| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-05 Medicare Secondary Payer | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 113** | **Date: August 6, 2015** |
| | **Change Request 9009** |

**SUBJECT: 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.**

**I. SUMMARY OF CHANGES:** There are situations where WCMSA or ORM benefits may terminate or deplete during a beneficiary's provider facility stay or upon a physician's visit and a residual payment is due. Under these circumstances Medicare may make a "residual" secondary payment. This CR instructs the shared systems, the A/B MACs, and DME MACs to pay this residual secondary payment by sending the primary payer payment amounts to the MSPPAY module and calculate Medicare's payment if such services are covered and reimbursable by Medicare.

**EFFECTIVE DATE: January 1, 2016**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 4, 2016**

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 2/50/Workers' Compensation (WC) |
| R | 5/TOC |
| N | 5/20.5 – Medicare Residual Payments Due When On-going Responsibility for Medicals (ORM) Benefits Terminate, or Deplete, During a Beneficiary's Provider Facility Stay or Upon a Physician, or Supplier, Visit. |
| R | 6/50.3 - MSP "W' Record and Accompanying Processes |

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

regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-05 | Transmittal: 113 | Date: August 6, 2015 | Change Request: 9009 |
|---|---|---|---|

**SUBJECT: 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.**

**EFFECTIVE DATE: January 1, 2016**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 4, 2016**

## I. GENERAL INFORMATION

**A. Background:** Pursuant to 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Liability insurance (including self-insurance), no-fault insurance, and workers' compensation, are collectively referred to as NGHP. Where an NGHP has reported ORM, the NGHP has ongoing responsibility for certain medical care related to the beneficiary's insurance or workers' compensation situation. Similarly, a CMS approved Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) amount is an allocation of funds from a workers' compensation-related settlement, judgment, award, or other payment that is used to pay for related items and services that are otherwise covered and reimbursable by Medicare. In these situations, the NGHP and WCMSA are the primary payers. Medicare is not permitted to make payment for related items and services until it receives documentation that ORM has been terminated or available funds have been appropriately exhausted. Where the WCMSA amount or ORM terminates or exhausts during a beneficiary's provider facility stay or physician visit, Medicare must be able to make a "residual payment" on a claim it would otherwise deny. For the purposes of this CR, the term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the WCMSA or ORM benefit or responsibility for payment terminates mid-service.

This CR instructs the shared systems, the A/B MACs, and DME MACs to pay this residual payment by sending the primary payer amounts to the MSPPAY module to calculate Medicare's payment if such services are covered and otherwise reimbursable by Medicare.

**B. Policy:** Beginning with the effective date of this change request, when WCMSA or ORM benefits are terminated or exhausted during a provider stay or physician visit and the claim is not fully paid by the WCMSA or by the NGHP, the A/B MACs, and DME MACs may make a residual payment on that claim by sending the primary payer amounts to the MSPPAY module to calculate Medicare's residual payment if such services are covered and otherwise reimbursable by Medicare.

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | |
|---|---|---|---|---|---|
| | | A/B MAC | DME | Shared-System Maintainers | Other |

| | | A | B | H H H | M A C | F I S S | M C S | V M S | C W F | |
|---|---|---|---|---|---|---|---|---|---|---|
| 9009.1 | The shared systems shall continue to allow a residual, or secondary, payment based on any one of the following Claim Adjustment Reason Codes received on an electronic, No-Fault insurance (CWF MSP Code D, Value Code 14), Workers' Compensation, (CWF MSP Code E, Value Code 15), or Liability insurance (including self-insurance) (CWF MSP Code L, Value Code 47) claim when primary payer benefits are terminated, exhausted or the claim contains a partial or zero payment:<br><br>27 – Expenses occurred after coverage terminated.<br><br>35 – Lifetime benefit maximum has been reached.<br><br>119 – Benefit maximum for this time period, or occurrence, has been reached.<br><br>149 – Lifetime benefit maximum has been reached for this source/benefit category. | | | | | X | X | X | | |
| 9009.1.1 | If an MSP Code D (Value Code 14), MSP Code E (Value Code 15),or MSP Code L (Value Code 47) claim is received with a partial, or zero, primary payment from the primary payer and none of the CARCs found 9009.1 appear on the claim, the MACs and shared system shall deny the claim based on the CWF utilization 6815 and ORM CWF utilization 6816, 6817, or 6818 error code received. | X | X | X | X | X | X | X | X | |
| 9009.1.2 | If received, the MAC shall fax the attestation form/letter it received from the reporting entity indicating WCMSA benefits are exhausted, to the BCRC (FAX: 405-869-3307). NOTE: For ORM (non-WCMSA), the Section 111 reporting entity shall report that benefits are exhausted via the quarterly data file process. | X | X | X | X | | | | | BCRC |
| 9009.2 | The MACs and shared systems shall receive, accept, and make payment on electronic MSP Type 14, 15 and 47 claims when the CAS segment shows one of the CARCs found in BR 9009.1 and the claim shows a zero payment or the claim is not paid in full and residual Medicare payment is due on Medicare covered and reimbursable services. | X | X | X | X | X | X | X | | |
| 9009.3 | MACs and shared systems shall receive, accept, and make payment on paper (hard copy) MSP Type 14,15, 47 or WCMSA claims when the claim includes an attached remittance advice (RA)/Explanation of Benefits (EOB) that**:** | X | X | X | X | X | X | X | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | 1. Shows the claim with a zero payment or was not paid in full by the primary payer and a residual payment is due; and<br><br>2. Contains a reason code indicated in BR 9009.1 or similar verbiage (if a reason code is not indicated):<br><br>• Expenses occurred after the coverage terminated;<br><br>• Lifetime benefit maximum has been reached;<br><br>• Benefit maximum for this time period, or occurrence, has been reached; or<br><br>• Lifetime benefit maximum has been reached for this source/benefit category. | | | | | | | | | |
| 9009.3.1 | If a paper (hard copy) No-Fault insurance (CWF MSP Code D, Value Code 14), Workers' Compensation (CWF MSP Code E,Value Code 15), or Liability insurance (including self-insurance) (CWF MSP Code L, Value Code 47) or WCMSA incoming claim with Value Code 15 (MSP Internal Code 19, CWF MSP Code W) is received and a partial payment has been made from a primary insurer and the claim, or attached primary payer remittance advice/EOB, does not include a reason for denial similar to any of the narrative descriptions included in 9009.4, the MACs and shared system shall deny the claim based on the CWF utilization 6816, 6817, or 6818 error code received. | X | X | X | X | X | X | X | X | |
| 9009.4 | CWF shall set a new NGHP over-rideable error code 6821 if MSP Type 14 (MSP Code D), 15 (MSP Code E) and 47 (MSP Code L) is indicated on the claim, but no MSP auxiliary record exists on CWF. | | | | | | | | X | BDS |
| 9009.4.1 | In situations where the MACs and shared systems receive the error code 6821, the MAC or indicated shared system shall create an "I" record, or send an ECRS Inquiry to the Benefits Coordination & Recovery Center, indicating a new MSP occurrence may exist. | X | X | X | X | X | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 9009.5 | CWF shall set a new NGHP over-rideable error code 6822 if MSP Type 14 (MSP Code D), 15 (MSP Code E) and 47 (MSP Code L) is indicated on the claim but a non-GHP matching record is not found on the MSP auxiliary file. | | | | | | | | X | BDS |
| 9009.5.1 | In situations where the MACs and shared systems receive the error code 6822, the MAC or indicated shared system shall create, as appropriate, an "I" record, or send an ECRS request to the Benefits Coordination & Recovery Center, indicating a new MSP occurrence may exist. | X | X | X | X | X | | | | |
| 9009.5.2 | The MACs and shared system maintainers shall override the 6821 and 6822 and process the claim as necessary. | X | X | X | X | X | | X | | BDS |
| 9009.6 | In the case of a Workers' Compensation claim, FISS shall update CEM and base system hard-coded logic to allow submission and/or manual entry of MSP Type 15 when EMC or paper claims are received. | | | | | X | | | | CEM-A |
| 9009.7 | CWF shall modify its HUIP, HUOP, HUHH, and HUHC claims to create a new 1-byte field, known as the "Residual Payment Indicator," at the claim header level. | | | | | | | | X | BDS |
| 9009.7.1 | CWF shall create and include a header level Residual Payment Indicator added for the HUOP record, which will also apply to the HUHH and HUHC claim query interfaces. (The BDS Claim type is HBIP, HBOP, HBHH, and HBHC) | | | | | | | | X | BDS |
| 9009.7.2 | CWF shall modify its HUBC and HUDC (HBBC and HBDC for BDS) claims to create a new 1-byte field Residual Payment Indicator at the claim header level and at the detail line level. | | | | | | | | X | BDS |
| 9009.7.3 | CWF shall: 1) accept a value of X or space in the new 1-byte Residual Payment Indicator field; and 2) ignore all other values that may be created in the new field. | | | | | | | | X | BDS, FPS, NCH |
| 9009.7.4 | CWF shall create a consistency edit if any other value than ‘X’ is submitted in the Residual Payment Indicator field. | | | | | | | | X | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | |
| 9009.7.5 | The MACs and shared systems shall accept the consistency edit. | X | X | X | X | X | | X | | BDS |
| 9009.8 | CWF shall include the 1 byte Residual Payment Indicator on the appropriate claim history screens (INPH, OUTH, HOSH, HHAH, PTBH, and DMEH), on HIMR (Health Insurance Master Record) for all Part A , Part B, and DME claims. | | | | | | | | X | BDS, FPS, NCH |
| 9009.9 | The shared systems shall modify their HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim query (The Part A BDS claim type is HBIP, HBOP, HBHH, and HBHC and for Part B BDS claim type is HBBC and HBDC) interfaces to CWF so that the value X or space may be input in the newly created Residual Payment Indicator field either at the detail level for Part B professional and DME claims, or header level for Part A inpatient or outpatient claims, as appropriate. | | | | | X | X | X | X | BDS |
| 9009.10 | The MACs and associated shared systems shall make a residual payment in MSP ORM situations by placing the 'X' at the header for the Part A MSP Type 14, 15, and 47 Part A inpatient or outpatient claims, or an ‘X’ at the header or detail line for the Part B Professional and DME MAC MSP Type 14, 15, and 47 claims. | X | X | X | X | X | X | X | X | |
| 9009.10.1 | CWF shall bypass the three new ORM utilization error codes (6816, 6817 and 6818) when the MACs determine a residual payment should be made on the claim and include an ‘X’ in the Residual Payment indicator field. | | | | | | | | X | BDS |
| 9009.11 | The MACs and associated shared systems shall make a residual payment in WCMSA MSP situations by placing the 'X' at the header for the Part A inpatient or outpatient claims, or an ‘X’ at either the header, or detail, for the Part B Professional and DME MAC claims. | X | X | X | X | X | X | X | | |
| 9009.11.1 | CWF shall bypass the existing ‘6815’ WCMSA utilization error code when the MACs determine a | | | | | | | | X | BDS |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | residual payment should be made on the claim and include an 'X' in the Residual Payment Indicator field. | | | | | | | | | |
| 9009.12 | CWF shall ensure when the 'X' is present in the header or detail Residual Payment Indicator field, and no other edits (consistency or utilization) are received, the claim processes through the system and allows for secondary payment. | | | | | | | | X | BDS |
| 9009.13 | The MACs and shared systems shall send the primary payer's MSP amounts, found on the incoming WCMSA, or ORM claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare based on business requirements found in this instruction. | X | X | X | X | X | X | X | | |

## III. PROVIDER EDUCATION TABLE

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

## IV. SUPPORTING INFORMATION

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

*"Should" denotes a recommendation.*

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

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Richard Mazur, 410-786-1418 or Richard.Mazur2@cms.hhs.gov , Brian Pabst, 410-786-2487 or Brian.Pabst@cms.hhs.gov

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

## VI. FUNDING

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

**ATTACHMENTS: 0**

# 50 - Workers' Compensation (WC)

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

## A - General

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

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

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

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

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

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

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary

information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

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

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

# Medicare Secondary Payer (MSP) Manual
## Chapter 5 - Contractor Prepayment Processing Requirements

*20.5 – Medicare Residual Payments Due When On-going Responsibility for Medicals (ORM) Benefits Terminate, or Deplete, During a Beneficiary's Provider Facility Stay or Upon a Physician, or Supplier, Visit.*

***20.5 Medicare Residual Payments Due When On-going Responsibility for Medicals (ORM) Benefits Terminate, or Deplete, During a Beneficiary's Provider Facility Stay or Upon a Physician, or Supplier, Visit.***

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

*There are situations where ORM 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 Medicare secondary payment. The term "residual payment" is defined as: a payment Medicare makes on a claim where available funds have been exhausted from the ORM benefit or responsibility for payment terminates mid-service.The A/B MACs, 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) and MACs (DME), and shared systems, shall receive, accept, and make a residual payment on electronic No-Fault insurance (CWF MSP Code D, Part A Value Code 14), Workers' Compensation, (CWF MSP Code E, Part A Value Code 15), or Liability insurance (including self-insurance) (CWF MSP Code L, Part A Value Code 47) ORM 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) and MACs (DME) and shared systems shall receive, accept, and make payment on MSP Type 14, 15 and 47 ORM paper (hard copy) claims when the claim includes an attached remittance advice/Explanation of Benefits 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 a No-Fault insurance (CWF MSP Code D, Part A Value Code 14), Workers' Compensation, (CWF MSP Code E, Part A Value Code 15), or Liability insurance (including self-insurance) (CWF MSP Code L, Part A Value Code 47) electronic, or hard copy claim, is received 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, 6816, 6817, and 6818 error code received.*

*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" at the claim header for those 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 three new ORM utilization error codes (6816, 6817 and 6818) 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 ORM claim, to MSPPAY for Medicare's Secondary Payment calculation when a residual payment is expected to be made by Medicare.*

## 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, a 'N' shall be placed on the "001" Total revenue charge line of the claim.

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

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

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

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

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

The shared systems shall include Reason Code 201, Group Code "PR", Remark Code *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.*