CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 116	**Date: November 24, 2015**
	Change Request 8486

Transmittal 111, dated May 8, 2015, is being rescinded and replaced by Transmittal 116, dated November 24, 2015, to add the term "prior" to the Summary of Changes, the Background, the Policy sections and BRs 8486.2, 8486.2.1, 8486.4, 8486.5, 8486.5.1, 8486.5.2, 8486.5.3, 8486.6, 8486.6.1, and modify one section of the IOM. We are re-communicating this transmittal, because we inadvertently sent out transmittal number 111 instead of 116. We apologize for any inconvenience. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated on December 3, 2015. The Transmittal Number, Date of Transmittal and all other information remain the same. This instruction may now be posted on the Internet.

SUBJECT: Instructions on Using the Claim Adjustment Segment (CAS) for Medicare Secondary Payer (MSP) Part A CMS-1450 Paper Claims, Direct Data Entry (DDE), and 837 Institutional Claims Transactions

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to alert the Medicare contractors about changes being made to the Medicare Part A provider DDE process. These changes will impact provider electronic MSP claims submission. All Part A Medicare Administrative Contractors (MACs) and their associated shared system shall use the CAS information included on incoming CMS-1450 (paper) claims, DDE claim submissions, and 837 Institutional Claims, including payment information from all payers when there is one or more payer(s) prior to Medicare, when processing MSP claims.

EFFECTIVE DATE: January 1, 2016 - for claims received on or after
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015 - for Requirements and Design; January 4, 2016 - Full Implementation

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
R	5/40.7.3.2 - Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format

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: 116	Date: November 24, 2015	Change Request: 8486

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IMPLEMENTATION DATE: October 5, 2015 - for Requirements and Design; January 4, 2016 - Full Implementation

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to alert the Medicare contractors about changes being made to the Medicare Part A provider DDE process. These changes will impact provider electronic MSP claims submission. When providers receive an 835 remittance advice from an insurer that pays prior to Medicare, the 835 shows all claim adjustments and payment amounts associated with the prior payer's claim determination. Adjustments found in the 835 Claim Adjustment Segment (CAS), which are more commonly termed "CAS adjustments," identify amounts that are subtracted from the charges. The Claims Adjustment Reason Code (CARC) associated with the CAS adjustment explains what factors caused the payer not to pay 100 percent of the charges. The 835 ERA prior payer information, including CAS claim adjustments, is then used when the provider submits an MSP claim to Medicare. Currently, the DDE process does not allow providers to report CAS adjustments from other prior payers. For this reason, providers must submit their Part A electronic MSP claims to Medicare using the 837 Institutional Claim format, which allows for reporting of claim adjustment amounts. This CR updates the DDE process to allow for claim adjustments so providers can also submit Part A MSP claims using the DDE process.

B. Policy: All Part A Medicare Administrative Contractors (MACs) and their associated shared system shall use the CAS information included on incoming CMS-1450 (paper) claims, DDE claim submissions, and 837 Institutional Claims, including payment information from all payers when there is one or more prior payer(s) to Medicare, when processing MSP claims.

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	HHH	MAC	FISS	MCS	VMS	CWF	
8486.1	The contractors and shared system shall update the DDE screens to allow for mapping of up to two (2) iterations for CMS-1450 (paper), DDE, and 837 Institutional claims submissions for both the claim level adjustments in the CAS, and the Coordination of Benefits (COB) Payer Paid Amount (AMT) reported in the 837 2320 loop. (**NOTE**: The COBA process shall accept these changes as received on the 837 COB flat file.)	X		X		X				COBA
8486.1.1	The contractors shall key Standard Code information received from providers submitting CMS-1450 (paper) claims on MSP claims into the newly created DDE fields. **NOTE:** When Standard Codes are not available from a prior payer(s) paper/proprietary remittance advice(s), the provider must translate the proprietary adjustment/denial edit messages to standard codes.	X		X						
8486.1.2	The contractors shall apply the edit created in BR 8486.3.1 when Standard Code information is not received with the claim.	X		X						
8486.1.3	The contractors shall instruct providers submitting claims via DDE to key the CAS information in the newly created DDE fields.	X		X						
8486.2	The contractors and shared system shall create a new field to capture the prior payer's paid date for DDE and CMS-1450 (paper) claims.	X		X		X				
8486.2.1	The contractors and shared system shall create edits to validate the CAS codes based on the prior payer's paid date field.	X		X		X				
8486.3	The contractors and shared system shall update the claims processing system to process MSP claims using the CAS and AMT information with the same logic and rules for the crossover process as found in CR 6426.	X		X		X				
8486.3.1	The contractors and shared system shall create a Reason Code edit for CMS-1450 (paper) and DDE claims to require CAS information when Medicare is the secondary payer. **NOTE:** This edit shall be set to Return To Provider (RTP) as necessary when this information is not available on the claim.	X		X		X				
8486.4	The contractors and shared system shall continue	X		X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	to follow and update system logic created in CR6426 to allow for the possibility of up to two (2) payers prior to Medicare being considered on incoming claims.									
8486.5	When there is more than one payer prior to Medicare, the shared system shall send the lowest Obligated to Accept as Payment in Full (OTAF) amount from all prior payers to Medicare, based on the Group Code CO CAS segment adjustment calculations **or** the VC 44 OTAF amounts, to MSPPAY for MSP payment calculation if the OTAF amount is less than the provider charges.					X				
8486.5.1	When there is more than one payer prior to Medicare, and if the CAS Group Code CO calculated OTAF adjustment amounts and the VC 44 OTAF amount, as found in the Value Information segment, appear on the claim, the shared system shall compare the CAS calculated OTAF amounts and the VC 44 OTAF amount, which must be greater than zero.					X				
8486.5.2	The shared system shall then take the following action: Send the lowest of all calculated CAS CO Group Code OTAF amounts, or VC 44 OTAF amount(s), to MSPPAY when there is more than one payer prior to Medicare; this is to occur only if the OTAF amount is less than the provider charges. **NOTE:** For multiple prior payers, if only one Value Code 44 is reported on the claim, then at least one of the calculated CAS CO amounts must match the Value Code.					X				
8486.5.3	The shared system shall return the claim to the provider (RTP) if none of the prior payer(s) calculated CAS CO amount(s) match(es) any of the VC 44 OTAF amount(s) found on the claim.					X				
8486.5.4	The contractors and shared system shall not consider the CAS CO group code, and accompanying adjustment amounts, when determining the OTAF if any of the following	X		X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARCs are reported with CAS Group Code CO on an incoming MSP claim: 15, 17, 29, 58, 61, 95, 112, 117, 125, 130, 150, 163, 164, 179, 181, 182, 197, 210, 223, B4, B5, B7, B8, B10, B16.									
8486.6	The contractors and shared system shall update their systems for CMS-1450 (paper) and DDE claims to add the prior payers adjustment amounts, found in the CAS, to the prior payer(s) payment amount(s) when any one of the listed CARCs are submitted on a claim: 15, 17, 29, 58, 61, 95, 112, 117, 125, 130, 150, 163, 164, 179, 181, 182, 197, 210, 223, B4, B5, B7, B8, B10, B16.	X		X		X				
8486.6.1	When there is more than one payer prior to Medicare, the shared system shall combine and send all the prior payer(s) paid amounts as one paid amount to MSPPAY.					X				
8486.6.2	The contractors and shared system shall send the adjusted payment amount reflected as the "paid amount" on the claim when transmitted to CWF for normal processing. **NOTE:** The adjusted payment amount is the incoming payment amount(s) or the apportioned incoming payment amount(s) plus the CAS CARC adjustment(s).	X		X		X				
8486.6.3	The contractors and shared system shall use the CARC OA23 on the outbound 835 to indicate the impact of the prior payer(s) adjudication including payments and/or adjustments for each amount adjusted.	X		X		X				
8486.6.4	The contractors shall store the adjusted payment amount(s) in their claims processing systems.	X		X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8486.7	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		

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
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov (for institutional claims processing information), Matthew Klischer, matthew.klischer@cms.hhs.gov (for 837I information), Richard Mazur, Richard.Mazur2@cms.hhs.gov (for policy information)

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.116, Issued: 12-03-15)

40.7.3.2 - Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format

(Rev.116, Issued: 12-03-15, Effective: 01-01-16 for claims received on or after, Implementation: 10-05-15 for Requirements and Design; 01-04, 16 - Full Implementation)

Medicare's secondary payment for Part A MSP claims is based on:

1) Medicare covered charges, or the amount the provider is obligated to accept as payment in full (OTAF), *whichever is lower (in the case where there are multiple prior payers to Medicare the lowest OTAF is used unless the Medicare covered charges are lower);*

2) what Medicare would have paid as the primary payer; and

3) the primary payer(s) payment.

MSP policy also dictates what the shared systems and contractors must take into consideration in processing MSP claims. This includes adjustments made by the primary payer*(s)*, which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer*(s)* are reported in the Claims Adjustment (CAS) segments on the 835 electronic remittance advice (ERA). The provider must take the CAS segment adjustments found on the primary payer*(s)* remittance advice and report these adjustments on the 837 when sending the claim to Medicare for secondary payment. 837 claims transaction examples are cited below.

Example 1: A Medicare beneficiary visits a hospital *that* charges $10,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is primary to Medicare. The beneficiary's Medicare deductible had already been met. The provider participates under the primary payer's employer group health plan. The contract amount *(the OTAF* amount) is the same as Medicare's fee schedule amount of $8,000. The primary payer *(Payer 1)* ultimately pays $7,200 for the services. The service amounts are broken down:

Medicare Fee schedule Procedure *$8,000*

Charges $10,000

Payer 1 Allowed Amount *$8,000 (*not sent to MSPPAY)

Payer 1 *Contractual Amount* (OTAF) *$8,000*

Payer 1 Patient Co-Insurance @ 10% *$800*

Payer 1 Payment Amount *$7,200*

The *Value Code(s)* 44 OTAF amount is found in the *HI* segment *(BE qualifier)* on the *837 Institutional Claim (837-I)* and this amount is sent to MSPPAY. If the OTAF is not found in the *HI* segment *(BE qualifier)*, but there is a group code CO *(Contractual Obligation)* in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY. *In the case where there are multiple prior payers to Medicare, perform the calculation (the charge minus the CO amount) for each prior payer contractual amount and send the lowest calculated contractual amount as the OTAF amount to MSPPAY, if the OTAF amount is lower than the charges.*

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*10000*7200*800*12*07256000236520**1~

CAS*CO*45*2000~

CAS*PR*2*800~

Provider Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI

CAS*CO*45*2000~

CAS*PR*2*800~

AMT*D*7200~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC *CO* 45 adjustments – *$10,000 - $2,000 = $8,000.*

(NOTE: The allowed amount is shown *here* and is used for purposes of balancing the remittance advice.)

Since *the HI segment (BE qualifier)* did not contain OTAF, the CO adjusted amount in the CAS is used to determine the OTAF. OTAF amount equals *charges* minus CO group code adjustments – *$10,000 - $2,000 = $8,000*

Medicare Abbreviated 835 to Provider

CLP*200725638901*2*10000*800**MB*0725600110236520**1~

CAS*OA*23*9200~

Example 2: *A Medicare beneficiary visits a hospital that charges $10,000 for the services. The beneficiary is a working aged beneficiary with employer group plan insurance that is prior to Medicare. The beneficiary's spouse is also working with employer group plan insurance that is prior to Medicare. The beneficiary's Medicare deductible had already been met. The provider participates under both prior payers' employer group health plans. The contract amount (the OTAF amount) for one of the prior payers, is the same as Medicare's fee schedule amount of $8,000. You must combine both prior payers' payment amounts and send the total payment amount to MSPPAY. The prior payers ultimately pay $7,200 for the services. The service amounts are broken down:*

Medicare Fee schedule Procedure $8,000

Charges $10,000

Payer 1 Allowed Amount $9,000 (not sent to MSPPAY)

Payer 1 Contractual Amount (OTAF) $9,000

Payer 1 Patient Co-Insurance @ 30% $3,000

Payer 1 Payment Amount $6,000

Payer 2 Allowed Amount $8,000 (not sent to MSPPAY)

Payer 2 Contractual Amount (OTAF) $8,000

Payer 2 Patient Co-Insurance @ 10% $800

Payer 2 Payment Amount $1,200

The Value Code(s) 44 OTAF amount is found in the HI segment (BE qualifier) on the 837-I and this amount is sent to MSPPAY. If the OTAF is not found in the HI segment (BE qualifier), but there is a group code CO in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY. In the case where there are multiple prior payers to Medicare, perform the calculation (the charge minus the CO amount) for each prior payer and send the lowest calculated contractual amount as the OTAF amount to MSPPAY if lower than the charges. The Medicare covered charges or the OTAF amounts are never combined.

Medicare payment is calculated as follows:

1) *The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: $8,000 - $0 = $8,000*

2) *The gross amount payable by Medicare minus the primary payments: $8,000 - $7,200 = $800*

3) *The lowest obligated to accept payment in full minus the primary payment: $8,000 - $7,200 = $800*

4) *The obligated to accept payment in full minus the Medicare deductible: $8,000 – $0 = $8,000*

5) *Pay $800 (lowest of amounts in steps 1, 2, 3, or 4)*

First Prior Payer's Abbreviated 835 containing the MSP amounts for MSP calculation:

*CLP*200725638901*1*10000*6000*3000*12*07256000236520**1~*

*CAS*CO*45*1000~*

*CAS*PR*2*3000~*

Second Prior Payer's Abbreviated 835 containing the MSP amounts for MSP calculation:

*CLP*200725638901*1*10000*7200*800*12*07256000236520**1~*

*CAS*CO*45*2000~*

*CAS*PR*2*800~*

Provider Abbreviated Secondary Claim to Medicare

*SBR*P*19*CBAGROUP******CI~*

CAS*CO*45*1000~

*CAS*PR*2*3000~*

*AMT*D*6000~*

*SBR*S*18*ABCGROUP******CI~*

CAS*CO*45*2000~

*CAS*PR*2*800~*

*AMT*D*7200~*

Shared System MSP calculation:

Allowed amount equals submitted charge minus highest CARC 45 adjustments – $10,000 - $2,000 = $8,000.

(NOTE: The allowed amount is shown here and is used for purposes of balancing the remittance advice.)

Since the HI segment (BE qualifier) did not contain OTAF, the CO adjusted amount in the CAS is used to determine the OTAF. The lowest OTAF amount from all the prior payers equals charges minus CO group code adjustments – $10,000-$2,000=$8,000

Medicare Abbreviated 835 to Provider

*CLP*200725638901*2*10000*800**MB*0725600110236520**1~*

*CAS*OA*23*9200~*

Example 3: *The patient receives the same service from the provider.* However, in this case the provider fails to follow plan procedures and is assessed a $500 penalty under the contract for not following plan procedures. Medicare bases its payment on the amount the primary payer would have paid if the provider followed plan procedures.

Medicare Fee schedule *$8,000*

Charges *$10,000*

Payer 1 *Contractual Amount* (OTAF) *$8,000*

Payer 1 CO Plan Procedures not followed *$*500

Payer 1 Patient Responsibility @ 10% *$*750

Payer 1 Payment Amount *$6,750*

The Value Code(s) 44 OTAF amount is found in the HI segment (BE qualifier) on the 837-I and this amount is sent to MSPPAY. If the OTAF is not found in the HI segment (BE qualifier), but there is a group code CO in the CAS, take the charge minus the CO amount and send this amount as the OTAF to MSPPAY. In the case where there are multiple prior payers to Medicare, perform the calculation (the charge minus the CO amount) for each prior payer and send the lowest calculated contractual amount as the OTAF amount to MSPPAY if lower than the charges. The Medicare covered charges or the OTAF amounts are never combined.

Medicare's Payment is calculated in the usual manner:

1) The gross amount payable by Medicare minus applicable Medicare deductible and coinsurance: *$8,000* - *$0* = $*8,000*

2) The gross amount payable by Medicare minus the primary payment: $*8,000 - $7,250* = $750

3) The obligated to accept payment in full minus the primary payment: $*8,000 - $7,250* = $750

4) The obligated to accept payment in full minus the Medicare deductible: $*8,000 – 0 = $8,000*

5) Pay $750 (lowest of amounts in steps 1, 2, 3, or 4)

Primary Payer Abbreviated 835 containing the MSP amounts for MSP calculation:

CLP*200725638901*1*10000*6750*750*12*07256000236520**1~

CAS*CO*45*2000**95*500~

CAS*PR*2*750~

Physician Abbreviated Secondary Claim to Medicare

SBR*P*18*ABCGROUP******CI

CAS*CO*45*2000**95*500~

CAS*PR*2*750~

AMT**D**6750~

Shared System MSP calculation:

Allowed amount equals submitted charge minus CARC 45 adjustments – *$10,000 - $2,000 - $500 = $7500*

OTAF amount equals submitted charge minus CO group code adjustments – *$10,000 -$2,000 = $8,000*

Medicare Abbreviated 835 to Provider

CLP*200725638901*2*10000*750**MB*0725600110236520**1~

CAS*OA*23*9250~