CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 114	**Date: September 18, 2015**
	Change Request 8984

NOTE: This Transmittal is no longer sensitive and is being re-communicated on September 18, 2015. This instruction may now be posted to the Internet.

Transmittal 110, dated March 6, 2015, is being rescinded and replaced by Transmittal 114, dated September 18, 2015, to include the Common Working File (CWF) newly defined Medicare Secondary Payer (MSP) maintenance transaction error codes (also known as SP edits) in business requirements 8984.5.2.2, 8984.5.2.6, 8984.5.3, and 8984.5.3.1. The CMS is also providing the newly defined CWF 6800 series MSP utilization error codes in requirement 8984.5.5. Additionally, CMS is including the newly defined MSP SP edits in chapter 6, section 30.6 of the Internet Only Manual (IOM). CMS is also including the newly defined 6800 series MSP utilization error codes in chapter 5, section 20.4.3 and chapter 6, section 40.8 of the IOM. All other information remains the same.

SUBJECT: Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM)

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claims processing requirements specific to Ongoing Responsibility for Medicals (ORM) for liability (including self-insurance), no-fault insurance, and workers' compensation in Medicare Secondary Payer (MSP) situations.

EFFECTIVE DATE: July 1, 2015; October 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015 - Design and Pre-Coding (CWF, FISS, and VMS); October 5, 2015 - Full implementation (CWF, FISS, MCS, and VMS)

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	5/20- Sources That May Identify Other Insurance Coverage
R	5/20.1- Identification of Liability and No-Fault Situations
R	5/20.2- Identify Claims with Possible WC Coverage
N	5/20.4- Identification of On-Going Responsibility for Medicals (ORM) in Liability, No-Fault, and Workers' Compensation Situations
N	5/20.4.1 - Background Regarding ORM for Contractors
N	5/20.4.2 - Policy Regarding ORM
N	5/20.4.3 - Operationalizing ORM for Liability, No-Fault, and Workers' Compensation Situations
R	6/30.3- MSP Auxiliary File Errors
R	6/40.8/ MSP Utilization Edits and Resolutions for Claims Submitted to CWF

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

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I. GENERAL INFORMATION

A. Background: Pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) in 2007, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to the Centers for Medicare & Medicaid Services (CMS). The applicable plan is the "Responsible Reporting Entity" (RRE) for this process. The required reporting includes instances where the RRE has assumed ongoing responsibility for medicals (ORM) associated to specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date, and this information is uploaded to Common Working File (CWF) by the Benefit Coordination & Recovery Center (BCRC).

NOTE: A Section 111 ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

The purpose of this change request (CR) is to educate and instruct the Medicare Administrative Contractors (MACs) and system maintainers about the policy and procedures surrounding MMSEA Section 111 ORM reporting. In addition, CMS plans to modify CWF to allow for a new 1-byte ORM indicator on the Medicare Secondary Payer Detail (MSPD) screen; the associated valid values are discussed herein. Further, this CR will instruct the MACs and system maintainers concerning how to handle and process claims based on the value present within the CWF ORM field on the MSPD screen.

NOTE: This CR represents the design and implementation requirements connected with CMS CR 8821.

B. Policy:

Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

This CR includes modifications to the Common Working File (CWF) Medicare Secondary Payer Detail (MSPD) screen. An ORM indicator is being added that will be populated with a "Y" for "Yes" (ORM responsibility assumed/exists) or a "space" (an ORM indicator of a "space" implies that an RRE has not assumed ORM). Please note that **where ORM is reported, this ORM indicator on associated MSP auxiliary records remains "Y" even where the ORM is subsequently terminated.** The "Y" denotes that the ORM existed for a particular period of time (not necessarily that it currently exists).

All Medicare Administrative Contractors (MACs) shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSP D (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. After comparing the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record, all MACs shall deny claims where the 1-byte ORM indicator on the MSPD screen equals "Y" **and** the diagnosis code(s) match(es) (or match(es) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed.

NOTE: While it may not occur frequently, there may be situations where an RRE will continue to assume ORM for a particular injury/illness and at the same time have a lump sum type settlement or other payment with respect to other alleged injuries/illnesses for the same date of accident/injury/loss. Consequently, it is possible that CWF could have both an open ORM occurrence as well as an open Medicare Set-Aside (MSA) occurrence, just not for the same diagnosis code(s). Therefore, the MACs shall determine which record on CWF is applicable in order to process the claim appropriately. For example, the MAC can review the diagnosis codes on the claim and compare them to the diagnosis codes on the open ORM occurrence and the MSA occurrence, as well as any other open CWF occurrences that fall within the date perimeters being reviewed, to find the correct match for processing.

As stated above, MACs shall deny payment for claims with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not apply to nor override this requirement. However, as stated, the reported ORM is not a guarantee that medicals will be

paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where a portion of a group of claims submitted to the RRE was sufficient to exhaust the policy.

Unless otherwise mentioned below, MACs shall assume that normal MSP claims processing requirements apply (i.e., checking claim service dates against MSP auxiliary record effective and termination dates; matching diagnosis codes on the claim against those on CWF (including the family of diagnosis codes policy); and affording appeal rights on MSP claims).

NOTE: CMS will issue a separate instruction, for implementation in a different systems release, to enable MACs to make a residual secondary payment (i.e., an MSP secondary payment) in ORM situations (where MSP D, E, or L records contain an ORM indicator of "Y") when an RRE's payment of a claim is incomplete. Until that time, when MACs need to make a residual secondary payment, they shall follow existing procedures, to include requesting permission from their CMS Contracting Officer Representative (COR) to pay the claim outside CWF.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8984.5.1	The Benefits Coordination & Recovery Center (BCRC) shall submit Ongoing Responsibility for Medicals (ORM) MSP records to the Common Working File (CWF).									BCRC
8984.5.2	CWF shall modify its BCRC Health Utilization Secondary Payer (HUSP) transaction and modify the 03 trailer response to include a new 1-byte ORM indicator field (valid values=Y or a space).								X	BDS
8984.5.2.1	The shared systems shall ensure that their MACs are unable to enter any value in the "ORM" field within the "I" HUSP maintenance transactions that MACs create.					X	X	X		
8984.5.2.2	CWF shall create and the MACs and the shared system maintainers shall accept an SP edit (SP 79) that will set if an ORM value is included in the ORM field of an incoming "I" HUSP record. **NOTE**: CWF/MAC/VDC requirement. MACs control the new Error on the CW screen. VDC will need to load the updated version of the CABEDMSP file.	X	X	X	X	X	X		X	BDS, VDCs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8984.5.2.3	CWF shall add a new 1-byte indicator to the MSP Detail file (MSPD) [valid values=Y (Yes) or a space]. **NOTE:** This indicator shall identify whether the Responsible Reporting Entity (RRE) has assumed ORM. Where ORM is reported, the indicator remains "Y" even when ORM is subsequently terminated. A "Y" ORM indicator value denotes that the ORM existed for a period of time, not necessarily that it currently exists. An ORM indicator of a "space" implies that an RRE has not assumed ORM.						X		X	BCRC, BDS
8984.5.2.4	CWF shall only allow the 1-byte ORM indicator to be populated on an MSP "D, E, or L" record.								X	BCRC, BDS
8984.5.2.5	CWF shall apply the same MSP consistency edit codes that it now applies for MSP codes "D, E, and L" (14, 15, and 47, respectively) regardless of the ORM indicator reported.								X	BCRC, BDS
8984.5.2.6	CWF shall establish a new SP80 edit to ensure that the 1-byte indicator is only received on HUSP transactions with MSP codes "D, E, and L."								X	BCRC, BDS
8984.5.2.7	CWF shall allow only contractor numbers 11100, 11110, 11122, 11141, and 11142 to add, change, or delete MSP records with an ORM occurrence (ORM indicator=Y).								X	BCRC, BDS
8984.5.2.8	CWF shall apply edit SP50 if contractor numbers other than those listed in 8984.2.7 attempt to add, change, or delete MSP records with an ORM occurrence (ORM indicator=Y) .								X	BCRC, BDS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8984.5.3	The CWF shall create a new SP error code (SP81) that sets when there is an existing ORM record (ORM indicator=Y) and some other entity besides the following contractor numbers of 11100, 11110, 11122, 11141, and 11142 attempts to modify the existing record's ORM indicator to equal a "space."								X	BDS
8984.5.3.1	When the BCRC receives the SP edit (SP81), discussed in 8984.3 it shall research the situation in order to resolve the edit and update CWF where appropriate.									BCRC
8984.5.4	The MACs, shared systems, BCRC, and REMAS shall accept and process the new 1-byte ORM indicator that is on the MSP CWF screen. **NOTE**: HP/MCS and their users need to be mindful of their testing responsibility due to the changes to the HIMR integration software.	X	X	X	X	X	X	X	X	BCRC, BDS, REMAS
8984.5.4.1	The CWF shall return, and the shared system maintainers and MACs shall accept and process, a revised MSP HUSC transaction and the 03 trailer response that now includes the 1-byte ORM indicator (valid values = Y or a space).	X	X	X	X	X	X	X	X	BCRC
8984.5.5	The CWF maintainer shall create three (3) new MSP overrideable utilization error codes (68XX), one for Liability (including self-insurance), No-Fault, and Workers' Compensation, as indicated below: • 6818-- "Liability record exists with a valid (Y) ORM indicator. MAC payment not allowed." • 6816-- "No- Fault record exists with a valid (Y) ORM indicator. MAC payment not allowed."								X	BDS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 6817-- "Workers' Compensation record exists with a valid (Y) ORM indicator. MAC payment not allowed."									
8984.5.1	When determining whether to apply the three (3) new 68xx error codes, CWF shall take the following steps by referencing the MSP auxiliary file: • Validate that the ORM indicator on the open MSP ORM record on CWF equals "Y"; and • Determine if the diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF (matching determination performed by CWF).								X	BDS
8984.5.5.1.1	If CWF determines that the new 68xx error codes apply, it shall return them to the A/B MAC or DME MAC with disposition code UR.								X	BDS
8984.5.5.2	When returning one of the new 68xx edits to the MACs, CWF shall also send a trailer 39 to the MACs to ensure that, as applicable, they can determine to which service detail lines the 68xx edit applies.								X	BDS
8984.5.5.3	The MACs and shared systems shall accept the three (3) new overrideable utilization error codes (68XX) when returned with a 08 trailer. **NOTE**: There may be contractor maintenance to add new error code to CW screen.	X	X	X	X	X	X	X		BDS
8984.5.5.4	When applying its 68XX editing logic for the applicable Liability, No-Fault, or Workers' Compensation record, CWF shall ensure that open NGHP MSP records with a "Y" ORM indicator are given precedence over another NGHP record, where all other variables except the ORM indicator match.								X	BDS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8984.5.5.5	MACs shall still be required on occasion and part of normal processes/procedures to make determinations on claims that are suspended for review with an associated ORM occurrence if : • The ORM indicator on the MSPD screen equals “Y”; and • The diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF.	X	X	X	X					
8984.5.6	The MACs and shared systems shall assume that normal MSP claims processing requirements apply in association with the ORM requirements, including, but not limited to, all of the following: • Verify if claim’s service dates fall inside or outside the MSP auxiliary record when making the claims payment determinations; • Confirm that the diagnosis codes on the claim match the diagnosis codes (or match within the family of diagnosis codes) contained in the MSP auxiliary record, in accordance with CMS prior claim payment direction; and • Continue to afford appeal rights on MSP claims.	X	X	X	X	X	X	X	X	BDS
8984.5.7	Upon denying the claim with an open ORM occurrence (with an indicator of "Y"), the A/B MACs (A, HHH) and shared systems shall create a “22” No Pay Code in the appropriate claim line and header of their HUIP, HUOP, HUHH, HUHC claim	X		X		X			X	BDS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	before sending it to CWF.									
8984.5.7.1	Upon denying the claim with an open ORM occurrence (with an indicator of "Y"), the A/B MACs (B) and DME MACs and shared systems shall create a “22” Payment Denial indicator in the HUBC and HUDC claim header transactions and a “22” in the claim detail pay process field before sending the claim to CWF.		X		X		X	X	X	BDS
8984.5.8	The MACs and the shared systems shall include Claim Adjustment Reason Codes (CARCs) 19, 20, and 21 as applicable, on the outbound 835 and the 837 crossover claims when denying claims due to ORM, together with CAS Group Code PR. These three (3) CARC codes are defined as follows : • CARC 19-- “This is a work-related injury/illness and thus the liability of the Workers’ Compensation Carrier.” • CARC 20– “This injury/illness is covered by the liability carrier.” • CARC 21-- “This injury/illness is the liability of the no-fault carrier.”	X	X	X	X			X		
8984.5.8.1	The MACs and shared systems shall ensure that the new Remittance Advice Remark Code (RARC) - N728 – (when CARC 19 is used) - is applied to outbound 835 Electronic Admittance Advices (ERAs) and 837 crossover claims when denying claims due to an ORM indicator of “Y” on an open Workers’ Compensation Insurance (“E” MSP Code) record. The definition of this RARC is as follows:	X	X	X	X			X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• N728: A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. (**NOTE**: To be used with Group Code PR.)									
8984.5.8.2	The MACs and shared systems shall ensure that the new RARC N725 (when CARC 20 is used) is applied to outbound 835 ERAs and 837 cross over claims when denying claims due to an ORM indicator of "Y" on an open Liability Insurance ("L" MSP Code) record. The definition of this RARC is as follows: • N725: A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. (NOTE: To be used with Group Code PR.)	X	X	X	X			X		
8984.5.8.3	The MACs and shared systems shall ensure that the new RARC N727 (when CARC 21 is used) is applied to outbound 835 ERAs and 837 crossover claims when denying claims due to an ORM indicator of "Y" on an open Auto/No-Fault Insurance ("D" MSP Code) record. The definition of this RARC is as follows: • N727: A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis. (NOTE: To be used with Group Code PR.)	X	X	X	X			X		
8984.5.9	As part of their denial of claims due to workers' compensation ORM, the MACs shall generate the new Medicare Summary Notice (MSN) message 21.33 on their communications to beneficiaries. MSN 21.33 reads as follows: "This claim was denied. Your workers' compensation insurance	X	X	X	X			X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	plan has the on-going responsibility for medicals (ORM). Your workers' compensation insurance plan is responsible for paying this claim." Spanish,21.33 – "El reclamo fue denegado. Su seguro de compensación al trabajador aún es responsable del pago de los gastos médicos (ORM). Por lo tanto, debe pagar este reclamo."									
8984.5.9.1	As part of their denial of claims due to liability insurance (including self-insurance) ORM, the MACs shall generate the new MSN message 21.34 on their communications to beneficiaries. MSN message 21.34 reads as follows: "This claim was denied. Your liability insurance plan has the on-going responsibility for medicals (ORM). Your liability insurance plan is responsible for paying this claim." Spanish, 21.34 – ". El reclamo fue denegado. Su seguro de responsabilidad civil aún es responsable del pago de los gastos médicos (ORM). Por lo tanto, debe pagar este reclamo."	X	X	X	X			X		
8984.5.9.2	As part of their denial of claims due to no-fault insurance ORM, the MACs shall generate the new MSN message 21.35 on their communications to beneficiaries. MSN message 21.35 reads: "This claim was denied. Your no-fault insurance plan has the on-going responsibility for medicals (ORM). Your no-fault insurance plan is responsible for paying this claim." Spanish, 21.35–" El reclamo fue denegado. Su seguro de auto/sin parte culpable aún es responsable del pago de los gastos médicos (ORM). Por lo tanto, debe pagar este reclamo."	X	X	X	X			X		
8984.5.10	MACs and shared systems shall only apply the prompt payment rules for liability insurance, no-	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	
	fault insurance and workers' compensation, if the ORM indicator on the MSPD screen equals a "space," which means ORM does not exist for this MSP record.									
8984.5.11	MACs and shared systems shall not allow or make Medicare payments on open ORM occurrences that contain an ORM indicator of "Y," unless the Claim Adjustment Reason Codes (CARC) on the claim permits Medicare to make a payment as identified in 8984.11.1.	X	X	X	X	X	X	X		
8984.5.11.1	MACs and shared systems shall make a Medicare payment for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; e.g., benefits exhausted or benefits no longer covered due to state imposed limits): • Any of the following CARCs are found on the ORM claim : 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 204, 242, 256, B1 (if a Medicare covered visit), B14, and • The service is covered and payable by Medicare.	X	X	X	X	X	X	X		
8984.5.11.2	The MACs and the shared systems shall make a payment, as appropriate, for those services related to diagnosis codes associated with the ORM MSP auxiliary record when the ORM record is terminated (i.e., claim's service date falls outside the termination date on the MSP auxiliary record) or deleted.	X	X	X	X	X	X	X		
8984.5.12	FISS shall ensure that its current screen-scraping routines used for creating "I" records will not, in any way, modify already existing MSP D, E, or L records having an ORM indicator of "Y."					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8984.5.13	CWF shall ensure that error code 68XX may be overridden by MACs and shared systems as follows: • Allow the 68xx to be entered in the claim header if applicable to the entire claims on which MSP NGHP diagnosis codes do not apply; or • Allow for individual claim service lines on which MSP NGHP diagnosis codes do not apply to be overridden with an "N." (**NOTE:** In these cases, CWF shall not apply the line level override to the entire claim but only to the identified claim service detail lines.)								X	BDS
8984.5.14	The shared systems, A/B MACs (B), and DME MACs shall allow for the override of payable lines with override code "N." **NOTE**: There maybe contractor maintenance to add new error code to CW screen.		X		X		X	X		
8984.5.15	A/B MACs (A, HHH) and shared system shall allow for the 68xx code to be entered in the claim header when: • The override applies to the entire claim; and • The diagnosis code on the claim is not related to the MSP occurrence.	X		X		X				
8984.5.15.1	Additionally, the shared system shall allow the claim to be overridden with code "N" at the claim or line level when the diagnosis code is not related, as will happen for outpatient-related facility claims.					X				
8984.5.15.2	The A/B MACs (A, HHH) and shared systems shall input an "N" on the "001" Total Revenue Charge line of the claim if the claim is to be allowed to pay.	X		X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8984.5.16	In reopening or claim appeal situations where the appellant or individual initiating the reopening is stating that ORM no longer applies due to benefits exhaustion, MACs shall continue to follow their current procedures for determining sufficiency of the information received as a basis for overturning or paying the claim at issue.	X	X	X	X					
8984.5.16.1	If MAC appeals or claims staff obtain an itemized schedule of payments from a third party payer (ORM entity) that confirms exhaustion of available benefits as of a specified date, these individuals, together with internal MSP staff, shall take the following steps, as applicable: • Appeals or claims staff shall contact your internal MSP personnel who regularly submit ECRS requests to the BCRC to request that they alert the BCRC that they have received documentation confirming exhaustion of benefits for a given MSP ORM occurrence. • MSP staff shall initiate an ECRS Assistance Request using existing action codes that will alert the BCRC that the benefits tied to a given MSP ORM occurrence have been exhausted. (**NOTE**: A third party payer letter indicating benefits were exhausted without an accompanying itemized schedule of payments is ***not*** sufficient evidence for initiating an alert to the BCRC via the ECRS process.)	X	X	X	X					
8984.5.16.2	When submitting an ECRS Assistance Request to the BCRC, the MACs shall indicate this relates to an open MSP record with ORM indicator=Y and shall provide the following: • The name of the third party payer; and • A request to apply a termination date to the record that equals the benefits exhaustion date, in accordance with the third party payer's itemized schedule of payment	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	notice.									
8984.5.16.3	At CMS's direction, the BCRC shall take the indicated action specified by the MACs via the ECRS Assistance Request.									BCRC
8984.5.16.4	From a claims processing scenario, should MACs obtain an incoming claim that contains PR*119 (benefits exhaustion) or any of the CARCs specified in 8984.11.1, they shall pay primary, in accordance with current procedures. **(NOTE:** MACs shall not initiate ECRS Assistance Requests to the BCRC in these situations.)	X	X	X	X					
8984.5.17	The CWF copy book shall be updated to show the MSP NGHP ORM indicator and the valid one (1) byte field indicator values of "Y" or a space.								X	BDS
8984.5.18	NGD shall modify its systems to accept and allow the 1 byte MSP NGHP ORM indicator (Valid values: Y or a space).								X	BDS, NGD
8984.5.19	1-800 Medicare call scripts shall be updated with the new ORM policy and procedures									1-800 Medicare
8984.5.20	**NOTE:** CMS will issue a separate instruction for a different systems release to enable MACs to make a residual secondary payment in ORM situations (where MSP D, E, or L records contain an ORM indicator of "Y") when an RRE's payment of a claim is incomplete. Until that time, when MACs need to make a residual secondary payment, they shall following existing procedures, as applicable. (for some this includes requesting permission from their CMS COR to pay the claim outside CWF)	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8984-05.21	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

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: N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Karen Ochab, 410-786-6406 or karen.ochab@cms.hhs.gov ((Brian Pabst; brian.pabst@cms.hhs.gov; 410-786-2487); (Rick Mazur; richard.mazur2@cms.hhs.gov; 410-786-1418))

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

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

Table of Contents
(Rev.114 , Issued:09-18-15)

20 - Sources That May Identify Other Insurance Coverage

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

In the past, MACs used the following guidelines to identify claims for otherwise covered services when there was a possibility that payment had been made or can be made by an insurer primary to Medicare.

- Information is received from a provider, physician, supplier, the beneficiary, contractor operations (e.g., medical or utilization review), other non-Medicare counterparts, or any other source indicating Medicare has been billed for services when there is a possibility of payment by an insurer that is primary to Medicare;

- The health insurance claim form shows that the services were related to an accident (i.e., the diagnosis is due to trauma) or occupational illness (e.g., black lung disease) or were furnished while the beneficiary was covered by a GHP or an LGHP which is primary to Medicare;

- The CWF indicates a validity indicator value of "Y" showing the presence of MSP coverage;

- Information in a *MAC*'s records indicate a primary payer;

- There is an indication that the beneficiary previously received benefits or had a claim pending for insurance that is primary to Medicare. The MAC assumes, in the absence of information to the contrary, that this coverage continues.

- Medicare has not made payment and the MAC is asked to endorse a check from another insurer payable to Medicare and some other entity. The MAC returns the check to the requester and advises that the insurer pay primary benefits to the full extent of the GHP's primary obligation. (The MAC follows the recovery instructions in Chapter 7, "Contractor MSP Recovery Rules," and Chapter 3 of Pub. 100-6, the Medicare Financial Management Manual, if the check relates to services for which Medicare paid primary.) As necessary, it follows up with the provider, physician, supplier, beneficiary, and/or attorney to find out if the beneficiary receives payment from the GHP;

- Medicare receives or is informed of a request from an insurance company or attorney for copies of bills or medical records. Providers are instructed to notify the COBC promptly of such requests and to send a copy of the request. If the request is unavailable, providers are to provide full details of the request, including the name and HICN of the patient, name and address of the insurance company and/or attorney, and date(s) of services for which Medicare has been billed or will be billed;

- Where a GHP's primary coverage is established because the individual forwards a copy of the GHP's explanation of benefits and the individual meets the conditions in Chapter 1, §10, the MAC processes the claim for secondary benefits; or

- Claim is billed as Medicare primary and it is the first claim received for the beneficiary and there is no indication that previous MSP development has occurred.

- *The CWF MSP auxiliary detail screen contains a 1-byte Ongoing Responsibility for Medicals (ORM) indicator, where the value is "Y," which indicates that a Section 111 Medicare, Medicaid, and S-CHIP Extension Act (MMSEA) Responsible Reporting Entity (RRE) has accepted ongoing responsibility for a particular liability, no-fault, and workers' compensation incident.* ***NOTE:*** *Further details regarding ORM, the new 1-byte ORM indicator on CWF, and how to handle and process claims based on the value present within the CWF ORM field are in Section 2.4 below.*

Other insurance that may be primary to Medicare is shown on the institutional claim as follows:

- A Value Code of 12, 13, 14, 15, 16, 41, 42, 43, 44, or 47;
- An Occurrence Code of 01, 02, 03, 04, 05, 24, 25, or 33;
- A Condition Code of 02, 05, 06, 08, 77, or D7;
- A trauma related diagnosis code is shown; or
- Another insurer is shown as the primary payer on line A of Payer Name .

Other insurance that may be primary to Medicare is shown on the Form CMS-1500 claim form when block 10 is completed. A primary insurer is identified in the "Remarks" portion of the bill.

With the installation of the *Benefits Coordination & Recovery Center (BCRC)*, the MAC uses ECRS to advise the *BCRC* of the possibility of another insurer, and awaits *BCRC* development before processing the claim.

20.1 - Identification of Liability and No-Fault Situations

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

MACs must be alert to identify liability and no-fault situations. However, *MACs shall* use the indicators listed below to identify claims in which there is a possibility that payment can be made by a liability insurer:

- The *MAC* receives information from a physician, a provider, a supplier, a beneficiary, the contractor's internal operations (e.g., medical or utilization review) or those of the contractor's non-Medicare counterpart, another *MAC*, or any other source, indicating Medicare has been billed for services when there is a possibility of payment by a liability insurer;
- The health insurance claim shows that the services were related to an accident;
- The claim shows a complementary insurer as an insurance organization that does not issue health insurance;

- The *MAC* or the RO is asked to endorse a check from another insurer payable to Medicare and the beneficiary;

- The *MAC* receives or is informed of a request from an insurance company or from an attorney for copies of bills or medical records;

- There is indication that a liability insurer previously paid benefits related to the same injury or illness or that a claim for such benefits is pending. There is no need to investigate this lead, however, if the *MAC's* records show that the services were furnished after the date of a final liability insurance award or settlement for the same injury or illness, and the award or settlement does not make provisions for payments for future medical services;

- The A/B MAC receives an ambulance claim indicating that trauma related services were involved;

- The CWF HIMR screen shows that an auxiliary record has been established for a known liability situation*; and*

- *A "Y" ORM indicator is present on the MSP auxiliary file for a liability, no-fault or workers' Compensation record. (See Section 20.4 for more information.)*

In addition, A/B MACs (A*, HHH*) use the following indicators on the institutional claim to identify the possibility of payment by a liability insurer.

- Another insurer is shown as Payer on line A of Payer Name or a primary payer is identified in "Remarks" on the bill;

- Occurrence Codes 01 through 03 or 24 are shown for Occurrence Span Code;

- Codes 1 or 2 are shown as the Type of Admission;

- Code 14 is the Value Code shown;

- Condition Codes 10, 28, 29, D7, and D8 are shown; *and*

- Remarks are shown.

For A/B MACs (B), completion of block 10 on the Form CMS-1500 indicates another insurer may be involved. The MAC receiving a claim on which there is an indication of liability or no-fault coverage submits an MSP record to CWF using the service date of the claim as the effective date of MSP and a validity indicator of "I." This causes CWF to generate an investigation record to the COBC to ascertain the correct MSP period. The BCRC develops the appropriate MSP dates with the insurer or beneficiary, or other party, as appropriate, and transmits a CWF maintenance transaction to reflect the proper MSP period.

Upon receipt of the CWF data, the MAC adjudicates the claim per Chapter 7, §50.4.

20.2 - Identify Claims with Possible WC Coverage

(Rev.114, Issued: 09-18-15, Effective:, 07-01-15 Implementation:07-06-15, Design and Pre- Coding (CWF, FISS, and VMS); 10-05-15- Full implementation (CWF, FISS, MCS, and VMS)The MAC must identify claims with possible WC coverage. If the provider submitting the claim provides information that clearly indicates the services will not be covered by WC, the MAC pays the claim. Such indications may be:

- A denial letter from the WC carrier*;*
- A supplemental statement *is included* in "remarks" on the claim form*;*
- Form CMS-1450 claims *contain* an occurrence code 24 (insurance denied) and the date of denial *is reported in* FLs 28-32*;*
- For A/B MACs (B), completion of block 10 on the Form CMS-1500 indicates another insurer may be involved*;*
- The beneficiary previously received WC for the same condition*;*
- The Common Working File's MSP auxiliary record contains a "Y" validity indicator and an MSP code ("E" or "H") that indicates the beneficiary is entitled to Black Lung benefits*; and*
- *A "Y" ORM indicator is present on the MSP auxiliary file for a liability, no-fault or Workers' Compensation record. (See Section 20.4 for more information.)*

Where it appears that the services may be compensatory by WC, the MAC receiving a claim on which there is an indication of WC coverage, submits an MSP record to CWF using the service date of the claim as the effective date of MSP and a validity indicator of "U." This causes CWF to generate an investigation record to the BCRC to ascertain the correct MSP period. The BCRC develops the appropriate MSP dates with the insurer or beneficiary, or other party, as appropriate, and transmits a CWF maintenance transaction to reflect the proper MSP period.

Upon receipt of the CWF data, the MAC adjudicates the claim to a final disposition.

20.4 - Identification of On-Going Responsibility for Medicals (ORM) in Liability, No-Fault, and Workers' Compensation Situations

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

20.4.1 - Background Regarding ORM for MACs

(Rev.114, Issued: 09-18-15, Effective:, 07-01-15 Implementation:07-06-15, Design and Pre- Coding (CWF, FISS, and VMS); 10-05-15- Full implementation (CWF, FISS, MCS, and VMS)*Pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) in 2007, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who*

are or were Medicare beneficiaries to the Centers for Medicare & Medicaid Services (CMS). The applicable plan is the "Responsible Reporting Entity" (RRE) for this process.

The required reporting includes instances where the RRE has assumed ongoing responsibility for medicals (ORM) associated to specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date, and this information is uploaded to Common Working File (CWF) by the BCRC.

***NOTE:** A Section 111 ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.*

20.4.2 – Policy regarding ORM:

***(Rev.114, Issued: 09-18-15, Effective:, 07-01-15 Implementation:07-06-15, Design and Pre- Coding (CWF, FISS, and VMS); 10-05-15- Full implementation (CWF, FISS, MCS, and VMS)**Pursuant to §1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.*

Systems Changes Made and MAC Contractor Operational Responsibilities

*An ORM indicator field was added to CWF that will be populated with two values: "Y," which denotes that ORM responsibility assumed/exists, or a "space," which signifies that an RRE has not assumed ORM. Please note that where ORM is reported, the ORM indicator on associated MSP auxiliary records remains a "Y" even where the ORM is subsequently terminated. **Important:** A "Y" ORM indicator value denotes that the ORM existed for a particular period of time (not necessarily that it currently exists).*

All MACs shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSP D (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. After comparing the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record, all MACs shall deny claims where the 1-byte ORM indicator on the MSPD screen equals "Y" and the diagnosis code(s) match(es) (or match(es) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim (s) be reprocessed.

MACs shall deny payment for claims with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information

that the policy limit has been exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

NOTE: *Unless otherwise mentioned, MACs shall assume that normal MSP claims processing requirements (e.g., checking claim service dates against MSP auxiliary record effective and termination dates; matching diagnosis codes on the claim against those on CWF (including the family of diagnosis codes policy); and affording appeal rights on MSP claims) apply.*

The MACs and shared systems shall only apply the prompt payment rules for liability insurance and the prompt payment rules for no-fault insurance and workers' compensation if the ORM indicator on the MSPD screen equals a "space," which means ORM does not exist for this MSP record.

Special Circumstance for MACs

While it may not occur frequently, there may be situations where an RRE will continue to assume ORM for a particular injury/illness and at the same time have a lump sum type settlement or other payment with respect to other alleged injuries/illnesses for the same date of accident/injury/loss. Consequently, it is possible that CWF could have both an open ORM occurrence as well as an open Medicare Set-Aside (MSA) occurrence, just not for the same diagnosis code(s). Therefore, the MACs shall determine which record on CWF is applicable in order to process the claim appropriately. For example, the MAC may review the diagnosis codes on the claim and compare them to the diagnosis codes on the open ORM occurrence and the MSA occurrence, as well as any other open CWF occurrences that fall within the date perimeters being reviewed, to find the correct match for MSP claims processing purposes.

Residual Payments on Claims

Until future instructions are issued, MACs shall follow existing procedures when they need to make a residual secondary payment in ORM situations (where an MSP D, E, or L records contain an ORM indicator of "Y," but the primary payer did not make complete payment on the claim). For example, they may need to request permission from their CMS Contracting Officer Representative (COR) to pay the claim outside of CWF.

20.4.3 - Operationalizing ORM for Liability, No-Fault and Workers' Compensation Situations CWF Utilization Error Codes Returned to MACs

(Rev.114, Issued: 09-18-15, Effective:, 07-01-15 Implementation:07-06-15, Design and Pre- Coding (CWF, FISS, and VMS); 10-05-15- Full implementation (CWF, FISS, MCS, and VMS)*The MACs and shared system maintainers shall accept and process a revised MSP HUSC transaction and the 03 trailer response from CWF that will now include the 1- byte ORM indicator with valid values.*

The MACs and shared systems shall accept and process the three (3) new overrideable utilization error codes (68xx) when returned with an 08 trailer. These 3 new error codes will be for Liability (including self-insurance), No-Fault, and Workers' Compensation records on CWF. These error codes will be:

6816 - -"No-Fault record exists with a valid (Y) ORM indicator. MAC payment not allowed."

6817--"Workers' Compensation record exists with a valid (Y) ORM indicator. MAC payment not allowed. "

6818 - -"Liability record exists with a valid (Y) ORM indicator. MAC payment not allowed."

When determining whether to apply any of the above 3 new error codes, as applicable, CWF shall take the following steps by referencing the MSP auxiliary file:

(1) Validate that the ORM indicator on the open MSP ORM record on CWF equals "Y"; and

(2) Determine if the diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the open MSP ORM record on CWF.

If CWF determines that the new 68xx error codes apply, it shall return them to the A/B MAC or DME MAC with disposition code equal to a UR. In addition, when CWF returns the new 68xx edits to the MACs, CWF shall also return a trailer 39 to the MACs to make certain that, as applicable, they can determine to which service detail line the 68xx edit applies.

Additionally, CWF shall ensure that error code 68xx may be overridden by MACs and shared systems as follows:

- *Allow the 68xx to be entered in the claim header if applicable to the entire claims on which MSP NGHP diagnosis codes do not apply; or*
- *Allow for individual claim service lines on which MSP NGHP diagnosis codes do not apply to be overridden with an "N." (NOTE: In these cases, CWF shall not apply the line level override to the entire claim but only to the identified claim service detail lines.)*

The MACs and shared systems shall accept the three (3) new overrideable utilization error codes (68xx) when returned via the 08 trailer.

When applying the 68xx editing logic to the applicable Liability, No-Fault, or Workers' Compensation record, CWF shall ensure that open NGHP MSP records with a "Y" ORM indicator are given precedence over another NGHP record, where all other variables except the ORM indicator match.

MAC Claims Processing Instructions

When the A/B MACs (A, HHH) and shared systems deny a claim, with an open ORM occurrence (with an indicator of "Y"), they shall create a "22" No Pay Code in the appropriate claim line and header of their HUIP, HUOP, HUHH, HUHC claim before sending it to CWF.

When the A/B MACs (B) and DME MACs and shared systems deny a claim, with an open ORM occurrence (with an indicator of "Y"), they shall create a "22" Payment Denial indicator in the HUBC and HUDC claim header transactions before sending them to CWF. In addition, they shall create a "22" in the claim detail pay process field before sending the claim to CWF.

Specified CARCs to Use In Denying Claims Due to ORM

The MACs and shared systems shall include the existing Claim Adjustment Reason Codes (CARCs) 19, 20, and 21, as applicable, on the outbound 835 and the 837 cross over claims when denying claims due to ORM, together with CAS Group Code PR. These three (3) CARC codes are defines as follows:

CARC 19 -- "This is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier." [Associated Remittance Advice Remark Code (RARC) is N728.]

CARC 20 – "This injury/illness is covered by the liability carrier." [Associated RARC=N725.]

CARC 21 – "This injury/illness is the liability of the no-fault carrier." [Associated RARC=N727.]

In conjunction with the three (3) CARCs mentioned above, the MACs and shared systems shall make certain that the three (3) new Remittance Advice Remark Codes (RARCs) for a D, E, or L records—namely, N725, N727, and N728, which may be referenced on the Washington Publishing Company web site for definition purposes—are matched up and applied to the corresponding CARC codes for these same types of records, as appropriate.

These 3 new RARC codes shall be applied to the outbound 835 Electronic Admittance Advices (ERAs) and 837 crossover claims when denying claims due to an ORM indicator of "Y" on an open NGHP MSP record.

***NOTE: Additionally,** three (3) new Medicare Summary Notices (MSN) messages have been developed specifically for the three (3) types of NGHP MSP ORM types of records. These will be communicated elsewhere in the IOM.*

Exceptions to Denial of Claims Policy Due to ORM

*The MACs and shared systems shall **not** allow or make Medicare payments on open ORM occurrences that contain an ORM indicator of "Y," unless the Claim Adjustment Reason Codes (CARCs) on the claim—specifically, CARCs 26,27,31,32,35,49,50,51,53, 55, 56, 60,96, 119, 149, 166, 167, 170, 184, 200, 204, 242, 256, B1 (if a covered Medicare visit), and B14—permit Medicare to make a payment.*

The MACs and the shared systems shall make a payment, as appropriate, for those services related to diagnosis codes associated with the ORM MSP Auxiliary record when the claim's service date falls outside the termination date on the MSP auxiliary record or deleted.

Possible MAC Review of Suspended Claims

MACs shall still be required, on occasion and part of normal process/procedures, to make determinations on claims that are suspended for review with an associated ORM occurrence if:

(1) The ORM indicator on the MSPD screen equals "Y"; and

(2) The diagnosis codes on the NGHP claim match the diagnosis codes (or match within the family of diagnosis codes) on the MSP ORM record on CWF.

Reopenings and Appeals for ORM Situations

In reopening or claim appeal situations where the appellant or individual initiating the reopening is stating that ORM no longer applies due to benefits exhaustion, MACs shall continue to follow their current procedures for determining sufficiency of the information received as a basis for overturning or paying the claim at issue.

If MAC appeals or claims staff obtain an itemized schedule of payments from a third party payer (ORM entity) that confirms exhaustion of available benefits as of a specified date, these individuals, together with internal MSP staff, shall take the following steps, as applicable:

- *Appeals or claims staff shall contact your internal MSP personnel who regularly submit ECRS requests to the BCRC to request that they alert the BCRC that they have received documentation confirming exhaustion of benefits for a given MSP ORM occurrence.*

- *MSP staff shall initiate an ECRS Assistance Request using existing action codes that will alert the BCRC that the benefits tied to a given MSP ORM occurrence have been exhausted.*

*(**NOTE:** A third party payer letter indicating benefits were exhausted without an accompanying itemized schedule of payments is not sufficient evidence for initiating an alert to the BCRC via the ECRS process.)*

Submitting ECRS Assistance Requests to the BCRC For ORM-Related Matters

When submitting the ECRS Assistance Request to the BCRC, the MACs shall indicate this relates to an open MSP record with ORM indicator=Y and shall provide the following:

- *The name of the third party payer; and*
- *A request to apply a termination date of the record that equals the benefits exhaustion date, in accordance with the third party payer's itemized schedule of payment notice.*

*From a claims processing scenario, should MACs obtain an incoming claim that contains PR*119 (benefits exhaustion) or any of the CARCs specified in CR 8821 they shall pay primary, in accordance with current procedures.*

*(**NOTE:** MACs shall not initiate ECRS Assistance Requests to the BCRC in these situations.)*

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

30.3 - MSP Auxiliary File Errors

(Rev.114, Issued: 09-18-15, Effective:, 07-01-15 Implementation:07-06-15, Design and Pre- Coding (CWF, FISS, and VMS); 10-05-15- Full implementation (CWF, FISS, MCS, and VMS)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 HIC Number	Valid HIC Number
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 intermediary/ carrier - Medicare Secondary-COB investigate, N -No MSP coverage
SP21	Invalid MSP Code	A=Working Aged B=ESRD C= Conditional Payment D= No Fault E= Workers' Compensation F= Federal G= Disabled H= Black Lung I= Veteran's Administration L= Liability
SP22	Invalid Diagnosis Code 1-5	Valid Diagnosis Code
SP23	Invalid Remarks Code 1-3	See the Valid Remarks Codes

Error Code	Definition	Valid Values
		Below
SP24	Invalid Insurer Type	See definitions of Insurer Type codes below
SP25	Invalid Insurer Name An SP25 error is returned when the MSP Insurer Name is equal to one of the following: Supplement Supplemental Insurer Miscellaneous CMS Attorney Unknown None N/A Un Misc NA NO BC BX BS BCBX Blue Cross Blue Shield Medicare	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; : Insurer Name must be present if Validity Indicator = Y
SP26	Invalid Insurer Address 1 and/or Address 2	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP27	Invalid Insurer City	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :
SP28	Invalid Insurer State	Must match U.S. Postal Service state abbreviation table.
SP29	Invalid Insurer Zip Code	If present, 1st 5 digits must be numeric. If foreign country "FC" state code, the nine positions may be spaces.
SP30	Invalid Policy Number	Alphabetic, Numeric, Space, Comma, & - ' . @ # / ; :

Error Code	Definition	Valid Values
SP31	Invalid MSP Effective Date (Mandatory)	Non-blank, non-zero, numeric, number of days must correspond with the particular month. MSP Effective Date must be less than or equal to the current date.
SP32	Invalid MSP Termination Date	Must be numeric; may be all zeroes if not used; if used, date must correspond with the particular month.
SP33	Invalid Patient Relationship	The following codes are valid for all MSP Auxiliary occurrences regardless of accretion date: 01 = Self; Beneficiary is the policy holder or subscriber for the other GHP insurance reflected by the MSP occurrence **–or-** Beneficiary is the injured party on the Workers Compensation, No-Fault, or Liability claim 02 =Spouse or Common Law Spouse 03 = Child 04 = Other Family Member 20 = Life Partner or Domestic Partner The following codes are only valid on MSP Auxiliary occurrences with accretion dates **PRIOR TO 4/4/2011**: 05 = Step Child 06 = Foster Child 07 = Ward of the Court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ donor

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

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

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

Error Code	Definition	Valid Values
SP67	Incoming term date is less than posted term date for Provident	
SP72	Invalid Transaction attempted	A HUSP add transaction is received from a FI or Carrier (non-COBC) with a validity indicator other than "I."
SP73	Invalid Term Date/Delete Transaction	A *MAC* attempts to change a Term Date on a MSP Auxiliary record with a "I" or "Y" Validity Indicator that is already terminated, or trying to add Term Date to "N" record.
SP74	Invalid cannot update "I" record.	A *MAC* submits a HUSP transaction to update/change an "I" record or to add an "I" record and a match MSP Auxiliary occurrence exists with a "I" validity indicator.
SP75	Invalid transaction, no Medicare Part A benefits	A HUSP transaction to add a record with a Validity Indicator equal to "I" (from an FI/carrier) or "Y" (from *BCRC*) with an MSP Type equal to "A," "B," "C," or "G" and the effective date of the transaction is not within a current or prior Medicare Part A entitlement period, or the transaction is greater than the termination date of a Medicare entitlement period.
SP76	MSP Type is equal to W (Workers' Compensation Medicare Set-Aside) and there is an open MSP Type E (Workers' Compensation) record.	
SP79	*A MAC attempts to create/enter a value in the ORM field on the incoming I HUSP record (makes sure that a MAC cannot update or overlay an ORM value in the ORM field).*	*Valid Values for the 1-byte ORM indicator on the CWF MSP Detail screen (MSPD) are: Y (Yes) or a space.* *A "Y" ORM indicator value denotes that the ORM existed for a period of time, not necessarily that it currently exists. An ORM indicator of a "space" implies that an RRE has not assumed ORM.*
SP80	*A MAC attempted to create/enter an ORM indicator on an MSP record other than a D,*	*The 1- byte ORM indicator (valid values = Y or a space)*

Error Code	Definition	Valid Values
	E, and L.	*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."*

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

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

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

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

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

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

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

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