CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 65	**Date: MARCH 20, 2009**
	Change Request 5371

This transmittal rescinds and replaces transmittal 64, dated January 9, 2009. The Requirements for 5371.11, 5371.12, and 5371.16.1 are updated with a technical clarification by the contractor; additionally in section 10.2, contractor number 11121 and 11122 were inadvertently omitted from the original chart. All other information remains the same.

Subject: New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers" Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments

I. SUMMARY OF CHANGES: Manual is being updated with new CWF MSP Types for WCMSAs. Background information with regard to WCMSAs has been added to the manual.

VMS and FISS will process full implementation in the July 2009 release; however, other systems will conduct analysis/design/development in the April 2009 release and coding/implementation in the July 2009 release.

New / Revised Material
Effective Date: April 1, 2009/ July 1, 2009
Implementation Date: April 6, 2009/ July 6, 2009

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

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

R/N/D	Chapter / Section / Subsection / Title
	Table of Contents
N	1/10.4.1-Workers" Compensation Medicare Set-Aside
R	1/20/Definitions
R	2/50/MSP Provisions
R	6/10.2/Definition of MSP/CWF Terms
R	6/40.8/MSP Utilization Edits and Resolution Claim Submitted to CWF
R	6/50.2/Sending of HUSC Files From CWF to Recovery Management and Account Systems
N	6/50.3 MSP "W" Record and Accompanying Processes

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

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 65	Date: March 20, 2009	Change Request: 5371

This transmittal rescinds and replaces transmittal 64, dated January 9, 2009. The Requirements for 5371.11, 5371.12, and 5371.16.1 are updated with a technical clarification by the contractor; additionally in section 10.2, contractor number 11121 and 11122 were inadvertently omitted from the original chart. All other information remains the same.

SUBJECT: New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers" Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments

VMS and FISS will process full implementation in the July 2009 release; however, other systems will conduct analysis/design/development in the April 2009 release and coding/implementation in the July 2009 release.

Effective Date: April 1, 2009/ July 1, 2009

Implementation Date: April 6, 2009/ July 6, 2009

I. GENERAL INFORMATION

A. Background:

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates CWF in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, please visit our website at: http://www.cms.hhs.gov/WorkersCompAgencyServices.

The CMS has determined that establishing a new MSP code in the shared systems and CWF, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds.

Currently, CMS identifies situations where it has reviewed a proposed WCMSA amount on CWF by applying "WCSA" in the Group Name field of the MSP Auxiliary file. However, the application of "WCSA" on the MSP Auxiliary file does not systematically prevent CMS from making payment for claims related to the WCMSA situation. The creation of a new MSP code specifically associated with these WCMSA situation will permit automated denials of diagnosis codes associated with the open WCMSA occurrence.

B. Policy:

Pursuant to 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Consequently, Medicare should not make payment for future medical expenses associated with a settlement, judgment or award because payments "has been made" for such items or services. A CMS determination regarding a proposed WCMSA amount is

a determination regarding the amount of future medicals associated with a particular WC settlement, judgment or award and is to be used in making claims payment determinations once there has been a settlement, judgment or award.

The Medicare Contractors shall pay primary on claims or services that are not related to the diagnosis codes on CWF Auxiliary records with an MSP code "W", assuming that no other MSP record exists on CWF.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5371.1	The CWF and contractor shared systems shall accept a new MSP code "W" for Workers' Compensation Medicare Set-aside Arrangement (WCMSA) for use on the HUSP records for application on the HUSP Auxiliary file.						X	X	X	X	COBC, ReMAS
5371.1.2	The CWF shall indicate the description name for the MSP code "W" record as 'WC Set-aside'.									X	
5371.1.3	The Medicare shared systems shall accept the description name of 'WC Set-aside" for MSP code "W" records.	X	X	X	X	X	X	X	X		
5371.2	The CWF and contractor shared systems shall accept a new contractor number 11119 on incoming MSP "W" HUSP records for application on the MSP Auxiliary file.						X	X	X	X	COBC
5371.2.1	The shared systems shall accept contractor number 11119, MSP code "W" and source code "19" on returned 03 CWF trailer response.						X	X	X		
5371.2.2	The CWF and the contractor shared systems shall accept a						X	X	X	X	COBC

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	"19" in the source code field on the HUSP and HUSC/HUST transactions for contractor 11119.										
5371.2.3	The CWF shall accept a "Y" Validity Indicator for HUSP transactions created by Contractor 11119.									X	COBC
5371.2.3.1	The shared systems shall accept a "Y" Validity Indicator, as well as MSP code W, for HUSC transactions for Contractor 11119.						X	X	X		COBC
5371.2.4	CWF shall return a '19' in the Source Code field of the Trailer '03' response.									X	
5371.2.5	CWF shall use the following address for contractor number 11119: WCMSA, P.O. Box 33847, Detroit, MI 48232.									X	
5371.3	CWF shall allow Contractors 11100, 11101,11102,11103,11104,11105, 11106, 11107,11108,11109,11110,11111, 11112,11113,11114,11115,11116, 11117, 11118,11125,11126,11140, 33333,55555,77777, 88888, 99999, and 11119 to update, delete, change records originated or updated by contractor 11119.									X	COBC
5371.3.1	CWF shall allow Contractors 11100,11101,11102,11103,11104, 11105,11106,11107,11108,11109, 11110,11111,11112,11113,11114, 11115,11116,11117,11118,11125, 11126,11140,33333,55555,77777,									X	COBC

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	88888,99999, and 11119 records to be updated, deleted, or changed by contractor 11119.										
5371.3.2	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'.									X	
5371.3.3	The Contractor shared systems shall accept and process HUSC/HUST transactions when an add, change or delete transaction is received for contractor "11119" or from contractor "11119".	X	X	X	X	X	X	X	X		
5371.3.4	The CROWD report shall be updated to reflect special project number "7019" as Workers' Compensation Set-aside Arrangements.	X	X	X	X	X	X	X	X		CROWD
5371.4	The CWF shall apply the same MSP consistency edits for MSP (Workers' Compensation) code E to MSP code W.									X	
5371.5	The Part A contractor system shall continue to accept claims with value code 15 for Part A claims that may be reviewed against an open "W" MSP auxiliary record.						X				
5371.5.1	The Part B and DME MAC contractor shared systems shall continue to accept claims with insurance code 15 in association with an open "W" MSP							X	X		

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	auxiliary record.										
5371.6	The CWF maintainer shall create a new utilization error code (6815)-"WCMSA exists. Medicare contractor payment not allowed".									X	
5371.6.1	CWF shall set this error under the following conditions when: • An occurrence on the MSP Auxiliary file exists with a MSP code "W". • A Medicare contractor attempts to pay a claim.									X	
5371.6.2	The shared systems shall accept the new error code (6815) as returned with the 08 trailer.						X	X	X	X	
5371.6.3	Following receipt of 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 Auxiliary file for MSP code "W", when there is no termination date entered for MSP "W" code.	X	X	X	X	X	X	X			Part B Cap
5371.6.4	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.	X	X	X	X	X	X	X	X		
5371.6.4.1	Upon denying the claim, the indicated contractors and shared systems shall… • populate a "W" in the MSP code field and • in addition to the requirements in 6.4, shall create a "19" in the HUBC and HUDC claim header transaction and a "19" in the claim detail pay process	X	X		X			X	X		

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	field.										
5371.6.4.2	Upon denying the claim, the indicated contractors and shared systems shall populate a 15 in the value code field in addition to the requirement provided in 6.4.	X		X		X	X				
5371.7	CWF shall ensure that error code 6815 may be overridden by Medicare contractors, with a code N or M, for claim lines or claims on which workers' compensation set-aside diagnosis do not apply. (NOTE: An example of a situation in which Medicare contractors may override claim lines is the billing of code 90658 & G0008 on two claim lines of a multi-line claim.)									X	
5371.7.1	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 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.	X	X	X	X	X					
5371.8	Carriers/DME MACs' shall override the payable lines with override code N.	X	X		X						
5371.8.1	The FI contractors shall override of the payable claims with override code N.			X		X					
5371.8.1.1	If the claim is to be allowed, a 'N' shall be placed on the '001' Total revenue Charge line of the			X		X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	claim.										
5371.8.2	The contractor shared systems shall allow an override of the new error code(6815) with code N.						X	X	X		
5371.9	The Comprehensive Error Rate Testing Contractor(CERT) shall accept the MSP code on the claim resolution field(position 465)						X		X		CERT
5371.10	The contractor shared systems shall bypass the MSPPAY module if there is an open MSP code “W”.						X	X	X		
5371.11	The CWF will create a new HUSP transaction error code 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)”.									X	COBC
5371.11.1	The Medicare contractor and 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.	X	X	X	X	X	X	X	X		
5371.11.2	The Medicare contractors and the shared systems shall make payment for those services related to diagnosis codes associated with the “W” Auxiliary record when a termination date is entered, and the claims dates of service is after the termination date.	X	X	X	X	X	X	X	X		
5371.12	The Medicare contractors and shared systems shall include	X	X	X	X	X	X	X			

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Reason code 201 Group code PR, Remark Code MA01, when denying claims based on a "W" MSP auxiliary record on outbound 837 claims.										
5371.12.1	The Medicare contractors and shared systems shall utilize Group code PR, Reason Code 201, Remark Code MA01, when denying claims based on a "W" MSP auxiliary record for 835 ERA and SPR messages.	X	X	X	X	X	X	X			
5371.13	The Medicare contractors and shared systems shall afford appeal rights for denied MSP code "W" claims.	X	X	X	X	X	X	X	X		
5371.14	The COBC shall convert existing WCMSA code "E" records to MSP code "W" records.										COBC
5371.15	The Medicare contractors shall generate MSN message 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies) or in Spanish, 29.33 - Su reclamación ha sido denegada por Medicare porque usted podría sacar dinero de su convenio/acuerdo para pagar por sus futuros gastos médicos y su tratamiento con medicinas recetadas relacionadas a su lesión (es).	X	X	X	X	X	X	X	X		
5371.16	As part of the provider education requirements below, contractors shall inform providers that a Workers' Compensation Set-aside Arrangement shall be designated on the 271 response with "EB" followed by the	X	X	X	X	X					

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	qualifier WC.										
5371.16.1	Those individuals and systems responsible for the 270/271 transaction shall ensure that documentation concerning the EB value and qualifier WC is updated in accordance with 5371.16.										270/271 dedicated staff and systems.

III. PROVIDER EDUCATION TABLE

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5371.17	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Cynthia Gross: (410) 786-3632

Post-Implementation Contact(s): Cynthia Gross, Phone: (410) 786-3632

VI. FUNDING

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

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

C. For the Coordination of Benefits Contractor and the Medicare Secondary Payer Recovery Contractor:

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

Medicare Secondary Payer (MSP) Manual

Chapter 1 - Background and Overview

Table of Contents
(Rev. 65, 03-20-09)

10.4.1 Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

(Rev. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

WC insurers, agencies, and attorneys have significant responsibilities under the MSP provisions of the Social Security Act to protect Medicare's interests when resolving WC cases. Because Medicare does not pay for an individual's WC-related medical services and/or prescription drugs when the individual receives a WC settlement, judgment or award that includes funds for future medical and/or prescription drug expenses, it is in the best interest of the individual to consider Medicare at the time of settlement. For this reason, CMS recommends that parties to a WC settlement set aside funds, known as WC Medicare Set-Aside Arrangements (WCMSAs) for all future medical and/or prescription drug services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare.

See Chapter 1, §20, for the definitions of a "Set- Aside Arrangement," "Workers' Compensation Medicare Set-Aside Arrangement," .

The CMS has published several policy memoranda to assist parties in preparing WCMSAs; they are currently available at http://www.cms.hhs.gov/WorkersCompAgencyServices.

20 - Definitions

(Rev. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

Accident - An unintended occurrence outside the normal course of events that causes illness, injury, or damage to a person or property.

Age 65 or older – An individual attains age 65 on the day preceding his or her 65th birthday.

Automobile - Any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

CMS' Claim - In the context of WC, no-fault, and liability claims, the amount that is determined to be owed to the Medicare program. This is the lesser of the total sum of the settlements, judgments, or awards related to the underlying WC, no-fault, or liability claim; or the amount that was paid out by Medicare, less any applicable share of procurement costs.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a Title X provision that provides continuation of GHP coverage if elected. For aged or disabled Medicare beneficiaries, COBRA continuation coverage is secondary to Medicare because the coverage is by virtue of COBRA law rather than by virtue of current employment status. For an ESRD related Medicare beneficiary, COBRA continuation coverage if elected, is primary to Medicare during the 30-month ESRD coordination period. See 42 CFR 411.161(a)(3) and 411.162(a)(3).

Compromise - A settlement of differences by mutual consent or adjustment of matters in dispute by mutual concession; a negotiated settlement between parties who are in essentially equal bargaining positions, wherein neither party admits or concedes that he is entitled to less than he desires, but accepts less to effect the goal of ending the dispute. In an MSP situation under the Federal Claims Collection Act, a compromise represents the acceptance by the Regional Office (RO) of less than the full debt owed to Medicare, when the amount of the full debt does not exceed $100,000, or by Central Office (CO) when the amount exceeds $100,000. An individual who accepts a compromise has no right to appeal the remaining debt.

Conditional Payment - A Medicare payment, conditioned upon reimbursement to Medicare, for services for which another insurer is primary payer.

Coordination Period - The term "coordination period" means a period of 30 months during which Medicare benefits are secondary to benefits payable under GHPs for individuals who are eligible for Medicare because of ESRD. See Chapter 2, §20.

Current Employment Status – See §50 of this chapter.

Eligibility - Eligibility means a beneficiary meets the legal requirements for Medicare benefits. It is still necessary to file an application to become entitled. (For example, a Social Security beneficiary is eligible for Medicare upon attaining age 65 but is not entitled until an application is filed and approved).

Employee - An individual who is working for an employer or an individual who, although not actually working for an employer, is receiving from an employer payments that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code (IRC).

Employer - Employer means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions. Included are the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the District of Columbia, and foreign governments.

Entitled - An eligible individual becomes entitled to Medicare by filing the appropriate application. Upon approval of the application, the individual is entitled. It may also be necessary to enroll for certain services in order to get them.

Family Member - Family member means a person enrolled in a GHP based on another person's enrollment. Family members may include, but are not limited to, a spouse (including a divorced or common law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

FICA - The term "FICA" stands for the Federal Insurance Contributions Act, the law that imposes Social Security taxes on employers and employees under §21 of the Internal Revenue Code.

Fiduciary - A person in a position of trust with regard to the affairs of another, who has a duty to act primarily for the benefit of the other, with respect to a particular undertaking.

GHP (Group Health Plan) - The term "GHP" means any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than insurance agents, the plan is not considered a GHP. However, if the plan includes insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State, and local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs which are under the auspices of one or more employers or employee organizations but which do not receive any contribution from the employer). Individual policies (including Medigap policies) purchased by or through an employee organization, employer or former employer of the individual or family member of the individual are considered employer offered GHPs. However, coverage under the TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is not considered to meet the definition of a GHP. It is secondary to Medicare since the law makes Medicare primary to TRICARE.

Any health plan (including a union plan) in which a beneficiary is enrolled because his/her employment or a family member's employment meets this definition.

Judgment - The official and authentic decision of a court of justice upon the respective rights of the parties to an action submitted to it for determination.

LGHP (Large Group Health Plan) - LGHP means a GHP that covers employees of either:

• A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

• Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

• It includes individual policies (including Medigap policies) purchased by an or through an employer or former employer of the individual or family member.

Liability - Responsibility or fault for damages arising out of a specified incident.

Liability Insurance - Insurance (including a self-insured plan) that provides payment based on alleged legal liability for injury, illness or damage to property. It includes, but is not limited to, automobile liability, uninsured and under-insured motorist, homeowner's liability, malpractice, product liability and general casualty insurance. It includes payments under State "wrongful death" statutes that provide payment for medical damages.

Liability Insurance Payment - A payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurer, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

Lump Sum Commutation Settlement - A workers' compensation settlement in which the beneficiary accepts a lump sum payment that compensates for all future medical expenses and disability benefits related to the work injury or disease.

Lump Sum Compromise Settlement - A workers' compensation settlement that provides less in total compensation than the individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. This may occur when compensability is contested.

MSP - Acronym denoting "Medicare Secondary Payer" provisions of the Social Security Act.

Med-Pay - A payment made by an insurer intended specifically to pay for medical expenses without regard to the fault of any party to the accident. Med-Pay is a form of no-fault insurance.

Multi-employer Group Health Plan - The term "multi-employer group health plan" means a plan that is sponsored jointly or contributed to by two or more employers (sometimes called a multiple employer plan) or by employers and unions (as under the Taft-Hartley law).

No-Fault Insurance - Insurance that pays for medical expenses for injuries sustained or on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It includes "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage.

Nonconforming Group Health Plan or Large Group Health Plan - A "nonconforming GHP or LGHP" means one that at any time during the calendar year takes into account that an individual is eligible for, or receives, benefits based on disability, e.g., a LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with these instructions.

Partial Waiver - A decision by the Medicare program to relinquish the right to collect a portion of a debt from a specific entity. A partial waiver is not to be confused with a compromise. It is different in that it does not arise from negotiation or offer, but under 1870(c) of the Act, which provides the beneficiary the right to request waiver and Medicare the authority to grant or deny waiver based on factual data. Section 1870(c) allows a partial waiver to a person who is without fault or where the adjustment or recovery would defeat the purpose of Title II or XVII of the Act (hardship) or be against equity and good conscience. An individual may appeal a determination based on 1870(c) of the Act if the determination grants only partial waiver of a debt.

Payment in full – Payment in full is an amount that the provider, physician, or other supplier is obligated to accept (e.g., contractually) or voluntarily accepts as full satisfaction of the charges for medical services to an individual from the insurer (e.g., the

GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation.

Plan - The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is a single plan if the arrangement provides for common administration of the health benefits. An arrangement may be administered by the employers directly, by a benefit administrator, by a multi-employer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

Primary Payer - When used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary Payment - When used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

Primary Plan - When used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

Proceeds - Benefits paid under any insurance plan or policy, or annuity contract.

Procurement Costs - Attorney fees and other costs directly related to securing a settlement or judgment that are borne by the beneficiary against whom CMS seeks to recover.

Prompt or Promptly - With regard to liability insurance means payment within 120 days after the earlier of the following:

• The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or

• The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

With regard to no-fault and WC insurance, prompt or promptly means payment within 120 days after receipt of the claim.

Proper Claim - A claim that is filed timely and meets all other claims filing requirements specified by the plan, program, or insurer (e.g., mandatory second opinion, prior notification before seeking treatment).

Recovery - Proceeds obtained from a judgment, settlement, erroneous or conditional payment. The establishment of a right existing in an individual through a law, formal judgment, or decree of a court.

Secondary – The term "secondary", when used with respect to Medicare payment, means that Medicare is the residual payer to all plans that are primary plans with respect to services provided to a Medicare beneficiary.

Self-Employed Person - An individual is considered to be self-employed during a particular tax year only if the individual's self-employment income, as determined by the IRS, was at least equal to the amount specified in §211(b)(2) of the Act, which defines self-employment income for Social Security purposes.

Set-Aside Arrangement – An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set-aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).

SSI - Supplemental Security Income for the Aged, Blind and Disabled is the Federal subsistence income maintenance program for eligible individuals. Title XVI of the Social Security Act enacted SSI in 1972 for the purpose of assuring a minimum level of income for people who are age 65 or over, blind, or disabled, and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level.

Self-Insured Plan - A plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a nonprofit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay for liability claims under the Federal Tort Claims Act. An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by failure to obtain insurance or otherwise) in whole or in part. (With regard to FTCA claims, CMS attempts to collect its mistaken payment from the Federal agency that is settling the claim. If a resolution cannot be reached, CMS must submit the conflict to the Department of Justice for resolution.)

Settlement - An adjustment or agreement by which parties having a dispute between them reach or ascertain what each owes the other. In the MSP liability context, settlement refers to a monetary amount from a liability insurer agreed to by a party in satisfaction of a liability dispute.

Spouse – Means a person of the opposite sex who is a husband or a wife.

Statute of Limitations - A specific time period after the right to assert a claim begins within which certain claims must be filed, and after which the claim may no longer be enforced.

Subrogation - Subrogation means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary.

Under-insured Motorist Insurance - Insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the party's policy or plan.

Uninsured Motorist Insurance - Insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or carries less than the amount of insurance required by law.

Waiver - The relinquishing of an established right. In an MSP situation, it is the forgiveness of the party's obligation to satisfy Medicare's claim, in whole or in part, if certain conditions are met.

Workers' Compensation Agency - The term "WC agency" means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal WC programs, the U.S. Department of Labor.

Workers' Compensation Carrier - The term "WC carrier" means any insurance carrier authorized to write WC insurance under the state or federal law, the state compensation fund where the state administers the WC program, and the beneficiary's employer where the employer is self-insured.

Workers' Compensation Law or Plan - A WC law or plan is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) - The recommended method to protect Medicare's interests in workers' compensation (WC) settlements, judgments, or awards which allocate funds from the settlement for future medical and/or prescription drug expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate.

Working Aged – Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age. This provision applies to group health plans (GHPs) of employers and employee organizations, including multi-employer and multiple employer plans which have at least one participating employer that employs 20 or more employees.

Wrongful Death - A death caused by a wrongful act, neglect, or fault, as seen in some WC, no-fault, and liability situations.

50 - Workers' Compensation (WC)

(Rev. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

A - General

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services that can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program).

These Federal programs provide WC protection for Federal Civil Service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs, for example:

- Coal miners totally disabled due to pneumoconiosis;
- Maritime workers (with the exception of seamen);
- Employees of companies performing overseas contracts with the United States government;
- Employees of American companies who are injured in an armed conflict;
- Employees paid from nonappropriated Federal funds (such as employees of post-exchanges);
- Offshore oil field workers; and
- Qualified claimants under the Department of Labor’s Energy Employees Occupational Illness Compensation Program.

The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion. However, they are considered liability insurance and the MSP liability rules apply.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of that State or territory. If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

B. Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

A WCMSA is an allocation of funds from a workers' compensation (WC) settlement, judgment or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. Where a WC settlement specifies that a portion of the settlement is for a WCMSA, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for as set forth in the following sections, Medicare will to pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease.

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

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(Rev. 65, 03-20-09)

10.2 - Definition of MSP/CWF Terms

(Rev. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

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 nonpayments.

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

CWF Source Codes	COB Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
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
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	Nonpayment / Payment Denial Codes	CROWD Special Project Numbers
0	11100 = COB Contractor	00 Effective 4/1/2002	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	Nonpayment/ 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
""	""	""	""
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	Nonpayment/ Payment Denial Codes	CROWD Special Project Numbers
99	11199 = To be determined	99	7099

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

(Rev. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

Exhibit 2, AB-00-36

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

Error Code	Error Description	Resolution
		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.
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.*	

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

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. 65, Issued: 03-20-09, Effective: 04-01-09/07-01-09, Implementation: 04-06-09/07-06-09)

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, 11125, 11126, 11140, 33333, 55555, 77777, 88888, 99999, to update, delete, change records originated or updated by contractor 11119;and CWF shall allow contractors 11100, 11101, 11102, 11103, 11104, 11105, 11106, 11107, 11108, 11109, 11110, 11111, 11112, 11113, 11114, 11115, 11116, 11117, 11118, 11119, 11125 11140, 33333, 55555, 77777, 88888, 99999 to be updated, deleted, or changed 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

P.O. Box 33847

Detroit, MI 48232

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 Medicare contractors 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 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 Medicare Contractors

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 HUS, 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.

Medicare contractors 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 Carriers, DMACS, 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 Part A contractors 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 date 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.*

Carriers/DME MACs shall override the payable lines with override code N.

The FI contractors shall override the payable claims with override code N. If a claim is to be allowed, a '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 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 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 Medicare Contractors:

- *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 Medicare contractors shall include Reason Code 201, Group Code "PR", Remark Code MA01, when denying claims based on a 'W' MSP auxiliary record on outbound 837 claims.

The Medicare contractors shall utilize Group Code "PR"; Remark Code MA01, Reason Code 201, when denying claims based on a "W" MSP auxiliary record for 835 ERA and SPR messages.

The Medicare Contractors 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.