| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-05 Medicare Secondary Payer | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11775** | **Date: December 30, 2022** |
| | **Change Request 12687** |

**Transmittal 11741 issued December 09, 2022, is being rescinded and replaced by Transmittal 11775, dated, December 30, 2022 to modify 12687.10.2 to remove "denial EOB"; remove VMS as a responsible entity from requirement 12687.10.3; add VMS as a responsible entity for 12687.10.3.1; and modify 12687.34.1 to update the count of ad-hoc DPP testing calls and extend their duration through January 31, 2023. All other information remains the same.**

**SUBJECT: Automation of the Medicare Duplicate Primary Payment (DPP) Process**

**I. SUMMARY OF CHANGES:** CMS and associated stakeholders designed and developed a new automated Duplicate Primary Payer (DPP) process. This instruction fully describes this process.

**EFFECTIVE DATE: October 1, 2022 - For CWF (requirements/coding/preliminary unit testing); for FISS (design/coding); for MCS (analysis/design/coding); for VMS (analysis & coding); January 1, 2023 - For CWF (testing/implementation); FISS (continued development/testing/implementation); MCS (continued coding/testing/implementation); and VMS (testing & implementation)**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 3, 2022 - For CWF (requirements/coding/preliminary unit testing); for FISS (design/coding); for MCS (analysis/design/coding); for VMS (analysis & coding); January 3, 2023 - For CWF (testing/implementation); FISS (continued development/testing/implementation); MCS (continued coding/testing/implementation); and VMS (testing & implementation)**

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 7/TOC |
| N | 7/20/20.5.1 - Automation of the Duplicate Primary Payer (DPP) Process |

**III. FUNDING:**
**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**

# Attachment - Business Requirements

| Pub. 100-05 | Transmittal: 11775 | Date: December 30, 2022 | Change Request: 12687 |
|---|---|---|---|

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## I. GENERAL INFORMATION

**A. Background:** Currently, the Centers for Medicare & Medicaid Services (CMS) recovery contractors, the Commercial Repayment Center (CRC) and Benefits Coordination & Recovery Contractor (BCRC), issue Conditional Payment Letters (CPLs), Conditional Payment Notices (CPN), and associated recovery demands to Group Health Plans (GHPs) and Non-Group Health Plans (NGHP) in situations where Medicare has determined that: 1) the GHP or NGHP is the rightful primary payer; and 2) Medicare has erroneously made a primary payment.

As part of the CPL and/or CPN review process, NGHPs have the right to register disputes about certain claims they believe should not be included as part of any future CMS recovery actions. For GHPs, there are times when concerns about certain claims are brought forth during the recovery demand phase. These are reviewed for validity as well. GHPs and NGHPs often send into the CRC and BCRC, within a specified timeframe, specific paperwork explaining why they believe they should not be required to repay Medicare on specific claims. This paperwork can be either an Explanation of Benefits (EOB) notice or a Remittance Advice (RA), a copy of a check, or other defense paperwork that clearly demonstrates that the GHP or NGHP has previously paid this claim to the provider of service prior to Medicare's payment. (This documentation submitted is known as a "documented defense.")

As stated, one such defense, or, as applicable, dispute, is where the GHP or NGHP has paid the claim correctly as primary. This creates a situation where the GHP or NGHP and Medicare have both paid the claim as primary. This situation is known as a Duplicate Primary Payment (DPP). When this occurs and is confirmed, the CRC and BCRC generate a paper package of information, which typically includes a cover letter, the affected claims identified, and all received and associated defense paperwork validating the DPP situation. (**Note**: The CRC and BCRC cannot adjust claims or recover this money. Therefore, this information needs to be sent to the appropriate A/B Medicare Administrative Contractor (MAC) or Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for that entity to recover this money for the Medicare Trust Fund. Currently, the CRC and BCRC mail this entire DPP package to the appropriate MAC, so that a DPP claims adjustment action may be undertaken.

During fifteen (15) weekly functional analysis and design workgroup sessions held between August through November 2021, CMS and the other workgroup members created the systematic and operational design for an automated DPP process. The envisioned process is heavily dependent upon the Common Working File (CWF) being a receiver of a DPP data file and a disseminator of that information to each appropriate A/B MAC or DME MAC and associated shared system. Under the envisioned process, as the CRC and BCRC enter information received from primary payer remittance advices or explanations of benefits into the Benefits Coordination & Recovery System (BCRS), the Medicare Secondary Payer Systems Contractor (MSPSC), in turn, uses the entered information to create a DPP file, known as the Health Utilization Duplicate Primary (HUDP) data file. Given the type of information normally received from the primary payer for NGHP cases and NGHP Ongoing Responsibility for Medicals (ORM) cases involving DPP, the BCRC and CRC will not have enough information needed to populate the DPP file fully. When this occurs, the MSPSC will send CWF a DPP file with a processing indicator set to "F," which stands for "full claim denial adjustment." By contrast, CMS envisions that the vast majority of information that the CRC enters into BCRS will result in MSPSC sending CWF a DPP file with an indicator set to "S," which means "secondary payment." Greater functional specifics of the DPP business requirements for all parties are provided below.

**B. Policy:** The shared systems, including CWF, and the A/B MACs and DME MACs shall perform the DPP processing and operational requirements specified in the business requirements below.

CMS will not activate the automated DPP process between MSPSC and CWF and between CWF and the shared systems until after the last shared system has implemented the DPP requirements. Until that time, the current manual mailing process between the BCRC and A/B MACs or DME MACs and between the CRC and A/B MACs or DME MACs shall continue unchanged.

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12687.1 | The MSPSC shall create a HUDP file that contains header and trailer records along with all DPP records and required data elements necessary for the shared system to identify claims and perform needed adjustments. | | | | | | | | | MSPSC |
| 12687.1.1 | The MSPSC shall ensure that the HUDP file contains all required elements included in Attachment A, DPP File Layout (HUDP)-version 3. | | | | | | | | | MSPSC |
| 12687.2 | CWF shall:<br><br>1) Accommodate a new HUDP transaction that will contain the Medicare Duplicate Primary Payment data for individual beneficiaries (see Attachment A); and<br><br>2) Develop an associated copybook for the new transaction (CABEHUDP) and share it with the | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | MSPSC and all affected stakeholders prior to implementation of the automated DPP process. | | | | | | | | | |
| 12687.2.1 | CWF shall accept a new transaction, known as the HUDP, from the MSPSC that contains the Medicare DPP data for a beneficiary (see Attachment A for the DPP File Layout).<br><br>**(Note:** This file shall contain both CRC and BCRC DPP cases that need to go to a particular A/B MAC or DME MAC.) | | | | | | | | X | MSPSC |
| 12687.3 | CWF shall edit the incoming HUDP transaction from the MSPSC and either:<br><br>1) Return each accepted record along with a disposition '01' to the MSPSC; and<br><br>2) Return the errors found on DPP records within the HUDP transaction to the MSPSC. | | | | | | | | X | MSPSC |
| 12687.3.1 | CWF shall return errors to the MSPSC on individual DPP records within the HUDP file that failed matching criteria edits; however, CWF shall allow all other DPP records that passed validation to complete processing. | | | | | | | | X | |
| 12687.3.1.1 | CWF shall return a disposition code 01 on all accepted HUDP DPP records to the A/B MACs and DME MACs' associated shared systems. | | | | | X | X | X | X | |
| 12687.3.2 | CWF shall edit the following fields on the incoming HUDP transaction:<br><br>Health Insurance Claim Number (HICN), MAC Contractor Number, Medicare Secondary Payer (MSP) Type Code/MSP Insurance Type Code, Claims Processing Indicator, and Dates of Service (DOS).<br><br>(**Note:** CMS presumes that CWF is validating each DPP record based on the provided HICN.) | | | | | | | | X | |
| 12687.3.3 | In checking for a matching MSP Auxiliary (MSPA) record, CWF shall compare the MSP Type Code and Medicare claim level DOS for PART A and PART | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | B/DME provided on the DPP record with the information on the MSP auxiliary file. | | | | | | | | | |
| 12687.4 | As part of its validation process, CWF shall generate disposition codes for the following four (4) conditions as appropriate:<br><br>Disposition codes:<br><br>60 – I/O error on data base<br><br>UR – Edit Reject (**Note**: Will also contain an<br><br>Edit Error Code)<br><br>AB – System Abend generated during<br><br>processing<br><br>CI – CICS processing problem | | | | | | | | X | |
| 12687.4.1 | CWF shall generate new edit error codes for the following conditions:<br><br>Edit Error Codes:<br><br>1. DP01- Beneficiary Identification Incorrect<br><br>• The Claim HICN or the Active HICN on the HUDP record is incorrect or beneficiary is not in file; or<br>• Claim HICN is inactive and no active HICN is provided on the HUDP.<br><br>2. DP02 – Invalid Claim From/Start or Thru End date.<br><br>• If Dates of Service are blank/zeros; or<br>• If the Dates of service is numeric but converts to an invalid date format.<br><br>3. DP03 – Beneficiary does not have MSP. | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | • A GHP MSP indicated on HUDP, but no GHP MSP Auxiliary record for the beneficiary exists; or<br>• A NGHP MSP indicated on HUDP, but no NGHP MSP Auxiliary record for the beneficiary exists.<br><br>4. DP04 – GHP/NGHP MSP indicated on the HUDP, and the beneficiary has MSP. CWF MSP file does not contain a matching MSP Type or Dates of Service (as compared to the MSP record effective dates) for the beneficiary.<br><br>5. DP05 – MSP Type on the incoming HUDP is blank or invalid. (**Note:** See Attachment A for valid MSP Type values.)<br><br>6. DP06 – MAC Claim Contractor number not valid.<br><br>• Contractor number is blank; or<br>• The contactor number is not found on the CWF Contractor table.<br><br>7. DP07—Claims Processing Indicator is blank or invalid. (**Note:** Valid values are S or F.) | | | | | | | | | |
| 12687.5 | After CWF has determined that an incoming DPP record has passed its validation, CWF shall use its internal contractor table to sort the DPP claims into separate files to be sent to the appropriate A/B MAC or DME MAC and associated shared system. | | | | | | | | X | |
| 12687.5.1 | CWF shall also read the Medicare Internal Control Number (ICN)/Document Control Number (DCN)/Claim Control Number (CCN) on the DPP record as part of its process for determining which A/B MAC or DME MAC should receive the DPP record. | | | | | | | | X | |
| 12687.5.2 | CWF shall ensure that <u>all</u> data fields in the HUDP file are transmitted to the appropriate A/B MAC or DME | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | MAC and associated shared system. | | | | | | | | | |
| 12687.5.2.1 | The shared systems shall:<br>• Accept <u>all</u> HUDP data elements received from CWF**;**and<br>• Pass these elements on to the A/B MACs and DME MACs as part of claims adjudication and exception report-generation processes (i.e., when the shared systems could not fully auto-adjudicate the DPP claims).. | | | | | X | X | X | | |
| 12687.5.2.1.1 | The VDCs that service the A/B MACs (Part A) and A/B MACs (HH&H) shall make the FISS-generated CSV data file (which contains all CWF HUDP data elements) available to their respective MACs whenever the file is created. | | | | | | | | | VDC |
| 12687.5.2.2 | The shared systems shall ensure that their A/B MACs and DME MACs will receive the Claims Processing Indicator value and COB&R Contractor Number on any exception reporting created. | | | | | X | X | X | | |
| 12687.6 | CWF shall not be required to store the HUDP transactions files. | | | | | | | | X | |
| 12687.7 | After CWF has transmitted DPP records to the shared system representing a particular A/B MAC or DME MAC, it shall:<br>• Accept all DPP adjustments generated by the shared system or individually by the A/B MAC or DME MAC as part of normal claims processing; and<br>• Apply all customary MSP and CWF editing to the DPP adjustment claims. | | | | | | | | X | |
| 12687.8 | FISS shall accept the new CWF-generated HUDP containing DPP records in the daily Unsolicited Response (UR) reply from CWF.<br><br>(**Note:** The CWF-transmitted HUDP DPP records will contain the MSP claim data for claims that were paid as duplicates by Medicare (i.e., as a DPP) and need to | | | | | X | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | be adjusted.) | | | | | | | | | |
| 12687.8.1 | MCS and VMS shall accept the new CWF-generated HUDP containing DPP records as part of the daily CWF reply.<br><br>(**Note:** The CWF-transmitted HUDP DPP records will contain the MSP claim data for claims that were paid as duplicates by Medicare (i.e., as a DPP) and need to be adjusted.) | | | | | | X | X | | |
| 12687.8.2 | MCS and VMS shall store the DPP information sent via the CWF daily UR reply or daily UR reply that results in a successful DPP adjustment being created for a minimum of twelve (12) months. | | | | | | X | X | | |
| 12687.8.2.1 | The A/B MACs (Part A) and A/B MACs (Part B), with assistance as necessary from their VDC(s), shall:<br><br>• Store all HUDP responses from CWF as received by the shared system as part of the DPP process; and<br>• Have the ability to print off all stored DPP reports and related DPP information.<br><br>(**Note:** All related tasks above shall be available for a minimum of 12 months from the date of creation.) | X | X | X | | | | | | VDC |
| 12687.8.2.2 | The DME MACs with assistance from their VDC shall:<br><br>• Store all HUDP responses from CWF as received by the shared system as part of the DPP process; and<br>• Have the ability to print off all stored DPP reports and related DPP information.<br><br>(**Note:** All related tasks above shall be available for a minimum of 12 months from the date of creation.) | | | | X | | | | | VDC |
| 12687.9 | FISS, MCS, and VMS shall review the DPP record to determine if a DPP adjustment claim can be created. | | | | | X | X | X | | |
| 12687.9.1 | FISS, MCS, and VMS shall not attempt to create DPP adjustments when the Claims Processing Indicator on | | | | | X | X | X | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | the HUDP DPP record is not equal to either S or F. | | | | | | | | | |
| 12687.9.1.1 | FISS, MCS, and VMS shall include these errant DPP records on a report for A/B MAC or DME MAC review/intervention for follow-up with the BCRC or CRC, as applicable. | | | | | X | X | X | | |
| 12687.9.2 | VMS shall use the HUDP DPP data to systematically generate transactions for the VMS Auto-Adjustment process daily if records are received from CWF for that jurisdiction. | | | | | | | X | | |
| 12687.9.3 | FISS, MCS, and VMS shall create a DPP adjustment claim from the HUDP transactions received on the CWF daily Unsolicited Response File when the required data are present on the HUDP transactions. | | | | | X | X | X | | |
| 12687.9.3.1 | FISS, MCS, and VMS shall create a DPP adjustment claim when the following required data are present on the HUDP DPP transaction:<br>• HICN;<br>• DCN (**Note:** This may also be known as the ICN or CCN, depending upon the system and A/B MAC or DME MAC involved);<br>• MSP Type or MSP Insurance Type Code<br>• 1-byte Claims Processing Indicator (valid values=S or F);<br>• Beneficiary's Last Name;<br>• Beneficiary's First Name;<br>• From and Thru Dates of Service; and<br>• Medicare Claim Total Submitted Charge Amount. | | | | | X | X | X | | |
| 12687.9.3.2 | In addition to the requirements in 12687.9.3.1, FISS, MCS, and VMS shall only attempt to create a well-formed DPP secondary adjustment claim (where the Claims Processing Indicator=S) if the incoming DPP record also contains:<br>• The Primary Payer Paid Amount;<br>• The Insurer/Primary Payer Name; and<br>• All other required elements from Attachment A that are necessary to create a Health Insurance Portability and Accountability Act (HIPAA) 837 compliant outbound claim. | | | | | X | X | X | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | |
| 12687.9.3.3 | MCS and VMS shall create an edit that will reject a DPP adjustment ICN/CCN for review/intervention by the A/B MAC or DME MAC when a detail level primary payer payment or primary payer allowed amount is greater than the Medicare online claim billed amount. | | | | | | X | X | | |
| 12687.9.4 | FISS, MCS, and VMS shall reject the DPP record/adjustment for A/B MAC or DME MAC review/intervention if the HICN and Medicare DCN/ICN/CCN cannot be found on active or purged history. | | | | | X | X | X | | |
| 12687.9.5 | FISS, MCS, and VMS shall reject the DPP record/adjustment for A/B MAC or DME MAC review/intervention if the Medicare DCN/ICN/CCN included on the DPP record/adjustment has been adjusted previously. | | | | | X | X | X | | |
| 12687.9.6 | MCS and VMS shall reject the DPP record/adjustment for A/B MAC (Part B) or DME MAC review/intervention if the DPP record/adjustment contains claim data for a date of service and procedure code that cannot be found on the Medicare DCN/ICN/CCN claim record. | | | | | | X | X | | |
| 12687.9.6.1 | FISS shall reject the DPP record/adjustment for A/B MAC (Part A) review/intervention if DPP record/adjustment contains claim level dates of service that do not match those on the Medicare claim. | | | | | X | | | | |
| 12687.9.7 | MCS shall reject the DPP record/adjustment for MAC (Part B) review/intervention if the DPP record/adjustment contains a Claim Adjustment Reason Code (CARC) at the claim level or any detail level that cannot be found on the CARC Standard Code table (H99TSTND). | | | | | | X | | | |
| 12687.9.8 | The indicated shared systems shall include the DPP record/adjustment on a report for A/B MAC or DME | | | | | | X | X | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | MAC review/intervention when the HUDP detail line information does not match the procedure code/modifier and date of service on the Medicare online claim. | | | | | | | | | |
| 12687.9.9 | The indicated shared systems shall include the DPP record/adjustment on a report for A/B MAC or DME MAC review/intervention when the DPP record line number for a claim does not equal the line number for the claim located within the shared system. | | | | | | X | X | | |
| 12687.9.10 | For situations where the dates of service for claims on the HUDP file equal or are greater than five (5) years, the shared system shall:<br>• Not attempt to create a DPP adjustment claim; and<br>• Include the DPP record on a report for A/B MAC or DME MAC review/intervention. | | | | | X | X | X | | |
| 12687.10 | FISS, MCS, and VMS shall automatically adjust all well-formed DPP Full Replacement records (Claims Processing Indicator=F) as full claim denial adjustments.<br><br>**Note:** A Full Replacement/Full Claim Denial Adjustment means reversing the claim to take back Medicare's full payment. | | | | | X | X | X | | |
| 12687.10.1 | FISS, MCS, and VMS shall map the MSP Insurance Type Code from the HUDP transaction to the created full claim denial adjustment | | | | | X | X | X | | |
| 12687.10.2 | VMS shall create a user table to allow the DME MACs to define the overpayment reason code and overpayment discovery code to be used for auto adjustments. | | | | | | | X | | |
| 12687.10.2.1 | MCS shall map the MAC-provided overpayment reason code and overpayment discovery code to the created full claim denial adjustment. | | | | | | X | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | (**Note**: This requirement for VMS is being fulfilled by the DME MAC actions to be taken in requirement 12687.20.) | | | | | | | | | |
| 12687.10.2.2 | MCS shall ensure that values will be assigned to the adjustment Medicare ICN based on the incoming HUDP Claim Processing Indicator and MSP Insurance Type code. | | | | | | X | | | |
| 12687.10.2.3 | FISS shall populate the adjustment reason code with the existing codes based on Insurance Type, as detailed in requirement 12687.23. | | | | | X | | | | |
| 12687.10.2.4 | MCS shall create a user table to allow the A/B MACs (Part B) to define the overpayment reason code and overpayment discovery code to be used for auto adjustments. | | | | | | X | | | |
| 12687.10.3 | FISS shall map full payments and Medicare's own allowed amounts to the claim level to ensure 100 percent recoupment. | | | | | X | | | | |
| 12687.10.3.1 | MCS and VMS shall map the detail billed amount to the Secondary Pay (SP), Secondary Allowed (SA), and Obligated to Accept as Payment in Full (OTAF) amount. | | | | | | X | X | | |
| 12687.10.4 | The A/B MACs and DME MACs shall ensure that an MSP full claim denial adjustment shall be included on the MSP savings report. | X | X | X | X | | | | | |
| 12687.11 | MCS and VMS shall reprocess all identified claim lines through the MSPPAY module when the Claim Processing Indicator field is equal to "S" and the primary insurer paid on the claim. | | | | | | X | X | | |
| 12687.11.1 | FISS shall reprocess the entire claim through the MSPPAY module when the Claim Processing Indicator field is equal to "S" and the primary insurer paid on the claim. | | | | | X | | | | |
| 12687.11.2 | The MACs and DME MACs shall ensure that an MSP DPP secondary claims adjustment resulting from a Claims Processing Indicator=S shall be included on the MSP savings report. | X | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12687.12 | For DPP adjustment claims, all A/B MACs (Part B) and DME MACs shall always set the 935 indicators to "Y" as part of requirements 12687.20 and 12687.20.1.<br><br>(**Note:** FISS will set up this indicator for its A/B MACs (Part A) as part of the design for this change request.) | | X | | X | X | | | | |
| 12687.13 | FISS shall ensure that DPP adjustment claims are processed using Type of Bill (TOB) frequency code "M." | | | | | X | | | | |
| 12687.13.1 | FISS shall always use the value F (Fiscal Intermediary) as the adjustment requestor identifier for DPP adjustment claims. | | | | | X | | | | |
| 12687.13.2 | FISS shall modify Reason Codes 31531, 31532, and 31535 to ensure that they are bypassed for DPP adjustments. | | | | | X | | | | |
| 12687.14 | MCS and VMS shall map the MSP primary payment amount at the header level of the claim if data are not provided at the detail level. | | | | | | X | X | | |
| 12687.14.1 | MCS and VMS shall map the MSP primary payment information at the detail level when provided.<br><br>(**Note:** The incoming date of service and procedure code and/or HCPCS code shall match to the Medicare ICN/CCN detail.) | | | | | | X | X | | |
| 12687.15 | For DPP processing, if the primary payer's allowed amount is not given, MCS shall subtract any CO-45 amounts from the billed amount and use that as the primary payer allowed amount. | | | | | | X | | | |
| 12687.15.1 | MCS shall calculate the OTAF amount by subtracting any Group Code CO plus CARC amount from the billed amount. | | | | | | X | | | |
| 12687.15.2 | MCS shall:<br><br>1) Calculate the OTAF at the header level if payment information is applied at the claim level; and<br><br>2) Apply the OTAF amount at the claim level. | | | | | | X | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12687.15.3 | MCS shall:<br><br>1) Calculate the OTAF at the detail level if payment information is applied at the claim detail level; and<br><br>2) Apply the OTAF amount at the detail level. | | | | | | X | | | |
| 12687.16 | To ensure that A/B MACs and DME MACs receive systematic reporting tied to the DPP process, FISS, MCS, and VMS shall create daily reports to document the DPP records received from the CWF UR reply process.<br><br>(**Note:** The daily reports shall contain granular, detailed information.) | | | | | X | X | X | | |
| 12687.16.1 | VMS shall ensure that reporting will be generated from the VMS Auto-Adjustment process for the new type "DPP MSP reprocessing."<br><br>(**Note:** CMS presumes that this is for DPP records with a Claims Processing Indicator equal to "S" or "F.") | | | | | | | X | | |
| 12687.16.2 | FISS, MCS, and VMS shall create a daily report that documents the DPP Adjustments that are successfully created from the HUDP transactions.<br><br>(**Note:** The daily reports shall contain granular, detailed information.) | | | | | X | X | X | | |
| 12687.16.3 | FISS, MCS, and VMS shall:<br><br>1) Create a daily report that documents HUDP transactions that errored out and did not result in the creation of DPP Adjustments; and<br><br>2) Make the report systematically available for the appropriate A/B MAC or DME MAC for review/intervention.<br><br>(**Note:** The daily reports shall contain granular, detailed information.) | | | | | X | X | X | | |
| 12687.16.3.1 | FISS, MCS, and VMS shall also: | | | | | X | X | X | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 1) Create a daily report of any DPP adjustment DCNs/ICNs/CCNs that are in a suspense location due to failed edits/audits; and<br><br>2) Make the report systematically available for the appropriate A/B MAC or DME MAC for review/intervention.<br><br>(**Note:** CMS presumes that the DPP adjustment was created but encountered normal systematic edits/audits under this scenario.) | | | | | | | | | |
| 12687.16.3.2 | The shared systems shall include detail regarding what required data elements were missing or what specific issue was encountered that prevented successful adjustment claim creation, when creating the daily reports for the scenarios discussed in 12687.16.3 and 12687.16.3.1. | | | | | X | X | X | | |
| 12687.17 | FISS, MCS, and VMS shall report off-line (purged from history) claims that could <u>not</u> be retrieved in the system and send this information to the appropriate A/B MAC or DME MAC daily for review and resolution. | | | | | X | X | X | | |
| 12687.17.1 | Once the shared systems send the report mentioned in 12687.17 to the associated A/B MAC or DME MAC, the A/B MAC or DME MAC shall work these DPP transactions manually, in order to capture manually DPP savings.<br><br>**(Note:** CMS will provide further guidance regarding timeframes for completion of this task as part of updated Joint Operating Agreements as well as in the Quality Assurance Surveillance Plan standards.) | X | X | X | X | | | | | |
| 12687.17.2 | FISS, MCS, and VMS shall:<br><br>1) Create a monthly report for pending (i.e., not finalized) DPP Adjustments created from the HUDP transactions<u>;</u> and<br><br>2) Make this information available for the associated A/B MACs or DME MACs for review. | | | | | X | X | X | | |
| 12687.17.3 | FISS, MCS, and VMS shall: | | | | | X | X | X | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 1) Create a monthly report of all successful DPP adjustments that have finalized and did not pend for review/intervention by the A/B MACs and DME MACs; and<br><br>2) Make this information available to the associated A/B MACs or DME MACs for review. | | | | | | | | | |
| 12687.17.4 | FISS, MCS, and VMS shall ensure that the monthly report contains claim payment and beneficiary specific information.<br><br>(**Note:** The monthly report shall contain high-level/summary-level detail and not the granular detail provided in the detail report.) | | | | | X | X | X | | |
| 12687.18 | MCS shall retain the various DPP reports and display them online for the A/B MAC or DME MAC to view for twelve (12) months after creation of the reports. | | | | | | X | | | |
| 12687.18.1 | The DME MACs with assistance from their VDC shall:<br><br>• Store all DPP-related reports created from the shared system as part of the DPP process; and<br>• Have the ability to print off all stored DPP reports and related DPP information.<br><br>(**Note:** All related tasks above shall be available for a minimum of 12 months from the date of creation.) | | | | X | | | | | VDC |
| 12687.19 | MCS shall create a DPP Response Generator to simulate the receipt of a DPP file from CWF for the User Acceptance Testing (UAT) testing regions. | | | | | | X | | | |
| 12687.20 | The DME MACs shall define the following fields for the event for the new type "DPP – MSP reprocessing" when setting up the adjustment type in the **VMS Auto Adjustment table:**<br><br>- Denial Action Code (AC)<br><br>- APEX and CIP value = P<br><br>- RANK | | | | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | - DCN ranges<br><br>- ORIGIN<br><br>- DEPT<br><br>- LOCN<br><br>- TYPE<br><br>- R/D<br><br>- ITEM STAT<br><br>**Notes:**<br><br>1) CMS presumes that this table is being used for the creation of Claims Processing Indicator "S" or "F" DPP adjustment actions.<br><br>2) CMS presumes that this business requirement is a DME MAC requirement and not a VMS systems requirement. | | | | | | | | | |
| 12687.20.1 | The A/B MACs (Part B) shall complete all required fields within the MCS-supplied DPP Adjustment Control table prior to implementation of the automated DPP process. | | X | | | | | | | RRB-SMAC |
| 12687.21 | The indicated shared systems shall always set the mass adjustment indicator to "O" in the claim header "mass adjustment indicator" when sending DPP adjustment claims to CWF for normal processing. | | | | | X | X | X | | |
| 12687.21.1 | The indicated shared systems shall always set the 23rd position of the Beginning of the Hierarchical Transaction Reference Identification (BHT03) file indicator to "S" (Mass Adjustments/other) for DPP adjustment claims for COBA processing purposes. | | | | | X | X | X | | |
| 12687.21.2 | VMS shall also include the value "S" in the 23rd byte in field 504-F4 (Message) of any outbound National Council for Prescription Drug Programs (NCPDP) batch COB claims that result from DPP adjustments. | | | | | | | X | | |
| 12687.22 | For DPP adjustments, A/B MACs and DME MACs shall process these claims as 935 adjustments, as set | X | X | X | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | by the assigned reason/discovery code.<br><br>(**Notes:**:<br><br>1) The exception to this requirement is provider-initiated or requested adjustments, which are not subject to the 935 requirements; for more information, see Pub.100-06, chapter 3, section 200.<br><br>2) CMS assumes that FISS automatically sets up the DPP adjustment claims with the 935 indicator properly set.) | | | | | | | | | |
| 12687.23 | For DPP adjustments, A/B MACs and DME MACs shall use the same reason/discovery codes as they do currently under the manual DPP process. | X | X | X | X | | | | | |
| 12687.24 | The A/B MAC or DME MAC shall contact the BCRC or CRC, as applicable, by phone or via fax to attempt a resolution to the issue when:<br><br>• The shared systems do <u>not</u> auto-adjudicate a DPP claim whose Claim Processing Indicator= S <u>and</u> include the claim on a report for A/B MAC or DME MAC review and intervention due to missing required elements.<br><br>(**Note:** CMS shall provide BCRC or CRC contact information (i.e., phone and fax options) to the A/B MACs or DME MACs prior to the implementation of this instruction.) | X | X | X | X | | | | | CMS |
| 12687.24.1 | If the BCRC or CRC is able to obtain the missing required information and enter it into BCRS, the MSPSC shall transmit the claim, with missing elements added, to CWF to re-initiate the DPP process. | | | | | | | | | BCRC, BCRS, CRC, MSPSC |
| 12687.24.2 | When there is conflicting information between the data on the DPP record and the claim within the A/B MAC or DME MAC's claims history, the A/B MAC or DME MAC shall:<br><br>1. Cancel the DPP claim if created by the shared system; and | X | X | X | X | | | | | CMS |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 2. Contact the BCRC or CRC, as applicable, by phone or via fax to attempt a resolution to the issue.<br><br>(**Note:** CMS shall provide BCRC or CRC contact information (i.e., phone or fax) to the A/B MACs or DME MACs prior to the implementation of this instruction.) | | | | | | | | | |
| 12687.24.3 | For the scenario in 12687.24.2, if the BCRC or CRC is able to resolve the conflicting DPP information and make the needed correction in BCRS, the MSPSC shall transmit the corrected claim to CWF to re-initiate the DPP process. | | | | | | | | | BCRC, BCRS, CRC, MSPSC |
| 12687.25 | For the scenario below, the A/B MAC or DME MAC and BCRC or CRC shall take the following actions:<br><br>• The A/B MAC shall <u>not</u> attempt to create an "I" record to replace the deleted MSP auxiliary record, as happens currently under the manual DPP process;<br><br>• The A/B MAC and DME MAC shall contact the BCRC or CRC (either by phone or fax) to resolve the discrepancy;<br><br>• The BCRC or CRC shall contact the primary payer regarding the discrepancy; and the<br><br>• The A/B MAC and DME MAC shall cancel the DPP adjustment claim that had been created.<br><br>**Scenario (applicable to above requirements):** On rare occasions a primary payer may delete a pre-existing MSP CWF auxiliary record, even though that entity had reported to CMS that it was the primary insurer. In such instances, when the shared system or A/B MAC or DME MAC attempts to finalize a DPP adjustment, CWF will return an error code indicating | X | X | X | X | | | | | BCRC, CMS, CRC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | there is no existing MSP record.<br><br>(**Note:** CMS shall provide BCRC or CRC contact information (i.e., phone and fax options) to the A/B MACs or DME MACs prior to the implementation of this instruction.) | | | | | | | | | |
| 12687.25.1 | FISS, MCS, and VMS shall bypass the creation of "I" records, which is a requirement in CMS change request 12116, as part of the automated DPP process. | | | | | X | X | X | | |
| 12687.25.2 | For the scenario in 12687.25, when the BCRC or CRC obtains confirmation that the MSP record should be re-established, the BCRC and CRC shall take the following actions, as applicable to each contractor:<br><br>• The BCRC shall re-establish the MSP auxiliary record at CWF; and<br>• The BCRC or CRC shall re-initiate the automated DPP process, whereby the MSPSC sends another HUDP transaction to CWF. | | | | | | | | | BCRC, CRC, MSPSC |
| 12687.26 | The MSPSC, CWF, and the A/B MACs and the DME MACs shall participate in User Acceptance Testing (UAT).<br><br>**Note**: CMS anticipates this testing will occur during December 2022. | | | | | | | | X | CMS, MSPIC, MSPSC |
| 12687.27 | All testing entities shall develop their individual test environments accordingly based on the requirements of this CR.. | X | X | X | X | X | X | X | X | CMS, MIST, MSPIC, MSPSC |
| 12687.27.1 | Upon receipt of the test HICNs, the A/B MACs and DME MACs participating in UAT testing shall copy production claims data and any supporting data into their UAT test regions. | X | X | X | X | | | | | |
| 12687.28 | All involved testing entities shall send all test data via secure email. | X | X | X | X | | | | X | MSPSC |
| 12687.28.1 | All involved testing entities shall communicate to all testers their secure email or resource email box details/link. | X | X | X | X | | | | X | MSPSC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12687.28.2 | In reporting MSPSC-specific problems identified during testing, the A/B MACs and DME MACs shall:<br><br>1) Capture the REMAS Claim Control ID and REMAS Case ID associated with the DPP claim, as derived from the incoming HUDP test file; and<br><br>2) Make those identifiers available to the MSPSC for problem research purposes.. | X | X | X | X | | | | | BCRC, CRC, MSPIC, MSPSC |
| 12687.29 | The MSPSC and the A/B MACs and DME MACs shall participate in test case development as necessary.<br><br>**Note:** CMS assumes the A/B MACs and DME MACs will modify the MSPSC-supplied test data as necessary to test MAC-specific test scenarios not covered by the MSPSC-created records; for example, an A/B MAC or DME MAC may want a specific Claim Adjustment Reason Code (CARC) to be present as part of its testing. | X | X | X | X | | | | | MSPSC |
| 12687.30 | The shared systems and A/B MACs and DME MACs shall test the ability to create DPP adjustments (i.e., DPP secondary adjustments as well as full claim denials (or, as applicable, full claim adjustments)) and have them flow through to CWF. | X | X | X | X | X | X | X | X | |
| 12687.31 | The MSPSC shall develop test HUDP files, using the data supplied to the testers, and send them to CWF for positive and negative testing. | | | | | | | | | MSPSC |
| 12687.32 | CWF shall send the HUDP test file to each shared system representing their associated A/B MACs and DME MACs for testing. | | | | | X | X | X | X | |
| 12687.33 | The MSPSC shall provide a sample test HUDP file to all indicated partner entities for their use in conducting DPP alpha and beta testing and for other DPP testing considerations. | X | X | X | X | X | X | X | X | MIST, MSPSC |
| 12687.34 | For initial calls, the indicated entities shall participate in a minimum of five, to a maximum of ten, one hour calls to coordinate the DPP integrated testing strategy.<br><br>**Note:** As initial calls unfold, all testing entities may not be required to attend all calls. CMS will alert all | X | X | X | X | X | X | X | X | CMS, MIST, MSPIC, MSPSC, VDC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | testers when certain entities are not required to attend. | | | | | | | | | |
| 12687.34.1 | During late December 2022 and through January 31, 2023, the indicated testing entities shall participate in a minimum of 10, to a maximum of 15, ad-hoc calls to discuss testing outcomes and any needed refinements.<br><br>**Note:** All testing entities may not be required to attend all calls. CMS will endeavor to alert all testers when certain entities are not required to attend. | X | X | X | X | X | X | X | X | CMS, MIST, MSPIC, MSPSC, VDC |
| 12687.35 | The MSPIC and MSPSC shall develop a testing strategy as a result of initial testing calls | | | | | | | | | CMS, MSPIC, MSPSC |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

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

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Karen Ochab, 410-786-6406 or Karen.Ochab@cms.hhs.gov (Brian Pabst, 410-786-2487 or Brian.Pabst@cms.hhs.gov, and Sheila Alston, 410-786-8334 or Sheila.Alston@cms.hhs.gov,)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: 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.

**ATTACHMENTS: 1**

**Attachment A--HUDP File Layout**

- Numeric fields will be right justified, zero filled. If no value available, the field will contain all zeros. **"Date- CCYYMMDD" is always a numeric field.**
- Alphanumeric fields will be left justified, space filled. If no value available, the field will contain spaces.

**Header Record:**

| Field # | Field Name | Position | Format | Length | Description/Value | Req? | Comments |
|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1-4 | Alphanumeric | 4 | HUHE | Y | |
| 2 | Filler | 5-5 | Alphanumeric | 1 | Space | | |
| 3 | Contractor Number | 6-10 | Alphanumeric | 5 | 79001 | Y | File may contain records from any or all of the COB&R contractors. Request from CWF on 4/27 is to make this one of the DPP contractor IDs |
| 4 | File Creation Date | 11-18 | Date - CCYYMMDD | 8 | Date File created in REMAS | Y | |
| 5 | Filler | 19-12150 | Alphanumeric | 12132 | Spaces - For Future Use | | |

**Trailer Record:**

| Field # | Field Name | Position | Format | Length | Description/Value | Req? | Comments |
|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1-4 | Alphanumeric | 4 | HUTR | Y | |
| 2 | Filler | 5-5 | Alphanumeric | 1 | Space | | |
| 3 | Contractor Number | 6-10 | Alphanumeric | 5 | 79001 | Y | |
| 4 | Detail Record Count | 11-17 | Numeric | 7 | Number of detail claim records (HUDP) contained within the file. Note: Does not include header and trailer records. | Y | |
| 5 | Filler | 18-12150 | Alphanumeric | 12133 | Spaces - For Future Use | | |

**Detail Record:**

| Field # | Field Name | Position | Format | Length | Description/Value | Req? | Comments |
|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1-4 | Alphanumeric | 4 | HUDP | Y | |
| 2 | Filler | 5-5 | Alphanumeric | 1 | Space | Y | |
| 3 | Claim HICN | 6-17 | Alphanumeric | 12 | HICN submitted on Medicare claim (IDR) | Y | CWF shall validate the HICN Number and reject record if HICN or active HICN not found. |
| 4 | Active/Principal HICN | 18-29 | Alphanumeric | 12 | Current active HICN for beneficiary (BIC) | Y | |
| 5 | Medicare ICN/DCN/CCN | 30-52 | Alphanumeric | 23 | Medicare Claim ID (IDR) | Y | |
| 6 | MAC Contractor Number | 53-57 | Alphanumeric | 5 | MAC Contract ID (IDR) submitted on the IDR claim. | Y | CWF shall reject this record if this field does not contain a valid MAC contract ID. |
| 7 | Responsible COB&R Contractor Id | 58-62 | Alphanumeric | 5 | The COB&R contractor submitting this DPP; valid values are:<br>79001 - NGHP BCRC<br>79501 - GHP<br>79801 - NGHP ORM | Y | |
| 8 | Claim Processing Indicator | 63-63 | Alphanumeric | 1 | **Valid Values :**<br>F - claim should be processed as full replacement/full claims denial; or<br>S - claim should be reprocessed as secondary | Y | For NGHP, the claim processing indicator will be an 'F' to indicate the DPP should be processed as a full replacement/full claims denial; no primary payer info is provided.<br><br>For GHP, the claim processing indicator will be 'S' and primary payer information must be provided so that the claim can be reprocessed as secondary. MSP should exist. |
| 9 | REMAS Claim Cntl Id | 64-78 | Numeric | 15 | Internal ReMAS Claim Id | Y | MSPSC Use only. |
| 10 | REMAS Case Cntl Id | 79-93 | Numeric | 15 | Internal ReMAS Case Id | Y | May be used by MACs to communicate issues back to the COB&R contractor; is not PII/PHI. |
| 11 | Beneficiary Last Name | 94-133 | Alphanumeric | 40 | Bene Last Name (BIC) | Y | |
| 12 | Beneficiary First Name | 134-173 | Alphanumeric | 40 | Bene First Name (BIC) | Y | |
| 13 | Beneficiary Middle Initial | 174-174 | Alphanumeric | 1 | Bene Middle Init (BIC) | N | |
| 14 | Medicare Claim Level Billed From Date of Service | 175-182 | Date - CCYYMMDD | 8 | Medicare Claim - Earliest From Date of Service on the claim (IDR) | Y | CWF will edit for a valid date and then verify that the claim service dates correlate to MSP Dates or reject to MSPSC. |
| 15 | Medicare Claim Level Billed Thru Date of Service | 183-190 | Date - CCYYMMDD | 8 | Medicare Claim - Latest Through Date of Service on the claim (IDR) | Y | CWF will edit for a valid date and then verify that the claim service dates correlate to MSP Dates or reject to MSPSC. |
| 16 | Medicare Claim Total Submitted Charge Amount | 191-201 | Numeric - 9(09)v99 | 11 | Medicare Claim Level Total of all Submitted Charges (IDR) | Y | |
| 17 | Insurer Name | 202-281 | Alphanumeric | 80 | Primary Payer Name | Required if "S" record; otherwise provided if available. | Insurer fields will be populated on "S" records but should not be compared to existing trailer 03 data as the CRC receives updates that may not be sent to CWF. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 18 | Insurer Address Line 1 | 282-321 | Alphanumeric | 40 | Primary Payer Address Line 1 | Required if "S" record; otherwise provided if available. | Insurer fields will be populated on "S" records but should not be compared to existing trailer 03 data as the CRC receives updates that may not be sent to CWF. |
| 19 | Insurer Address Line 2 | 322-361 | Alphanumeric | 40 | Primary Payer Address Line 2 | Not required; provided if available | Will be provided if available and other insurer fields are populated |
| 20 | Insurer Address Line 3 | 362-401 | Alphanumeric | 40 | Primary Payer Address Line 3 | Not required; provided if available | Will be provided if available and other insurer fields are populated |
| 21 | Insurer City | 402-425 | Alphanumeric | 24 | Primary Payer City | Required if "S" record; otherwise provided if available. | Insurer fields will be populated on "S" records but should not be compared to existing trailer 03 data as the CRC receives updates that may not be sent to CWF. |
| 22 | Insurer State Code | 426-427 | Alphanumeric | 2 | Primary Payer State Code | Required if "S" record; otherwise provided if available. | Insurer fields will be populated on "S" records but should not be compared to existing trailer 03 data as the CRC receives updates that may not be sent to CWF. |
| 23 | Insurer Zip Code | 428-436 | Alphanumeric | 9 | Primary Payer Zip Code | Required if "S" record; otherwise provided if available. | Insurer fields will be populated on "S" records but should not be compared to existing trailer 03 data as the CRC receives updates that may not be sent to CWF. |
| 24 | MSP Insurance Type Code | 437-438 | Alphanumeric | 2 | **Valid Values:**<br>12 = Working Aged (A)<br>13 = ESRD (B)<br>14 = No - Fault (D)<br>15 = Workers' Compensation (E)<br>43 = Disability (G)<br>47 = Liability (L) | Y | Note - Black Lung MSP is not included in MSP Recovery and is excluded from this interface. |
| 25 | MSP Type Code | 439-439 | Alphanumeric | 1 | **Valid values for MSP** = A, B, D, E, G, L | Y | CWF shall reject the record if this field does not contain a valid value.<br>Further, CWF shall validate that there is an undeleted MSP record with this MSP type that correlates to the DOS. |
| 26 | Patient Relationship | 440-441 | Alphanumeric | 2 | **CWF Patient relationship code valid values:**<br>00 = UNKNOWN<br>01 = Patient is insured<br>02 = Spouse<br>03 = Natural child where policyholder has final responsibility<br>04 = Natural child where policyholder doesn't have final responsibility<br>05 = Step child<br>06 = Foster child<br>07 = Ward of the court<br>08 = Employee<br>09 = Unknown<br>10 = Handicapped dependent<br>11 = Organ donor<br>12 = Cadaver donor<br>13 = Grandchild<br>14 = Niece/nephew<br>15 = Injured plaintiff<br>16 = Sponsored dependent<br>17 = Minor dependent of a minor dependent<br>18 = Parent<br>19 = Grandparent | Y | |
| 27 | Primary Payer Member Identifier | 442-471 | Alphanumeric | 30 | Primary Payer Beneficiary/Patient Membership ID/Policy Number | N | If no value provided, SSMs must gap fill to create a HIPAA compliant claim. |
| 28 | Primary Payer Group Number | 472-491 | Alphanumeric | 20 | Primary Payer Group Number | N | |
| 29 | Primary Payer Claim Paid Date | 492-499 | Date - CCYYMMDD | 8 | Primary Payer Claim-level Paid Date; date must be in the past | Required for "S" record; otherwise may be blank | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 30 | Primary Payer Claim Total Paid Amount | 500-510 | Numeric - 9(09)v99 | 11 | Primary Payer Claim-Level Total Paid Amount; must be > zero for Part A, could be =zero for Part B/DME if provided at the line level. | Required for **PART A and** "S" record; otherwise may be blank | |
| | **PART A CARC Codes and Amounts** | 7 Occurrences | | | | | |
| 31 | Primary Payer CAS Group Code(1) | 511-512 | Alphanumeric | 2 | **CAS Group Code valid values:**<br>CO - Contractual Obligation<br>PR - Patient Responsibility<br>OA - Other Adjustment | Required if **PART A and** "S" record; otherwise may be blank | CAS Group Code will only be provided on the interface if there is a CARC. |
| 32 | Primary Payer CARC Code(1) | 513-516 | Alphanumeric | 4 | | Required if **PART A and** "S" record; otherwise may be blank | |
| 33 | Primary Payer CARC Amount(1) | 517-527 | Numeric - S9(09)v99 | 11 | Primary Payer Claim Level CARC Amounts | Required if **PART A and** "S" record; otherwise may be blank | |
| 34 | Primary Payer CAS Group Code(2) | 528-529 | Alphanumeric | 2 | | | |
| 35 | Primary Payer CARC Code(2) | 530-533 | Alphanumeric | 4 | | | |
| 36 | Primary Payer CARC Amount(2) | 534-544 | Numeric - S9(09)v99 | 11 | | | |
| 37 | Primary Payer CAS Group Code(3) | 545-546 | Alphanumeric | 2 | | | |
| 38 | Primary Payer CARC Code(3) | 547-550 | Alphanumeric | 4 | | | |
| 39 | Primary Payer CARC Amount(3) | 551-561 | Numeric - S9(09)v99 | 11 | | | |
| 40 | Primary Payer CAS Group Code(4) | 562-563 | Alphanumeric | 2 | | | |
| 41 | Primary Payer CARC Code(4) | 564-567 | Alphanumeric | 4 | | | |
| 42 | Primary Payer CARC Amount(4) | 568-578 | Numeric - S9(09)v99 | 11 | | | |
| 43 | Primary Payer CAS Group Code(5) | 579-580 | Alphanumeric | 2 | | | |
| 44 | Primary Payer CARC Code(5) | 581-584 | Alphanumeric | 4 | | | |
| 45 | Primary Payer CARC Amount(5) | 585-595 | Numeric - S9(09)v99 | 11 | | | |
| 46 | Primary Payer CAS Group Code(6) | 596-597 | Alphanumeric | 2 | | | |
| 47 | Primary Payer CARC Code(6) | 598-601 | Alphanumeric | 4 | | | |
| 48 | Primary Payer CARC Amount(6) | 602-612 | Numeric - S9(09)v99 | 11 | | | |
| 49 | Primary Payer CAS Group Code(7) | 613-614 | Alphanumeric | 2 | | | |
| 50 | Primary Payer CARC Code(7) | 615-618 | Alphanumeric | 4 | | | |
| 51 | Primary Payer CARC Amount(7) | 619-629 | Numeric - S9(09)v99 | 11 | | | |
| | | **End Occurs** | | | | | |
| 52 | Beneficiary Birth Date | 630-637 | Date - CCYYMMDD | 8 | | Y | Field added 6/27/22 - per request from CWF; may be ignored by SSMs if not useful |
| 53 | Beneficiary Sex Code | 638-638 | Alphanumeric | 1 | M - Male<br>F - Female<br>U - Unknown | Y | Field added 6/27/22 - per request from CWF; may be ignored by SSMs if not useful |
| 54 | REMAS Interface Control ID | 639-668 | Alphanumeric | 30 | Internal ReMAS Interface Id | Y | Field added 6/28/22 - REMAS Interface tracking information; CWF will return this field in REMAS response records |
| **55** | **CWF File Run Date** | **669-676** | **Date - CCYYMMDD** | **8** | **FISS Requested** | **Y** | **Reserved for FISS use only. Data populated by CWF.** |
| 56 | Filler | 677-740 | Alphanumeric | 64 | Spaces - For Future Use | | Adjusted filler space to accommodate new fields added to filler; Adjusted all subsequent field #s accordingly |
| 57 | CWF Disposition Code | 741-742 | Alphanumeric | 2 | 01 - Approved (response sent to MAC)<br>60 - I/O error on data base (response returned to MSPSC)<br>UR - Edit Reject (response returned to MSPSC)<br>AB - Transaction caused CICS ABEND (response returned to MSPSC)<br>CI - CICS processing problem ( response returned to MSPSC) | Y | Response file to MSPSC will only include records that errored out; all records that are accepted by CWF will be sent to the MACs with '01' disposition code. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 58 | CWF Edit Error Code | 743-746 | Alphanumeric | 4 | CWF will generate new error codes for HUDP response sent back to MSPSC | Y | Required for Response file to MSPSC.<br>DP01- Beneficiary not found in CWF<br>DP02 – Invalid DOS<br>DP03- GHP/NGHP MSP indicated on claim, no MSP Auxiliary file exists. Bene does not have MSP.<br>DP04- GHP/NGHP MSP indicated on claim. Bene has MSP but MSP Type/DOS not found.<br>DP05 - MSP File exists at CWF but no MSP is indicated on the incoming HUDP. (When MSP Type is blank)<br>DP06- Claim Contractor number not valid |
| 59 | Filler | 747-750 | Alphanumeric | 4 | Spaces - For Future Use | | |
| **PART B/DME Claim Line Data Start** | | **Occurs 50** | | | | | |
| 60 | Claim Line Number(1) | 751-755 | Numeric | 5 | Claim Line # from Medicare claims (IDR) | Y | |
| 61 | Medicare Claim Line Level From Date of Service(1) | 756-763 | Date - CCYYMMDD | 8 | Medicare Claim Line From Date of Service (IDR) | Y | Note - CWF will validate that MSP exists for the DOS at the header level rather than the line level. |
| 62 | Medicare Claim Line Level To Date of Service(1) | 764-771 | Date - CCYYMMDD | 8 | Medicare Claim Line To Date of Service (IDR) | Y | |
| 63 | Medicare Claim Line Level Submitted Amount(1) | 772-782 | Numeric - 9(09)v99 | 11 | Medicare Claim Line Submitted Amount (IDR) | Y | |
| 64 | HCPCS Code(1) | 783-787 | Alphanumeric | 5 | Medicare Claim Line HCPCS Code (IDR) | Y | |
| 65 | HCPCS Modifier Code(1) | 788-789 | Alphanumeric | 2 | Medicare Claim Line HCPCS Modifier Code (IDR) | N | Added 3/22/2022 - Will be provided on interface if on IDR claim; note that BCRS does **not** retain the positioning of the modifier on the IDR claim |
| 66 | HCPCS Modifier Code(2) | 790-791 | Alphanumeric | 2 | Medicare Claim Line HCPCS Modifier Code (IDR) | N | Added 3/22/2022 - Will be provided on interface if on IDR claim; note that BCRS does **not** retain the positioning of the modifier on the IDR claim |
| 67 | HCPCS Modifier Code(3) | 792-793 | Alphanumeric | 2 | Medicare Claim Line HCPCS Modifier Code (IDR) | N | Added 3/22/2022 - Will be provided on interface if on IDR claim; note that BCRS does **not** retain the positioning of the modifier on the IDR claim |
| 68 | HCPCS Modifier Code(4) | 794-795 | Alphanumeric | 2 | Medicare Claim Line HCPCS Modifier Code (IDR) | N | Added 3/22/2022 - Will be provided on interface if on IDR claim; note that BCRS does **not** retain the positioning of the modifier on the IDR claim |
| 69 | Primary Payer Allowed Amt - Line Level(1) | 796-806 | Numeric - 9(09)v99 | 11 | Primary Payer Allowed Amt at the line level - must be greater than zero | Required if **PART B/DME and** "S" record; otherwise may be blank | |
| 70 | Primary Payer Paid Amt - Line Level(1) | 807-817 | Numeric - 9(09)v99 | 11 | Primary Payer Paid Amt at the line level -must be greater than zero if not provided at the header level. | Required if **PART B/DME and** "S" record; otherwise may be blank | |
| | **CARC Codes and Amounts - Line Level(1)** | **7 Occurrences** | | | | | |
| 71 | Primary Payer CAS Group Code(1) | 818-819 | Alphanumeric | 2 | CAS Group Code valid values (per CMS xls):<br>CO - Contractual Obligation<br>PR - Patient Responsibility<br>OA - Other Adjustment | Required if **PART B/DME and** "S" record; otherwise may be blank | CAS Group Code will only be provided on the interface if there is a CARC. |
| 72 | Primary Payer CARC Code(1) | 820-823 | Alphanumeric | 4 | Primary Payer Line Level CARC Codes; if provided, must be valid x12 code | Required if **PART B/DME and** "S" record; otherwise may be blank | |
| 73 | Primary Payer CARC Amount(1) | 824-834 | Numeric - S9(09)v99 | 11 | Primary Payer Line Level CARC Amounts | Required if **PART B/DME and** "S" record; otherwise may be blank | |
| 74 | Primary Payer CAS Group Code(2) | 835-836 | Alphanumeric | 2 | | | |
| 75 | Primary Payer CARC Code(2) | 837-840 | Alphanumeric | 4 | | | |
| 76 | Primary Payer CARC Amount(2) | 841-851 | Numeric - S9(09)v99 | 11 | | | |
| 77 | Primary Payer CAS Group Code(3) | 852-853 | Alphanumeric | 2 | | | |
| 78 | Primary Payer CARC Code(3) | 854-857 | Alphanumeric | 4 | | | |
| 79 | Primary Payer CARC Amount(3) | 858-868 | Numeric - S9(09)v99 | 11 | | | |
| 80 | Primary Payer CAS Group Code(4) | 869-870 | Alphanumeric | 2 | | | |
| 81 | Primary Payer CARC Code(4) | 871-874 | Alphanumeric | 4 | | | |
| 82 | Primary Payer CARC Amount(4) | 875-885 | Numeric - S9(09)v99 | 11 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 83 | Primary Payer CAS Group Code(5) | 886-887 | Alphanumeric | 2 | | | |
| 84 | Primary Payer CARC Code(5) | 888-891 | Alphanumeric | 4 | | | |
| 85 | Primary Payer CARC Amount(5) | 892-902 | Numeric - S9(09)v99 | 11 | | | |
| 86 | Primary Payer CAS Group Code(6) | 903-904 | Alphanumeric | 2 | | | |
| 87 | Primary Payer CARC Code(6) | 905-908 | Alphanumeric | 4 | | | |
| 88 | Primary Payer CARC Amount(6) | 909-919 | Numeric - S9(09)v99 | 11 | | | |
| 89 | Primary Payer CAS Group Code(7) | 920-921 | Alphanumeric | 2 | | | |
| 90 | Primary Payer CARC Code(7) | 922-925 | Alphanumeric | 4 | | | |
| 91 | Primary Payer CARC Amount(7) | 926-936 | Numeric - S9(09)v99 | 11 | | | |
| | | **End CARC Occurs** | | | | | |
| 92 | Filler | 937-978 | Alphanumeric | 42 | Spaces - For Future Use | | |
| | | | | | | | |
| 93-121 | Part B/DME Line #2 Data | 979 -1206 | | 228 | | | If Line #2 exists, see Line #1 Data for required fields. |
| 122-150 | Part B/DME Line #3 Data | 1207 - 1434 | | 228 | | | If Line #3 exists, see Line #1 Data for required fields. |
| 151-179 | Part B/DME Line #4 Data | 1435 - 1662 | | 228 | | | If Line #4 exists, see Line #1 Data for required fields. |
| 180-208 | Part B/DME Line #5 Data | 1663 - 1890 | | 228 | | | If Line #5 exists, see Line #1 Data for required fields. |
| 209-237 | Part B/DME Line #6 Data | 1891 - 2118 | | 228 | | | If Line #6 exists, see Line #1 Data for required fields. |
| 238-266 | Part B/DME Line #7 Data | 2119 - 2346 | | 228 | | | If Line #7 exists, see Line #1 Data for required fields. |
| 267-295 | Part B/DME Line #8 Data | 2347 - 2574 | | 228 | | | If Line #8 exists, see Line #1 Data for required fields. |
| 296-324 | Part B/DME Line #9 Data | 2575 - 2802 | | 228 | | | If Line #9 exists, see Line #1 Data for required fields. |
| 325-1481 | Part B/DME Line #10 thru 50 Data | 2803 - 12150 | | 9348 | | | If Line #10 thru 50 exists, see Line #1 Data for required fields. |
| | | | | | | | |
| **Part B/DME Line Data** | | **End Occurs** | | | | | |

## Claim Adjustment Reason Codes (CARC
## Possibly Included in Primary Payer EOB

| CARC Code |
|---|
| 1 |
| 2 |
| 3 |
| 24 |
| 44 |
| 45 |
| 59 |
| 61 |
| 94 |
| 100 |
| 102 |
| 103 |
| 118 |
| 144 |
| 161 |
| 169 |
| 172 |
| 186 |
| B10 |
| B22 |

**Source: x12.org/codes/claim-adjustment-reason-codes**

****NOTE: Other add-ins to primary payer paid amount us**

| CARC Codes (active) |
|---|
| 29 |
| 58 |
| 61 |
| 95 |
| 112 |
| 117 |
| 130 |
| 150 |
| 163 |

164
179
181
182
197
210
223 *
B4
B7
B8
B10 *
B16

**NOTE: With the exception of the codes denoted by *, all**

**:s)**
**:/RAs**

## Definition:

Deductible Amount
Coinsurance Amount
Copayment Amount
Charges are covered under a capitation agreement/managed care plan
Prompt Pay discount
Charge exceeds fee schedule/maximum allowable or contracted/legislated
fee arrangement (definitely used by Medicare and others)
Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging,
Adjusted for failure to obtain second surgical opinion.

Processed in excess of charges (used by Medicare in PPS/DRG situations where Medicare pays more than the
billed amount)
Payment made to patient/insured/responsible party
Major Medical adjustment
Provider promotional discount
ESRD network support adjustment
Incentive adjustment, e.g., preferred product/service
Provider performance bonus
Alternate benefit has been provided.
Payment is adjusted when performed/billed by a provider of this specialty
Level of care change adjustment
Allowed amount has been reduced because a component of the basic procedure/test was paid.
The beneficiary/patient is not liable for more than the change limit for the basic procedure/test.
This payment is adjusted based on the diagnosis.

**sed by FISS in MSP claims situations, as per CMS direction:**

**HUDP Update Version**

**4.4.2022**

**6.27.2022**

**7.5.2022**

**7.12.2022**

**8.2.2022**

**Update Description**

Identify the MSP contractor # to be used in file header/trailer
In the comments of multiple fields, clarify that for processing 'F', full claim denial DPPs, there is still expected to be an MSP period related to the service
Modify comments and field definitions on claim header and line CARC fields to allow CARC amounts that may be greater than, less than or equal to 0.
Clarify that for Part B/DME, the primary payer paid amount on the line is required and must be greater than 0 on a DPP line, if not provided at the claim level.

Add fields to claim filler area - Bene DOB, Gender, FISS Reserve, REMAS Interface control ID
Per request from FISS/CMS, switched order of fields in filler to DOB, Gender, REMAS Interface Control ID followed by FISS-requested 'CWF File Run Date'; adjusted field number and displacements as needed.
Slight modification to the comments column for CWF File Run Date field

Addition of note to HUDP File Layout tab to define numeric/alphanumeric default values

# Medicare Secondary Payer (MSP) Manual

## Chapter 7 – MSP Recovery

### Table of Contents
*(Rev.11775, 12-22)*

**Transmittals for Chapter 7**

## *Section 20.5.1—Automation of the Duplicate Primary Payer (DPP) Process*

***(Rev.11775, Issued:12-30-22, Effective: October 1, 2022 - For CWF (requirements/coding/preliminary unit testing); for FISS (design/coding); for MCS (analysis/design/coding); for VMS (analysis & coding); January 1, 2023 - For CWF (testing/implementation); FISS (continued development/testing/implementation); MCS (continued coding/testing/implementation); and VMS (testing & implementation), Implementation: October 3, 2022 - For CWF (requirements/coding/preliminary unit testing); for FISS (design/coding); for MCS (analysis/design/coding); for VMS (analysis & coding); January 3, 2023 - For CWF (testing/implementation); FISS (continued development/testing/implementation); MCS (continued coding/testing/implementation); and VMS (testing & implementation) )***

*As described in Section 20.5, the A/B MACs and DME MACs currently handle DPPs manually. Through this process, one or both of the Medicare Secondary Payer (MSP) contractors mail(s) a package of information that demonstrates a DPP situation. If the A/B MAC or DME MAC receives enough detailed information about the primary payer's action taken on various claims, the A/B MAC or DME MAC will initiate DPP adjustments to recover the Medicare primary payment from the provider. To realize greater efficiencies in this process, CMS has decided to automate the DPP process.*

*Through the automated DPP process, two of the Medicare Secondary Payer (MSP) contractors within the Coordination of Benefits & Recovery (COB&R) program enter information from the primary payer's explanation of benefits or remittance advices or other payment remittances into the Benefits Coordination and Recovery System (BCRS). The information (i.e., required data elements) that the contractors enter into BCRS will normally result in one of two types of Health Utilization Duplicate Primary Payment (HUDP) transactions that the COB&R systems contractor will create: one that contains a Claims Processing Indicator value of "F" (primarily for a non-group health plan (NGHP)transaction) or one that contains a Claims Processing Indicator value of "S" (for a Group Health Plan (GHP)transaction). If, for example, the information for an NGHP transaction that one of the COB&R contractors enters is very limited, such as the beneficiary name (surname and first name), MSP Insurance Type Code, date of incident, and diagnosis code, the COB&R systems contractor will build a HUDP transaction with the Claims Processing Indicator set to "F." By contrast, the information for a GHP transaction that one of the COB&R contractors enters may be very comprehensive, providing enough of the required claims data to enable the shared system maintainer representing an A/B Medicare Administrative Contractor (MAC) or Durable Medical Equipment Medicare Administrative Contractor (DME MAC) to create and complete a DPP secondary claim adjustment. Under this scenario, the COB&R systems contractor will build a HUDP transaction with the Claims Processing Indicator set to "S."*

### ***Initiation of the Automated DPP Process***

*Following the creation of the HUDP file containing various DPP records for multiple beneficiaries and case types, the COB&R systems contractor shall transmit the file to the Common Working File (CWF). This action could occur on a daily basis. CWF shall review the*

*incoming HUDP to determine if the Health Insurance Claim Number (HICN), MAC Contractor Number, MSP Type Code, Claims Processing Indicator, and Claim-From Date and Claim-Through Date (also known as Dates of Service (DOS)) are present and valid. CWF shall also attempt to find a matching MSP auxiliary record (MSPA) when the incoming HUDP transaction Claims Processing Indicator is set to "S" or "F."*

*If CWF determines there are issues with the incoming HUDP transaction, the system shall return the applicable disposition code or error condition code to the COB&R systems contractor for resolution.*

*If CWF determines that a portion of the incoming HUDP DPP records contains errors while other segments of the DPP records do not, CWF shall allow the DPP records without detected issues to be transmitted to the shared system representing a given MAC. And CWF shall return the DPP records that failed validation to the COB&R systems contractor. CWF shall transmit the HUDP DPP records that passed validation to the shared system representing a given MAC via the current daily Unsolicited Response (UR) file or daily CWF reply file, as applicable to the shared system.*

*CWF shall return a disposition code 01, denoting acceptable of the record, to the COB&R systems contractor. CWF shall also transmit a disposition code 01 to the shared systems and associated A/B MACs and DME MACs as part of the HUDP file.*

***A/B MAC and DME MAC Shared Systems Actions***

*Upon receipt of the HUDP DPP records, the shared system shall determine whether it can create either a full claim denial adjustment (or full claim adjustment, as applicable) when the HUDP DPP record Claims Processing Indicator is set to "F" or attempt to create a DPP secondary claim adjustment when the Claims Processing Indicator is set to "S."*

*To the greatest extent possible, the shared system shall auto-adjudicate the identified DPP claims where Medicare inappropriately paid as primary.*

*For HUDP DPP records where the Claims Processing Indicator is set to "F," the shared system, or, as applicable, the A/B MAC or DME MAC, shall:*

- *Fully deny the claim as a full claim denial adjustment. (Note: **No matter how the shared systems or A/B MACs or DME MACs achieve the adjustment result or what terminology is used to describe the adjustment (i.e., a full claim denial, full claim adjustment, full replacement), CMS's intention is that the shared systems or A/B MACs or DME MACs shall reverse the claim(s) to take back Medicare's full payment from the provider.)***
- *Capture the MSP Type Code (Part B)/MSP Insurance Type Code (Part A) from the HUDP DPP record and associate it with the full claim denial adjustment.*
- *Ensure that MSP savings are appropriately captured under the reported MSP Type Code (Part B)/MSP Insurance Type Code (Part A).*
- *Initiate a full recovery from the provider.*

*For HUDP DPP records where the Claims Processing Indicator is set to "S," the shared system shall review the HUDP DPP record to ensure all required information is present. Additionally, the shared system shall review the A/B MAC or DME MAC's on-line DPP claim to extract other required data elements needed to create a Health Insurance Portability and Accountability Act (HIPAA) 837 compliant outbound claim as well as a compliant outbound Electronic Remittance Advice (ERA).*

*When the shared system cannot create and/or complete a DPP adjustment due to problems with the HUDP DPP record's content (e.g., missing required data elements or information that conflicts with the online DPP claim), the shared system shall include the information from the DPP record on to a report for A/B MAC or DME MAC review/intervention.*

*As part of the automated DPP process, the shared system shall create DPP reporting on a daily and monthly basis and make the reports available to the associated A/B MAC or DME MAC. All A/B MACs and DME MACs, with the assistance of their Virtual Data Centers (VDCs), as necessary, shall store/retain all HUDP DPP records received from CWF and the various reports created and display them on-line for twelve (12) months.*

***A/B MAC and DME MAC Requirements***

*When adjudicating DPP adjustments, the shared system shall always set the claim header Mass Adjustment Indicator field value to "O" before transmitting the claims to CWF for normal processing. Additionally, the shared systems shall always set the Beginning of the Hierarchical Transaction Reference Identification (BHT03) file value position 23 to "S" before creating outbound 837 coordination of benefits (COB) claims that result from DPP adjustments. The DME MAC shared system shall also include the value "S" in the 23rd byte 504-F04 (Message) field indicator when creating outbound National Council for Prescription Drug Programs (NCPDP) batch COB claims that result from DPP adjustments.*

*All A/B MACs and DME MACs shall always process DPP adjustments as "935 adjustments." An exception to this rule is provider-initiated or requested adjustments, which are not handled as 935 adjustments. (See Pub.100-06, chapter 3, section 200 for more information.)*

*For DPP adjustments, A/B MACs and DME MACs shall use the same reason/discovery codes as they have done under the manual DPP process.*

*When incoming claims have dates of service that are five (5) or more years old, the shared system shall not create an automated DPP adjustment claim. The shared systems shall instead include the DPP records on a report for A/B MAC or DME MAC review/intervention.*

*When the shared systems do not auto-adjudicate a DPP claim whose Claim Processing Indicator= S and, instead, include the claim on a report for A/B MAC or DME MAC review and intervention due to missing required elements, the A/B MAC or DME MAC shall contact the BCRC or CRC, as applicable, by phone or via fax to attempt a resolution to the issue.*

*If the appropriate MSP contractor is able to obtain the missing required information and enter it into BCRS, the COB&R systems contractor shall transmit the claim, with missing elements added, to CWF to re-initiate the DPP process.*

*When there is conflicting information between the data on the DPP record and the claim within the A/B MAC or DME MAC's claims history (e.g., the procedure codes and modifiers do not match), the A/B MAC or DME MAC shall:*

1) *Cancel the DPP claim if created by the shared system; and*
2) *Contact the BCRC or CRC, as applicable, by phone or via fax to attempt a resolution to the issue.*

*As with the missing required data scenario, if the appropriate MSP contractor is able to resolve the conflicting DPP information and make the needed correction in BCRS, the COB&R systems contractor shall transmit the corrected claim to CWF to re-initiate the DPP process.*

*During the interval between CWF validating the incoming HUDP transaction and the time that the shared system receives an HUDP DPP record via the CWF UR daily response or daily CWF reply, it is possible that the primary payer may have deleted the MSP auxiliary record. When this occurs, it is important that all stakeholders involved take certain steps to address the deleted MSP auxiliary record. In this situation, the A/B MAC or DME MAC shall:*

- *Not attempt to create an MSP Investigational ("I") record on CWF;*
- *Contact the appropriate MSP contractor to request that the primary payer be notified regarding the discrepancy between the evidence it has submitted to confirm its primacy status and the action taken to delete the MSP auxiliary record; and*
- *Cancel the DPP adjustment.*

***Important:*** *For the automated DPP process, all shared systems shall bypass their normal logic that requires the creation of an MSP "I" record when it has been determined that CWF does not contain an associated MSP auxiliary record.*

*Once the appropriate MSP contractor has re-established the MSP auxiliary file, the COB&R systems contractor shall reinitiate the HUDP transaction, thereby restarting the DPP process.*