Medicare Secondary Payer (MSP) Manual
Chapter 6 - Medicare Secondary Payer (MSP)
*Common Working File (*CWF*)* Process

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(Rev. 11996, 04-27-23)

Transmittals for Chapter 6

10 - General Information

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs) obtain information pertinent to the identification of MSP for each beneficiary via the CWF, MSP auxiliary file. The auxiliary file is associated with the beneficiary's master record within CWF.

The *MSP Contractor* completes MSP updates on a daily basis upon receipt of notice that another payer is primary to Medicare (e.g., an explanation of benefits, a beneficiary questionnaire, a notice from a third-party payer, *Section 111 reporting,* etc.). Every claim for a given beneficiary is validated against the same MSP data housed in a CWF, MSP auxiliary file, thus permitting uniform processing. Contractor claims data inconsistent with a CWF, MSP auxiliary file will cause rejects and/or error conditions. An MSP auxiliary record consistent with an identified MSP situation must be present before a payment is approved for an MSP claim. An MSP auxiliary record is established by an MSP maintenance transaction submitted to CWF. The claim must agree with the MSP auxiliary record that was established, or it will not process.

The *MSP Contractor* is the source for establishing new MSP records, with the exception of four situations described in §10.1, below. The *MSP Contractor* submits MSP maintenance transactions on the basis of information obtained outside the claims process. Examples include, voluntary MSP *insurer* data match agreements, *MMSEA* Section 111 reporting, attorney, beneficiary, provider information, and 411.25 Notices.

10.1 - Overview of CWF MSP Processing

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

The CWF MSP auxiliary file is updated with maintenance transactions from the MSP contractor responsible for coordination of benefits (formerly known as the Benefits Coordination & Recovery Center or Coordination of Benefits Contractor and hereafter termed the “MSP contractor”), except for the following situations:

1. If the A/B Medicare Administrative Contractor (MAC) (Part A), A/B MAC (Part B), or A/B MAC (HHH) (collectively referred to as A/B MACs) or Durable Medical Equipment Medicare Administrative Contractor (DME MAC) receives a phone call or correspondence from an attorney/other beneficiary representative, beneficiary, third-party payer, provider, another insurer’s Explanation of Benefits (EOB) or other source that establishes, exclusive of any further required development or investigation, that MSP no longer applies, it must add termination dates to MSP auxiliary records already established by the MSP contractor with a "Y" validity indicator where there is no discrepancy in the validity of the information contained on CWF. (See §20.1.4)
2. If the A/B MAC receives a claim for secondary benefits and could, without further development (for example, the EOB from another insurer or third-party payer contains all necessary data) add an MSP occurrence and pay the secondary claim, it submits a validity indicator of "I" to add any new MSP occurrences (only if no MSP

record with the same MSP type already exists on CWF with an effective date within 45 days of the effective date of the incoming "I" record). An “I” record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF. It cannot submit a new record with a "Y" or any record with an "N" validity indicator. **Note**: Effective October 1, 2021, DME MACs no longer submit “I” records and instead submit an Electronic Correspondence Referral System (ECRS) Inquiry to create an MSP record.

3. If the A/B MAC receives a claim for conditional payment, and the claim contains sufficient information to create an "I" record without further development, it must add the MSP occurrence using an "I" validity indicator (only if no MSP record with the same MSP type already exists on CWF with an effective date within 45 *calendar* days of the effective date of the incoming "I" record). An “I” record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF.

A/B MACs shall transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. "I" records should only be submitted to CWF if no MSP record with the same MSP type already exists on CWF with an effective date within 45 days of the effective date of the incoming "I" record. Therefore, "I" records submitted to CWF that fail these edit criteria will be rejected with an SP 20 error code. Receipt of an "I" validity indicator will result in a CWF trigger to the MSP contractor. The MSP contractor will develop and confirm all "I" maintenance transactions established by the A/B MAC. If the MSP contractor receives an affirmative confirmation of MSP through its development efforts within 45 calendar days, the MSP contractor will convert the “I” to a “Y” validity indicator. If the MSP contractor has not received confirmation of MSP through its development efforts within 45 calendar days, the MSP contractor will automatically delete the "I" validity indicator. Also, if the MSP contractor develops and determines there is no MSP, the MSP contractor will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to the A/B MAC on its claim attachment or unsolicited refund documentation. If the A/B MAC has the actual date that Medicare became secondary payer, it shall use that as the MSP effective date. If that information is not available, it shall use the Part A entitlement date as the MSP effective date. It may include a termination date when it initially establishes an "I" record. It may not add a termination date to an already established "I" record.

Prior to April 1, 2002, the A/B MACs and DME MACs posted MSP records to CWF where beneficiaries were entitled to Part B benefits, but not entitled to Part A benefits. An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF edits to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. If an A/B MAC or DME MAC submits an Electronic Correspondence Referral System (ECRS) transaction to the MSP contractor to add a GHP MSP record where there is no Part A entitlement, the MSP contractor will return reason code of 61. A/B MACs or DME MACs should not submit an ECRS request to the MSP contractor to establish a GHP MSP record when

there is no Part A entitlement. A/B MACs that attempt to establish an "I" record will receive a CWF error.

The CWF will continue to allow the posting of MSP records where there is no Part A *entitlement, but there is Part B entitlement, and where NGHP* situations exist, such as automobile*/No-Fault*, liability, and workers' compensation. Where a non-employer GHP situation exists, *A/B MACs and DME MACs* continue to submit ECRS transactions and establish "I" records, as necessary. Note: In the past A/B MACs and DME MACs have sent ECRS requests to the MSP contractor requesting that section 111 records be updated. The MSP contractor has rejected most of these requests based on CMS hierarchy of Section 111 entities taking precedence on updating contractor number 11121 and 11122 MSP records. However, CMS has clarified that the MSP contractor shall accept MACs ECRS requests to update contractor number 11121 and 11122 MSP records based on conditions below. A/B MACs and DME MACs shall continue to submit ECRS requests to the MSP contractor for contractor numbers 11121 and 11122 for the following circumstances:

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

Please note it is to the discretion of the MSP *Contractor* to approve these Section 111 ECRS requests upon review. Approval or denial of such ECRS requests shall be sent to the A/B MACs or DME MACs by the MSP *Contractor*.

MSP Auxiliary maintenance transactions, for the four situations listed above, and claims for payment approval may be submitted to CWF in the same file. The CWF processes the MSP maintenance transactions before processing claims. This procedural flow is to assure processing for claim validation against the most current MSP data. If the MSP claim is accepted, the CWF host will return all MSP data on a beneficiary's auxiliary file to the submitting contractor via an "03" trailer. If the claim is rejected, the host will return only those MSP records that fall within the dates of service on the claim. A maximum of 17 MSP auxiliary records may be stored in CWF for each beneficiary *(see §30 below)*.

The validity indicator field of each CWF MSP auxiliary record indicates confirmation that:

Another insurer is responsible for payment ("Y" in the field); A/B MACs and DME MACs may access the MSP auxiliary file through the online CWF file display utility Health Insurance Master Record (HIMR).

A/B MACs and DME MACs cannot delete MSP auxiliary records. They send such requests to the MSP contractor via ECRS. (See *Pub. 100-05,* Chapter 5, §10.)

10.2 - Definition of MSP/CWF Terms

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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 *(the N validity indicator is no longer used, but will be seen on older MSP CWF records)*
- I - See §10.1.
- *D – Deleted MSP Record*

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 *(note: currently not used)*
- G = Disabled
- H = Black Lung (BL)
- L=Liability
- W=Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)

NOTE: VA and other Federal payments are *MSP* exclusions rather than MSP non-payments. *Where the VA authorized services, Medicare does not make payment for items or services furnished by a non-Federal provider pursuant to such an authorization. Although certain MSP billing procedures apply, VA is not an MSP provision.*

Cost Avoided Claim - A claim returned without payment because CWF indicators indicate another insurer is primary to Medicare. (See *Pub. 100-05,* Chapter 5 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.)

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

MSP **Contractor Numbers prior to January 1, 2001**

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

CWF Source Codes	*MSP* Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
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 *MSP* Contractor numbers and nonpayment/payment denial codes will be used.

***MSP* Contractor Numbers Effective January 1, 2001**

CWF Source Codes	*MSP* Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
0	11100 = *MSP* Contractor	00 Effective 4/1/2020	6000
1	11101 = Initial Enrollment Questionnaire	T	6010
2	11102 = IRS/SSA/CMS Data Match	Y	6020
3	11103 = HMO Rate Cell	U	6030
4	11104 = Litigation Settlement	V	6040
5	11105 = Employer Voluntary Reporting	Q	6050
6	11106 = Insurer Voluntary Reporting	K	6060
7	11107 = First Claim Development	E	6070
8	11108 = Trauma Code Development	F	6080
9	11109 = Secondary Claims Investigation	G	6090
10 - Effective 4/1/2002	11110 = Self Reports	H	7000

CWF Source Codes	*MSP* Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
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 *MSP* 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	*MSP* Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
12	11112 = Blue Cross-Blue Shield Voluntary Data Sharing Agreements	12	7012
13	11113 = Office of Personnel Management (OPM) Data Match	13	7013
14	11114 = State Workers' Compensation (WC) Data Match	14	7014
15	11115 = WC Insurer Voluntary Data Sharing Agreements (WC VDSA)	15	7015
16	11116 = Liability Insurer Voluntary Data Sharing Agreements (LIAB VDSA)	16	7016
17	11117 = Voluntary Data Sharing Agreements (No Fault VDSA)	17	7017
18	11118 = Pharmacy Benefit Manager Data	18	7018
19	11119 = Workers' Compensation Medicare Set-Aside Arrangement	19	7019
20	11120 = *COBA*	20	*N/A*
21	11121= MIR Group Health Plan	21	7021

CWF Source Codes	*MSP* Contractor Numbers	Non-payment/ Payment Denial Codes	CROWD Special Project Numbers
22	11122= MIR *Non*-Group Health Plan	22	7022
23	11123 = To be determined	23	7023
24	11124 = To be determined	24	7024
25	11125 = Recovery Audit Contractor-California	25	7025
26	11126 = Recovery Audit Contractor-Florida	26	7026
27	11127 = To be determined	27	7027
“”	“”	“”	“”
39	11139 = GHP Recovery	39	7039
41	11141 =NGHP Non *Ongoing Responsibility for Medicals (*ORM*)*	41	7041
42	11142 = NGHP ORM Recovery	42	7042
43	11143 = *MSP Contractor* /Medicare Part C/Medicare Advantage	43	7043
“”	“”	“”	“”
99	11199 = To be determined	99	7099

20 - MSP Maintenance Transaction Record Processing

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

20.1 - Types of MSP Maintenance Transactions

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

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

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

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

20.1.1 - MSP Add Transaction

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

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

- Medicare beneficiary identifier;
- MSP type (MSP code);
- Validity indicator;
- MSP effective date;
- Contractor identification number;
- Insurer name (CWF will allow a space in the second position provided the third position contains a valid character other than a space.);
- Patient relationship; and
- Insurance type.

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

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

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

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

(2) Patient Relationship: Use “01” if *there is* no indication of other insured member, and use “02” if another member is shown, but uncertain of relationship.

(3) MSP Type: For GHP, use the current reason for entitlement: working aged (12), disability (43), or ESRD (13). For NGHP, if not identified, the default to be used is No-Fault (14).

20.1.2 - MSP Change Transaction

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

A*n MSP record* match occurs when the following items are the same:

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

When these items match, the record is overlaid.

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

20.1.3 - MSP Delete Transaction

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

The MSP maintenance type "1" is used to delete an MSP auxiliary occurrence. This transaction checks the beneficiary's master record for an MSP indicator. The *MSP Contractor* is responsible for submitting this transaction. *A/B MACs and DME MACs* advise the *MSP Contractor*, via the ECRS, of the need to process an MSP maintenance type 1 transaction (delete).

Only certain *MSP* contractor numbers may delete MSP occurrences originated or last updated by certain other *MSP* contractor numbers. No contractor number may update or delete a MSP occurrence originated or last updated by contractor number 11100 except contractor number 11100. Please see the table below for the exact criteria for deletion of MSP occurrences last updated by *MSP* contractor numbers. A match shall occur in order to delete the MSP occurrence originated or last updated by one *MSP* contractor number with a delete transaction submitted under a certain *MSP* contractor number. For example, *MSP* contractor numbers 11100, 11110, 11141 and 11140 are the only contractor numbers that may delete a MSP occurrence originated or last updated by 11110. The *MSP Contractor is* the sole contractor that may delete *MSP* contractor numbers. The *MSP Contractor* shall maintain the necessary logic to control updating and deleting MSP occurrences based on *MSP* contractor numbers. *A/B MACs and DME MACs* shall follow the current restrictions regarding deletion of MSP records.

Originating or Last Updating Contractor Number	*MSP* Contractor Number That Can Update/Delete
11100	11100
11110	11100, 11110, 11139, 11141, 11140, 11142
11141	11100, 11110, 11139, 11141, 11140, 11142
11140	11100, 11110, 11139, 11141, 11140, 11142
11121	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11122	*11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142*
11143	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11139	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11142	11100, 11110, 11141, 11140, 11121, 11143, 11139, 11142
11105	11100, 11110, 11141, 11140, 11121, 11143, 11105, 11102, 11139, 11142
11102	11100, 11110, 11141, 11140, 11121, 11143, 11105, 11102, 11139, 11142
All others	Any

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

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

20.1.4 - MSP Termination Date Transaction

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

A/B MACs and DME MACs add termination dates to MSP auxiliary records already established on CWF with a "Y" validity indicator, where there is no discrepancy in the validity of the information contained on CWF. They handle phone calls and written inquiries relating to simple terminations of existing MSP occurrences. Simple terminations are defined as terminations that can be made to a*n* MSP auxiliary record without further development or investigation. They shall not transfer these calls or written inquiries to the *MSP Contractor*. In determining whether a call is to be handled by them or the *MSP Contractor*, the *A/B MAC or DME MAC* establishes the basis of the call. The following are examples when **not** to transfer a termination request to the *MSP Contractor* for further action.

EXAMPLE 1:

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

A/B MACs and DME MAC **action:** The *A/B MACs and DME MACs* checks for matching auxiliary record on CWF and terminates, if no conflicting data are presented. The *A/B MACs and DME MACs* does not transfer the call to the *MSP Contractor*.

EXAMPLE 2:

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

A/B MACs and DME MACs **action:** The *A/B MACs and DME MACs* checks for matching auxiliary record on CWF and terminates if no conflicting data are presented. The *A/B MACs and DME MACs* does not transfer the call to the *MSP Contractor*.

EXAMPLE 3:

Scenario: The *A/B MACs or DME MACs* receives written correspondence that benefits are exhausted for an automobile case.

A/B MACs and DME MACs a**ction:** The *A/B MAC and DME MAC* checks for matching auxiliary record on CWF. The *MSP Contractor* terminates in accordance with existing guidelines (e.g., accounting of monies spent).

EXAMPLE 4

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

A/B MAC and DME MAC **action:** The *A/B MAC and DME MAC* checks for matching auxiliary record on CWF and terminates if no conflict in evidence is presented. It does not transfer the call to the *MSP Contractor*.

MSP Contractor **Role**

The *MSP Contractor* adds termination dates to records not covered in A, above. In addition, the *MSP Contractor* updates MSP occurrences as a result of a request from an *A/B MAC or DME MAC*, or as a result of *the MSP Contractor* development and investigation. The following are examples of when to transfer a termination request to the *MSP Contractor* for further action.

EXAMPLE 1:

Scenario: The termination date is greater than six months prior to the date of accretion (i.e., SP 57 error code) for all *MSP Contractor* numbers (e.g., 11100-111*45*, 33333,

77777, 88888, or 99999). (All *MSP Contractor* numbers follow the old data match 6-month termination rule.)

A/B MAC and DME MAC **action:** The ***A/B MAC and DME MAC*** sends a CWF assistance request to the *MSP Contractor*.

MSP Contractor **action:** The *MSP Contractor* checks for matching record on CWF and terminates. In cases where discrepant information exists, the *MSP Contractor* investigates to determine the proper course of action.

EXAMPLE 2:

Scenario: The ***A/B MAC and DME MAC*** receives information with regard to termination that is discrepant with the information contained on CWF.

A/B MAC and DME MAC **action:** The ***A/B MAC and DME MAC*** forwards to the *MSP Contractor* for investigation via ECRS.

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

20.2 - MSP Maintenance Transaction Record *A/B MAC and DME MAC* MSP Auxiliary File Update Responsibility

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

*T*he capability to update the CWF MSP auxiliary file is essentially a function of only the MSP ***C***ontractor. *The* ***A/B MAC and DME MACs*** do not have the capability to delete any MSP auxiliary file records, including those that a specific A/B MAC or DME MAC established. If it is believed that a record should be changed or deleted, A/B MACs and DME MACs use the MSP Contractor via the *ECRS* (discussed in *Pub. 100-05*, Chapter 5, CWF Assistance Request option, to notify the MSP *C*ontractor of the needed revision. A/B MACs and DME MACs process claims in accordance with existing claims processing guidelines.

There are only two instances in which A/B MACs and DME MACs retain the capability to update CWF. They are:

A. A claim is received for secondary benefits and the contractor could, without further development (for example, the EOB from another insurer or third-party payer contains all necessary data), add an MSP occurrence and pay the secondary claim. A/B MACs must use a validity indicator of "I" to add new MSP occurrences and update CWF. An “I” record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF. **Note**: Effective October 1, 2021, DME MACs no longer submit“I”records and instead submit an Electronic Correspondence Referral System (ECRS) Inquiry to create an MSP record. A/B MACs cannot submit a new record with a "Y" or any record with an "N" validity indicator.

B. A claim is received for conditional payment, and the claim contains sufficient information to create an "I" record without further development. A/B MACs add the MSP occurrence using an "I" validity indicator. An “I” record is to be added to the CWF within 10 calendar days when the claim is suspended for MSP (internal system or CWF, whichever suspends first) if no MSP record with the same MSP type already exists in CWF.

A/B MACs will transmit "I" records to CWF via the current HUSP transaction. The CWF will treat the "I" validity indicator the same as a "Y" validity indicator when processing claims. Receipt of an "I" validity indicator will result in a CWF trigger to the MSP Contractor. The MSP contractor will develop and confirm all "I" maintenance transactions established by the A/B MAC. If the MSP contractor receives an affirmative confirmation of MSP through its development efforts within 45 calendar days, the MSP contractor will convert the “I” to a “Y” validity indicator. If the MSP contractor has not received confirmation of MSP through its development efforts within 45 calendar days, the MSP contractor will automatically delete the "I" validity indicator. Also, if the MSP contractor develops and determines there is no MSP, the MSP Contractor will delete the "I" record. An "I" record should never be established when the mandatory fields of information are not readily available to an A/B MAC on a claim attachment. If the A/B MAC has the actual date that Medicare became secondary payer, they use that as the MSP effective date. If that information is not available, the A/B MAC shall use the Part A entitlement date as the GHP MSP effective date. A/B MACs may include a termination date when they initially establish an "I" record. However, they may not add a termination date to an already established "I" record.

CWF accepts an "I" record only if no MSP record (validity indicator of either "I" or "Y," open, closed, or deleted status) with the same MSP type already exists on CWF with an effective date within 45 calendar days of the effective date of the incoming "I" record. Therefore, "I" records submitted to CWF before 45 calendar days have elapsed will reject with an SP 20 error code. The resolution for these cases is to transfer **all** available information to the MSP contractor via the Electronic Correspondence Referral System (ECRS) CWF assistance request screen. It will be the responsibility of the MSP contractor to reconcile the discrepancy and make any necessary modifications to the CWF auxiliary file record.

A refund or returned check is no longer a justification for submission of an "I" record. Since an "I" record does not contain the source (name and address) of the entity that returned the funds, the MSP contractor lacks the information necessary to develop to that source. Follow the examples below to determine which ECRS transaction to submit.

1. An MSP inquiry should be submitted when there is no existing or related MSP record on the CWF. A “related” record means if an MSP record on CWF matches and has the same HICN/MBI, MSP type, MSP effective date, Insurance type, patient relationship code, and validity indicator.
2. The CWF assistance request should be submitted when the information on the CWF is incorrect or the MSP record has been deleted.
3. The check or voluntary refund either opens and/or closes the MSP case or MSP issue. Under these circumstances, the A/B MACs or DME MACs shall submit an MSP inquiry to open or close the MSP record. **Note:** The A/B MACs or DME MACs should refer to the ECRS manual for more information regarding closed cases.

The check should be deposited to unapplied cash until the MSP contractor makes an MSP determination.

30 - CWF, MSP Auxiliary File

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

30.1 - Integrity of MSP Data

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

30.1.*1* - MSP Effective Date Change Procedure

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

- Delete the auxiliary record containing the incorrect MSP effective date using an MSP delete transaction; and
- Submit a CWF, MSP maintenance transaction with the correct MSP effective date to establish a new auxiliary record.

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

30.1.*2* - CWF/MSP Transaction Request for Contractor Assistance

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

Instances occur when the *A/B MAC or DME MAC* determines that the MSP effective date is not correct. When this happens, the contractor shall advise the *MSP Contractor*, via ECRS, of the need to change the MSP effective date and shall provide the *MSP Contractor* with documentation to substantiate the change.

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

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

30.2 - MSP Termination Date Procedure
(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

A. Future Termination Dates

For Non-GHP records, the termination date edits identified for GHP do not apply as the termination date may be more than 6-months from the MSP effective date. For GHP records, the termination date cannot be greater than the current date plus 6 months, except for MSP code = B; and for GHP records, the termination date cannot be greater than the first day the beneficiary turned 65 if the MSP code is B or G. For ESRD, CWF uses the following criteria:

- MSP effective date prior to February 1, 1990, allows for termination date up to 12 months after the effective date;
- MSP effective date February 1, 1990, through February 29, 1996, allows for termination date up to 18 months after the effective date; or
- MSP effective date March 1, 1996, and later allows for termination date up to 30 months after the effective date.

B. Termination for "Y" Validity Indicator

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

30.3 - MSP Auxiliary File Errors
(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition

period and after for certain business areas that will continue to use the HICN as part of their processes.

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

Error Code	Definition	Valid Values
SP11	Invalid MSP transaction record type	"HUSP," "HISP," or "HBSP"
SP12	Invalid Medicare beneficiary identifier	Valid Medicare beneficiary identifier
SP13	Invalid Beneficiary Surname	Valid Surname
SP14	Invalid Beneficiary First Name Initial	Valid Initial
SP15	Invalid Beneficiary Date of Birth	Valid Date of Birth
SP16	Invalid Beneficiary Sex Code	0=Unknown, 1=Male, 2=Female
SP17	Invalid Contractor Number	CMS Assigned Contractor Number
SP18	Invalid Document Control Number	Valid Document Control Number
SP19	Invalid Maintenance Transaction Type	0=Add/Change MSP Data transaction, 1=Delete MSP Data Transaction
SP20	Invalid Validity Indicator	Y= Beneficiary has MSP Coverage, I= Entered by *the A/B MAC or DME MAC – MSP Contractor* investigate, N -No MSP coverage
SP21	Invalid MSP Code	A=Working Aged B=ESRD C= Conditional Payment D= No Fault E= Workers' Compensation F= Federal G= Disabled H= Black Lung L= Liability
SP22	Invalid Diagnosis Code 1-5	Valid Diagnosis Code
SP23	Invalid Remarks Code 1-3	See the Valid Remarks Codes Below
SP24	Invalid Insurer Type	See definitions of Insurer Type codes below

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

Error Code	Definition	Valid Values
SP30	Invalid Policy Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP31	Invalid MSP Effective Date (Mandatory)	Non-blank, non-zero, numeric, number of days must correspond with the particular month. MSP Effective Date must be no more than 3 months in the future from the current date.
SP32	Invalid MSP Termination Date	Must be numeric; may be all zeroes if not used; if used, date must correspond with the particular month for GHP records. The MSP Termination Date is Greater than Six Months from the current date for non-Group Health Plan MSP Auxiliary Records.
SP33	Invalid Patient Relationship	The following codes are valid for all MSP Auxiliary occurrences regardless of accretion date: 01 = Self; *the beneficiary* is the policy holder or subscriber for the other GHP insurance reflected by the MSP occurrence **–or-** Beneficiary is the injured party on the Workers Compensation, No-Fault, or Liability claim 02 =Spouse or Common Law Spouse 03 = Child 04 = Other Family Member 20 = Life Partner or Domestic Partner

Error Code	Definition	Valid Values
		The following codes are only valid on MSP Auxiliary occurrences with accretion dates **PRIOR TO 4/4/2011**: 05 = Step Child 06 = Foster Child 07 = Ward of the Court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ donor 12 = Cadaver Donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored Dependent 17 = Minor Dependent of a Minor Dependent 18 = Parent 19 = Grandparent 20 = Life Partner or Domestic Partner
SP34	Invalid subscriber First Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP35	Invalid Subscriber Last Name	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP36	Invalid Employee ID Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP37	Invalid Source Code	Spaces, A through W, 0 – 19, 21, 22, 25, 26, 39, 41, 42, 43. See §10.2 for definitions of valid CWF Source Codes.
SP38	Invalid Employee Information Data Code	Spaces if not used, alphabetic values P, S, M, F. See §30.3.4 for definition of each code.
SP39	Invalid Employer Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP40	Invalid Employer Address	Spaces if not used. Valid Values:

Error Code	Definition	Valid Values
		Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP41	Invalid Employer City	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP42	Invalid Employer State	Must match U.S. Postal Service state abbreviations.
SP43	Invalid Employer ZIP Code	If present, 1st 5 digits must be numeric. If foreign country 'FC' is entered as the state code, and the nine positions may be spaces.
SP44	Invalid Insurance Group Number	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP45	Invalid Insurance Group Name	Spaces if not used. Valid Values: Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP46	Invalid Pre-paid Health Plan Date	Numeric; number of days must correspond with the particular month.
SP47	Beneficiary MSP indicator not on for delete transaction.	Occurs when the code indicating the existence of MSP auxiliary record is not equal to "1" and the MSP maintenance transaction type is equal to '1.'
SP48	MSP auxiliary record not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP49	MSP auxiliary occurrence not found for delete data transaction	See MSP Auxiliary Record add/update and delete function procedures above.
SP50	Invalid function for update or delete Contractor number unauthorized	See MSP Auxiliary Record add/update and delete function procedures above
SP51	MSP Auxiliary record has 17 occurrences and none can be replaced	
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B and G when the Validity Indicator is "Y"	Accretion Dates prior to 4/4/2011:

Error Code	Definition	Valid Values
		Patient Relationship must be 01 or 02 for MSP Code A (Working Aged). Patient Relationship must be 01, 02, 03, 04, 05, 18 or 20 for MSP Codes B (ESRD) and G (Disabled). Accretion Dates 4/4/2011 and subsequent: Patient Relationship must be 01 or 02 for MSP Code A (Working Aged). Patient Relationship must be 01, 02, 03, 04, or 20 for MSP Codes B (ESRD) and G (Disabled).
SP53	The maintenance transaction was for Working Aged EGHP and there is either a ESRD EGHP or Disability EGHP entry on file that has a termination date after the Effective date on the incoming transaction or is not terminated, and the contract number on the maintenance transaction is not equal to "11102," "11104," "11105," "11106," "33333," "66666,", "77777," "88888," or "99999."	
SP54	MSP Code A, B or G has an Effective date that is in conflict with the calculated age 65 date of the Bene.	For MSP Code A, the Effective date must not be less than the date at age 65. For MSP Code G, the Effective date must not be greater than the date at age 65.
SP55	MSP Effective date is less than the earliest Bene Part A or Part B Entitlement Date.	
SP56	MSP Prepaid Health Plan Date must be = to or greater than MSP Effective date or less than MSP Term*ination* date.	
SP57	Termination Date Greater than 6 months prior to date added for Contractor numbers other than 11100 – 11119, 11121, 11122, 11126, 11139, 11141, 11142, 11143, 33333, 55555, 77777, 88888, and 99999.	

Error Code	Definition	Valid Values
SP58	Invalid Insurer type, MSP code, and validity indicator combination.	If MSP code is equal to "A" or "B" or "G" and validity indicator is equal to "I" or "Y" then insurer type must not be equal to spaces. *Mapped coverage type must equal "J", "K", or "A".*
SP59	Invalid Insurer type, and validity indicator combination	If validity indicator is equal to "N" then insurer type must be equal to spaces.
SP60	Other Insurer type for same period on file (Non "J" or "K") Insurer type on incoming maintenance record is equal to "J" or "K" and Insurer type on matching aux record is not equal to "J" or "K."	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP61	Other Insurer type for same period on file ("J" or "K") Insurer type on incoming maintenance record is not equal to "J" or "K" and Insurer type on matching aux record is equal to "J" or "K."	Edit applies only to MSP codes: A - Working Aged, B - ESRD EGHP, G - Disability EGHP
SP62	Incoming term date is less than MSP Effective date.	
SP66	MSP Effective date is greater than the Effective date on matching occurrence on auxiliary file	
SP67	Incoming term date is less than posted term date for Provident	
SP72	Invalid Transaction attempted	A HUSP add transaction is received from a *A/B MAC and DME MAC* (non-*MSP Contractor*) with a validity indicator other than "I."
SP73	Invalid Term Date/Delete Transaction	A MAC attempts to change a Term Date on a*n* MSP Auxiliary record with a "I" or "Y" Validity Indicator that is already terminated, or trying to add Term Date to "N" record.
SP74	Invalid cannot update "I" record.	A MAC submits a HUSP transaction to update/change an "I" record or to add an "I" record and a match MSP

Error Code	Definition	Valid Values
		Auxiliary occurrence exists with a "I" validity indicator.
SP75	Invalid transaction, no Medicare Part A benefits	A HUSP transaction to add a record with a Validity Indicator equal to "I" (from an *A/B MAC or DME MAC*) or "Y" (from *the MSP Contractor*) with an MSP Type equal to "A," "B," "C," or "G" and the effective date of the transaction is not within a current or prior Medicare Part A entitlement period, or the transaction is greater than the termination date of a Medicare entitlement period.
SP76	MSP Type is equal to W (Workers' Compensation Medicare Set-Aside) and there is an open MSP Type E (Workers' Compensation) record.	
SP77	A diagnosis cannot be added to this occurrence by a Part A/Part B/DME MAC.	
SP78	The diagnosis code submitted is not allowed on an MSP Type 'D' record.	When an incoming HUSP transaction with a Validity Indicator equal to 'I' or 'Y' is received from an A/B, DME MAC or the *MSP Contractor* for an MSP Type 'D' record, and the transaction contains one of the CMS identified ICD 9 or ICD 10 diagnosis codes.
SP79	A MAC attempts to create/enter a value in the ORM field on the incoming I HUSP record (makes sure that a MAC cannot update or overlay an ORM value in the ORM field).	Valid Values for the 1-byte ORM indicator on the CWF MSP Detail screen (MSPD) are: Y (Yes) or a space. A "Y" ORM indicator value denotes that the ORM existed for a period of time, not necessarily that it currently exists. An ORM indicator of a

Error Code	Definition	Valid Values
		"space" implies that an RRE has not assumed ORM.
SP80	A MAC attempted to create/enter an ORM indicator on an MSP record other than a D, E, and L.	The 1- byte ORM indicator (valid values = Y or a space) shall only be received on HUSP transactions with MSP Codes "D, E, and L."
SP81	A contractor, other than the following contractor numbers of 11100, 11110, 11122, 11141, and 11142, attempts to update, remove or set the existing ORM record indicator of a "Y" to a "space."	To ensure that no other entity than the following contractor numbers (11100, 11110, 11122, 11142, and 11142) can modify an existing record's ORM indicator to equal a "space," if originally it was a "Y."
SP82	MSP Type 'L' or 'D' does not exist.	When an incoming HUSP transaction is submitted for LMSA (MSP Type S) and no Liability (MSP Type L) MSP Auxiliary record exists; or when an incoming HUSP transaction is submitted for NFMSA (MSP Type T) and no No-Fault Auto (MSP Type D) MSP Auxiliary record exists.
SP83	No Termination Date present for a Liability or No-Fault Auto occurrence.	When an incoming HUSP transaction is submitted for LMSA (MSP Type S) and the Liability (MSP Type L) record on the MSP Auxiliary File does not have a Termination Date; or when an incoming HUSP transaction is submitted for NFMSA (MSP Type T) and the No-Fault Auto (MSP Type D) record on the MSP Auxiliary File does not have Termination Date.
SP84	Invalid Effective date for LMSA or NFMSA or open record.	An HUSP transaction is submitted by contractor '11144'

Error Code	Definition	Valid Values
		or '11100' for LMSA (MSP Type S) and posted to the MSP Aux file is a Liability (MSP Type L) with a Termination Date. If the Effective Date of the LMSA (MSP Type S) is not one day after the Termination Date of the Liability (MSP Type L). If the Effective Date of the LMSA (MSP Type S) is one day after the Termination Date of the Liability (MSP Type L), and the diagnosis codes on the LMSA (MSP Type S) are not an Exact or not a Family Match with the Liability (MSP Type L) diagnosis codes. AND/OR An HUSP transaction is submitted by contractor '11145' or '11100' for NFMSA (MSP Type T) and posted to the MSP Aux file is a No-Fault (MSP Type D) with a Termination Date. If the Effective Date of the NFMSA (MSP Type T) is not one day after the Termination Date of the No-Fault (MSP Type D). If the Effective Date of the NFMSA (MSP Type T) is one day after the Termination Date of the No-Fault (MSP Type D), and the diagnosis codes on the NFMSA (MSP Type T)

Error Code	Definition	Valid Values
		are not an Exact or not a Family Match with the No-Fault (MSP Type D).
SP91	*Invalid Employer Size (Mandatory). Field must contain a numeric character.*	
SP99	*Medicare ID (HICN or MBI) required if individual is less than 45 years of age.*	

30.3.1 - Valid *MSP* Remarks Codes

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

MSP

Remark Code	Definition
01	Beneficiary retired as of termination date.
02	Beneficiary's employer has less than 20 employees.
03	Beneficiary's employer has less than 100 employees
04	Beneficiary is dually entitled to Medicare, based on ESRD and Age or ESRD and disability
05	Beneficiary is not married.
06	The Beneficiary is covered under the group health plan of a family member whose employer has less than 100 employees.
07	Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan that has elected the working aged exception.
08	Beneficiary's employer has less than 20 employees and is in a multiple or multi-employer plan that has not elected the working aged exception.
09	Beneficiary is self-employed.
10	A family member of the Beneficiary is self-employed.
20	Spouse retired as of termination date.
21	Spouse's employer has less than 20 employees.
22	Spouse's employer has less than 100 employees.
23	Spouse's employer has less than 100 employees but is in a qualifying multiple or multi-employer plan.
24	Spouse's employer has less than 20 employees and is multiple or multi-employer plan that has elected the working aged exception.
25	Spouse's employer has less than 20 employees and is multiple or multi-employer plan that has not elected the working aged exception.
26	Beneficiary's spouse is self-employed
30	Exhausted benefits under the plan
31	Preexisting condition exclusions exist

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

30.3.2 - Valid *MSP* Insurance Type Codes

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

MSP Insurer Type Code	Definition
A	GHP Hospital and Medical Coverage **-or-** Other Non-GHP
B	GHO
C	Preferred Provider Organization (PPO)
D	Third Party Administrator arrangement under an Administrative Service Only (ASO) contract without stop loss from any entity.

E	Third Party Administrator arrangement with stop loss insurance issued from any entity.
F	Self-Insured/Self-Administered.
G	Collectively-Bargained Health and Welfare Fund.
H	Multiple Employer Health Plan with at least one employer who has more than 100 full and/or part-time employees.
I	Multiple Employer Health Plan with at least one employer who has more than 20 full and/or part-time employees.
J	GHP Hospitalization Only Plan - A plan that covers only Inpatient hospital services.
K	GHP Medical Services Only Plan - A plan that covers only non-inpatient medical services.
M	Medicare Supplemental Plan, Medigap, Medicare Wraparound Plan or Medicare Carve Out Plan.
R	GHP Health Reimbursement Arrangement
S	GHP Health Savings Account
SPACES	Unknown

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

30.3.3 - Other Effective Date and Termination Date Coverage Edits

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

Other Termination date coverage edits are:

- For Group Health Plan (GHP) records the termination date cannot be greater than the current date plus six months, except for MSP code = B, and

- For GHP records the termination date cannot be greater than the first day the beneficiary turned 65 if the MSP code is B or G.

  Note: For Non-GHP records the termination date edits identified above do not apply as the termination date may be more than 6-months from the MSP effective date.

30.3.4 - *MSP* Employee Information Data Code

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

30.4 - Automatic Notice of Change to MSP Auxiliary File

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

The Common Working File (CWF) sends MSP transactions to all contractors of record when an MSP auxiliary record is created or changed for any beneficiary.

Alerts are sent to *the A/B MACs and DME MACs* when an update is made to an MSP record.

40 - MSP Claim Processing

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

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

40.1 - CWF, MSP Claim Validation

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

There are four conditions that may occur when a*n A/B MAC and DME MAC* validates claims against the CWF, MSP auxiliary file:

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

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

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

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

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

40.2 - CWF Claim Matching Criteria Against MSP Records

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

HICN/MBI, MSP type, MSP effective date and termination date, insurance type, patient relationship code and validity indicator for the same insurer. Note, NGHP records includes matching on the family of diagnosis codes.

40.3 - Conditional Payment

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

To make a conditional payment, *A/B MACs and DME MACs* indicate conditional payment on the CWF, Part B Claim by placing a "C" in the "MSP code" field (field 97 of the CWF Part B Claim record.). Intermediaries indicate conditional payment on the CWF Inpatient/SNF Bill by placing zeros (0) in the **"value amount" field (position 77b)** along with the appropriate "value code." An MSP auxiliary record for the beneficiary

with a "Y" validity indicator must be present. The CWF will reject the claim with error code 6805 when a claim for conditional payment is submitted and there is no matching MSP auxiliary record present.

40.4 - Override Codes

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

- Dates of service on the claim fall within the effective and termination dates on auxiliary record; and
- Validity indicator is equal to "Y."

The correct use of override codes is as follows:

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

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

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

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

Contractors receive error code 6806 when the MSP override code equals "M" or "N" and no MSP record is found with overlapping dates of service.

40.5 - MSP Cost Avoided Claims

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

A/B MACs and DME MACs shall follow the instructions cited in *Pub. 100-05,* Chapter 5 for counting savings on MSP cost avoided claims.

They shall submit ALL MSP cost avoided claims to CWF.

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

PAYMENT/DENIAL CODE FIELDS IN CWF CLAIM RECORD

Contractor	Type of Claim	CWF Record	Field
A/B MAC (Part B) and DME MAC	Full Claim Denial	HUBC	16 Payment/Denial
A/B MAC (Part B) and DME MAC	Full Line Item Denial	HUBC	63 Payment/Denial Code
A/B MAC (Part A) and DME MAC	Inpatient hospital and inpatient SNF Denial	HUIP	58 Nonpayment Code
A/B MAC (Part A) and DME MAC	*Health Utilization* Outpatient *(HUOP)*	HUOP	59 No Pay Code
A/B MAC (HH&H)	*Health Utilization* Home Health *(HUHH)*	HUHH	59 No Pay Code
A/B MAC (HH&H)	*Health Utilization* Hospice *Claim (HUHC)*	HUHC	59 *N*o Pay Code

If *a* denial indicator is incorrect, the CWF software will correct the denial indicator based on the matching MSP auxiliary record and send the correct value back to the contractor on the response record header. It is not necessary for an MSP auxiliary record to be present in order to post MSP cost avoided savings. If one is present, the *A/B MAC or DME MAC* uses the "X" or "Y" override code as appropriate.

40.6 - Online Inquiry to MSP Data
(Rev. 125, Issued: 03-22-19, Effective: 04-22-19, Implementation: 04-22-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

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

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

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

- The MSP indicator on the beneficiary file is not set. In this case the message "MSP not indicated" is displayed;
- No record is found. In this case, a message "MSP auxiliary file not found" is displayed; or
- MSP **is** indicated. In this case, the MSP auxiliary file is read and the screen will display an MSP Record.

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

- Summary selection number;
- MSP code;
- MSP code description;
- Validity indicator;
- Delete indicator;

- Effective date; and
- Termination date, if applicable.

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

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

40.7 - MSP Purge Process

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

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

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

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

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

Error Code	Error Description	Resolution
6801	*GHP* 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	*GHP* MSP indicated on claim - no match on MSP auxiliary file.	(1) Analyze CWF auxiliary file.

Error Code	Error Description	Resolution
		(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	*GHP* MSP auxiliary record exists - no *GHP* MSP indicated on claim but dates of service match *a GHP occurrence*.	(1) Deny claim. Advise beneficiary/provider: "Resubmit claim with other payer's Explanation of Benefits for possible secondary payment. If other insurance has terminated, resubmit with documentation showing termination dates of other insurance." If you have documentation showing termination of the insurance coverage indicated in the CWF, MSP occurrence, process as follows: (2) Post a termination date; or (3) Resubmit claim as MSP. If the termination date is incorrect, submit a CWF assistance request via ECRS.
6805	*GHP* MSP conditional payment claim and matching MSP record with "*I"or* "Y" validity indicator not found *for these dates of service*.	(1) *A/ B MACs only:* 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" and no *GHP* 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 *(Insurer type= "W")*. Medicare contractor payment not allowed.	

Error Code	Error Description	Resolution
6816	No-Fault over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6817	Workers' Compensation over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6818	Liability over-rideable utilization error code to be used when a valid (Y) ORM indicator is on the MSP CWF auxiliary file and the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF. MACs shall deny the claim(s) as a Medicare payment is not allowed.	
6819	*A non-GHP ('D', 'H' or 'L') MSP auxiliary record exists, and no non-GHP MSP is indicated on the claim, but the Dates of Service match, the diagnosis on the claim is a match within the family of diagnosis codes OR a non-GHP ('E') MSP auxiliary record exists, and no non-GHP MSP is indicated on the claim, but the Dates of Service match, the diagnosis on the claim is an exact match or a match within the family of diagnosis codes.*	
6821	*Non-GHP MSP indicated on claim; no MSP Auxiliary file exists. This indicates no Non-GHP MSP file found.*	
6822	*Non-GHP MSP indicated on the claim; a Non-GHP match does not exist on MSP Auxiliary file.*	
6823	*Beneficiary has a non-GHP MSP Type record 'S' on the Auxiliary file; there is a matching diagnosis on the claim and auxiliary file, and the claim contains payment (full or conditional).*	
6824	*Beneficiary has a non-GHP MSP Type record 'T' on the Auxiliary file; there is a matching diagnosis on the claim and auxiliary file, and the claim contains payment (full or conditional).*	
6825	*Non-GHP MSP conditional payment claim, but a non-GHP MSP record with a Validity Indicator equal to 'I' or 'Y' is not present for these Dates of Service.*	
6826	*MSP Override Code is 'N' or Cost Avoid and no non-GHP MSP record is found with overlapping Date of Service.*	
6830	*Part A claim was processed and only a Part B (Insurer Type 'K') matching non-GHP record was found.*	

6832 *The non-GHP MSP occurrence ('D', 'E', 'H', 'L', 'S', 'T', or 'W') does not contain a diagnosis code.*

6833 *The ICD-9 diagnosis on the claim is not an exact or Family match to the ICD-10 diagnosis on the open non-GHP MSP Aux record (Value Code '14' (MSP Codes 'D' or 'T'), Value Code '15' (MSP Codes 'E' or 'W'), Value Codes '47' (MSP Codes 'L' or 'S'), or*
the ICD-10 diagnosis on the claim is not an exact or Family match to the ICD-9 diagnosis on the open non-GHP MSP Aux record (Value Code '14' (MSP Codes 'D' or 'T'), Value Code '15' (MSP Codes 'E' or 'W'), Value Codes '47' (MSP Codes 'L' or 'S').

6834 *When the claim is secondary and it shows there is a GHP insurer, but the MSP record on CWF has only a non-GHP MSP occurrence.*

6835 *When the claim is secondary and it shows there is a non-GHP insurer, but the MSP record on CWF has only a GHP MSP occurrence.*

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

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

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

An MSP situation cannot exist when a beneficiary has GHP coverage (i.e., working aged, disability and ESRD) and is entitled to Part B only. CWF will edit to prevent the posting of these MSP records to CWF when there is no Part A entitlement date. Currently, if a contractor submits an ECRS transaction to the *MSP Contractor* to add a GHP MSP record where there is no Part A entitlement, the *A/B MAC and DME MAC* will receive a reason code of 61*, MSP cannot exist without Part A entitlement*.

A/B MACs and DME MACs shall not submit an ECRS request to *the MSP Contractor* to establish a GHP MSP record when there is no Part A entitlement. *A/B MACs and DME MACs* that attempt to establish an "I" record will receive a CWF error.

The CWF *shall* continue to allow the posting of *Part B* MSP records where there is no Part A entitlement when *N*GHP situations exists, such as automobile, liability, and workers' compensation. Where a*n N*GHP situation exists, the *A/B MAC and DME MAC shall* continue to submit ECRS transactions and establish "I" records, as necessary.

40.10 – ICD-10 and ICD 9-CM Diagnosis Code *Tables Involving* Non-GHP *MSP* Claims

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

CMS annually instructs CWF to upload and implement the ICD-10 tables in CWF for NGHP MSP claims transactions. In order to be prepared to meet the time line to implement the annually updated ICD-10 diagnosis codes by the mandated time frame of October, CWF implements the ICD-10 updates effective with each October release. CMS also provides CWF with the Diagnosis and Procedure Codes Conversion Tables that are used to associate ICD-10 codes to ICD-9 codes found in CWF MSP records. CWF loads and converts ICD-10 to ICD-9 diagnosis codes for purposes of determining whether ICD 10 diagnosis codes on incoming MSP claim are related to the NGHP MSP record in CWF.

40.10. 1 - *Certain* Diagnosis Codes *Not Allowed on NGHP MSP Records*
(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

There are certain diagnosis codes that systems must not apply to MSP Type 14, CWF MSP Type D No-Fault records *and MSP Type 14, CWF MSP Type L Liability records and MSP Type 15, CWF Type E or W, Workers' Compensation records*. In order for these MSP claims not to deny and process correctly, the CWF must only allow those diagnosis codes related to the accident or injury. CMS has provided *a comprehensive list of* diagnosis codes that *apply and do not apply to NF, L or WC MSP records. The list of diagnosis codes and excluded diagnosis codes may be found at the Coordination of Benefits Overview website at https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists.*

50 - Special CWF Processes
(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

Special CWF MSP Processes are identified below.

50.1 - Extension of MSP-ESRD Coordination Period
(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

are submitted for applicable individuals during the 30-month coordination period. This provision does not apply to individuals who would reach the 18-month point on or before July 31, 1997. These individuals would continue to have an 18-month coordination period.

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

50.*2* - MSP "W' Record and Accompanying Processes

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

I. Common Working File Requirements (CWF)

CWF accept*s* a*n* MSP code *of* "W" for Workers' Compensation Medicare Set-Aside Arrangements (WCMSA) for use on the HUSP records for application on the HUSP Auxiliary File. The CWF indicate*s* the description name for a*n* MSP code "W" record as "WC Medicare Set-Aside.

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

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

CWF will create and send a 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 use*s* the following address for contractor number 11119:

WCMSA Proposal/Final Settlement
P.O. Box 138899

Oklahoma City, OK 73113-8899

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

The CWF maintainer create*s* error code (6815). The message for this new error code (6815) read*s* "WC Set-Aside exists. Medicare contractor payment not allowed". CWF activate*s* 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 ensure*s* that error code 6815 *is* overridden by **MACS (A/B) and MACs (DME)** with a code N or M, for claim lines or claims on which workers' compensation set-aside diagnosis do not apply. CWF accept*s* the new error code (6815) as returned on the 08 trailer.

The CWF create*s* a HUSP transaction error code, SP76, to set when an incoming HUSP transaction with MSP Code "W" is submitted and the beneficiary MSP Auxiliary file contains an open MSP occurrence with MSP code "E" with the same effective date and diagnosis code(s).

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

A/B MACs and DME MACs shared systems accept*s* 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 *utilizes* the description name of 'WC Medicare Set-Aside' for MSP code "W" records.

The shared system*s:*

- *Utilizes* contractor number "11119" on incoming MSP 'W' HUSP records for application on the MSP Auxiliary file.
- *A*ccept*s* contractor number 11119 and MSP code "W" and source code "19" on the returned 03 CWF trailer.
- *Accepts* "19" in the source code field on the HUSP, and HUST transactions for contractor 11119.
- *A*ccept*s* a "Y" validity indicator, as well as, MSP code W for transactions created by contractor 11119.
- *A*ccept*s* and process*es* HUST transactions when an add, change or delete transaction is received for contractor 11119 or from contractor 11119.

- *Reflects CROWD/ report* special project number '7019' as Workers' Compensation Set-Aside Arrangements.

- *A*ccept*s* "19" in the header Payment Indicator field and in the detail Payment Process Indicator field for Contractor 11119.

The MACS (A/B) and MACS (DME) and their systems 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 accept*s* error code (6815) as returned with the 08 trailer. Following receipt of the utilization error code 6815, the *A/B MACs and DME MACs* systems 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 create a "19" Payment Denial Indicator in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, HUDC claims.

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

- Populate a "W" in the MSP code field and

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

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

- 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 *A/B MAC or DME MAC* contractor received error code 6815, *it* shall:

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

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

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

The MACs (A) override the payable claims with override code N. If a claim is to be allowed, an 'N' *is* placed on the "001" Total revenue charge line of the claim.

The shared systems allow*s for* an override of new error code 6815 with the code N.

The Comprehensive Error Rate Testing (CERT) contractor accepts the MSP code "W" in the claim resolution field.

The shared systems bypasses the MSPPAY module if there is an open MSP code "W".

The shared systems does 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 makes 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 includes Reason Code 201, Group Code "PR", Remark Code N722 and "Alert" Remark Code MA01, when denying claims based on a 'W' MSP auxiliary record on outbound 837 claims.

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

The shared system will afford appeal rights for denied MSP code "W" claims.

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

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

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

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

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

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

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

The CROWD/*MDX* reflect*s* special project number "7019" as Workers' Compensation Medicare Set-Aside Arrangements.

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

There are situations where WCMSA benefits may terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit and a residual Medicare secondary payment is due. Under these circumstances Medicare may make a residual secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The A/B MACs (A/B), DME MACs and shared systems may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

The MACs (A/B), MACs (DME), and shared systems, receive, accept, and make a residual payment on MSP Type 15 (MSP Code E) WCMSA electronic claims when the CAS segment shows one of the following CARCs and primary payer benefits are terminated, exhausted or the claim contains a partial or zero payment:

27 – Expenses occurred after coverage terminated.
35 – Lifetime benefit maximum has been reached.
119 – Benefit maximum for this time period, or occurrence, has been reached.
149 – Lifetime benefit maximum has been reached for this source/benefit category.

The MACs (A/B), MACs (DME), and shared systems receive, accept, and make payment on MSP Type 15, WCMSA paper (hard copy) claims when the claim includes an attached remittance advice (RA)/Explanation of Benefits (EOB) that**:**

1) Shows the claim with a zero payment or was not paid in full by the primary payer and a residual payment is due;

2) Is a Medicare covered and reimbursable service; and

3) Contains a reason code for denial or similar verbiage if a reason code is not indicated:

   - Expenses occurred after the coverage terminated;
   - Lifetime benefit maximum has been reached;
   - Benefit maximum for this time period, or occurrence, has been reached; or
   - Lifetime benefit maximum has been reached for this source/benefit category.

NOTE: If an MSP Type 15, WCMSA electronic, or hard copy claim, is received and there is a corresponding WCMSA record on CWF and the claim contains a partial, or

zero, payment from a primary insurer and the claim, or attached primary payer remittance advice/EOB, does not include a reason code for denial or similar verbiage if a reason code is not indicated, the *A/B MACs, DME* MACs and shared system deny the claim based on the CWF utilization 6815.

In order for the residual payment to occur, CWF performs the following functions:

CWF HUIP, HUOP, HUHH, HUHC (HBIP, HBOP, HBHH, and HBHC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level. Valid values for the field = X or space.

CWF HUBC and HUDC (HBBC and HBDC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level and at the detail level. Valid values for the field = X or space.

NOTE: The shared systems must ensure that the MACs are able to input an "X" in the header of their claims, and at the service line level, when applicable, that are sent to CWF, for situations when the claim is not paid, or not paid in in full, by the primary payer.

CWF shall override the 6815 WCMSA utilization error code when the MACs determine a residual payment should be made on the claim.

The MACs make a residual payment by placing the "X" at the header for the Part A claims, or an 'X' at either the header or detail line for Part B Professional and DME MAC claims.

The A/B MACs, DME MACs and shared systems must send the primary payer's MSP amounts, found on the incoming WCMSA claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare.

NOTE: When applicable, the *A/B* MAC*s and DME MACs* send the attestation form/letter, it received from the reporting entity indicating WCMSA benefits are exhausted, to the *MSP Contractor*. For ORM, the Section 111 reporting entity shall report that benefits are exhausted via the normal quarterly data file process.

50.3 - MSP "W' Record and Accompanying Processes

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

I. Common Working File Requirements (CWF)

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

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

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

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

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

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

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

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

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

The CWF will create a new HUSP transaction error code, SP76, to set when an incoming HUSP transaction with MSP Code "W" is submitted and the beneficiary MSP Auxiliary file contains an open MSP occurrence with MSP code "E" with the same effective date and diagnosis code(s).

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

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

The shared system shall accept a new contractor number "11119" on incoming MSP 'W' HUSP records for application on the MSP Auxiliary file.

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

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

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

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

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

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

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

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

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

- Populate a "W" in the MSP code field and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are situations where WCMSA benefits may terminate, or deplete, during a beneficiary's provider facility stay or upon a physician's visit and a residual Medicare secondary payment is due. Under these circumstances Medicare may make a residual secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA benefit or responsibility for payment terminates mid-service. The A/B MACs (A/B), DME MACs and shared systems may pay this residual secondary payment by sending the primary payer amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

The MACs (A/B), MACs (DME), and shared systems, shall receive, accept, and make a residual payment on MSP Type 15 (MSP Code E) WCMSA electronic claims when the CAS segment shows one of the following CARCs and primary payer benefits are terminated, exhausted or the claim contains a partial or zero payment:

27 – Expenses occurred after coverage terminated.

35 – Lifetime benefit maximum has been reached.
119 – Benefit maximum for this time period, or occurrence, has been reached.
149 – Lifetime benefit maximum has been reached for this source/benefit category.

The MACs (A/B), MACs (DME), and shared systems shall receive, accept, and make payment on MSP Type 15, WCMSA paper (hard copy) claims when the claim includes an attached remittance advice (RA)/Explanation of Benefits (EOB) that**:**

4) Shows the claim with a zero payment or was not paid in full by the primary payer and a residual payment is due;

5) Is a Medicare covered and reimbursable service; and

6) Contains a reason code for denial or similar verbiage if a reason code is not indicated:

- Expenses occurred after the coverage terminated;
- Lifetime benefit maximum has been reached;
- Benefit maximum for this time period, or occurrence, has been reached; or
- Lifetime benefit maximum has been reached for this source/benefit category.

NOTE: If an MSP Type 15, WCMSA electronic, or hard copy claim, is received and there is a corresponding WCMSA record on CWF and the claim contains a partial, or zero, payment from a primary insurer and the claim, or attached primary payer remittance advice/EOB, does not include a reason code for denial or similar verbiage if a reason code is not indicated, the MACs and shared system shall deny the claim based on the CWF utilization 6815.

In order for the residual payment to occur, CWF performs the following functions:

CWF HUIP, HUOP, HUHH, HUHC (HBIP, HBOP, HBHH, and HBHC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level. Valid values for the field = X or space.

CWF HUBC and HUDC (HBBC and HBDC for BDS) claims allow for a 1-byte field (Residual Payment Indicator) at the claim header level and at the detail level. Valid values for the field = X or space.

NOTE: The shared systems must ensure that the MACs are able to input an “X” in the header of their claims, and at the service line level, when applicable, that are sent to CWF, for situations when the claim is not paid, or not paid in in full, by the primary payer.

CWF shall override the 6815 WCMSA utilization error code when the MACs determine a residual payment should be made on the claim.

The MACs make a residual payment by placing the "X" at the header for the Part A claims, or an 'X' at either the header or detail line for Part B Professional and DME MAC claims.

The A/B MACs, DME MACs and shared systems must send the primary payer's MSP amounts, found on the incoming WCMSA claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare.

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

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

(Rev. 11996, Issued:04-27-23; Effective: 05-29-23; Implementation: 05-29-23)

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

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

Until Part A shared system changes are effectuated to convert HIPAA individual relationship codes to CWF patient relationship codes, A/B MACs (A) may move claims with a systems age of 30 days or older that have suspended for resolution of patient relationship code, including SP-33 or SP-52 edits, to condition code 15 (CC-15).

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

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

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

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

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

A/B MACs (A) allow CWF patient relationship codes, since these files should be populated with information sent back to the A/B MACs (A)' systems via the automated transaction.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R11996MSP	04/27/2023	Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 6	05/29/2023	13160
R11381MSP	04/29/2022	Updating the Common Working File (CWF) Logic Tied to Medicare Secondary Payer (MSP) Investigational Records to Match Newly Revised Development Timeframes	10/03/2022	12678
R10753MSP	05/11/2021	Update the Common Working File (CWF) to Accept a Group Health Plan (GHP) and non-GHP (NGHP) Medicare Secondary Payer (MSP) Effective Date 3 Months from the Current Date for Medicare Enrolled and Medicare Entitled Beneficiaries	10/04/2021	12176
R10243MSP	07/31/2020	Updating the Common Working File (CWF) to allow for a Medicare Secondary Payer (MSP) Termination Date Greater than the Current Date Plus Six Months for non-Group Health Plan (NGHP) MSP Auxiliary Records	01/04/2021	11771
R125MSP	03/22/2019	Update to Publication (Pub.) 100-05 to Provide Language-Only Changes for the New Medicare Card Project	04/22/2019	11193
R124MSP	08/31/2018	Updates to Chapters 5 and 6 of Publication 100-05 to Further Clarify Medicare Secondary Payer (MSP) Processes that Include Electronic Correspondence Referral System (ECRS) Requests Submissions and Timely Submission of MSP I Records, General Inquiries and Hospital Reviews	10/01/2018	10855

R121MSP	06/01/2018	Update the International Classification of Diseases, Tenth Revision (ICD-10) 2019 Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims	10/01/2018	10803
R119MSP	04/07/2017	Implement the International Classification of Diseases, Tenth Revision (ICD-10) 2018 General Equivalence Mappings (GEMs) Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims	10/02/2017	9947
R114MSP	09/18/2015	Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM)	07/06/2015	8984
R113MSP	08/06/2015	Instructions for the Shared Systems and Medicare Administrative Contractors (MACs) to follow when a Medicare Residual Payment must be Paid on Workers' Compensation Medicare Set-aside Arrangement (WCMSA) or for Ongoing Responsibility of Medicals (ORM) Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Claims	01/04/2016	9009
R110MSP	03/06/2015	Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM) – Rescinded and replaced by Transmittal 114	07/06/2015	8984
R107MSP	10/24/2014	Update to Pub. 100-05, Chapters 05 and 06 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	11/28/2014	8947

R95MSP	08/23/2013	Update of the Common Working File (CWF) to not Allow Certain Diagnosis Codes on No-Fault Medicare Secondary Payer (MSP) Records	01/06/2014	8351
R94MSP	06/28/2013	Update the Medicare Secondary Payer Manuals to Indicate Unsolicited Refund Documentation is No Longer a Justification for Submission of an "I" Record	07/30/2013	8253
R89MSP	08/30/2012	Expanding the Coordination of Benefits (COB) Contractor Numbers to Include 11139 and 11142 for the Common Working File (CWF)	01/07/2013	7906
R88MSP	08/17/2012	Expanding the Coordination of Benefits (COB) Contractor Numbers to Include 11139 and 11142 for the Common Working File (CWF)	01/07/2013	7906
R81MSP	07/29/2011	Requesting the Common Working File (CWF) to Cease Submitting First Claim Development (FCD) and Trauma Code Development (TCD) Alerts to the Coordination of Benefits Contractor (COBC)	01/03/2012	7483
R77MSP	01/21/2011	Categorizing Diagnosis Codes 500-508 and 800-999 on Incoming Medicare Secondary Payer (MSP) Claims and on the MSP Auxiliary File for non-Group Health Plan (GHP) Claims	07/05/2011	7149
R76MSP	11/19/2010	Common Working File (CWF) Medicare Secondary Payer (MSP) Coordination of Benefits Contractor (COBC) Number Update and Implementation of MSP Group Health Plan (GHP) COBC Hierarchy Rules as related to Mandatory Insurer Reporting	04/04/2011	7216
R74MSP	04/28/2010	New Medicare Secondary Payer Insurer Type Codes	10/04/2010	6768

R65MSP	03/20/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments	04/06/2009/ 07/06/2009	5371
R64MSP	01/09/2009	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers Compensation Medicare Set-Aside Arrangements (WCMSAs) to Stop Conditional Payments - Rescinded and replaced by Transmittal 65	04/06/2009/ 07/06/2009	5371
R61MSP	10/03/2008	Expanding the Mandatory Insurer Reporting (MIR) Coordination of Benefits (COB) Contractor Numbers for the Common Working File (CWF)	01/05/2009	6182
R60MSP	09/19/2008	Expanding the Mandatory Insurer Reporting (MIR) Coordination of Benefits (COB) Contractor Numbers for the Common Working File (CWF) - Rescinded and replaced by Transmittal 61	01/05/2009	6182
R43MSP	10/31/2005	Expanding the Voluntary Data Sharing Agreement (VDSA) Coordination of Benefit (COB) Contractor Numbers for the Common Working File (CWF)	04/03/2006	3826
R31MSP	07/08/2005	Full Replacement of CR 3770,Expanding the Number of Source Identifiers for Common Working File (CWF) MSP Records	10/03/2005	3909
R12MSP	03/05/2004	Converting HIPAA Individual Relationship Codes to Common Working File (CWF) Patient Relationship Codes	03/19/2004	3117
R09MSP	02/06/2004	Converting Health Insurance Portability and Accountability ct (HIPAA) Individual Relationship Codes to Common Working File (CWF) Patient Relationship Codes	07/06/2004	3116
R08MSP	02/06/2004	Common Working File MSP Modifications	07/06/2004	2775

R06MSP	01/162004	Automatic Notice of Change to MSP Auxiliary File	01/01/2004	2608
R01MSP	10/01/2003	Initial Issuance of Manual	N/A	N/A

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