding WCMSA record on CWF 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 MACs and shared system shall deny the claim based on the CWF utilization 6815.

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 MACs are able to input an "X" in the header of their 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 6815 WCMSA utilization error code when the MACs determine a residual payment should be made on the claim.

The 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 WCMSA claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare.

NOTE: When applicable, the MAC shall send the attestation form/letter, it received from the reporting entity indicating WCMSA benefits are exhausted, to the BCRC. For ORM, the Section 111 reporting entity shall report that benefits are exhausted via the normal quarterly data file process.

60 – Use of Inter-Contractor Notices (ICNs) and CWF for Development Conditional Payment Amount

(Rev. 1, 10-01-03)

As a result of the implementation of the Coordination of Benefits Contractor (COBC), lead recovery contractor identification and notification will be done by the COBC; the lead recovery contractor continues to be responsible for the identification and recovery of Medicare's MSP claim. Medicare manual sections cited in the Budget Performance Requirements (BPRs) address the responsibilities of the lead contractor.

The CMS has designated fiscal intermediaries as the leads for all new liability, no-fault, workers' compensation, and FTCA recoveries. Carriers retain the lead for any pre-existing pending cases for which they were the lead recovery contractor prior to the implementation of the COBC.

Prior instructions called for lead recovery contractors to issue ICN requests to all contractors having paid claims related to an identified liability, no-fault, workers' compensation, or FTCA case. The ICN requests are for purposes of developing the conditional payment amount associated with any claims paid by another contractor. Effective October 1, 2002, contractors began to utilize CWF to identify related conditional payments in certain situations.

60.1 – General Rules for the Use of ICNs vs CWF for Development of Medicare's Conditional Payment Amount

(Rev. 1, 10-01-03)

When the date of the accident/injury/illness/incident is within 18 months of the contractor's notification of lead recovery contractor status via COBC, contractors must develop the total conditional payment amount through the use of CWF, rather than ICNs. Where the initial conditional payment amount was obtained through the use of ICNs; but the notice of settlement, judgment, or award is less than 22 months from the date the initial conditional payment amount was furnished, the lead recovery contractor will obtain updated amounts through the use of CWF. Where workload permits, the lead recovery contractor should update the conditional payment amounts near the end of the expiration of the 22-month period in order to avoid the need for an ICN at the time of settlement, judgment, or award. When obtaining claims information from the CWF, the lead recovery contractor must retrieve archived claims via the appropriate command (i.e., MSPA, MSPB, INPL, OUTL). If the data is purged and the lead recovery contractor has the ability to retrieve it, they must do so. Contractors have been furnished with OSCAR access (for institutional provider information), the UPIN directory disc (for physician, nurse practitioner, clinical nurse specialists, and physician assistant information), and with a process to gain access to the National Supplier Clearinghouse (NSC) (for DMEPOS supplier information).

Where the date of accident/injury/illness/incident in comparison to the lead notification via COBC is greater than 18 months, the lead recovery contractor will send ICNs to the non-lead contractors. Non-leads must respond to the ICN request within 45 days from receipt, except in response to a notice of settlement, judgment, or award. Non-lead contractors have 30 days to respond to a notice of settlement, judgment, or award ICN if they had no prior ICN request; and 15 days to respond if the ICN request is a request to update the conditional payment amount previously received. Where the time span between the development of the initial conditional payment amount and notification of a settlement, judgment, or award exceeds 22 months, the lead recovery contractor may develop the updated conditional payment amount by ICN.

All contractors should be aware that because product liability situations are often unknown for some time after the product at issue is first used, many product liability situations are likely to exceed the 18-month time frame for initial notification and will require the use of ICN requests to develop Medicare's conditional payment amounts.

NOTE: The retention period for CWF claims data has been increased to a minimum of 24 months. This change, in conjunction with the rules stated above, will allow lead recovery contractors to deal with occasional backlog situations. Even where the initial notification of an accident/injury/illness/incident is near the end of the 18-month period, contractors will have adequate time to develop the conditional payment amount without the need for ICNs.

A. ICN Requests By The Lead Recovery Contractor When the 18-Month Period Has Not Expired

Non-lead contractors do not need to respond to ICN requests sent within the 18-month period. They should annotate such ICNs with the reason the ICN is not being processed and immediately return the ICN to the lead contractor (to ensure that the lead contractor can obtain the information from CWF while it is still available). If a non-lead contractor experiences repeated problems with this issue from a particular lead contractor, they should notify their regional office (RO).

ICN Backlog Issues

If an ICN backlog (for issuing and/or replying to ICN requests) develops, contractors are required to report the situation to their RO MSP Coordinator immediately, provide a plan for elimination of the backlog, and obtain RO approval of the plan. The plan for eliminating an ICN backlog must involve simultaneously working both new and old lead assignments in order to minimize the number of ICNs that must be issued. Non-lead contractors must respond to ICN requests where the 24-month CWF minimum period for claims data retention has expired even if they believe that the issuing contractor should have been able to obtain the information from the CWF before the 24-month period expired. If a receiving contractor is concerned about repeated situations with a particular contractor, it must notify its RO. The RO will ascertain whether the other contractor at issue is in the midst of eliminating a backlog.

ICN Request Content Issues

ICN requests must always provide sufficient information for the non-lead contractor to readily identify if an incoming ICN is an initial request or a follow-up request and whether or not a settlement, judgment, or award has occurred (including the date). ICN requests should also be clearly marked to show that no CWF record exists, in those limited circumstances where a contractor has been directed not to establish a CWF record.

Contractors are reminded that ICN requests must include a narrative description of the accident/injury/illness/incident and/or related diagnosis codes as well as the date of the accident/injury/illness/incident.

ICN Responses

Non-lead contractors responding to ICN requests are reminded that ICN responses must specifically annotate/identify all related claims; the non-lead contractor may not simply furnish a “history dump” without further identification of those claims which are related to the accident/injury/illness/incident. Non lead contractors are reminded that they must also furnish appropriate claims detail; they may not simply furnish a dollar total for related claims.

Reminder Regarding Termination Updates to the CWF

When the lead recovery contractor is notified, by writing or via telephone conversation of a settlement, judgment, or award, the date of that settlement, judgment or award should be entered in the termination field of the CWF immediately. The lead recovery contractor must **not** delay entry of the termination date until the recovery demand letter is issued or until the debt is repaid and the case is closed. Failure to perform a timely update puts the Medicare trust funds at risk.

Reminder Regarding Savings Information to Non-Lead Contractors

The lead recovery contractor continues to be responsible for reporting appropriate savings amounts to non-lead contractors even where conditional payment amounts were developed using CWF. The lead recovery contractor must furnish sufficient detail with this notification for the non-lead to report appropriate savings and process any necessary claim adjustments. If there is a beneficiary specific recovery in a situation where CMS has determined that a CWF MSP record is not appropriate, all savings should be reported by the lead contractor without any claim adjustments.

70 - Converting Health Insurance Portability and Accountability Act (HIPAA) Individual Relationship Codes to Common Working File (CWF) Medicare Secondary Payer (MSP) Patient Relationship Codes

(Rev. 107, Issued: 10-24-14, Effective: ASC X12: January 1, 2012; ICD–10: Upon Implementation of ICD-10, Implementation: ICD–10: Upon Implementation of ICD–10; ASC X12: 11-28-14)

CMS has realized that its Common Working File (CWF) HUSP transaction does not allow for the correct association of HIPAA individual relationship codes, as found in the HIPAA 837 (4010/5010) institutional and professional claims implementation guides, with corresponding MSP Type Codes, such as working aged (A), end-stage renal disease (B), and disability (G). Therefore, effective July 6, 2004, all A/B MACs (A) that receive incoming electronic HIPAA, DDE, or hard copy claims that are in the HIPAA ASC X12 837 format shall convert the incoming individual relationship codes to their equivalent CWF patient relationship codes. Until further notice, A/B MACs (A) shall continue to operate under the working assumption that all providers will be including HIPAA individual relationship codes on incoming claims.

Before CMS' systems changes are effectuated, A/B MACs (A) may receive SP edits (i.e., SP-33 and SP-52) that indicate that an invalid patient relationship code was applied. A/B MACs (A) are to resolve those edits by manually converting the HIPAA individual relationship code to the CWF patient relationship code, as specified in the conversion chart below. If the A/B MAC (A) receives MSP edits and can determine that the HIPAA individual relationship code rather than the CWF patient relationship code was submitted on the incoming claim, it shall manually work the MSP edits incurred by converting the HIPAA individual relationship code to the appropriate CWF patient relationship code.

Until Part A shared system changes are effectuated to convert HIPAA individual relationship codes to CWF patient relationship codes, A/B MACs (A) may move claims

with a systems age of 30 days or older that have suspended for resolution of patient relationship code, including SP-33 or SP-52 edits, to condition code 15 (CC-15).

The A/B MAC (A) contractor system shall utilize the conversion charts, found below, to cross-walk incoming HIPAA individual relationship codes to the CWF patient relationship code values.

For MSP Occurrences with accretion dates PRIOR to 4/4/2011:

HIPAA Individual Relationship Codes	**Convert To CWF Patient Relationship Codes**	**Valid Values**
18	01	Patient is Insured
01	02	Spouse
19	03	Natural Child, Insured has financial responsibility
43	04	Natural Child, insured does not have financial responsibility
17	05	Step Child
10	06	Foster Child
15	07	Ward of the Court
20	08	Employee
21	09	Unknown
22	10	Handicapped Dependent
39	11	Organ donor
40	12	Cadaver donor
05	13	Grandchild
07	14	Niece/Nephew
41	15	Injured Plaintiff
23	16	Sponsored Dependent
24	17	Minor Dependent of a Minor Dependent
32,33	18	Parent
04	19	Grandparent
53	20	Life Partner
29	N/A	Significant Other
30	N/A	?
31	N/A	?
36	N/A	?
G8	N/A	?
Other HIPAA Individual Relationship Codes	N/A	?

For MSP Occurrences with accretion dates 4/4/2011 AND SUBSEQUENT:

HIPAA Individual Relationship Codes	Convert To CWF Patient Relationship Codes	Description
18	01	Self; Beneficiary is the policy holder or subscriber for the other GHP insurance reflected by the MSP occurrence –or- Beneficiary is the injured party on the Workers Compensation, No-Fault, or Liability claim
01	02	Spouse
19	03	Child
43	03	Child
17	03	Child
10	03	Child
15	04	Other
20	04	Other
21	04	Other
22	04	Other
39	04	Other
40	04	Other
05	04	Other
07	04	Other
41	01	Self; Beneficiary is the policy holder or subscriber for the other GHP insurance reflected by the MSP occurrence –or- Beneficiary is the injured party on the Workers Compensation, No-Fault, or Liability claim
23	04	Other
24	04	Other
32,33	04	Other
04	04	Other
53	20	Life Partner
29	N/A	Significant Other
30	N/A	?
31	N/A	?
36	N/A	?
G8	N/A	?

HIPAA Individual Relationship Codes	Convert To CWF Patient Relationship Codes	Description
Other HIPAA Individual Relationship Codes	N/A	?

A/B MACs (A shall allow for the storing of CWF patient relationship codes in their internal MSP control files, since these files should be populated with information sent back to the A/B MACs (A)' systems via the automated HUSC transaction.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
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
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
R121MSP	06/01/2018	Update the International Classification of Diseases, Tenth Revision (ICD-10) 2019 Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims	10/01/2018	10803
R119MSP	04/07/2017	Implement the International Classification of Diseases, Tenth Revision (ICD-10) 2018 General Equivalence Mappings (GEMs) Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims	10/02/2017	9947
R114MSP	09/18/2015	Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM)	07/06/2015	8984
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

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
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
R95MSP	08/23/2013	Update of the Common Working File (CWF) to not Allow Certain Diagnosis Codes on No-Fault Medicare Secondary Payer (MSP) Records	01/06/2014	8351
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
R89MSP	08/30/2012	Expanding the Coordination of Benefits (COB) Contractor Numbers to Include 11139 and 11142 for the Common Working File (CWF)	01/07/2013	7906
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
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 Coordination of Benefits Contractor (COBC)	01/03/2012	7483
R77MSP	01/21/2011	Categorizing Diagnosis Codes 500-508 and 800-999 on Incoming Medicare Secondary Payer (MSP) Claims and on the MSP Auxiliary File for non-Group Health Plan (GHP) Claims	07/05/2011	7149

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
R74MSP	04/28/2010	New Medicare Secondary Payer Insurer Type Codes	10/04/2010	6768
R65MSP	03/20/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments	04/06/2009/ 07/06/2009	5371
R64MSP	01/09/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments - Rescinded and replaced by Transmittal 65	04/06/2009/ 07/06/2009	5371
R61MSP	10/03/2008	Expanding the Mandatory Insurer Reporting (MIR) Coordination of Benefits (COB) Contractor Numbers for the Common Working File (CWF)	01/05/2009	6182
R60MSP	09/19/2008	Expanding the Mandatory Insurer Reporting (MIR) Coordination of Benefits (COB) Contractor Numbers for the Common Working File (CWF) - Rescinded and replaced by Transmittal 61	01/05/2009	6182
R43MSP	10/31/2005	Expanding the Voluntary Data Sharing Agreement (VDSA) Coordination of Benefit (COB) Contractor Numbers for the Common Working File (CWF)	04/03/2006	3826
R31MSP	07/08/2005	Full Replacement of CR 3770,Expanding the Number of Source Identifiers for Common Working File (CWF) MSP Records	10/03/2005	3909

R12MSP	03/05/2004	Converting HIPAA Individual Relationship Codes to Common Working File (CWF) Patient Relationship Codes	03/19/2004	3117
R09MSP	02/06/2004	Converting Health Insurance Portability and Accountability ct (HIPAA) Individual Relationship Codes to Common Working File (CWF) Patient Relationship Codes	07/06/2004	3116
R08MSP	02/06/2004	Common Working File MSP Modifications	07/06/2004	2775
R06MSP	01/162004	Automatic Notice of Change to MSP Auxiliary File	01/01/2004	2608
R01MSP	10/01/2003	Initial Issuance of Manual	N/A	N/A

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