CMS Manual System

Pub. 100-05 Medicare Secondary Payer

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 21 **Date: October 29, 2004**

CHANGE REQUEST 3407

SUBJECT: Instructions on Processing Certain Types of Medicare Secondary Payer (MSP) Claims and to Balance the Outbound Remittance Advice

I. SUMMARY OF CHANGES: Update the manual to reflect instructions cited in CR 2758 (B-03-050) and to instruct the Medicare Carriers, Shared Systems and DMERCs on what amounts to send to MSPPAY and CWF for proper MSP payment calculation and to balance the outbound remittance advice.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/30/30.5/ Instructions to Physicians and Suppliers On How to Submit Claims to a Medicare Carrier When There Are One or More Primary Payers

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-05	Transmittal: 21	Date: October 29, 2004	Change Request 3407

SUBJECT: Instructions on Processing Certain Types of Medicare Secondary Payer (MSP) Claims and to Balance the Outbound Remittance Advice

I. GENERAL INFORMATION

A. Background:

1) Change Requests (CRs) 2050 and 2758 instructed the Part B shared systems and Carriers how to process incoming Medicare Secondary Payer (MSP) claims when there is more than one primary payer. The CRs instructed contractors to combine the other payer paid amounts and send this total to the MSP Payment (MSPPAY) module to calculate Medicare's secondary payment. However, when the Part B shared systems combined the payment amounts, and this amount exceeded the physician or supplier billed amount, the systems received CWF error 95x3 indicating that CWF cannot accept a payment amount that exceeds the billed amount. This CR instructs the shared systems and carriers to send the billed amount as the paid amount to MSPPAY and CWF when the paid amount exceeds the billed amount on MSP claims with one or more primary payers.

2) Carriers and the Part B shared systems ask how to process MSP claims when the 1) the primary payer allowed amount(s) are greater than the billed amount; 2) the primary paid amount(s) are greater than the primary payer contractual amounts (a.k.a. the obligated to accept as payment in full (OTAF) amounts); and 3) the primary paid amount(s) are in excess of the primary allowed amount. When MSP claims of these types are received and processed it causes the outbound remittance advice (RA) to be out of balance. The Health Insurance Portability and Accountability Act provisions state that all claim information sent on an 835-remittance advice must balance. This CR instructs the shared systems and carriers how to balance the outbound 835-remittance advice for the above types of MSP claims.

B. Policy:

The Health Insurance Portability and Accountability Act provisions state that all claim information sent on an 835-remittance advice must balance.

C. Provider Education:

None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3407.1	When the other insurer paid amount, or combined paid amount exceeds the physician or supplier billed amount, the shared systems shall send the billed amount in place of the primary payer's paid amount to MSPPAY and CWF.			X	X		X	X		
3407.2	When the primary payer allowed amount exceeds the physician or supplier's billed amount, the shared systems shall send the billed amount in place of the primary payer allowed amount to MSPPAY.			X	X		X	X		
3407.3	When the primary paid amount is greater than the primary allowed amount, and less than billed charges, the shared systems shall send the primary payer paid amount instead of the primary allowed amount to MSPPAY.			X	X		X	X		
3407.4	When the primary payer paid amount exceeds the primary payer contractual amount, the shared system shall send the primary payer contractual amount instead of the primary payer paid amount to MSPPAY.			X	X		X	X		
3407.5	MSPPAY will calculate and return the calculated amounts to the shared system in the usual manner.			X	X		X	X		
3407.6	Carriers and DMERCs must follow the above business requirements for Hardcopy and electronic MSP claims.			X	X					
3407.7	The remittance advice shall show the billed amount, the Medicare payment amount, and the "impact amounts" from the primary payer(s) on which the Medicare payment is based, and all Medicare adjustments. This amount will depend on the payment methodology followed in the above business requirements.			X	X		X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3407.8	When the primary payment exceeds the billed amount, and Medicare's payment is equal to zero, the outbound 837 shall show Medicare's zero payment in the 2320 AMT segment for the claim level or the 2430 SVD02 if the claim is at the detail. The shared systems shall identify in the CAS segment (the 2320 for claim level and 2430 for the line level) of the outbound 837 the amount that exceeds the billed amount and the reason why Medicare is making a zero payment by using group code and claims adjustment reason code CO 94 (processed in excess of charges), with an accompanied negative dollar amount, and OA 23 (payment adjusted because charges have been paid by another payer) with an accompanied dollar amount.			X	X		X	X		
3407.9	Shared Systems shall no longer use reason code 35 on the outbound remittance advice unless the life time benefit has been reached is the reason the claim is being adjusted. Shared systems instead shall use Group Code "CO" with Reason Code "45" on the outbound remittance advice when the OTAF amount minus the other payer's payment is the lowest of the three MSP calculations and is used to identify Medicare's Secondary payment.			X	X		X	X		

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	MSPPAY will calculate and return the calculated amounts to the shared system in the usual manner. The payment amounts will be based on the MSP amounts sent to MSPPAY by the shared systems.

	No changes to MSPPAY are required.
	The Shared Systems shall reject incoming electronic MSP claims that include multiple primary payers.

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date: April 4, 2005** **Pre-Implementation Contact(s): Richard Mazur, (410) 786-1418, RMazur@cms.hhs.gov** **Post-Implementation Contact(s): Richard Mazur, (410) 786-1418, RMazur@cms.hhs.gov**	**Medicare Contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider Billing Requirements

Table of Contents

Rev. 21, 10-29-04

30.5 - Instructions to Physicians and Suppliers On How to Submit Claims to a Medicare Carrier When There Are *One or More* Primary Payers

(Rev. 21, Issued: 10-29-04, Effective:04-01-05, Implementation: 04-04-05)

AB-03-011 *and B-03-050*

A - When Medicare is the Secondary Payer (MSP) Following One Primary Payer

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. Physicians and suppliers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010A1 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at http://hipaa.wpc-edi.com/HIPAA_40.asp). Physicians and suppliers must follow model 1 in section 1.4.2.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Physicians and suppliers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837 as identified below:

***Primary Payer Paid Amount**:*

For line level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount:

For line level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.

For claim level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF):

For line level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

For claim level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

B - When Medicare is the Secondary Payer Following Multiple Primary Payers

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500. Physicians and suppliers must attach the other payers' EOB, or remittance advice, to the claim when sending it to Medicare for processing.

***C* – Submission of MSP Claims With Multiple Primary Payers Where There is More Than One Insurance Type Code**

When a carrier receives claims with more than one insurance type code, the carrier must send the shared system and CWF the insurance type code associated with the highest other payer total claim payment amount. For example, a Medicare beneficiary sustains injury in a car accident. Five services were performed on the beneficiary. Since the services performed were related to the accident, the automobile insurer (referred to as insurance type code 14) makes a $500.00 payment on each line of the claim totaling $2,500.00. The beneficiary also has coverage through the spouse's employer health plan. The spouse's plan (referred to as insurance type code 12) makes a $400.00 payment on each line of the claim totaling $2000.00. The carrier must send insurance type code 14 (not insurance type code 12) to the shared system and CWF.

D - Amounts Carriers and Shared Systems must send MSPPAY on electronic and paper claims with one or more Primary Payers

There are situations with MSP claims when the 1) the primary payer allowed amount(s) are greater than the billed amount; 2) the primary paid amount(s) are greater than the primary payer contractual amounts (a.k.a. the obligated to accept as payment in full (OTAF) amounts); and 3) the primary paid amount(s) are in excess of the primary allowed amount. When MSP claims of these types are received and processed it causes the outbound remittance advice (RA) to be out of balance. To prevent this from occurring the following actions must be taken:

When the other insurer paid amount, or combined paid amount exceeds the physician or supplier billed amount, the shared systems shall send the billed amount in place of the primary payer's paid amount to MSPPAY and CWF.

When the primary payer allowed amount exceeds the physician or supplier's billed amount, the shared systems shall send the billed amount in place of the primary payer allowed amount to MSPPAY.

When the primary paid amount is greater than the primary allowed amount, and less than billed charges, the shared systems shall send the primary payer paid amount instead of the primary allowed amount to MSPPAY.

When the primary payer paid amount exceeds the primary payer contractual amount, the shared system shall send the primary payer contractual amount instead of the primary payer paid amount to MSPPAY.

The remittance advice shall show the billed amount, the Medicare payment amount, and the "impact amounts" from the primary payer(s) on which the Medicare payment is based, and all Medicare adjustments. The impact amount, as found in 2.2.13 of the 835 Implementation Guide, is defined as the

amount on which Medicare's payment is based. This amount will depend on the payment methodology followed in the above business requirements.

Shared Systems shall no longer use reason code 35 on the outbound remittance advice unless the life time benefit has been reached is the reason the claim is being adjusted. Shared systems instead shall use Group Code "CO" with Reason Code "45" on the outbound remittance advice when the OTAF amount minus the other payer's payment is the lowest of the three MSP calculations and is used to identify Medicare's Secondary payment.

***NOTE:** In regards to the outbound 837, when the primary payment is equal to or exceeds the billed amount, and Medicare's payment is equal to zero, the outbound 837 shall show Medicare's zero payment in the 2320 AMT segment. The shared systems shall identify in the CAS segment of the outbound 837 the amount that exceeds the billed amount and the reason why Medicare is making a zero payment by using group code and claims adjustment reason code CO 94 (processed in excess of charges), with an accompanied negative dollar amount, and OA 23 (payment adjusted because charges have been paid by another payer) with an accompanied negative dollar amount.*

E - When a carrier receives a hard copy claim with multiple primary payer amounts.

Carriers must take into consideration instructions found in 30.5.D above when sending the correct amounts to MSPPAY for payment calculation.

Primary Payer Paid Amounts: For line level service claims, the carrier must add all primary payer paid amounts for that service line and send the total line level payment amount to MSPPAY. If only claim level information is sent to Medicare, the carrier adds all other payer paid amounts for that claim and send the total claim payment amount to MSPPAY. *Note: If the payment amount is greater than the billed amount, send the billed amount to MSPPAY instead of the other payer paid amount.*

Primary Payer Allowed Amount: For line level services, carriers use one of the two fields as follows:

- Either the higher of the allowed amount for that service line, or
- The total of the other payer paid amounts, whichever is higher, and send it to MSPPAY.

If only claim level information is sent to Medicare, carriers use one of the two fields as follows:

- Take the total claim level allowed amount, or
- The total of the paid amount, *if less than the billed amount,* whichever is higher, and send it to MSPPAY.

Obligated to Accept as Payment in Full Amount (OTAF): For line level services, the carrier takes the lowest OTAF amount for that service line, which must be greater than zero, and sends that amount to MSPPAY. If only claim level information is sent to Medicare, the carrier takes the lowest claim level OTAF amount, which must be greater than zero, and sends it to MSPPAY. (**NOTE:** If submitted charges are lower than the OTAF amount, they send the lowest Medicare covered charge for that service line to MSPPAY.

Claim Example:

Below is an example of a hard copy Part B MSP claim, with more than one *primary payer,* sent to a Medicare carrier. All services are Medicare covered services.

Payer 1	**Submitted Covered Charges**	**Other Payer Allowed Amount (Medicare Part B only)**	**OTAF**	**Other Payer Paid Amount**
Line 1	$60.00	$60.00	$50.00	$40.00
Line 2	$40.00	$30.00	$30.00	$30.00
Total	$100.00	$90.00	$80.00	$70.00

Payer 2	**Submitted Covered Charges**	**Other Payer Allowed Amount (Medicare Part B only)**	**OTAF**	**Other Payer Paid Amount**
Line 1	$60.00	$50.00	$50.00	$40.00
Line 2	$40.00	$30.00	$0	$30.00
Total	$100.00	$80.00	$50.00	$70.00

The carrier must send the following line level other payer amounts to MSPPAY based on the instructions cited above.

Line 1:	Other Payer Allowed Amount (Part B):	*$60.00*
	OTAF:	$50.00
	Other Payer Paid Amount:	*$50.00 (the OTAF amount is substituted for line1)*
Line 2	Other Payer Allowed Amount (Part B)	*$40.00*
	OTAF:	$30.00
	Other Payer Paid Amount	*$30.00 (the billed amount is substituted for line1)*

Based on the example above, since Payer 2 had no OTAF amount on service line 2 and Payer 1 had an OTAF amount greater than zero on service line 2, Payer 1's OTAF of $30.00 is used and sent to

MSPPAY. *Since the combined payment amount is higher than the primary payer OTAF amount for Line 1 and line 2, the OTAF amounts are sent to MSPPAY in place of the paid amounts.*